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Extended Research Article

Opportunities and practices supporting responsive health care for forced migrants: lessons from transnational practice and a mixed-methods systematic review

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Abstract

Background: For those displaced across borders, significant adversity before, during and after displacement journeys, including attitudes and structures in countries of transit and arrival, contributes to considerable risk of poor physical and mental health, and poor and exclusionary experiences of health care.

Objectives: We aimed to understand the opportunities and practices that can support better healthcare responses for forced migrants.

Design: We integrated (1) local stakeholder perspectives, from workshops and dialogue; (2) evidence and knowledge from a mixed-methods systematic review; and (3) learning from five case examples from current international practice.

Review methods and data sources: We ran database searches (American Psychological Association PsycINFO, EMBASE, the Cochrane Central Register of Controlled Trials, Cumulative Index to Nursing and Allied Health Literature, MEDLINE, National Institute for Health and Care Research Journals Library) in February 2022, searched relevant agency websites and conducted backward and forward citation searches, extracted data, assessed methodological quality and integrated qualitative and quantitative findings.

Case examples: We studied three services in the UK, one in Belgium and one in Australia, conducting semistructured interviews with providers, collaborators and service users, and making site visits and observations if possible.

Results: The review identified 108 studies. We identified six domains of impact: (1) benefit from and creation of community, including linkages with formal (health) services; (2) the formation of networks of care that included traditional and non-traditional providers; (3) proactive engagement, including conducting care in familiar spaces; (4) considered communication; (5) informed providers and enhanced attitudes; and (6) a right to knowledge (respecting the need of new arrivals for information, knowledge and confidence in local systems). The case examples drew attention to the benefits of a willingness to innovate and work outside existing structures, 'micro-flexibility' in interactions with patients, and the creation of safe spaces to encourage trust in providers. Other positive behaviours included engaging in intercultural exchange, facilitating the connection of people with their cultural sphere (e.g. nationality, language) and a reflexive attitude to the individual and their broader circumstances. Social and political structures can diminish these efforts.

Limitations: Review: wide heterogeneity in study characteristics presented challenges in drawing clear associations from the data. Case examples: we engaged only a small numbers of service users and only with service users from some services.

Conclusions: We found that environments that enable good health and enable people to live lives of meaning are vital. We found that these environments require flexibility and reflexivity in practice, intercultural exchange, humility and a commitment to communication. We suggest that a broader range of caring practitioners can, and should, through intentional and interconnected practice, contribute to the health care of forced migrants. Opening up healthcare systems to include other state actors (e.g. teachers and settlement workers) and a range of non-state actors, who should include community leaders and peers and private players, is a key step in this process.

Future work: Future work should focus on the health and health service implications of immigration practices, the inclusion of peers in a range of healthcare roles, alliance-building across unlikely collaborators and the embedding of intercultural exchange in practice.

Study registration: This study is registered as PROSPERO (CRD42021271464).

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Supplementary material can be found on the NIHR Journals Library report page (https://doi.org/10.3310/MRWK3419).

Supplementary material has been provided by the authors to support the report and any files provided at submission will have been seen by peer reviewers, but not extensively reviewed. Any supplementary material provided at a later stage in the process may not have been peer reviewed.

Glossary

Access to care We based our interpretation of access largely on Saurman's (Saurman E. Improving access: modifying Penchansky and Thomas's Theory of Access. *J Health Serv Res Pol* 2016;**21**:36–9. https://doi.org/10.1177/1355819615600001) modified theory of access originally proposed by Penchansky and Thomas (Penchansky R, Thomas JW. The concept of access: definition and relationship to consumer satisfaction. *Med Care* 1981;**19**:127–40. https://doi.org/10.1097/00005650-198102000-00001). This is loosely considered as 'the degree of fit between the user and the service' (Saurman E. Improving access: modifying Penchansky and Thomas's Theory of Access. *J Health Serv Res Pol* 2016;**21**:36–9. https://doi.org/10.1177/1355819615600001) and can be thought about in relation to the following independent but interconnected domains:

> **Acceptability** The alignment of knowledge, attitudes and characteristics between a service and a patient's social or cultural concerns (such as the language, communication, cultural and experiential considerations and attitudes shown by workers) and the usefulness and relevance of a service.
> **Adequacy of accommodation** The design and the usability of a service, including appointment structures and administrative procedures (we also considered this issue as it relates to systems and intersectoral requirements).
> **Affordability** Direct or indirect costs to patients.
> **Availability** Sufficient resources to meet patient needs.
> **Awareness** Awareness of health resources, including the effectiveness of communication and information strategies and how well these consider context, knowledge and literacy.
> **Physical access** Physical location, proximity and journeying.
> **Health agency*** People have the capacity (the tools and the right conditions) to access care. *We add to the above attention to health agency to acknowledge the broader conditions and context in which forced migrants are located and the more nuanced barriers impacting access (Nussbaum M. *Creating Capabilities: The Human Development Approach*. Cambridge, MA: Belknap Press; 2011), such as confidence, a lack of trust, certain knowledge, stigmatising beliefs or attitudes to seeking help. Although this could be interpreted very broadly, we attempt to keep the focus as it directly links to a health need.

Caring practitioners We use the term 'practitioners' and later 'caring practitioners' to refer to anyone who may be in a position to acknowledge, notice or support health care for forced migrants. We suggest that this term includes a comprehensive range of people who may be in traditional healthcare roles, such as general practitioners, nurses, healthcare assistants and allied workers, to people in gatekeeping roles of those services, such as receptionists, to those in other providers, such as housing services, schools, settlement services, community organisations, neighbourhood volunteers, and faith and multicultural communities. We would also include here roles such as interpreters, legal advisers, employment officers and language tutors.

Forced migrants We acknowledge that forced migrants are a heterogeneous group but use this as a collective term to refer to people who have been forcibly displaced and cannot return home safely due to fear of persecution for reasons of race, religion, nationality or membership of a particular social group or political opinion (UNHCR. *The 1951 Refugee Convention*. UNHCR. URL: www.unhcr.org/about-unhcr/who-we-are/1951-refugee-convention). We include here people who may be described as asylum seekers, refused asylum seekers, refugees, undocumented people and unaccompanied asylum seekers, children or young people. We do this while also acknowledging the risk of arbitrary categorisation, the absence of agreement on where the line between voluntary and forced migration may be drawn (Fiddian-Qasmiyeh E, Loescher G, Long K, Sigona NE. *The Oxford Handbook of Refugee and Forced Migration Studies*. Oxford: Oxford University Press; 2014) and that each of these classifications is recognised by nation states in different ways with associated rights, access to care and consequential adversities faced.

List of abbreviations

A&E	accident and emergency department
ASD	autism spectrum disorder
CAMHS	Child and Adolescent Mental Health Service
EMDR	eye movement desensitisation and reprocessing
ESOL	English for speakers of other languages
GP	general practitioner
HARP	Health Access for Refugees Programme
IOM	International Organization for Migration
IQR	interquartile range
JBI	Joanna Briggs Institute
MORRA	Moments of Opportunity for Responsive health care for Refugees and people seeking Asylum
NGO	non-governmental organisation
NIHR	National Institute of Health and Care Research
PACCT	Psychiatry Assisting a Cultural diverse Community in creating healing Ties
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
PTSD	post-traumatic stress disorder
RCT	randomised control trial
TB	tuberculosis
WHO	World Health Organization

Plain language summary

Our question

How can we improve and shape health care to better respond to refugee and asylum-seeking communities?

What we did

We (1) gathered the views of local refugee and asylum-seeking communities, healthcare staff and other stakeholders (such as council and community workers) about their ideas for improvements in healthcare provision; (2) searched for research articles on our topic and summarised the evidence; (3) sought current examples of high-quality health services for people who are refugees or seeking asylum to find out how they worked and what we could learn from them.

What we found

Our summary of the research articles showed that refugee and asylum-seeking communities benefit from health services that:

- deliver care in groups and in places that are familiar
- support understanding and confidence in local systems
- are delivered by people who they trust, who have some shared understanding or interest in refugee experiences and different cultures or a shared language.

The case study services showed:

- a willingness to try new ways of working
- that creating welcoming spaces and building trust with patients is possible
- the importance of showing an interest and taking action in relation to someone's health and their interests, hopes and broader situation
- that a total commitment to communicating well, using good interpreters, and sometimes bilingual workers and peers, was essential.

Our learning from stakeholders informed our research decisions and was incorporated into a map of important healthcare people and places and a table of possible responsive healthcare actions.

Conclusions

Our study showed that health care must be flexible, be interested in individuals and culture, committed to communication and learning, and support people to live meaningful lives. We recommend that a wide range of traditional and non-traditional health providers, such as community leaders, peers, schools and settlement services, work together to improve care.

Scientific summary

Background

During 2022, a record 103 million people were forcibly displaced inside or across borders worldwide. In the UK, although numbers are low in relation to other comparable economies, in the 12 months to September 2022, 85,902 people sought asylum, 143,377 people were awaiting an initial decision, 17,378 people received refugee or alternative forms of humanitarian protection, 213,307 Ukrainian refugees were granted visas under the Ukraine Family and Ukraine Sponsorship schemes, and an estimated half a million undocumented migrants were living in the UK.

For those seeking and receiving asylum, a complex set of interconnecting adversities, before, during and after arrival in receiving countries produce significant risks to poor health. Beginning with the original persecution or exposure to war and violence that typically drive displacement, adversities include risks of trafficking, precarity and trauma throughout the displacement journey, isolation and difficult experiences adapting to a new dominant culture, and the prevailing attitudes and structures in transit and receiving countries. These factors are often paid limited attention in the settlement context, despite heavy evidence that compared with native-born populations, forced migrants typically face a greater risk of diverse and comorbid health conditions, including infectious, cardiovascular and chronic respiratory diseases, cancers, and diabetes, and an increased risk of developing poor mental health.

Postmigration stressors are complex and intersecting, and when it comes to navigating and negotiating access to health care in settlement or receiving country contexts, studies increasingly highlight poor experiences and substantial barriers. This aligns with broader evidence that public systems rely heavily on individual agency, provide best for those with minimal needs and are in a position to shape, frame and reproduce inequalities. While international human rights law provides us with an ethical framework in which to recognise rights to health care and to the social and material conditions for good health, health and care practices are often neither sufficiently responsive nor adequately equipped to ensure quality care for forced-migrant communities.

Aims and objectives

This project aimed to integrate evidence and knowledge about interventions and practices that support responsive health care and improved health agency for forced migrants across different healthcare moments of opportunity. We considered three key questions:

1. What are the healthcare moments of opportunity for forced-migrant communities?
2. What practices and models could be used in these moments of opportunity to support responsive health care and improved health for forced-migrant communities?
3. How can these practices and models be integrated into UK health and civil society systems?

Our objectives were to undertake:

1. Stakeholder engagement and dialogue to support: (1) the identification of existing and potential moments of opportunity; and (2) community and service priorities in (responsive) health care for forced-migrant communities.
2. A systematic search, data extraction and quality appraisal of published peer-reviewed and ‘grey’ literature.
3. Identification of and the collection of data from, existing international examples (case studies) of services taking active measures in improving access to care for forced migrants.
4. A synthesis of findings through attention to the capabilities framework and a further process of engagement and dialogue between and with important stakeholders resulting in a guiding framework that provides a set of core principles and considerations in the delivery of a responsive system of health care for forced-migrant communities.

Approach 1. Workshops and stakeholder engagement

We held two cross-community workshops with adult forced migrants who had been in the UK for between 3 months and 4 years. We conducted many individual conversations and one online group conversation with stakeholders from health, social care, voluntary, faith, and local authority groups and services. We documented key concerns, priorities and ideas for health care for forced-migrant communities. This intelligence helped to inform our systematic review, the qualitative data collection and understanding of local issues.

Approach 2. Systematic review

Methods

We conducted a mixed-methods convergent integrated systematic review. We included experimental and observational studies, qualitative studies and primary mixed-method studies allowing us to draw on the strength of the different constituent research approaches to produce a broad conceptualisation of evidence, deemed especially useful in the case of complex interventions or complex systems. We included studies conducted in any country and in any language. We included studies with two types of participant: (1) adults or children who are forced migrants; and (2) participants who are relevant to a healthcare 'moment of opportunity' for a forced migrant; this included any worker (voluntary or paid, professional or lay) who could play an instrumental role in supporting healthcare access and healthcare experiences. We included studies that aimed to deliver responsive health care for forced migrants. We included studies only where this aim was clearly captured within the stated aims and objectives of the study (not intervention). We included studies regardless of outcome measures, but considered outcomes based on three criteria, namely whether they reported a direct measure of access (e.g. quality of communication, acceptability or appropriateness), a proxy measure of access (e.g. knowledge gain from a practice improvement training programme, such as on cultural awareness as reported by workers) or no measure of access (e.g. a clinical/psychosocial measure only). We searched the American Psychological Association PsycINFO (OVID Technologies 1967–), EMBASE (OVID), the Cochrane Central Register of Controlled Trials, Cumulative Index to Nursing and Allied Health Literature (EBSCO Publishing 1994–), MEDLINE (Ovid Technologies Inc. 1996–), applying no restrictions on language or publication status, from inception to 28 February 2022. This was supplemented by a grey literature search of relevant material, and forward and backward citation searches. We assessed methodological quality using the study design-specific tools from the Joanna Briggs Institute and developed an additional assessment tool to allow the explicit consideration of appropriateness of interventions for cross-cultural settings. We 'qualitised' relevant quantitative data by translating these findings into textual descriptions. These findings were pooled with the textual summaries of qualitative findings and examined and categorised through a framework synthesis approach to data analysis. We conducted a thematic synthesis of intervention and practice designs, in what we saw as their critical features as they related to aspects of access.

Results

A total 108 studies were selected for inclusion. Most (72) were judged to be of high quality. Forced-migrant participants were drawn from most continents of the world. Most interventions related to mental health. There was substantial heterogeneity in the design of interventions and practices, the health and institutional contexts of interventions, the participant groups and reported outcomes. Outcomes fell into a number of distinct domains, including acceptability, awareness and health agency. Direct measures of access were reported in 64 studies, proxy measures in 48, and 15 studies reported no measure of access. Consistent with our focus on responsive care, we sought within the descriptions of the interventions or service practices to identify any actions that might foster a responsiveness to the needs and contexts of the study population. We identified that programmes of care were overwhelmingly informed by multiple knowledges and perspectives (collaboration, published evidence, experts). The majority of studies also described practices that had recognised language and communication, displacement (and settlement) experiences, potential disconnects between the cultural traditions, values and expectations of arriving and local societies, the broader systems in which participants or services were located, and a set of resource practices and mechanisms for reaching people, namely engaging with, and seeking representation from, communities. We further identified six domains of impact of interventions: (1) the benefit from and creation of community, including linkages with formal (health) services; (2) the formation of networks of care that included traditional and non-traditional healthcare providers; (3) proactive engagement, including conducting care in familiar spaces; (4) considered communication, particularly relating to the

benefits of bilingual workers; (5) informed providers and attitudes that saw improved knowledge and compassion; and (6) a right to knowledge that identified the importance of respecting the need of new arrivals for information, knowledge and confidence in local systems, including normalising and understanding the impacts of experiences of war.

Approach 3. Case study enquiry

Methods

Maintaining our broad view of evidence we concurrently identified examples of relevant interventions and models of care in current practice, globally, that were taking active steps to improve access to care for forced migrants. We intentionally sought variability through different contexts, characteristics and models of care. We used case study methodology to understand possibilities and practices in responsive care and located these within the different local knowledges, experiences, skills and attributes of workers alongside the experiences of those engaging in services. We also took into account the broader institutional and political contexts in which this all takes place. We conducted semistructured interviews with providers, collaborators and service users, face to face or remotely, and one to one or as part of a small group interview. For UK settings, we made site visits and conducted short-term observation of clinics, where appropriate, and provider settings. Visits and observations served to broaden our understanding of the local contexts, providing the opportunity to acquire the tacit knowledge that can be drawn from observing workers' personal qualities, the range of interactions taking place within any given space, the informal reflexive perceptions and insights between participants and researchers, bringing a vital aspect to our enquiry. We reviewed service information and evaluations where available. Qualitative evidence, including field notes and documents, was combined in a broad thematic analysis.

Results

Five sites were identified from a 'long list' of more than 80. Three were in the UK: (1) a non-clinical outreach advocacy, education and support service helping to improve access to state healthcare systems; (2) a community-based, holistic health screening and care planning service; and (3) an inclusion health general practitioner and well-being service that includes holistic health screening. One was in Belgium (a stepped-care mental health service taking a human rights, transcultural and community approach to mental health care) and one in Victoria, Australia (a nurse-led service providing holistic health assessments and care co-ordination for patients with complex needs). Our exploration of these services provides a resource of contrasting services that each demonstrates what is possible in the health care of forced migrants. Taken together, however, the services show a willingness to innovate and work outside existing structures, a complementary 'micro-flexibility' in their interactions with patients and clients, and the creation of safe spaces to encourage trust in providers. A further subset of active behaviours was identified: engaging in intercultural exchange (navigating with humility, interest and reflexivity different perceptions); facilitating the connection of people within their cultural sphere (faith, nationality, experiences, language, gender); a focus on the individual; and a reflexive attitude to the individual and their broader circumstances.

Synthesis of findings

We synthesised the three approaches to our study with attention to Nussbaum and Sen's capabilities framework and ideas of health justice, as discussed by Venkatapuram (Venkatapuram S. *Health Justice: An Argument from the Capabilities Approach*. Cambridge: Polity Press; 2011), to a 'capability to be healthy'. We developed a tentative set of responsive principles, which we explored through four stakeholder 'conversations'. We saw this as a further form of evidence synthesis that could help to 'transform' and root the research findings through the exchange of reflections, ideas, insights and evidence in the context of the social, cultural and structural realities in which contributors were located. Overall, we found that environments that enable good health and enable people to live lives of meaning are of vital importance. We identified responsive healthcare spaces as spaces in which flexibility and reflexivity is nurtured, in which communication is prioritised and where there is a radical commitment to intercultural exchange that begins from a place of humility and that uses shared communities as spaces of trust and conduits to broader societal bridges and formal care. We found that these elements are supported by a 'linked-up-ness' between a range of unlikely collaborators and a deep commitment to interprofessionality and interconnectivity between public, community and

private players and services. For those in protracted asylum and immigration system contexts particularly, we have identified a systems battle that is in constant tension with services driving a community of care. While we found that these systems are permeable, the combination of dehumanising immigration regimes, implicit or active exclusion from state structures, and lack of accountability as to where the responsibility for the health and well-being of refugees and people seeking asylum is located, constrains capabilities for health and is likely to waste human and material resources within healthcare systems as well.

Recommendations for future research

Our key research recommendations are as follows. At policy level, we suggest a rapid, cross-sector review of the health and health service implications of existing and proposed immigration practices and their implications in the short, medium and longer terms. For refugee communities, we suggest that there should be further exploration of the role and training of non-specialist peers in healthcare practice in a range of facilitative and delivery roles, including translation. For practitioners, we suggest that research is conducted to better understand: (1) how we motivate, engage and leverage alliance-building relationships across a broad constituency of caring practitioners; and (2) the models and possibilities for embedding intercultural exchange, competencies and reflexivities in both professional education and professional practice.

Conclusion

Our study poses important questions around local and national capacity to dismantle some of the structures, institutional behaviours and ideas that affirm the current experience of healthcare contexts for forced migrants. At the same time, we have shown that it is feasible within a range of organisational contexts for healthcare practice to do this. To our knowledge, it has not previously been recognised how broad a range of caring practitioners and agencies can, and should, through intentional and interconnected practice, contribute to the health care of forced migrants. Opening up healthcare systems to include other state actors, such as teachers and settlement workers, and a range of non-state actors, who should include religious and ethnic community leaders, is a key step in this process. We argue that community is and should be prioritised as a conduit for engagement in a range of healthcare provision, benefiting important social connections and bridging access to statutory care. Refugee patients and communities should be seen as partners in their care deserving of knowledge, skills and confidence in healthcare navigation and psychoeducation, particularly as it relates to normalising responses to war and settlement stressors. An appetite for a networked community of knowledgeable healthcare providers should be recognised and enabled through broad, reflexive and considered programmes of collaborative and informed practice.

Study registration

This study is registered as PROSPERO (CRD42021271464).

Funding

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Everyday healthcare encounters

These are comments made by a number of people with whom we talked during this study. They were all seeking asylum in the UK. We did not intentionally seek to explore existing experiences but these were commonly shared and repeated. We include these comments here as a forward to this research because these words provide a short but visceral account of some of the everyday healthcare encounters many forced migrants describe.

This is about the man from Yemen, with an 'idea of the British to be polite but it's not … Yemen was better even with the war … friendly but not here … even if they have no resources, doctors from all sorts of countries, they are better than this, *they care*'.

This is about the patient who has walked 3700 miles for 2.5 years, his greeting from the NHS, 'you have 10 minutes'.

This is about the young men who see the doctor take the 'easy solution', prescribe 'benzos' 'sleeping pills' without knowing or understanding their situation, 'too quick … to prescribe psychology medicine'. 'Dazed' 'I can do little but lie in bed all day. It has been months. Day in, day out'. 'Fear of addiction'.

This is about the man from Iran who walks away from the general practice reception because the receptionist does not understand, 'doesn't want to help' … flailing arms tell him the only thing to do is to leave without receiving care.

This is about the patient who feels that the health service is 'very, very much not friendly and I think that maybe, intentionally, that they're trying to really bother us asylum seekers'.

Chapter 1 Background

Introduction

By the end of 2022, a record 108 million people were forcibly displaced inside or across borders worldwide.[2] Although numbers are low in relation to other comparable economies, in the 12 months to September 2022, 85,902 people sought asylum in the UK, 143,377 people were awaiting an initial decision, 17,378 people received refugee or alternative forms of humanitarian protection, 213,307 Ukrainian refugees were granted visas under the Ukraine Family and Ukraine Sponsorship schemes,[3] and an estimate of more than half a million undocumented migrants[4] were living in the UK.

For those seeking and receiving asylum, a complex set of interconnecting adversities, before, during and after arrival in receiving countries, produce significant vulnerabilities to poor health.[5] Beginning with the original persecution or exposure to war and violence that typically drive displacement, adversities include risks of trafficking, precarity and trauma throughout the displacement journey, isolation and difficult experiences adapting to a new dominant culture,[6] and the prevailing attitudes and structures in transit and arrival countries.[7,8] These factors are often paid limited attention in the settlement context despite heavy evidence that, compared with native-born populations, forced migrants typically face a greater risk of diverse and comorbid health conditions, including infectious, cardiovascular and chronic respiratory diseases, cancers and diabetes,[8–10] and an increased risk of developing poor mental health, including post-traumatic stress disorders (PTSDs).[10,11]

Postmigration stressors are complex and intersecting. Public policy shapes, frames and produces inequalities,[12] and is often charged with legitimising and encouraging racism and xenophobia[13] through the explicit delivery or interpretation[14] of policies of *hostility*. These stressors have direct and more nuanced impacts on health and access to care for refugee and other minoritised populations,[15,16] through conscious and unconscious prejudice and through forms of 'street-level bureaucracy'[17] that can perform as everyday bordering in public sector healthcare settings. Immigration procedures and uncertainty,[18] detainment, the adultification of young males[19] and (vulnerable) children,[20] hierarchies of deservingness,[21] threats of deportation and significant waits for asylum decisions,[22,23] repeated relocation[24] and charging policies all amplify anxiety and stress, deter people from seeking health care and erode trust in public services.[25–27] Spatial influences such as pseudo-incarceration, confinement to cramped and isolated contingency spaces such as hostels and hotels with limited or no access to health and other services,[28] green space, recreational space, private space and spaces to congregate, or access opportunities for community and religious connections and support networks, often for months and increasingly years,[23] can play a determinant role in health and help-seeking.[24,29] Restrictive policies including on employment and securing comparative work, limit ambitions and attachment to valued social roles, compounding the likelihood of poor socioeconomic conditions, acting as a further threshold to adequate health care.[30]

Broader acculturative issues associated with moving into settlement spaces see language barriers not only presenting as communication challenges in the development of social connections and local knowledge, but also undermining the accessibility and quality of healthcare provision.[31] Loss, mourning and change to family dynamics, including fear for those left behind, can also influence engagement in society and help-seeking behaviours. Traditional practices, cultures and values in tension with new local spaces can, for example, present difficulties in relation to child-rearing strategies, driving mistrust between forced-migrant communities and statutory services, as well as driving intergenerational tensions, as children more easily assimilate to local contexts through socialisation systems such as schools.[32] Altered roles, fragile social status, cultural isolation, including socioreligious aspects, are described as reducing a sense of self, further contributing to accumulative stress,[33] markers for anxiety and depression,[34] and reducing capabilities in managing health conditions. A disconnection from religious networks, especially, can reduce trusted (and often traditional sources of) social support, further contributing to a cycle of poor health that is both fed by and feeds low

social participation.[35,36] For children especially, caregiver mental health becomes increasingly influential to a child's emotional and behavioural responses during and following displacement.[37]

When it comes to navigating and negotiating access to primary and secondary care, studies increasingly highlight poor experiences and substantial barriers,[24,38–40] aligning with broader evidence that public systems rely heavily on individual agency and provide best for those with minimal needs.[41,42] Indeed health systems are often charged with being designed for a dominant majority[43] that assumes healthcare services and healthcare users share a language and common culture and struggle to be flexible to an ever-increasing expansion of divergent, minoritised and socioculturally diverse native and immigrant populations. A growing focus on intersectionality as a theoretical framework to democratise public health[44] and engage head-on with discussions that bring to surface oppressions that potentially damage healthcare interactions[45] for those at the intersection of different marginalised experiences, including race, gender, sexuality and (dis)ability forces some engagement in this issue. One aspect of this encourages greater understanding and attentiveness to the intersecting factors influencing someone's context and specific experiences of advantage and disadvantage.[46] Arguably, however, as a general rule, there is currently limited scope or priority given to enhancing the understanding of care providers in relation to refugee health and the experiences of those seeking asylum,[38] despite the repercussions of knowledge limitations and cultural incompatibilities that at the most basic level often result in providers failing to recognise fundamental rights to care.[47–49]

In a more nuanced capacity, knowledge of the complexity of forced migration and its impact on individuals and their context is further limited by systemic factors such as appointment structures that rarely account for high levels of complex needs, specialist referrals and time for translation.[40,50] Translation itself and communication is frequently reported as poor,[44] immediately informing first encounters, which are well documented as being crucial to later events.[39,51,52] Skills in operating in cross-cultural interactions,[53] including awareness of cultural variations in symptom expression and treatment-seeking,[54] the use of diagnostic instruments and delivery of care that is both clinically and culturally informed, are limited and not prioritised.[39,55–57] Further still, little attention is given to securing new knowledge and understanding for new arrivals in health systems, including general practitioner (GP) registration, access to specialist care and medication,[24] healthcare rights and charging practices.[21]

This extensive range of factors associated with language, culture, knowledge, gender, race and citizenship create, replicate or uphold a complex set of adversities across healthcare spaces for forced-migrant communities that enable the denial of care,[3] inappropriate care encounters that compromise the quality of care[56] (including increased risk of medical errors),[58] reduce patient satisfaction and trust,[59] and lead to the avoidance or disengagement from care,[60] increased acute presentations, contribute to poor health outcomes and have long-term impacts on individuals and care systems.[50,61]

Rationale

Good health allows us to play an active part in society; it supports the capacity to engage in everyday activities and social relationships and to be economically active.[62] Conversely, poor health has consequences for individuals and for society, including lower social cohesion, discrimination and barriers to accessing and sustaining good employment.[30,63] Yet, while international human rights law provides us with an ethical framework in which to recognise rights to health care and rights to the social and material conditions for good health,[64] health and care practices are too often neither responsive nor equipped to ensure quality care for forced-migrant communities.[38,53]

There have been increasing calls from prominent bodies to centre the inclusion of migrants' health within regional and national health strategies,[65] including 'equitable access to universal health coverage', the adoption of refugee- and migrant-sensitive health systems and interventions,[47] the identification of 'good practice examples to demonstrate solutions to some of the barriers posed',[66] and to take a broad community focus, which includes education and workplace settings, in supporting the (mental) health of those displaced by war and violent conflict.[67] Although a number of toolkits have now been published aimed at specific provider groups such as GPs,[68] doctors[69] and maternity services,[70] there remains no framework around which forced-migrant health care might be considered. It is this absence of a guiding framework and understanding of the range of practical actions in responsive health care for forced-migrant communities that this study has aimed to address.

Although this study is concerned primarily with healthcare responses rather than with the intersection of a range of determinants of health, the evidence indicates that broader conditions and the spaces in which forced migrants are often located can be neither detached from healthcare approaches nor fully engaged by direct healthcare providers alone. As such, this study takes a broad approach to considering the healthcare opportunities that occur both within traditional healthcare provider encounters and beyond, placing the responsibility of responsive practice right across the public domain.

Theoretical framework

Different frames of reference encourage us to think about broader conditions and contexts when considering healthcare opportunities for people with refugee backgrounds. The responsibility of receiving societies in shaping refugee integration opportunities,[71] the hegemony inherent in the design of existing provision, which is in tension with a care system that might hope to be responsive and equitable to a diverse public,[72] and ecological[73] and social justice[74] perspectives that aim to force concern with the contextual realities in which a person is located, consider broader stressors, community and social connections and challenge the exclusionary measures and restrictive policies inherent in public service responses. Broadly, these are lines of thinking with which we have approached this research.

This study took a mixed-methods approach combining (approach 1) participatory aspects and community engagement with empirical evidence through (approach 2) a mixed-methods systematic review and (approach 3) a qualitative analysis of five contemporary case studies. The systematic review and case studies ran concurrently and independently of one another but were continually informed by ongoing engagement with people with a refugee background, refugee and asylum-seeker support services, and health and other public service providers. Results of each strand were analysed independently before being synthesised and discussed with a range of critical stakeholders. These conversations informed our framing of study findings and recommendations.

This combined approach aimed to provide an interpretation of responsive health care from a range of epistemological perspectives,[75] which included an explorative attitude and the active pursuit of a community of inquiry[76] aligned with ideas of pragmatism and 'practical usefulness' that attempted to bridge different practice worlds (academic, clinical, social, community).

Although our methodology is neither participatory nor action research, we have borrowed aspects of these methods, working with a multisector team, working closely with a community researcher on most aspects of our case study methods and carrying out heavy stakeholder engagement. As such, there was a broad attempt to soften the boundaries in terms of a research team with an entirely externalist, 'spectator' position[77] and, although we cannot argue democracy between different contributors, there was concerted attempt at inclusivity, one of the principles of participatory research.[78]

Approach 1

Our programme of work began with three cross-community workshops and a series of one-to-one conversations with important stakeholders in North West England. These stakeholders represented different forced-migrant communities, public service individuals from regional and local bodies and services including primary and secondary care health services, pharmacy providers, social care and public health teams, police teams, accommodation services, and community organisations and civil society groups. These workshops and conversations focused around health encounters (within and outside typical healthcare settings) and were used to help ground the work in both the needs of forced-migrant communities and those of (caring) practitioners in the field. We encouraged individuals to reflect on their healthcare journeys and the received or missed opportunities for care, and practitioners to reflect on their existing practice, the broader local context, experiences and challenges in healthcare encounters, service priorities and expectations, and proposals and ideas people had for responsive care. Outputs from this early engagement helped to refine our focus for both the systematic review and our case study methodologies and provided an early map on which we have continued to identify wide-reaching moments of opportunity in which responsive healthcare practices can or could be located.

Approach 2

To understand what is already known on the topic, we conducted a mixed-methods systematic review to enable us to identify and appraise available peer-reviewed and grey literature on interventions and practices that explicitly aimed to support access to health care for forced-migrant communities. A mixed-methods approach can bring interpretive and critical contributions, drawing on the strengths of quantitative and qualitative methodologies and broaden the conceptualisation of evidence to produce more informative conclusions[79] particularly in the case of complex interventions or complex systems, enhancing the usefulness of findings to a range of decision-makers and workers.[80] We conducted a thematic synthesis of intervention and practice designs, in what we saw as their critical features as they related to aspects of access,[81] and where outcomes provided direct or proxy measures of access to health care (see *Glossary*) we conducted meta-synthesis following the Joanna Briggs Institute (JBI) integrative approach to mixed-methods systematic reviews.[79] This is an interpretative approach that allowed us to account for the high degree of heterogeneity between included studies and to remain sensitive to the contextual nature of qualitative research, the aims of our research,[82] and our objective of 'practical usefulness'.[83]

Approach 3

Maintaining our broad view of evidence,[84] we concurrently identified examples of relevant interventions and models of care in current practice (globally) that were taking active steps to improve access to care for forced migrants. We used case study methodology to understand possibilities and practices in responsive care and located these within the different local knowledges, experiences, skills and attributes of workers alongside the experiences of those engaging in services while also taking account of the broader institutional, political and community contexts in which this all takes place. We conducted semistructured interviews with providers, collaborators and service users, face to face or remotely, and one to one or as part of a small group. These allowed us to gain insights from a range of individuals about everyday experiences and practices, the subjective value, essential aspects and contributions individuals attributed to each service, and the further developments in care that were seen to be important. For UK settings, we made site visits and conducted short-term observation of clinics and provider settings, where appropriate. Visits and observations served to broaden our understanding of the local contexts, providing the opportunity to acquire the tacit knowledge that can be drawn from observing workers personal qualities, the range of interactions taking place within a given space[85] and the informal reflexive perceptions and insights between participants and researcher,[86] bringing a vital aspect to our enquiry.[75,87] We collected documents such as service information and evaluations where available. Qualitative evidence, including field notes and documents, was combined in a broad thematic analysis.[88]

Synthesis

We synthesised the different strands of our research with attention to Nussbaum[43] and Sen's[89] Capability Framework and ideas of health justice and a 'capability to be healthy', as discussed by Venkatapuram.[90] We considered how far the practices identified throughout the research went in recognising the dynamic, reflexive and iterative processes that influence this capability, which Venkatapuram suggests involves the intersection of an individuals' personal features or needs, their agency, and their surrounding social and physical conditions.

We developed a tentative set of responsive principles, which we explored through a series of stakeholder conversations. We saw this as a further form of evidence synthesis that could help to 'transform'[91] and root the research findings through the exchange of reflections, ideas, insights and evidence in the context of the social, cultural and structural realities in which each contributor exists. This provided a tangible learning and reflective experience and helped to determine better how the evidence gathered throughout the project could be constructed and fostered in practice.

Research questions and aims

This project aimed to integrate evidence and knowledge on interventions and practices that support responsive health care and improved health agency for forced migrants across different healthcare moments of opportunity. We did this through the unique integration of community and stakeholder engagement and dialogue, a mixed-methods systematic review and examination of contexts and experiences within current practice examples.

Throughout this process, we considered three key questions:

1. What are the healthcare 'moments of opportunity' for forced-migrant communities?
2. What practices and models could be used in these moments of opportunity to support responsive health care and improved health for forced-migrant communities?
3. How can these practices and models be integrated into UK health and civil society systems?

Objectives

Our research plan incorporated the following objectives:

- Stakeholder engagement and dialogue to support the identification of existing and potential moments of opportunity and community and service priorities in (responsive) health care for forced-migrant communities.
- A systematic search that included data extraction from, and quality appraisal of, published peer-reviewed and grey literature.
- Identification of, and the collection of data from, existing practical examples (case studies) of services taking active measures in improving access to care for forced migrants, globally.
- Synthesis of findings through attention to the capabilities framework[43,90] and a further process of engagement and dialogue between and with important stakeholders.
- Production of a guiding framework that provides a set of core principles and considerations in the delivery of a responsive system of health care for forced-migrant communities.

Chapter 2 Approach 1. Cross-community and interprofessional workshop: what are the healthcare moments of opportunity for forced-migrant communities?

We took the view that healthcare moments of opportunity occur both within and beyond the traditional health practitioner exchange and sought to begin to map and seek wide-ranging input on where these moments might be located for forced-migrant populations. It was important for us to understand who is significant in those encounters, what actions do or could take place, what impacts occur or could occur, and what challenges there might be to using these as opportunities for health.

To begin to explore some of these questions, we conducted three cross-community workshops and a series of one-to-one conversations with important stakeholders in North West England. This would help inform the scope of our systematic review, our qualitative data collection and our final framing of findings. Stakeholders included members of local forced-migrant communities and people from state and non-state services, organisations and agencies who have some form of encounter (human, informational or policy) with forced migrants in the area.

Workshops with forced-migrant communities

We held two workshops with two groups of adult forced migrants (23 individuals) in two different towns between August and November 2021. Most attendees were in the UK with some members of their family and many had children. Individuals had arrived from a range of countries including Afghanistan, Albania, Iraq, Russia, Sudan and Syria. One group included people who had arrived only through resettlement routes, while the other included predominantly people who had travelled by informal routes to the UK, of whom the majority remained within the asylum system. People had been in the UK for between 3 months and 4 years. There was an equal balance of genders in both groups, but a slight bias in language, in that, in one group, most people had some or good spoken and written English.

Workshops took place in a faith space and a school (both spaces were familiar to some attendees). We involved professional and/or informal interpreters in both sessions who were generally known to those attending. A Kurdish and a Syrian meal were provided during or after the events and participants received a small voucher. Both workshops lasted approximately 3 hours.

We used the analogy of a *river* as someone's health or healthcare journey, *boulders* as obstacles or problems arising, *calm* when things were going okay, *rapids* when things were high stress, and *life rings* as good encounters or help. *Hazards* (boulders; rapids) were seen as opportunities where things could have been better. We attempted to use these analogies and discussion to explore with attendees what is going on when *hazards* occur, what people felt could have happened differently at those points (or earlier upstream) and who or what was being seen as a lifeline or support. We also encouraged conversation around what people felt mattered most in relation to their health.

Workshops and conversations with other stakeholders

We spoke with people in frontline and management, voluntary and paid roles, from a range of providers and agencies including maternity, accident and emergency departments (A&E), general practice, pharmacy, language support services [English for speakers of other languages (ESOL) and interpreters], police services, regional migration and public health agencies, health and social care commissioners, state refugee integration and resettlement teams, accommodation and housing providers, voluntary and community and some state health advocacy services, women's, well-being and migrant groups, and faith, multicultural and equality groups and services.

Although we saw engaging education, welfare benefit and employment services as important, we were not successful in engaging these services. We also struggled to engage with some health teams. We conducted one online group conversation in October 2021 and a series of individual conversations with those who could not attend. In our conversations, we encouraged people to think about:

1. existing encounters with forced-migrant communities
2. ideas and suggestions of what else could be possible and what this would require
3. service priorities
4. interdependencies with other colleagues or organisations that are critical to existing encounters or future ideas

Community perspectives

Our main learning from these events is incorporated into the map of players (opportunities) and table of responsive and potential responsive mechanisms actions. In addition, we talked about a range of priorities from different perspectives that were seen as important issues relating to forced-migrant health. Although many were described, some were more frequently discussed:

- the importance of good health for daily life (forced-migrant communities)
- that doctors provide information about a patient's health issue (forced-migrant communities)
- that people are able to get the medicine they need, when they need it (forced-migrant communities)
- that people are able to understand all of the information that a healthcare worker provides (forced-migrant communities and providers)
- that healthcare services have a plan for supporting refugees and asylum seekers to access the care that they need (forced-migrant communities and providers)
- that people have a good understanding of all the different individuals who can help with a healthcare issue (forced-migrant communities)
- that people are able to access their medical records (forced-migrant communities)
- that doctors should not ask about someone's asylum status (forced-migrant communities)
- that best practice guidance is made available to clinical workers (providers)
- that translators are made more readily available (providers)
- that institutional racism within certain public bodies is addressed (providers)
- that good relationships between GPs and community groups are developed (providers)

Chapter 3 Approach 2. Mixed-methods systematic review

Methods

The protocol for this project was published on PROSPERO.[92] We followed JBI guidelines for mixed-methods convergent integrated systematic reviews.[93]

Types of studies

We included experimental and observational studies, qualitative studies and primary mixed-method studies. We excluded comparative studies (where a study compares outcomes between a 'host' and forced-migrant population) that do not evaluate an intervention. We included studies conducted in any country and in any language.

Types of participants

We included studies evaluating two types of participants:

1. **Primary participants**: adults or children who are forced migrants (see *Glossary*). This included participants who were described as asylum seekers, refused asylum seekers, refugees, unaccompanied minors, undocumented migrants (but not where a person is also defined as an economic migrant or migrant having entered a country for the purpose of education), forcibly displaced persons (but not internally displaced persons) and defectors (North Korea).

We excluded studies in which participants were mixed; that is, defined for example as 'migrants', of whom only some were defined as being forced migrants. We recognise, however, the risks that these categorisations present, as well as the exclusionary narratives of deservingness that often become associated with the categorisation of individuals in refugee and migrant contexts.[21,94]

2. **Secondary participants**: participants who are relevant to a healthcare moment of opportunity for a forced migrant. To align with a capabilities approach[43,89,90] and supported by our early stakeholder workshops and engagement, this included any worker (voluntary or paid, professional or lay) who could play an instrumental role in supporting healthcare access and healthcare experiences for forced migrants (e.g. nurses, GPs, other health workers and trainee health workers, provider gatekeepers, teachers, accommodation providers, interpreters, community leaders including faith leaders, community organisations, settlement or resettlement workers, cultural brokers and peers).

Types of interventions

We included studies of interventions or practices that aimed to deliver responsive health care for forced migrants. We included studies only where this aim was clearly captured within the stated aims and objectives of the study (not intervention). We used the definition for access to care as set out previously but this can be loosely summarised as practices that attended to one or more of the following conditions: physical access, availability of services, organisational structures, affordability, service design and acceptability, awareness (of health resources) and health agency (as the capacities or tools to access care) (see *Theoretical framework*). We included interventions in any setting.

Types of outcome measures

We included studies regardless of outcome measures. However, to ensure that the review could meaningfully address the research question and as there is no established core outcome set for this topic, we considered outcomes along the following lines:

- **Direct measures of access**: those which provided a clear measure of access as determined by patient/forced-migrant data such as patient satisfaction, acceptability and appropriateness of care, help-seeking behaviour, knowledge and awareness (such as of trauma symptoms or awareness of a service), clinic visits or missed appointments.

- **Proxy measure of access**: those relating to patient/forced-migrant data, which indicated the potential for access, such as intention to visit a psychosocial counsellor, or data that related to caring practitioner outcomes, such as knowledge or comfort in skills related to refugee health care, satisfaction with a training programme, cultural awareness. We suggest that practitioner measures are important because they tell us about the capacity for workforce change and the implementation of new interventions.
- **Other measures (no measure of access)**: typically clinical, health-related quality of life and psychosocial measures. We do not report these outcomes.

We collected outcome data reported at any time point within the study.

Search methods for identification of studies

Electronic searches

We conducted electronic searches of American Psychological Association PsycINFO (OVID Technologies 1967–), EMBASE (OVID), Cochrane Central Register of Controlled Trials, Cumulative Index to Nursing and Allied Health Literature (EBSCO Publishing 1994–), MEDLINE (Ovid Technologies Inc. 1996–), applying no restrictions on language or publication status (see *Appendix 1*). We searched all databases from inception to 28 February 2022.

Searching other resources

We searched websites and databases, and/or contacted via e-mail the following agencies that we deemed relevant to the study: Amnesty International, Australian Research on Refugee Integration Database, the Australian, Danish, Norwegian, and UK Refugee Councils, International Organization for Migration, the International Committee of the Red Cross, the Refugee Studies Centre, Oxford, UNHCR and the World Health Organization (WHO). We also searched the NIHR Journals Library and OpenGrey (opengrey.eu).

We conducted backward citations on relevant systematic reviews and included studies, and forward citations on included studies (31 March 2022).

Data collection and analysis

Selection of studies

We used reference management software EndNote™ X9/2021 (Clarivate Analytics, PA, USA) to collate the results of searches and to remove duplicates. Using Covidence 2018 software (Melbourne, VIC, Australia), two of five review contributors (SL, MP, AR, SC, PM) independently screened the results of the search of titles and abstracts against the inclusion criteria to identify potentially relevant studies. Results were compared at regular intervals and consensus was reached through discussion. During these discussions, we refined the inclusion and exclusion criteria to meet the specific objectives of the review and finalised the inclusion criteria. We sourced the full texts of all potentially relevant studies and two of four review contributors (AR, PM, SC, MP) considered whether or not they met the inclusion criteria; again, we reached consensus through discussion that also included review author LN. We recorded the reasons for the excluded full text studies. Where abstracts only were available, we included them in the review only if they provided adequate information and relevant results. We recorded the number of papers obtained at each stage and included this information in a Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow chart (see *Appendix 7*). In the event of finding associated publications from the same study, we created a composite data set based on all eligible publications.

Data extraction and management

We designed a data extraction template (see *Appendix 2*) in Microsoft Excel® (Microsoft Corporation, Redmond, WA, USA) to collect and record details from individual studies, including details about study population, study methods, intervention details (including development and any rationale provided by authors of specific aspects or adaptions) and outcomes of relevance to the review. Qualitative data were summarised with corresponding illustrations. One author (AR, PM) extracted data, which were checked by a second author (AR, PM). Any disagreements that arose were resolved through discussion. Additional data clarification was received from one included study author (Harkensee).[95]

Methodological quality

Joanna Briggs Institute tools

We conducted quality appraisal using the JBI study design-specific checklists,[96] which allowed us to assess methodological quality and possibility of bias in the design, conduct and analysis of each study. As the JBI does not provide a quality assessment tool for diagnostic accuracy comparison studies, we drew on processes outlined by Chasse and Ferguson[97] for the three studies using this study design (see *Appendix 4*). Two authors (AR, PM) made independent assessments of quality and consensus was reached through discussion. We did not exclude studies on quality but instead used the tools to assign a quality score to each study. As no common cut-off is currently provided for JBI tools[93] and different reviews use varied scoring mechanisms to determine overall quality of studies, we followed a common practice of reviews published in *JBI Evidence Synthesis* to score based on total 'yes' scores. For each item on the quality assessment tool where the study was regarded to have met the criteria ('yes'), we awarded a score of 1; if the criteria were unclear or were not met, we gave a score of 0. Where we regarded a particular item as not applicable for a particular study, we removed it from the total scoring. Total quality scores were therefore calculated as a total of the maximum number of 'yes scores' of applicable questions. Total and percentage scores are presented for each study.

Quality of the study was determined as:

- 'high quality' with a score of 70% or above
- 'moderate quality' with a score between 50% and 69%
- 'low quality' where a score was ≤ 49%

We considered the quality appraisal results during data synthesis and discuss the assessments within the review.

MORRA tool

We developed an additional assessment tool to consider the quality and influence of studies on questions of access to health care for our specific study population. This provided an opportunity to consider how well studies provided meaningful evidence around access to care, including detail on how an intervention or practice had been adapted or is appropriate for our primary study population, whether the study population is appropriate to be saying something about the acceptability of the intervention or care, and whether the methods and procedures adopted by authors were appropriate for conducting research in cross-cultural settings and with people who are displaced. The full checklist and procedure are provided in *Appendix 4*.

Tool scores were obtained as per details set out for JBI tools. However, we graded quality as follows:

- high quality with a score of 10 or above
- moderate quality with a score of between 6 and 9
- low quality with a score of 5 or below

Going forward we refer to this procedure as the 'MORRA tool', an acronym which reflects one of our study objectives to identify the Moments of Opportunity for Responsive health care for Refugee communities and People seeking Asylum.

Data transformation

We followed the JBI convergent integrated approach to mixed-methods systematic reviews.[79] Relevant quantitative outcome data were converted into 'qualitised data', a process of translating numerical values into textual descriptions and providing a narrative interpretation of the data. This allowed us to consider (the quantitative) findings (now in textual form) from experimental, quasi-experimental, observational and mixed-methods studies alongside the textual summaries of findings drawn from qualitative (and qualitative aspects of mixed methods) studies. This resulted in a combined synthesis (rather than the separate synthesis) of quantitative and qualitative study findings.

Data synthesis and integration

We made use of the convergent integrated approach as per the JBI methodology for mixed-methods systematic reviews.[98] We pooled, examined and categorised the textual descriptions (converted from the quantitative data) and the

qualitative narratives that had been extracted directly from qualitative and the qualitative aspects of mixed-methods studies. We used the framework synthesis approach[99] to organise the data into broad themes that were interpreted and further refined. In contextualising findings, we drew only on the detail described in studies results/findings. The review findings are presented in table and narrative format.

Differences between protocol and research delivered

Search methods

In the protocol, we stated that we would search clinical trials registers ClinicalTrials.gov and WHO trials register search portal. As we identified a high number of clinical trials during our search of other databases, we made a pragmatic decision not to conduct further searches. A list of relevant ongoing studies is provided in *Table 16*, *Appendix 6*.

Type of participants

We initially took an inclusive approach to studies of participants described as Latinx (Latino, Latina and/or Hispanic) including all studies at the title and abstract stage. We assessed a sample of full texts of these studies (*n* = 109, approximately half) and noted that study authors did not use any terms to infer that participants were forced migrants (participants were commonly described as immigrants or foreign born). These studies were almost exclusively conducted in North America and focused on a range of health conditions, preventive health care and parenting. We used this sampling method to determine that we expected none of the remaining Latinx studies to be eligible, and we subsequently excluded these studies without viewing further full texts.

Types of interventions

We identified a very high number (340) of studies that included interventions or practices that aimed to improve access to health care for forced migrants. We initially explored different ways of managing this volume of studies but ultimately made a further pragmatic decision to tighten the inclusion criteria to include only those studies that stated within their study (rather than intervention) aims or objectives an attempt to improve access or reduce barriers to health care. Studies did not need to use the language of access explicitly but it needed to be clearly inferred. We expected this to better align studies with measurable outcomes of access, though ultimately this was not necessarily the case. We acknowledge that this did limit our engagement in the subject, and we suspect a potentially broader evidence base, in terms of health need and potentially, health service focus, may be accounted for within these exclusions. To address this, we suggest that a rapid framework analysis be conducted on these studies (available from the authors) to ascertain cognisance or divergence with our current findings.

Types of outcomes

Our intention was to limit outcomes only to those that were likely to be meaningful to intended users and recipients of the reviewed evidence. We had originally anticipated that this might include some mental health and quality of life measures; however, following early workshops and some tentative sampling of relevant studies, while important, it was decided to align outcome measures with our review aims, making the decision to only include outcome measures in the synthesis of findings that could meaningfully address the question of access to care. These are detailed within the study.

Results

Study inclusion

After the removal of duplicates from the search results, we screened 14,278 titles and abstracts, which included forward and backward citation searches. We looked at the full text of 1247 records and selected 108 studies for inclusion, based on the review criteria. We identified 24 ongoing studies (see *Table 16*, *Appendix 6*), found 2 studies for which we were not able to effectively assess eligibility (see *Table 15*, *Appendix 5*), and excluded 1108 records. See PRISMA flow chart (see *Appendix 7*).

Methodological quality

Critical appraisal

Details of the quality assessments can be found in *Appendix 4*. In summary, the majority of studies (72) were of high quality,[100–166] 44 studies were of moderate quality[95,104–107,116,119,122,150,151,154,155,157–159,161,167–191] and 25 studies were of low quality.[120,121,126,173–176,179,183,184,191–204] Thirty-one of these studies used mixed methods and have been assessed with more than one tool. Five studies[110,128,130,133,134] met all quality assessment criteria (all quasi-experimental studies). Common quality issues related to blinding of participants and limited blinding of those delivering interventions: randomised controlled trials (RCTs), differences in participants at baseline (RCTs; quasi-experimental studies), incomplete follow-up (RCTs), a lack of clarity on randomisation (RCTs), lack of validated approaches to outcome measurement (cross-sectional studies), variation in conduct of tests and incomplete inclusion of participants (diagnostic accuracy studies). Qualitative studies often did not address researchers' influence on the research and vice versa, or locate researchers culturally or theoretically, and most did not state a philosophical perspective, making it difficult to deduce congruity with the methodology. It is also worth noting that there were a high number of single-arm before-and-after studies with quantitative outcomes, which led to high use of 'non-applicable' assessments within the quasi-experimental tool.

MORRA tool assessment

MORRA tool scores can be found in *Table 14*, *Appendix 4*. The mean MORRA tool score was 9.5 (SD = 2.4), suggesting moderate quality. Overall, just over half (49, 52.7%)[95,100,102,106,107,110,111,113–115,118,121,123–125,132,135,137,141,142,144–146,148,150,152,154,155,157,159,161,167–170,172,175–177,181,186–189,191,192,203,205–207] the studies (with a measure of access) were of high quality, 38 (40.9%)[103–105,108,109,112,116,117,120,126,130,131,134,143,147,151,153,156,158,162–166,173,176,178–180,185,194,195,197,198,200,202,204] were of moderate quality, while 6 (6.5%)[122,160,193,196,199,201] were of low quality. Most low-quality studies did not provide adequate details on how interventions or protocols were adapted to improve access or engagement and the population was not considered adequate to be saying something about the acceptability or effectiveness of the intervention.[122,160,193,196,199]

Characteristics of included studies

We included 108 studies (see *Table 6*, *Appendix 3*). A total of 33 (30.6%) studies were quasi-experimental studies,[116,123–125,127–129,131–137,139–145,177,178,180,184,185,201–203,207] 31 (28.7%) were mixed-method studies,[95,104–106,108,110,111,116,118–122,126,150,151,154,157–159,161,163,169,173–176,179,183,197,208] 21 (19.4%) were RCTs,[100–103,114,148,149,167–172,188–190,192–196,198] 14 (13.0%) were qualitative studies,[107,109,112–115,117,153,156,160,162,199,200,206] 6 were cross-sectional studies,[146,164–166,186,204] 2 were comparative studies for diagnostic accuracy,[147,187] and 1 was a cohort study.[167]

Study country

Most (92) studies[95,100–102,104–106,108–117,120–122,125–127,130,131,133–137,139–147,149–151,153,156–170,172–189,191–197,199–211] were conducted in high-income countries; 8 were conducted in upper-middle-income countries[103,107,124,129,154,169,171,198] and 7 in lower-middle-income[118,123,132,190] or low-income[119,128,148] countries. One study[210] was conducted across three locations: Germany and Sweden (high-income) and Egypt (low-middle-income), and another[202] across six (all high-income; see *Tables 7* and *8*, *Appendix 3*).

Overall population characteristics

Of the included studies, a total 11,813 participants were included. Participants fell into 2 overarching categories with 85 studies[95,100–102,105–107,109–111,113,114,116,118,119,129,131–133,135–137,139–152,154,155,157,159–170,179,184,186–192,195,198,199,203,204,207–210] reporting forced-migrant participants and 38 studies reporting practitioner participants (see *Glossary*);[100,103,104,107,108,111,112,114,116,117,119,121–123,130,138,141,153,156,158,160,173–176,180,182–185,193,194,196,197,199–202] 15 studies reported participants in both categories.[100,107,111,114,119,121–123,160,173–176,184,199]

Of those reporting forced-migrant participants, most referred to participants as refugees or people with a refugee background,[101,102,105,106,109,110,113,115,118,120,124,125,127–129,131–134,136,137,143–145,148–151,154,159,161–169,172,178,179,181,189–192,195,198,203–211] some described refugees and asylum seekers,[15,95,126,142,157,160,167,170,171,177,206] three studies[146,187,188] referred to asylum seekers only, while others described female defectors,[135] undocumented immigrants,[186] resettled Bhutanese adults[139] and refugee and resettled adults.[140] Foka *et al*.[110] and Lee and Park[134] sometimes referred to their refugee participants as 'forcibly displaced' and 'children who had defected from North Korea', respectively.

Forced-migrant participants

The total number of forced-migrant participants was 8952, with studies reporting a range of 7 to 1303 participants and a median of 61 participants [interquartile range (IQR), 37–126]. These figures do not include 2 retrospective service evaluation studies that used service utilisation records of refugee and asylum-seeking service users, 1 including 55,452 records[144] and another including 29,000 records.[145] Most studies (43, 50.6%) involved adult forced migrants only;[100,101,105,107,114,115,118–120,121,128,131,133,135–137,139,140,142,143,147,149,150,152,154,155,157,162,169,170,172,174,176–178,181,184,187,189,190,192,195] 14 studies (16.5%) included children only,[95,110,123,125–127,129,134,151,159,161,164,175,205] and 22 (25.9%) studies included a mix of both children and adults,[102,106,109,111,113,124,132,144–146,148,163,167,168,173,179,186,191,198,199,203,206] of which 8 involved families [child(ren) and parent/carer].[106,124,163,167,168,173,179,191] Four studies involved some participants who were unaccompanied minors,[102,109,126,161] including Van Es *et al.*,[161] in which all participants were unaccompanied minors, and Koch *et al.*,[102] in which unaccompanied minors made up the majority (93.2%) of participants. One study included elderly participants only.[165] Female forced migrants were represented more than males in most studies (mean percentage 60.1% standard deviation 26.9%) (*Figure 1*); 17 (22.2%) studies had female-only participants[105–107,113,118,120,135–137,145,148,166,169,171,189,195,206] and 3 included male-only participants.[100,102,170]

Most studies included participants with no formal diagnosis. Of those who required a diagnosis, 21 (24.7%)[95,101,102,107,119,124,131,133,134,142,145,149–151,161,166,170,172,174,176,189,205] were typically mental health or psychological disorder diagnoses, including PTSD, trauma psychopathology, intrusion and avoidance disorder,[95,102,124,131,133,142,170,174,176,205] anxiety,[101,176] depression,[95,161,166,205] somatoform disorder[133,176] and mental/psychological distress.[119,150,151,189] In Hinton *et al.*,[149] participants had treatment-resistant PTSD and panic attacks, and in Fazel *et al.*,[109] although no diagnosis was described, participants were all attending a school-based mental health service. In addition, one study[173] described the inclusion of participants with 'special healthcare needs', which appeared to relate to a combined set of health, healthcare access and social and linguistic needs. In Yelland *et al.*,[145] all participants were pregnant women, and in Dababnah *et al.*,[107] participating adults all had a child with autism spectrum disorder (ASD).

Most studies included participants of a single 'national community' (39; 45.9%),[102,105,106,113,115,118,119,121,123–125,128,129,131–136,139,140,143,146,148–151,154,159,166,169,171,172,188–190,198,210] most commonly Syria,[123,124,129,150,151,169,189,198,210] Bhutan[115,121,136,139,140] and Afghanistan,[102,155,159,166,171] or were inclusive of all local people with a refugee and/or asylum-seeking background (39.2%).[95,100,101,109,110,120,126,134,137,142,145,147,157,161,162,165,167,168,173–175,177,184,186,187,191,192,203–206] Nine studies reported participants who were from a shared geographical region (Middle East and North Africa,[107,163,164,176,181] sub-Saharan Africa[111,114] and East Asia and Pacific),[127,169] four studies were unclear, describing a majority from El Salvador, Guatemala and Honduras,[122] participants from Arabic-, Farsi- or Tamil-speaking backgrounds,[170] and participants from unspecified countries in Africa.[178,195] Three studies[144,160,199] did not report home country. *Figure 2* indicates the number of studies including forced-migrant participants from different world regions.

Most studies (58)[95,101,102,105–107,110,111,113,118,119,122,125,126,129,132,134,135,139,140,143,144,146,148,151,152,154,157,159–174,181,184,186–188,190–192,195,198,199,203–205] provided no indication of local language proficiency. Where this was reported, studies tended to have no[115,142–149,167,175] or few local language-proficient participants,[120,121,131,133,136,137,147,155,176,177,179] although five studies reported more than half,[100,114,127,145,178] and a further four studies reported that all participants were proficient in the local language.[109,123,124,128] In five studies, participants' home or regional language was similar to the local language spoken in the host or settlement country; Arabic for Syrians in Lebanon[123] and Turkey,[124,150,189] and Swahili as the lingua franca in both the Eastern Democratic Republic of the Congo and the Ugandan refugee settlement where the Congolese participants were residing.[128] One UK study described all participants as speaking 'sufficient' English.[109]

Where reported (55 of the 85 studies), most studies (29)[100–102,106,109,113,115,120,121,124–126,128,134,137,147,149,152,159,163,164,166,171,172,178,186,198,203,206] described forced-migrant participants living in host or settlement countries between 1 and 5 years, 16 studies[95,111,114,136,143,144,146,154,162,167,170,173–175,187,192] described new arrivals or people living in the country for less than 1 year, and 10 studies[105,130,131,135,139,140,142,151,155,168] included participants who were more than 6 years post arrival. Of the 16 studies with participants who were < 1 year or newly arrived in the settlement or host country, 5 stated that the participants were newly arrived or recently resettled, 3 stated that the participants had arrived within a mean of 7.6 months prior to the study,[111,174,192] 3 within 1 year,[114,154,167,175] 3 within a mean of < 2 months after arrival,[95,146,187] and one 3–12 months prior to the study.[136]

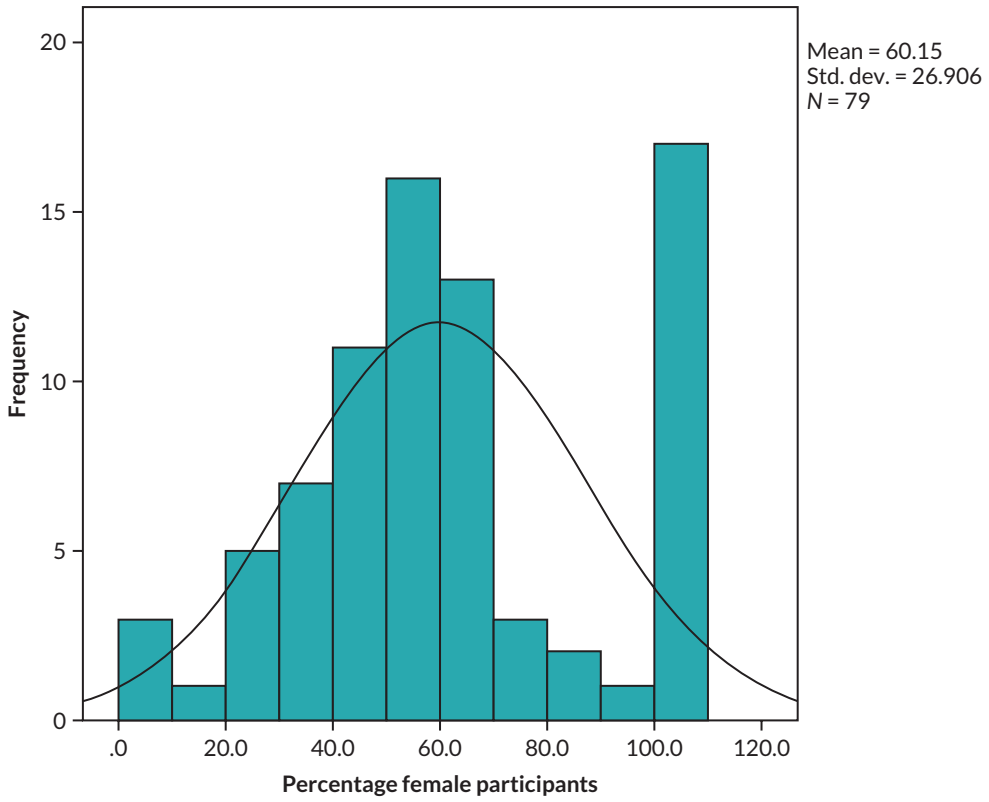

FIGURE 1 Female representation within studies.

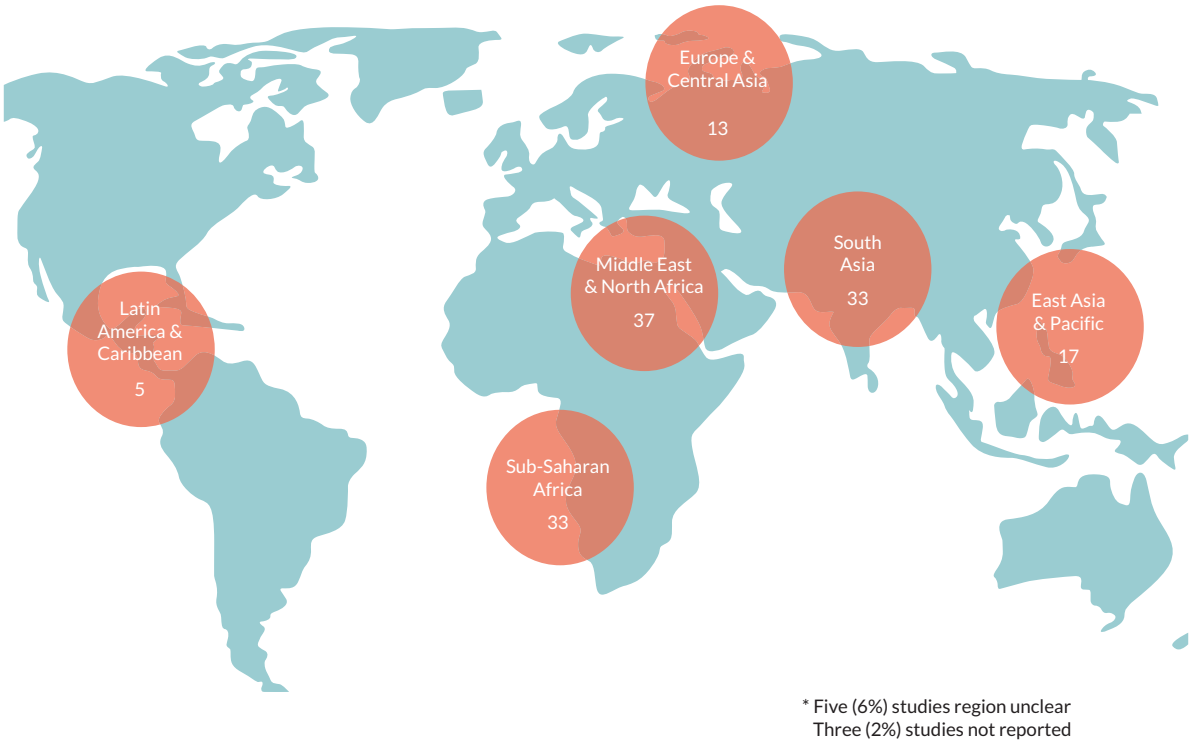

FIGURE 2 Studies including participants from world regions.

Practitioner participants

The total number of practitioner participants was 2975, with a median of 54 (IQR = 26–115). This did not include figures from 10 studies from which the number of practitioner participants was not reported.[100,122,123,174–176,196,197,199,200] Of the 38 studies reporting practitioner participants, 10 involved health workers only[100,108,117,122,138,183,193,196,197,202] (including GPs or physicians,[100,117,183,193,196,197,202] nurses,[100,117,183,202] mental health professionals,[122,138,193] and primary care practitioners[108,202]). Six studies involved students,[103,111,112,114,173,174] mainly health sciences students (nursing, medical and psychology students) and six studies reported non-health professionals only,[107,123,185,194,199,200] including teachers,[107,199] social workers, (re)settlement workers and non-governmental organisation (NGO) case managers,[194,200] and community workers.[185] Seven studies included lay persons[121,130,141,160,182,201,205] described as community members,[201] patient navigators,[121] lay counsellors,[205] lay psychoeducation trainers,[160] and religious and community leaders.[130,141,182] Six studies reported including participants from across a range of sectors.[104,116,175,176,180,184]

Intervention focus

Most interventions included a focus on mental health[100–102,104,105,108,109,111,114,116,119,122,125–130,132–134,136,141,142,146,147,149–151,153,154,157,159–164,166,168–170,174,176,177,180–182,184,185,187–193,198–200,204,205,207,208] including trauma, psychosocial health needs, psychoeducation and mental health screening. Many were focused on supporting and improving health system navigation or health advocacy[95,105,109,111,114,121,143–146,157,161,164,172,174,184,186,192,201,203] or on building practitioner, community or service capacity in cross-cultural and refugee health responses.[100,103,104,108,112,116,117,130,138,141,156,158,173,175,180,183,193,194,196,197,200,202,210] *Table 1* provides a further breakdown.

Healthcare delivery and location

Most care was delivered in the community (38),[105–107,109–111,113,115,118,121,123–127,129,132,139,140,148,150,155,158,159,165,167,169,171,172,174,179,181,186,189,191,192,199,204] including in schools,[109,123–127,129,191,199] religious spaces,[105,106,140] community spaces within refugee 'camp' settings,[110,179] and within outdoor community spaces.[159] Seventeen interventions delivered care within health facilities,[95,100–102,133,142,144,145,147,153,157,164,166,176,187,203,206] eight within participants home[114,120,125,126,137,160,168,173,198,205] (including two delivered both at home and at school[125,126]), and four provided care remotely, through web-based programmes,[135,170] an interactive smartphone application,[206] and via Zoom (Zoom Video Communications, San Bruno, CA, USA).[159] The programme using Zoom also provided care within the community.[159] Two interventions delivered care within refugee reception centres[154,162] and two studies did not describe a specific location, but acknowledged a refugee camp setting[190] and care provided within the local municipality.[163]

TABLE 1 Intervention healthcare need of focus

Intervention focus	Frequency	
	n	%
Mental health, including psychoeducation and prevention, psychosocial support	57	53
Health system navigation, advocacy and addressing access barriers	28	26
Practitioner training and local capacity building	23	21
General health including knowledge	17	16
Mental and psychosocial health needs and assessment	12	11
Health behaviours: physical activity, nutrition, hygiene	6	6
Women's health, including antenatal care and family planning	5	5
Cancer	3	3
General health needs and assessment	5	5
Oral health including promotion	2	2
Diabetes	1	1

Most (74) care was delivered as group interventions[101–106,110,115–119,123,124,127–132,136,140–143,150,151,154–156,158–160,163,167–169,171,172,178,179,181–183,185,188,189,191,194,195,200,201,204] or interventions that included group activities.[107,109,111,120,114,120,125,126,134,145,173–177,192,197,199,202,205] These tended to also be associated with community or school-based delivery in contrast to individual activities which tended to be delivered at health facilities.

Study outcomes

Studies reported a range of outcomes. A total of 61 studies reported direct measures of access,[95,100,102,105–107,109–111,113–115,119,121,123–126,132,135,137,142–147,150,151,154,157,159–170,172,175–177,179,186–189,191,192,195,203,204,206,208,210] 60 studies reported proxy measures of access[103,104,106–108,112,114–118,120–126,130,131,134,137,138,141–143,147,150,153,156,158,160,161,165,169,170,172,173,175–178,180–183,185,192–197,199–205] and 15 studies[101,127–129,133,136,139,140,148,149,171,174,184,190,198] provided no measure of access; 29 studies reported both direct and proxy measures.[105–107,114,115,120,121,124–126,137,142,143,147,150,160,161,165,170,172,173,175–177,181,192,195,203,204] Details of the outcome measures we have attributed to access can be found in *Table 2*. Other outcomes reported by studies heavily related to anxiety, depression, PTSD and other psychosocial measures. An overview can be found in *Appendix 8*.

TABLE 2 Direct and proxy measures of access to care

Domain of access[3]	Direct measure of access to care, all forced migrant	Proxy measure of access to cares
Accessibility (physical)	Experiences[100,107,109,113,122,125,126,151,157,168,186,214]	
Availability	Diagnostic accuracy of a psychiatric instrument;[187] mental health literacy and capacity to respond[130]	Caring practitioners: use of new mental health assessment tool;[105,176] feasibility of recruitment of programme facilitators;[124] attendance and satisfaction with course;[107,201] interpreter use[145]
Acceptability (institutional structures and programme design)	Experiences: patient satisfaction;[100,102,106,107,111,119,157,159,163,176,195] patient acceptance;[100,150,169,208] quality of communication;[146] experiences and impact of programme[95,107,109–111,113,114,126,154,160,163,170,175,179,181,191,204,210]	Caring practitioners: *engagement and experiences* – engagement/motivation (in training);[105,108,114,158,175] expectations and experiences;[107,114,175] utilisation and acceptability[183,205]
	Engagement: use;[143,145,159,162,165,172,189,203] engagement and attendance;[102,105–107,113,114,119,124,125,142–170,175,177,179,188,189,192,201,208] help-seeking behaviour;[121,161] retention;[124,173,176] rate of missed appointments;[121,186] incidence rates of emergency care;[144] screening efficacy[166]	*Knowledge, skills and delivery of care* – knowledge and skills in refugee mental health (including recognition);[116,138,141,185,199] confidence in management of suicide;[180] engagement in conversations with stressed refugees;[105] helping intention and behaviour;[185] confidence in helping;[185] perceived knowledge/skills of relevance to asylum seekers and refugees;[100,173] refugee status identification;[200] barriers to performing a 'good job';[100] cultural awareness/perceived acceptability of care;[103,112,147,151] overview of clinical worldview[108]
		Programme evaluation: review/evaluation of programme;[151,156,160,161,199] treatment approach;[205] clinical management;[138] use of refugee specific referral pathways;[200] continuity of care[167]
		Attributes: interpreter use;[145,200] basic communication skills;[138] general and linguistic characteristics of participating practices and GPs[197]
		Attitudes and behaviours: stereotyping;[167] risk of xenophobia;[103] attitude and responsiveness among service providers;[103,194] negative attitude towards mental illness;[141,185] changes in attitudes to suicide[180]

TABLE 2 Direct and proxy measures of access to care (*continued*)

Domain of access[3]	Direct measure of access to care, all forced migrant	Proxy measure of access to cares
Affordability	Use of free-call phones;[120] experiences[107]	
Adequacy Accommodation	Barriers and engagement;[146,159] impressions and experience of mental health services integrated within the school system;[109] psychometric properties and tool utility;[147] rate of missed appointments;[186] multisector co-ordination of care;[175] usability of smartphone application;[210] post-arrival healthcare and service access;[164] adherence[161]	Caring practitioner: barriers to performing a 'good job';[104] quality of affidavits for psychiatric evaluation;[122] co-operation between agencies;[176] knowledge of primary care professionals;[202] fidelity;[146] experiences of teachers;[126] implementation process and barriers/feasibility;[117,150,204] willingness to support online course[202]
Awareness	Attendance;[113] navigation of health resources;[114,115,135] time to first antenatal clinic visit;[167] awareness of service;[137,203,204] gestation period at first hospital visit;[145] healthcare access problems[121]	
Health agency		Forced migrant: *help-seeking* – help-seeking intentions;[100,162,181] self-stigma for help-seeking;[170] capacity for seeking advice on health care;[118] access to resources;[169] use of other services[165] *Health knowledge, awareness, management* – breast;[169] cervical cancer;[137,169] contraceptive;[195] diabetes risk;[178] dietary;[123] oral;[167] mental health;[106,107,132,143,172,178,181] COVID-19;[159] general health;[115,134,203] skills and confidence;[107,135] medication management[118,165] '*Integration*' – acculturation;[120,131,177,192] self-efficacy in post-migration stressors;[142] social support;[120] psychological need frustration (autonomy frustration; competence frustration; relatedness frustration);[198] healthcare access problems[121] *Stigma and attitude* (tuberculosis;[203] trauma, mental health[143,181,204])

Theoretic frameworks

Most studies provided no conceptual or theoretical premise around which interventions and methodologies had been considered, although some reported approaches underpinned by a focus on participants' cultural,[104,116,127,131,132,149,150,156,160,166,178,189,200,205] language[113,146,169] and social[100,103,106,111,114,150,161–163,166,170,174,179,190] needs and values, or interventions that drew on the patient-centred culturally sensitive health care[178] and cultural adaptation process[106] models. There was reference to broader factors and the determinants of health and equity in healthcare access. This sometimes drew on human ecology[100,106,131,167, 192,204,208,210] and human rights perspectives,[183,184,205] a focus on reducing conflict or prejudice through the 'contact hypothesis'[103] and critical/feminist postmodernist theories,[106] and aligned with some aspects of what authors of other studies referred to as holistic, multilayered and multiagency frameworks.[108,125,154,164,199] Several authors acknowledged participatory concepts such as community-based participatory research,[105] the community advocacy model[111] and social interaction learning theory,[106] while others referenced behavioural models[119,137,194] and self-efficacy theories,[139,140] including the health belief model.[178]

Funding and sponsorship

Most studies (60, 71.4%) reported funding. This was typically received from public funding bodies, charities and foundations, or funded by universities (see *Appendix 3*). Six studies reported not having received any specific

funding[103,137,162,165,183,186] and 24 (22.2%) studies did not report information on funding sources.[110,116,120,122,124,127,131,134,135,142,146,149,156,157,169,178,182,189,193,195,196,198,199,201]

Possible signifiers of responsive practice

We reviewed all descriptive details that authors provided throughout each article to attempt to identify factors that may have influenced the capacity for study interventions or services to be responsive or create responsive conditions in the health care of forced migrants. We considered the *design of the service or intervention*, with attention to what was informing programme decisions and considered delivery mechanisms or practices and contexts that had the potential to be *facilitators of responsive care*.

Descriptive details are provided below and a comparative view between the direct, proxy and no measure studies is provided in *Table 3*. Overwhelmingly, practice was co-informed by multiple knowledges and perspectives shaping what programmes of care were delivered and what programmes of care looked like. The majority of studies also reported a range of practices that recognised *language and communication*, *displacement (and settlement) experiences*, potential

TABLE 3 Frequency of reporting potential responsive mechanisms

	Direct measure studies: frequency (*n* = 61)		Proxy measure studies: frequency (*n* = 60)		No measure studies: frequency (*n* = 15)	
Potential responsive mechanisms	***n***	**%**	***n***	**%**	***n***	**%**
Design of intervention						
Collaborative approaches	39	63.9	30	50.0	9	60.0
Community initiative/conceptualised by community	12	19.8	11	18.0	6	40.0
Published evidence	22	36.1	21	35.0	9	60.0
Validated manuals or tools	20	32.8	16	26.7	5	33.3
'Experts' and experience	19	31.1	22	36.7	5	33.3
Language and communication						
Translation of written materials	19	31.1	16	26.7	3	20.0
Non-readers and visual communication	9	14.8	5	8.3	2	13.3
Oral communication	40	65.6	31	51.7	8	53.3
Enhanced interpretation	36	59.0	30	50.0	11	73.3
Other communication considerations	11	18.0	11	18.3	1	6.7
Cultural and experiential recognition						
Displacement experiences	39	63.9	41	68.3	8	53.3
Health risks and potential vulnerabilities	42	68.9	39	65.0	9	60.0
Broader social and societal context	31	50.8	29	48.3	5	33.3
Engaging communities and responding to needs	37	60.7	37	61.7	5	33.3
Community representation	23	37.7	14	23.3	5	33.3
Flexing for divergent views and traditions	26	42.6	26	43.3	7	46.6
Other engagement practices						
Costs and resource	19	31.1	14	23.3	6	40.0
Reaching people	41	67.2	30	50.0	8	53.3

disconnects between the *cultural traditions, values and expectations* of those arriving and receiving societies, the *broader systems* in which participants or services were located as determinants or important to health, and a set of *resource* practices and mechanisms for *reaching people*.

Design of intervention

Most authors (99, 91.7%)[95,100–108,110–117,119,120,121,123–125,127–143,145–147,149–151,153,154,156–161,163–176,178–187,189–195,198,200–206,208,210] provided some detail on the inception or design of interventions, often describing several practices that had been used to meet the specific contextual or cultural needs of the study population. These fell into a number of loose categories: *multisector collaboration or consultation*, whereby different stakeholders played a role in informing what was often a process of iterative and reflexive design; *community initiatives* or *conceptualised by local communities*, where programmes were seen to have evolved within the community itself or be driven by active requests from community members; *published evidence* that saw some engagement with relevant literature; *validated manuals or policy guidance*, which often saw the heavy adaption of evidence-based models of care or policy guides, typically designed for other population groups; and *experts*, whereby studies would sometimes refer to authors' own expertise or attempts to seek input from field experts, such as in refugee health.

Multisector collaboration or consultation

Frequently, studies described forms of multisector collaboration or consultation,[95,100,102,104–108,110–113,115,117,119,121,123–125,127,128,130–132,136,137,139–143,145,147,153,154,156,158–160,165,166,168,170–175,179,181–184,186,187,189–192,201,203,205,206,208,210] often between different stakeholders such as academic,[121] state,[205] including settlement agencies,[110,137] social support services,[118] different health service providers[102] and refugee communities, including community leaders.[100] Some authors used the language of co-production[179] with community elders, for example, as co-planners and co-adapters (as well as co-evaluators and implementers), one study[131] describing working with a local Cambodian community leader to combine 'Cambodian cultural traditions and Buddhism philosophy with standard Western mental health techniques', to develop and tailor practices that would be familiar to the Cambodian refugee community. Others reported engaging with prospective participant/patient groups or associated services, seeking to understand priority health needs,[95,100] the availability of broader support services,[100] selection of programme topics important to community members,[105] review and approval of intervention manuals,[205] including to ensure procedures were culturally or linguistically appropriate[115] or relevant to the local (e.g. newly arrived) refugee community.[124]

Studies sometimes discussed *iterative processes* whereby intervention practices or programme content might go through multiple phases of piloting and refining (see e.g. Nickerson *et al.*[170] and Eytan *et al.*[187]) while there was also reference to the ongoing evolution of services (e.g. Harkensee and Andrew[95]).

Some programmes or services had been developed in response to identified local needs, including a high prevalence of community violence,[132] reports of families struggling to navigate local health services,[95] low numbers accessing provision,[135] and the need to build capacity across local providers in working with refugee and asylum-seeking patients.[132] There was occasional reference to study authors' own experiences working with refugee communities,[95,110,124,172] reported to justify a particular area of focus or approach.

Community initiatives or conceptualised by local communities

Some interventions originated as community initiatives or were described as having been conceptualised by local communities.[101,113,121,127,132,136,139,160,171,174,186,203,204,208] In Lambert,[186] for example, a voluntary organisation recognising high need among service users had begun referring clients to local dental clinics, bringing in collaborators to improve the system of referral and increase appointment attendance as difficulties became apparent. In Guerin *et al.*,[113] women from the local Somali community, acknowledging concerns for their health, had expressed interest to a male community leader in accessing physical activity opportunities, leading to an activity programme that remained heavily shaped by the local women.

Published evidence

Studies would often[100–103,105,106,114,119,116,121,123–125,128,132,134,139,140,147,149–151,153,154,158,159,165,169,171,173,174,178–180,183,190–192,194,202,205,208,210] refer to drawing on published evidence or 'reviews of the literature' to determine intervention content[169] or focus,[124]

as well as specific frameworks such as 'social ecological theory'[179] and the 'framework for culturally sensitive interventions'.[102] Some studies[105,124,168,192,194,202] described previous related work of authors that had often been through previous implementation and adaption on which approaches were framed.

Validated manuals or policy guidance

Many studies also talked about existing validated manuals, policy guidance or government issued standards[95,101,102,106,107,111,114,116,120,123–125,128,132,139,140,142,147,166,168,171,176,178,183,185,187,190,191,195,201,202,208–210] on which interventions were based, usually with heavy adaptions for the study population. This included guidance from the US Centers for Disease Control and Prevention[132] and National Institutes of Health,[178] which were described as heavily tailored, culturally and linguistically, for refugee participants. Studies also drew upon existing guidance specifically designed for working with conflict-affected communities, such as that set out by the US National Center for Trauma-Informed Care,[107,201] psychoeducational modules from the Center for Victims of Torture, and components of peace education as defined by UNESCO.[132]

Several studies referred to existing evidence-based manuals, tools or frameworks, such as the CHIME (connectedness, hope and optimism about future, identity, meaning in life and empowerment dimensions) framework of recovery[142] and the community advocacy model,[118] again usually heavily adapted for working with a forced-migrant participant group.[176] Occasionally, authors reported the use or further adaption of a tool or programme already validated for refugee populations; see, for example, El-Khani *et al*.,[124] who describe the addition of further caregiver sessions to the validated Teaching Recovery Techniques programme and Eytan *et al*.,[187] who report the further modification of the Mini International Neuropsychiatric Interview (a diagnostic tool used to identify neuropsychiatric conditions, including PTSD), which authors indicate is 'too direct' and 'complex' for the 'level of education and mastery of the language' of the majority of their respondents' despite having already been translated into 39 different languages (typically considered 'a sign of transcultural validity'). There was reference to drawing on 'age-appropriate science textbooks' used by local schools (Lebanon) for health and nutrition education sessions and published material and evidence available from similar low-to-middle-income country settings.[123]

Experts

A number of studies[101,103,116,120,121,123,129,131,134,135,138,142,146,150,151,154,156–160,163,165,166,169,171,172,174,181,184,187,189,193,194,198,200,202,204] loosely referred to the opinion of experts in the justification, shaping or design of programme content. Experts were generally acknowledged as academic or clinical, often with expertise in the field of refugee health or prior experience working with refugee populations, but there was also reference to legal experts and experts from related NGOs, such as the Red Cross.[202]

Potential facilitators of care

We identified a substantial number of intersecting considerations, values and practices that authors either explicitly attributed to, or we felt had the potential, to facilitate responsive health care. These related to *language and communication*, where authors would describe practices that might prioritise the use of specialist interpreters, involve bilingual workers, include training in cross-cultural communication or account for low literacy or non-readers among patient or client groups. These also related to *displacement acknowledgement*, whereby intervention design or practices accounted in some way for the influence of displacement (including settlement) on participants' physical and mental health risks, their social needs and need for new knowledge, understanding and connection with local public systems. There was common reference also to the potential *disconnect* between the cultural traditions, values and expectations of those arriving and of receiving societies, sometimes with efforts to support the maintenance of *arriving* traditions, improving understanding and skills among a workforce in delivering care that is inclusive of a refugee and asylum-seeking community or addressing structural mechanisms that saw recognition of a need, particularly for this population, to improve partnerships and collaborate on healthcare practice. Finally, there was some consideration placed on facilitating *physical access*, such as transport and child care, and mechanisms for *reaching and engaging communities*.

We loosely group these into specific reference points, although studies generally reported multiple aspects and these should be seen as intersecting in the majority of cases.

Language and communication

Studies overwhelmingly[95,100–102,105–107,109–111,113–119,121,123,124,127–137,139,140,142,143,145–161,163,166,167,169–172,174–179,184,186–192,201–208,210] made reference to a range of considerations and adaptions relating to language and communication. Often, these were explicitly acknowledged as necessary to ensure access for refugee participants or to improve the acceptability and linguistic meaning of intervention procedures.[95,101,102,105,107,110,111,113,114,118,119,135,137,139,140,142,143,145,167,169–172,175,176,178,179,184,186,187,192,203] Studies would typically describe various practices.

Translation of written materials

The translation of written intervention materials including manualised scripts into participants preferred or spoken language was common.[95,100,101,105,106,115,117,124,130–132,135,137,139,150,160,166,167,169–171,175,178,187,189,201–203,205,210] This ranged from the use of standard clinical templates, such as future appointment letters, translated into languages commonly spoken by the local asylum-seeking community,[95] the production of local health guides, which might include a map with directions to the local hospital, produced in several languages and made available to newly arrived refugees,[203] health education leaflets and 'handouts', such as relating to the diagnosis and management of specific conditions, vaccinations, or supplements; and a patient health record, which the authors of one study[117] described as a small, 15-page booklet that included patient information produced in 10 languages. One study[95] described a repository of such materials drawn from trusted sources such as Public Health England, the US Centers for Disease Control and Prevention, the European Centre for Disease, Doctors of the World, the Red Cross and Melbourne Children's Hospital,[211] available in a range of languages and passed on to patients, where relevant, at the end of a consultation. Several studies specified that translated materials had been produced by 'certified' translators,[95,169] included the practice of back translation,[100,124] or the use of two translators.[119]

Studies often described attempts to ensure that manualised scripts, narratives and screening tools used by services or as part of interventions were translated either in their written form or orally and held linguistic and cultural meaning for participant populations (see e.g. Alrashdi *et al.*[167]). As with participant materials, this was often carried out through consultation with stakeholders and interest groups or, as in Nickerson *et al.*,[170] with community advisory boards (made up of different linguistic speakers), where consultation aimed to ensure that strategies, such as belief systems around trauma symptoms and help-seeking were optimally culturally relevant yet standardised across language groups. Others described similar efforts to avoid certain (Western) terminology such as PTSD and depression, using cultural idioms and colloquial terms, such as 'murug (sorrow)' and 'qaracan (shock)' instead,[132] or changing local metaphors to align better with patients' own traditionally rooted phrases, replacing, for example, 'knots in the stomach' with 'discomfort in the stomach'.[119] One study reported developing a shared vocabulary to address the issue of mental health terminology which did not always have a direct translation between English and the Nepali language.[124]

Non-readers and visual communication

A number of studies[101,102,106,118,119,123,137,146,167,171,177,179,210] talked about using simple language (avoiding clinical, technical, and complicated terminology) as well as being prepared to provide further explanations of key concepts where required. Visual materials and illustrations were described to support the inclusion of non-readers and those with low literacy or low local language proficiency. Authors of one study,[179] for example, described a decision to run a family well-being programme in the parents' native language (Hmong, an oral tradition) as a means of showing respect for family hierarchy and parents who were typically non-readers, while Griggs *et al.*[177] reported navigating low literacy in participants' first language through trialling group-based routine outcome measures.

Several studies talked about ensuring that illustrations, printed materials or media depictions expressed ideas in culturally relevant forms,[102] were visually appealing[123] and represented participant communities, including in real-life scenarios.[135] This was seen as bringing clarity of interpretation and improving the local relevance of materials[205] and included the depiction of certain hairstyles or props, and figures participating in common cultural practices or represented within typical sociocultural contexts[119,137] or countries of origin.[114] Ballard *et al.*[106] referred to the use of cultural symbols displayed on treatment centre walls and visual materials featuring images of the participant group (Karen families in Karen clothes), created by a community artist. The authors reported cultural informants, who had been involved in the design of the intervention, feeling 'so good about' the symbols, describing this as the 'first time' they had seen themselves represented in this way.

Oral communication

Reference to work with or improving skills in working with interpreters was common.[95,100–102,104–114,116,118,119,121,122,126,128,129,134–137,139,140,142,143,145–147,154,156,157,163,164–179,182,184–188,191–193,197,203,205,210] Interpreter use was predominantly described as an in-person practice, although telephone interpretation was also reported, particularly where a language might be more difficult to find. Some studies used both. Where studies[104,106,112,145,168,173,184,197,202] reported focus on improving staff skills and capacity, there was reference to specific training that workers received or quality improvement approaches that focused on skills and recommendations for working with interpreters, including interpreter-assisted psychotherapy, making improvements in cross-cultural communication, and standardising the use of interpreters in early labour following clinical concern that women were missing out on important information.[145] There was some emphasis placed on reminding workers of communication principles in health care and improving patient interaction,[168,202] as well as opportunities (student training) to practise and observe interpreter-assisted communication, which also included students being encouraged to provide constructive feedback to local agencies and medical centres.[173] Others described including requests for use of professional interpreters in all referrals[175,203] and efforts to improve data systems to establish recording methods for documenting patients' preferred language and need for translation.[145,186,198]

Some studies made it clear that interpreters were prioritised from the beginning of any interaction. Harkensee and Andrew,[95] for example, described families contacted or visited by a specialist migrant health visitor 'with the help of a translator' as part of a first introduction to the service. Again, on attending the clinic for a first appointment, the translator would be part of a 'welcome' that would also include the receptionist, health visitor and clinic nurse. Another study[203] described the inclusion of information regarding how to request an interpreter when making an appointment on a service information sheet (provided in several languages to new arrivals), while Lambert[186] described a relationship between dentists and refugee welfare organisations that ensured clients were only supported to access a particular dentist where languages spoken were matched or where clients were accompanied by a translator.

One study[109] indicated that, although the children attending their school-based mental health service spoke 'sufficient English', they would still work with interpreters when talking with parents or carers. Another highlighted the importance of culturally centred language that is familiar and comfortable to participants and accounts for differences in subcultural groups, describing the practice of interpreters 'checking in' with participants throughout each session to assess and address comprehension.[106] One study[135] acknowledged the need to ensure that the appropriate dialect was used.

Enhanced interpretation

Studies often described some form of enhanced characteristic relating to interpretation.[105,106,110–112,114,118,119,121,123,125–129,131–135,137,139,140,142,143,145,146,148–150,156,159–161,163,167,169–173,175–179,181,184,187–191,197,120,204,205,208] Here, there was some reference to working with specialist health care or medical interpreters,[112,173,175,205] interpreters who 'know the health literature'[169] or those who were also registered nurses.[105] There was mention of interpreters who were experienced at working with a service, resulting in 'familiarity with a programme' and 'good working relationships' between practitioner and interpreter which were framed as facilitating consultations.[126,177] One study[102] described the use of interpreters, if possible, who were gender specific.

There was common acknowledgement of cultural mediators, cultural brokers or ethnic, bi/multilingual, bicultural, biprofessional workers, sometimes described as 'co-facilitating',[114] 'in partnership with clinical staff',[176] or 'culturally mediating' sessions.[176] These workers were often also referred to as having a refugee or migrant background, with some authors[106] reporting specific efforts to employ members of participants' communities as a way of *building capacity*[111,114] among the refugee community. In one study,[125] 'cultural brokers' were described as 'integral', involved in clinical team meetings. In implementation, they worked between Somali families, clinicians and social workers, bringing not only translation but a 'nuanced understanding of both cultural perspectives' to the delivery of a youth mental health service. Others similarly described these cross-cultural roles as a means to improve effectiveness, bring essential cultural insight[106] or provide a 'critical link' to communities.[125]

There was some reference to interventions being delivered in participants' native language, where health educators who shared the same language and sometimes culture or ethnic background as participants would be specifically employed to deliver the programme[137] or, as in Woodland *et al.*,[175] where patients would be referred preferentially

to a local bilingual GP. Other studies also described clinic staff,[134,169] including GPs, allied health practitioners, nurses,[197] mental health workers[134,141] and reception staff,[197] again sharing the same languages as participants or local refugee communities, and there was reference to an advocacy team established on the bases of student advocates bilingual competencies.[173]

These shared *reflections* of participants also included characters[137,170] at the centre of educational interventions, where Nickerson *et al*.,[170] for example, described a series of videos featuring Arabic-, Farsi- and Tamil-speaking men sharing personal experiences in overcoming stigma.

Other communication considerations

Other communication considerations mentioned by authors included the grouping of participants based on language,[110] or setting a limit on the number of languages allowed per group to 'facilitate the group process'.[142,154] One study[145] described initiatives to enhance the engagement of professional interpreters, although it was not clear what these initiatives involved, and another[184] described the inclusion of interpreters in staff training programmes around the bureaucratic and legal issues facing participants. One study referred to communication with Kosovan asylum seekers that sometimes took place through a shared (second) language (English or German).[146]

There was reference to additional time allocated to programmes to account for interpretation,[114] the use of dictionaries as an additional communication tool,[146] and fairy tales, singing and dancing to convey health education messages to children (although it was not clear whether these were traditional to participants or to the local culture).[134] One study[199] reported the decision to provide therapeutic support to children and young people through art psychotherapy, psychodrama and horticulture, in part because as therapies 'they had been demonstrated to bridge cultural and language barriers'. There was reference to advocates supporting language skills as part of holistic models of care[111,192] and the provision of support with access to language courses,[101] while Lee and Shin[135] described the use of video subtitles against translated audio content as a way of supporting participants to understand commonly used local words. Some studies[111,114,192] expressed the importance of acknowledging the expertise and assets of participants, including their multilingual abilities while there was occasional reference to participants who spoke 'fluently'[201] or 'understood'[182] the local language.

Cultural and experiential recognition

Some form of cultural or experiential recognition was widespread (101, 93.5%).[95,100–108,110–118,122–143,145–151,153,154,156–168,170–194,197–206,208,210] Authors using the language of 'cultural competence', demonstrating 'cultural safety' or described an interest in ensuring that interventions were 'relevant' or 'sensitive' to the study population. Again, studies generally reported a range of practices and considerations.

Displacement experiences

Interventions were typically described with at least some consideration given to *displacement experiences*.[95,100,102–108,110–112,114–116,118,122,124,130–132,134,135,137,138,141–143,145,146,149,150,154,156–161,164,166–168,173,175,176,178,179,182–184,187,189,190,192–194,197,199–206,208,210] Sometimes this was in the form of acknowledging the complexity for people arriving and settling in a new country, the stress associated with acculturation and migration,[166] adjustment challenges,[134] role changes,[192] grief,[157] current living conditions,[160] as well as experiences in flight,[158] and in a persons' country of origin.[176,199] Studies would also refer to certain health,[145] behavioural[124] or social[142] risks, including social isolation[192] resulting from these experiences and identify particular intervention practices that aimed to reduce or manage these stressors. This included the importance of acknowledging the influence of traumatic and stressful experiences to patients or clients themselves, normalising someone's stress responses,[106] working to trauma-informed care principles,[107,114,116] and taking a refugee/cultural context into account,[102] as well as creating safe spaces[114] or using peer-led practices[132] to enable the sharing of common experiences, stabilising stress and increasing social support.

There was recognition in some studies of the absence of local knowledge that those who are newly arrived face with responding efforts to support and facilitate knowledge acquisition. This might involve making clear peoples' rights to care, regardless of, for example, proof of residence,[203] and providing information[100] including guides on local health and community services (sometimes produced in languages commonly spoken by local asylum seekers).[95] There were explicit efforts, often through advocacy or peer support, to directly support physical access to a particular health

service,[203] to encourage help-seeking and support individuals to navigate, utilise and negotiate their own access to local providers.[111,143,192] There was also reference to the value of cross-cultural exchange where creating spaces to facilitate mutual learning between local and refugee individuals around topics of interest such as health care, safety issues and the roles of men and women in each other's native countries, was seen as one way in which people could both adapt and understand new systems and cultures *and* maintain connection with their native cultural identities.[111,114,192] Intervention efforts also often included facilitating broader connections to well-being and other community services, such as language classes, schools, faith groups or refugee community support groups. This was sometimes managed through social prescribing[95] or peer- and student-led models of care.[111,114,192,208]

There was frequent reference to supporting staff in being aware and developing skills to navigate and support in response to these experiences and stressors. This ranged from taught modules, seminars and tailored education,[183] such as with nurses and primary care practitioners,[175,202] medical[173] and nursing students.[103] Sometimes this support was framed as a whole-system approach, one study[145] describing professional development right across the workforce that included not only clinicians but also managers and front-of-house reception staff, with a heavy focus upon building staff confidence and capacity in 'doing things differently' to support families of refugee backgrounds. There was reporting of practice-based or experiential learning through preceptorship programmes or clinic visits,[103,112,183,200] where workers might have the opportunity to shadow or be guided by specialists, such as medical anthropologists,[112] refugee health fellows[183] or specialist refugee health services.[197]

In one such case, a refugee health fellow would take a proactive approach to 'identifying and contacting general practices … with a high refugee caseload' or that had been previously identified as 'requiring support with refugee patients'. Fellows would attend clinics and provide 'intentionally informal and interactive' sessions to 'nurture engagement and participant-led discussion that was tailored and relevant to the needs and experiences of each member of staff', with further visits, secondary consultation, tailored education and ongoing assistance provided as needed.[183]

Training topics were described as focusing on 'refugee health'[173] and 'refugee experiences',[103,175] identification and case management of patients with a refugee background,[143,175,197] including support with improving data management systems that are able to record refugee status, preferred language and interpreter needs on a patients' electronic medical record.[197] Other training focused on specific health challenges, needs and their presentation[141] (see also *Health risks and vulnerabilities*), including specific care considerations for unaccompanied refugee minors[104] and refugee families.[103] Some included general information about different countries from which patients may be arriving,[108] causes of migration,[103] international humanitarian response,[173] refugee resettlement and asylum application processes, healthcare policy and rights to care for newly arrived refugees (and other migrants), health financing, such as Medicaid,[108,173,193,202] and 'attitudes of local people toward refugees'.[103] There was also reference to training that considered the role of faith, spirituality and beliefs in well-being and stigma,[104,141] and the healthcare navigation challenges faced by patients with a refugee background.[121] There was reference to courses on the social and mental health impact of migration and difficulties in the adaptation process,[103] building trust with a client, explained as 'vital for refugees who will naturally be distrustful of authority figures because of past experiences',[194] and curriculums designed around principles of trauma-informed care.[116,173]

Studies often described practices that emphasised the cultural aspects of delivering care. Sometimes authors simply referred to the language of cultural sensitivity, transcultural competency or humility as a grounding to practice or an intervention but there was also emphasis placed on recognising how culture may influence healthcare behaviours or perceptions.[112,116,173,184,200,202] One study suggested that providing 'packages of learning together', such as with a focus on acute health needs of refugees, legal issues, provider–patient communication, socioeconomic and cultural aspects of health and illness, distress or pain, and specific issues resulting from living under difficult living conditions could support workers' broader understanding and therefore better 'enable the delivery of culturally sensitive health care'.[202]

The use of case examples of migration *stories* were also described,[103] including through exposure to refugee speakers, documentaries or 'books on refugee/asylee resilience'.[173] Virtual training activities were also reported and used to simulate client interactions around mental health[108,141] or interpersonal and intercultural competence.[138]

Beyond training, there was occasional acknowledgement of the need to consider the impact on staff of working with people with refugee backgrounds; authors referring to compassion fatigue, burnout and secondary trauma,[116] psychohygienic measures to deal with the 'burden' on staff of working with forced-migrant clients,[176] the ethical challenges of delivering health care to refugee patients,[173] the evaluation of working capacity[104] and of self-care.[173] Authors sometimes made clear that time was made available during working hours for training courses[104] or that courses were designed to be easily accessible and not demanding on time.[202]

Health risks and potential vulnerabilities

There was heavy reference to health risks and vulnerabilities experienced by refugee populations.[95,100,102,104,107,111,112,114,116,124,127,129,131,132,137,139,141–143,145,146,149–151,153,154,156–160,162,164,166,170,171,173,175,176,178,183,184,186–192,197,202–204,206,210] This included a focus on maternal and child health outcomes,[145] cervical cancer screening[137] and mental health (see below). Sometimes this provided the rationale for health promotion practices aiming, for example, to foster individual 'empowerment' through health management and prevention sessions such as for diabetes.[178] Health promotion also took the form of information sheets (usually in recipients' first language) that might describe prevention, diagnosis or self-care of certain conditions,[94,178,203] while one study[107] reported community lectures, which authors described as part of a broader programme to reduce ASD stigma among members of local Arab and Muslim communities.

Some studies[95,103,146,153,166,187,197,203,206] described health screening and extended medical assessments. These were typically nurse-led and would include questions relating to various physical symptoms such as headache, abdominal pain, dysuria, palpitation, cough dyspnoea, insomnia, which authors reported might be indicative of underlying conditions, including mental health needs and infectious diseases. Screening might also include health behaviours, current health problems and treatment, and exposure to traumatic events[146] and there was occasional reference to the 'refugee journey', including travel history, with particular interest in exposure risk to infectious diseases[95] and violence.[187] One such study[206] described screening as part of an interdisciplinary clinic providing specialist health care to refugees and asylum seekers for up to 2 years after arrival, while another[95] framed their screening programme as a means to facilitate first contact and referral with other health services (which included making recommendations to GPs around specific tests they might want to consider, such as the micronutrient status of menstruating females). Others referred to training modules on acute health needs of refugees, flight-specific health needs, red flags, infectious diseases, and vaccination coverage[202] and medical screening or evaluation of refugee populations.[112,173]

A further study[203] described working with communities to outline *why* newly resettled refugee children would benefit from attending a health check and another acknowledged that despite high levels of need, people may have other priorities following initial arrival, aside from health.[137]

Authors made reference to sessions longer than might be usual to account for complex needs and/or translation, training that included principles of health prevention and access for patients with a refugee background,[173,202] help-seeking,[114] and how to consider ethnocultural issues in clinical interactions.[143] Authors occasionally referred to staff and collaborators who already had extensive experience in refugee health.[142, 178,206]

Most common were health risks that were framed in relation to mental health,[100,102,103,106,111,112,114,116,122,124–126,130,132,138,140–143,149–151,154,156–160,162,166,170,173,176,177,180,181,185,188,191,192,198,200–202,204,210] studies often acknowledging the psychosocial consequences of war and displacement and the potential exposure to traumatic events that people may have faced. Studies sometimes referred to practices aimed at preventing further escalation of mental health needs[114,124] or limiting repercussions of health needs such as on integration,[176] with reference to the use of cross-cultural relationships between refugee families and students as a means of humanisation, increasing access to resources, and making social connections that could reduce settlement impacts on mental health.[111,114,192]

Group activities were sometimes described as being selected to provide the opportunity for social connections or for people to talk with others about shared experiences.[179] Studies also acknowledged mental health impacts of the loss or dilution of roles[192] and this was sometimes used as justification for working with communities themselves to deliver interventions, drawing on peers, community leaders and elders not only as a mechanism of cultural acceptability, but as a strengths-based approach, supporting social connections, providing meaningful social roles,[192] and valuing and

showing respect.[179] There was acknowledgement too and corresponding practices in recognising the link between the mental health of broader family members and that of children.[95,124]

Several interventions concentrated on building capacity within local services or communities, including training of local mental health service providers and paraprofessionals, such as refugee settlement staff, public health nurses, school co-ordinators, community health workers, refugee community leaders, volunteers and interpreters, in understanding the impact of 'exposure to violence' and the 'migration process', in providing refugee trauma-informed care, promoting refugee resilience and identifying mental health needs, disorders and risk factors,[116,132,173,187] including the physical symptoms indicative of psychosocial needs.[95] There were also reports of supporting integration workers to convey 'non-judgemental attitudes'[102] and to develop the skills in conducting conversations with people who are 'mentally stressed'.[176] There was reference to understanding hidden and collective trauma, as well as recognising the multiple perspectives on mental health, particularly in relation to cultural expressions of stress, trauma,[102] stigma,[114] suicide and domestic violence,[200] with one study[170] focusing specifically on refugee men as a population they described as 'less likely to access psychological treatment than women' and for whom help-seeking was often highly stigmatised. One study specifically aimed to help professionals and caregivers to normalise children's reactions to war and violent conflict.[124] Other studies described similar psychoeducation approaches to support refugee participants to understand how traumatic experiences, stress and resource poverty can impact day-to-day life, bodies and mental health.[132,170]

Broader contexts

Many studies[95,100,101,104,106,107,110,111,114,116–118,121,124,125,127,129,131–134,137,139,142,145,154,156,157,160,161,164,167,168–170,175,176,179,180,183,184,186,189,192,194,197,199,202–206,208] drew attention to the intersection of various sociocultural, socioeconomic, structural and institutional contexts impacting health and barriers to care (see also *Costs and resource*). Authors largely associated these with interventions that took holistic,[111,114,192] multisystem[167,175] and collaborative approaches to address resilience, stabilisation and social and community bonds, as well as interventions that included concern with access to safe housing and living conditions[176] and material goods.[114]

Strengths-based[110,111,114,192] and ecological perspectives[192] often saw interventions seeking to recognise and '(re-)vitalise' the resilience[142,179,192] of people whom one study[192] described as having 'faced abnormally difficult situations'. Attempts to cultivate psychological resources[110] and self-efficacy through advocacy,[111,114,121,192] reciprocal mutual learning between local and refugee communities[111,114,192] and a focus upon community bonds and social connections,[110,132,142,145,192] both between refugee and ethnically minoritised communities, and more broadly, were described. This was sometimes linked to supporting people to recognise their strengths and abilities and to enhancing meaningful social roles, with clinical as well as psychosocial interventions putting importance on 'future planning',[110] 'building community in settings of displacement',[124] and the hopes and aspirations of individuals,[95] including access to school and learning opportunities. One study described this being managed through social prescribing.[95]

Multidisciplinary approaches aimed at better connecting refugee clients or patients with services and their broader communities were framed as influencing healthcare barriers and meeting holistic and psychosocial health needs.[101] One study described 'consultation with other providers, such as teachers and advocacy with other service systems' as important components of their mental health service,[205] while several talked about facilitating early support and navigation of 'complex medical systems' (see e.g. Malabranche *et al.*[206]).

Some interventions were part of efforts to redesign local responses,[114,192] engender sustainable change[132,192] and 'social justice'[114] or deliver 'whole-of-system' improvement strategies that in one study[145] included multiple services reforming data systems, professional development, partnership working and improved use of interpreters. There was reference to local cross-sector collaborations, ensuring that health services were informed of new approaches to improving refugee health care in their area[117] and intentional working between sectors (health, social care, voluntary and community),[100,175] which was framed as facilitating access to clinics and programmes[95] and optimising patient engagement and care transitions (such as between maternity, child health and community support).[145] There was also reference to mobilising community leaders to host and support delivery of psychoeducation sessions as a means to build local capacity directly within a specific (Somali) community.[132]

Authors reported the practice of mapping community and help-seeking resources and information identifying specialist organisations working with refugee communities to support signposting, referrals and clinical guidance for staff.[108,132,170,197,202] There was also reference to the development of formal arrangements, such as information sharing, health recommendation letters sent to GPs and other relevant partners following screening or appointments, and new referral pathways or linkages[95,175,186] often between a range of providers, including general practice, mental health services, dental, vision, hearing and dietary services, pharmacies, local (re)settlement agencies, housing providers, and the voluntary and community sectors. One study[186] described ensuring that other local providers were aware of particular programmes working to support refugee populations to access their care, another[110] focused on efforts to ensure that the characteristics of a localised refugee population were shared with care providers, while others acknowledged the importance of communication in relation to where forced migrants were being resettled or housed, acknowledging the absence of this information being provided by immigration authorities.[95,203,206]

Sometimes interdisciplinary support was co-located[206] or formed part of a local working group focused on improvements and collaboration,[145] and in-kind contributions from partners were sometimes seen as a way of leveraging health resources.[175] There was reference to the benefit of collaborating with those with extensive cross-cultural experience[132,137,178] as a way of providing cultural insights and help in identifying community needs.[107] Equally, networking across sectors, including local leadership, was presented as a means to promote the needs of refugee communities, build capacity, and advocate on behalf of, monitor or seek help in reaching a specific community.[175,203]

In some studies, there was acknowledgement of policy issues impacting people with a refugee background, as well as the broader oppression and prejudices experienced by immigrants or study participants, and this was sometimes used to explain certain aspects of practice. In Lee and Shin,[135] for example, the rationale for remote delivery was in light of North Korean refugee participants not wishing to meet with other defectors in public. Authors in other studies acknowledged the practice of making people aware that screening was always voluntary, that health examination outcomes would not influence migration status or jeopardise rights to access services,[203] and that giving people space to talk about negative racial interactions, alongside other topics such as healthcare access, was important.[114,192] Authors in a further study highlighted adaptions in response to Muslim women who feared 'derogatory comments', 'prejudicial jokes' or 'having things thrown at them' if they were too visible to passers-by during physical activity sessions.[113]

Engaging communities and responding to needs

Many studies[95,100–102,105–107,111,113–116,119,123,124,131,132,136,137,139–141,143,145,147,156,157,160,165–167,170,172–174,176,179–183,189,191–193,202–204,206,210] referred to local refugee communities actively initiating, developing, adapting or verifying the content of interventions or programmes. This was commonly framed as an important mechanism in ensuring cultural sensitivity,[123] in assuring the appropriateness or utility of the programme approach[147] and in sustaining community buy-in.[107]

This engagement was sometimes described as 'consultation', 'input', 'focus groups' or 'informant interviews', sometimes with local stakeholders such as 'community leaders' from the religious,[214] cultural and linguistic communities of participants.[147] It often involved community meetings in which practical details might be discussed, such as appropriate times or locations that an intervention should take place.[113] Studies described working with community advisers to generate specific session content relating, for example, to stigmatising beliefs around help-seeking[170] or to adapt, as in Ornelas *et al*.,[137] a cervical cancer screening video to increase its relevance to, and engagement with, different refugee population groups. Other contributions included checking the acceptability of intervention procedures,[166] reviewing materials for usefulness with the study population,[124] and iterative processes of refining content for 'clarity'[205] and 'acceptance'.[100] There was also reference to participants setting the topics for programme sessions, one study[143] reporting families prioritising discussion around how 'family members get help for sadness, fear, and sleep problems'. There was some emphasis on the collaborative nature of these programme–community relationships,[172] in McDonald *et al*.,[179] for example, *respected elders* (married men with children from the local Hmong community with 'prominent professions' such as a lawyer, a public health inspector and a pharmacist) were invited to be co-planners, co-adapters, co-evaluators and implementers of a programme, which authors framed as an important aspect of their approach that reflected the historical leadership role of 'male' elders in the community.

Several interventions were framed as responsive models of care able to adapt and tailor to individual or local needs or concerns.[95,111,114,179,192] Guerin *et al*.,[113] for example, reported the painting of glass doors and windows so that women

could not be seen during their exercise sessions and emphasised the importance of constant consultation with diverse populations, cautioning against making any assumptions of cultural competency.

There was also reference to the value of cross-cultural exchange,[111,114,192] where authors described creating spaces to facilitate mutual learning between local and refugee individuals around topics of interest which might range from health care to safety issues and the roles of men and women in participants' native countries.

Community representation

The delivery of programme content by refugee or shared communities was common.[103,105,106,108,110,111,114,121,123,125,130–132,137,138,141,143,148,150,156,157,160,161,163,167,168,170,172,176,179,182,185,188,190,191,193,194,201,204,205,208,210] Sometimes this included people in dual positions, with both a refugee background and qualified in public health or working for a resettlement agency[105] or, more frequently, it related to what were sometimes described as *lay members*, people with a shared cultural, religious or refugee background, or from the same home country as programme participants, usually bilingual or multilingual, delivering care. Sometimes referred to as patient navigators[121] or community leaders,[132] they would often be volunteers, sometimes paid workers (although this was not always clear) and would typically receive some form of training and supervision. Authors sometimes suggested these forms of peer-led processes[132] brought 'cultural value', referencing cultural traditions of solidarity and cohesiveness, cultural reluctancy to seek support and guidance outside of the family[143] and cultural reflections of patriarchy and respect of elders.[179]

A number of studies used videos to convey health messaging or impart health knowledge, often visually representing participant populations. Ornelas *et al*.,[137] for example, as part of their cervical cancer screening programme, depicted characters representing several generations of Burmese and Bhutanese women, as well as a character specifically requesting to be seen by a female doctor. Similarly, Nickerson *et al*.[170] drew on video case studies of refugee men to evidence the benefits of sharing experiences for those struggling with psychological problems and to help identify the different professional roles and informal contacts from whom the men could seek support.

Studies sometimes made reference to seeking assistance from interpreters with similar backgrounds to participants[105,110,111,114,167,176] (see *Enhanced interpretation*). Such individuals were seen as not only supporting translation, but also as acting as cultural mediators, expected to convey cultural content or nuance.[176] This was sometimes anticipated to improve the effectiveness of intervention delivery, particularly where practices involved motivational interviewing (see as an example, Alrashdi *et al*.[168]).

Flexing for divergent views and traditions

In addition to sociolinguistic practices, some authors[101,102,104,106,111,113–115,118,119,121,123,125,127,128,130–133,135,137,139,141,142,149,150,156,159,160,165,169,171,173,178,179,188,189,191,192,199,200,203–206,208] identified specific mechanisms that were introduced to negotiate, engage or reach across different cultural or ethnic communities. Sheikh and MacIntyre,[203] for example, described using *ethnic radio* (listened to by culturally and linguistically diverse communities) and networking with 'influential members of the community' to target sub-Saharan African refugee communities in their health promotion campaign. Similarly, following advice from cultural informants that their target population (Karen refugees) were 'unlikely to ever call a number on a flyer', Ballard *et al*.[106] referred to the use of personal invitations made by 'local leaders', including religious leaders, teachers and interpreters to encourage attendance at a group-based psychosocial programme for parents and children. Here, people were also encouraged to 'bring along friends'.

Practices would often be framed around valuing or enabling the maintenance or exchange of cultural practices or traditions, such as traditional music or dance.[114,191] This saw one study[179] describe the use of traditional ceremonies, chanting and storytelling as part of a group programme of nutritional and psychological education,[115] and another[142] reporting the sharing of supportive cultural wisdoms and rituals in discussions around migration stressors.

There was reference to the importance of traditional cuisines and sharing meals[123,179,188] with authors in one study suggesting[179] that a shared meal, prepared by participants, provided an opportunity for social connections. Others described the provision of traditional *manakeesh* (thyme pastries) for Syrian children[123] and the guiding of participants to local stockists of their native ingredients as part of a diabetes awareness programme.[178] Elsewhere, the development

and cooking of a menu by Palestinian women for Palestinian children, as part of a health education and nutrition programme, was framed as providing broader benefits in terms of income creation, identity preservation for the women in the refugee context and promoting native culture among the children.[118]

Some studies talked about using and maintaining historical traditions, such as collectivist attitudes and the role of community leaders or elders who would be seen as a source of 'protection', 'advice' and 'support'.[143,179] There was occasional reference to giving space to the contrast or intersection of different cultures between local workers and forced-migrant participants,[111,114,192] something that was also acknowledged as beneficial in terms of intergenerational relationships (between refugee children and their parents). This was framed as providing an opportunity for children to 'hear parents talk about their cultures in a positive setting' and showing children 'that [local] Americans can have positive views of cultural practices and viewpoints other than their own'. There was also reference to opportunities for parents to understand the challenges their children might face in school[111,114] and to talk about and acknowledge the differences between living in your homeland versus the settlement country.[132] There was discussion around the broader fostering of intercultural exchange as important in the development of relationships and the acculturation process, supporting well-being through recognising as assets, the knowledge, experiences and strengths that refugee communities bring to settlement spaces.[114,192]

There was reference to participatory and interactive learning approaches delivered in informal settings as 'required' in the context of participants' 'African culture and beliefs',[178] 'co-operative approaches' as the cultural norm[107] and making use of group discussions as a method to integrate opinions of participants' own cultural group.[102] Authors in one study[121] described the use of a patient navigator model because it was similar to programmes in participants' native Nepal and similarly storytelling traditions in another,[179] while another study[113] made reference to the religious practice of Ramadan and the need to acknowledge its influence on engagement.

The organisation of same-sex groups[102,150,188] shaped decisions in how one intervention was provided and a number of studies drew attention to 'uneasiness' for some women in seeing male providers for women's health examinations,[137] the right to request a female physician[137] and the benefit of a majority female workforce as an important aspect of 'care for many refugee women'.[167]

Other engagement practices

Although not always independent from some of the cultural and experiential considerations already reported, a number of further practices were described that may also foster responsive care.

Costs and resource

Authors[105–107,111,113,117,118,120,121,123,124,127,129,132,136,138,139,167,171,174–176,179,186,203,210] sometimes gave attention to resource scarcity (participants or an organisations), including the provision of resources as part of an intervention that was sometimes framed as incentivising[105] or facilitating participation.[111] This included being sensitive to people's financial constraints[106,107] and saw providers stressing to service users that services were free of charge,[175,203] identifying contingency funds to be used where required, such as for pharmaceuticals where these items were not met through statutory funding,[175,203] providing or subsidising transport (see below) and providing free or highly subsidised meals and refreshments.[106,118,123,132,171,179]

Several studies also reported the provision of programme-specific resources such as toothbrushes, toothpaste and floss,[167,186] stress balls, yoga mats,[159] a public health record with pockets to insert documents and vaccination cards,[117] books and information pamphlets with suggestions, for example, around supporting children through settlement[105] and accessing services.[203] One study[120] reported providing each person taking part in a broad physical and psychosocial health promotion programme with a mobile phone that included a range of unlimited free-call numbers on speed dial, including for peer support group members, a telephone interpreter service, a small quota of personal contacts and participant-chosen service providers.

There was reference to the provision of additional social activities, such as craft workshops, excursions and walks, as an add-on to a group psychotherapy and social counselling programme[176] and, in one study,[113] the offer of subsidised gym membership.

Several studies described interventions specifically designed to be delivered with limited resources[110,118,124] and there was recognition of the benefit of sharing office space, telephones, computers and internet connection[121] with other services. One study[175] reported ensuring that state financing arrangements were fully used (in the Australian context through Medicare and bulk billing).

Reaching people

Practices to 'maximise accessibility' or support engagement were described by a number of auth ors.[95,102,104–106,109,111–114,118,119,121,122,124–128,132,135–137,139,142,143,147,154,157,159–162,164,165,168,171,173–175,179,186,187,191–194,198,199,201–205,208] These were often associated with physical access, involving, for example, the provision of transport[112] or support with transport costs, one study[106] suggesting without which most participants would have been unable to attend. Others highlighted the importance of making people aware that they may qualify for transport assistance when booking an appointment[137,193] and there was reference to accompaniment of individuals to appointments[186] and the provision of clear instructions on 'how to get a child's health checked', including a map and directions.[203] Home visits[125,143,173,205] were also described, as was the use of mobile-based interventions, framed by some studies as a mechanism enabling access to health education at users' convenience,[102,135,202] with one intervention described as being tech-based but available offline to limit issues with costs of data or unpredictable internet access.[210]

Many studies described the hosting of interventions by local community-based organisations, sometimes nationality specific or places of worship (in Chaudhary *et al.*,[201] a local masjid), justifying these spaces as more familiar,[132] accessible,[121] comfortable[173] or appropriate[179] for healthcare delivery, 'already at the heart of the community'.[121] With the same rationale, one study[205] included the option to meet in public places such as a park or a restaurant, while schools were also described as an important location in which the mediating role that schools can play in helping children navigate the acculturation process can be exploited.[106,109,126,134,199] Here, it was mental health services particularly that schools often hosted.[109,126,205] School locations too were framed as reducing power disparities between both child and therapist and the school and therapist, seen as a way to facilitate both patient engagement in mental health services and improve integration of education and health.[199] There was frequent reference to clinics or sessions taking place in close proximity to the communities within which refugee populations tended to live,[104,113,118,143,203] or intentional efforts to refer patients/clients to the closest available clinics.[186] One study[122] described telephone psychiatric evaluations of asylum seekers as a tool that may increase the accessibility of support for harder to reach individuals.

Several studies[105,111,114,118,188] acknowledged the provision of free child care, often by an onsite nursery or an informal arrangement in which young children were cared for by programme staff. This was framed particularly around its benefit to women through enabling mothers to fully participate in programme activities.

One study[124] described delivering child and parent sessions in parallel and another[118] during school hours to address the same issue.

There was often reference to interventions and screening that could be provided by non-specialists,[110,118,124,147] including clinical staff, such as nurses and GPs who might not, for example, have specialist mental health training, but also from social workers, settlement workers, teachers or lay members of communities. One driver of delivery by community members was reported as an aim to improve the cultural alignment of practices, presented also as an efficient way to guide individuals towards preventive care and social services and increase engagement. More broadly, non-specialist delivery was referenced as a mechanism to reduce delivery costs and improve the sustainability of a programme.[132,142,186,187] Here authors sometimes referred also to practices that were brief and could be incorporated into existing care, such as motivational interviewing which was described as a mechanism for creating more empathetic interactions between refugee individuals and resettlement workers providing psychosocial support.[194] Although most studies referencing non-specialist delivery also reported some form of training and support for workers there was also reference to a tool (diagnostic screening for major depressive disorders and PTSD in asylum seekers and refugees) designed as 'sufficiently simple' to require no training.[147]

The timing of an intervention was reported in some studies to have been chosen to coincide with (follow) an existing activity (language class),[113] a regular local orientation session,[178] to accommodate church schedules or school[106] (also see

child care) or to take place during accessible hours (as specified by community members), such as Saturday mornings,[179] after dark,[113] or with weekday and weekend sessions to accommodate different schedules.[121]

Some studies adopted strategies to address some of the factors influencing the risk of missed appointments. This included emphasising to participants the importance of communicating 'in advance' any changes they wish to make to an appointment time,[203] making multiple reminder calls,[106] including a home visit (camp setting) as a reminder the day prior to an upcoming group.[205] For one study, whose primary aim was reducing missed appointments, a flagging system enabling workers in a community organisation to be notified of a client's upcoming dental appointment, dedicated support work, reminders, supported attendance and no-show fees (paid by the organisation to clinics if appointments were missed) were all used.[186]

Some studies acknowledged the importance of a comfortable and trusting relationship between those delivering and receiving care. While this was sometimes linked to peer delivery (see above), consistency over time was also framed as beneficial,[111,114,192] and suggested by one author[173] as well suited to a mutually beneficial relationship, such as with medical students. Authors of another study[205] suggested that as asylum or (re)settlement case management activities typically build trust, these roles were well suited to mental health 'assessment' and supporting 'engagement into mental health services'.

Regular praise, encouragement and rewards when engaging children,[134] setting ground rules at the beginning of group activities,[205] being conscious of social sensitivity such as in relation to physical activity and weight,[100] and efforts to ensure children's group activities were appropriately matched with the child's age[110] were also reported as mechanisms to support engagement.

Table 3 summarises the frequency of reported mechanisms of potential responsive practice.

Themes of impact

Reported impacts were considered for inclusion in line with our indicative framework of access to care. This resulted in 93 studies providing a range (and often multiple) evidence of impact. Measures are detailed in *Table 2* but most commonly related to the *acceptability of services* (through direct measures such as patient experiences, engagement, and utilisation and proxy measures such as knowledge,
skills and attitudes of caring practitioners), *adequacy of accommodation*, such as ongoing patient
barriers (direct) and co-operation between agencies (proxy) and health agency (including measures relating to help-seeking intentions, health knowledge and awareness, and acculturation). Through
an iterative process, findings from each measure were categorised into six main themes of impact (*Figure 3*): (1) utilising and creating community; (2) networks of care (including the subthemes non-
specialists, schools, shared communities, building capacity and systems); (3) proactive engagement;
(4) considered communication; (5) informed providers and attitudes; and (6) a right to knowledge (including subthemes behaviours; health promotion; self-stigma). These themes should be seen as intersecting and simultaneous. A brief summary of themes of impact can be found in *Appendix 8* with a narrative description below.

Utilising and creating community

The role of community as a beneficial *mechanism* in the design or delivery of a programme and the creation of community as a beneficial *outcome* of programmes was indicated in participant engagement,[105,124,150,151,154,163,173,179,188] reduced stigma,[105,115] increased community connections, mutual help and measures of acculturation and help-seeking,[105,107,109–111,114,115,131,132,143,154,177,192] and health awareness and knowledge.[105,115,151,163,195] This often related to group activities, usually where there was shared heritage or gender, or where activities were led by someone with a shared background. Programme activities were usually interactional and often involved conversational learning, providing an opportunity for an awareness, for example, of the symptoms of stress and distress in a context in which mental health might be more commonly stigmatised.[105,115] This was seen to have multiple 'benefits' in helping people to recognise that others' experienced similar problems,[150,160] to no longer feel 'ashamed', and to strengthen community relationships; 'they [community workers] make us trust ourselves and trust each other and we can use conversation without being scared with one another'.[105] Two studies[150,163] reported the occasional participant who found the group format challenging.

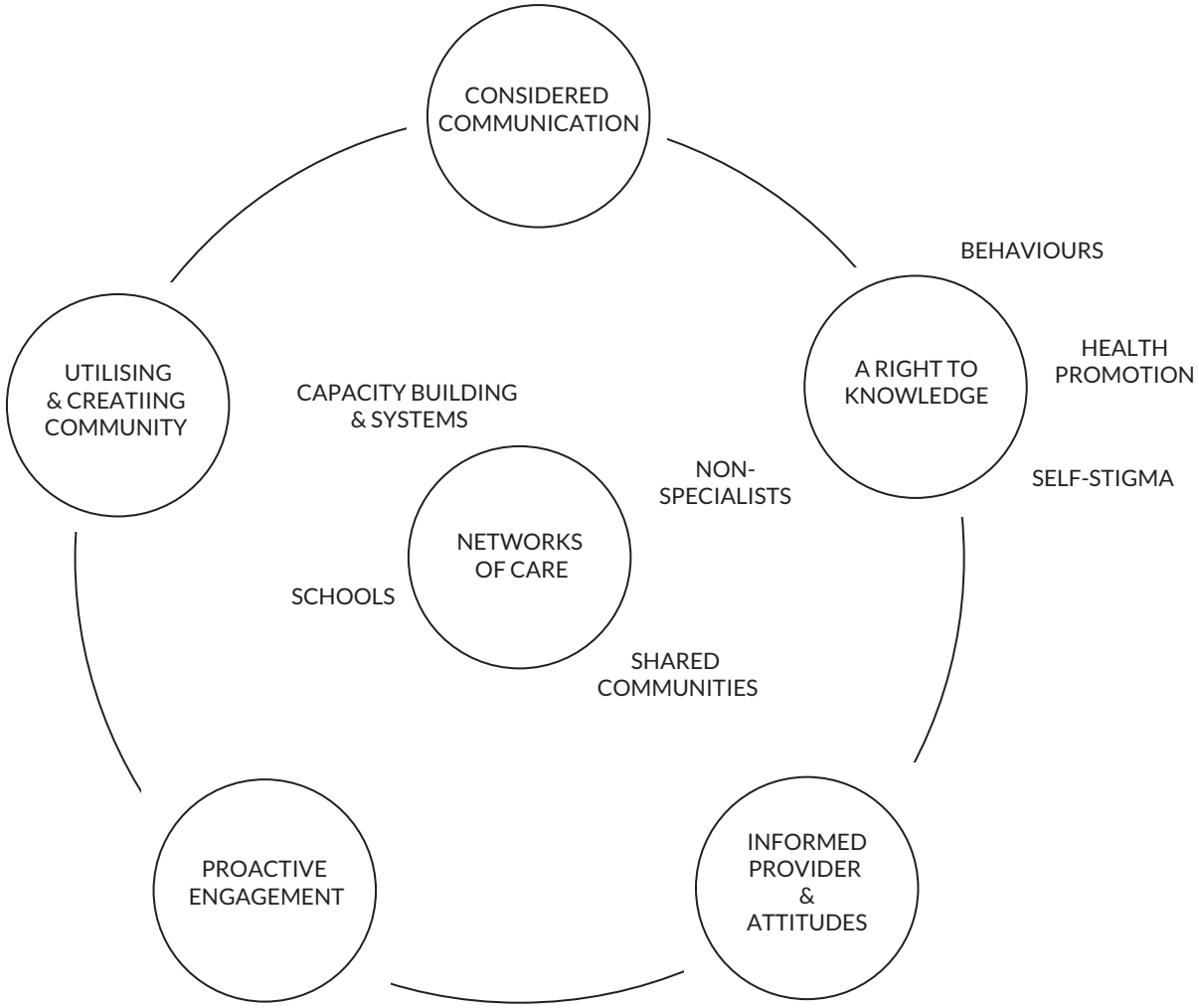

FIGURE 3 Themes of impact.

Impact here was often associated with an element of community empowerment or motivation, with people reporting a new capacity 'to fight for our own' and to 'help our people',[105] having greater self-confidence within their community,[107] or emerging as 'refugee leaders developing their own community health and well-being initiatives'.[114] There was reference to the realisation of community connections,[105,107,109,110,115,132,150,177] an indication that peer-led, group-based and shared heritage supported this and that these approaches provided important opportunities for friendship,[109,191] increased belonging and social support,[115,169] and the development of new social connections,[107,110,115,154,159,163,177] including opportunities to develop connections outside of a shared community;[159] one physical activity programme providing 'safe exposure to non-Somali women'.[113]

Although limited, there was evidence that such contexts also supported the attainment of new knowledge, as evidenced in a study comparing group with individual contraceptive counselling for resettled African refugee women, seeing considerably greater improvement in understanding of birth control[195] and gains in awareness and sensitivity to symptoms of anxiety and depression.

> *[T]here is a lot of things we learn here. Before we don't know is a sickness. You feel those feelings, but you don't think this is affecting you or anything. And a lot of our people have the same, a lot of this.*[105]
>
> *p.348*

Another programme also reported improved health knowledge, as well as competence in coping with both physical and psychological health concerns, identifying group interactions as a way of creating 'healthy communities',[115] and a further

study saw children describe increased social connections from a well-being and resilience programme that had allowed them 'to talk together, to speak together about stories, to share stories and experiences, and to be happy together'.[110]

There was some association between shared communities and a confidence and increase in seeking support and connections with wider communities and services,[111,177] with practices of mutual help *within* communities seen to support increased comfort in seeking help more widely, including increased engagement with broader health services.[115] Cross-cultural and intergenerational learning activities[114,131,179] were also seen to support this transition. The sharing of parental culture and traditions such as games, stories and ethnic foods with young children, for example, were seen to be activities in which groups and families were happy to engage but also which offered 'parental empowerment', maintained 'respectful habits of (parents') own traditional culture' and were seen as 'comforting and central' to the success of a programme focused on the resilience of refugee children and the gradual introduction of non-traditional local values and activities'.[179]

Similarly, student–refugee relationships, which typically included a combination of one-to-one, family and group encounters, were seen in several studies to support measures of acculturation to host[111,114,192,208] (and home)[192] cultures, such as through motivating action, independence, confidence in local communities 'reduc[ed] feelings of difference and being outsiders',[111] and increased navigation of health and other resources.[114,159,169] There was suggestion that these outcomes had been fostered by the 'comfort and trust' enabled through the 'strong' student–refugee relationship, 'now I see that a white person is like a human being just like anybody else'.[114] One study identified slightly higher engagement from households than individuals, suggesting that family/household-based interventions might support more flexible engagement.[192]

A health promotion intervention that included peer support and provision of mobile phones with predetermined free-call numbers was seen to enhance interpersonal, community and local connectedness. Participants referring to the phones as an important means of gaining assistance in high-risk situations: 'this phone is very important, I think [for] emergencies – emergency contact, doctor, Centrelink [welfare agency], schoolteacher'. Although they were found to be used more frequently for intracommunity calls, participants sought help from family, friends and community members to help with communication with agencies and professionals, including doctors and dentists, 'I don't ask my friends to come and help me at home. But sometimes if I need to make appointment, or I need to go to hospital, I call … to help me out with that. Because she can speak English'.[120]

Networks of care

Impact was also achieved through the creation of a community of care, a network of *non-traditional* healthcare providers, *re*-locating care in spaces of familiarity (schools, community and religious spaces), performed through or co-supported by trusted others (often community leaders and teachers), and often overlaying this, an attempt to create a frame or network of knowledgeable providers and actors.

'Non-specialists'

The 'non-specialist' theme included non-specialist nurses,[187] integration workers (although more limited data to support),[176] volunteers from asylum-seeker welfare centres,[147] sociolegal staff, interpreters (and medical workers)[162] able to effectively use culturally adapted screening tools to identify PTSD, major depressive episodes and/or to facilitate and encourage timely mental health referrals or engagement with therapeutic services. There was evidence of a range of welfare, public health, settlement and school staff and bilingual workers and interpreters (often also alongside healthcare workers) engaging in training on the healthcare needs of refugees and asylum seekers,[104,116,153,202] mental health literacy,[153,185] and motivational interview training[194] and leading to a range of practice outcomes: significant improvement in recognition of PTSD, depression and cultural expressions of trauma and stress-related symptoms;[116,153,154,185] knowledge of mental health problems[185] and trauma impacts,[116] and knowledge of culturally responsive trauma-informed care,[116] evidence-based interventions,[185] and appropriate support, healthcare systems and care management.[104] These trainings also saw improved knowledge of external resources,[153] competency, skills and confidence in the management of suicide[180] and other mental health needs,[153] the intention of workers to help, and confidence *in* helping, decreased negative attitudes towards mental health[185] and suicide,[180] recognition of the need to take time to build a rapport with clients[194] and increased emotional engagement[104] and empathetic responses.

> *[T]he way I communicate with my client is better now than what it was when I began. I am able to listen to my client and be able to put myself in the client's shoes. Before it was hard for me to put myself in the client's perspective.*[194]
>
> *p.66*

One study[185] noted that despite improvements, they were not maintained over time (6-month follow-up).

Training was sometimes referred to as empowering workers with the tools to support communities[153] and as 'useful'[194] and 'relevant'[180,194] to workers' roles, with opportunities to discuss techniques with others,[194] role play and observation,[180] the inclusion of former patients talking about their own experiences, and practical examples of good care facilitating learning, 'it is always a good thing to hear how others handle or have handled these things, these aspects. I also think it is valuable to bring up and discuss successful examples'.[104]

Schools

Schools were seen to 'welcome' assistance to better comprehend, recognise and support the challenges, experiences and needs of refugee children[107,124,126,175,199] with several multisector partnerships delivering school-based mental health support, health screenings and/or health advocacy seen as successfully implemented with high satisfaction from students, families, teachers and programme partners.[124,126,175,199] One study reported high fidelity to a stepped-care psychosocial model that largely centred around the school setting and involved a range of preventive general and specialist interventions delivered by teachers, clinicians and social workers.[125] Another study, similarly using a school environment, described high levels of collaboration, more appropriate and efficient use of tertiary health services, rapid response to health system barriers, improved co-ordination of services and increased capacity of local networks to meet the needs of refugee young people as impacts of their programme.[175]

School-based counselling was seen as taking 'the weight … and responsibility off staff' and as spaces in which families can be offered 'helpful' and 'useful' 'non-threatening support'[126] with schools and teachers as valuable mediators of contact with mental health services,

> *You know, he saw me the last two years, you know how I was suffering all the years. And he knew it really deep down what was going on in my life. So, um, the teacher, he made it really easy for me.*[109]
>
> *p.373*

Shared communities

Working with communities to provide health care, including disseminating knowledge to other members of communities, was seen as a viable way to build community resilience, reach refugee communities and to fit a model of help-seeking that begins within social networks before gradually moving to formal services.[121] These programmes often involved the *up-skilling* and training of members of often faith, linguistic, ethnic or refugee communities as a way of supporting peers and new arrivals and assisting in linkage to care. Programmes were seen to improve mental health literacy (in one study reported as 'concordant with that of mental health professionals'),[182] increase the likelihood of members correctly identifying depression or other mental health problems among people in their community,[130,141,182] result in community leaders 'more likely to encourage the use of professional help'[182] and have knowledge of mental health treatment options,[141] and have greater confidence in providing help themselves.[141,153,182] Training, however, provided mixed results in terms of stigma and attitudes toward people with symptoms of poor mental health, studies showing improvements[141] and minimal or no change.[160,182]

Health programmes delivered by peers and community members or co-delivered for example with nurses, physicians, psychologists working alongside community leaders were seen to have good and sometimes the increasing attendance over time, by members of the refugee community.[179,201] Experiences of these forms of care were described by recipients as positive[160] and culturally sensitive,[150,160] and there was an appreciation that living situations and problems were taken seriously.[160] These programmes were seen as feasible to implement and could maintain fidelity to programme design,[150] although one study[121] reported challenges in supervising high numbers of volunteers and doing so flexibly over weekends. These programmes saw positive community impacts: reduced family-related acculturation stress,[131] improved mental health and trauma awareness,[115,132] reduced mental health stigma and improved attitudes towards

trauma mental health,[115,143] improved understanding of mental health counselling services,[115,143] and improved use and competency accessing psychiatric[143] and 'proper health resources'.[115] Repeated social modelling by peers and opportunities for practice were seen as potential facilitators of improved knowledge of health services, patient activation (active engagement in their care) and health service navigation:

> *[the patient navigator] tell me … you have to learn to make calls by yourself … I'll dial the phone … you have to speak and ask for the interpreter. That's what she told me and I spoke … She was there. I was safe, secure. I feel good about that.*[121] *p.531*

In one study,[121] participants reported feeling comfortable seeking help from community members because this was seen as 'the correct way to behave in society' and 'altruism and mutual assistance' were in line with their (Nepali) 'cultural and social norms'. It was highlighted however that in order to seek help, people needed to perceive someone as a leader, having some form of 'qualification', 'English proficiency', were 'educated', or knew 'the system'. Similarly, elsewhere participants identified the need for 'community resource centres … where volunteers are available to help to solve their problems' because 'communities would typically turn to other community members for help'.[182] In a further study, some intercultural mediators suggested that improvements could be seen if they were to receive additional training focused on how their role fit into the treatment approach and if there were better communication between themselves and the therapist.[161]

Therapists in another study described working with an intercultural mediator as one of the most important elements of the treatment model.[150]

Capacity building and systems

Explicit intersectoral capacity building prioritised the development of systems for multisector co-ordination of care, increasing the detection of specific health conditions outside of traditional health settings, linking refugee communities with formal health services and improving the capacity of workers across a wide range of sectors to respond to refugee and asylum-seeking communities. On the whole, these were seen to improve local systems through increasing formal relationships between service providers, creating networks of care, improving understanding of local support and healthcare systems, and introducing new referral pathways,[104,106,175,183] including timely referrals into specialist health screening.[95] This was reflected in improved time to first clinic visit for antenatal care for government and privately sponsored refugees who benefited from formal arrangements between local agencies and a specialist refugee health clinic versus asylum seekers who more readily missed out on those arrangements.[206]

The benefits of having care co-ordinated within a single service and ease of access to attend multiple health services at one site was recognised by clients in one programme,[157] while the increase of multisector referral pathways was seen to benefit partners, increasing the knowledge base of collaborators to the needs of refugee communities[104,175] and influencing the ways in which GPs and others worked, including through referrals for social support activities.[175,183,196] In-kind contributions from programme partners were seen as enabling one programme to be delivered at low cost.[175]

Some programmes, however, saw less impact and raised several challenges. A systems reform of maternity care involving hospitals and community-based services had only minimal impact on gestation period at first hospital visit, which remained 'well past' recommended time frames, and although improvements in total antenatal visits were seen, this was also reflected in the locally born (Australian) population. Authors suggested that a range of intersecting factors including workforce shortages, no increase in resources, other perinatal priorities and the complexity of implementing change in complex and changing systems may have been influencing factors.[145] Others identified the potential for further work on increasing co-operation,[176] communication[164] and the sharing of information between providers, one study reporting a practitioner working in social services expressing the importance of staff in refugee reception being informed of a client's health treatment to facilitate appropriate support,[104] while another saw participants suggest shared templates between services as a means to reduce variation in practice and enable quality assurance.[153] Further understanding of 'how other care providers and organisations worked', and the creation of 'clear structures and local forums for collaboration' were also proposed, with issues raised about the participation of health services in collaborative partnerships.

> *[W]ell, when this new assignment was initiated, there were collaborative working groups, to make local agreements between the social services and the employment agencies and so on … but there were no representatives from the healthcare organisations present in those.*

There was further emphasis on 'too much reliance on [collaboration] being driven or dependent on individuals'. In municipalities where collaboration worked well, it was seen as 'anchored in the organisational structure with many diverse care providers involved'.[104]

Proactive engagement

Engaging people in their usual habitus saw good acceptability and engagement where health care shifted out of traditional spaces into community agencies,[107] faith spaces such as a local masjid,[201] into the home,[137,165,168] within a reception centre[162] and into schools.[109,125,126,175,191] This saw what were seen as important elements of outreach work,[161] the flexibility of clinicians and mental health workers moving between locations (clinic, participant's home and public spaces) improving acceptability and engagement[205] and schools being described as the preferred 'safe' and 'familiar' location for mental health interventions, 'less stigmatising and more convenient' than clinic-based settings,[109,125] with high attendance in one programme attributed to the 'normal school hours' in which the intervention took place, meaning that students were already present.[125] These were spaces that were able to act as a conduit through which refugee communities could feel 'supported and informed about health issues' and gain confidence in using more formal health services.[162,175] One study, however, identified concern from some students around privacy, 'not wanting peers to see them (accessing the service) and potentially making fun of them or asking questions'.[109]

Actively considering the best ways in which to reach different populations with health and health service information proved successful through the use of a combination of ethnic radio, social and community networks, and culturally and linguistically designed materials,[113,203] including a resulting increase in parental knowledge relating to tuberculosis (TB).[203] There was the use of opportune moments (such as a health clinic waiting room) to engage newly arrived refugees in a psychosocial risk assessment while awaiting appointments, seen as acceptable and influencing the intention of patients to visit a psychosocial counsellor.[100] While some attributed increased attendance over time to participants sharing their positive experiences of services with others in their community,[105,201] there was also reference to one programme needing to do more to advertise their offer.[107]

Facilitated attendance was also seen to be of benefit, the use of 'healthcare navigators' and 'community health workers' addressing linguistic needs and health service navigation (such as through knowledge and physical access)[157] and appointment reminders improving entry into services,[132] as well as reductions in missed appointments.[121,186] One study highlighted the potential of being able to deliver psychiatric assessments over the telephone with minimal impact upon quality, versus in-person practice, suggesting that, despite some acknowledgement of difficulties in building a rapport with clients and logistical challenges with paperwork this could make mental health referrals and affidavits more accessible to asylum seekers.[122] Another[210] identified no learnability issues from a mental health interface that had been designed to mimic smartphone messaging applications though some users indicated that it should not replace a real psychotherapist, and that shorter (currently 30 minutes), higher-frequency sessions would be preferable.

For women, barriers of travel and caring responsibilities,[107,113,151] including costs and journey times (despite some efforts in intervention designs to avert these), were flagged as issues by some participants.

> *[M]y whole time was spent on the journey, and it was agony … I would reach home tired, barely able to make food … and I am responsible for a house and my children and husband. If I could not attend, it was because of that, I swear.*[107] *p.1306*

Religious factors were reported as barriers to satisfaction and attendance at a psychoeducation programme, with women citing exhaustion from long sessions (5 hours, twice a week, including travel) 'especially during Ramadan'.[107] Flexibility for online options was suggested as feedback from some participants to address this issue. One study reported a mid-programme adaption that saw a female *leader* brought in to support women's engagement, marking a move from an all-male team, something that had originally been presented as a strength, reflecting cultural values and traditions surrounding gender hierarchy.

> *At first, the elders noted that only the fathers spoke in the group and the mothers were silent. They realised that in order to encourage the mothers to speak and build social networks, they would have to organise separate fathers' and mothers' groups …*

Finding, however, that mothers remained reluctant to speak, something further attributed to 'cultural rules'.

> *[T]he team recruited the wife of one of the team members to attend and facilitate the mother's group. This adaption process was effective, with the mothers' group talking freely and laughing.*[179]
>
> *p.120*

Several studies reported participants expressing a wish for more support (longer or additional training sessions)[107,110,151,182] or not wanting programmes to end,[154,208] with one study reporting improved acceptability as a result of extending the number of sessions in response to requests.[176] One study highlighted that participants' (teachers and parents) had 'expressed relief' that they could have access to a year of virtual follow-up sessions.[107] Some of these,[110,182] but not all,[107] were relatively short programmes.

Considered communication

Reported impacts related to communication considerations were varied. Several studies highlighted the benefits of bilingual workers and the presence of in-person interpreters, and there was evidence to suggest organisational efforts to improve communication practices were mostly feasible and had a range of benefits. Impacts were complicated by individual preferences and challenges in working with interpreters.

In one study,[157] access to onsite interpreting was highly valued and seen as setting the service apart from others, with information described as being explained well, leading to increased understanding of health conditions and management of medication, and clients feeling comfortable to ask questions when they did not understand. Elsewhere, there was evidence to suggest that the use of trained (vs. ad hoc) interpreters during health screening of asylum seekers substantially improved the subjective quality of communication, increased reporting of traumatic events and psychological symptoms and improved trauma-related referrals.[146] The same study, however, acknowledged that interpretation by family members may have a small 'influencing role' (increase) in the decisions of health professionals regarding *general* medical care referrals, suggesting an advocacy effect, while another study saw some GPs reporting that patients often preferred interpretation by family or friends and 'always come with someone who speaks English'.[197] One study[176] indicated that the use of interpreters acting as cultural mediators was seen as helpful in therapeutic sessions.

Efforts to improve the engagement of interpreter services in primary care found a need to promote and advertise the availability of trained interpreters to patients, 'there is a poster now on the wall in the waiting room to increase patients' awareness of this service. This has led to the patients driving the interpreter use rather than GPs'.[197] The 'presence of an interpreter and clarity of communication' were cited by refugee parents as important to an 'excellent service' which had given attention to making full use of in-person interpreters throughout all interactions (and providing some translated materials)[94] and the provision of a mobile phone with a free-call number for an interpretation service used to engage with welfare services was seen as 'a tool of empowerment'.[120]

Efforts to improve workers' awareness of interpretation services, bilingual specialists and cross-cultural communication needs were also reported as beneficial. One study reported training modules on provider–patient communication/cultural issues as particularly important for workers' daily practice.[202] Medical students in one study were seen, in the absence of an interpreter, to resist drawing on the language skills of the patient's relatives, and to heed advice and seek professional interpretation,[112] reporting also a preference for in-person versus telephone because it was seen as more 'personable' and allowed for greater interaction with clients. The benefit of matching patients and interpreters by gender as a way to enhance communication, trust and patients' comfort levels, was also described, '[with] the translator [being] female … she felt a lot more open and able to talk about everything much more freely'.[112] Elsewhere, capacity building and workers/students involved in experiential learning led to increased frequency or improved working practices with interpreters[145,156,183,196] (described in one study as a marker of quality of primary care[183]) and 'more

confidence' from practice staff and medical students who felt more 'relaxed' 'in asking about and recording interpreter needs', communicating with patients across cultures and language barriers[156,173] and scheduling interpreters.[197]

Access to software for recording interpreter needs and the extra time required to arrange and use interpreting services was flagged as a barrier to making changes in some settings,[197] and one study reported some concern regarding the quality and accuracy of interpretation, 'sometimes the patients talk for 5 minutes and the interpreter sums it up in a few short sentences'. A lack of availability of interpreters was also flagged, as were the problems arising when 'people didn't turn up' to their appointments involving prebooked interpreters.[197] One study[183] reported unspecified challenges working with interpreters.

There was reporting of benefits of bilingual workers with proficiency in a range of languages,[121,164,176,196,197,205] including acceptability, engagement and retention in treatment,[205] 'we need bilingual GPs when you've got a lot of patients and some of them don't speak English at all'.[196] Capacity-building practices had increased access to lists of bilingual workers that could be used by health providers.[196] Delivery by peer facilitators in shared Arabic language was cited by participants as a main reason for the good acceptability of a group mental health programme[150] and an e-mental health application that used texts and audio in Levantine Arabic was seen by users as a key positive aspect: 'the language is good, it is very close to the Syrian accent, as if someone is speaking to you. One can understand this better because it is simple and not academic. Better than formal Arabic'. The application could also receive microphone and picture input, as well as text to enable customisation to users' literacy or preference.[210]

Several studies identified the difficulties in managing cross-language communication. One[95] reporting some children feeling uncomfortable 'because the doctor did not speak their language'. Another,[205] drawing attention to the challenge of matching patients with bilingual and ethnic paraprofessionals, cited the possibility of matching languages with fewer than half of participants, despite the programme being staffed by workers collectively speaking 15 languages. A further study[208] highlighted that despite the inclusion of bilingual co-facilitators, there remained an importance for local language proficiency to support independent access to local resources and the development of meaningful cross-language relationships.

Some studies reported that materials or tools that had been adapted or verified by cultural and linguistic communities were seen as 'relatable and helpful'[119] and 'culturally valid and useful'.[147] One study[150] indicated the benefits of including illustrations within health materials, particularly where participants could not read or write, although others suggested that challenges remained for those with low or no literacy, with a self-help manual described as 'text heavy',[119] and illiteracy impacting participants' perceived capacity for independent healthcare navigation.[121]

One study reported participant difficulties due to different dialects, despite attempts for linguistic match.[119]

Informed provider and attitudes

Interlinking with language and communication practices (*considered communication*) and the cross-sector capacity building (*networks of care*) already described there was evidence to highlight the importance of the preparedness of healthcare professionals to engage in practice development. Many of these personal professional development practices or organisational mechanisms led to improved knowledge and a perceived capacity for a more proportionate and compassionate response to refugee patients, with some data reflecting patients' acceptability of these more informed contexts.

Good acceptability of programmes, evidenced by high levels of participation, was sometimes associated with practices that had taken into account different aspects of the migration and settlement experience and/or the cultural and religious values of intended participants.[113,119,154,173,176,189] Cultural informants were seen to verify tools as appropriately reflecting trauma manifestations of forced-migrant populations,[147] and one study reported asylum-seeking participants expressing 'a sense of relief that someone had finally put what they had been experiencing into words'.[187] In a further study, constant consultation with the intended community (Somali Muslim women) saw a range of cultural, religious and financial considerations shape a programme that was 'well attended and enjoyed', with the provision of a culturally *safe* place to exercise, seen as important not just for attending participants 'but also for the integrity of their whole community'.[113]

Studies identified good engagement from a range of healthcare professionals and services in training and service development activities,[103,104,107,175,183,196] including through experiential learning,[103,112,114] virtual patient training models,[108,138] and by delivering training flexibly to maximise attendance[104] and online (although the latter was seen to have less engagement).[202] Two studies[108,202] reported a preparedness of participants to recommend the training programme to others. These programmes typically engaged a range of healthcare workers, including GPs and other primary care practitioners, mental health workers, midwives, infectious disease specialists and nutritionists. Programmes were seen to influence improvement in a range of practices from refugee status identification in healthcare records,[183,196] the conducting of refugee health assessments and history taking,[138,183] with workers becoming more open to ask people about their stories, 'make a full assessment of a patient's physical, emotional, social and spiritual status',[108] and promote blood screening.[183] One study reported the new introduction of longer appointment times[183] and another reported that this was needed to support greater impact.[161] A further study[164] flagged a lack of adequate training for staff in the implementation of a new in-depth holistic health assessment as one reason to explain difficulties in utilisation and completion.

There was reference to 'refugee patients as "teachers" of their culture' from medical students who had taken part in supported clinical encounters with refugee patients.[112] Experiential training generally resulted in enhanced awareness of the need to understand different patient perspectives[173] and the influence of factors such as gender, family structure, ethnomedical treatments and beliefs, religion and spirituality on health care, 'I'm going to be more conscious of how patients see me … [their] views … it adds certain sensitivity'.[112] Experiential methods were also reported as a way of recognising the 'resilience people demonstrate after having experienced trauma' and saw participants transforming their 'initial ideas of refugees as victims or people without agency, into people with a strong desire to make changes in their lives',[114] and this included a focus on patient empowerment.[112] One study[103] reported influences on attitudes and opinions, including xenophobia, while another[156] reported participants reflecting on their own cultural bias.

More generally, training increased workers knowledge base in the health needs of refugee patients and appropriate ways of responding, including in treatment, management of care,[104,138,175,200] and improved skills or knowledge in culturally sensitive care, including understanding how trauma and trauma symptoms may be expressed through different languages and cultural values, and recognising the continuing effect of past and current stressors.[103,108,112,114,106,138,156,158,161] One study highlighted training modules on acute health needs and legal issues as particularly important, although this did not always correlate with improvements in knowledge.[202] Following training, some studies found respondents reporting self-reflection and changing attitudes: workers would 'pay greater attention to their interview skills',[108] had increased understanding of the refugee experience,[104,114,158] had cultivated greater emotional engagement[104] and empathetic responses,[112,156,158] and would 'be more sensitive to a patient's story', working slowly where appropriate to avoid furthering a patient's trauma.[108] For patients, these 'attentive, respectful, and caring attitudes' led to feelings of 'safety and trust' and were seen both as a particularly 'helpful supporting factor' in care engagement,[162] perceived quality of care, and satisfaction with care which were all enhanced by positive relationships of trust and rapport between clients and providers.[157] Intercultural mediators in one study made similar reflections, pointing out the benefits of taking time to build trust and understand the patient's context, 'my experience is that when more time is invested in the beginning, the outcomes are better'.[161]

One study found that female providers and GPs, rather than mental health professionals, were associated with more continuity of care and warm and competent attitudes (as opposed to attitudes of ambivalence) towards asylum seekers.[193]

Practice development led to an increase in appropriate referrals and new referral pathways,[183,196,200] including a greater awareness of what to do if a referral is initially denied,[200] and an increase in knowledge of appropriate specialists.[196] One study identified improved efforts to engage clients with health literacy.[183]

Training and discussion appeared to strengthen participants reflexivity, one study describing respondents move from identifying communication barriers in their work towards 'emphasising the enduring and exposed social situations of refugees and other immigrant groups'.[104] Another indicated a heightened awareness of the presence of refugees in their community.[114] This also saw an increase in concern for refugee integration into communities and greater understanding of how social inequities lead to health disparities,[114,158] several studies reporting workers taking up a new focus on ensuring that the well-being of refugee patients also involved help with broader societal engagement such as learning

to take the bus and finding employment[112] and making referrals for social support.[183,196,200] One study[153] found that practitioners from a range of services indicated that a new health examination was too heavily focused on infectious disease identification and control rather than other health conditions, particularly mental health.

Vignettes as training mechanisms in mental health and crisis intervention[200] and stereotyping and continuity of care[193] showed limited benefit in improving participants evaluation of the presented case.

The introduction of a personal health record for asylum seekers residing in reception centres saw mixed views on its benefit citing it as important for complex conditions yet 'not suitable to carry enough information for the actual therapy and monitoring of these patients' and engaged with less for those with more minor health issues and where local systems had an electronic health record, it was seen as redundant. It did, however, reduce GP time and enable nurses to use information and carry out tasks such as preparing prescriptions without consulting the doctor, and it enabled the transmission of health-related information after the transfer of an asylum seeker to subsequent accommodation. This was seen as a key benefit, 'I am very certain, that it [the personal health record] improves the continued care'.[117]

The introduction of new practices was sometimes seen as challenging and requiring of careful facilitation, especially in pressured clinical environments, 'here I do not receive any support, […] and that's why I don't do it' and also to ensure adequate engagement with workers prior to making changes, 'many of us [doctors] didn't know that this personal health record exists at all or what it is for exactly and well maybe that's also why it was difficult in the beginning'.[118]

A right to knowledge

Behaviours

Studies reported high participant engagement[106,111,137,165,177,201] in health education/navigation activities, reported participants as highly satisfied or describing positive experiences,[107,110,111,135,137,159,162,168,170,181] sometimes drawing their peers into programmes[106] or being prepared to recommend programmes to others.[107,201] One self-directed online intervention for refugee men with post-traumatic stress, though described as 'interesting, relevant and useful' and showing positive effects on help-seeking behaviour, saw limited engagement with most participants completing less than half of the 11 modules.[170] A group mental health intervention that also included use of a 'self-help manual' and was delivered separately for men and women was found to be acceptable with high levels of participation from women but male participation was much lower, with participants often expressing disinterest or being disruptive.[119]

Systems knowledge or health service navigation provided mixed results. Several studies described improvement in understanding and awareness of available health services,[114,115] health screening (cervical cancer),[135] a potential gain in appropriate use of emergency care[165] and good transitions into universal care.[157,161,162] The use of healthcare navigators in one study, however, resulted in no change to health system knowledge despite significant reduction in missed or avoided healthcare appointments.[121] There was greater help-seeking behaviour and greater competency in access and use of health services[111,115,118,121,143,170,172] and concerns relating to local health systems were alleviated,[160] in one study, increasing further for those completing more programme sessions.[170] There was also increased willingness and confidence to be screened for cervical cancer and vaginitis.[135]

Initiatives led to small[118] and good[165] increases in decision-making on taking medications and care management[118] though despite improved trauma mental health knowledge for one study[172] this did not influence mental health visits. Illiteracy was reported as leaving some participants feeling incapable of learning healthcare navigation, while others were motivated by being more self-sufficient; 'People are not available to help you all the time, so that's what made me learn … . I collected the courage in me and because I have to go [to the hospital]'.[121]

Health promotion

Health education activities around contraception,[195] breast[169] and cervical cancer,[137,169] diabetes,[178] coronavirus disease discovered in 2019 (COVID-19),[159] stigma and knowledge of infectious diseases,[210] and general physical and psychological health[115,123,134,150,159,160,162,175] all positively impacted participants' knowledge and awareness of conditions and risk factors,[165] with parents in one study[175] reporting feeling 'supported and informed about health

issues'. One study[167] reported no improvement in knowledge from a short culturally and linguistically designed oral health programme.

A number of programmes focused specifically on trauma-informed psychoeducation and were seen as helpful and appropriate, leading to good[110,132,143,177] or small[105,115,172,181] increases in knowledge and skills in mental health literacy or PTSD, and identification of symptoms of anxiety and depression.[104] Respondents reported improvement in knowledge of the physical and mental health impacts of trauma,[115] learning 'positive things about themselves, including how to deal with challenges'[110] and gaining satisfaction from new knowledge and understanding.[107,168] One study described high participant involvement in sessions on traumatic stress and its symptoms with people willing to share 'stories about fleeing war, losing family members … and current resettlement stressors' with one participant describing,

> *before if I experienced traumatic, I don't really know how to handle it … after I learned this, it helped me … if I feel depressed or I feel sad, I can just go around, just go outside and look around, so I don't keep thinking about what happened …*[106]
>
> *p.227*

A further study[142] resulted in improved self-efficacy in postmigration stressors for some participants, although the majority saw no change.

Self-stigma

Reductions in (self) stigma or improved perceptions and attitudes around mental health and trauma were reported in several studies.[105,115,143,160,181] An online intervention, however, specifically aimed at reducing mental health stigma and increasing help-seeking in refugee men with post-traumatic stress, was seen to have limited impact on self-stigma for PTSD and showed small increases in self-stigma for help-seeking. Findings did, however, identify that where men engaged in more training modules (many completed less than half), lower levels of self-stigma for PTSD and help-seeking were observed at follow-up and neither measure appeared to prevent actual help-seeking behaviour, which improved.[170] Decreased TB-related stigma was identified in one study.[203]

Two studies[162,206] reported small numbers of service users reporting feelings of shame, non-acceptance or fear of stigmatisation preventing the seeking of further mental health support.

Some issues with feasibility, such as dropout, were ascribed to the receipt of news concerning asylum status or changes in housing provision.[161] Non-engagement in a further study was ascribed to a belief that a secure residence status would lead to an improvement in mental state without treatment.[162]

Studies awaiting classification

We identified two studies that were completed without peer-reviewed published results (see *Appendix 5*).

Ongoing studies

We identified 24 studies which, on completion, may be eligible for inclusion in our review (see *Appendix 6*).

Discussion

The aim of this review was to identify existing knowledge relating to responsive health care for forced migrants. We identified 108 studies, of which 93 provided elements of impact relating to responsive care.

On the whole, studies were interested in improving access to mental and psychosocial health care (including aspects of psychoeducation for forced-migrant communities), supporting health system navigation, and the training and capacity building of health and broader caring practitioners. A smaller number of studies were concerned with women's health, cancer, general health, health behaviours and oral health. The design of interventions and practices, the institutional contexts of interventions, the participant groups and reported outcomes differed considerably. What was more consistent was the attribution of potential mechanisms of responsive care with the majority of studies reporting

drawing on multiple and collaborative approaches to intervention design. Most studies also reported mechanisms for improving oral communication including enhanced interpretation through the involvement of specialist interpreters, bilingual and sometimes bicultural workers and the delivery of care in participants' native languages. Most interventions also considered a range of cultural and experiential factors as part of their approach (high engagement with communities, consideration of displacement experiences, health risks and potential vulnerabilities, broader social and societal contexts) and appropriate mechanisms for reaching and engaging refugee communities in care. Owing to the complexity of design factors, however, and little direct methodological alignment between potential mechanisms and reported impacts, we did not attempt to make any associations between these characteristics and study findings. Given the general positive implications of the vast majority of findings, however, particularly in respect to participant engagement and acceptability, we posit that these attributes were beneficial.

Overall, the review has highlighted what might be usefully summarised as beneficial outcomes from cultivating *communities of care*; using and creating community for members of forced-migrant communities and actively driving an interprofessional and intersectoral network of care provision. The review also highlights, as others have,[213,214] that access to healthcare resources for migrant communities is positively leveraged through a combination of resources outside of public healthcare systems. What the review has also allowed us to articulate is the possibilities for these leverages to also form part of intentional pathways of health care, through intentional *community* enactments, through the locating of care in spaces of familiarity (schools, community and religious spaces), through the delivery or co-delivery of care by trusted others (often community leaders and teachers), and through an intentional drive for a networked community of knowledgeable healthcare providers.

Consistent with articulations of social capital in settlement contexts,[215,216] *community* was seen as a valuable conduit to engage groups with a *shared* identity (ethnicity, nationality, language, gender and religion) in health resources (health knowledge, systems knowledge and health care) and *shared communities* as spaces in which confidence, belonging, social connections, reductions in mental health stigma and mutual help could develop and go on to support a bridging process into wider social and public systems. This stress on shared community along lines of different identity markers has been made by others in a range of displacement healthcare contexts (see, e.g. Pertek[217] for religious coping) as well as more broadly in minoritised communities, where shifting focus to communities themselves and valuing the contribution of community resources enacts some of the more transformative practices of co-production as has been encouraged, for example, by Burgess and Choudary.[218] In our review, this extended to proactively selecting methods of engagement based on common characteristics of intended communities (e.g. ethnic radio, community networks) and highlighted the importance of considering where healthcare resources might be otherwise located (outside of traditional healthcare spaces). We suggest that this importance for opportunities for shared community should be at the forefront of decisions in the locating of newly arrived forced migrants across cities and regions, where the need for a *critical mass* of similar ethnicities to provide an anchor for new arrivals has previously been raised as a concern outside of diverse urban centres.[219,220]

Our results also highlight the importance and positive reception of skilling non-traditional healthcare providers in a range of refugee health knowledges. As others have long identified,[221] actively improving interconnectivity across a range of traditional and non-traditional health services is vital, and here it allowed for non-traditional providers to perform important negotiations with refugee communities in the entry, navigation and mediating of contact with health systems, creating new mechanisms for detecting refugee community health needs, and developing (new) avenues for help-seeking and the delivery of care. As we evidence, this situates enablers of health more broadly across and within communities (offering a more intentional commitment to systemic change), offers benefits to intersectoral relationships and has positive influences upon the empathetic and informed responses of workers. It also allowed for the locating of health care within opportune and familiar spaces, providing a range of further benefits from high patient/refugee community engagement and acceptability as well as comfort in help-seeking, and patient linkages and referrals to a diversity of formal health and other support services.

Schools and community-based programmes particularly were acknowledged in the review as spaces in which children, families, staff/community leaders and statutory health engagement benefited. This concurs with existing knowledge that has shown community organisations to be trustworthy spaces able to foster connectivity with other sectors[222] and schools as effective spaces to locate refugee psychosocial health care, support broader difficulties associated

with forced migration[223] and nurture continuity of care.[224] More broadly, as illustrated in iterations of Promise Neighbourhoods across the United States, schools are already recognised as spaces in which everyday practices can sustain a 'culture of good health',[225] bring staff, community health, social welfare services, faith-based partners and families together,[226] and benefit not only health but also educational engagement and outcomes.[225]

This wider perspective on where and who should be conscious of the healthcare needs of forced-migrant groups leans on ecological, social justice and grassroots health strategies and offers a much more holistic set of healthcare opportunities that can be performed through or co-supported by trusted others. By design, they embed a requirement for intersectoral action[227] and account for the intersection of the different social and structural systems in which a person is located.[228]

Key to what we describe as a *community of care* are knowledgeable and considered providers: a health workforce (traditional or otherwise) that is skilled, confident and reflexive with a comprehensive understanding of refugee health needs, cross-cultural care and communication practices, and a good understanding of a range of local health resources. Despite high reference to language considerations in intervention descriptions, limited evidence of impact that could be aggregated was reported, although some studies demonstrated that supporting workers' awareness of interpretation services and understanding of the importance of good cross-cultural communication benefited frequency of interpreter use, confidence in asking patients about, and improved management of, language needs and confidence in communicating across cultures and language barriers, although there was also occasional concern about challenges in working with interpreters, including the quality of interpretation. Benefits, however, of bilingual workers, particularly as they related to patient engagement, were indicated, supporting findings of a recent review[229] identifying enhanced implementation and effectiveness in primary care where there exists cultural and linguistic congruence between patients and workers. More broadly, limited evidence appears available in this field and we would suggest this warrants further attention both in respect of bilingual and bicultural health professionals and the motivating of foreign language proficiency among the clinical workforce.[230]

Beyond communication, we found a range of benefits from individual and broad service development mechanisms leading to improvements in a range of refugee health considerations and skills including those relating to migration and settlement experiences, cultural and religious values and sensitivity, common health needs and appropriate ways of responding (including treatment, appropriate referrals, and management of care that included broader societal engagement and social support), and a perceived capacity for a more proportionate and compassionate response to refugee patients, including empathy and reflexivity in practice. There were positive but limited data reflecting patients' acceptability of these more *informed* contexts.

Experiential training was described in some studies as an important way of learning some of these skills and understanding different perspectives, but only one study[183] acknowledged long-term engagement with professional development and the one study[185] that provided evidence of long-term follow-up indicated benefits of a short (two sessions, 7 hours) mental health literacy training were not all maintained over time. Although most studies did engage with a range of topics and practice considerations and a small number reported resulting changes in attitudes of staff, there is more broadly a push for recognition that because of ethnocultural, racial, linguistic and power gaps between health professionals and the populations they serve in the refugee context,[231,232] competencies must go well 'beyond the mere possession of multicultural sensitivity', must attain an *acceptable* level of knowledge, 'a sufficient shift in attitude',[233] and should also be seen as a lifelong learning process requiring of continuous professional development.[234]

Finally, findings articulated a benefit from a respect for the need of new arrivals for information, knowledge and confidence in local systems, seeing patients as partners in their care with a right to a range of supports in their adjustment to and navigation of new healthcare environments. This included good acceptance of efforts to improve awareness of available health services, create confidence and trust in providers and shifts in help-seeking behaviour, competency and use of statutory services. Mechanisms did not rely on informational procedures alone; rather, they included a range of practices, sometimes providing assistance, taking place over a period of time, and as previously discussed often using shared communities. The review has demonstrated that a focus on health perceptions and gaining health knowledges that align with local understandings of health can be well received by arriving populations and, on the whole, lead to greater awareness and knowledge of a range of health conditions, risks and symptoms.

A particular volume of evidence was noted here in respect to trauma and mental health with respondents reporting benefits including empowerment and coping from a focus on normalising and supporting people to understand their own symptoms and responses to war and settlement stressors. Likewise, a review of school-based social and emotional interventions for refugee and war-traumatised youth[235] highlighted the contribution of psychoeducation as a mechanism to support resilience and coping, including in respect of challenges and stresses relating to settlement. It is worth noting, however, the indication of more challenging engagement with men in two studies of mental health interventions that were wholly or partly self-directed suggests further attention is warranted as to the most appropriate mechanisms for reaching and engaging a group that faces specific vilification in the displacement context.

In sum, opening up healthcare systems to include other state actors such as teachers and settlement workers and a range of non-state actors that should include religious and ethnic community leaders is important. We found that community was a conduit for engagement in a range of healthcare provision, benefited important social connections and bridged access to statutory care. Refugee patients and communities should be seen as partners in their care deserving of knowledges, skills and confidence in healthcare navigation and psychoeducation, particularly as it relates to normalising responses to war and settlement stressors. An appetite for a networked community of knowledgeable healthcare providers should be recognised and enabled through broad, reflexive and considered programmes of collaborative and informed practice.

Strengths and limitations

We searched available literature comprehensively and used rigorous methods to assess and synthesise a range of evidence. Our mixed-methods approach allowed us to integrate quantitative and qualitative findings and gain a broad understanding of current knowledge in the field. We have provided a rich and comprehensive description of approaches taken in improving access to health care for forced migrants and though the wide heterogeneity in study methods, contexts, interventions and outcome reporting presented challenges in drawing clear associations from the data, the review has built a compelling narrative about the ways in which interventions and healthcare practice can be beneficially designed and delivered for our study population. The challenges faced in the synthesis of data, however, would suggest benefits from a more intentional focus on what constitutes beneficial outcome measures or lines of inquiry of importance both to communities in displacement and settlement contexts and in the context of access to health care and we would encourage researchers to pay particular attention to this perspective. We see our MORRA tool as starting this conversation. An initial further question, we suggest, would be to ascertain what role communities themselves have had in influencing the sorts of measures collected.

The review was limited to studies that focused on forced-migrant groups only. This was important because of the specific intersection of factors and adversities that are faced in contexts of persecution, forced migration, protracted displacement and settlement. However, we acknowledge that other migrant groups share many of these experiences and that our inclusion criteria, which also excluded studies with mixed populations, may have limited our engagement with the evidence. Further, we acknowledge that our limiting of included studies to only those that specifically articulated study aims to improve access to health care further restricted our pool of data. This is worth noting because a significant proportion of studies at this stage did report interventions that both explicitly and implicitly aimed to improve access to care for our study population. Although we have not assessed this comprehensively, many of these studies also reported relevant measures of impact, and there was some indication of a broader range of health focus. As we detail in *Differences between protocol and research delivered*, this was a pragmatic decision to manage the significant volume of relevant studies to our inquiry. However, given that the exclusion of these studies totalled 232 titles (available on request from the authors), we suggest that a rapid framework analysis be conducted to ascertain cognisance or divergence with our findings.

We had a high number of studies (71) where full articles could not be retrieved. This included some theses, but most were book chapters and historic articles and/or abstracts, which we suggest would be unlikely to have influenced the study findings. Several included studies were found to be of low methodological quality. Most quantitative studies, for example, had small sample sizes and were not well powered to determine the effectiveness of the interventions in improving access to care. This is likely to impact on the quality of evidence offered. However, given the volume of studies included in our synthesis and the integrated contribution of both qualitative and quantitative findings,

we suggest that there remains a strength and rigour to the review that offers in-depth evidence on interventions to improve access to health care among refugee and asylum seeker communities.

For the benefit of future researchers, we note that none of the studies that referred to immigrants or migrants only in their title and abstract went on to report a refugee population within the main body of the article.

Chapter 4 Approach 3. Case examples

Objectives

We sought to identify current examples of services and models of care that were taking active steps to improve access to health care for forced-migrant patients and communities. We aimed to identify promising and divergent practices and use case study methodology including one-to-one and group interviews, site visits, short-term observation of clinics and provider settings, informal conversations, and some documentary analysis to understand possibilities and practices in responsive care. As well as the explicit mechanisms being used to improve healthcare access, we aimed to identify providers' knowledges, relationships, experiences, skills and attributes, and understand these as part of the broader local context and the experiences of those engaging with the service.

Methods

Types of services

We aimed to identify services taking active steps to improve healthcare experiences for forced-migrant communities. We sought services operating in any country, globally, and placed no limitations on the context of delivery, the scale of the service or the individuals involved. Services could be directly delivering health care or facilitating access to other providers.

In selecting case studies, we sought variability, loosely using the following criteria to agree a final shortlist of services that could inform the study through different contexts, characteristics and models of care:

- healthcare moment of opportunity
- health need
- delivery location
- patient or client group
- organisational context
- theoretical or ideological approach.

Types of participants

We aimed to involve a representative sample of workers from across different roles and responsibilities within each case study service (including front-line workers, voluntary workers, gatekeepers, managers and collaborators). We encouraged a service contact within each service to assist with the recruitment of previous or current service users and where possible the inclusion of individuals representing different identity characteristics and backgrounds, such as immigration status, capacity for the local language, time in the country, health needs, gender, lone individuals/families.

We took a pragmatic approach to sample size based on study team and service capacity. This loosely equated to 2 days per case study for site visits, observation, informal conversation and face-to-face interviews and one additional day per case study for remote video interviews.

Search methods to identify services

We used the following methods to select an initial list of possible services meeting our criteria:

- We sought knowledge and suggestions from the relevant networks of the project team and from the advisory group, the study steering committee and its wider network.
- We e-mailed or spoke with contacts in the American Public Health Association Caucus for Refugee and Immigrant Health, the UK Migrant Health Consortium, IOM, European Centre for Disease Control, the European Study Group on Infections in Migrants and Travellers and the UK Refugee Councils.

- We circulated request for information via IMIX (a communication network across the refugee and migration sector in the UK), City of Sanctuary UK and NIHR Clinical Research Networks.
- We conducted web-based searches.
- We posted a request for information on our Twitter page.
- We identified studies about possible services when screening the results of the database searches for the systematic review.

Information about identified services was collated in a directory of services. This information was retrieved from service websites, published reports, and some e-mail and telephone correspondence. Using our criteria (see *Types of services*), we selected a shortlist and agreed case study selection with the full project team.

Participant recruitment and ethical considerations

Ethical approval was granted by the Health Research Authority London Bridge Research Ethics Committee.

Using e-mail and telephone, we invited contacts from our shortlist of services to take part in the study. A main contact at each service supported the organisation of site visits, advised on the common languages spoken by service users and invited colleagues and clients or service users to take part. Participant information sheets outlining the research process were provided to potential participants (see *Report Supplementary Material 1*), and informed consent was obtained prior to engagement in writing or verbally.

Study materials were developed in consultation with the multidisciplinary project team (including people with lived experience) with final versions (before translation) proofread by two people with lived experience. Being aware that service user participants may have experienced traumatic events and other difficult experiences, we attempted to ensure that all service user materials, including the interview guide, worked to avoid distress and re-traumatisation. We did not encourage participants to discuss their displacement experiences or individual health conditions. We also emphasised to participants that anything that they shared with us would remain anonymous and would not be shared with any other individuals beyond the research team, including the UK Home Office and police service. Service-user materials were translated into nine languages commonly spoken by users of the five services (Amharic, Arabic, Dari, Farsi, Kurdish Sorani, Oromo, Pashto, Spanish and Tigrinya). This was undertaken by professional interpreters who were native speakers and the translations were checked by a second native speaker.

Although we identify the case study services, data collected from all participants have been anonymised.

Interviews, site visits and observations

Group and individual interviews were conducted between 28 July and 27 October 2022, in person, via Microsoft Teams® (Microsoft Corporation, Redmond, WA, USA), WhatsApp (Meta, Menlow Park, CA, USA) video or via telephone. Site visits, service observations and informal conversation with workers took place during the same period. All in-person activities were co-conducted by an experienced researcher (AR) and a community researcher (ZK). All online and telephone interviews were conducted by AR, with the exception of one online interview in which ZK was also involved. ZK is a native Pashto speaker, is fluent in Dari and speaks English and some Arabic. Experience and positionality of the qualitative researchers are discussed further in *Strengths and limitations of qualitative data* and *Author positionality*. The majority of interviews lasted 1 hour, a time frame agreed through consultation during our planning stages to limit the burden on participants. However, a number of interviews exceeded this time frame (up to 120 minutes) where participants expressed a wish to continue a conversation, and one interview lasted only 15 minutes. The latter related to a participant in a high-stress situation and it was deemed not appropriate to continue the conversation.

Three staff interviews involved interpreters. Most service-user interviews involved interpreters or were conducted in Dari or Pashto by ZK. Most interviews were recorded, with the exception of some interviews with service users where individuals requested for there to be no audio recordings. In these cases, written notes were made during conversations, discussed for accuracy between AR and ZK following the interview and used in analysis in the same way as the recorded and transcribed interviews. Field notes were made following site visits and observations. Reflective conversations took place between AR and ZK immediately following site visits and again after all field notes for each visit were notated.

We developed semistructured interview guides and a service observation guide (see *Report Supplementary Material 2*). This was a collaborative process with the research team including lived experience contributors.

We collected any available service information sheets and published evaluations from services.

Differences between protocol and research delivered

We had initially planned for six case examples. Despite canvassing a large number of services for potential engagement, we faced difficulties in securing engagement from a sixth participating service within the study time frame. Reasons were often cited as relating to sudden influxes of clients and pressure on services. Our planning and conducting of data collection coincided with readjustments to service delivery following COVID-19 lockdowns, the Taliban takeover in Afghanistan and the Russian invasion of Ukraine. Although a further site would have provided additional variation, richness and contextualisation, we have been able to gather substantial insight from the five services studied.

Analysis of the results

Two researchers (AR, KB) transcribed the interviews and produced a verbatim account of each event. Transcripts were read by AR and an initial coding frame developed. This was discussed and amended with ZK before being finalised (see *Appendix 8*). Coding was undertaken using Nvivo12 (QSR International, Warrington, UK) software and included the coding of fieldnotes and service documents. Guided by our research aims and following principles of thematic analysis as set out by Braun and Clarke,[88] coded extracts were developed iteratively into broad themes. A further reflective discussion was undertaken with ZK to agree final themes and findings.

Results

We identified a longlist of services of interest that were taking active steps to improve healthcare experiences for forced-migrant communities which we compiled in a directory. These services were designed for refugee, asylum-seeking and migrant communities (56) or for those working directly with people with these backgrounds (25). In seeking to identify services, we identified 10 health guides or policy documents aimed to be useful to health workers supporting individuals with a refugee background, such as the City of Sanctuary Maternity Stream Resource pack[74] and Safe Surgeries Toolkit.[72]

The identified programmes were primarily situated within the voluntary, community or non-profit sector and delivered a range of practices including the provision of healthcare information, delivery of mental health and psychosocial care, maternal health support, health advocacy, care planning and health screening. Programmes often involved health workers but also relied on volunteers and there was some involvement of people with refugee backgrounds. Most programmes were located in the UK, with others in the United States, Germany and Australia, as well as Afghanistan, Austria, Belgium, Denmark, Norway and Poland. Several operated across several countries. The directory contains some details about the activities that services provided.

Five of these services were included as case studies. Services were chosen for their range of priorities, their variability in staffing and worker expertise, their health context which included clinical and non-clinical settings, and their state and non-state organisational structures.

We visited three services (UK only) and observed service activities over 5 days. Observations included reception spaces, social spaces, drop-in activities and clinical appointments. We undertook 24 one-to-one interviews in person (12) and over Microsoft Teams (12) and 5 in-person group interviews, which included a total of 11 individuals. We had informal conversations with 12 workers.

Participants included the following: clients and services users (most were male and lone adults covering a range of age groups), service managers/directors, health advocates, interpreters, office managers, well-being project leads and staff, social prescribers, reception staff, nurses (migrant health, refugee health and inclusion health nurses, chief nurses), mental health workers (leads, ethnotherapist, psychologists, psychiatrists), clinical consultants, GPs, healthcare assistants, network managers, communications and fundraising staff, project volunteers and project partners.

We did not collect home country data for service user participants but services each worked with individuals from a substantial range of countries that included Afghanistan, Eritrea, Ethiopia, Iran, Iraq, Myanmar, Nigeria, Sri Lanka, Sudan, Syria, Tibet, Ukraine and Venezuela.

Five case examples

We set out below key details and contextual findings from our five case examples and provide a brief summary of each service model. We then present a thematic analysis, which highlights overarching themes that we have attributed to the data and approaches taken by providers to their practice.

Location and institutional context

Three services were based in the UK: two services in West Yorkshire, Bevan, and Health Access for Refugees Programme (HARP) and one in London, Respond); one service was based across Belgium (Solentra), and one service in Victoria, Australia (Victorian Refugee health Program). One service was part of a state (NHS) hospital trust (Respond), one service was a social enterprise delivering state health care (NHS, Bevan), one was a not-for-profit organisation also delivering state health care (Victorian Refugee Health Program). A further service was a not-for-profit (Solentra) and a final service was a charity (HARP). Services were generally funded through a combination of local and national state health commissioning, regional/global migration funds, charitable trusts and foundations, as well as some informal sources, such as local faith organisations and private donors. All services were free at the point of access.

Models of care

Case study 1: A non-clinical outreach advocacy, education and support service helping to improve access to state healthcare systems (UK).
Case study 2: A community-based, holistic health screening and care planning service (UK).
Case study 3: A stepped-care mental health service taking a human rights, transcultural and community approach to mental health care (Belgium).
Case study 4: A nurse-led service providing holistic health assessments and care co-ordination for patients with complex needs (Australia).
Case study 5: An inclusion health GP and well-being service that includes holistic health screening (UK).

Patients and clients

One service (case study 2) worked with asylum seekers, only, while all other services worked with people with a range of immigration statuses. One service (case study 5) also worked with people who were homeless or in insecure accommodation and sex workers. Although there was some crossover between patient groups, we focused specifically on their refugee and asylum-seeker provision. All services worked with children, adults and families; one service (case study 3) worked heavily with unaccompanied minors and young lone males.

Four services worked predominantly with people who were newly arrived or within 2 years of arriving within the local country. One service (case study 3) worked with people at any point in their settlement journey. Services stressed, however, that a needs-led approach typically governed the period of engagement and patients were often never formally discharged, with people told clearly how to get in touch and re-engage where needed.

Delivery setting, care provision and workers

Provision was delivered across a range of settings that included initial and contingency accommodation (four services), health clinics (four services) and community centres or spaces, including schools (three services). Two of the services (case studies 4 and 5) based within health clinics were co-located with community, well-being and social support services and three services (case studies 2, 3 and 4) described occasional or initial home visits. A summary of offered provision is detailed in *Table 4* and worker roles in *Table 5*.

Supporting workers

Services put substantial effort into supporting all staff and supporting staff resilience. This ranged from regular, formal and informal supervision (with clinical specialists or psychologists), reflective practice and the use of designated meetings focused on making sure staff were ‘okay’ or to work through different cases and complex issues and share suggestions. One service had a WhatsApp group with consultants and GPs on call to front-line nurses, offering advice,

TABLE 4 Summary of care provision

Provision	Details
Holistic health assessment and health screening	Mental health; emotional and psychological well-being; experiences of torture and trauma; physical health; infectious diseases; sexual and reproductive health; child development; family functioning; safeguarding; migration/social/medical history; child behaviour; women's health; oral and dental health. Can lead to immunisations; prescribing; signposting; referrals. Reports prepared for GPs and electronic and hand-held health plan to stay with family/individual both (flagging health needs, mental health and social referrals)
Health system navigation	Support with understanding and learning how to use local healthcare services; understanding rights to care; digital skills for using health service systems; locating and managing pharmacy/prescriptions; confidence building; managing expectations around health care, appointments and waiting times; physical support to access services (transport, accompanying); information and signposting to services; geographical mapping of services
Health knowledge	Health awareness/education sessions (various health conditions/needs including family planning, early years); ESOL for health
Health advocacy	Support with making/querying/chasing up appointments (telephone, online, in person); drawing attention to urgent medical/dental care needs; challenging charging; bringing attention to concerns on individuals' behalf; appointment reminders; support with understanding medical and Home Office correspondence; letter writing (multisector/social welfare/immigration)
General practice	Inclusion health general practice; collaborating with or advising general practice; resource sharing; drop-in and walk-in provision; co-location with other services
Specialist consultation and referrals	Paediatrics, respiratory and infectious diseases, optometry, primary care, mental health (all in-house or satellite provision); rapid referrals; multisector referrals
Mental health care	Transcultural approaches; ethnotherapeutic consultations; community-based consultation; mental health triage; crisis management and case work; dedicated young person care; trauma-informed care approaches; eye movement desensitisation and reprocessing (EMDR); psychotherapy; narrative exposure therapy
Social prescribing, social support assessments, other health and well-being provision	Support identifying and connecting people with: community; social activities; hobbies; ESOL; education (school, college); arts activities; child play activities; social support services; employability support; faith and multicultural groups; volunteering opportunities; sport and physical activity opportunities; holiday activities
Dental care	In-house emergency care; dental referrals; help with making dental appointments
Other provision/practices	Welcoming new arrivals; informal child care; play activities; material goods
Capacity building	Training and awareness raising among other services; specialist supervision and intervision

TABLE 5 Summary of workers

Clinical	Other health workers	Other workers
Nurses, advanced nurse practitioners, migrant health nurses, inclusion health practitioners, immunisation nurses, practice nurses Healthcare assistants GPs Paramedics Psychotherapists, psychologists, psychiatrists, mental health workers, ethnotherapists Occupational therapists Paediatricians Infectious disease consultants's	Social prescribers, young person's workers, family violence workers, health and well-being officers, health advocates, yoga instructors	Peer volunteers, bicultural workers, intercultural mediators, interpreters, social workers, care co-ordinators, case workers, front of house and reception teams, administrative and operational leads/ teams, communications workers, regional facilitators, public health consultants

sometimes mid-consultation. Elsewhere, there were organised phone-ins from outreach staff to GPs, and an 'open door policy' with staff encouraged to seek advice and support. There were also broader service network events bringing wider colleagues together as opportunities for professional development and to share experiences and knowledge.

Language and interpreters

All services had a central commitment to supporting communication and interpretation. Services had mechanisms for keeping a record of the languages spoken and whether people could read and write in their own language. These details were included in external referrals. All clinical services had access to telephone language services. Two services worked almost entirely with professional, in-person interpreters, one entirely with informal in-person interpreters, one service used telephone interpreters only and a final service engaged a combination of all three. Some services had in-house or pseudo in-house block-booked in-person interpreters. Interpreters were often valued as part of the team and often well paid to acknowledge their skill and contribution.

Printed materials were sometimes produced in clients' common languages and some services used simple colour printed illustrations with no text for patient messaging.

Case study 1

The HARP is a community outreach programme delivered by the Refugee Council in West Yorkshire, UK (*Figure 4*).[236] With a focus on overcoming barriers to health care for asylum seekers and refugees, HARP adapted its community-based model to respond to the sharp increase in use of temporary contingency hotel accommodation in the UK in 2021. Working across both urban and remote suburban sites in West Yorkshire, their focus is primarily upon health, health-related issues, health advocacy and awareness raising but describe, because of high levels of need, additional drop-in support relating to medical and dental appointments, medication and basic needs.

Predominantly charity and foundation funded, they have no formal responsibility for facilitating access to health provision, although this is a common activity of the service. The primary focus of the service is health education support, such as health access workshops to improve understanding of the NHS and its services, supporting people to access provision in an appropriate way and at the appropriate time, and providing ESOL for health and condition-specific health awareness sessions. The HARP approach includes capacity building, proactively reaching out to health services and other organisations to raise awareness and provide training, for example, around understanding needs and entitlements, and reactively, responding to issues raised by clients or partner services.

The HARP offers opportunities for peer volunteers to receive training and mentoring to provide advocacy support to their peers. This commonly includes translation and directly supporting physical access to medical appointments and the collection of prescriptions. Peer volunteer advocates also support the broader training and awareness provided by the service.

The HARP is delivered by a small staff team, with volunteers working in and across different sites. The service works predominantly with asylum-seeking males, but also with families and women in women's only accommodation.

Case study 2

Respond is a community-based holistic health screening and care planning service working with people seeking asylum across five London boroughs in the UK (*Figure 5*). Core screening and health planning sits within a flexible delivery model that works across a number of GP practices and contingency/temporary accommodation sites at any given time. Clients are actively approached by the team, usually by telephone and with telephone interpreters (where appropriate) and invited to an appointment. Text messages, verbal reminders within accommodation settings, and sometimes additional phone calls will be made as appointment reminders; flexibility and understanding are seen as a priority in supporting attendance.

The service team includes a healthcare assistant, infectious and inclusion health practitioners (with advanced nurse practitioner backgrounds), consultant leads in paediatrics and infectious diseases, including specialism in safeguarding and looked after children, a matron providing management support, a GP also involved in research and service evaluation, and administrative, operational and service management support.

WHAT	NON-CLINICAL, OUTREACH ADVOCACY, EDUCATION AND SUPPORT TO ACCESS THE UK HEALTHCARE SYSTEM
WITH	ASYLUM SEEKERS AND REFUGEES; LOCAL PUBLIC SERVICE TEAMS, EDUCATIONAL INSTITUTIONS, COMMUNITY GROUPS
WHERE	INITIAL AND CONTINGENCY ACCOMMODATION (MOSTLY HOTELS), WEST YORKSHIRE, UK

HARP Direct health access (HARP staff) Drop-in and casework	**VOLUNTEERS (Former clients)** Peer support	**CAPACITY BUILDING** Proactive and reactive – responding to need
SUPPORT telephone communication with GPs, midwives, hospitals, dentists, mental health/well-being services, and social care services; making, querying or chasing up appointments.	**SUPPORT** awareness raising and capacity building sessions including drawing attention to current situations within hotels and barriers experienced by asylum seekers seeking care.	**AWARENESS RAISING** with NHS and other public service teams and community groups supporting understanding of needs, entitlements, experiences, and working with interpreters. Undertaken via talks, staff meetings, training sessions and conferences. Face-to-face and online.
UNDERSTANDING health service letters and texts about appointments, referrals and test results.	**ADVOCACY** with hotel staff bringing to attention Home Office, health and accommodation issues on behalf of hotel residents.	**GP TRAINEE AND MEDICAL STUDENT** talks on refugee and asylum seeker needs in partnership with local university and health trust.
UNDERSTANDING directions to clinics procedures and expectations around appointments and waiting times.	**FACILITATE** healthcare appointments through in-person reminders.	**SCHOOL/COLLEGE STUDENT** information sessions and awareness for those interested in medical school.
EDUCATION + AWARENESS through specialised health workshops incl. men's health, women's health, mental health, and maternal health; health service navigation through organised sessions and one-to-one engagement.	**ACCOMPANYING** to medical appointments and pharmacy helping with locating, physically accessing, moral support.	**ADVOCACY** approach responding to issues flagged by clients and other services and raising concerns, including supporting the wider understanding of clients' needs.
ADVOCACY with health services drawing attention to urgent medical and dental care needs; challenging charging.	**ADVOCACY** to all services (including HARP) with benefit of language, cultural, faith and home-country understanding.	**STAFFING** **Small team** moving across different accommodation sites supported with monthly clinical supervision.
ESOL FOR HEALTH encouraging learning of words that can help with communicating health issues and needs.	**SUPPORT** understanding Home Office communications, asylum processes, removals and transfers.	
SIGNPOST to community groups and activity providers, such as climbing walls, Wildlife Trusts, gyms, kick boxing.	**INTERPRETATION** Formal and informal.	
WELCOMING new arrivals and provision of resources such as mobile phones, bikes and shoes (via donations).		

FIGURE 4 Health Access for Refugees Programme case example.[1]. Reproduced from Robinson *et al*.[1] This is an Open Access article distributed in accordance with the terms of the Creative Commons Attribution (CC BY 4.0) license, which permits others to distribute, remix, adapt and build upon this work, for commercial use, provided the original work is properly cited. See: https://creativecommons.org/licenses/by/4.0/. The figure includes minor additions and formatting changes.

Respond takes a trauma-informed and family-based approach. An expert multidisciplinary team meets regularly and often involves wider community partners such as family support workers, social care, school nursing, health visiting, education and the voluntary and community sectors. The meetings offer opportunities for case discussion, clinical support, fast-track referrals to specialists outside of standard care pathways and awareness raising (which might relate to COVID-19 outbreaks, a new resource or an influx of new arrivals from a particular country). A virtual extension of this service has recently become available to all services and locations across the UK.

Following screening, an electronic and hand-held health plan, including signposting and referrals, aims to support engagement with other services and address some of the health impacts of disruptions to care from the common relocation of asylum seekers to different parts of the UK.

Integral to the core screening and care planning provided, the service relies on its capacity to flex and adapt to moving in and out of new locations, working in different ways and in different sorts of spaces, to continually engage and liaise with other services to identify new accommodation sites and appropriate GP practices, as well as consider new ways of engaging clients.

Case study 3

Solentra is a non-profit organisation offering transcultural mental health care to people with a refugee or migrant background (*Figure 6*). The organisation works across the three regions of Belgium, both individually with clients and in a systemic way with important figures, including extended family (sometimes in other countries), and professionals and support workers from across a person's broader environment.

Their approach places human rights to good mental health and the United Nations Sustainable Development Goals[237] as central priorities alongside their own model of care, known as Psychiatry Assisting a Cultural diverse Community in creating healing Ties (PACCT).[39] PACCT takes a stepped-care approach, with heavy focus on daily stressors that may threaten psychological well-being and impact a persons' coping resources. Step 1 of the approach focuses on building local capacity to ensure that front-line responses to the individual are understanding of their situation and concerned with meeting their basic needs, such as housing, legal support, schooling, leisure activities and social contact. Step 2 uses community-based consultation to understand a person's difficulties from within the cultural and migration frame of the individual (and their family), as well as the current societal conditions in which they are living. It aims to identify and articulate underlying assumptions, values and expectations held by each system or individual, to work with what clients themselves see as important, and to build a protective community. Step 3 involves one-to-one ethnotherapeutic consultations.

Solentra's approach is flexible and can be outreach or clinic based. They have a core commitment to working with ethnotherapists or interpreters to deliver therapy in a client's mother tongue, regardless of local language proficiency, and will aim to always work consistently with the same interpreter, interpreters that understand their framework and who often have shared experiences with clients, allowing them to perform as 'mediators for therapy'.

Referrals are typically received through social workers, other psychologists, doctors and other health staff, school staff, language tutors, guardians (workers or volunteers supporting integration of unaccompanied minors), support workers and family. These referrers will be services (or family) with which Solentra will aim to work closely.

Recognising the challenges for broader professionals in communicating and co-operating across language and culture, Solentra offers a range of online and in-person learning modules, intervision and supervision. They deliver additional standalone psychosocial and mental health projects which have evolved in response to local need.

Case study 4

The Victorian Refugee Health Program, Australia is a nurse-led service providing holistic health assessments and care co-ordination to refugees and asylum seekers with complex needs (*Figure 7*). Service aims are set by the Victoria (state) Department of Health but delivery models, including the level of support and care which can be provided varies across 15 individual state services, influenced by a variety of factors including the structure of the local community health service, the size of a local refugee community and the services urban/rural location.

WHAT	**COMMUNITY-BASED HOLISTIC HEALTH ASSESSMENT AND CARE PLANNING**
WITH	ASYLUM SEEKING ADULTS, FAMILIES AND CHILDREN
WHERE	INITIAL AND CONTINGENCY ACCOMMODATION SITES, PRIMARY CARE SITES, FIVE LONDON BOROUGHS, UK.

RESPOND MODEL, University College London Hospitals NHS Foundation Trust	ENGAGING CLIENTS	PARTNERSHIPS
Holistic health assessment and care planning with asylum seekers within temporary accommodation. Includes a focus on physical health, infectious diseases, emotional and psychological well-being, sexual and reproductive health, child development and family functioning, access to play, education, and social support services or resources, trauma and safeguarding, oral and dental health. Each area of focus will consider an associated response or action including multisector referrals (often rapid and outside of standard care pathway), booking and facilitation of access to other services, and some provision of resources and signposting.	**Proactive 'referrals'** with administrative staff constantly working to identify and connect with new contingency accommodation (hotel) sites. Some referrals also via primary care and social care. Information about the service is often passed on through word of mouth and from workers within accommodation settings but the team will directly approach new arrivals by telephone to offer an appointment. **Appointment times vary depending on needs** and whether the client is a family or a lone individual. DNA rates addressed through active planning and reminders.	**Relationships with GP** practices vary but include sharing of space and resources, direct linking in with practice staff, and sometimes include working with a dedicated RESPOND GP. **Expert migrant health multidisciplinary team (MDT)** brings together a range of health, social care, housing, education and other support services to support informed working and aholistic care response. Operates outside of standard care pathway with dedicated fast-track for specialist referrals. Partnerships across the NHS, with local authority, Early Help, housing, education and welfare services, and the voluntary and community sector.
Electronic and handheld health plan follows an appointment and flags health needs and referrals to GPs, supports engagement with other services and stays with the family or individual as they are moved around the country.	**Telephone interpretation** used, including when making appointment bookings. **Family-based care approach** supported by informal child care and play activities provided by a healthcare assistant to support engagement with parents and allow for sensitive conversations.	**Regular** training and clinical psychology support through peer and specialist routes for staff to be able to reflect on their emotionally challenging work.
Core activities delivered by an Infection and Inclusion Health Practitioner (advanced nurse practitioner) and health care assistant taking a holistic and trauma-informed approach with additional capacity from consultants in paediatrics and infectious diseases providing specialist care. A broader team of clinicians offering immediate guidance to workers around complex cases and a dedicated administrative team supports appointment bookings.	**Trauma-informed** care approach. **Very flexible** approach to working across and between boroughs, sites, sectors, with tertiary services, and GP practices and with the complexity of needs.	**Virtual RESPOND Advice and Guidance MDT** offered nationally to all services and locations for complex case planning, advice and guidance.

FIGURE 5 Respond case example 2. Reproduced from Robinson *et al.*[1] This is an Open Access article distributed in accordance with the terms of the Creative Commons Attribution (CC BY 4.0) license, which permits others to distribute, remix, adapt and build upon this work, for commercial use, provided the original work is properly cited. See: https://creativecommons.org/licenses/by/4.0/. The figure includes minor additions and formatting changes.

WHAT	NON-PROFIT ORGANISATION TAKING A HUMAN RIGHTS APPROACH TO TRANSCULTURAL MENTAL HEALTH CARE
WITH	ASYLUM SEEKING AND REFUGEE CHILDREN AND YOUNG PEOPLE AND THEIR FAMILIES; SOME ADULTS; SERVICES IN CONTACT WITH ASYLUM SEEKERS AND REFUGEES
WHERE	OUTREACH INCLUDING RECEPTION CENTRES AND SCHOOLS, AND CLINIC-BASED, REGIONAL TEAMS ACROSS BELGIUM

SOLENTRA **MODEL OF CARE** PACCT Model (Psychiatry Assisting the Cultural diverse Community in Creating healing Ties)	**STEPPED CARE & PROJECTS**	**CAPACITY BUILDING** Proactive and reactive – responding to need
All projects draw on Solentra's PACCT model which frames transcultural mental health care around human rights and a broad ecological vision of health and takes a flexible, mobile and phased (stepped care) approach. PACCT focuses on working with a person's protective environment, as a 'whole system'. A primary focus is placed on daily stressors that impact a person's coping resources and there is a heavy focus on learning from clients.	**Helpdesk** phone line, with call-back function, as a first-line discussion for care providers, including teachers and community workers working with refugees. **Community-based consultation** (with schools, social workers or other support service, and usually the family) to form a protective community for a child. A form of training on the job the approach aims to enable all 'players' to understand a situation, be part of defining the issues, and part of defining the solutions.	**Training and education courses** to support the knowledge, skills and attitude of those coming into contact with people with refugee backgrounds. Including: psychosocial support of refugee families, transcultural skills, detecting psychological problems and psychosocial education, and addressing resilience amongst migrants and refugees.
Multidisciplinary team with a range of skills, experience and backgrounds (clinical, therapeutic and professional expertise, working in other countries, bi- and multilingual, shared culture or experiences with clients). **Translators and cultural intermediaries** always involved when considered necessary.	**Ethnotherapeutic consultation** referrals will be accepted where advice, training and community consultations have not been enough. Involve cross-cultural validated diagnostic instruments (where available), always with translators or intercultural mediators to facilitate therapy in the mother tongue of the client and/or ethnopsychologists. Flexibly delivered in recognition that people are in 'survival mode' and often facing many problems. Take a range of approaches including transcultural psychiatry, EMDR, psychotherapy, narrative exposure therapy, physicality and movement to express emotions and communicate.	**Training and peer review** provided to Public Centres for Social Welfare (and other services) to support services to understand a persons' environment and deliver culturally sensitive work. This includes a focus on a person's strengths and resilience; being aware and recognising the psychological issues refugees can face which impede the integration process and making appropriate referrals at the right time to the right person. **Intervision and supervision** with own and staff of other services delivered flexibly in groups and individually.
Independent but collaborate with a regional mental health centre and deliver many projects in partnership, or for, state providers.	**Other standalone projects** often evolve in response to need for example, social integration programmes, and a school-based youth mental health crisis group.	**E-Learning Academy** for culturally sensitive work: interactive modules including building a relationship of trust, communication skills with unaccompanied minors, supporting well-being and the best interests of a child, community-based working, agency and resilience.

FIGURE 6 SOLENTRA case example 3. Reproduced from Robinson *et al.*[1] This is an Open Access article distributed in accordance with the terms of the Creative Commons Attribution (CC BY 4.0) license, which permits others to distribute, remix, adapt and build upon this work, for commercial use, provided the original work is properly cited. See: https://creativecommons.org/licenses/by/4.0/. The figure includes minor additions and formatting changes.

WHAT	PHYSICAL AND MENTAL HEALTH ASSESSMENTS, CARE CO-ORDINATION, HEALTH EDUCATION AND SPECIALIST REFERRALS
WITH	NEWLY ARRIVED ASYLUM SEEKING AND REFUGEE LONE ADULTS, FAMILIES AND CHILDREN, SOME ONGOING CARE FOR THOSE IN THE COMMUNITY REGARDLESS OF IMMIGRATION STATUS
WHERE	OUTREACH AND CLINIC BASED (USUALLY COMMUNITY HEALTH CENTRES) IN AREAS OF HIGH REFUGEE RESETTLEMENT, VICTORIA, AUSTRALIA

VICTORIAN REFUGEE HEALTH PROGRAM	CO-LOCATED SERVICES & PARTNERSHIPS	BROADER STRUCTURE
Typically, a nurse-led team aiming to support increased access into health systems, health service navigation, initial assessment, some case management, health and care referrals, health advocacy and wider health capacity building. Work with newly arrived asylum seeking and refugee lone adults, families and children, some ongoing care for those in the community regardless of immigration status. Actively work to identify people who may have come in on a spousal visa often via established relationships with different communities. Use of in-person and telephone interpreters.	**Dispersed model** with 15 separate refugee health services and 60 funded Refugee Health Nurse positions across the state. Most are part of a Community Health model that is unique to Victoria. **Direct referral** and close working with state settlement service who will refer individuals/families within a week to 1 month of arrival or sooner if health needs are flagged by IOM during pre-arrival screening. Health assessments will usually take place over a series of three or four visits. This extended period is seen as important for developing trust and relationships.	**Nurse-led teams also support local capacity building** supporting culturally and population-sensitive work both formally and informally, including training for workers in contact with refugees and asylum seekers, secondary consultation and support to other service providers, including GPs. **National Refugee Health Service framework** is currently being developed.
Comprehensive health assessments within 1 month of a person arriving, encouraged over several appointments. Includes migration, social and medical history; women's health; sexual health; psychosocial history including settlement stressors; physical examination; health screening; management and referral planning; and for children and adolescents, developmental, education and behavioural assessments. Some aspects include GP involvement.	**Usually co-located** within a community health centre which are often seen as a community hub, typically located in lower socioeconomic areas, some with gym spaces, a pool and community garden. One service is located within a tertiary hospital. Co-located colleagues often also have high experience with refugee clients and can include counsellors, physiotherapists, occupational therapists, GPs, podiatrists, dentists and early intervention services. Some services receive satellite provision from specialist refugee health paediatricians and optometrists.	**A state-wide facilitator** informs the Department of Health and policy about issues on the ground, supports workforce development with refugee health nurses and allied health professionals, offers particular support to the smaller more isolated/rural teams, and addresses capability within mainstream health services (e.g. to understand pre-arrival experiences and trauma-informed care).
Team varies by service but always includes a Refugee Health Nurse, often a bi-cultural worker, social worker or care co-ordinator.	Services are usually well-linked with other organisations and a specialist trauma service (Foundation House).	**Victorian Refugee Health Network** brings together the 15 services for collaboration, projects, development of resources, sharing knowledge, and national advocacy. Includes three **Refugee Health Fellows** (specialistsin infectious diseases, child health and primary care) providing consultation to providers.

FIGURE 7 Victorian Refugee Health Program case example 4. Reproduced from Robinson *et al.*[1] This is an Open Access article distributed in accordance with the terms of the Creative Commons Attribution (CC BY 4.0) license, which permits others to distribute, remix, adapt and build upon this work, for commercial use, provided the original work is properly cited. See: https://creativecommons.org/licenses/by/4.0/. The figure includes minor additions and formatting changes.

Although not a gatekeeper of the GP or other health services, for more complex cases, large families, those with additional needs and for asylum seekers outside of settlement support provision the Refugee Health Program will support people through all or most aspects of a refugee health assessment, general health service navigation, and provide initial care management. This includes TB and other screening, identification of other physical or mental health or social needs, support with learning how to call an ambulance, how to attend the local hospital, and how to access GPs, optometrist and dentists. The program will provide crisis management for new or previously discharged clients and, if not already working closely with the GP, they will provide a report for GPs and any other referral services, highlighting a patient's needs and investigations. Approaches are need led by the person or the family, and may include wraparound support for those with more complex needs including social aspects, material needs and advocacy.

Teams are typically small but will always include nurses, sometimes, advanced nurse practitioners, and may include an immunisation nurse, practice nurse, social worker or care co-ordinator, and bicultural worker. Where teams are located within a large community health centre, there are typically strong internal (co-located) relationships with GPs, women's health, counselling services, physiotherapists, speech therapists, dieticians, occupational therapists, early intervention and disability services, smoking cessation, family violence prevention, men's behaviour change, drug and alcohol services, and with the practice reception and administrative staff. Though broader services are not refugee specific they sometimes share the same staff (who might work part time for different services) and will usually have substantial experience working with refugee clients.

They work closely with settlement case workers from where most referrals will come as well as youth services, schools, lawyers, and community and voluntary sector settlement organisations, charities and NGOs.

Case study 5

Bevan is a social enterprise providing 'responsive' NHS GP and health and well-being services designed to meet the needs of people who are homeless, in unstable accommodation or have come to Bradford and Leeds as refugees or to seek asylum (*Figure 8*). With a focus on holistic care, general practice is provided with the addition of onsite Arabic interpreters, includes a degree of advocacy, social referrals and letter writing, and is co-located with Bevan's well-being centre, which offers a range of informal and more structured well-being support.

A dedicated young person worker works with young people, families and schools, supporting access to mental health and recreational and social activities such as football and martial arts. A weekly young person's well-being drop-in provides GP contact, health checks and well-being activities without appointment. A mental health lead supports mental healthcare planning and mental health and social referrals for adults.

An outreach 'hotel' team includes an immunisation nurse, nurse practitioner, healthcare assistants and a social prescriber, and provides clinical health checks and health screening, including some social history, offer of contraceptive counselling and contraception, catch-up vaccinations, some medical prescribing, and social prescribing to residents in temporary accommodation sites across the area. Their approach is to take a 'holistic picture of people's health' and can lead to a range of clinical and social referrals, including support with accessing community, social and educational activities. The team attempt to cover most residents in each site before moving onto another location. Assessments, including referrals, are added to GP patient records.

Health and well-being activities take place in a dedicated well-being centre or outreach in communities, public spaces and temporary accommodation settings. Activities include a women's group with a focus on women's health and family planning delivered by a nurse, social prescriber, psychotherapist, GP and health advocates. Social prescribers and health advocates provide one-to-one support to explore people's aspirations, support access to services and resources, and to support mental health. This includes a range of social, educational and physical activity opportunities, and local service navigation.

There is heavy involvement of volunteer peer advocates supporting patients in the GP waiting room with a 'welcoming face' and social support, help to complete NHS registration forms, make appointments, use the internet and set up and operate the NHS App on people's smartphones. Peer advocates also work alongside the different programmes,

WHAT	INCLUSION HEALTH GP AND HEALTH AND WELLBEING SERVICE
WITH	PEOPLE TYPICALLY EXCLUDED FROM CARE, INCLUDING REFUGEES AND ASYLUM-SEEKERS, SEX-WORKERS, AND PEOPLE WHO ARE HOMELESS
WHERE	A GP PRACTICE AND WELLBEING CENTRE, OUTREACH TO CONTINGENCY HOTELS, WEST YORKSHIRE, UK.

BEVAN
HOLISTIC APPROACH
GP service and health checks

Inclusion health GP surgery providing NHS general practice care. Includes some advocacy, social referrals and letter writing. Some flexibility in appointments to accommodate walk-ins, alongside pre-booked and on-the-day appointments. In-house Arabic interpreters, otherwise typically telephone interpretation for other languages. Active reception team liaise and refer to social prescribers, well-being services, and organise interpreter schedules in advance of appointments (where language needs known). Peer volunteers offer support to register with the practice.

'Hotel' temporary accommodation team outreach support includes health screening, including mental health and TB and blood-borne viruses, catch-up immunisations, medical prescribing, and support to access and understand appropriate use of NHS services. Delivered by clinical and social prescribing team with some remote GP support available to workers. Social prescribers provide well-being activities and provide one-to-one support. Collaborate with community partners to deliver additional support and health information activities.

Mental healthcare planning triage, on-the-day walk-ins, and case management providing mental healthcare planning and mental health and social referrals for adults.

HOLISTIC APPROACH
Health and well-being service

Smart Health Inclusion Peer Advocates providing peer support to enable socially excluded groups to improve digital skills and overcome barriers to access health and well-being services, including the internet, NHS App and online appointment booking.

Young person's project dedicated young person's worker providing one-to-one, family and community support, weekly well-being drop-in with GP contact, health checks and well-being activities without appointment.

Social prescribing team support social connections into the community and access to other services. Includes ESOL, college courses, arts activities, men's woodwork, physical activities, support with making telephone calls, health and early years information sessions, volunteering. Constant evolution of new activities being tried.

Starting Well women's group offering group and one-to-one support including yoga, group-led and guided discussion in language specific groups on women's health (contraception, smears, preconception care, mental health). Delivered by nurse, social prescriber, GP sexual health specialist, physiotherapist, peer volunteers.

Life in the UK hotel-based sessions focused on supporting local and systems knowledge and understanding (e.g. when to call an ambulance, go to a pharmacy or go to the doctor and other UK-legal or social norms). Support with basic language, such as, "I need an interpreter".

VOLUNTEERS (usually former clients)
Peer support

GP reception welcome volunteers offering a friendly introduction to the GP practice, supporting social connections and confidence in the waiting room, letting people know what services and activities are available, and delivering the **Smart Health Inclusion programme.**

Group and one-to-one support to support attendance and engagement in well-being, social prescribing and health information activities.

OTHER ASPECTS

Services developed in consultation with service users
Open kitchen for all well-being visitors to make, tea, coffee, toast and lunch
Some reimbursement of travel costs
ESOL classes and social workers co-located during certain days of the week
Food parcels sometimes home-delivered

FIGURE 8 Bevan case example 5. Reproduced from Robinson *et al.*[1] This is an Open Access article distributed in accordance with the terms of the Creative Commons Attribution (CC BY 4.0) license, which permits others to distribute, remix, adapt and build upon this work, for commercial use, provided the original work is properly cited. See: https://creativecommons.org/licenses/by/4.0/. The figure includes minor additions and formatting changes.

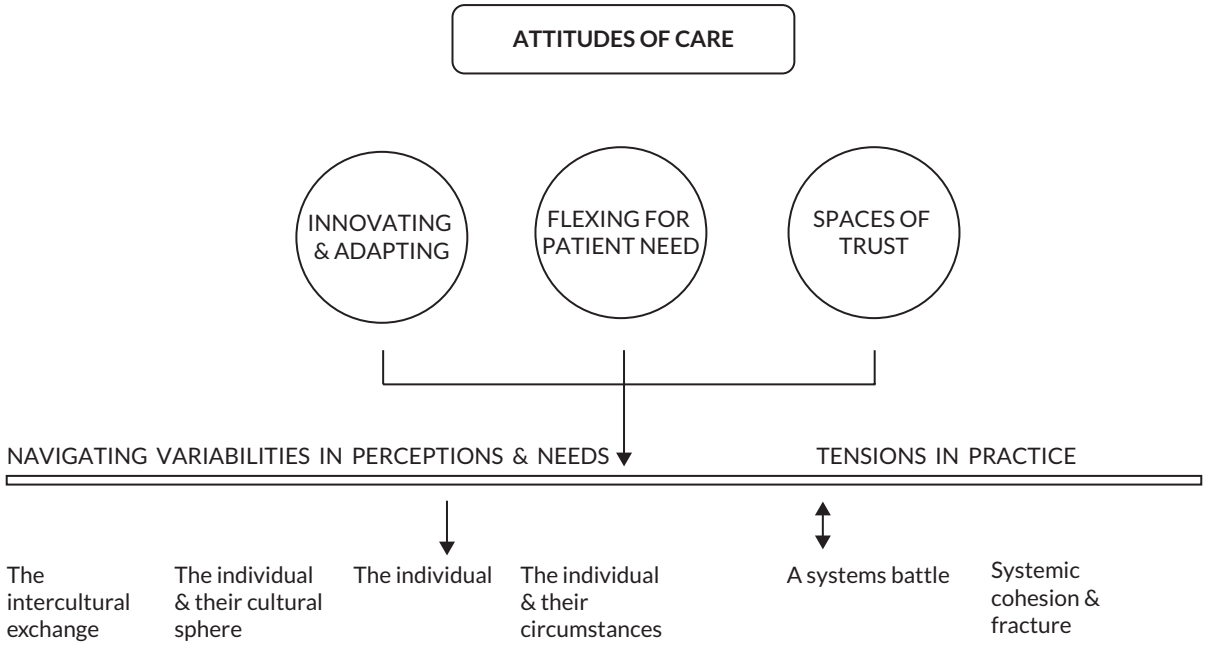

FIGURE 9 Communities of care. Reproduced from Robinson *et al.*[1] This is an Open Access article distributed in accordance with the terms of the Creative Commons Attribution (CC BY 4.0) license, which permits others to distribute, remix, adapt and build upon this work, for commercial use, provided the original work is properly cited. See: https://creativecommons.org/licenses/by/4.0/. The figure includes minor additions and formatting changes.

exploring people's interests and signposting or supporting access to other groups and services. The broader staff team is multidisciplinary and also includes people with shared backgrounds to patients.

Communities of care: themes and findings

We present a series of dominant themes that help to highlight the attitudes, priorities and capacities demonstrated by the five case examples in their work with forced-migrant clients and patients (*Figure 9*). These should be seen as interconnecting. They do not encompass everything that services worked to achieve or delivered but present as overarching *attitudes of care* (innovating and adapting; flexing for patient need; spaces of trust), approaches for *navigating variabilities in perceptions and needs* (individual, the individual and their circumstances, the individual and their cultural sphere, and the intercultural exchange), and highlighting of the *tensions (inherent) in practice* (a system battles; systemic cohesion and fracture).

Attitudes of care

Innovating and adapting

Innovating and adapting are models of health care that do not 'fit in a box' or 'even its own box'. This meant constant reinvention and navigating unpredictability, 'a case of testing something … if it doesn't work you trial, you trial, you test it … it doesn't work, you go back to the drawing board, and you look at different ways'. Services were 'evolving all the time', always 'looking for ways to improve' and to meet the changing conditions of policy environments and local contexts and the changing needs of patients and clients.

For patients, this was commonly discussed in relation to appointment systems: testing out flexibility for walk-ins, 'because some people do just need seeing there and then'; triage mechanisms, whether in fact a social prescriber could pick up some initial primary care instead of a clinician; and flexing on length of appointment slots. One worker talked about these dilemmas, explaining a 'new trial' of something 'slightly different'. Reducing health assessment appointment times for 'not so complex cases' while recognising if,

> *We know it's going to be complex, well we know for a fact just by previous, how we've been running, 45 minutes isn't enough. So maybe can we look to increase that to an hour so instead of just being very rigid in what we've been doing we want to try and be more flexible so obviously we can support our staff … but most of all we're giving the care that the patient really needs.*

There were shifts in staffing skill mix, one service talking about the increasing inclusion of social workers or care co-ordinators in their nurse-led team to 'get a handle' on the social support needs of an increasing number of asylum seekers being referred with no access to state support. Services talked about a 'commitment to having no waiting lists' feeling a 'duty of care' to see people as soon as they are made aware of new patients, something that required navigating the constant ebbs and flows of patient numbers, thinking about additional projects or new ways of working; 'this is our problem … how can we think about it, how can we be more effective?'. An increase in Afghan students referred were described as 'all talking about the same thing … after the attack that happened in Afghanistan … they had the same problem, the same worriedness for their family because they did not know what would happen to them', and this led quickly to a new programme of school-based group therapy. During COVID-19, 'a free helpline delivered by native speakers in Arabic, Farsi, and Spanish, a stress reduction consultation where we tried to respond also to the questions people had, the concerns, and if needed we could also do a follow-up session'.

Where services were providing health care to residents in initial or contingency accommodation there was a continuous process of identifying new locations (both formally and informally), negotiating access to accommodation sites or local GP surgeries, rethinking how workers can move between different settings, and navigating new relationships with sites and other local providers,

> *What became clear, very quickly, was that you couldn't set it up in one way and stick to it because the need kept moving and as soon as a hotel shut something else opened and every patch had a different infrastructure, different MDT members who were able to work in different ways. So, what we learned was that we needed to be really quick … we needed to set up where we were needed and in the way that we were needed.*

It meant a heavy resource commitment to operations and building relationships, 'it's getting out there, finding out who's doing what, how we can work together'.

These were also settings that were highly unpredictable, some relationships were established and worked well, with some trust in accommodation providers, 'let us know' … 'if you are aware of any patient that is medically unwell … don't wait for the GP … get them in to us straight away' but people also talked about a 'general hostility', accommodation staff 'quite obstructive at certain points as well', sometimes 'really up against it to get in to help people', at times 'being turned away by security'. Some blame was placed on communication challenges, exacerbated by high staff turnover within accommodation contractors and constantly having to make new relationships.

With changing locations, there often came changing environments that demanded significant flexibility as to where workers were prepared to do their work. 'It is very much adapting …' from one day to the next. 'It could be a different space every day … tomorrow we could come and somebody may well be in this room … and then we're kind of like … well where do we see people?'. There was sometimes the provision of care 'in a little corner' of a communal 'lounge', some more like corridors or walk-ways than clinics, with *security watching on*, or in rooms like cupboards with no windows, no air and no space, a staff room, security sleeping as bloods are taken. It was not only that rooms might change but that the rooms themselves were not your typical clinical space. There was some concern about ensuring that a person feels comfortable, 'coming into a bedroom with someone they've never met before, who says they're from the GP surgery …' or that spaces are not always conducive to the calm, quiet disclosure of health concerns.

> *Language Line on loud speaker … being very close to the dining room and then all the stuff going on there getting prepped for dinner and then somebody coming by with a hoover and it was just very, very noisy and the person I was with just got very overwhelmed with it all and very sort of frustrated, he couldn't sort of tell me, couldn't hear the interpreter, I couldn't hear what the interpreter was saying.*

This inability to 'control the environment' was seen as an 'eternal challenge'. One service described working on 'developing a minimum standard' while also being 'very mindful' that this was never going to be the 'same as an outpatient department'.

Ultimately, teams were 'very mobile', delivering care outside the realms of usual practice ('there are lots of things that we will be more flexible about, than we might in other services') and outside of typical boundaries of their roles,

psychologists … nurses … 'sometimes we feel like we are lawyers, sometimes we're social workers …'. It was seen as 'a form of entrepreneurship … seeing opportunities, creating opportunities … something that a regular centre … don't have'. There was recognition that these attitudes were made possible first by institutional structures, although one service felt they had 'hit luck' as part of a large health agency, which they described as 'the opposite of blinkered'. Services generally talked about the importance of sitting outside of the 'restrictive agendas' of certain agencies where 'layers of bureaucracy' were seen to 'encroach on delivery'. One interviewee spoke of the 'infinite amount of focus and possibility' that independence from state structures and large providers could offer,

> *So we're not constrained by red tape, so something like this, which is a new project, let's recruit staff for it, let's have a look at skill mix. Let's get the money to support them. Let's try it. If it doesn't work, we'll try it a different way, that's the kind of thinking. And there is that flexibility to say, look, actually, there is an unmet need here, what can we do here … So yeh, it is really, really refreshing.*

An example was given of a need for condoms and sexual health information, the ability to make condoms immediately available to hotel residents on a daily basis, of bringing in an outside provider, getting 'everybody together … let's do it'.

Senior leadership was actively involved in delivery in the majority of services, meaning, as one provider put it,

> *[they] are also invested … things happen and things happen a lot more easily and a lot more quickly and innovation does turn into … you know … a real tangible service for people. We're just like … that's a good idea let's make it happen and it's relatively simple.*

There was the impression that the specialist nature of each service helped here too, 'everybody's head is in the same place … and it's easier to get my head around the ideas that people have because it's my world as well' with managers often referred to as 'enablers', 'innovating' and 'forging' new provision, and 'very prepared to help think of a solution'. These were environments with an ethos of support in which workers were 'free … to be looking for what the problems are', 'to notice' and to 'have a few ideas', and to be supported and encouraged by managers and 'a very strong supportive team'. There was a lot of 'talking together' and sometimes 'disagreements' described as helping to foster new practices and changed thinking and a spirit in which services were seen as 'still discovering together' the best ways of delivering care. This included seeking regular feedback from service users, 'we always have a little talk after a session … so they can tell us what they thought or what didn't really help and stuff … "oh actually … that was good …" or maybe we should try this differently'.

People talked about 'a different kind of culture', 'different attitudes towards the[ir] position … you're not on that pedestal … you come out of that'. This seemed to be coupled with a mentality of 'creativity', 'able to be afraid or be insecure and still standing', and that this was a 'vocation' more than a job, and that without that, it is 'difficult to handle' and work in this context; 'I don't think it would suit someone who wanted to go in and work by the book'.

Flexing for patient need

There was a flexibility too in the microinteractions with patients and clients. A women's group, for example, allowed for those who came along to bring forward their own issues for discussion, which might be talking about 'good relationships', discussing nutrition and preparing food together. It might also be a fluid practice of referral, 'if someone comes to one of our groups and just expresses a support need then we'll pick that up'. It could be seen in how services engaged patients; a health drop-in where anything goes, from the availability of bikes to the provision of shoes (most residents with only flipflops on their feet). Or it could be the *purpose* of the service, helping someone to understand a referral letter for the hospital, linking a volunteer with someone trying to find the GP practice.

There was much talk about engagement. Word of mouth had proved best for one service at engaging hotel residents, 'they need to hear that it's happening …' and so described 'working hard' to recruit new volunteers in the hotels 'to get them spreading out the word'. An arrangement in another service allowed for young children to be cared for by the healthcare assistant, with a door propped open for everyone's peace of mind, but with enough privacy for a parent to discuss more sensitive issues.

There was heavy reflection on why someone might not attend an appointment, recognising trauma may not make it 'easy to come' or *will* make it easy 'to forget'. It was described that someone might arrive at their clinic (rather than the hospital) because it makes sense to go to the one that you know and not the one described in the 'letter that you don't understand', 'it's just not made clear'. It was often described that people simply cannot get there; 'I didn't have the money', a 'taxi doesn't come, or it comes late and they miss the appointment'.

There was reference to text message reminders, a day before a service appointment. Or, for a more complex case, there might be a phone call prompting, reminding or checking that someone was planning to attend or was on their way, clarifying that 'it's okay to be a bit late'; 'we'll fit you in'.

> *It depends on the patient really. So, some patients, if it gets to 50 minutes late and it's something really minor, we'll be like 'no sorry you need to play by the rules' if its half an hour … some people will let way for half an hour, some people if they turn up at all we're just grateful. It depends on how vulnerable they are and so there's always a bit of flexibility.*

There was reference to volunteers residing in hotels knocking on clients' doors and 'motivating people and encouraging them' to attend a planned appointment. In one service an arrangement involved hotel managers and security guards (who were providing some form of gatekeeping in and out of buildings) who would pass on reminders about a planned health assessment if someone went out.

There was an emphasis on 'finding out why' an appointment was missed; 'the first thing we do is, we pick up the phone'. Services talked about re-offering appointments, putting in place support, such as help with navigation, telling the time and peer advocates emphasising the benefits of the offered care; 'we will try and talk to them and make them understand how useful that is, help them see what they're missing'. There was also occasional reimbursement of travel costs for some appointments and a feeling that, with a 'bit of perseverance' or support people will subsequently attend.

One psychologist explained, 'well for us it's like, okay, they're not here, we're going to go out, we're going to mobilise', going on to explain that they recognised it was a different kind of culture stepping outside the clinic, making it sometimes difficult for new colleagues. Similarly, other services described often making home visits for first contact, or recognised that on occasion, the expectation for a mother alone with four children, might have more success all round if the clinic were to go to them.

Trust

Trust was a theme threading through many conversations. There was recognition of 'huge amounts of fear' with people 'worried about disclosing information', and 'always getting a bit alarmed' by medical consent forms. Mistrust was attributed to not knowing 'who to trust', to experiences of racism and discrimination, and to fear of government institutions. There was sometimes reluctance and refusal of catch-up vaccinations.

> *People are worried about being tagged with the vaccines … a colleague, from a different community … pointed out that … when you tap in to why, actually, it kind of, in their mind, actually it might make sense, they feel like the Home Office might track them, or something like that … I suppose it's kind of having that conversation ….*

Workers acknowledged that there was no 'expectation [for people] to be open and cooperative after one meeting', 'in the initial contact they wouldn't trust me, and I don't blame them … that's why my first contact, I don't ask any sort of gruelling questions, it's just about getting to know them'. There was a need to do a lot of 'explaining', of making people 'aware', of working 'really slowly'. People talked about providing 'active reassurance that there are no ties' with the 'Home Office', with 'the police' and 'reiterating all the time … it's just to go on the healthcare record … it's not passed on to anybody else', and 'being really clear about who we are, what we do, why we're calling them, why we're offering this appointment' and that nothing is 'compulsory'.

People talked about the importance of 'creating a space of trust' sometimes in relation to the service 'welcome'. Reception spaces which might be shaped by language provision and peer support, getting it right, 'the welcome to the surgery, how to register, how to book an appointment, that is actually one of the key things'. This included seeing receptionists 'as part of the team' who might themselves refer people and tell patients about the social and well-being

support available. It might just be 'having a welcoming smile' … 'saying "welcome Mr and Mrs, have a seat, do you want some coffee? Want some tea? Welcome to […]", smile …'. It might be a first interaction that might see a worker acknowledge someone's situation, share some form of familiarity with someone's home country, a shared connection over a local dish, offering a moment of happy reflection. Some workers had a little of some of their client's language, able to exchange a few words, or described efforts to learn 'a handful of phrases to support relationship-building'.

> *Maybe, what also helps is that … when I speak Arabic to people it opens up as well. So, it helps, and I've never been to Afghanistan, but I also ask the interpreter, 'teach me some words' so I can at least greet a person in their mother tongue and that's … people are smiling and are saying you know 'do you know more?' and I'm like 'no, no, no, […] is difficult', and then we talk about languages, how hard it is.*

When it came to mental health, this was seen as particularly important, especially where people acknowledged mental health as 'a big taboo topic' or 'group cultures where talking about your problems outside of your circle, it's just not done … you would be completely rejected by your community'. Here there was heavy emphasis on the importance of a 'good' relationship; with that 'we have already gone half of the way', slowing things down 'putting a break on ourselves', 'there cannot be a focus on quick results', 'it takes time to build this rapport and someone's confidence', being patient, 'there is no limitation for being patient with patients'.

People talked about working indirectly around mental health, 'so one-to-one emotional support and building on that and then once they feel ready … I would make that referral'. Others talked about doing small practical things to build trust and those relationships, 'by showing people their rights, for example, you prove that you are worth the while to listen to and then you can start opening up and relating'. Others talked about concentrating on peoples' hobbies and interests, 'building that rapport slowly, slowly, and then they will come to you and they'll tell you "actually I'm struggling with this and that … can you support me?"' People talked also about avoiding 'a demand for someone's ID, their address' while completing GP registration, and not taking photocopies which they described as a 'known barrier'. Several people talked about the importance of face-to-face contact, 'it has to be in person … you know, you need to build that rapport' others suggesting a fear for some patients engaging online; 'he feels everybody is hearing everything. It's not safe. He does not feel safe to say everything'. It was common for providers to be flexible too with appointment times, 'people find it difficult to come to morning sessions or morning appointments because if you've not slept, why do you want to wake up early to make your day longer?' This would include in determining when or how frequently an activity or an appointment would take place, something often decided mutually. Providers described seeing the investment of someone's time as important and considered this part of the 'relationship of trust'. Outreach provision was seen as a further facilitator of 'constructing a trustworthy relationship', closing down some of the barriers and equalising relations between individuals, families, state structures (schools) and clinical services.

> *So when we were assisting the teacher in the conversation with the parents on how to express the problems that a child had in school this was much more like trust building, and not, okay, being sent by the teacher to the hospital as it happens normally because the teacher says, 'I suppose you have a psychiatric problem', these kind of referrals do not work. So we do the other way, you need to go there.*

The same service explained that the teacher or social assistant with whom they might work together with the student or client, will, 'tell the refugee, "you don't need help, I need help … I ask for a lot of expertise because I'm not competent" …'

Building trust and rapport was explained by one worker as 'the most important thing in our job … to make that connection to provide the situation that they can trust us', it was a process, it took time, it could take months, and 'some people remained suspicious'.

Navigating variabilities in perceptions and needs

Intercultural exchange

The ability to navigate different viewpoints and be aware of the complexity of an intercultural exchange was seen as important in creating and sustaining patient engagement with services. This required 'recognition of different health

beliefs' of different interpretations of 'child development', 'behaviour' and 'experiences of pain'. There was a need to resist 'ethnocentrism'; 'systems here were created for a white majority, pretty much designed that way … and yeah kind of sort of fairly entrenched in those structures and ideas'. People also drew attention to the 'conditioning that they get' in practice, certain institutional cultures and a resistance to doing things differently.

This required a preparedness on the part of workers (and managers) to become aware and reflect upon their own values and motives, in order to be more effective.

> *I think it's … stop pretending that everyone that works in the health service understands the needs of these populations … they don't. Be humble, listen to the patients, start including peers in the decision-making process from commissioning down.*

There was recognition of boundaries between normality and pathology and symptoms and syndromes that might be understood and explained differently among different cultures. There was some acknowledging of somatic expressions of mental health and of seeking to understand someone's own interpretation of what was going on, 'Okay … what you went through … what did it do for the body?'

There was reference to adapting classical therapeutic techniques, one provider talking about using only the physical aspects of EMDR because cognition and emotion was seen to be less present in their patients, 'within our refugee conception of themselves, it's much more the body … . War trauma … an unaccompanied minor … violated … it's too heavy for words but his body will express it', explaining that often yoga and stress relief exercises might be the best approach. Practices which others also stressed as beneficial and activities which service users 'might not otherwise have considered'.

Explicit intercultural dialogue was described as part of the outreach methodology of one provider that sought to bring together different 'important actors' (such as schools, integration services, families) and the individual to actively facilitate a process that brings to the surface 'the unconscious values' of each party. This was seen to 'offer a space to bring different identities together' and help each group to 'understand' and become 'acquainted' with each other's values and perspectives. It was also described as facilitating trust and enabling 'an adaptation process' that allows for 'home cultures' to co-exist in the settlement space as people adapt to 'living in a Western society'.

The importance of family and extended family perspectives in certain cultures was a further consideration. There was 'a need' some said to bring parents into consultations but to do this in a 'sensitive' way; 'you have to put it to the [family], you have to ask which person can begin or which one can say how they feel, or what is the problem'. It required an overt 'welcome' of this input, 'acknowledging respect and thanks for their contribution'. One service explained that they did this even where parents might remain, for example, in Afghanistan:

> *We cross-borders … so that we make that connection in terms of you know, how do the parents see what's important in educating their son … so we can actually learn from that and then we can have more bi-cultural identity.*

In describing how they broach this contact, they explained:

> *We don't say, 'well listen, we are psychologists' but it's more like, you know, 'Your son has arrived [here]. He's residing here' so the parents themselves are very grateful, extremely grateful that they know like, okay, this person is actually asking me about my son, and about his well-being … so just the fact that you are talking as person to person, you easily get into, yeh, a very close relationship … and we don't say necessarily that 'your son has psychiatric problems' because we know that whatever they have is a normal reaction to an abnormal situation.*

Interpreters, too, were sometimes acknowledged as contributing to the intercultural exchange. One service talked about efforts to work with people that understood their therapeutic frame. It involved training or a form of experiential learning. There was the sharing of case files, 'so that I can prepare, research and ensure that I [interpreter] have the full terminology of the specialist clinical language that will be necessary', 'a mini training before and after … because heavy stuff is happening, and we [psychologists] are trained in not taking it in, but interpreters not'.

An interpreter who worked in this way described it as a,

> *… protection that the psychologist gives to the translator … it's a way to negotiate what happened and what was in the session. It's a way to protect the translator from the affection that he gets in the session. It's a very sensitive thing as a translator for these patients, psychologists' patients, it's very important to keep a space between you and the patient. The story of it. Try not to get involved in it …*

There was the attempt to 'fix' a translator to a particular client. This was seen as building a 'stronger' therapeutic environment, 'each time we sit together … and this person, this patient he will feel more and more comfortable to talk and say everything inside him. Because he trusts the translator as he trusts the psychologist'. This was seen as creating a context in which the interpreter could be seen as mediators of therapy, bringing a skill and cultural sensitivity, to the therapeutic encounter.

Interpreters talked about the responsibility they felt to maintain trust and bring their cultural understanding to an interpreter encounter. One interpreter used the example of gynaecology and the use of the word, 'vagina' where a female patient and her husband may both be present, 'so this women comes from another land that maybe they don't accept this word. And especially [with] the husband beside her …'. The interpreter explained that if they were to translate directly, what had been asked, it would be seen as 'a big shame … it will be the last word that I translate and they will leave and never come back. So I have to say it in another way … I can ask, with another name that is more respectable to this person, more acceptable'. But shifting terminology means conveying this clearly to the health professional, 'when I translate to this women in this words that she accepts in her culture I directly re translate for, and tell the psychologists what I have translated for her. What words I have used. So everything must be clear and to the psychologists'.

Individuals and their cultural sphere

It was here where facilitating the connection of people with shared cultures, faiths, experiences and languages were felt to enable 'better' care or contribute to creating an environment in which there was a greater balance of empathy and understanding. This might be through bringing clients or patients together in group-based practices, including therapy, health education and social activities, not always with a shared culture or language but a shared understanding of some experiences, 'it really helped them because they had the same feeling, they had the same pain for their families and when they were talking with each other … when they shared these feelings … it helped them to feel that they are not alone'.

Some services saw the engagement of peer or lived experience advocates, usually volunteers, supporting clinical workers or group activities, providing translation, and supporting service and local navigation. There was reference to groups 'thriving' with the inclusion of peer volunteers, creating a more 'welcoming' environment, in which individuals could feel 'safe' and 'understood'. That when someone 'with a shared experience says, "I know how you feel …" it's because genuinely they do … I think it does make a massive difference … and can also give hope'.

> *The advantage of being hired on the lived experience is you empathise with the people and even on the difficult patients who are finding it difficult to speak out, or to mention, or to open up and say this is what I need, you can actually read them and say, look I am here because of one, two, three and to be honest I am still on the same journey that you are.*

There were lessons learnt from COVID-19 vaccine outreach work that had been delivered alongside 'members of different communities that knew their communities'. This had been seen to help engage people and had been a driver in one service of greater collaboration between clinical and social prescribing teams:

> *So we're working really closely with the social prescribing team who are looking at getting volunteers to help at hotel sessions whether that be making appointments or helping with immunisation sessions … so it's looking at how we can utilise their skills as well and they can become advocates for explaining things but also that's that trusted member of the community that can … you know … be a positive link.*

In one service, bicultural workers connected to settlement communities were seen as 'bridging that gap between their culture and the health service', somebody able 'to support mutual understanding because they are able to resonate with patients' experiences'. They were framed as workers who might have some loose education or understanding in community development or social services, 'who are able to negotiate, able to be that bridge between mainstream and their particular communities … able to have strong links within the community … that's really important … they're a community leader'. Bicultural workers were also seen as 'helping to identify gaps that may be able to be met in ways that [services] haven't looked at' and helping to deliver care, particularly health promotion, 'because navigating the health system is crucial and we do the best we can and use interpreters, we never do it without an interpreter but if you've got somebody here, who knows the community and knows the health system and can do that link'.

There was some reference to practice managers, receptionists, nurses and therapists from shared or similar communities able to, by proxy, help navigate and bridge understanding, and although no service described the intentional recruitment of staff with minoritised characteristics, this was reflected across staff more broadly in many of the services. Gender, however, was acknowledged sometimes as a factor in certain decisions: a male co-ordinator was employed to help navigate some of the more complex contexts, such as family planning and faith perspectives, the benefit of flexibility to specify the desired gender of an interpreter, especially for women's health, and one worker talked about being able to call on her (male) colleague in certain situations:

> *So many times I'll ring him when I'm in the hotel … I'm like, 'do you have a moment, I've got this patient here'. He's Arabic. Even if he's not Arabic, he's male, can I task you to be helping out with this, so we're working hand in hand like that.*

Although one worker pointed out, 'it's not the experience of the whole population', the propensity for someone with a shared background and language to 'know what it means … to have the experience', the understanding of 'what's going on in my society', nuances of culture, faith, language, the health services in different countries and attitudes to health, was widely recognised as a benefit to service users (and to teams and services as a whole). In the delivery of mental health care, particularly, this was articulated by workers from several services. Seen as 'providing that assurance', helping to reduce stigma and build trust in a service, 'no, no, no you're not nuts … and no I work here also' and that some activities, are just 'better held with someone who knows more about the culture, knows more about the language'. One worker, who described themselves as coming from a 'similar culture to the service users' reflected:

> *I think it's amazing that some of my colleagues have had the same lived experiences, because I remember when I was younger, I accessed psychotherapy but I could not relate to my counsellor at all, and I absolutely hated it. It was only when I went to uni and I thought 'oh, okay, culture does make …' and I'd just thought I hated the idea of psychotherapy because of my culture, but it wasn't, it was more because I couldn't relate to my counsellor … and I think in any role you need to be able to relate.*

It seemed quite simple really, 'imagine you are sick abroad how nice it would be for you to see an English doctor'; 'Patients are more comfortable telling us certain things … If I can speak Arabic you're more comfortable talking to me than a doctor who does not speak Arabic'.

Working in 'the mother language' was seen as helping the therapeutic exchange to be more 'emotional and sensitive …'.

> *In every language there are words, expressions, that we cannot translate. So it's not easy for people sometimes to express themselves, say those words or those expressions, their thoughts, their feelings in other languages. We cannot translate it …*
> *It instils more confidence … it's much more trustworthy because an interpreter communication has always those flaws, a risk of excluding important detail … Working with an interpreter is not the best solution. I mean it's the best solution given the circumstances that we do not speak each other's language but …*

The individual

There was some emphasis on being clear that 'every migration tells a different story', that the experiences and cultures of patients and clients should never be homogenised, and effort should be made to develop an understanding of each individual's context. *Showing an interest* appeared instrumental to each services approach to care. That might be

following trauma-informed principles or instinctively acknowledging someone's 'terrible' or 'very difficult' situation. The emphasis rarely on past events, although sometimes an interest in current events taking place in someone's home country, but only very carefully, with several workers explaining that they 'don't tend to go into much detail about someone's journey'. It was common to show an interest in what people used to do in their home country, to 'ask about [someone's] affinities and what [they] liked' and this was seen as a way of understanding the person and their cultural habitat, 'genuine curiosity' of others' worlds, creating more equal relationships of 'trust' and 'reciprocity', 'in this way he is teaching me so we are the same … and this is going to create a better self-esteem'.

> *You do see that not everybody is as adventurous to visit those different cultural worlds or war trauma … so there is this, I don't know, they're anxious, they're afraid, and this is also one of the obstacles like being afraid of that story… and that's the danger that you also have in just like people who are used to … people meeting … people.*

People talked about spending time to understand someone's 'rituals, traditions, behaviours, that come from their cultures'. In different contexts, this seemed to be a clear priority, 'just get to know them', and then it is, 'what they want to do, what are their expectations' what can be achieved together. In this way, volunteer advocates talked about giving people

> *…a lot of time … we stay and then chatting with them and making sure everything is okay … we talk about their problems … what makes you happy? They talk to us about finding places … we make sure you're really happy before you leave this building. That's our priority. We don't work with minutes or with time.*

Facilitating, supporting and signposting in response. Here, social prescribing services seemed essential, 'it's all about connecting you with your community'. It required placing the individual in a space of autonomy, creating the conditions for 'people themselves who have the wisdom to resolve their problems' to be 'part of defining the solutions'.

A further rationale for community-based consultation was the need for

> *…honouring the experience and the knowledge of the refugee themselves but it's also kind of capacity building of the social assistant. Not to see a victim but to be culturally sensitive. To be aware of the migration experience. Not to start from I've got this man before me he's a refugee.. but who was this man in his home country.. what can we continue. Because the mourning process is helped by continuation. What can we continue. So okay he was a lawyer, his diploma is not recognised so he cannot be a lawyer but there is some kind of analytic capacity so how can we translate it in our labour market.*

The individual and their circumstances: caring communities, coping and resiliency

There was both wide recognition of the complexity of clients' and patients' contexts and active practice that sought to engage with, influence, or support an individual's navigation of the situation they now find themselves in. There was universal acknowledgement, often also to patients and clients themselves, of the 'many stress factors' shaping someone's situation, 'even if the person talks another language, has another culture, he has the same needs as people living, born [here]' …. 'the connection between people … [and the connections] between a society and the people'. One worker explained:

> *A lot of the symptoms that we think could be from a psychological origin [are] much more related to the mourning process of migration … it's a loss experience and the stress of acculturation … you should not come to a psychologist; in that sense, a teacher or social assistant is much better placed to resolve this stress.*

They went on to explain,

> *Talking about wanting to have your job back doesn't help. It's much more helpful to have a good social assistant thinking about, what you are able to do, and to translate what the refugees still can do, into the new environment. 'Okay, this is possible … this is not possible'.*

People talked about clients as 'disconnected … from all the resolving or the problem-solving skills, or even problem-solving resources' of home and that it was these that services and receiving societies 'have to put in place through informal or formal aid so that [people] can at least, get back on their feet and solve their problems themselves'. There was a commonly shared view that 'it takes a society to heal war trauma' and people talked about 'prioritising daily stressors' giving attention to 'environmental factors', 'basic needs', a 'good lawyer', 'schooling', 'leisure activities', 'financial situations', 'barriers of language' and 'enforcing social contact'. In different ways, these factors were all described as 'instrumental in improving people's circumstances' and 'very important to help patients to get better' or simply 'for stabilisation … coping mechanisms … as long as you're in the asylum procedure'. Although there was mixed focus or capacity in being able to drive some of these factors, helping to stabilise someone's environment was seen as a priority and often expressed as justification for well-being aspects of provision or work that took place with other sectors to support redress of these conditions. One interviewee described the need to actively affirm the importance of reconnecting people with their inner resilience,

> *First of all, is that you know, people have already come from a very difficult area and sometimes they … because they have been through so much, they don't see their own strength anymore. So that's where I try to have the person relate themselves back with how they have overcome already so many obstacles and that they have it in them to make something good out of this bad.*

For some providers, this saw workers enabling and creating the conditions for social connections through group activities, active engagement with peer advocates and social prescribing that made possible connections with communities, faiths, interests, nature, sports, language classes, learning, training, volunteering and work opportunities, and the capacity, through knowledge and confidence, to independently engage with services and make more informed decisions about their health; '[people] just need a network around them to support them in adjusting into a culturally new environment', 'you know a lot of people … when [these] things start to improve their mood starts to improve'.

This, one service explained, justified why they 'work so hard' to engage with front-line workers. Taking a 'systemic view' of health and of the further deterioration of mental health. They explained their work with schools, social welfare assistants and other stakeholders who have a 'much more confidential relationship' with people, making those responders 'aware' to consider 'basic needs', 'resiliency' and 'how trauma works, and this is what you can do'. Although they were the only service to articulate this work through the language of human rights, explaining the 'importance' of always 'stating the universality of being a human', a multilayered perspective and focus on 'changing the rules and advocacy' was reflected by others. Each service in some form driving broader shifts in local responses to forced-migrant communities.

Service providers talked about meetings with dental hospitals and community mental health teams, 'to explain the needs of our clients' and where they felt these needs were not being met, flagging disconnects in rigid referral procedures in social care and mental health that do not recognise the 'vulnerabilities' and 'safeguarding issues' of clients, 'constantly fighting the cause and advocating on people's behalf'. One worker talked about advocacy with housing, 'to get a family with children with disabilities living in a hotel room into a proper house', and 'myth busting' with other groups and services. There was common reference to trying to increase capability of health professionals working in 'mainstream health services' to understand 'those pre-arrival experiences', 'trauma-informed care', 'who this group are, why they're here, demystifying some of that, reducing some of those barriers', and reminding colleagues that interpreter services 'are free, here's how you use it'. Some services talked about 'subtly' offering support, doing something quickly in a 'lunch break', going over a refugee health assessment, sharing information about 'local contact points' for refugee support in the neighbourhood, and encouraging external providers to, 'just call us' for any secondary consultation.

A free helpdesk for care providers offered by one service was available for outside professionals to seek advice and new perspectives on a specific case. More formal training, intervision and supervision were also offered to external agencies or individuals, with a formal arrangement at a national level to provide e-learning and supervision to social welfare workers supporting unaccompanied minors. Modules covered well-being and the best interests of the child, building a relationship of trust, community-based working, agency, resilience, and knowledge around trauma, mourning, accumulative losses and acculturation.

Tensions in practice

A systems battle

In constant tension with services driving a *community of care* and a permanent point of bordering for individuals was what we have termed, a systems battle. The reality of immigration policies and the structural design of institutions governing the broader health care and social adjustment of patients and clients were seen to diminish and frustrate impact. At a very functional level, 'demystifying' the 'terribly entrenched bureaucratic structures' of health and societal systems and supporting service navigation was a central activity provided by most services, 'a human face to the NHS … "I am from your GP surgery … and I am here … and these are the services we can offer … and I am here to help"'.

Although not equally reflected across the different national contexts nor always experienced in the same way for people with different asylum statuses or nationalities, racialised discrimination and xenophobia in broader health services and systems, community aggression, violence, including in schools and on the peripheries of accommodation sites, were all acknowledged by service users and workers. It was the hotel regimen, however, that was particularly emphasised, 'it adds to people's stress, the whole process is adding to people's stress'.

One person told us, that 'it's really, really helpful to just get out' get involved in things and 'see other places' but accommodation was often isolated, an A-road and supermarket only, a bus ride that people cannot afford from services and communities. Faith appeared to be a strength for some people as was volunteering. Some talked about 'deep depression' … 'You're in the same room 24/7' and workers talked about witnessing a 'loss of hope'; 'that is their living space … that is how they're living'. People smoke in shared rooms, sometimes of up to nine people. Often no windows, 'sometimes they will open a crack'. We hear that in some rooms where there are windows, there is no way to block out the light. People described 'no opportunities or activities inside the hotel … nothing to be busy with … no single opportunity … just I can run on the main road up and down'. Everyone talked about food. Including food affecting people's mental health; the 'loss of role from what they were used to … looking after the house, cooking their food'. Meals on throwaway plates, throwaway cutlery and throwaway cups, there is 'no food from 5pm to 9am', meals are only ever, 'chicken and bread' or 'living off biscuits' because they don't trust the food, there's no halal information and people do not trust what they're told.

> *The diet that [people] would have … they've lost … you're eating food that you're not even used to … that probably you think is making you unwell. Like someone's diabetes and eating chips every day is not going to be helping anyone.*

People talked about coughing, flu, COVID-19 symptoms but no COVID-19 tests. They cannot sleep either; several people tell us, because of their own nightmares or because of someone else's. One worker offers some techniques for managing nightmares but later explains, 'they need at least a proper environment … in a hotel, therapies won't work … these are very, very hostile environments'.

There was often talk of people living 'in constant fear that somebodies going to knock on the door and say, "get your things together, there's a taxi outside"'. People are moved without being informed in their language what is going on, one worker tells us. Often with no warning, sometimes with warning, but then the move does not happen. Workers talked about the impact that this has on people, 'on their levels anxiety', 'on their health care', away from 'the trusted service', 'split up from family', they will 'lose their friends', 'the networks of support' that people have built up, they will 'miss out on their health assessments, or their care is disrupted'. 'You know, they're all human beings they're not just numbers … what we're sort of doing is retraumatising them through the system … we're retraumatising people, we're disempowering them, meaning that it's harder for them to do things'. One service had developed a hand-held health record; if people managed to get their assessment, this would remain with them when they were moved.

These spaces are *policed* by men in high-visibility jackets, lots of them, steel-toed boots, walkie talkies; some wear stab vests. You get mixed impressions as to whose safety they might be protecting. The toilet is out of service. There is some suspicion that this is not the case that it is a ploy instead for stopping people congregating in the only shared space, the vestibule of the hotel. In most, there is nowhere to congregate at all. In another, we are told that only recently have rooms and showers started to be cleaned; people tell us that it is a balance between challenging and retaining a relationship with these systems.

More than health care, what people really wanted was 'to work … to have my papers as soon as possible …' *If we can't change that … you're shaking your head …* 'Nothing … nothing actually … nothing, it just depends on yourself and how much you can handle'.

> *You'll not starve, you'll not sleep in the street but you're not allowed to work … you're not allowed to do anything … as an adult, that's devasting. No services, no activities, no nothing, just stay in the hotel until [they] decide. Well, that's okay if it's a few months but sometimes it drags to years. It drags to years and then you are mentally demolished, and you feel that you are worthless. I think another person who doesn't understand how it is to be sitting there. Every day you're looking at your phone. Every time an email comes in, you're checking it's the Home Office. When you miss a call, you get frustrated, what if it's the Home Office … That gets to you without you knowing it.*

Workers talked 'sometimes … feel[ing] like you're flying by the seat of your pants and putting out spot fires', that they're merely keeping a patient's 'head above water'. Several questioned 'the cost', 'the work', and 'the burden' on health services for 'keeping people like this'.

Systemic cohesion and fracture

There were clearly active and important internal and external partnerships and relationships which were critical components of each model of care. Sometimes good relationships with (re)settlement services, NGOs and community agencies, schools, social workers, carers of unaccompanied children and young people and some accommodation sites. GPs were sometimes integrated or strongly associated with services and usually co-located, providing mostly informal, supportive relationships both ways, clinical support and advice, the shared or co-informing on patients' initial health assessments and receptive to concerns, 'we are able to phone practice managers, discuss a particular case or a general issue with [a] local practice, prioritise a case of concern, and they will listen, they will take us at our word, you know'. One service spoke of an external torture and trauma service as a 'vital piece' of their approach, although waiting lists were an issue here and elsewhere. A separate but associated programme of refugee health fellows, a rotating group of specialists that are on call (paediatrics, adults, infectious disease specialists, GPs) providing technical and clinical support, and secondary consultations.

> *They can often unblock the pathway if you're worried about urgency or this persons really vulnerable and … 'I'm sending them to the ED now but can somebody when they get there, just like, fish them out and make sure they get where they need to go because they're really ill …' sometimes you can call the fellow and they'll wander down to the emergency department.*

One service talked about formal multidisciplinary meetings which enabled broad issues 'to be discussed', plans 'formulated' and 'plugged into the local networks'. Some talked of stakeholder meetings for 'organisations that are interested in refugee health'. Some described these 'as being well attended by a core panel' others talked about 'health … accommodation services' … 'they sometimes just fall off the radar'.

On the whole, good relationships appeared to have been long existing, 'like who do you know and can you talk …', or had relied on working very hard or as one provider explained:

> *It's very much on their terms whether we have that good relationship … [we] try to change things for the positive and create systems change more than to criticise or condemn … obviously we do at times, we have to make complaints and raise quite serious issues but on the whole we bite our lips and try to do what we can to improve especially with the NHS as well … it's about improving the system rather than condemning them for what they've done wrong.*

Rarely were relationships institutionalised, although there was some indication that where services could in some way locate staff or build strong connections with regional, state or national structures this saw benefits. Some strategic 'influence' with access to decisions makers, commissioners, taking that 'voice' from 'on the ground', trusted across the different spaces and in a position to 'nudge' decisions, funding and practice. More progressive local and national politics was clearly helpful.

There was a feeling that good things happened elsewhere because of individuals and not by design. The co-ordination and communication of information, responsibilities and commitments across broader systems and services was often seen as poor. Data were seen as a factor here:

> *I think that these individuals get lost in data sets … they're not coded as asylum seekers for the most part, so there's no way of identifying how many asylum seekers are registered with GPs … And because they are one patient, or a small number of patients in a list size of thousands, they don't get noticed, even within the practice and because they're looked after by generalists, not specialists, again they don't necessarily understand the needs to identify it or advocate for their needs. So, I think all of those things mean that they're quite invisible.*

There was talk of the abdication of responsibility, again particularly within accommodation settings, acknowledged by service users as well as workers. Left often to other residents to care and look out for their peers. Who will call the ambulance? Who will check on each other? We hear about a young person:

> *He described a terrible journey … 'I am 17 years. The Home Office decided to add 10 more years on my age. I'm now 27 and I want to kill myself' …. Do we call for adults or do we call for the children … adult services … Crisis Help … CAMHS [Child and Adolescent Mental Health Services]?*

The young person ends up at A&E:

> *If he's a child he's not supposed to be in a hotel, he's a minor.*

Over the phone, Crisis Help tell them,

> *'Please make sure there are no sharp objects in his room … a health hazard'. We can't do that. We don't have the authority to do that. We ask the hotel to do that, the hotel team are like, 'we can't we're not allowed to do that'. We ask the housing team as well, they're like 'We just accommodate them, we cannot go and do a search in their rooms'. So, it's a complicated issue. You know. We're standing there and we know he's at risk but how do we help.*

We hear a lot about suicidal thoughts and self-harm. Who strategically is thinking about refugee patients and the health care of forced migrants, 'there's nobody highlighting them and they're lost in the whole picture … commissioners really don't have any idea'.

Discussion

This study of five transnational case examples has drawn attention to the possibilities and mechanisms with which to negotiate the delivery of health care in spaces without common culture or language and in complex and often constricted and hostile contexts and settings. Although provision was wide-ranging, it was largely underpinned by what we have discussed as shared *attitudes of care*, and a range of organisational dynamics (*innovating and adapting; flexing for patient need*; *spaces of trust*) that weave through the design, delivery and operational mechanisms of healthcare activities.

We demonstrated the considered flexibility with which services were operating; they flexed because they had to but also because flexing and shifting was seen as important to actively learn and respond well to the changing and individual needs of service users and because the environments in which they were operating and their service users were existing, was in constant flux. Although clearly challenging, the range of contexts considered has demonstrated that even for state and public health providers, often constrained by rigid structures and the instrumentalisation of staff,[14,238] an ambitious organisational attitude of innovation, reflexivity and support is possible, workers can take on a fluidity in their professionalisms, have ideas and autonomy, and explore the best responses to the people in their care.

This capacity for reflexivity has been highlighted as important both as part of direct interactions of care and as a reflection on systemic spaces. This included an active resistance by staff and services of ethnocentrism and the

conditioning inherent in professional training and as others have encouraged a 'self-reflection in personal biases, privileges, and power imbalances in [their] interaction with patients'.[239] This aligns with broader inequity scholarship, which is increasingly prepared to acknowledge the structural systems that directly frame and disprivilege the social contexts and institutional interactions for racially, ethnically and other minoritised societal groups.

Alongside this, we identified an openness to considering divergent approaches to patient care. As others have pointed out, this needs (as well as legislation and race equity policies) a new set of activities through which 'individual, organisational and community change, and movement-building' can take place.[240] What this research might contribute here is an articulation as to how some of these activities could be enacted, how alongside engendering reflexivity and flexibility in healthcare practice we might begin to navigate variabilities in health perceptions and needs.

At a very basic level, the need to counter broader fear and unease in the displacement and immigration context, *actively* create spaces of trust and safety, through reassurance, transparency, avoiding known barriers and, crucially, through valuing the patient perspective and the conscious gift of patience and time all appeared vital mechanisms. First encounters mattered and as others have documented,[39,51,52] a *real welcome*, taking different forms, but reception spaces, a 'welcoming smile', utilising peer support, throwing in an Arabic greeting, a Farsi welcome, a cup of tea, a glass of water, 'how are you …' should not be underestimated.

A dynamic commitment to language and making communication work without question concurs with extensive literature on the importance of dominant language proficiency as both a postmigration stressor,[241] a concern of clinical risk and medical error[242] and multilingualism as central to health equity, self-expression and equal participation.[243] Not only did this commitment involve high use of in-person interpreters, full utility of interpreters on the telephone, an attitude towards interpreters often articulated as a vital component of the intercultural exchange, requiring trust and helping to build trust and bringing an important sensitivity to a clinical encounter but also attention to the benefit of a bilingual and bi-cultural workforce. The less-understood role of non-specialist bilingual peers in healthcare contexts was identified, never in clinical or therapeutic interactions but strongly articulated as a beneficial part of a broader informal offer of care and support; on reception, in waiting rooms, co-delivering care and through social prescribing. The delivery of clinical care in the mother tongue, especially in the therapeutic exchange, was also highlighted, the sensitivities of expression and feelings again not to be underestimated in their importance, if *care* really matters and, more broadly, other bilingual and/or bi-cultural workers. Each of these contributions highlighting a role that was rooted in nuance but heavily valuable in the delivery and design of care. Bridging *gaps* between cultures and the health service and the other way, negotiating new forms of operation, decisions framed with better understanding, new perspectives on where the gaps are, and other ways of doing things and echoing what Burgess and Choudary[218] highlight in their case for methods of bidirectional co-production, creating 'welcoming and positive' statutory spaces that are 'safe to enter'.

Maintaining connection with native identity and traditional values has been well documented[244–246] in the context of migration and particularly so, in the context of forced migration where loss and the mourning process are supported by the maintenance of shared connections.[73] Similarly, we identified the locating of people within their *cultural sphere* (group activities, peer support, bicultural workers) as creating dynamic spaces of shared experience and community that were felt to nurture understanding and hope, and the negotiation of new connections and bridges with the local space, including theirs and other healthcare services. We identified also a pattern of *intercultural exchange*, conscious practices within micro/meso interactions that *give* on the part of *receiving* communities and create space for a negotiation for how diversity in identities, perspectives and understanding can co-align or co-integrate. Both play to the responsibility of healthcare providers to see a role in supporting the dynamic process of integration[247,248] enacting what Phillimore[71] discusses as 'refugee–integration–opportunity structures'. We identified a commitment on the part of providers to ensure that people know how *this* society functions, its (health) systems, norms and expectations, but also that providers actively welcomed new understanding through a humility and capacity for inquisitiveness – a preparedness on the part of workers and organisations to become aware, sensitive and knowledgeable about others, *actively* creating spaces for exchanging cultural understandings through interpersonal interest, the contribution of interpreters, peers and bilingual and bicultural colleagues (as discussed above), and through self-reflection actively making shifts to facilitate this knowledge exchange and shift how care is imagined and delivered.

In crafting a caring and responsive healthcare community, the research also points to an essential reflexiveness in respect of *individuals' and their circumstances*. As others[71,249] have discussed, services recognised that you cannot always separate someone's ill health and how they explain their ill health from the social structural dynamics and factors in which their clients and patients were located. The recognition of these factors and efforts to actively respond with facilitative mechanisms of *coping* and *resiliency* and advocacy for change was commonly indivisible from more clinical aspects of the care that we studied. Again, the research highlighted that through an inquisitiveness of people's individual context and own understandings of solutions, a prioritisation of what can be done about daily stressors, basic, social, cultural and future-oriented needs showed that there is a capacity for this to be built into healthcare responses. Although advocacy in health care by which clinical professionals see a role in the broader context of their patients is fairly underexplored,[250] this research has shown that multiplicity in professional practice is possible, a nurse leaning towards social aspects of care but also ensuring efficiency in clinical prescribing, a psychologist supporting wider colleagues and collaborators to recognise the importance of structural and social factors and good culturally sensitive interactions, a GP engaging with housing. There was a visible eye on broader needs but also on the best collaborators for the job, divergent roles within healthcare practice (advocates, volunteers, social prescribers) and broader networked approaches, *who are the specialists or the gatekeepers or the decision-makers?* Clinicians had to hand the resources for a societal response, good intersectoral relations, particularly with the community sector, social workers, schools, settlement services and clinical specialists arguably facilitated by the productive capacities of flexibility influencing practice and driving a natural divergence both within and across fields of care. Others have indicated that institutional arrangements at the local and country level matter for the establishment of such collaborations but that this requires the integration policy field and local policy forums to include a diversity of actors, including immigrant advocacy bodies as respected partners to drive collaboration and successfully generate shared perspectives and projects.[251]

Finally, although the aim of the study was not to interrogate further barriers to care, we highlighted the inherent tensions around which most services were required to navigate and compensate to maintain their handle on providing or supporting access to care. We articulate this in part as a *systems battle*, to which much of what services were required to do revolved around compensating for both exclusionary strategies and what Norman[252] terms 'strategic indifference'. However, to differing degrees across the national contexts, services were operating in hostile immigration environments, which could be observed to disempower people in states of precarity and hinder the process of social inclusion including health inclusion. In such processes, Norman suggests that there is a rational and strategic inaction on the part of the state and a reliance on others (usually non-state actors) to step in and provide, what governments do not explicitly deny but make difficult to achieve.[252] This seems an appropriate reflection, particularly on the asylum backlogs and contingency accommodation regimen in the UK context, and our evidence certainly echoes what several recent reports have articulated around risk of harm produced by conditions in these spaces and contexts.[23,28,253] We would argue that this places unacceptable limits on the achievement of health and fosters contexts of wasted resources within healthcare systems and suggest that this justifies a rapid review of practices and their implications on short-, medium- and long-term outcomes both for individuals and health providers.

Strengths and limitations of qualitative data

Our qualitative case examples allowed us to engage with critical perceptions of those actively working to improve healthcare experiences across a range of international jurisdictions and contexts. We conducted more than 50 hours of interviews and engaged in 5 days of observations and informal conversation with a wide range of workers in different roles. Observations were brief which we acknowledge has methodologically implications. There are also substantial ethical and practical issues with entering and observing participants particularly within healthcare settings; however, this proved crucial to the broader study in revealing what takes place on the ground both within organisational structures and beyond as to how broader political and social structures maintain an influence on care.

The two researchers [an experienced qualitative researcher in health inequalities (AR) and a community researcher (ZK)] brought a set of contrasting perspectives and backgrounds, which we suggest benefited the study and broadened reflections. ZK spoke a shared language with some participants as a native Pashto speaker and being fluent in Dari, which was often visibly well received, *faces lighting up* when realising the shared language and a degree of 'lived familiarity',[77] which enabled an immediately trusting and relaxed interaction and conversation. ZK's role as a health advocate and integration officer working with asylum seekers and refugees also added a further direction of interest

and perspectives, particularly in conversations with service providers. AR approached this work as a current 'insider' of the UK health service but has wide experience conducting qualitative research from within and across different sectors and settings often relating to access to care and is involved, as a volunteer, in local refugee responses. Depending on the context and participants interviewed, we moved in and out of different roles. Though we acknowledge that all these positions bring with them subjectivities, we saw them as strengths bringing a degree of balance to the research.

We recognise the potential, however, for power imbalances between researchers and participants and were particularly aware and attentive to this in the context of asylum seekers. As described above, sometimes this was felt to be mediated by ZK. Although we set the agenda for discussions, we tried to build rapport with participants, actively listened during interviews, for example by reflecting back the language used by participants, and allowed discussions to diverge in directions important to the participants. Although this was not the intended direction of interviews, it often led to in-depth listening to negative experiences that participants had received within broader health services or as part of their experiences within the immigration system (extracts of these have been included at the beginning of this report).

Despite using a professional translation service that included practices of back translation by two native speakers, the final production of some of our translated participant materials was flagged as being wooden and sometimes lacking coherence, which reiterates the challenges in multilingual communication and highlights the difficulties in communicating research procedures. We also found it difficult to encourage some forced-migrant participants to engage in information materials which, despite efforts to keep to a minimum, were extensive and referenced often very unrelatable concepts and institutions with which we were told many people were not familiar. We would welcome future engagement on these issues with other researchers, ethics committees and communities to explore innovations in the meaningful management of ethics in research with migrant and cross-cultural/national populations.

We conducted thematic analysis of qualitative data, which allowed us to directly represent the descriptions of respondents' viewpoints, experiences, beliefs and perceptions, and took an essentialist approach, aiming where we could, to report experiences, meanings and the reality of participants that could be construed from the conversations conducted and observations of practice and contexts (where these had been possible).[254] Some interviews relied on interpreters and note taking. In our documenting, through the process of translation and in our validating of the data, we remained (and we would encourage readers to remain) conscious of the risk of interpretations altering respondents' meaning as we moved between the different processes of word transition and linguistic structures. Otherwise, we transcribed interviews verbatim using colloquial language, broken language and grammar as spoken.

We engaged with only a small number of service users and only with service users from some services. This was as a result of unexpected restrictions imposed on services by accommodation providers where services were delivered, overburdening of service users already involved in service evaluation, service capacity constraints and unworkable ethics time frames in non-UK sites. Although we also interviewed workers who were former service users and talked with a high number of people locally with different refugee and asylum-seeker backgrounds and experiences, genders and ages, offering a range of insights and perspective, we suggest that further qualitative research should prioritise evaluative methodologies that are able to consider, in more depth, the experiences and healthcare impacts of similar services, particularly as they relate to the medium and longer terms. We would encourage attention to variation in outcome and experience in relation to gender, lone or kin groups, educational, literacy and linguistic background and capacities, and immigration statuses.

We provided opportunity for included services to validate interpretations and correct misunderstandings. This is often seen as a strategy to support trustworthiness in qualitative data and can address some issues associated with transparency and imbalances of power in the research process.[255,256]

Chapter 5 Stakeholder conversations and local reflections

We used a series of four conversation events (November/December 2022) to discuss early research findings with a range of stakeholders with the aim of considering the research in a real-word context, the relevance and applicability to the local context, the challenges in bringing learning to practice, and the gaps remaining. This involved:

- Two community events in towns in North West England to which we invited people from the local asylum-seeking and refugee community; 23 individuals attended these events. Attendees had a range of immigration statuses, including people residing in hotel contingency accommodation and people from a range of countries (Afghanistan, Ethiopia, Iran, Iraq and Syria).
- We conducted one online event (31 attendees) with a range of clinicians, health and public health commissioners, regional representatives of government departments and other public, community and private sector workers (health, social care, housing/accommodation, language services).

We used these three sessions to discuss early research findings that had been framed as a series of responsive healthcare principles/priorities with tangible examples. We encouraged conversation around whether these were priorities shared by local refugee communities and services; whether they were feasible or already existing within local delivery; whether these practices would make a difference to local experiences and, if so, when and where should they be located. If not, why not, and what other practices would people suggest.

These conversations informed a shortlist of priorities for a subsequent combined stakeholder dialogue, which took place in person and further engaged conversation around what learning was feasible locally (18 attendees). We used three primary questions around which to base discussions: (1) What would make principles/practices difficult to become reality? (2) What things exist already that could be built on to make this a reality? (3) What new things or approaches would be needed to help carry this forward? The following sets out a summary of the reflections, ideas and difficulties that were discussed. They highlight a motivation across different sectors to see improvements and an appetite for change, but also recognition of systemic challenges limiting collaborative working and capacity for change.

People talked about the need and drive for new cultures of care to be able to enact research findings:

1. **Openness and transparency –** who is doing what and who is responsible and funded for what.
2. **Professional responsibility** to understand refugee community needs, including experiences and impacts of trauma and migration, different cultural backgrounds, faith, health care in other countries and cultures, stigmatising belief systems, immigration rights/rights to care, best practice in communication.
3. **Organisational support and opportunities for learning and specialist training** that draws on experts in the field and people with lived experience (but not relying on people with lived experience).
4. **Equalising the field** with the community sector and strengthening the contribution of voluntary and community groups who may be better placed to deliver some healthcare practices.
5. **Radical change** in how services communicate within and across each other.
6. **A culture of welcome** – prioritising first encounters and reception spaces.

Key ideas to enact change included:

Systems

1. **To explore safeguarding** as a route to mandatory training and accountability for quality of care, including as a route for faith and cultural challenges and age disputes for children.

2. **A new co-ordinating mechanism** to act as a central point of contact for the refugee community and services. This should include lead responsibility for local refugee and asylum-seeking populations and in managing linkages across different parts of health system and other services. The Office for Health Improvement and Disparities' tools and position may indicate the department as best located to do this.
3. **Partnership events and opportunities to bring colleagues and organisations together** is needed to counter isolated working, foster collaboration and support learning. This should include dedicated time for workers and teams to reflect and build in new initiatives including funding and collaboration; this would need to be enabled from the top down and healthcare workers would need to be released from duties to engage.
4. **Cross-sector** shared funding, objectives and cultures could help support practice change.
5. **Mapping of local provision** so that providers (and refugee community) are aware of what is available, which could use GoogleMaps® (Google Inc., Mountain View, CA, USA) or similar and could be interactive.
6. **Professional and public engagement** activities and events could open up conversations, stories and understanding of migration and displacement and provide an opportunity to share information on local provision. A range of existing local and national models could be adopted, as could encouraging professionals to take up occasional volunteering with local groups. Hearing from NHS staff with migrant backgrounds would also be positive.
7. **Specialist training** needs to be rapidly introduced and could include lunchtime learning sessions.
8. **A clinical helpline** for guidance and supervision for providers is needed. New national virtual multidisciplinary team advice and guidance for complex cases provided by the Respond service detailed in this report may address some of this need.
9. **Individualised support offered to GP practices** to support local solutions. Could also explore floating GPs with specialisms including linguistic skills or the use of dedicated practices for initial registrations and care.
10. **Patient forums,** 'voice groups' and appointment feedback mechanisms should actively work to be inclusive of refugee communities.
11. **Patient case notes and records** need to be maintained, shared and travel with the person.

Health care

1. Peer-led and peer-delivered care bringing bilingual and bicultural understanding could include:
   A. **Supporters** from the refugee and asylum seeker community valued and upskilled to support peers in a range of contexts (e.g. A&E and reception spaces helping with navigation and registration), a friendly face and knowledge on rights. Existing models such as Bevan, the youth worker model in A&E, 'champions' and doulas within maternity services, 'friends of hospital' schemes could be borrowed from and adapted.
   B. **Avenues for training former asylum seekers and refugees** to become healthcare assistants could be supported locally with capacity for progression into other health/care roles.
   C. **Interpreter training** could be offered to people from the refugee and asylum-seeker community enabling those with good English to access valued roles and boost local access to interpreters.
   D. **Peer-led mental health support** may help careful engagement around the cultural acceptance of mental health. Mechanisms to support mental health and understanding of the impact of experiences, symptoms, provision and care should be prioritised on arrival in the UK.

2. **Language and communication needs** require rethinking and equalising; levels of qualification/sector specialism of interpreter should be considered. Access to translation should be provided in all settings, including on surgery and labour wards, during telephone communications, in dentistry, and on immediate arrival in reception spaces. Visual cues and easy to read information should be available and linguistically accessible, including information about the NHS and other providers, and in appointment letters (video and audio formats might be appropriate). Utility of peers could be capitalised on in certain settings (see above).
3. **Navigation of care and appointment systems** should be provided upon country arrival and should actively include awareness of rights to care and communication support, understanding of all public services and their remit, and a clear picture of the expectations people can have of provision. Efforts to help new arrivals understand the limitations of systems and universal challenges could reduce frustrations and stress. Access to advocates should be prioritised.
4. **An initial holistic health screening** should be provided upon arrival.

5. **Social prescribing** is a promising route but requires valuing with a budget and the same specialist understanding of refugee and settlement experiences as other providers. Models that are driven by the community may help to ensure this.
6. **Dedicated focus on building confidence** between asylum-seeker and refugee communities and NHS services. Outreach visits, one-to-one and group conversations with NHS staff within hotels may help. 'Drop-in' health care close to housing or town centre, Sure Start, multiagency forums and community services may also provide safe spaces for shared understanding and reaching communities in a personal and meaningful way. Welcoming attitudes, a culture of understanding for example taking time to explain medical terms and prescriptions, gender specific personnel (particularly for some female appointments), should all be a priority. Care should be taken to engage with a patient's notes rather than always asking patients to repeat themselves (which can be retraumatising).
7. **Physical access and mapping of routes** to providers, including best public transport routes should be part of a responsibility of services.
8. **English language learning and ESOL providers can help with** signposting, vocabulary and confidence building in healthcare communication and navigation. Resources could be shared between providers and embedded into courses as part of any ESOL learner journey. This would need to be differentiated to account for levels of English and native literacy. Incorporating 'I need an interpreter' into English language role plays should also be a priority. This provision needs to be accessible to all displaced people regardless of immigration status.
9. **Acceptable arrangements** should be made with families with children to support adult participation in language courses and other health-related activities.

Dominant difficulties that were felt to overshadow potential change included:

1. Low morale, overstretched, resource scarce and stressed workforce that recognises low confidence and a skill shortage in the understanding of the lived experience of refugees and asylum seekers.
2. Reliance on voluntary sector to pick up gaps and failings.
3. Subcontracting currently diluting or creating a loss of accountability.
4. Inequity in resources/contracts across different parts of the broad health system.
5. Tech and remote care developments further excluding refugee populations.
6. Dental care responsibilities remain unaccounted for.
7. Impacts of asylum system on creating (mental) health problems.
8. Relatively small asylum seeker and refugee community makes local prioritisation challenging.
9. Resistance to learning and changing practice.
10. Geographical location of health services – difficult for many to reach without significant social/knowledge/financial resource.

Chapter 6 Health as capability: summarising the research

This research has drawn together three approaches. It has considered insights from local communities and data from a wide range of literature and international examples of current practice, bringing this to a range of conversations with important stakeholders in North West England. The research has shown that there is no simple antidote to what is an entrenched and complex environment influencing the health and healthcare experiences of people seeking and receiving asylum. Despite this complexity, it has also shown that a set of reflexive attitudes can shift practice and a range of mechanisms can enact communities of care in which forced migrants feel able to positively engage and in which positive healthcare impacts can be enabled.

The capabilities approach, originally set out by Sen[89,257] and Nussbaum,[43,72] centres ideas around what individuals are realistically able to *do* and *be* in their lives. It encourages attention to the spaces in which people are located, their access or lack thereof to certain resources, their individual capacities, their availability of social support and the structural conditions in which they are located.[89,257] In Venkatapuram's[90] further reflections on the approach, he locates capabilities through a conception of the capability to be healthy, discussing this through four nuanced, responsive and iterative components: (1) a person's personal features and needs; (2) their behaviours and conversion skills; (3) their surrounding social conditions; and (4) their surrounding physical (environmental) conditions. Venkatapuram suggests that each component must be able to come together to create the practical possibility of achieving a capability (for health).

This conception echoes the importance our research has placed on the need for there to be an interest, attention and redress (by caring practitioners and the state) of the disabling physical and social conditions influencing health and healthcare experiences for forced migrants. Our research brings to this a range of clear suggestions (as well as further recognition of the limitations) as to how we might recognise and shape these social and structural contexts and better prioritise a person's individual needs, including their 'conversion skills' to improve healthcare possibilities. We have set these out in a number of ways.

We have articulated healthcare opportunities as a *map of players* (see *Appendix 9*) who reach across civil society and local, regional, national and transnational public, private and non-governmental groups and organisations. We suggest that responsibilities lie with all of these 'players' to play a part in the health care of forced-migrant communities and that these contributions should be approached through a bi-directional, collaborative and largely horizontal lens. We have identified a summary of responsive and potential responsive mechanisms as a list of actions for guiding policy and practice decisions and best using those opportunities or interactions that are on or shape the frontlines of care. We also identify a set of philosophies of care. These have been drawn from the synthesis of our transnational learning from current practice (see *Communities of care*) and our systematic review (see *Themes of impact*) to provide an overall conception of what we suggest creating *responsive communities of care* requires (*Figure 10*). We briefly summarise this conception below.

Attitudes of care

Spaces of trust

Every effort made to create welcoming spaces. Enabled through active warm greetings, compassionate reception, clear information, excellent and valued interpreters and active reassurance of detachment from immigration authorities. Further supported by enabling shared and new community connections; locating care in familiar spaces such as schools, community and shared community spaces; involving peers or trusted others in delivery or co-delivery of care. Enabling non-traditional providers to perform important negotiations with refugee communities in the entry, navigation and mediating of contact with formal health systems, creating new mechanisms for detecting health needs, and new avenues for help-seeking and the delivery of care.

Innovating and adapting

Actively learning and active flexibility across providers. Enabled and supported by management.

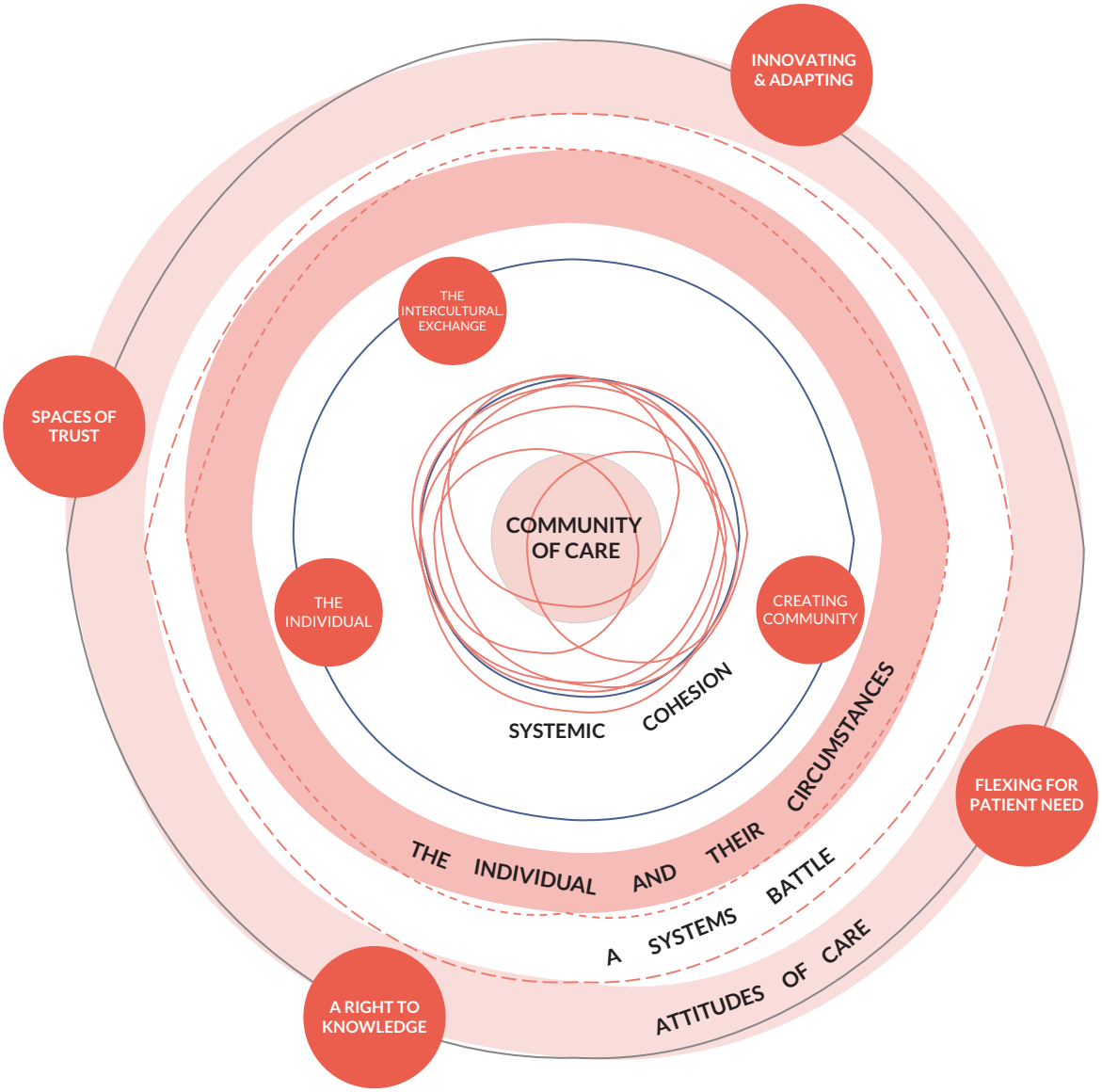

FIGURE 10 Responsive communities of care.

Flexing for patient need

Highly individualised care that can enact flexibility in the microinteractions with patients and clients and pay attention to the best ways in which to reach people.

A right to knowledge

Respecting the need of new arrivals for clear information, knowledge and confidence in local systems. Giving assistance, time and patience, using shared communities. Supporting knowledge that normalises the symptoms and responses to war and settlement stressors.

Systems battle

Being prepared through flexibility and advocacy to negotiate (and challenge) the reality of immigration policies and the structural systems governing the health care and social adjustment of refugee and asylum-seeker communities. This battle is permeable but in constant tension with driving a community of care.

The individual and their circumstances

Recognising the multidimensionality of the problems faced by forced migrants, including displacement as a loss experience and the importance of environments that enable good health and enable people to live lives of meaning. Giving attention to social needs and daily stressors, future-oriented needs and advocacy. Enacted by health workers

stepping outside of professionalisms (acting as 'lawyers … social workers') and a diverse range of other caring practitioners that includes teachers, settlement workers, interpreters, community leaders, community workers, peers and others, each caring and empathetic, equipped to both understand, reflect upon and be reflexive.

The intercultural exchange

With humility and reflexivity, navigating different perceptions and intercultural exchange through dialogue and interest in others, supporting engagement and acting as a possible pathway to democratising health care. Highly valuing interpreters and drawing on their skill and cultural sensitivity where appropriate. Valuing bi-cultural colleagues and peers. Supporting a preparedness of healthcare professionals to engage in practice development. Can take place through training though we suggest this needs further inquiry as to the long-term implications and sustaining of new knowledge and attitudes.

Creating community

Facilitating the connection of people with shared ethnicities, faiths, experiences and languages to create communities of empathy and understanding in which group-based practices, health education and social activities can take place. Building confidence, belonging and social connections, and supporting a bridging process into wider social and public systems, including confidence in use of more formal health services.

The individual

Actively engaging with the essentiality in the ability of people to continue with their lives and to do so, at least tentatively, with meaning and agency. Effort made to develop an understanding of an individual's context and show an interest in their affinities; helping to create *hopeful* conditions in which these can become an achievable goal. Important for the individual, to live lives of meaning but also *necessary*, to achieve access and benefit from healthcare opportunities.

Systemic cohesion

Mainstreaming a responsibility and commitment to systemic change through actively improving interconnectivity, intense collaboration and interprofessionalism across a range of traditional and non-traditional health services, and recognising and valuing enablers of health (caring practitioners) located more broadly across and within communities. Dismantling and navigating usual structures of care in a range of organisational contexts is feasible and a role of accountability as to where the responsibility for the health and well-being of refugees and people seeking asylum is located is required.

This conception or glossary of *communities of care* highlights the need for what Pathare[258] suggests as a 'recalibration' of our understanding of the importance of the everyday and structural social determinants of people's health. Our findings highlight how these factors both influence an individual's context and influence healthcare interactions and that this is key to imagining responsive health care. A capabilities perspective forces recognition of the role of providers (and states) to protect, promote and restore health capabilities through a reflexive and enabling offer of care that is critically engaged in the specific contexts of individuals in displacement and settlement spaces and that is prepared to embrace a neighbourhood-to-institutional perspective that reaches across civil society and prioritises social relations, the enabling of lives of meaning and agency, and a flexing and reflexivity in practice that is prepared to navigate variabilities in health perceptions and needs.

Chapter 7 Reflections on stakeholder involvement and cross-sector working

We delivered a range of community workshops, conversations and events with important stakeholders including refugee communities (46 individuals) and the community, public and private sector (88 individuals) throughout the study period. These are summarised in *Chapters 2* and *5* and discussed briefly in the theoretic framework and were intended as a means to help ground the work as we moved through the study in both the needs of forced-migrant communities and those of caring practitioners in the field.

We worked with Bayan Faiq (BF), who brought a lived experience contribution to the project team throughout the entirety of the project and is established as someone representing the local refugee and asylum-seeker community. We also sought additional input from two further people with lived experience in relation to specific aspects of the study (planning and co-facilitation of community workshops; planning content and reviewing participant materials such as information sheets and consent forms). We benefited also from the consultancy of AC, an extensively experienced patient advocate with whom members of the research team had previously worked.

Our project team was multisector. In addition to academic researchers and BF, the team included a practising GP partner (AL) and GR and ZK, the director and a reintegration caseworker respectively, at Global Link. Global Link is an established organisation well connected with most of the asylum-seeking and refugee communities in the Lancaster district, providing social spaces and activities, workshops and a broad range of support, including advocacy and support in accessing health care.

ZK acted as a community researcher on most aspects of our case study methods, which brought an important component to service visits, data collection and data analysis (see *Strengths and limitations of qualitative data*). The different perspectives and contributions drawn from the multidisciplinary team and contributors with lived experience brought important debates to project decisions such as case study selection and workshop and event planning; emphasised the importance of clarity in communication which needed to be succinct and framed for different audiences; helped to maintain a realism in the limitations and challenges across different sectors; helped to clarify different expectations we might have of different participants and the lines of enquiry we should follow; and hugely supported the involvement of members of the local asylum-seeker and refugee community and the making of connections with other stakeholders in the area. Conversely, for those in practice, the project helped to further inform understanding of challenges and facilitators in access to health care, provided understanding of spaces otherwise difficult to enter (i.e. asylum-seeker accommodation) and witness to broader conditions experienced by people in the immigration system, and improved understanding of issues of capacity in both the local and national UK healthcare system.

We see our stakeholder engagement, our lived experience contributors and multisector team as a particular strength of the project and consciously attempted to ensure that this involvement was meaningful in both directions.

In our stakeholder engagement, we tried to ensure that communication was adapted and useful to the different audiences and we used the different activities as a means to support the validity and relevance of our research, and in the latter events attempted to reach some of those who may be able to make use of our learning.

Feedback suggested that people from refugee communities appreciated being listened to throughout the project, particularly by ‘someone from the NHS’ and, on the whole, people were pleased to be able to contribute ideas and reflections. Although we did not explicitly encourage conversation around health needs, it proved important to listen to people’s experiences. There was often a mood of exasperation, a general feeling of dismissal and that, as refugee patients, ‘we don’t have value’. These conversations proved important, often in nuanced and not immediately recognised ways, to our study and ensured that, as researchers, we were continually brought back to the lived spaces in which the research is intended to be located and of the complexity of people’s situations.

Other stakeholders also expressed benefit from activities. Later conversations were seen as informative, worthwhile, supporting new links between local providers, opportunities for conversations across sectors that did not always take place, and as a positive activity that helped to identify possible areas of achievable change. These conversations led to a list of actionable suggestions and offers by stakeholders to be taken forward, locally. These conversations also informed the final framing of research findings and the priorities we set out for future work.

Forced-migrant community members who participated in the research or attended workshops were provided vouchers to acknowledge their contribution.

Bayan's health story

Bayan provides a short reflection on her healthcare experiences running up to and during the period of this study (as told to GR).

Facing political and personal persecution, Bayan left Iraq in 2015, with her husband and children, taking a challenging 18-month journey to the UK. The family was refused asylum in Germany, France and the UK, before gaining leave to remain on appeal. A speaker of four languages and a successful businesswomen in Iraq, Bayan's health began to decline rapidly in 2019, with deteriorating eyesight and eye pain, unexplained hair loss, sudden bodily 'attacks', leaving her unable to move her leg or arm, and with an inability to swallow, leaving her only able to eat in the presence of her immediate family in case of choking. This also led to substantial weight loss.

Bayan has been referred to hospitals across the region and received a range of investigations. She describes substantial travel for appointments, sometimes of more than 100 miles, which would often prove 'wasted' because of breakdowns in communication within the system that would mean procedures or discussions of conditions could not go ahead in the absence of scans that had not been shared. Other appointments felt wasted because they ended with no resolution. She has been 'blamed' for telephone consultations that have not happened and is routinely told by different professionals, 'there's nothing we can do'. At no point in the more than 3 years of poor health has Bayan received NHS treatment or medication and has received only one diagnosis in relation to her eyesight.

Despite Bayan's high literacy in speaking and reading English, she has required a local advocate to support her health service interactions. In desperation, in 2022 she travelled to Iran to seek medical help. Within 2 weeks she received a diagnosis of Behçet's disease and multiple sclerosis and was prescribed a 6-month prescription for medication to manage symptoms. On return to the UK, Bayan's health improved significantly. However, her Iranian diagnoses are not recognised in the UK, and she has been unable to access the same prescription. Her health is now back in decline.

Equality, diversity and inclusion

As we set out in our theoretical framework and in our description of engagement practices, this project has attempted to take seriously the contribution and inclusion of a range of people and groups who are often on the periphery of academic research, policy and practice decisions and of society. This has included situating contributions from different members of our study population as central to the interpretation of our data. Throughout our qualitative methods, we attempted also to consider and respond to barriers to engagement. We were flexible as to where and how we conducted interviews through, for example, note taking rather than recorded interviews, and via WhatsApp video rather than in person, according to that which was most comfortable for the participant. We worked with a community researcher to bring a broader perspective to the research, which provided an additional benefit of softening the disconnect often produced by researcher–participant power imbalances.

There are boundless ways to connect with different and often marginalised groups and we continually wish to expand on our capacities to conduct research that is able to explore new ways of meaningful inclusion.

Chapter 8 Recommendations and conclusion

Recommendations for future research

These are provided in no order of priority.

Interconnectivity in practice

We have tentatively articulated that a network of an extremely broad constituency of caring practitioners and localities of significance is essential to the health and healthcare experiences of forced migrants. We have also articulated that this necessitates interprofessional, intersectoral and interconnecting responses, alliance-building across unlikely collaborators, and a shift to greater equity in relationships, horizontal accountability and co-governance. Further understanding however is needed as to:

- how such an approach emerges
- the functions and accountability of each player or contributor
- how the network is operated in different local, regional and national contexts
- what the deep codes of collaboration are that foster sustainability and motivate, engage, leverage and democratise relationships between different sectors and 'players' particularly where they must cross traditionally explicit or implicit hierarchical boundaries (such as those between public and private bodies and neighbourhood communities).

Caring practitioners

- Further qualitative research should prioritise evaluative methodologies to test the implications of (a networked) adoption of responsive philosophies of care, exploring in depth, the implications in the short, medium and longer terms on forced migrants' health and healthcare experiences. We encourage attention to variation in outcome and experience in relation to gender, lone or kin groups, educational, literacy and linguistic background and capacities, and immigration statuses.
- Greater understanding should be developed of the range of approaches that can be used to embed intercultural exchange and competencies, and attitudes and reflexivities of disprivilege, in both professional education and professional practice.
- Given unprecedented levels of global migration (not only in the context of forced displacement), multilingualism in the professional workforce could be seen as a vital asset. Further understanding as to how we motivate foreign language proficiency among the clinical workforce and how we welcome bilingual and bi-cultural professionals into healthcare practice should be explored, together with the implications for practice and migrant patients.
- Home Office/immigration contractors (such as reception, accommodation and security services) play a significant role in contextualising someone's asylum experience. Research should explore how, on this frontline of receiving and settlement societies, we can:
  - rethink and value the workforce to become part of a networked community of care, that is skilled and informed with the agency to respond with care on the frontlines of arrival
  - explore how contractual transparency, safeguarding and human rights legislation can enforce a duty of care on these front-line services.

Refugee communities

- To explore further the role and training of non-specialist peers in healthcare practice in a range of facilitative and delivery roles, including interpretation.
- To develop understanding of how language practices, from trained volunteers to linguistic specialists, in written, audio, in-person and remote forms could be carefully triaged for different contexts and needs to improve access to appropriate and effective provision.

Structural

- To evidence the health, health service and moral implications of existing immigration practices.
- To explore how reflexive questions of disprivilege could be embedded in policy decisions.

Methodological

- We have tentatively suggested the MORRA tool as a means to give attention to participant contexts when conducting and assessing the quality of research. We encourage further development of this idea to support better evaluation and measurement of both how interventions influence access to care and how authors and researchers engage in cross-cultural research.
- This study has highlighted that there is much to be learnt from the experiences of other jurisdictions. We suggest further work to understand how transnational strategies for learning and the sharing of good practice can be embedded in practice.

Concluding thoughts

This research has identified a primary need for reflexivity in healthcare practice and a radical commitment to intercultural exchange. We have identified that dynamic practice and humility can bring health care to forced-migrant groups. We encourage engagement with the conception of philosophies of care and responsive actions that we have set out but suggest that the primary shift in approach comes from a long-term commitment to dialogue and reflexivity with patients, clients and communities, interrogating personal and organisational practice, democratising decision-making in health care and co-production. To do this, we emphasise a critical need for co-ordination and 'linked-up-ness' between unlikely collaborators with a deep commitment to interprofessionality and interconnectivity between public, community and private players and services that is governed by a democratic line of responsibility and communication with all relevant local, regional and national departments.

Additional information

CRediT contribution statement

Amy Robinson (https://orcid.org/0000-0001-9850-4116) Conceptualisation, Funding acquisition, Project administration, Methodology, Investigation, Data curation, Formal analysis, Visualisation, Writing – original draft.

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Author positionality

The primary investigative and analytical team comprises AR, PM, ZK and KB. AR is a mixed-methods researcher with more than 10 years' experience undertaking qualitative health research within communities and healthcare settings in the UK. Her training lies in conflict resolution (regional/state) and policy evaluation. She has trained with the Children and War Foundation in recognising the psychosocial impacts of experiences of war and is interested in rights to recognition in healthcare interactions. PM identifies as an African living in sub-Saharan Africa. Although not from a

conflict-affected setting, his background evaluating mental health projects among refugees and internally displaced persons in East Africa and the Middle East has provided first-hand experience of the challenges faced in accessing and implementing interventions for improved health care. As such, PM considers himself an informed 'outsider' and clarifies: 'I did not impose my perceptions and belief to bias the study based on my previous experiences. The first author and I independently worked on developing the themes, which we reflected upon and triangulated our perspectives, ensuring objectivity in the data synthesis process'. ZK is a multilingual reintegration caseworker working with asylum seekers and refugees at Global Link, Lancaster. He is a native Pashto speaker and is fluent in Dari. He has an educational background in agriculture, economics and planning, and business administration (MBA). KB is a Doctor of Philosophy candidate in the area of critical sociology conducting research in imperial memory and racial injustice in contemporary Britain.

Data-sharing statement

Further data from either part of the project are available on request from the corresponding author.

Ethics statement

Research ethics were reviewed by London Bridge Research Ethics Committee with approval received from the NHS Health Research Authority 1 June 2022, ref: 22/PR0603.

Information governance statement

University Hospitals of Morecambe Bay NHS Trust is committed to handling all personal information in line with the UK Data Protection Act (2018) and the General Data Protection Regulation (EU GDPR) 2016/679. Under the Data Protection legislation, University Hospitals of Morecambe Bay NHS Trust is the Data Processor; University Hospitals of Morecambe Bay NHS Trust is the Data Controller. You can find out more about how we handle personal data, including how to exercise your individual rights and the contact details for our Data Protection Officer here (www.uhmb.nhs.uk).

Disclosure of interests

Full disclosure of interests: Completed ICMJE forms for all authors, including all related interests, are available in the toolkit on the NIHR Journals Library report publication page at https://doi.org/10.3310/MRWK3419.

Primary conflicts of interest: Andrew Smith reports Council membership of the Royal College of Anaesthetists, March 2022 to present.

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Appendix 1 Search strategies

	APA PsycInfo
1	exp Asylum Seeking/ or exp Immigration/ or exp Refugees/ or refugee*.mp.
2	undocumented immigrant*.mp.
3	exp Migrant Workers/ or migrant*.mp.
4	asylum.mp.
5	(migrant* or immigrant* or emigrant*).mp. [mp = title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]
6	(forc* adj2 (migran* or migrat* or immigra* or emigra*)).mp. [mp = title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]
7	(displac* adj1 (forced or mass or person* or people* or population* or child* or young*)).mp. [mp = title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]
8	ndergra*.mp. [m = =title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]
9	or/1-8
10	'GP'.mp.
11	care prov*.mp. or exp Health Care Services/
12	exp Well Being/ or exp Health/ or exp Caregivers/ or wellbeing.mp.
13	(wellbeing or well-being or well being).mp. [mp = title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]
14	dentis*.mp. [mp = title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]
15	(mental* or ndergradu*).mp. [m = =title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]
16	exp Mental Disorders/ or exp Chronic Mental Illness/ or mental*.mp. or exp Mental Health/
17	exp Schizophrenia/ or exp Psychosis/ or exp Mental Disorders/ or exp Autism Spectrum Disorders/ or ndergradu*.mp. or exp Anxiety Disorders/ or exp Bipolar Disorder/ or exp Major Depression/
18	prescri*.mp.
19	psychoso*.mp.
20	(mental* adj1 (health* or ill* or well* or disease* or disorder*)).mp. [mp = title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]
21	(mental* adj1 (health* or ill* or well* or disease* or disorder*) adj2 (promot* or prevent*)).mp. [mp = title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]
22	or/10-21
23	9 and 22
24	randomly.ab.
25	trial.ti.
26	exp Intervention/ or exp Randomized Controlled Trials/ or exp Clinical Trials/ or randomized controlled trial.mp.
27	exp Clinical Trials/ or exp Intervention/ or exp Treatment Effectiveness Evaluation/ or controlled clinical trial.mp.
28	placebo.ab.

continued

	APA PsycInfo
29	24 or 25 or 26 or 27 or 28
30	exp animals/ not humans.sh.
31	29 not 30
32	Case control.tw.
33	(cohort adj (study or studies)).tw.
34	Cohort analy$.tw.
35	(Follow up adj (study or studies)).tw.
36	(observational adj (study or studies)).tw.
37	Longitudinal.tw.
38	Retrospective.tw.
39	Cross sectional.tw.
40	Comparative study.pt.
41	exp Experimental Design/ or exp Quasi Experimental Methods/ or quasi-experiment$.mp.
42	(pre test or pretest or (posttest or post test)).m_titl.
43	(time adj series).m_titl.
44	((evaluat$ or intervention or interventional) adj8 (control or controlled or study or program$ or comparison or 'before and after' or comparative)).mp. [mp = title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]
45	((intervention or interventional) adj8 (effect* or evaluat* or outcome*)).m_titl.
46	(controlled before or 'before and after stud$' or follow up assessment).mp. [mp = title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]
47	32 or 33 or 34 or 35 or 36 or 37 or 38 or 39 or 40 or 41 or 42 or 43 or 44 or 45 or 46
48	47 not 30
49	31 or 48

APA PsycInfo strategy

	MEDLINE
1	refugees/
2	'transients and migrants'/
3	'emigrants and immigrants'/
4	(undocumented immigrant* or migrant*).ti,ab.
5	(undocumented immigrant* or migrant*).ti,ab.
6	'emigration and immigration'/
7	asylum.ti,ab.
8	refugee*.ti,ab.
9	(migrant* or immigrant* or emigrant*).ti,ab.
10	(forc* adj2 (migran* or migrat* or immigra* or emigra*)).ti,ab.
11	(displac* adj1 (forced or mass or person* or people* or population* or child* or young*)).ti,ab.

	MEDLINE
12	ndergra*.ti,ab.
13	or/1-12
14	health/
15	health care/
16	primary care/
17	secondary care/
18	maternal health services/
19	patient/
20	patient care/
21	'GP'.ti,ab.
22	care prov*.ti,ab.
23	(wellbeing or well-being or well being).ti,ab.
24	dentis*.ti,ab.
25	(mental* or ndergradu*).ti,kf.
26	prescri*.ti,ab,kf.
27	psychoso*.ti,ab,kf.
28	(mental* adj1 (health* or ill* or well* or disease* or disorder*)).ti,ab,kf.
29	(mental* adj1 (health* or ill* or well* or disease* or disorder*) adj2 (promot* or prevent*)).ti,ab,kf.
30	or/14-29
31	13 and 30
32	randomized controlled trial.pt.
33	controlled clinical trial.pt.
34	randomized.ab.
35	placebo.ab.
36	clinical trials as topic.sh.
37	randomly.ab.
38	trial.ti.
39	32 or 33 or 34 or 35 or 36 or 37 or 38
40	exp animals/ not humans.sh.
41	39 not 40
42	exp case control studies/
43	exp cohort studies/
44	Case control.tw.
45	(cohort adj (study or studies)).tw.
46	Cohort analy$.tw.
47	(Follow up adj (study or studies)).tw.

continued

	MEDLINE
48	(observational adj (study or studies)).tw.
49	Longitudinal.tw.
50	Retrospective.tw.
51	Cross sectional.tw.
52	evaluation studies/
53	program evaluation/
54	Comparative study.pt.
55	quasi-experiment$.ti,ab.
56	(pre test or pretest or (posttest or post test)).ti,ab.
57	(time adj series).ti,ab.
58	((evaluat$ or intervention or interventional) adj8 (control or controlled or study or program$ or comparison or 'before and after' or comparative)).ti,ab.
59	((intervention or interventional) adj8 (effect* or evaluat* or outcome*)).ti,ab.
60	(controlled before or 'before and after stud$' or follow up assessment).ti,ab.
61	42 or 43 or 44 or 45 or 46 or 47 or 48 or 49 or 50 or 51 or 52 or 53 or 54 or 55 or 56 or 57 or 58 or 59 or 60
62	61 not 40
63	41 or 62
64	31 and 63

MEDLINE (Ovid SP) strategy

	CENTRAL
#1	MeSH descriptor: [Refugees] explode all trees
#2	MeSH descriptor: [Transients and Migrants] explode all trees
#3	MeSH descriptor: [Emigrants and Immigrants] explode all trees
#4	undocumented immigrant* or migrant*
#5	undocumented immigrat* or migrat*
#6	MeSH descriptor: [Emigration and Immigration] explode all trees
#7	asylum
#8	refugee
#9	migrant* or immigrant* or emigrant*
#10	forc* near/2 (migran* or migrat* or immigra* or emigra*)
#11	displac* near/1 (forced or mass or person* or people* or population* or child* or young*)
#12	ndergra*
#13	#1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10 or #11 or #12
#14	MeSH descriptor: [Health] explode all trees
#15	MeSH descriptor: [Delivery of Health Care] explode all trees
#16	MeSH descriptor: [Primary Health Care] explode all trees

	CENTRAL
#17	MeSH descriptor: [Secondary Care] explode all trees
#18	MeSH descriptor: [Maternal Health Services] explode all trees
#19	MeSH descriptor: [Patients] explode all trees
#20	MeSH descriptor: [Patient Care] explode all trees
#21	'GP'
#22	care prov*
#23	wellbeing or well-being or well being
#24	dentis*
#25	mental* or ndergradu*
#26	prescri*
#27	psychoso*
#28	mental* near/1 (health* or ill* or well* or disease* or disorder*)
#29	(mental* near/1 (health* or ill* or well* or disease* or disorder*)) near/2 (promot* or prevent*)
#30	#14 or #15 or #16 or #17 or #18 or #19 or #20 or #21 or #22 or #23 or #24 or #25 or #26 or #27 or #28 or #29
#31	#13 and #30

CENTRAL strategy

	EMBASE
1.	refugees/
2.	'transients and migrants'/
3.	'emigrants and immigrants'/
4.	(undocumented immigrant* or migrant*).ti,ab.
5.	(undocumented immigrat* or migrat*).ti,ab.
6.	'emigration and immigration'/
7.	asylum.ti,ab.
8.	refugee*.ti,ab.
9.	(migrant* or immigrant* or emigrant*).ti,ab.
10.	(forc* adj2 (migran* or migrat* or immigra* or emigra*)).ti,ab.
11.	(displac* adj1 (forced or mass or person* or people* or population* or child* or young*)).ti,ab.
12.	ndergra*.ti,ab.
13.	1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12
14.	health/
15.	health care/
16.	primary care/
17.	secondary care/
18.	maternal health services/

continued

	EMBASE
19.	patient/
20.	patient care/
21.	'GP'.ti,ab.
22.	care prov*.ti,ab.
23.	(wellbeing or well-being or well being).ti,ab.
24.	dentis*.ti,ab.
25.	(mental* or ndergradu*).ti,kf.
26.	prescri*.ti,ab,kf.
27.	psychoso*.ti,ab,kf.
28.	(mental* adj1 (health* or ill* or well* or disease* or disorder*)).ti,ab,kf.
29.	(mental* adj1 (health* or ill* or well* or disease* or disorder*) adj2 (promot* or prevent*)).ti,ab,kf.
30.	or/14-29
31.	13 and 30
32.	Clinical Trial/
33.	Randomized Controlled Trial/
34.	controlled clinical trial/
35.	multicenter study/
36.	Phase 3 clinical trial/
37.	Phase 4 clinical trial/
38.	exp randomization/
39.	Single Blind Procedure/
40.	Double Blind Procedure/
41.	Crossover Procedure/
42.	placebo/
43.	randomi?ed controlled trial$.tw.
44.	rct.tw.
45.	(random$ adj2 allocat$).tw.
46.	single blind$.tw.
47.	double blind$.tw.
48.	((treble or triple) adj blind$).tw.
49.	placebo$.tw.
50.	Prospective Study/
51.	or/31-50
52.	exp animals/ not humans.sh.
53.	51 not 52
54.	Clinical study/
55.	Case control study/

	EMBASE
56.	Family study/
57.	Longitudinal study/
58.	Retrospective study/
59.	Prospective study/
60.	Randomized controlled trials/
61.	59 not 60
62.	Cohort analysis/
63.	(Cohort adj (study or studies)).mp.
64.	(Case control adj (study or studies)).tw.
65.	(follow up adj (study or studies)).tw.
66.	(observational adj (study or studies)).tw.
67.	(cross sectional adj (study or studies)).tw.
68.	or/54-58,61-67
69.	68 not 52
70.	53 or 69
71.	31 and 70

EMBASE (Ovid SP) strategy

	CINAHL
S48	S39 AND S47
S47	S12 AND S46
S46	S13 OR S14 OR S15 OR S16 OR S18 OR S19 OR S20 OR S21 OR S23
S45	S39 AND S44
S44	S12 AND S43
S43	S13 OR S14 OR S15 OR S16 OR S17 OR S18 OR S19 OR S20 OR S21 OR S23
S42	S39 AND S41
S41	S12 AND S40
S40	S13 OR S14 OR S15 OR S16 OR S17 OR S18 OR S19 OR S20 OR S21 OR S22 OR S23
S39	S24 OR S25 OR S26 OR S27 OR S28 OR S29 OR S30 OR S31 OR S32 OR S33 OR S34 OR S35 OR S36 OR S37 OR S38
S38	TI (trial or effect* or impact* or intervention* or before N5 after or pre N5 post or ((pretest or "pre-test) and (posttest or 'post test')) or quasiexperimen* or quasi W0 experiment* or pseudo experiment* or pseudoexperiment* or evaluat* or 'time series' or time W0 point* or repeated W0 measure*) or AB (trial or effect* or impact* or intervention* or before N5 after or pre N5 post or ((pretest or "pre-test) and (posttest or 'post test')) or quasiexperimen* or quasi W0 experiment* or pseudo expe ...
S37	TI (randomis* or randomiz* or randomly) OR AB (randomis* or randomiz* or randomly)
S36	MH 'Case Studies'
S35	MH 'Health Services Research'

continued

	CINAHL
S34	MH 'Multicenter Studies'
S33	MH 'Quasi-Experimental Studies'
S32	MH 'Pretest-Posttest Design'
S31	MH 'Experimental Studies'
S30	MH 'Nonrandomized Trials'
S29	MH 'Intervention Trials'
S28	MH 'Clinical Trials'
S27	MH 'Randomized Controlled Trials'
S26	PT research
S25	PT clinical trial
S24	PT randomized controlled trial
S23	(mental* N1 (health* or ill* or well* or disease* or disorder*)) N2 (promot* or prevent*)
S22	psychoso*
S21	prescri*
S20	ndergradu*
S19	dentis*
S18	(wellbeing or well-being or well being)
S17	care provi*
S16	MH patient care
S15	MH patients
S14	MH maternal health services
S13	MH health
S12	S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7 OR S8 OR S9 OR S10 OR S11
S11	ndergra*
S10	(displac* N1 (forced or mass or person* or people* or population* or child* or young*))
S9	(forc* N2 (migran* or migrat* or immigra* or emigra*))
S8	(migrant* or immigrant* or emigrant*)
S7	refugee*
S6	asylum
S5	MH 'emigration and immigration'
S4	AB (undocumented immigrat* or migrat*)
S3	AB (undocumented immigrant* or migrant*)
S2	MH 'transients and migrants'
S1	MH refugees

CINAHL (EBSCO host) strategy

Appendix 2 Data extraction template

Primary study details
Study ID
Year of publication
Main reviewer
Author(s)
Year
Title
Journal
Volume
Issue
Pages
Stated aims/objectives
Summary preceding Methods
Purpose in Abstract
Study design
Conflicts of interest (details)
Funders/sponsorship
Start date
End date
POPULATION
Forced-migrant description *How do they describe the forced-migrant population?* That is, *asylum seekers, forced migrants, refugees, displaced persons …*
Practitioner participants *Description*
Participants *Total no.*
Participants *Intervention group no.*
Country of origin
Family, lone person, unaccompanied child *State if not reported*
Key inclusion or demographic details
Clinical information about participants' diagnosis
Age group *Children, adults, elderly, mixed*
Time in country *Mean, range or description*
Gender *Female n (%)*
Host language proficiency
INTERVENTION OVERVIEW
Name of intervention or programme
Summary of type of intervention (what the intervention was about/addressing)
Country in which intervention delivered

continued

Primary study details

Individual activity
Y/N

Group activity
Y/N

Purpose of intervention
For example, *cancer screening, health assessment, access to local services, health literacy, preventing spread of communicable diseases*

Theoretical or conceptual framing of the intervention

Design of intervention
Who or what has been involved in developing, informing the model, for example *patient population, academic, delivery experts*

Organisational context
For example, *NHS Trust, UNHCR refugee camp, voluntary or community organisation, local authority, government initiative, academic*

Description of intervention
Dumped

Comparison or control
Where applicable

INTERVENTION FURTHER DETAILS – CHECKLIST

Delivery location
For example, *community clinic or health centre, community centre, contingency accommodation, remotely, home, hospital, detention facility*

Delivered by
Who, role? Skills training or experience?

Time point of delivery
What do they tell us about where in a healthcare journey this takes place, that is *newly arrived*

WHAT is delivered
For example, *behaviour change intervention, trauma counselling, information session*

Resources
What materials and procedures?

HOW delivered?
How much or how often, and for how long?

Flexible or individualised approach?

External partners
Who? How do they connect? What do they do?

Language and communication
For example, *multilingual workers, translation of materials, adaptions for non-readers. All info, such as at which stage, which information, who the interpreters are*

What reference do they give to culture/the refugee experience?
Do they describe any adaptions or considerations?

Other facilitators
May not be framed as specific to population. Such as child care, reimbursement of travel costs, time of day

OUTCOMES

Primary outcome *(or first reported outcome)*

Primary outcome measure

Secondary outcomes

Secondary outcome measure

Relevant outcomes.
Outcomes that show efficacy or impacts of intervention in terms of access/ engagement. Consider surrogate markers

Study procedures – data collection
Relevant outcomes only

Was sample size calculation based on a relevant outcome?

Did the intervention produce a statistically significant improvement?
Y/N/mixed/unclear

Appendix 3 Characteristics of included studies

Summary of included studies

TABLE 6 Summary of included studies

					Potential facilitators of care													
					Communication					Culture and experience						Other		
Study	Country of study	Aim of study	Participants; participants age group and country of origin	Type of intervention	Translation materials	Visual materials/ non-readers	Interpreters and oral communication	Enhanced translation	Other considerations	The displacement experience	Health risks and vulnerabilities	Broader social and societal context	Engaging and responding to communities	community delivery/ staff representation	Flexing for divergent views and traditions	Resource	Reaching people	Measure of responsive care	MOORRA tool (score out of 12)
Acarturk 2022[150]	Jordan	In recognition of the gap in good-quality evidence for children and limited availability of scalable psychological interventions in adverse settings. WHO developed early adolescent skills for emotions programme targeting refugee youth and caregivers. The aims of this trial were to determine the safety and feasibility of the programme and to test and assess trial procedures.	Refugee and asylum seekers; adults; Syria	Problem management plus (PM+) a psychological intervention delivered by non-specialist healthcare providers; group; community	✓			✓		✓	✓			✓	✓		✓	Direct: acceptability; feasibility; perceived impact. Direct: acceptability and lessons for improvement	12
Ahmad 2012[100]	Canada	To examine tool potential to integrate medical and social services	Refugees; adults; global. practitioner: physicians; nurses	Mental health; individual; health facility	✓					✓	✓	✓	✓					Direct: patient acceptance of the tool; patient satisfaction with the visit. Proxy: patient intention to visit psychosocial counsellor.	12

TABLE 6 Summary of included studies (*continued*)

Study	Country of study	Aim of study	Participants; participants age group and country of origin	Type of intervention	Potential facilitators of care													Measure of responsive care	MO-RRA tool (score out of 12)
					Communication					Culture and experience						Other			
					Translation materials	Visual materials/ non-readers	Interpreters and oral communication	Enhanced translation	Other considerations	The displacement experience	Health risks and vulnerabilities	Broader social and societal context	Engaging and responding to communities	community delivery/ staff representation	Flexing for divergent views and traditions	Resource	Reaching people		
Aizik-Reebs 2021[188]	Israel	To examine efficacy and safety outcomes of a randomised waitlist control study of a novel specialised mindfulness-based trauma recovery for refugees	Refugee and asylum seekers; adults; Eritrea	Mindfulness-based, trauma-sensitive intervention for trauma recovery; group; community space	✓			✓		✓	✓			✓	✓	✓	✓	Direct: engagement	12
Akhtar 2021[151]	Jordan	To determine the safety, feasibility, responses to assessment of an early adolescent skills for emotions programme targeting refugee youth	Refugees; children; Syria	Skill-based psychological intervention for children displaying symptoms of internalising emotional disorders; group; NR							✓							Direct: acceptability and lessons for improvement	8
Alrashdi 2021a[167]	USA	To evaluate the preventive outreach education programme targeted refugee children on oral health-related quality of life and dental caries	Refugees and asylum seekers; mixed ages; global	Oral health; group; community centre	✓	✓	✓	✓					✓	✓		✓		Proxy: oral health knowledge	11

continued

TABLE 6 Summary of included studies (*continued*)

Study	Country of study	Aim of study	Participants; participants age group and country of origin	Type of intervention	Potential facilitators of care													Measure of responsive care	MO-RRA tool (score out of 12)
					Communication					Culture and experience						Other			
					Translation materials	Visual materials/ non-readers	Interpreters and oral communication	Enhanced translation	Other considerations	The displacement experience	Health risks and vulnerabilities	Broader social and societal context	Engaging and responding to communities	community delivery/ staff representation	Flexing for divergent views and traditions	Resource	Reaching people		
Baarnhielm 2014[104]	Sweden	Evaluate the outcomes of locally organised cross-cultural mental health training for staff in refugee reception and health care	Practitioner: social workers, Swedish language teachers, employment officers, nurses, psychologist, physicians	Mental health; group; community			✓			✓	✓	✓			✓		✓	Proxy: practitioner-perceived knowledge of relevance to asylum seekers and refugees (asylum-seeking process and health-related aspects); barriers to performing a 'good job' (change in effects)	9.6
Baird 2017[105]	USA	To test acceptability and feasibility of a community-based, culturally tailored mental health intervention for South Sudanese refugee women	Refugees and asylum seekers; adults; South Sudan	Mental health; group; religious centre	✓		✓	✓		✓			✓	✓		✓	✓	Direct: new use of mental health assessment tool; attendance as marker of acceptability (usefulness and relevance). Proxy: engagement in training in conversations with stressed refugees; knowledge and awareness of mental health impacts	9

TABLE 6 Summary of included studies (*continued*)

Study	Country of study	Aim of study	Participants; participants age group and country of origin	Type of intervention	Potential facilitators of care													Measure of responsive care	MORRA tool (score out of 12)
					Communication					Culture and experience						Other			
					Translation materials	Visual materials/ non-readers	Interpreters and oral communication	Enhanced translation	Other considerations	The displacement experience	Health risks and vulnerabilities	Broader social and societal context	Engaging and responding to communities	community delivery/ staff representation	Flexing for divergent views and traditions	Resource	Reaching people		
Ballard 2018[106]	USA	To test the feasibility of implementation of an adapted parenting intervention to promote healthier mental health and family developmental outcomes among Karen refugees	Refugees and asylum seekers; mixed; Burma	Parenting; group; religious facility	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓	✓	Direct: engagement and satisfaction. Proxy: knowledge	10
Bayne 2019[122]	USA	To evaluate the efficacy of telephonic versus in-person psychiatric assessments	Refugees and asylum seekers; NR; unclear. Practitioners: psychiatrists; psychologists	Mental health; individual; immigration detention centre			✓			✓	✓						✓	Proxy: quality of written affidavits for psychiatric evaluation	3.6
Bernhardt 2019[173]	USA	To describe the design and preliminary outcomes from a longitudinal patient experience and curriculum in refugee/asylee health	Refugees and asylum seekers; mixed; global. Practitioners: preclinical medical students	General health, health advocacy, training and capacity building; group and individual; home			✓	✓	✓	✓	✓		✓		✓		✓	Direct: retention of refugee participant. Proxy: comfort in skills related to refugee/asylee healthcare provision; Retention of student	9.6
Betancourt 2020[168]	USA	To assess the feasibility and acceptability of the Family Strengthening Intervention for RefugeesR, delivered by refugees for refugees	Refugees and asylum seekers; mixed; global (South Asia, sub-Saharan Africa)	To promote youth mental health and family relationships; group; home			✓			✓		✓	✓				✓	Direct: feasibility; acceptability; satisfaction	10

continued

TABLE 6 Summary of included studies (*continued*)

Study	Country of study	Aim of study	Participants; participants age group and country of origin	Type of intervention	Potential facilitators of care													Measure of responsive care	MO-RRA tool (score out of 12)
					Communication					Culture and experience						Other			
					Translation materials	Visual materials/ non-readers	Interpreters and oral communication	Enhanced translation	Other considerations	The displacement experience	Health risks and vulnerabilities	Broader social and societal context	Engaging and responding to communities	community delivery/ staff representation	Flexing for divergent views and traditions	Resource	Reaching people		
Birman 2008[205]	USA	To provide a detailed description of the clientele, programme and impact of a mental health programme serving a diverse group of refugee children and adolescents	Refugees and asylum seekers; children; global	Case management and mental health services; both group and individual; home			✓	✓		✓		✓	✓		✓		✓	Proxy: use and acceptability	10.5
Brakemeier 2017[176]	Germany	To create a quickly implementable programme for the treatment mental disorders in refugees and to support integration into the new working and social world	Refugee and asylum seekers; adults; Middle East and North Africa. Practitioner participants: therapists and interpreters	Integrated psychotherapy, counselling, occupational therapy and psychiatry intervention; group and individual; health facility			✓	✓	✓	✓	✓	✓	✓	✓		✓		Direct: dropout (attendance); patient satisfaction. Proxy: co-operation between agencies (psychotherapists and federal integration workers); new use of mental health assessment tool	10
Chaudhary 2019[201]	USA	To assess whether the LHEP model implemented for community members of a local mosque improves health outcomes of newly arrived Syrian refugees	Practitioner participants: volunteer community members	Health education knowledge awareness, health navigation training; group; religious centre	✓				✓	✓	✓		✓				✓	Proxy: community health activities; satisfaction with the course; attendance	4

TABLE 6 Summary of included studies (*continued*)

Study	Country of study	Aim of study	Participants; participants age group and country of origin	Type of intervention	Potential facilitators of care												Measure of responsive care	MOORRA tool (score out of 12)
					Communication					Culture and experience						Other		
					Translation materials	Visual materials/ non-readers	Interpreters and oral communication	Enhanced translation	Other considerations	The displacement experience	Health risks and vulnerabilities	Broader social and societal context	Engaging and responding to communities	community delivery/ staff representation	Flexing for divergent views and traditions	Resource	Reaching people	
Chiumento 2011[199]	UK	To raise awareness of a multiagency school-based CAMHS for refugee children for replication across community mental health services	Refugee and asylum seekers; mixed; NR. Practitioner participants: head teacher or link teacher	Mental health service; group and individual; school					✓	✓		✓			✓		✓	Proxy: review of school-based CAMHS; teacher skills and knowledge in psychoeducation	2
Dababnah 2019[107]	Turkey	To explore the feasibility and acceptability of psychoeducation for Syrian refugee parents and teachers of children with ASD	Refugee and asylum seekers; adults; Middle East and North Africa. Practitioner participants: teachers of children with ASD	Psychoeducation training programme; group and individual; community			✓		✓	✓	✓	✓	✓			✓		Direct: experiences reported as knowledge, skills and confidence. Proxy: attendance of teachers in training sessions	12
Delilovic 2018[153]	Sweden	To identify mental and physical health needs demanding care, to detect and control for infectious diseases among newly arrived asylum seekers and refugees	Practitioner participants: healthcare professionals; health centre administrator; policy and government officials	Health assessment														**Proxy:** challenges with responding to migrant's needs; ongoing barriers for asylum seekers; perceptions and attitudes relating to implementation	7.2

continued

TABLE 6 Summary of included studies (*continued*)

					Potential facilitators of care														
					Communication					Culture and experience						Other			
Study	Country of study	Aim of study	Participants; participants age group and country of origin	Type of intervention	Translation materials	Visual materials/ non-readers	Interpreters and oral communication	Enhanced translation	Other considerations	The displacement experience	Health risks and vulnerabilities	Broader social and societal context	Engaging and responding to communities	community delivery/ staff representation	Flexing for divergent views and traditions	Resource	Reaching people	Measure of responsive care	MORRA tool (score out of 12)
Ekblad 2013[108]	USA	To develop the initial refugee trauma virtual patient case system and investigate the potential of that system to train primary care professionals in the management of culturally diverse, highly traumatised refugee patients with comorbid health and mental health problems	Practitioner participant: primary care practitioners	Mental health virtual patient training model; individual; remote			✓			✓			✓					Proxy: overview of clinical worldview; motivation to use virtual patients for training	7.5
ElHarake 2018[123]	Lebanon	To evaluate the impact of a 6-month pilot school-based nutrition intervention on changes in dietary knowledge, attitude, and behaviour of Syrian refugee children enrolled in informal primary schools in Lebanon	Refugee and asylum seekers; children; Syria. Practitioner participants: school supervisors	Health and nutrition sessions; group; school		✓		✓					✓	✓	✓	✓		Proxy: dietary knowledge	11

TABLE 6 Summary of included studies (*continued*)

Study	Country of study	Aim of study	Participants; participants age group and country of origin	Type of intervention	Potential facilitators of care													Measure of responsive care	MO-RRA tool (score out of 12)
					Communication					Culture and experience						Other			
					Translation materials	Visual materials/ non-readers	Interpreters and oral communication	Enhanced translation	Other considerations	The displacement experience	Health risks and vulnerabilities	Broader social and societal context	Engaging and responding to communities	community delivery/ staff representation	Flexing for divergent views and traditions	Resource	Reaching people		
El-Khani 2018[124]	Turkey	To test the feasibility of delivering and evaluating teaching recovery techniques + parenting with displaced families	Refugees and asylum seekers; mixed; Syria	Mental health and parenting programme; group; school	✓					✓	✓	✓	✓			✓	✓	Direct: retention and engagement. Proxy: feasibility of recruitment of programme facilitators	12
El-Khani 2021[154]	Serbia	To evaluate the feasibility of delivery and potential impact of strong families with refugees. Specifically, the feasibility of recruiting local non-specialist intervention facilitators, recruitment of caregivers as well as their engagement and retention in the intervention and study. The second aim was to assess potential benefits of the intervention including cultural appropriateness	Refugee and asylum seekers; Afghanistan	Intervention focused on recognising and building on strengths and skills in managing stress for primary caregivers and their children; group; reception centres			✓	✓	✓	✓	✓	✓					✓	Direct: experiences of the intervention; engagement and satisfaction	12

continued

TABLE 6 Summary of included studies (*continued*)

Study	Country of study	Aim of study	Participants; participants age group and country of origin	Type of intervention	Potential facilitators of care													Measure of responsive care	MO-RRA tool (score out of 12)
					Communication					Culture and experience						Other			
					Translation materials	Visual materials/ non-readers	Interpreters and oral communication	Enhanced translation	Other considerations	The displacement experience	Health risks and vulnerabilities	Broader social and societal context	Engaging and responding to communities	community delivery/ staff representation	Flexing for divergent views and traditions	Resource	Reaching people		
Ellis 2013[125]	USA	To establish that a multi-tiered approach to intervention would provide services matched to the level of mental health distress as defined by symptoms of depression or PTSD, and would effectively engage refugee youths with the highest level of need in targeted mental health services	Refugees and asylum seekers; children; Somalia	Mental health and resilience programme; group and individual; school and home				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Direct: engagement Proxy: fidelity	10.5
Elswick 2021[191]	USA	To focus on implementation of the Trauma Healing Club offering promotion activities, prevention activities, and direct intervention to children, families, and community partners; used culturally sensitive processes	Refugees and asylum seekers; regions in Africa	Mental health and trauma healing club; group and individual; school			✓	✓			✓		✓		✓	✓	✓	**Direct:** perceptions on intervention	12

TABLE 6 Summary of included studies (*continued*)

Study	Country of study	Aim of study	Participants; participants age group and country of origin	Type of intervention	Potential facilitators of care													Measure of responsive care	MO-RRA tool (score out of 12)
					Communication					Culture and experience						Other			
					Translation materials	Visual materials/ non-readers	Interpreters and oral communication	Enhanced translation	Other considerations	The displacement experience	Health risks and vulnerabilities	Broader social and societal context	Engaging and responding to communities	community delivery/ staff representation	Flexing for divergent views and traditions	Resource	Reaching people		
Erenofülu 2020[169]	Turkey	To evaluate the effect of health education given to refugee women in their own language on awareness of breast and cervical cancer	Refugees and asylum seekers; adults; Syria	Breast and cervical cancer awareness; group; community	✓		✓	✓										Proxy: breast and cervical cancer awareness	12
Eskici 2021[189]	USA	To evaluate the effectiveness, feasibility and acceptability of a group form of CA-CBT, a treatment that was prepared by many means including preparatory focus groups and consultation of cultural experts	Refugees and Asylum seekers; Mixed; Syria	Group culturally adapted cognitive behavioural therapy; group; school				✓		✓	✓	✓	✓		✓			Direct: feasibility and acceptability	12

continued

TABLE 6 Summary of included studies (*continued*)

					Potential facilitators of care														
					Communication					Culture and experience						Other			
Study	Country of study	Aim of study	Participants; participants age group and country of origin	Type of intervention	Translation materials	Visual materials/ non-readers	Interpreters and oral communication	Enhanced translation	Other considerations	The displacement experience	Health risks and vulnerabilities	Broader social and societal context	Engaging and responding to communities	community delivery/ staff representation	Flexing for divergent views and traditions	Resource	Reaching people	Measure of responsive care	MMORRA tool (score out of 12)
Eytan 2002[146]	Switzerland	To assess the impact of trained and ad hoc interpreters during medical screening on referral to medical and psychiatric care	Refugees and asylum seekers; mixed; Kosovo	Health, symptom and trauma exposure screening; individual; NR		✓	✓	✓	✓	✓	✓							Direct: quality of communication; referral to medical and psychological care	12
Eytan 2007[187]	Switzerland	To adapt and validate a standardised psychiatric instrument, to detect major depression and PTSD among newly arrived asylum seekers, during a routine health screening	Refugees and asylum seekers; adults; global	Mental health screening; individual; health facility	✓		✓	✓		✓	✓						✓	**Direct:** availability of care – diagnostic accuracy of a psychiatric instrument delivered by non-specialist nurses; acceptability – (although no data provided to support finding)	12
Fazel 2009[126]	UK	To provide a mental health service for a vulnerable refugee population who were not presenting to local mental health services in significant numbers	Refugees and asylum seekers; children; global	Mental health intervention; group and individual; school and home			✓	✓			✓						✓	Direct: experiences of the intervention. Proxy: experiences of teachers	7

TABLE 6 Summary of included studies (*continued*)

Study	Country of study	Aim of study	Participants; participants age group and country of origin	Type of intervention	Potential facilitators of care													Measure of responsive care	MO-RRA tool (score out of 12)
					Communication					Culture and experience						Other			
					Translation materials	Visual materials/ non-readers	Interpreters and oral communication	Enhanced translation	Other considerations	The displacement experience	Health risks and vulnerabilities	Broader social and societal context	Engaging and responding to communities	community delivery/ staff representation	Flexing for divergent views and traditions	Resource	Reaching people		
Fazel 2016[109]	UK	To assess whether schools are the right location for adolescent refugee mental health services	Refugees and asylum seekers; mixed; global	Mental health service; group and individual; school			✓										✓	Direct: impressions and experience of mental health services integrated within the school system	7
Foka 2021[110]	Greece	To determine whether the Strengths for the Journey intervention improves positive psychological resources such as well-being, hope and optimistic thinking, and self-esteem and reduces depressive symptoms in child and adolescent refugees that are living in camps in Lesvos	Refugees and asylum seekers; children; global (Middle East and North Africa and South Asia)	Preventive intervention for psychological resilience; group; refugee camp			✓	✓	✓	✓		✓		✓				Direct: experiences of the intervention	12
Fox 2005[127]	USA	To test the effectiveness of a school-based intervention designed to decrease depressive symptoms among Southeast Asia refugee children	Refugees and asylum seekers; children; East Asia and Pacific	Mental health intervention; group and individual; school				✓		✓	✓	✓			✓		✓	No measure	

continued

TABLE 6 Summary of included studies (*continued*)

Study	Country of study	Aim of study	Participants; participants age group and country of origin	Type of intervention	Potential facilitators of care													Measure of responsive care	MO-RRA tool (score out of 12)
					Communication					Culture and experience						Other			
					Translation materials	Visual materials/ non-readers	Interpreters and oral communication	Enhanced translation	Other considerations	The displacement experience	Health risks and vulnerabilities	Broader social and societal context	Engaging and responding to communities	community delivery/ staff representation	Flexing for divergent views and traditions	Resource	Reaching people		
Goninon 2021[128]	Uganda	To assess the effectiveness of a culturally sensitive group trauma-focused cognitive-behavioural therapy intervention among a sample of Congolese refugees living in a Ugandan refugee settlement	Refugees and asylum seekers; adults; Congo	Mental health intervention; group; religious centre and refugee camp				✓							✓	✓	✓	No measure	
Goodkind 2004[208]	USA	To assess the impact of an intervention to promote the well-being of refugees through individual and collective empowerment and by improving the community's responsiveness to their needs	Refugees and asylum seekers; adults; Laos and Vietnam	Refugee well-being project focused on advocacy and innovative group learning; group and individual; community				✓		✓		✓	✓				✓	Direct: attendance; acceptability;	12
Goodkind 2014[111]	USA	To adapt and test the feasibility, acceptability, appropriateness, and preliminary outcomes of the refugee well-being project with refugees from several countries in Africa	Refugee and asylum seekers; mixed; Sub-Saharan Africa.Practitioner participants: undergraduate students	Holistic intervention focused on advocacy, well-being and learning; group and individual; community			✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	Direct: experiences; satisfaction; access to resources	12

TABLE 6 Summary of included studies (*continued*)

Study	Country of study	Aim of study	Participants; participants age group and country of origin	Type of intervention	Potential facilitators of care													Measure of responsive care	MO-RRA tool (score out of 12)
					Communication					Culture and experience						Other			
					Translation materials	Visual materials/ non-readers	Interpreters and oral communication	Enhanced translation	Other considerations	The displacement experience	Health risks and vulnerabilities	Broader social and societal context	Engaging and responding to communities	community delivery/ staff representation	Flexing for divergent views and traditions	Resource	Reaching people		
Goodkind 2017[174]	USA	To test the effectiveness of the 6-month intervention to reduce psychological distress, increase protective factors, and engage and retain refugee adults with PTSD in an evidence-based trauma treatment (narrative exposure therapy)	Refugee and asylum seekers; adults; global. Practitioner participants: undergraduate students	Holistic intervention focused on advocacy, well-being and learning; group and individual; community			✓						✓	✓		✓	✓	No measure	
Goodkind 2020[192]	USA	To demonstrate that addressing social determinants of mental health through a social justice approach contributes to improved mental health for refugees	Refugee and asylum seekers; adults; global	Holistic intervention focused on advocacy, well-being and learning; group and individual; community			✓		✓	✓	✓	✓	✓		✓		✓	Direct: participation; engagement. Proxy: acculturation	11
Gormez 2017[129]	Turkey	To assess the effectiveness of an innovative, school-based,teacher-delivered group psychological treatment programme	Refugee and asylum seekers; Syria	Psychological support programme; group; school			✓	✓		✓	✓					✓		No measure	

continued

TABLE 6 Summary of included studies (*continued*)

Study	Country of study	Aim of study	Participants; participants age group and country of origin	Type of intervention	Potential facilitators of care												Measure of responsive care	MOORRA tool (score out of 12)
					Communication					Culture and experience						Other		
					Translation materials	Visual materials/ non-readers	Interpreters and oral communication	Enhanced translation	Other considerations	The displacement experience	Health risks and vulnerabilities	Broader social and societal context	Engaging and responding to communities	community delivery/ staff representation	Flexing for divergent views and traditions	Resource	Reaching people	
Griggs 2022[177]	UK	To investigate the feasibility of a group-based stabilisation intervention for asylum seekers and refugees delivered within an NHS Improving Access to Psychological Therapies service	Refugee and asylum seekers; adults; global	Stepped-care mental health; group and individual; NR		✓	✓	✓			✓							Proxy: psychological functions in (connections; integration; understanding symptoms). Direct:attendance	11
Griswold 2007[112]	USA	Findings from a qualitative investigation of cultural awareness that medical students developed in the context of providing medical care to refugees	Practitioner participant; undergraduate medical students	Cultural awareness programme individual; health facility			✓	✓		✓	✓						✓	Proxy: cultural awareness	9.6
Guerin 2003[113]	New Zealand	Devising appropriate exercise for the Somali women in Hamilton, New Zealand, and to interview them more systematically about the constraints, benefits and improvements that might be made	Refugee and asylum seekers; adults; Somalia	General health, health behaviours physical activity and nutrition programme; group and individual; community			✓						✓		✓	✓	✓	Direct: attendance and enjoyment of sessions	12

TABLE 6 Summary of included studies (*continued*)

Study	Country of study	Aim of study	Participants; participants age group and country of origin	Type of intervention	Potential facilitators of care													Measure of responsive care	MO-RRA tool (score out of 12)
					Communication					Culture and experience						Other			
					Translation materials	Visual materials/ non-readers	Interpreters and oral communication	Enhanced translation	Other considerations	The displacement experience	Health risks and vulnerabilities	Broader social and societal context	Engaging and responding to communities	community delivery/ staff representation	Flexing for divergent views and traditions	Resource	Reaching people		
Gurung 2020[130]	USA	Examining and comparing the effectiveness of bilingual mental health first aid training offered with and without a culturally appropriate orientation to mental health terminology and concepts used in mental health care in the United States	Practitioner participant with refugee backgrounds: Bhutanese community leaders	Mental health and suicide prevention; group; NR	✓					✓	✓		✓		✓			Proxy: mental health literacy; capacity to respond	9
Han 2012[131]	USA	To develop and implement a culturally competent programme with Cambodians: pilot psycho-social-cultural treatment group programme	Refugee and asylum seekers; adults; Cambodia	Educational and counselling intervention; group; NR				✓		✓	✓	✓	✓	✓	✓			Proxy: family-related acculturation stress	9
Harkensee 2021[95]	UK	To identify health needs and healthcare access barriers of accompanied refugee and asylum- seeking children and pilot a new service model to address these issues	Refugee and asylum seekers; children; global	General health and health needs assessment; individual; health facility and home	✓		✓			✓	✓	✓	✓				✓	Direct: experiences	10

continued

TABLE 6 Summary of included studies (*continued*)

Study	Country of study	Aim of study	Participants; participants age group and country of origin	Type of intervention	Potential facilitators of care													Measure of responsive care	MO-RRA tool (score out of 12)
					Communication					Culture and experience						Other			
					Translation materials	Visual materials/ non-readers	Interpreters and oral communication	Enhanced translation	Other considerations	The displacement experience	Health risks and vulnerabilities	Broader social and societal context	Engaging and responding to communities	community delivery/ staff representation	Flexing for divergent views and traditions	Resource	Reaching people		
Heenan 2019[164]	Australia	The aim of this study is to examine refugee health assessments in Syrian and Iraqi children in the context of changes to offshore immigration screening, updated Australian refugee health guidelines, and the primary care refugee health model in Victoria	Refugee and asylum seekers; children; Syria and Iraq	Offshore immigration screening, new refugee health guidelines and primary care refugee health model; systems and individual; clinics and community						✓	✓	✓					✓	Direct: post-arrival healthcare and service access	8
Hess 2014[114]	USA	Refugee well-being programme designed with the aim of preventing further psychological distress and promoting refugee well-being	Refugee and asylum seekers; adults; sub-Saharan Africa.Practitioner participants: psychology or anthropology undergraduate students	Holistic intervention focused on advocacy and well-being; group and individual; home			✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	Direct: expectations and experiences; service engagement; navigation of health and other resources. Proxy: expectations and experiences	12
Hinton 2005[149]	USA	We hypothesised that the third generation of the manual-based protocol would be effective in the treatment of Cambodian refugees with PTSD and comorbid panic attacks	Refugee and asylum seekers; adults: Cambodia	Adapted cognitive behavioural therapy for Cambodian refugees with treatment-resistant PTSD) and comorbid panic attacks				✓		✓	✓				✓			No measures	

TABLE 6 Summary of included studies (*continued*)

Study	Country of study	Aim of study	Participants; participants age group and country of origin	Type of intervention	Potential facilitators of care													Measure of responsive care	MO-RRA tool (score out of 12)
					Communication					Culture and experience						Other			
					Translation materials	Visual materials/ non-readers	Interpreters and oral communication	Enhanced translation	Other considerations	The displacement experience	Health risks and vulnerabilities	Broader social and societal context	Engaging and responding to communities	community delivery/ staff representation	Flexing for divergent views and traditions	Resource	Reaching people		
Hocking 2018[147]	Australia	Reports on the development and validation of a brief screening tool for PTSD and major depressive disorders in adult asylum seekers and refugees (STAR-MH) suitable for use by non-mental health workers	Refugee and asylum seekers; adults; global	Mental health screening; individual; health facility			✓						✓				✓	Direct: psychometric properties and tool utility. Proxy: cultural acceptability	9
Husby 2020[163]	Denmark	Aim was to contribute to the prevention of psychiatric disorders among refugees. The objective was to evaluate the acceptability, satisfaction and self-reported outcome of the parent group intervention, MindSpring, for a population of Arabic-speaking adult refugees living in Denmark who had obtained asylum no more than 5 years before intervention	Refugee and asylum seekers; adults; Syria, Palestine	Intervention for refugees with the purpose of strengthening participants' ability to cope with psychosocial problems, preventing pre- and post migratory stressors evolve into psychiatric disorders; group; community			✓	✓						✓				Direct: satisfaction and outcome survey	8

continued

TABLE 6 Summary of included studies (*continued*)

					Potential facilitators of care														
					Communication					Culture and experience						Other			
Study	Country of study	Aim of study	Participants; participants age group and country of origin	Type of intervention	Translation materials	Visual materials/ non-readers	Interpreters and oral communication	Enhanced translation	Other considerations	The displacement experience	Health risks and vulnerabilities	Broader social and societal context	Engaging and responding to communities	community delivery/ staff representation	Flexing for divergent views and traditions	Resource	Reaching people	Measure of responsive care	MMORRA tool (score out of 12)
Im 2016[115]	USA	Explores the impact of a peer-led intervention for health promotion with the Bhutanese refugee community	Refugee and asylum seekers; adults; Bhutan	Peer-led health promotion workshops; group; community	✓					✓	✓		✓		✓			Direct: competency in access to proper health resources. Proxy: improvement in health knowledge	11
Im 2018[132]	Kenya	Explore the effect of the psychosocial education sessions on both mental health and psychosocial domains among Somali refugee youth affected by multiple refugee traumas	Refugee and asylum seekers; adults; Somalia	Psychoeducational sessions; group; community	✓					✓	✓	✓	✓	✓	✓	✓	✓	Proxy: perceived mental health awareness	11
Im 2020[116]	USA	To identify refugee service providers' mental health training needs and to evaluate the training programme in building competencies and providing tools and resources to refugee-serving professionals and refugee community leaders	Practitioner participants: mental health services; healthcare providers, refugee resettlement services, interpretation services, community health workers, teachers, social workers, refugee community leader	Interactive training curriculum to support culturally competent trauma-informed care; group; school and health facility			✓			✓	✓	✓	✓					**Proxy:** knowledge and skills in refugee mental health	7.2

TABLE 6 Summary of included studies (*continued*)

Study	Country of study	Aim of study	Participants; participants age group and country of origin	Type of intervention	Potential facilitators of care													Measure of responsive care	MO-RRA tool (score out of 12)
					Communication					Culture and experience						Other			
					Translation materials	Visual materials/ non-readers	Interpreters and oral communication	Enhanced translation	Other considerations	The displacement experience	Health risks and vulnerabilities	Broader social and societal context	Engaging and responding to communities	community delivery/ staff representation	Flexing for divergent views and traditions	Resource	Reaching people		
Im 2022[156]	USA	This paper introduces an innovative community-based programme to build and enhance competences and partnerships among mental health professionals and refugee community leaders, while facilitating intercultural, mutual learning between participants	Practitioner participants: mental health providers and refugee community leaders	Capacity building interactive training on cross-cultural trauma-informed care for refugee			✓	✓		✓	✓	✓	✓	✓	✓			Proxy: evaluation	9.6
Jahn 2018[117]	Germany	Experiences of healthcare providers in reception centres using a patient-held health record in a German federal state	Practitioner participant: physician and nurses	Training and capacity building; group; asylum-seeker reception centre	✓							✓				✓		Proxy: patient-held health record implementation – process and barriers	6
Jirovsky 2018[202]	Austria, Croatia, Greece, Hungary, Italy, Slovenia	To support capacity building of primary healthcare professionals in high-quality care refugees and asylum seekers	Practitioner participant: primary healthcare professional	Training and capacity building; group and individual; remote	✓					✓	✓	✓	✓				✓	Proxy: knowledge of primary care professionals; willingness to support online course	9.6

continued

TABLE 6 Summary of included studies (*continued*)

Study	Country of study	Aim of study	Participants; participants age group and country of origin	Type of intervention	Potential facilitators of care													Measure of responsive care	MMORRA tool (score out of 12)
					Communication					Culture and experience						Other			
					Translation materials	Visual materials/ non-readers	Interpreters and oral communication	Enhanced translation	Other considerations	The displacement experience	Health risks and vulnerabilities	Broader social and societal context	Engaging and responding to communities	community delivery/ staff representation	Flexing for divergent views and traditions	Resource	Reaching people		
Kananian 2020[101]	Germany	To compare culturally adapted CBT+ problem solving (CA-CBT+) for Afghan refugees with a waitlist control condition, including evaluation at long-term follow-up	Refugee and asylum seekers; adults; global	Psychoeducation programme; group; health facility	✓	✓	✓		✓	✓		✓	✓		✓			No measure	
Koch 2020[102]	Germany	To examine the feasibility, acceptability, and effectiveness of the culturally modified skills training STARC among treatment-seeking Afghan refugees in a routine clinical setting	Refugee and asylum seekers; mixed; Afghanistan	Mental health training; group; health facility		✓	✓			✓	✓		✓		✓		✓	Direct: attendance; satisfaction	12
Kruse 2009[133]	Germany	To investigate the effects of the first stage of psychotherapy adapted to the particular needs of war refugees on PTSD symptoms and somatoform disorders among war refugees with PTSD and comorbid somatoform disorder	Refugee and asylum seekers; adults; Bosnia	Trauma-focused psychotherapy; individual; health facility				✓		✓	✓	✓			✓			No measure	

TABLE 6 Summary of included studies (*continued*)

Study	Country of study	Aim of study	Participants; participants age group and country of origin	Type of intervention	Potential facilitators of care													Measure of responsive care	MO-RRA tool (score out of 12)
					Communication					Culture and experience						Other			
					Translation materials	Visual materials/ non-readers	Interpreters and oral communication	Enhanced translation	Other considerations	The displacement experience	Health risks and vulnerabilities	Broader social and societal context	Engaging and responding to communities	community delivery/ staff representation	Flexing for divergent views and traditions	Resource	Reaching people		
Lambert 2018[186]	Belgium	To describe the preliminary results of referring undocumented immigrants to the dental practitioner, assisted by community health workers	Refugee and asylum seekers; mixed; global	Oral health; individual; NGO facility			✓				✓	✓				✓	✓	Direct: rate of missed appointments	11
Lee 2013[134]	South Korea	A health education programme for the formation of healthy lifestyles for pre-school-age children from North Korea	Refugee and asylum seekers; children; North Korea	Health education programme; group and individual; NR					✓						✓			Proxy: health knowledge (healthy lifestyles)	8
Lee 2018[135]	South Korea	To develop a women's health mobile video intervention programme to meet the language challenges of female North Korean defectors and evaluate the impact of the programme on their behavioural confidence	Refugee and asylum seekers; adults; North Korea	Women's health; individual; remote and home	✓		✓	✓		✓							✓	Direct: behavioural confidence on prevention and management for vaginitis and cervical cancer including access to testing	10

continued

TABLE 6 Summary of included studies (*continued*)

					Potential facilitators of care														
					Communication					Culture and experience						Other			
Study	Country of study	Aim of study	Participants; participants age group and country of origin	Type of intervention	Translation materials	Visual materials/ non-readers	Interpreters and oral communication	Enhanced translation	Other considerations	The displacement experience	Health risks and vulnerabilities	Broader social and societal context	Engaging and responding to communities	community delivery/ staff representation	Flexing for divergent views and traditions	Resource	Reaching people	Measure of responsive care	MORRA tool (score out of 12)
Lepiece 2018[193]	Belgium	To evaluate if facilitation of care for asylum seekers decreases healthcare provider stereotype manifestation and if the four types of stereotypes impact differently continuity of care	Practitioner participants: GPs and mental health professionals	Clinical vignettes as mental health training; Individual; NR			✓			✓			✓				✓	Proxy: continuity of care; stereotyping	4.8
Maduma 2018[178]	USA	To raise diabetes risk awareness among African refugees who receive services at Refugee Focus	Refugee and asylum seekers; adults; unclear	Diabetes awareness; group; social service centre	✓		✓	✓		✓	✓				✓			Proxy: diabetes risk awareness; knowledge	9
Malebranche 2019[206]	Canada	To characterise the healthcare utilisation and obstetric and newborn outcomes among recently arrived pregnant refugees and asylum seekers receiving antenatal care	Refugee and asylum seekers; mixed; global	Specialist refugee clinics for antenatal care; individual; health facility			✓			✓	✓	✓	✓		✓			Direct: adequate or better care (measured by number of appointments attended); time to first antenatal clinic visit	12
McBride 2017[157]	Australia	To describe the MHRHW service model, to explore clients' experiences with MHRHW and capture their feedback on defining aspects of the service model	Refugee and asylum seekers; mixed; global	Holistic and intensive transitional care			✓				✓	✓	✓	✓	✓		✓	Direct: satisfaction	12

TABLE 6 Summary of included studies (*continued*)

Study	Country of study	Aim of study	Participants; participants age group and country of origin	Type of intervention	Potential facilitators of care													Measure of responsive care	MO-RRA tool (score out of 12)
					Communication					Culture and experience						Other			
					Translation materials	Visual materials/ non-readers	Interpreters and oral communication	Enhanced translation	Other considerations	The displacement experience	Health risks and vulnerabilities	Broader social and societal context	Engaging and responding to communities	community delivery/ staff representation	Flexing for divergent views and traditions	Resource	Reaching people		
McDonald 2012[179]	USA	To describe and evaluate the process of culturally adapting and implementing this universal parenting programme for refugees	Refugee and asylum seekers; mixed; global	Family well-being programme; group; refugee camp		✓	✓	✓		✓		✓	✓	✓	✓	✓	✓	Direct: participation; programme integrity and delivery (experiences)	9
McDonald 2021[158]	Sweden	To evaluate training outcome on: (1) participants' perceived knowledge and skills regarding mental health and care for newly arrived refugee patients, asylum seekers, and undocumented refugees; (2) participants' perceived knowledge and skills after training; and (3) whether any changes were related to participants' recent experiences working with these groups of people	Practitioner participants: mental health professionals, social workers, nurse assistants, administrative staff	Comprehensive cross-cultural training for mental healthcare professionals							✓	✓	✓	✓	✓			Proxy: experiences of the training programme; knowledge and attitudes	7.2
Miner 2017[165]	USA	To assess the impact of a home healthcare pilot project on meeting the home healthcare needs of refugee patients	Refugee and asylum seekers; adults; global	Home healthcare community service management of chronic illness and other health conditions to support adults and caregivers								✓			✓		✓	Direct: health service Use. Proxy: management of medication	8

continued

TABLE 6 Summary of included studies (*continued*)

Study	Country of study	Aim of study	Participants; participants age group and country of origin	Type of intervention	Potential facilitators of care													Measure of responsive care	MO-RRA tool (score out of 12)
					Communication					Culture and experience						Other			
					Translation materials	Visual materials/ non-readers	Interpreters and oral communication	Enhanced translation	Other considerations	The displacement experience	Health risks and vulnerabilities	Broader social and societal context	Engaging and responding to communities	community delivery/ staff representation	Flexing for divergent views and traditions	Resource	Reaching people		
Mitschke 2013[136]	USA	To assess the impact of a group-based financial education course on the mental health of Bhutanese refugee women resettled in the United States	Refugee and asylum seekers; adults; Bhutan	Mental health training; group; community	✓		✓						✓			✓	✓	No measure	
Nazzal 2014[204]	USA	To propose essential steps and components for community programmes targeted toward preventing mental illness and improving psychosocial adjustment among newly arrived refugee populations	Refugee and asylum seekers; unspecified; global	Community-oriented model for working with refugees; mental health focus; group; community				✓			✓	✓	✓	✓	✓	✓	✓	Direct: perceptions of mental illness and mental health services; mental health awareness. Proxy: delivery and programme challenges	8
Nickerson 2020[170]	Australia	To evaluate the efficacy of an online intervention in reducing self-stigma and increasing help-seeking in refugee men	Refugee and asylum seekers; adults; unclear	Web-based training modules on mental health stigma and help-seeking; individual; remote	✓		✓	✓			✓	✓	✓	✓				Direct: experiences and engagement Proxy: self-stigma for help-seeking	12
Ornelas 2018[137]	USA	To develop and evaluate educational videos to promote cervical cancer screening among Karen-Burmese and Nepali-Bhutanese refugee women	Refugee and asylum seekers; adults; global	Educational programme to promote cervical cancer screening; individual; home	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓	Direct: awareness of cervical cancer screening; willingness to be screened. Proxy: knowledge of cervical cancer	12

TABLE 6 Summary of included studies (*continued*)

Study	Country of study	Aim of study	Participants; participants age group and country of origin	Type of intervention	Potential facilitators of care												Measure of responsive care	MORRA tool (score out of 12)
					Communication					Culture and experience						Other		
					Translation materials	Visual materials/ non-readers	Interpreters and oral communication	Enhanced translation	Other considerations	The displacement experience	Health risks and vulnerabilities	Broader social and societal context	Engaging and responding to communities	community delivery/ staff representation	Flexing for divergent views and traditions	Resource	Reaching people	
Ozaydin 2021[103]	Turkey	To evaluate the effect of the intervention in reducing xenophobia and improving attitudes towards refugees and intercultural sensitivity among nursing students	Practitioner participant: nursing students	Educational training on migration issues and refugee health; group; university						✓			✓					Proxy: risk of xenophobia; attitude towards refugees; intercultural sensitivity	8.4
Pantziaras 2015a[207]	Sweden	To assess the impact of training with a virtual patient on confidence in providing clinical care for traumatised refugee patients	Practitioner participant: residents in psychiatry	Mental health; individual; remote						✓	✓		✓			✓		Proxy: confidence in addressing mental health problems after trauma and knowledge of post-traumatic stress disorder symptoms, clinical management, and basic communication skills	7.2
Potocky 2019[194]	USA	The purpose of this pilot study was to determine the effect of a brief motivational interviewing training webinar on participants' empathetic responses to hypothetical refugee statements	Practitioner participant: case managers	Virtual patient refugee trauma training; group; remote						✓		✓	✓				✓	Proxy: empathetic responsiveness among refugee service providers; usefulness and relevance of the webinar	7.2

continued

TABLE 6 Summary of included studies (*continued*)

Study	Country of study	Aim of study	Participants; participants age group and country of origin	Type of intervention	Potential facilitators of care													Measure of responsive care	MO-RRA tool (score out of 12)
					Communication					Culture and experience						Other			
					Translation materials	Visual materials/ non-readers	Interpreters and oral communication	Enhanced translation	Other considerations	The displacement experience	Health risks and vulnerabilities	Broader social and societal context	Engaging and responding to communities	community delivery/ staff representation	Flexing for divergent views and traditions	Resource	Reaching people		
Poudel-Tandukar 2021b[139]	USA	To assess the effect of a peer- led family-centred social and emotional well-being intervention on preventive and mental health outcomes among resettled Bhutanese adults in Massachusetts	Refugee and asylum seekers; adults; Bhutan	Family-centred health promotion; Individual (family); community			✓	✓					✓	✓				No measure	
Poudel-Tandukar 2021a[140]	USA	To assess the social and emotional well-being programme's effect on engagement in health-promoting behaviours and mental health outcomes among resettled Bhutanese adults in Western Massachusetts	Refugee and asylum seekers; adults; Bhutan	Health education and problem-solving activities; group; religious centre	✓		✓	✓			✓	✓	✓	✓	✓	✓	✓	No measure	
Procter 2021[180]	Australia	To evaluate a novel suicide prevention education programme specifically tailored to working with asylum seekers and refugees	Practitioner participant: NGO staff; volunteers; students	Suicide prevention education training; group; community							✓	✓	✓					Proxy: changes in attitudes to suicide; confidence in management of suicide; competence/skill	9.6

TABLE 6 Summary of included studies (*continued*)

Study	Country of study	Aim of study	Participants; participants age group and country of origin	Type of intervention	Potential facilitators of care													Measure of responsive care	MORRA tool (score out of 12)
					Communication					Culture and experience						Other			
					Translation materials	Visual materials/ non-readers	Interpreters and oral communication	Enhanced translation	Other considerations	The displacement experience	Health risks and vulnerabilities	Broader social and societal context	Engaging and responding to communities	community delivery/ staff representation	Flexing for divergent views and traditions	Resource	Reaching people		
Rosenberg 2022[159]	USA	To assess the feasibility and acceptability of an evidence-based social–emotional learning curriculum with wellness components for refugee children and nurture engagement and trust within the community for future initiatives	Refugee and asylum seekers; mixed; Afghanistan	Culturally specific, multilingual, trauma-informed wellness, and physical education; group and individual; community				✓		✓	✓				✓	✓	✓	Direct: feasibility; satisfaction; barriers and facilitators of engagement	10
Royer 2016[195]	USA	To evaluate the feasibility of group contraceptive counselling and its associations with family planning knowledge acquisition, service satisfaction, method uptake and continuation	Refugee and asylum seekers; adults; unclear	Contraceptive counselling; group; NR														Direct: satisfaction. Proxy: contraceptive knowledge	6
Russell 2020[196]	Australia	To determine if an outreach facilitation intervention could increase refugee status identification, interpreter use, and use of refugee specific referral pathways for general practice patients from refugee background	Practitioner participants: GPs	Capacity building outreach support from specialist refugee health facilitators; Individual/practice based; health facility														Proxy: refugee status identification; interpreter use; use of refugee specific referral pathways	3.6

continued

TABLE 6 Summary of included studies (*continued*)

Study	Country of study	Aim of study	Participants; participants age group and country of origin	Type of intervention	Potential facilitators of care													Measure of responsive care	MO-RRA tool (score out of 12)
					Communication					Culture and experience						Other			
					Translation materials	Visual materials/ non-readers	Interpreters and oral communication	Enhanced translation	Other considerations	The displacement experience	Health risks and vulnerabilities	Broader social and societal context	Engaging and responding to communities	community delivery/ staff representation	Flexing for divergent views and traditions	Resource	Reaching people		
Ryan 1987[200]	USA	To describe a mental health and crisis intervention training programme' conducted in two American cities for non-professional, refugee resettlement workers	Practitioner participants: Southeast Asian refugee resettlement workers	Mental health training programme; group; school				✓		✓	✓				✓			Proxy: understanding of cross-cultural aspects of clinical work with refugees	6
Sahyoun 2019[118]	Lebanon	To investigate changes in household economics and food security status, decision-making, mental health and social support in participating women	Refugee and asylum seekers; adults; Middle East and North Africa	Community kitchen nutrition programme; group; community		✓	✓	✓		✓		✓			✓	✓	✓	Proxy: capacity for seeking advice on health care and in decision-making on taking medications	12
Saito 2021a[197]	Australia	Aimed to improve the primary care management of people from refugee backgrounds with outreach facilitation delivered to general practices	Practitioner participants: GPs; practice nurse; practice manager	Practice facilitation to address interpreter engagement; group and individual; health facility			✓	✓		✓	✓	✓						Proxy: general and linguistic characteristics of participating practices and GPs; assessment and recording of interpreter needs; barriers and use of interpreter services	8.4

TABLE 6 Summary of included studies (*continued*)

Study	Country of study	Aim of study	Participants; participants age group and country of origin	Type of intervention	Potential facilitators of care													Measure of responsive care	MOORRA tool (score out of 12)
					Communication					Culture and experience						Other			
					Translation materials	Visual materials/ non-readers	Interpreters and oral communication	Enhanced translation	Other considerations	The displacement experience	Health risks and vulnerabilities	Broader social and societal context	Engaging and responding to communities	community delivery/ staff representation	Flexing for divergent views and traditions	Resource	Reaching people		
Shaw 2019[171]	Malaysia	To assess effectiveness of an 8-week somatic-focused Ca-CBT group intervention for female refugees	Refugee and asylum seekers; adults; Afghanistan	Mental health intervention; group; NGO facility		✓	✓	✓		✓	✓				✓	✓	✓	No measure	
Sheikh 2009[203]	Australia	To examine the impact of targeted, active health promotion and awareness of a new refugee health service through social networks	Refugee and asylum seekers; mixed; global	Paediatric services and health service awareness and navigation; individual; health facility	✓		✓		✓	✓	✓	✓	✓		✓	✓	✓	Direct: use of service; awareness of service. Proxy: health knowledge; stigma	10
Slewa-Younan 2020a[141]	Australia	To determine whether the training was successful in improving the recognition of PTSD related problems among refugees	Practitioner participants: Arabic-speaking religious and community leaders	Mental health; group; school				✓		✓	✓		✓		✓			Proxy: recognition of mental health problems, negative attitude towards mental illness, treatment knowledge, providing support and helping advice	10
Slewa-Younan 2020b[181]	Australia	To improve mental health literacy among two Arabic-speaking refugee populations in south-western Sydney, Australia	Refugees and asylum seekers; adults; Middle East and North Africa	Psychoeducation training; group; community				✓			✓		✓					Direct: experiences of the programme. Proxy: mental health literacy and attitude; help-seeking intentions	12

continued

TABLE 6 Summary of included studies (*continued*)

					Potential facilitators of care														
					Communication					Culture and experience						Other			
Study	Country of study	Aim of study	Participants; participants age group and country of origin	Type of intervention	Translation materials	Visual materials/ non-readers	Interpreters and oral communication	Enhanced translation	Other considerations	The displacement experience	Health risks and vulnerabilities	Broader social and societal context	Engaging and responding to communities	community delivery/ staff representation	Flexing for divergent views and traditions	Resource	Reaching people	Measure of responsive care	MMORRA tool (score out of 12)
Subedi 2015[182]	USA	To determine the impact of mental health first aid training on Bhutanese refugee community leaders' knowledge of appropriate first aid responses and stigmatising attitudes towards people with mental illness	Practitioner participants (with a refugee background): Bhutanese refugee community leaders	Menta health training; group; university			✓		✓	✓			✓					Proxy: mental health literacy; stigmatising attitude	7
Timlin 2020[183]	Australia	To build capacity of GPs to respond to the needs of asylum seekers and refugees	Practitioner participants: GPs, practice nurses	Capacity building; group; health facility						✓	✓	✓	✓					Proxy: treatment approach; acceptability of the 'GP engagement' initiative	8
Tol 2018[119]	Uganda	We describe the translation, adaption, and the first uncontrolled piloting of SH + with South Sudanese refugees in northern Uganda and assess the feasibility and acceptability of the intervention	Refugee and Asylum seekers; Adults; South Sudan Practitioner participants: Self-Help Plus facilitators	Adapted CBT intervention; group; home and refugee camp	✓	✓	✓	✓					✓		✓		✓	Direct: acceptability; participation	12

TABLE 6 Summary of included studies (*continued*)

Study	Country of study	Aim of study	Participants; participants age group and country of origin	Type of intervention	Potential facilitators of care													Measure of responsive care	MO-RRA tool (score out of 12)
					Communication					Culture and experience						Other			
					Translation materials	Visual materials/ non-readers	Interpreters and oral communication	Enhanced translation	Other considerations	The displacement experience	Health risks and vulnerabilities	Broader social and societal context	Engaging and responding to communities	community delivery/ staff representation	Flexing for divergent views and traditions	Resource	Reaching people		
Trilesnik 2019[184]	Germany	To evaluate if refugees have better access to mental health care as a result of the project	Refugee and asylum seekers; adults; global. Practitioner participant: Physicians of psychiatric clinics psychiatrists, psychologists, occupational, art, music and body therapists, nurses, social workers	Stepped-care psychosocial, psychiatric, and psychotherapeutic care services; Individual; psychological counselling centre			✓	✓		✓	✓	✓						No measure	
Uitterhaegen 2005[160]	Netherlands	Field results: This article is about a community-based intervention programme. Asylum seekers and refugees are trained to provide psychoeducation and psychosocial support to fellow groups of refugees and asylum seekers. These trained refugees work in their own language and culture, with a professional coach from a local mental health institute	Refugee and asylum seekers; NR; NR	Peer-delivered psychoeducation and psychosocial support	✓			✓		✓	✓	✓	✓	✓	✓		✓	Direct: evaluation of group intervention Proxy: evaluation of group intervention	4

continued

TABLE 6 Summary of included studies (*continued*)

Study	Country of study	Aim of study	Participants; participants age group and country of origin	Type of intervention	Potential facilitators of care												Measure of responsive care	MO-RRA tool (score out of 12)
					Communication					Culture and experience						Other		
					Translation materials	Visual materials/ non-readers	Interpreters and oral communication	Enhanced translation	Other considerations	The displacement experience	Health risks and vulnerabilities	Broader social and societal context	Engaging and responding to communities	community delivery/ staff representation	Flexing for divergent views and traditions	Resource	Reaching people	
Uribe Guajardo 2018[185]	Australia	To examine whether the novel adapted training course delivered to community-based workers was effective in changing participants' knowledge, increasing the quality of helping intentions and increasing positive behaviours and attitudes towards Iraqi refugees with depression and PTSD	Practitioner participant: community-based workers assisting Iraqi refugees in their resettlement	Mental health literacy training course; group; NR			✓				✓		✓					Proxy: recognition and knowledge of mental health problems; helping intention and behaviour; attitudes (towards an Iraqi refugee with PTSD and depression); confidence in helping	7.2
Van Es 2021[161]	Netherlands	To evaluate a trauma-focused treatment approach for unaccompanied refugee minors	Refugee and asylum seekers; children; global	Short and flexible multimodal trauma-focused treatment approach, specifically adapted for unaccompanied refugee minors; Individual; NR				✓		✓		✓		✓			✓	Direct: exposure; adherence. Proxy: feasibility/ evaluation	12
van Heemstra 2019[142]	Netherlands	To evaluate a transdiagnostic intervention for promoting self-efficacy in traumatised refugees and the potential to improve self-efficacy and mental health	Refugee and asylum seekers; adults; global	Mental health information and empowerment sessions; group; health facility			✓	✓	✓	✓	✓	✓			✓		✓	Direct: participation. Proxy: self-efficacy in postmigration stressors	10

TABLE 6 Summary of included studies (*continued*)

Study	Country of study	Aim of study	Participants; participants age group and country of origin	Type of intervention	Potential facilitators of care													Measure of responsive care	MORRA tool (score out of 12)
					Communication					Culture and experience						Other			
					Translation materials	Visual materials/ non-readers	Interpreters and oral communication	Enhanced translation	Other considerations	The displacement experience	Health risks and vulnerabilities	Broader social and societal context	Engaging and responding to communities	community delivery/ staff representation	Flexing for divergent views and traditions	Resource	Reaching people		
Vijayakumar 2017[190]	India	To assess the effectiveness and acceptability of regular contact and use of safety planning cards by community volunteers in reducing suicidal behaviour	Refugee and asylum seekers; adults; Sri Lanka	Regular contact and use of safety planning cards				✓		✓	✓			✓				No measure	
Walker 2015[120]	Australia	To discuss a health promotion intervention in which mobile phones were used by refugee women to exchange social support and enhance connectedness with their heritage and host communities	Refugee and asylum seekers; adults; global	Peer support strengths-based programme; group and individual; home and community												✓		Direct: use of free-call phones. Proxy: social support and acculturation	10
Weine 2003[143]	USA	To examine whether the Tea and Families Education and Support group led to changes in the identified major constructs of social support, mental health service use, knowledge and attitudes regarding trauma mental health, and family process	Refugee and asylum seekers; adults; Kosovo	Manualised family support and education intervention; group; home and community			✓	✓		✓	✓		✓	✓			✓	Direct: service use. Proxy: trauma mental health knowledge and stigma	10

continued

TABLE 6 Summary of included studies (*continued*)

Study	Country of study	Aim of study	Participants; participants age group and country of origin	Type of intervention	Potential facilitators of care												Measure of responsive care	MO-RRA tool (score out of 12)
					Communication					Culture and experience						Other		
					Translation materials	Visual materials/ non-readers	Interpreters and oral communication	Enhanced translation	Other considerations	The displacement experience	Health risks and vulnerabilities	Broader social and societal context	Engaging and responding to communities	community delivery/ staff representation	Flexing for divergent views and traditions	Resource	Reaching people	
Weine 2008[172]	USA	To determine the effects of a multiple-family group in increasing access to mental health services for refugees with PTSD	Refugee and asylum seekers; adults; Bosnia	Family information session and support; group; community			✓	✓					✓	✓				Direct: number of visits to mental health services. Proxy: knowledge regarding trauma mental health	12
Weinstein 2016[198]	Jordan	To examine the relation between need frustration and psychological distress as reflected in symptoms of depression, generalised stress, and PTSD in a sample of Syrian refugees, and (b) investigate the effects of a basic, easy-to-implement psychosocial intervention which encourages individuals to seek out need-satisfying activities	Refugee and asylum seekers; mixed; Syria	Self-directed mental health programme; individual; home							✓						✓	No measure	8
Wenner 2020[144]	Germany	To determine if access to healthcare among newly arriving refugees differs between the healthcare voucher model and the electronic health card	Refugee and asylum seekers; mixed; NR	Healthcare access model providing an electronic health card; individual; health facility														Direct: incidence rates of emergency care	10.8

TABLE 6 Summary of included studies (*continued*)

Study	Country of study	Aim of study	Participants; participants age group and country of origin	Type of intervention	Potential facilitators of care													Measure of responsive care	MO-RRA tool (score out of 12)
					Communication					Culture and experience						Other			
					Translation materials	Visual materials/ non-readers	Interpreters and oral communication	Enhanced translation	Other considerations	The displacement experience	Health risks and vulnerabilities	Broader social and societal context	Engaging and responding to communities	community delivery/ staff representation	Flexing for divergent views and traditions	Resource	Reaching people		
Woodland 2016[175]	Australia	To describe the development of the optimising health and learning programme a school screening programme for young people from refugee backgrounds and report on the process and impact evaluation of the programme	Refugee and asylum seekers; children; global. Practitioner participants: service providers and students	Intersectoral partnership development and school-based health screening; group and individual; English language schools	✓		✓	✓		✓	✓	✓				✓	✓	Direct and proxy: participation and experiences. Direct and proxy: multisector co-ordination of care	10
Yelland 2020[145]	Australia	To evaluate systems reform in public hospitals, Victoria, Australia, to improve access to antenatal care for women of refugee background	Refugees and asylum seekers; mixed; global	Quality improvement and demonstration initiatives in universal health services, including maternity hospitals; group and individual; health facility			✓	✓	✓	✓	✓	✓	✓					Direct: total antenatal visits. Gestation period at first hospital visit; interpreter use	12
Yun 2016[121]	USA	To describe the impact of a community-based patient navigation intervention on patient activation levels among Bhutanese refugees in the US	Refugee and asylum seeker; adults; Bhutan. Practitioner participants: patient navigators	Health education and navigation information and support; individual; community			✓	✓				✓		✓	✓	✓	✓	Direct: missed or avoided healthcare appointments; help-seeking behaviour; healthcare access problems. Proxy: healthcare access problems	10

continued

TABLE 6 Summary of included studies (*continued*)

					Potential facilitators of care														
					Communication					Culture and experience						Other			
Study	Country of study	Aim of study	Participants; participants age group and country of origin	Type of intervention	Translation materials	Visual materials/ non-readers	Interpreters and oral communication	Enhanced translation	Other considerations	The displacement experience	Health risks and vulnerabilities	Broader social and societal context	Engaging and responding to communities	community delivery/ staff representation	Flexing for divergent views and traditions	Resource	Reaching people	Measure of responsive care	MORRA tool (score out of 12)
Zehetmair 2021[162]	Germany	To gain a deeper understanding of the barriers that refugees face in their mental healthcare efforts and to develop strategies in addressing them we assessed the perspectives of refugees attending the psychosocial walk-in clinic in the state registration and reception centre in Heidelberg, with a focus on the facilitating and impeding factors when seeking help in the psychosocial walk-in clinic	Refugee and asylum seeker; adults; Eastern Europe	Psychosocial walk-in clinic providing consultations, counselling, psychopharmacological medication, and further treatment recommendations; individual; reception centre							✓						✓	Direct: access to the psychosocial walk-in clinic	8

CA-CBT, culturally adapted cognitive–behavioural therapy; MHRHW, Monash Health Refugee Health and Wellbeing; STAR-MH, Screening Tool for Asylum-seeker and Refugee Mental Health; STARC, Skills Training of Affect Regulation – a Culture-sensitive approach.

Additional characteristics of included studies

TABLE 7 Participants, funding and country (included studies)

Study characteristics	Frequency (*n*)	Per cent (%)
Classification of funding source (*n* = 78)[a]		
Charities and foundations	17	21.8
Private sector	2	2.6
Public funding	31	39.7
United Nations/European Union	5	6.4
University	15	19.2
Mixed (university and/or charities and foundations and/or public funding)	8	10.3
Participants (*n* = 108)		
Forced-migrant participants	85	78.7
Practitioner participants	38	35.2
Both	15	13.9
Country of intervention[b]		
High-income countries	96	83.5
Upper-middle-income countries	10	8.7
Low, middle-income countries	6	5.2
Low-income countries	3	2.6

a Twenty studies did not report a funding source and four studies reported receiving no funding.
b Two studies Burchert *et al.*[210] and Jirovsky *et al.*[202] conducted interventions in more than one country (three and six, respectively).

TABLE 8 Intervention delivery country (by outcome measures)

	Direct measure studies (*N* = 63)[a] frequency		Proxy measure studies (*N* = 65)[b] frequency		No measure studies (*N* = 15)	
Delivery country	*n*	%	*n*	%	*n*	%
Australia	**10**	**15.9**	12	18.5	–	–
Austria	–	–	1	1.5	–	–
Belgium	1	1.6	1	1.5	–	–
Canada	2	3.2	–	–	–	–
Croatia	–	–	1	1.5	–	–
Denmark	1	1.6	–	–	–	–
Egypt	1	1.6	–	–	–	–
Germany	**5**	**7.9**	2	3.1	3	20.0
Greece	1	1.6	1	1.5	–	–
Hungary	–	–	1	1.5	–	–

continued

TABLE 8 Intervention delivery country (by outcome measures) (*continued*)

Delivery country	Direct measure studies (*N* = 63)[a] frequency		Proxy measure studies (*N* = 65)[b] frequency		No measure studies (*N* = 15)	
	n	%	*n*	%	*n*	%
India	–	–	–	–	1	6.7
Israel	1	1.6	–	–	–	–
Italy	–	–	1	1.5	–	–
Jordan	1	1.6	–	–	1	6.7
Kenya	1	1.6	–	–	–	–
Lebanon	–	–	2	3.1	–	–
Malaysia	–	–	–	–	1	6.7
Netherlands	3	4.8	3	4.6	–	–
New Zealand	1	1.6	–	–	–	–
Serbia	1	1.6	–	–	–	–
Slovenia	–	–	1	1.5	–	–
South Korea	1	1.6	–	–	–	–
Sweden	1	1.6	4	6.2	–	–
Switzerland	2	3.2	–	–	–	–
Turkey	**4**	**6.3**	5	7.7	1	6.7
Uganda	1	1.6	–	–	2	13.3
United Kingdom	4	6.3	3	4.6	–	–
United States	**21**	**33.3**	27	41.5	6	40.0
Delivery country classification						
HI	**54**	**85.7**	58	89.2	9	60.0
UMI	5	7.9	5	7.7	3	20.0
LMI	3	4.8	2	3.1	1	6.7
LI	1	1.6	–	–	2	13.3

a Includes one study[210] delivered across three countries.
b Includes one study[202] delivered across six countries.

Appendix 4 Methodological quality

Critical appraisal

TABLE 9 Critical appraisal randomised controlled trial studies

Study	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Total	%	Study quality
Acarturk 2022[150]	Y	Y	Y	N	N	Y	Y	N	Y	Y	Y	Y	N	9	69.2	Moderate
Ahmad 2012[100]	Y	Y	N	N	Y	U	Y	Y	Y	Y	Y	Y	Y	10	76.9	High
Aizik-Reebs 2021[188]	Y	U	N	N	N	U	Y	Y	Y	Y	Y	Y	Y	8	61.5	Moderate
Akhtar 2021[151]	Y	N	N	N	N	Y	Y	N	Y	Y	Y	Y	N	7	53.8	Moderate
Alrashdi 2021a[167]	Y	U	Y	N	N	Y	Y	U	Y	Y	Y	Y	Y	9	69.2	Moderate
Bakesiima 2021[148]	Y	Y	Y	N	N	Y	Y	Y	Y	Y	Y	Y	Y	11	84.6	High
Betancourt 2020[168]	Y	N	U	N	N	Y	Y	Y	Y	Y	Y	Y	Y	9	69.2	Moderate
Erenofülu 2020[169]	Y	U	Y	N	N	N	Y	Y	Y	Y	Y	Y	Y	9	69.2	Moderate
Eskici 2023[189]	Y	U	Y	N	N	U	Y	N	Y	Y	Y	Y	N	7	53.8	Moderate
Goodkind 2017[174]	Y	U	U	U	U	U	Y	U	U	U	U	U	U	2	15.4	Low
Goodkind 2020[192]	Y	N	N	N	N	U	N	N	Y	Y	Y	Y	Y	6	46.2	Low
Hinton 2005[149]	Y	Y	Y	U	U	Y	Y	Y	Y	Y	Y	Y	Y	11	84.6	High
Kananian 2020[101]	Y	Y	Y	N	U	Y	Y	N	Y	Y	Y	Y	Y	10	76.9	High
Koch 2020[102]	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	12	92.3	High
Lepiece 2018[193]	U	U	U	U	U	U	U	N	U	Y	Y	N	N	2	15.4	Low
Nickerson 2020[170]	Y	U	Y	N	Y	U	Y	Y	Y	Y	Y	Y	U	9	69.2	Moderate
Ozaydin 2021[103]	Y	Y	Y	N	N	Y	Y	Y	Y	Y	Y	Y	N	10	76.9	High
Potocky 2019[194]	U	U	U	N	N	N	Y	N	Y	Y	Y	Y	U	5	38.5	Low
Royer 2016[195]	U	U	Y	N	N	N	Y	U	Y	U	Y	U	U	4	30.8	Low
Russell 2020[196]	U	U	U	N	N	U	U	U	U	U	U	Y	U	1	7.7	Low
Shaw 2019[171]	N	N	N	N	N	N	Y	Y	Y	Y	Y	Y	Y	7	53.8	Moderate
Saito 2021a[197]	U	U	Y	N	N	U	Y	N	Y	Y	Y	N	U	5	38.5	Low
Vijayakumar 2017[190]	Y	U	Y	N	U	U	Y	N	Y	Y	Y	Y	N	7	53.8	Moderate
Weine 2008[172]	Y	U	Y	N	N	U	Y	Y	Y	Y	Y	Y	Y	9	69.2	Moderate
Weinstein 2016[198]	U	U	N	N	N	U	Y	Y	U	Y	Y	Y	U	5	38.5	Low
	18	7	14	0	3	9	22	12	21	22	23	21	9			
	72	28	56	0	12.0	36	88	48	84	88	92	84	36			

TABLE 10 Critical appraisal qualitative studies

Study	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Total	%	Study quality
Acarturk 2022[150]	N	Y	Y	Y	Y	N	N	Y	Y	Y	7	70	High
Akhtar 2021[151]	U	Y	Y	Y	Y	N	N	Y	Y	Y	7	70	High
Baarnhielm 2014[104]	U	Y	Y	Y	Y	N	U	Y	Y	Y	7	70	High
Baird 2017[105]	U	Y	Y	Y	Y	Y	N	Y	Y	Y	8	80	High
Ballard 2018[106]	Y	Y	Y	Y	Y	N	N	Y	Y	Y	8	80	High
Bayne 2019[122]	U	Y	Y	Y	Y	N	N	N	Y	Y	6	60	Moderate
Bernhardt 2019[173]	U	Y	U	Y	Y	N	N	U	Y	Y	5	50	Moderate
Brakemeier 2017[176]	U	Y	U	U	Y	N	N	U	Y	Y	4	40	Low
Burchert 2019[210]	U	Y	Y	Y	Y	N	N	Y	Y	Y	7	70	High
Chiumento 2011[199]	U	U	N	U	N	N	N	N	N	Y	1	10	Low
Dababnah 2019[107]	Y	Y	Y	Y	Y	Y	N	Y	U	Y	8	80	High
Delilovic 2018[153]	U	Y	Y	Y	Y	N	N	Y	Y	Y	7	70	High
Ekblad 2013[108]	U	Y	Y	Y	Y	N	N	Y	Y	Y	7	70	High
El-Khani 2021[154]	U	Y	Y	Y	Y	N	N	Y	Y	Y	7	70	High
Elswick 2022[191]	U	U	U	Y	Y	N	N	Y	N	Y	4	40	Low
Fazel 2009[126]	U	Y	N	N	N	Y	N	U	Y	Y	4	40	Low
Fazel 2016[109]	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	9	90	High
Foka 2021[110]	U	Y	Y	Y	Y	N	N	Y	Y	Y	7	70	High
Goodkind 2004[208]	U	Y	Y	Y	Y	N	N	Y	Y	Y	7	70	High
Goodkind 2014[111]	U	Y	Y	Y	Y	U	N	Y	Y	Y	7	70	High
Goodkind 2017[174]	U	Y	Y	Y	Y	N	N	N	Y	N	5	50	Moderate
Griswold 2007[112]	U	Y	Y	Y	Y	N	N	Y	Y	Y	7	70	High
Guerin 2003[113]	U	Y	Y	Y	Y	U	N	Y	Y	Y	7	70	High
Harkensee 2021[95]	U	Y	Y	Y	Y	N	N	N	Y	Y	6	60	Moderate
Hess 2014[114]	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	9	90	High
Husby 2020[163]	N	Y	Y	Y	Y	N	N	Y	U	Y	6	60	Moderate

continued

TABLE 10 Critical appraisal qualitative studies (*continued*)

Study	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Total	%	Study quality
Im 2016[115]	Y	Y	Y	Y	Y	N	N	Y	Y	Y	8	80	High
Im 2020[116]	U	Y	Y	Y	Y	N	N	Y	Y	Y	7	70	High
Im 2022[156]	U	Y	Y	Y	Y	N	N	Y	Y	Y	7	70	High
Jahn 2018[118]	U	Y	Y	Y	Y	U	N	Y	Y	Y	7	70	High
McBride 2017[157]	U	Y	Y	Y	Y	N	N	Y	Y	Y	7	70	High
McDonald 2012[179]	U	Y	U	U	U	N	N	N	N	Y	2	20	Low
McDonald 2021[158]	U	Y	Y	Y	Y	N	N	Y	Y	Y	7	70	High
Rosenberg 2022[159]	U	Y	Y	Y	Y	N	N	Y	Y	Y	7	70	High
Ryan 1987[200]	Y	U	U	U	U	N	N	N	U	U	1	10	Low
Sahyoun 2019[118]	Y	Y	Y	Y	Y	N	N	Y	Y	Y	8	80	High
Saito 2021a[197]	U	Y	U	U	Y	N	N	U	Y	Y	4	40	Low
Timlin 2020[183]	U	Y	Y	U	U	N	N	N	U	Y	3	30	Low
Tol 2018[119]	U	Y	Y	Y	Y	N	N	Y	Y	Y	7	70	High
Trilesnik 2019[184]	N	Y	Y	U	U	N	N	U	Y	U	3	30	Low
Uitterhaegen 2005[160]	N	Y	Y	Y	Y	N	N	Y	Y	Y	7	70	High
Van Es 2021[161]	U	Y	Y	Y	Y	N	N	Y	Y	Y	7	70	High
Walker 2015[120]	U	Y	Y	Y	Y	N	N	Y	Y	Y	7	70	High
Woodland 2016[175]	U	Y	Y	Y	Y	N	N	N	Y	Y	6	60	Moderate
Yun 2016[120]	U	Y	Y	Y	Y	N	N	Y	Y	Y	7	70	High
Zehetmair 2021[162]	U	Y	Y	Y	Y	N	N	Y	Y	Y	7	70	High
	7	43	38	38	40	5	0	33	39	43			
	15.2	93.5	82.6	82.6	87.0	10.9	0	84.8	84.8	93.5			

TABLE 11 Critical appraisal quasi-experimental studies

Study	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Total	%	Study quality
Baarnhielm 2014[104]	Y	N/A	N/A	N	Y	N	N/A	Y	Y	4/6	66.7	Moderate
Baird 2017[105]	Y	N/A	N/A	N	Y	Y	N/A	U	N/A	3/5	60.0	Moderate
Ballard 2018[106]	Y	N/A	N/A	N	Y	N	Y	Y	N	4/7	57.1	Moderate
Bayne 2019[122]	Y	U	Y	Y	N/A	Y	Y	Y	Y	7/8	87.5	High
Bernhardt 2019[173]	Y	N/A	N/A	N	N/A	N	N/A	U	U	1/5	20.0	Low
Birman 2008[205]	Y	N/A	N/A	N	Y	Y	N/A	Y	Y	5/6	83.3	High
Brakemeier 2017[176]	Y	N/A	N/A	N	Y	Y	N/A	Y	U	4/6	66.7	Moderate
Chaudhary 2019[201]	N	N/A	N/A	N	N	Y	N/A	U	U	1/6	16.7	Low
Dababnah 2019[107]	Y	N/A	N/A	N	N	Y	N/A	Y	N/A	3/5	60.0	Moderate
Ekblad 2013[108]	Y	N/A	N/A	N	Y	Y	N/A	Y	N/A	4/5	80.0	High
El Harake 2018[123]	Y	N	Y	Y	Y	Y	Y	Y	Y	8/9	88.9	High
El-Khani 2018[124]	Y	N/A	N/A	N	Y	Y	N/A	Y	Y	5/6	83.3	High
El-Khani 2021[154]	Y	N/A	N/A	N	Y	N	N/A	Y	Y	4/6	66.7	Moderate
Elswick 2021[191]	Y	N/A	N/A	N	Y	N	N/A	Y	N	3/6	50	Moderate
Ellis 2013[125]	Y	N/A	N/A	N	Y	Y	N/A	Y	Y	5/6	83.3	High
Fazel 2009[126]	Y	U	Y	Y	Y	Y	Y	Y	Y	8/9	88.9	High
Foka 2021[110]	Y	Y	Y	Y	Y	Y	Y	Y	Y	9/9	100	High
Fox 2005[127]	Y	N/A	N/A	N	Y	Y	N/A	Y	Y	5/6	83.3	High
Goninon 2021[128]	Y	Y	Y	Y	Y	Y	Y	Y	Y	9/9	100	High
Goodkind 2004[208]	Y	N/A	N/A	N	Y	Y	N/A	Y	N	4/6	66.7	Moderate
Goodkind 2014[111]	Y	N/A	N/A	N	Y	Y	N/A	Y	Y	5/6	83.3	High
Gormez 2017[129]	Y	N/A	N/A	N	Y	Y	N/A	Y	Y	5/6	83.3	High
Griggs 2022[177]	Y	N/A	N/A	N	Y	U	N/A	Y	Y	4/6	66.7	Moderate
Gurung 2020[130]	Y	Y	Y	Y	Y	Y	Y	Y	Y	9/9	100	High
Han 2012[131]	Y	N/A	N/A	N	Y	Y	Y	Y	Y	6/7	85.7	High
Husby 2020[163]	Y	N/A	N/A	N	Y	Y	N/A	Y	Y	5/6	83.3	High

continued

TABLE 11 Critical appraisal quasi-experimental studies (*continued*)

Study	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Total	%	Study quality
Im 2018[132]	Y	N/A	N/A	N	Y	Y	N/A	Y	Y	5/6	83.3	High
Im 2020[116]	Y	N/A	N/A	N	N/A	U	N/A	Y	Y	3/5	60.0	Moderate
Jirovsky 2018[202]	Y	N/A	N/A	N	Y	N	N/A	U	N	2/6	33.3	Low
Kruse 2009[133]	Y	Y	Y	Y	Y	Y	Y	Y	Y	9/9	100	High
Lee 2013[134]	Y	Y	Y	Y	Y	Y	Y	Y	Y	9/9	100	High
Lee 2018[135]	Y	N/A	N/A	N	Y	Y	N/A	Y	Y	5/6	83.3	High
Maduma 2018[178]	Y	N/A	N/A	N	Y	Y	N/A	U	N	3/6	50.0	Moderate
McDonald 2012[179]	Y	U	Y	Y	Y	N	Y	U	U	5/9	55.6	Moderate
Mitschke 2013[136]	Y	U	Y	Y	Y	N	Y	Y	Y	7/9	77.8	High
Ornelas 2018[137]	Y	N/A	N/A	N	Y	Y	N/A	Y	Y	5/6	83.3	High
Pantziaras 2015a[207]	Y	N/A	N/A	N	Y	Y	N/A	Y	Y	5/6	83.3	High
Poudel-Tandukar 2021a[140]	Y	N/A	N/A	N	Y	Y	N/A	Y	Y	5/6	83.3	High
Poudel-Tandukar 2021b[139]	Y	N/A	N/A	N	Y	Y	N/A	Y	Y	5/6	83.3	High
Procter 2021[180]	Y	N/A	N/A	N	Y	U	N/A	Y	Y	4/6	66.7	Moderate
Sahyoun 2019[118]	Y	N/A	N/A	N	Y	Y	N/A	Y	Y	5/6	83.3	High
Sheikh 2009[203]	Y	U	U	Y	Y	U	U	U	N	3/9	33.3	Low
Slewa-Younan 2020a[141]	Y	N/A	N/A	N	Y	Y	N/A	Y	Y	5/6	83.3	High
Slewa-Younan 2020b[181]	Y	N/A	N/A	N	Y	N	N/A	Y	Y	4/6	66.7	Moderate
Subedi 2015[182]	Y	N/A	N/A	N	Y	N	N/A	Y	Y	4/6	66.7	Moderate
Timlin 2020[183]	Y	N/A	N/A	N	Y	N	N/A	Y	N	3/6	50.0	Moderate
Trilesnik 2019[184]	Y	N/A	N/A	N	Y	N	N/A	Y	Y	4/6	66.7	Moderate
Tol 2018[119]	Y	N/A	N/A	N	Y	N	N/A	Y	Y	4/6	66.7	Moderate
Uribe Guajardo 2018[185]	Y	N/A	N/A	N	Y	N	N/A	Y	Y	4/6	66.7	Moderate
Van Es 2021[161]	Y	N/A	N/A	N	Y	N	N/A	Y	Y	4/6	66.7	Moderate
van Heemstra 2019[142]	Y	N/A	N/A	N	Y	Y	Y	Y	Y	6/7	85.7	High
Walker 2015[120]	Y	N/A	N/A	N	U	U	N/A	N	N	1/6	16.7	Low
Weine 2003[143]	Y	N	Y	Y	Y	N	Y	Y	Y	7/9	77.8	High

TABLE 11 Critical appraisal quasi-experimental studies (*continued*)

Study	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Total	%	Study quality
Wenner 2020[144]	Y	N	Y	Y	N	Y	Y	Y	Y	7/9	77.8	High
Yelland 2020[145]	Y	N	Y	Y	Y	U	Y	Y	Y	7/9	77.8	High
Yun 2016[121]	Y	N/A	N/A	N	Y	N	N/A	U	N	2/6	33.3	Low

TABLE 12 Critical appraisal cross-sectional studies

Study	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Total	%	Study quality
Bayne 2019[122]	Y	N	U	Y	N	N	Y	Y	4/8	50	Moderate
Eytan 2002[146]	Y	Y	Y	Y	Y	N	U	Y	6/8	75	High
Harkensee 2021[95]	Y	Y	U	Y	N/A	N/A	U	Y	4/6	66.7	Moderate
Heenan 2019[164]	Y	Y	Y	Y	N/A	N/A	Y	Y	6/6	100	High
Lambert 2018[186]	Y	N	Y	Y	N	N	Y	Y	5/8	62.5	Moderate
McBride 2017[157]	Y	Y	U	Y	N/A	N/A	U	Y	4/6	66.7	Moderate
Miner 2017[165]	Y	Y	Y	Y	N/A	N/A	Y	Y	6/6	100	High
Nazzal 2014[204]	N	N	U	U	N/A	N/A	U	N	0/6	0	Low
Rosenberg 2022[159]	Y	Y	U	U	N/A	N/A	U	Y	3/6	50	Moderate
Woodland 2016[175]	Y	Y	N	N	N	N	N	Y	3/8	37.5	Low
	9/10	7/10	4/10	7/10	1/4	0/4	4/10	9/10			
	90	70	40	70	25	0	40	90			

TABLE 13 Critical appraisal diagnostic accuracy comparative studies

Study	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Total	%	Study quality
Blackmore 2022[166]	U	Y	Y	N	N	Y	Y	Y	Y	Y	Y			
Eytan 2007[187]	U	Y	Y	N	N	Y	N	Y	Y	Y	Y		63.6	Moderate
Hocking 2018[147]	U	Y	Y	N	N	Y	Y	Y	Y	Y	Y		72.7	High
	0	100	100	0	0	100	66.7	100	100	100	100			

Critical Appraisal Diagnostic Accuracy Comparative Studies Tool Composite tool based on processes outlined by Chasse and Ferguson[97]

1. Were the participants willing to consent and be enrolled different from those who declined?
2. Did the comparative diagnostic study have consecutive inclusion of participants?
3. Were there clear criteria for inclusion in the study?
4. Were tests conducted in the same way for all participants?
5. Did the study have complete inclusion of participants?
6. Were assessors of the comparative test blinded to results of the validating tool?
7. Was the comparative reference measure a validated/ 'gold standard' reference measure for this diagnosis?
8. Was there clear reporting of the demographics of the participants in the study?
9. Was there clear reporting of clinical information of the participants?
10. Was appropriate statistical analysis used?
11. Did statistical analysis assess the differential ability of the tool to correctly identify diagnosis in a heterogeneous population?

MORRA tool

1. **Does the study provide evidence around how effective the intervention was in improving access or engagement?**

Do measures align in some way with our definition of access to care.

2. **Are the procedures/methods used appropriate to answer this question?**

With a focus on the full methodology and its reporting were appropriate methods used to obtain measures of access and were these clearly described.

3. **How is this evidence analysed and presented? Are results reported clearly, do they provide data? Is this adequate to draw conclusions around access to care?**

Though this addresses issues of credibility and quality appraisal as discussed elsewhere we wanted to ensure that we were also attentive at this stage to the reliability of the presented data, and the appropriate reporting and analysis of data to support the conclusions drawn by study authors.

4. **Have the study procedures adequately considered the barriers to engaging in cross-cultural research with forced-migrant populations?**

Have studies discussed cultural competence in the research process. Have researchers taken any steps to enhance trust and rapport between researchers and participants, and reduce the risk of power imbalance, for example, through the use of bilingual or bi-cultural study teams. Do authors make reference to appropriate translation of study materials such as forward- and back translation and consider literacy levels, comprehension and familiarity with research processes and materials. Have measurement instruments or study materials been validated for, or by, participants cultural community?

5. **Does the study provide adequate details on how interventions or protocols were adapted to improve access or engagement?**

Have authors provided detail on how an intervention or practice has been adapted or is appropriate for the study population?

6. **Is the study population appropriate to be saying something about the acceptability or effectiveness of the intervention on access to care?**

Is there a clear measure of access associated with the primary study population (forced migrants, '2'). If studies do not provide an outcome measure of access associated with the primary population can measures still tell us something about access to care, such as, *the knowledge in refugee health care amongst a provider group*, or *attitudes from a provider group towards refugee patients*. We would consider these as providing the potential for access only and score as '0'.

MORRA tool scores

TABLE 14 MORRA tool assessment scores

No.	Ref. ID	MORRA 1a	MORRA 1c	MORRA 1d	MORRA 2a	MORRA 2b	MORRA 3a	Total	Score weighted out of 12	Study quality
1	Acarturk 2022[150]	2	2	2	2	2	2	12	12	High
2	Ahmad 2012[100]	2	2	2	2	2	2	12	12	High
3	Aizik-Reebs 2021[188]	2	2	2	2	2	2	12	12	High
4	Akhtar 2021[151]	2	2	2	0	0	2	8	8	Moderate
5	Alrashdi 2021a[167]	2	1	2	2	2	2	11	11	High
6	Baarnhielm 2014[104]	2	2	2	N/A	2	0	8	9.6	Moderate
7	Baird 2017[105]	2	1	0	2	2	2	9	9	Moderate
8	Ballard 2018[106]	2	1	1	2	2	2	10	10	High
9	Bayne 2019[122]	2	0	1	N/A	0	0	3	3.6	Low
10	Bernhardt 2019[173]	2	2	2	N/A	2	0	8	9.6	Moderate
11	Betancourt 2020[168]	2	1	2	2	1	2	10	10	High
12	Birman 2008[205]	1	N/A	N/A	2	2	2	7	10.5	High
13	Blackmore 2022[166]	2	1	2	2	0	2	9	9	Moderate
14	Brakemeier 2017[176]	2	2	1	1	2	2	10	10	High
15	Burchert 2018[152]	2	2	2	2	2	2	12	12	High
16	Chaudhary 2019[201]	1	N/A	N/A	N/A	1	0	2	4	Low
17	Chiumento 2011[199]	1	N/A	N/A	N/A	0	0	1	2	Low
18	Dababnah 2019[107]	2	2	2	2	2	2	12	12	High
19	Delilovic 2018[153]	2	2	2	N/A	0	0	6	7.2	Moderate
20	Ekblad 2013[108]	2	1	2	N/A	N/A	0	5	7.5	Moderate
21	El-Khani 2018[124]	2	2	2	2	2	2	12	12	High
22	El-Khani 2021[154]	2	2	2	2	2	2	12	12	High
23	ElHarake 2018[123]	2	2	2	1	2	2	11	11	High
24	Ellis 2013[125]	1	N/A	N/A	2	2	2	7	10.5	High
25	Erenofülu 2020[169]	2	2	2	2	2	2	12	12	High
26	Elswick 2022[191]	2	2	2	2	2	2	12	12	High

TABLE 14 MORRA tool assessment scores (*continued*)

No.	Ref. ID	MORRA 1a	MORRA 1c	MORRA 1d	MORRA 2a	MORRA 2b	MORRA 3a	Total	Score weighted out of 12	Study quality
27	Eskici 2023[189]	2	2	2	2	2	2	12	12	High
28	Eytan 2002[146]	2	2	2	N/A	2	2	10	12	High
29	Eytan 2007[187]	2	2	2	2	2	2	12	12	High
30	Fazel 2009[126]	2	0	0	1	2	2	7	7	Moderate
31	Fazel 2016[109]	2	2	1	0	0	2	7	7	Moderate
32	Foka 2021[110]	2	2	2	2	2	2	12	12	High
33	Goodkind 2004[155]	2	2	2	2	2	2	12	12	High
34	Goodkind 2014[111]	2	2	2	2	2	2	12	12	High
35	Goodkind 2020[192]	2	2	1	2	2	2	11	11	High
36	Griggs 2022[177]	2	2	2	2	1	2	11	11	High
37	Griswold 2007[112]	2	2	2	N/A	2	0	8	9.6	Moderate
38	Guerin 2003[113]	2	2	2	2	2	2	12	12	High
39	Gurung 2020[130]	2	1	2	2	2	0	9	9	Moderate
40	Han 2012[131]	0	N/A	N/A	2	2	2	6	9	Moderate
41	Harkensee 2021[95]	2	2	1	1	2	2	10	10	High
42	Heenan 2019[164]	2	2	2	0	0	2	8	8	Moderate
43	Hess 2014[114]	2	2	2	2	2	2	12	12	High
44	Hocking 2018[147]	2	2	2	0	1	2	9	9	Moderate
45	Husby 2020[163]	2	2	2	0	0	2	8	8	Moderate
46	Im 2016[115]	2	1	2	2	2	2	11	11	High
47	Im 2018[132]	2	1	2	2	2	2	11	11	High
48	Im 2020[116]	2	0	2	N/A	2	0	6	7.2	Moderate
49	Im 2022[156]	2	2	2	N/A	2	0	8	9.6	Moderate
50	Jahn 2018[117]	2	1	0	N/A	2	0	5	6	Moderate
51	Jirovsky 2018[202]	2	2	0	N/A	2	0	8	9.6	Moderate
52	Koch 2020[102]	2	2	2	2	2	2	12	12	High

continued

TABLE 14 MORRA tool assessment scores (*continued*)

No.	Ref. ID	MORRA 1a	MORRA 1c	MORRA 1d	MORRA 2a	MORRA 2b	MORRA 3a	Total	Score weighted out of 12	Study quality
53	Lambert 2018[186]	2	1	2	2	2	2	11	11	High
54	Lee 2013[134]	2	2	2	0	0	2	8	8	Moderate
55	Lee 2018[135]	2	2	2	0	2	2	10	10	High
56	Lepiece 2018[193]	2	1	0	N/A	1	0	4	4.8	Low
57	Maduma 2018[178]	2	1	0	2	2	2	9	9	Moderate
58	Malebranche 2019[206]	2	2	2	N/A	2	2	10	12	High
59	McBride 2017[157]	2	2	2	2	2	2	12	12	High
60	McDonald 2012[179]	2	1	0	2	2	2	9	9	Moderate
61	McDonald 2021[158]	2	2	2	N/A	0	0	6	7.2	Moderate
62	Miner 2017[165]	2	2	2	0	0	2	8	8	Moderate
63	Nazzal 2014[204]	2	2	0	1	1	2	8	8	Moderate
64	Nickerson 2020[170]	2	2	2	2	2	2	12	12	High
65	Ornelas 2018[137]	2	2	2	2	2	2	12	12	High
66	Ozaydin 2021[103]	2	2	2	N/A	1	0	7	8.4	Moderate
67	Pantziaras 2015a[207]	2	2	2	N/A	0	0	6	7.2	Moderate
68	Potocky 2019[194]	2	2	0	N/A	2	0	6	7.2	Moderate
69	Procter 2021[180]	2	2	2	N/A	2	0	8	9.6	Moderate
70	Royer 2016[195]	2	1	1	1	0	1	6	6	Moderate
71	Rosenberg 2022[159]	2	2	2	2	0	2	10	10	High
72	Russell 2020[196]	2	1	0	N/A	0	0	3	3.6	Low
73	Ryan 1987[200]	2	1	0	N/A	2	0	5	6	Moderate
74	Sahyoun 2019[118]	2	2	2	2	2	2	12	12	High
75	Saito 2021a[197]	2	2	1	N/A	2	0	7	8.4	Moderate
76	Sheikh 2009[203]	2	2	0	2	2	2	10	10	High
77	Slewa-Younan 2020a[141]	2	2	2	2	2	0	10	10	High
78	Slewa-Younan 2020b[181]	2	2	2	2	2	2	12	12	High

TABLE 14 MORRA tool assessment scores (*continued*)

No.	Ref. ID	MORRA 1a	MORRA 1c	MORRA 1d	MORRA 2a	MORRA 2b	MORRA 3a	Total	Score weighted out of 12	Study quality
79	Subedi 2015[182]	2	1	2	2	0	0	7	7	Moderate
80	Timlin 2020[183]	2	2	0	2	2	0	8	8	Moderate
81	Tol 2018[119]	2	2	2	2	2	2	12	12	High
82	Uitterhaegen 2005[160]	2	0	0	0	0	2	4	4	Low
83	Uribe Guajardo 2018[185]	2	0	2	N/A	2	0	6	7.2	Moderate
84	Van Es 2021[161]	2	2	2	2	2	2	12	12	High
85	van Heemstra 2019[142]	2	0	2	2	2	2	10	10	High
86	Walker 2015[120]	2	0	2	2	2	2	10	10	Moderate
87	Weine 2003[143]	2	2	1	2	2	1	10	10	Moderate
88	Weine 2008[172]	2	2	2	2	2	2	12	12	High
89	Wenner 2020[144]	2	2	2	N/A	1	2	9	10.8	High
90	Woodland 2016[175]	2	2	1	1	2	2	10	10	High
91	Yelland 2020[145]	2	2	2	N/A	2	2	10	12	High
92	Yun 2016[121]	2	1	1	2	2	2	10	10	High
93	Zehetmair 2021[162]	2	2	0	0	0	2	8	8	Moderate

Appendix 5 Studies awaiting classification

TABLE 15 Studies awaiting classification

No.	Authors	Year	Title	Journal or trial registration number
1	Betancourt[259]	2015 completed 2019	Addressing Mental Health Disparities in Refugee Children: a Community-based Participatory Research (CBPR) Collaboration	clinicaltrials.gov/show/NCT02562794
2	Stichting VU[260]	2017 completed 2022	STRENGTHS: fostering responsive mental health systems in the Syrian refugee crisis	trialsearch.who.int/Trial2.aspx?TrialID = NTR6842

Appendix 6 Ongoing studies

TABLE 16 Ongoing studies

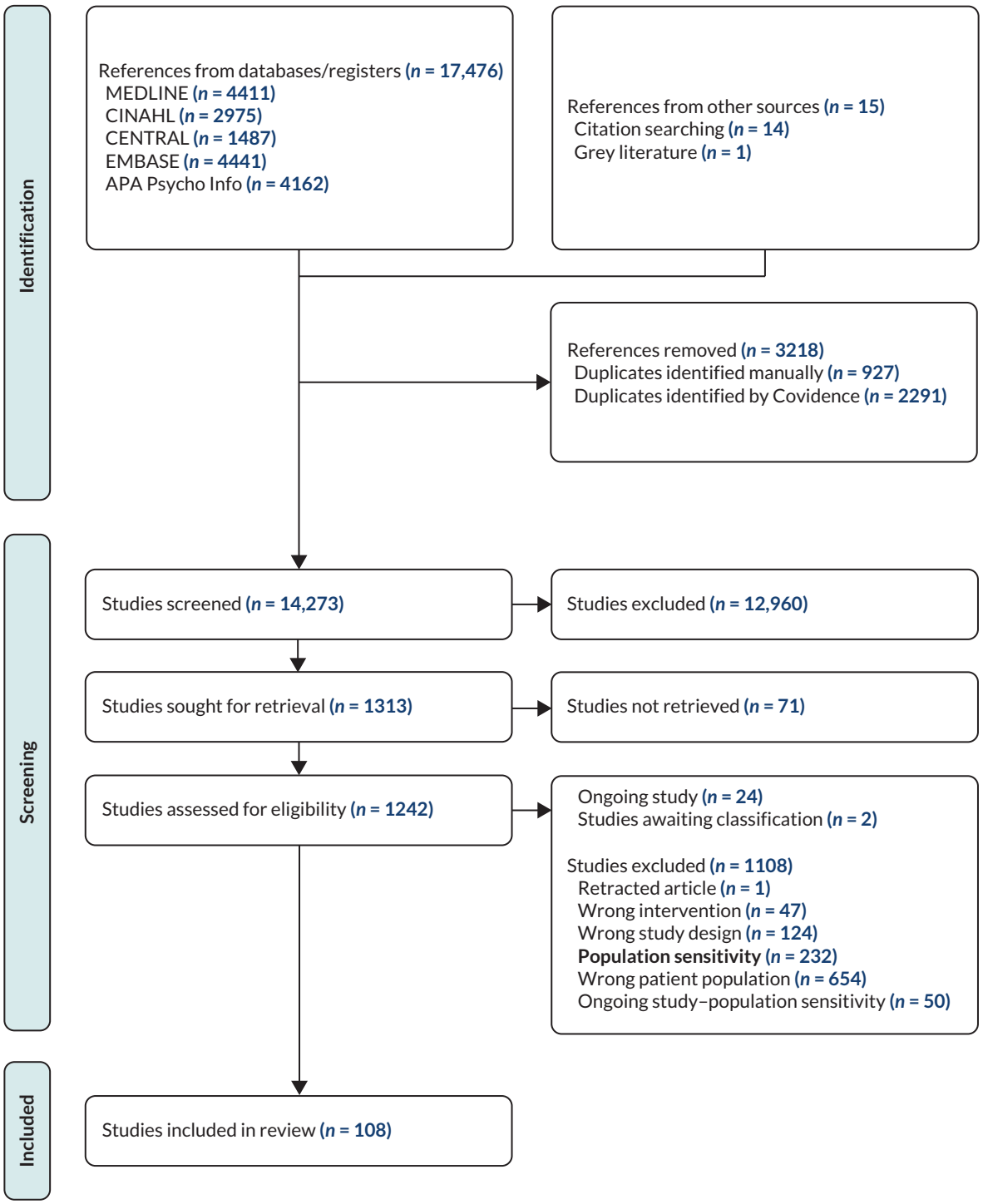
No.	Authors	Year	Title	Journal or trial registration number
1	Golchert[261]	2019	HELP@APP: development and evaluation of a self-help app for traumatized Syrian refugees in Germany – a study protocol of a randomized controlled trial	*BMC Psychiatry*
	Jung[262]	2019	HELP@APP: study design for the development and evaluation of a self-help app for traumatized Syrian refugees in Germany	*Das Gesundheitswesen*
2	Furaijat[263]	2019	Implementing a digital communication assistance tool to collect the medical history of refugee patients: DICTUM Friedland – an action-oriented mixed methods study protocol	*BMC Health Services Research*
3	Fischer[264]	2021	Development and Evaluation of a Digital Health Intervention for Substance Use Reduction in Young Refugees With Problematic Use of Alcohol and/or Cannabis-Study Protocol for a Single-armed Feasibility Trial	*Frontiers in Public Health*
4	Durbeej[265]	2021	Evaluation of a school-based intervention to promote mental health of refugee youth in Sweden (The Refugees Well School Trial): study protocol for a cluster randomized controlled trial	Trials [Electronic Resource]
5	Sarkadi[266]	2020	Evaluation of the Teaching Recovery Techniques community-based intervention for unaccompanied refugee youth experiencing post-traumatic stress symptoms (Swedish Unaccompanied youth Refugee Trial; Support): study protocol for a randomised controlled trial	Trials [Electronic Resource]
6	Nielsen[267]	2021	Community With Immigrants – a Step on the Road to Employment	https://clinicaltrials.gov/show/NCT04725487
7	de Graaff[268]	2019	Effectiveness of a peer-refugee delivered psychological intervention to reduce psychological distress among adult Syrian refugees in the Netherlands: study protocol	*Eur J Psychotraumatol*
8	Wenner[269]	2019	Inequalities in realised access to healthcare among recently arrived refugees depending on local access model: study protocol for a quasi-experimental study	*BMJ Open*
9	Ullmann[270]	2018	Preventive treatment in stress-related disorders: Countering post-traumatic LHPA activation in refugee mothers and their infants	*Molecular Psychiatry*
10	Goodman[271]	2019	When I became a refugee, this became my refuge: A proposal for implementing a two-generation intervention using yoga and narrative to promote mental health in Syrian refugee caregivers and school readiness in their preschool children	*Journal of Infant, Child and Adolescent Psychotherapy*
11	Alozkan Sever[272]	2021	Feasibility and acceptability of Problem Management Plus with Emotional Processing (PM + EP) for refugee youth living in the Netherlands: study protocol	*European Journal of Psychotraumatology*
12	RASASA[273]	2019	Implementing Psychosocial Interventions to Syrian Refugee Women Who Are Exposed to Psychological Trauma	https://clinicaltrials.gov/show/NCT03912077
13	Boston College[274]	2019	Addressing Mental Health Disparities in Refugee Children	https://clinicaltrials.gov/show/NCT03796065
14	COSTAR Study[275]	2019	Community-based Socio-therapy Adapted for Refugees: the COSTAR study	www.isrctn.com/ISRCTN20474555

continued

TABLE 16 Ongoing studies (*continued*)

No.	Authors	Year	Title	Journal or trial registration number
15	ISRCTN10892553[276]	20192019	Delivering a contextualized package of care for child development (0–12 months) and maternal mental health in the camps for forcibly displaced Myanmar nationals in Bangladesh	www.isrctn.com/ISRCTN10892553
16	Weise[277]	2021	Efficacy of a Low-threshold, Cultural Sensitive Group Psychoeducation in Asylum Seekers (LoPe): a multicentre randomized controlled trial	*BMJ Open*
17	Kananian[278]	2022	Culturally Adapted Cognitive Behavioural Group Therapy for Mental Disorders in Refugees plus Problem Management Training (CA-CBT+): a randomized controlled trial (ReTreat)	*BMJ Open*
18	Boge[279]	2019	Mental health in refugees and asylum seekers (MEHIRA): study design and methodology of a prospective multicentre randomized controlled trail investigating the effects of a stepped and collaborative care model	*European Archives of Psychiatry and Clinical Neuroscience*
19	Akhtar[212]	2020	Testing Group Psychological Help for Adult Syrian Refugees in Jordan	*Public Health*
20	HERA Inc.[280]	2021	A Mobile Health Intervention to Increase Uptake of Prenatal Care in Syrian Refugee Population in Turkey	https://classic.clinicaltrials.gov/ct2/show/NCT05094518
21	Logie C[281]	2022	Mental Health Literacy and Mental Health Promotion With Urban Refugee Youth in Kampala	https://clinicaltrials.gov/show/NCT05187689
22	Kaptan[282]	2021	Protocol of a feasibility trial for an online group parenting intervention with an integrated mental health component for parent refugees and asylum seekers in the United Kingdom: (LTP + EMDR G-TEP)	*SAGE Open Medicine*
23	Husain N[283]	2021	Culturally Adapted CMAP Plus LTP for Refugee Mothers with History of Self-harm in Pakistan	https://clinicaltrials.gov/show/NCT05171192
24	Schafer[284]	2021	A Randomized Controlled Trial of STARC (Skill Training in Affect Regulation – a Culture-sensitive approach) in refugees with substance use problems	https://trialsearch.who.int/Trial2.aspx?TrialID=DRKS00017668

Appendix 7 PRISMA flow chart



Appendix 8 Review findings

Other outcomes measured by studies

TABLE 17 Other reported outcomes

Other reported outcomes	Frequency
Anxiety or depression	29[101,104–106,110,119,124,125,127,129,136,139,140,149,151,161,165,166,168,171,172,176,177,184,187–190,198]
PTSD and trauma	24[101,102,106,124,125,128,129,131–133,136,149,151,161,168,171,172,177,187,188,190,191,198,205]
Other psychosocial and mental health measures	25[101,102,106,111,112,118,119,121,124,126,129,133,142,149,151,154,166,168,171,176,177,190,198,205,208]
Health-related quality of life	8[101,163,165,176,184,188,208,209]
Behavioural measures (i.e. parenting, alcohol use, English proficiency)	12[106,119,129,148,149,151,154,159,179,190,192,209]
Physical health (clinical assessments)	9[95,113,106,121,123,134,165,186,209]

Summaries of main themes of impact

Theme	Studies underpinning themes
Using and creating community	Acceptability: culturally adapted gPM + was well attended, most completed treatment and described a good and beneficial experience. Participants cited positive views of the format of sessions as group sessions, describing benefits as opportunities to share problems and concerns with each other and meeting new people. Two (of 24) participants spoke about the challenges of the group format, citing that listening to others' problems induced stress (Acarturk)[150] Caregivers indicated they were initially wary of the program but following the first group caregiver session were much more willing for their child to attend though some had expressed they expected the intervention would be related to their child's education and were upset to discover otherwise. Children and caregivers indicated they would have preferred additional sessions (Akhtar)[151] Most participants attended more than half of the nine sessions; slightly higher rate for women versus men (Aizik-Reeb)s[188] Children indicated they enjoyed group sessions and learned new skills (Akhtar)[151] Children enjoyed the group intervention which motivated caregivers to continue participating; provided needed engaging activities and stimulation, and an opportunity to connect with others (El Khani)[154] Additional intervention benefits were seen in increasing opportunities to connect with and integrate within the Afghan refugee community and gaining tools to integrate into the American community (Rosenberg)[159] Very high overall satisfaction and knowledge gain deemed useful to everyday/family life, regarding mental health, and equipping for life in Denmark. Participants felt more able to talk about and understand stress and the group format was seen as helping to develop new acquaintances, good friendships, and reduce loneliness. One participant found it hard to participate in group activities (Husby)[163] Participants appreciated that the problems addressed in the groups reflected their personal problems, that the situation in which they were living was acknowledged and benefited from recognising that other group members experienced similar problems. The shared background of the trainer, the coach and other group members created a positive social experience and gave a sense of support. Many found that simply talking about problems with fellow refugees relieved some of their stress (Uitterhaegen)[160] Good and increased attendance over time may have resulted from women sharing their positive experiences with others in their community (Baird)[105] The refugee family health partnership project saw a very high retention of refugee/asylee participants (Bernhardt)[173] High levels of retention and engagement from children and caregivers in group approach to normalising responses to trauma (El-Khani)[124]

Theme	Studies underpinning themes
	Sharing of culture and traditions was seen to be enjoyable by parents and children, offer parental empowerment and maintain respectful habits. Sharing ethnic foods was reported to be comforting and central to the success of the programme. The eight week programme supported the gradual introduction of non-traditional values and activities (McDonald)[179] High engagement in group and one-to-one sessions as part of a holistic refugee well-being project. Newly arrived refugees are prepared to engage in welcoming, safe spaces in which they are able to share their culture and become accustomed to a new culture. Slightly higher engagement from households than individuals suggests this might be a good approach for more flexible engagement (Goodkind)[192]
	Health promotion intervention that included peer support and provision of mobile phones with predetermined free-call numbers was seen to enhance interpersonal, community and local connectedness. Phones were found to be used more frequently for intra-community calls. Participants sought help from family, friends and community members to help with communication with agencies and professionals, including doctors and dentists, 'I don't ask my friends to come and help me at home. But sometimes if I need to make appointment, or I need to go to hospital, I call … to help me out with that. Because she can speak English' (Walker)[120] Good attendance at group stabilisation sessions (Griggs)[177]
	Holistic community-based individual and group programme focused on cultural exchange and advocacy to promote well-being and reduce psychological distress was had very high satisfaction, full completion and good attendance from primary participants (Goodkind)[111] Health agency: community-based peer-delivered initiative aimed at assisting families and promoting mental health in a Kosovar refugee community resettled in the US resulted in improved use of statutory services (Weine)[143]
	Knowledge gain related to English and citizenship knowledge, resources they had been able to access, and understanding of the ways in which society is structured. Participants' satisfaction with resources (including health) increased significantly throughout the intervention but though it remained high at follow-up (3 months), decreased at the end of the intervention. Participants benefited from teaching undergraduates about their culture, values, and ways of life, and experienced improved social support, formed more critical understandings about American and Hmong cultures and how to decide what aspects of each to preserve or adopt, developed strong relationships with the undergraduates with whom they worked, and gained self-efficacy and confidence in their abilities to accomplish their goals (Goodkind)[208]
	Refugee children and adults from the same family studied with the same student every time, fostering the development of comfort and trust and opened up broader relationships with Americans, raised consciousness about inequities they had formerly taken for granted, broadened empathy, notions of community, and feelings of a common humanity (Hess)[114] Small group sessions with women of shared heritage helped build trust within community; Enable women to feel that they can 'fight for our own', and see the benefit of community awareness and strengthening their relationships in improving mental health and well-being within their community. Women described the intervention as something they could continue themselves, 'to [help] our people' (Baird)[105]
	A refugee well-being project taking a strengths-based holistic approach, with high focus on cross-cultural learning, building relationships with new and shared communities was effective in improving acculturation to host culture and increasing/ retaining acculturation with home culture (Goodkind)[192]
	Participants described gaining the health knowledge to help other community members, drawing on group/community support to refine the skills needed for a healthy lifestyle, relieving isolation through group participation, and helping each other for healthy communities, 'If we become healthy, then we can help our families become healthy, then our communities become healthy, and then the society becomes healthy'. The community health workshop was able to bring community members together by increasing access to potential resources and information, while motivating people to rebuild and strengthen the Bhutanese community. As the sense of community developed, self-help emerged among the participants and the importance of mutual help and community participation became highlighted and the comfort level of seeking help and open discussion about problems increased. Connections outside of the refugee community were described that included expanding English classes for elders, addressing transportation issues to explore other neighbourhoods, and gaining more information on available services and resources outside the Bhutanese community (Im)[115]
	The intervention resulted in significant reduction in family-related acculturation stress and improving intergenerational communication (Han)[131] Strong focus on reducing stigma and social isolation including through efforts to improve community knowledge of psychoeducation and ASD. Participants reported high self-confidence in the community and reduced isolation though some participants felt the program could have an even greater role in increasing local community awareness (Dababnah)[107] Refugee participants described a sense of 'satisfaction' and 'taking on the role of teacher' in the shared learning and sharing of cultures between themselves and students. Some participants emerged as refugee leaders developing their own organisations to directly address health and well-being (Hess)[114]

continued

Theme	Studies underpinning themes
	Peer-led, adapted psychoeducation for Somali Refugee Youth, delivered in a community setting, with facilitated attendance, by trained peers and professional counsellors with a shared heritage, resulted in improvement in perceived sense of community and social support (Im)[132] Many found the psychoeducation sessions helpful in solving problems, making friendships with peers and social connections (Fazel)[109] The interactive, group-based approach to the well-being and resilience programme was seen as some of the best parts of the intervention, children describing making social connections and activities such as being together, 'to talk together, to speak together about our stories, to share our stories and experiences, and, to be happy together' (Foka)[110]
	Strong bonds and relationships were identified between refugee adults and students and these were seen as motivating action. Advocacy included access to health care in almost all relationships leading to knowledge and confidence to access resources independently (Goodkind)[111] All refugee participants discussed the importance of the intervention in helping to reduce feelings of difference and being outsiders and indicated an increase in social support and social networks with other refugees and Americans outside of the intervention (Goodkind)[111] Comparing group with individual contraceptive counselling for resettled African refugee women saw no difference in women's satisfaction between the two groups but significantly higher improvement in contraceptive knowledge among group arm (Royer)[195]
	Tailored and culturally adapted community-based activity classes seen as an important way to enable safe exposure to non-Somali women (Guerin)[113] The exchange of cultural knowledge saw refugee participants recognise their own knowledge and contributions, helping them to feel empowered, see beyond racism, and recognise the ways in which education and improved access to resources can help to address health and social disparities. Refugee participants described a sense of 'satisfaction' and 'taking on the role of teacher' between themselves and the students (Hess)[114] Affordability: participants referred to the free-call phones as an important means of gaining assistance in high-risk situations: 'this phone is very important, I think [for] emergencies – emergency contact, doctor, Centrelink [welfare agency], school teacher' (Walker)[120]
Networks of care	
'Non-specialists'	Availability: provision of psychiatric assessment by non-specialist nurses increasing timely access and availability of care (Eytan)[187] Integration workers were able to use mental health/trauma screening tool and support referral into the programme – limited data to support (Brakemeier)[176] Volunteers were able to administer the brief mental health screening tool (usually within a short 6-minute administration time) irrespective of whether an interpreter was used (Hocking)[147]
	Availability (proxy): facilitators (reception centre workers) reported that involvement in sessions and spending more time with children allowed them to identify children requiring additional support, such as signs of stress (El Khani)[154] Acceptability (proxy): intercultural mediators found the approach useful and felt their work was an important addition to the approach and pointed out the benefits of taking time to build trust, understanding the patient's context and spending time with minors, 'My experience is that when more time is invested in the beginning, the outcomes are better'. Some suggested their work could be improved through more training focused on their role in the treatment approach, better communication with the therapist (Van Es)[161]
	Doctors, healthcare workers including midwives, infection control specialists, nutritionists, public health specialists and some migration officers and health managers, mostly female, participated in the course focused on comprehensive range of knowledge and skills in relation to primary care for refugees and broader refugee experiences. A majority expressed a will to promote the online course among their peers (Jirovsky)[202] Participants appreciated the parts of the course where former patients had talked about their own experiences of mental illness. They also appreciated case discussions and practical examples of good care. A woman working in social services said: 'it is always a good thing to hear how others handle or have handled these things, these aspects. I also think it is valuable to bring up and discuss successful examples, although the context may differ' (Baarnhielm)[104]
	The intervention resulted in short-term improvement in refugee resettlement workers' empathetic responses to common refugee scenarios. Participants reported that the training was useful and relevant, and that they applied the skills in their practice. Facilitating factors included discussing the techniques with others (Potocky)[194] Mental health literacy training for community-based resettlement workers led to a significant improvement in recognition of PTSD and depression, increased knowledge of mental health problems and evidence-based interventions, improved intention to help and decreased negative attitudes. Of note was the significant improvement in participant's confidence in helping an Iraqi refugee. Not all improvements were maintained at 6-month follow-up (Uribe Guajardo)[185]
	A suicide prevention education for staff, volunteers, and students from a range of NGOs resulted in significant improvement in attitude to suicide and improved competency and skills and confidence in management of suicide. Almost all felt the training was relevant to their role, believed it will make a positive contribution to their professional practice, and that the training held their interest. The opportunity to participate in role plays or observe others, learning intervention approaches such as safety planning, and learning about key concepts in suicide were described as particularly helpful (Proctor)[180]

Theme	Studies underpinning themes
Schools	Acceptability: group approach to normalising responses to trauma, delivered in school setting by teachers trained to become program facilitators resulted in high levels of retention and engagement from children and caregivers (El-Khani)[124] Participation in the school-based Health and Learning partnership programme was high, all participants were screened and linked to GP and specialists for care as needed. Parents felt supported and informed about available health services (Woodland)[175] Many students found the support of a referring teacher valuable and the sessions helpful in solving problems, making friendships with peers, and improving concentration on studies. Many doubted the need to delve into their past experiences (Fazel)[109] All respondents indicated that the trauma healing club was very helpful, peers and teachers were very supportive, and they would recommend the intervention to others. Being with friends and gaining new friends was seen as particularly important (Elswick)[191] Attendance rates for tiered mental health services were seen as high because meetings were school based and occurred during normal school hours with all students present participating. All students referred for higher levels of care successfully agree to and engaged in treatment. Families of students referred for Tiers 3 and above consented to treatment and engaged in high number of sessions (Ellis)[125] Acceptability (proxy): teachers (with shared mother tongue) trained and used as facilitators to deliver the child mental health recovery programme reported a 'very positive' impact on daily interactions with children as a result of the skills learned during training (El-Khani)[124] Most teachers completed the programme and attended most sessions. Teachers felt the programme was appropriate for the needs of children with ASD, had gained knowledge and skills in reinforcing positive behaviour which they felt could be beneficially applied to all children, and resulted in decreased stress and high self-confidence. All said they would recommend the programme to others. Many teachers requested more information and follow-up support (Dababnah)[107] Schools welcomed support with the challenges and experiences faced by refugee children enabling schools to provide more tailored support to refugee children, including addressing impacts of the refugee experience on children's mental health – not supported by data (Chiumento)[199] Weekly consultations between mental health key workers and link teachers were seen as positive and enhancing teachers' understanding of how emotional and behavioural problems manifest and can be managed in this group. Teachers reported relief in having 'the weight and responsibility of counselling' taken from them, felt it was positive to be 'able to offer families non-threatening support within school'. They did not like the fact that 'so few children can be seen' by the service (Fazel)[126] Health and learning partnership programme increased capacity of local networks to meet needs of refugee young people, saw health partners benefiting from increased knowledge base of needs of refugee students and appropriate ways of responding and teachers and teachers' aides better recognising and supporting the student's individual learning needs (Woodland)[175] Adequacy (proxy): supervision via Skype for teachers delivering a mental health recovery programme was feasible (El-Khani)[124] 16 intersectoral programme partners were identified as part of the health and learning partnership programme with high levels of collaboration reported. Benefits including rapid response to health system barriers, improved coordination of services; increase of multisector referral pathways (Woodland)[175] Stepped-care, gateway approach to engage key community members (family, community leaders, and school personnel) in identifying and referring youths for mental health care was delivered with high fidelity to the treatment (Ellis)[125] Availability: it proved feasible for teachers to trained and used as facilitators to deliver the child mental health recovery programme (teaching recovery techniques) with support and supervision provided online via Skype (El-Khani)[124] Availability proxy: the project aimed to address the specific mental health needs of school-age refugees and asylum seekers who were not presenting to local mental health services in significant numbers. The intervention involved weekly consultation between mental health key worker and the link teacher. Teachers reported liking that the service 'takes the weight and responsibility of counselling off staff' and was able to 'offer families non-threatening support within school'. Concerns were raised in respect of low capacity and that non-refugee families were unable to access the support (Fazel)[126] Students found the school-based mental health intervention very useful, had benefited from teacher support to access the service and most said that they would refer their friends to be seen by the service if they felt that they had a problem (Fazel)[126]

continued

Theme	Studies underpinning themes
Shared communities	Health agency: repeated social modelling by peers and repeated practice was required to build confidence in appointment making (Yun)[121] Significant reduction in family-related acculturation stress through informal group-based counselling, emphasising ongoing intergenerational dialogue (Han)[131] Peer-led psychoeducation, delivered in a community setting, with facilitated attendance, by trained peers and professional counsellors with a shared heritage, resulted in improvement in perceived sense of community and social support (Im)[132]
	The programme brought community members together by increasing access to potential resources and information. Participants gained the health knowledge. People were motivated to 'rebuild and strengthen' their community. Self-help emerged and the importance of mutual help and community participation was acknowledged and comfort in seeking help and open discussion of problems increased. Connections outside of the refugee community were described that included expanding English classes for elders, addressing transportation issues to explore other neighbourhoods, and gaining more information on available services and resources outside the Bhutanese community (Im)[115] Community-based peer-delivered initiative resulted in improved service use, trauma mental health knowledge, and trauma mental health attitude (Weine)[143]
	Acceptability: participants appreciated that their living situation and problems were taken seriously and described a positive social experience with the trainer and coach (and group) who all shared a refugee background (Uitterhaegen)[160] Culturally adapted version of Group Problem Management Plus provided by non-specialist peer providers had good acceptability to participants, citing the facilitators interaction with the group, their cultural sensitivity, and their use of informal Arabic language (Acarturk)[150] Acceptability (proxy): Peer facilitators described the culturally adapted Group Problem Management Plus as feasible to implement and maintained fidelity to the intervention design. Facilitators reported some challenges in the management of reconciling different opinions from participants within the group (Acarturk)[150]
	Therapists described one of most important elements of the trauma-focused treatment model as working with an intercultural mediator with a similar background to the minor (Van Es)[161] There was no change in personal and perceived stigma following training. Participants reported that Bhutanese refugees in their communities would typically turn to other community members for help. Participants suggested that longer support from government and resettlement agencies in the adjustment process was necessary (Subedi)[182]
	Culturally tailored mental health literacy training for Arabic-speaking religious and community leaders resulted in significant improvement in recognition of mental health problems, improved attitude toward people with mental health symptoms, increased knowledge in mental health treatment and providing support to people with mental health, and a reduction in negative attitudes to those with mental illness. Specific understanding of PTSD improved but only slightly (Slewa-Younan)[141] High attendance and satisfaction from training members of a local mosque about healthcare-related topics that they could disseminate and/or deliver alongside health professional to the Syrian refugee community. Encouraged greater focus on mental health for subsequent training (Chaudhary)[201]
	Availability (proxy): refugee leaders benefited from being able to work on arrival because care was delivered in their native language, their personal experiences in understanding what is important for refugees and asylum seekers was perceived important, and they benefited on a personal level, feeling useful again and regaining self-esteem. They were also able to work with other troubled refugees and asylum seekers without becoming overburdened themselves (Uitterhaegen)[160] Following mental health first aid training refugee community leaders were more likely to encourage the use of professional help; gain substantial knowledge about mental illness; were more likely to correctly identify depression; to report feeling confident in providing help; and most were motivated to participate because of a desire to help others in their communities (Subedi)[182]
Capacity building and systems structures	Adequacy: delivering workshop with external agencies shows the potential for increasing cooperation between different important agencies (Brakemeier)[176]
	Lack of offshore-to-onshore communication and communication in the onshore service delivery system saw a breakdown in procedures limited availability of screening results and health information to post-arrival healthcare providers; few individuals receiving a summary copy of their health assessment; difficulties defining TB screening status (leading to avoidable duplication of tests, some cases of serious medical conditions not generating appropriate alerts for follow-up, and significant delays in care). Despite good access to primary care (often language congruent), health screening and catch-up vaccination for new arrivals was inefficient and not consistent with guidelines with high number of incomplete post-arrival health screenings and vaccination schedules and limited contact of new arrivals was seen with the refugee health programme. As well as communication, complicated procedures and a lack of training were suggested as further factors influencing findings (Heenan)[164]
	Having care coordinated within one service and ease of access was recognised by clients describing that being able to attend multiple health services at the one site was a notable benefit of the service model (McBride)[157] Adequacy (proxy): a more holistic approach to health examinations was encouraged. Templates differed and led to differences in practice which some felt should be standardised to increase data availability on determinants of health for asylum seekers, reduce variation in practice and enable better quality assurance and evaluation. Ambiguity in entitlements to care led to problems with no guarantee of follow-up; questions among workers of the right to health care; and question of equality for asylum seekers given limited access (Delilovic)[153]

Theme	Studies underpinning themes
	Acceptability and availability (proxy): training participants (mental health professionals, refugee clients, refugee nurses, resettlement workers, bilingual community health workers, community leaders and volunteers in the refugee community) gained awareness and knowledge: refugee trauma during migration and resettlement; common stress and trauma responses; mental health consequences of refugee experiences; cultural beliefs and values that affect mental health experiences and help-seeking; distinctions between traumatic and routine stress; visible and invisible responses to trauma and stress. Bonds formed through workshop interaction with participants feeling empowered with tools for community support, new skills and external resources, and community leaders gaining more interest and motivation for helping other community members (Im)[156]
	Participants (mental and other healthcare workers, settlement workers, interpreters, case workers, community workers, teachers, social worker, community leaders, community volunteers) described helpful training content in relation to: refugee trauma and trauma-informed care, 'As a caseworker, I need to do better about addressing trauma on a daily basis'; cultural competency and cultural idioms of distress, 'I am planning to add contents about Western and non-Western culture scenario into my agency's presentation curriculum'; partnership building, and understanding mental health symptoms and clinical skills. Though some interest in a greater focus on community partnership building, trauma recovery, and techniques of mental health assessment (Im)[116]
	All professions gained from the training regardless of prior knowledge of mental health and previous experience working with refugees although previous experience was associated with general confidence working with refugees prior to the training suggesting work experiences alone do not build competencies in how to respond to refugee mental health needs (Im)[116] Awareness: participants reported being encouraged to use the therapeutic service by medical staff, social legal process counselling staff, interpreters, and peers (Zehetmair)[162] Participants (health, settlement, language, community, school providers) highly valued mutual learning and networking opportunities throughout the training (Im)[116]
Counter care – structural contexts	Some deviations from programme and issues with feasibility, such as dropout, were ascribed to: news concerning asylum status; change in housing; and restrictions due to COVID-19 (van Es)[161] Though most reported no barriers to use of a psychosocial walk-in clinic, some reported insufficient appointments and resulting long waiting times, stigmatisation fears and feelings of shame about seeking psychotherapeutic support, and a belief that a secure residence status would lead to an improvement of their mental state (Zehetmair)[162]
Proactive engagement	Acceptability: use of digital technologies, mostly commonly, Facebook, via smartphone, was widespread. Laptops were described as devices mainly used for education purposes but also as too expensive. Despite high use low technical literacy was the most common barrier. To maximise the learnability of the app, essential features of the initial prototype were therefore designed in ways that were expected to feel familiar to users that have experience with messaging apps. For example, the narrative content screens (i.e. texts and illustrations) were presented in a format resembling prototypical messaging apps such as WhatsApp audio input via the phone's microphone and picture input via the phone's camera were added as alternatives to text input for all interactive exercises in order to increase the flexibility and customizability of the app There was no indication of learnability issues around the interface of the revised version. Furthermore, respondents indicated that they found the prototype easy to use, not complicated and specifically pointed out the easy to understand language used in the text. Common user comments included that an app should not replace a real psychotherapist, that shorter (currently 30 minutes) higher frequency sessions would be more preferable (Burchert)[210]
	Community-based activity classes, tailored and adapted to the religious and cultural needs of participants, located in close proximity to most participants homes and delivered following existing language classes are well attended and enjoyed. Attendance at the fitness centre was encouraged with information evenings, a number of phone calls, and offers to help with transport (Guerin)[113] Referring to the programme, several said they 'don't want it to end' (El Khani)[154] Concern and disappointment expressed as the 6-month programme ended (Goodkind)[208] Cultural and religious reasons remained barriers to attendance for some women (Guerin)[113]
	Home-visiting programme promoting youth mental health and family relationships had good retention and attendance across weekly sessions with primary carers reporting satisfaction with information gained and most reporting general satisfaction with the programme, length of the sessions, and activities during sessions. Almost all would recommend the programme to a neighbour or friend (Betancourt)[168] Acceptability (proxy): therapists described the most important elements of the approach as their outreach work, working on a mutual established goal, and working with an intercultural mediator with a similar background to the minor (Van Es)[161]
	Adequacy: the interviewees highlighted the clinics' walk-in approach and relatively short waiting times as key facilitating aspects (Zehetmair)[162] Use of healthcare navigators resulted in no change to health system knowledge but significant reduction in missing or avoiding healthcare appointments because of language or navigation factors. Volunteer patient navigators were bilingual refugees and speakers of participant's language (Yun)[121] Agency: all participants engaged in home care service with percentage of participants using emergency or other hospital care less than the general home care population (other factors could have influenced this). Care also led to improvements in medication management (Miner)[165]

continued

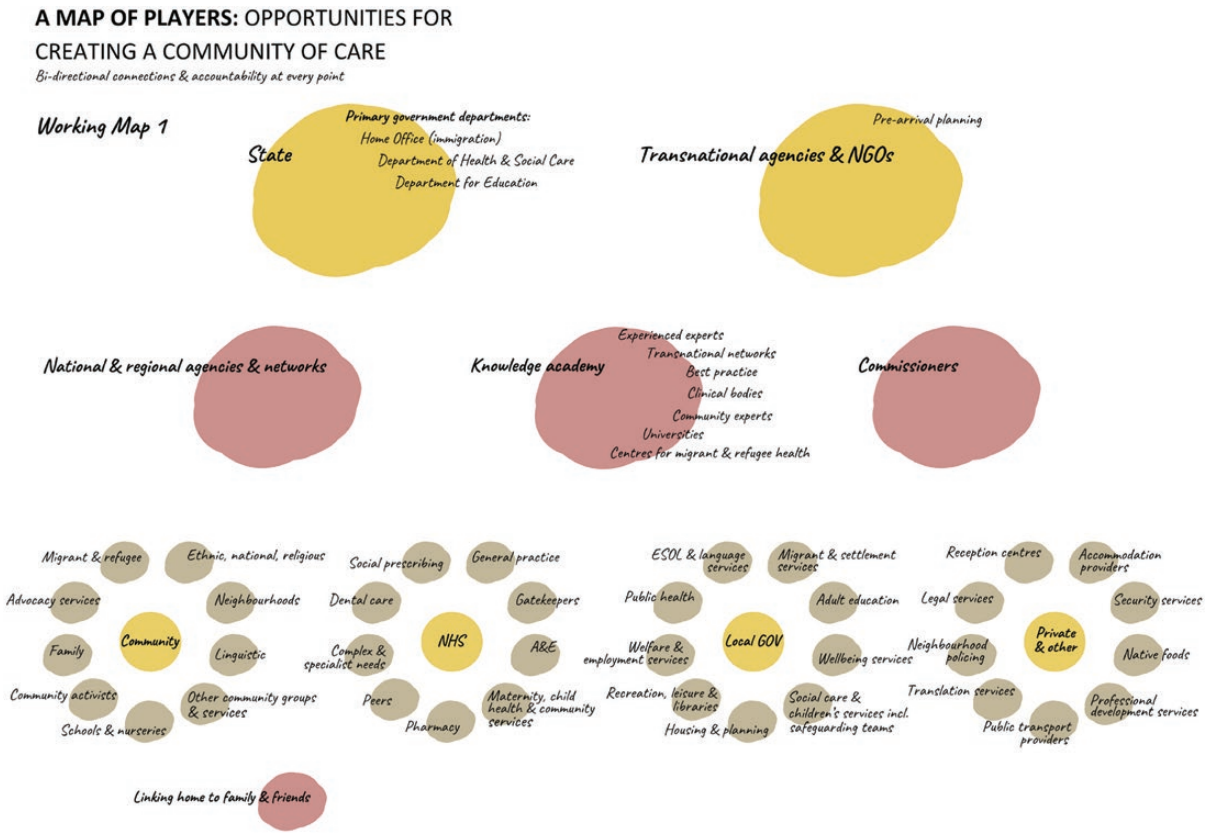
Theme	Studies underpinning themes
	Home-visiting family strengthening intervention for refugees aimed at promoting youth mental health and family relationships was found to have good retention and attendance across weekly sessions. All primary carers reported satisfaction with information gained during the intervention and most reported satisfaction with participation in general, the length of the sessions, and the exercises during the sessions. Almost all said they would recommend to a neighbour or friend (Betancourt)[168] Awareness: access to health services higher in schools delivering the programme (Woodland)[175] Adequacy accommodation: assistance from trained community health workers to access dental appointments, who ensured linguistic needs, physical access needs and appointment reminders were supported resulted in a significant reduced rate of missed dental health appointments (Lambert)[186]
	Health agency: home care provision led to substantial improvements in medication management (Miner)[165] Accessibility – physical: transportation costs and journey time were cited as impacting attendance and attrition (Dababnah)[107] Assistance from trained community health workers to access dental appointments, who ensured linguistic needs, physical access needs and appointment reminders were supported resulted in a significant reduced rate of missed dental health appointments (Lambert)[186]
	Childcare responsibilities and looking after family, and transportation problems remained barriers for some women (Guerin)[113] Bi-cultural workers were recognised as providing support with getting to the service, including directions to catch public transport, walk or drive. Some clients with limited English proficiency continued to describe challenges in reaching the service (McBride)[157] Small number of non-completers indicated having multiple children at home who would be unsupervised and cost of transport as barriers to attendance (Akhtar)[151] Using iPad and interactive survey to conduct psychosocial health assessment and health promotion while in waiting room is acceptable (not clear how this differs for those who do or do not have experience of using computers) (Ahmad)[100]
	Quality of telephone versus in-person psychiatric assessments were seen as similar and were equally effective in general summary of history of torture, psychiatric history, diagnoses considered. Building rapport with the client was more difficult, but could be overcome. Providers emphasised the convenience and a sense of satisfaction in participating in immigration work (Bayne)[122] Home-visiting programme promoting youth mental health and family relationships had good retention and attendance across weekly sessions with primary carers reporting satisfaction with information gained and most reporting general satisfaction with the programme, length of the sessions, and activities during sessions. Almost all would recommend the programme to a neighbour or friend (Betancourt)[168]
	Trauma-informed, psychoeducation training programme designed for conflict-affected population aimed at teachers and caregivers of children with ASD saw all participants satisfied with programme content but some improvements recommended, including more centres or meeting locations for families to participate, need for services located outside of urban areas, flexible program delivery methods, including online, increased programme advertising (Dababnah)[107] Attendance rates for tiered mental health services were seen as high because meetings were school based and occurred during normal school hours with all students present participating. All students referred for higher levels of care successfully agree to and engaged in treatment. Families of students referred for tiers 3 and above consented to treatment and engaged in high number of sessions (Ellis)[125]
	School was seen as the preferred location for a mental health intervention for forced-migrant students with good English and mostly a number of years residing in the UK. Reasons for this preference included feelings of safety and familiarity, schools as less stigmatising and more convenient. Occasional missed lesson but majority of appointments were made in free periods, break times and after school. Schools seen as carrying less stigma than clinic-based services and better accessed by families than other institutions (Fazel)[109] All students found the school-based mental health service 'very helpful' or 'helpful'. Teachers had made it easy for students to access the support and student found it useful. One student did not like missing lunch to attend and most said that they would refer their friends to be seen by the service if they felt that they had a problem (Fazel)[126]
	Affordability: transportation costs and journey time were cited as impacting attendance and attrition. Teachers stressed the need for more school resources and one noted financial support is needed to support families (Dababnah)[107] Financial constraints prohibited even low-cost childcare for some women but did not appear to deter commitment to low-cost gym membership (Guerin)[113] Participants referred to free-call phones as an important means of gaining assistance in high-risk situations: 'this phone is very important, I think [for] emergencies – emergency contact, doctor, Centrelink [welfare agency], school teacher' (Walker)[120]

Theme	Studies underpinning themes
Considered communication	Acceptability: linguistically and culturally adapted self-help plus mental health intervention to address psychological distress among South Sudan refugees in Uganda was found to be acceptable. The illustrative manual was seen as relatable and helpful although the text heavy manual was also seen as a challenge especially for those with low literacy. Audio content was also a challenge for some participants due to different dialects (Tol)[119] Most families were well engaged with primary care, largely seeing language-congruent GPs, with the quality of GP referrals (related to general child health issues) identified as excellent in most cases. This did not mitigate difficulties however in implementing post-arrival health screening. Suggested barriers linked to new locations of settlement (lack of experience), the implementation of a more in-depth holistic health assessment without adequate training, and Medicare restrictions leading to patient billing (Heenan)[164] The use of texts in Levantine Arabic was mentioned as a key positive aspect of the e-mental health app's user experience, 'The language is good. It is very close to the Syrian accent, as if someone is speaking to you. One can understand this better because it is simple and not academic. Better than formal Arabic' (Burchert)[210] Delivery by peer facilitators in shared Arabic language was cited by participants as a main reasons for the good acceptability of the group mental health programme (Acarturk)[150] Access to onsite interpreting was highly valued and seen as setting the service apart from others. Information was explained well, leading to increased understanding of patients' health conditions and medical. Instructions were clearly provided regarding medications and clients felt comfortable to ask questions when they did not understand (McBride)[157] Acceptability (proxy): training participants gained improved knowledge about the intersection of trauma and culture, including understanding how trauma and trauma symptoms may be expressed through different languages and cultural values and the programme led to improved working practices with interpreters and community volunteers (Im)[156] Capacity building project with GPs within universal primary health was seen to influence the way that GPs work with asylum seekers and refugees across all domains of focus including use of interpreters. The intervention was deemed highly acceptable by GP participants (Timlin)[183] Facilitators reported the perceived benefits of illustrations used in the intervention materials, particularly where participants could not read or write (Acarturk)[150] Medical students in the Refugee Family Health Partnership experienced increased comfort in understanding different patient perspectives, comfort in communicating with patients across cultures and language barriers. Student retention was very high (Bernhardt)[173] Agency: their own insufficient language skills were described by some participants as a potential barrier to future engagement in mental health services (Zehetmair)[162] The importance of local language proficiency was highlighted by difficulties for participants in accessing local resources without student or interpreter support. Despite full engagement throughout the 6-month programme, a salient issue of frustration was an inability to communicate between students and participants. Despite some translation provided by bilingual co-facilitators and participants realising that relationships can develop across language barriers, as relationships grew stronger, participants' inability to fully express themselves to each other was highlighted (Goodkind)[208] Adequacy (proxy): systems reform in public hospitals aimed to improve access to antenatal care for women of refugee background. A focus on training staff, including gatekeepers, in relation to refugee experiences and working with and providing interpreters, as well as improving multidisciplinary working did not have an impact on gestation period at first hospital visit. Although improvements in total antenatal visits were seen this was also reflected in the Australian-born population. Gradual and iterative implementation over 3 years (Yelland)[145]
Informed provider and attitudes	Acceptability: all caregivers and facilitators viewed the programme as culturally appropriate, one respondent describing approach as closely fitting her value system, 'What we learnt … is all in our religion; to respect each other, our families as well and respect the elderly' (El Khani)[154] Therapists' attentive, respectful, and caring attitude led to feelings of safety and trust, and alongside the receiving of psychiatric medication were seen as the most helpful supporting factors in users experience of a walk-in mental health clinic (Zehetmair)[162] Culturally adapted group CBT with Syrian women, delivered in shared language, by women, was seen as feasible and acceptable with very low dropout (Eskici)[189] The Dari translation of the Edinburgh postnatal depression scale is valid and reliable for detecting women at risk of depression and anxiety during pregnancy. Some items perform less well and a lowered overall cut-off score. Understanding cultural sensitivities and translation difficulties with particular items may require additional clinical judgement and further discussion with the woman during screening (Blackmore)[166]

continued

Theme	Studies underpinning themes
	Acceptability (proxy): training participants developed greater empathy and compassion for different cultural groups and understanding of their own cultural bias (Im)[156] Practitioner participants from a range of services indicated that the health examination was too heavily focused on infectious disease identification and control rather than other health conditions, encouraging a need to change focus to mental health (Delilovic)[153] Many teachers and parents requesting more information and follow-up with relief expressed that they could have access to a year of virtual follow-up sessions. Participants would have liked longer meetings; more application and reinforcement of content from lectures within the cooperative groups; and additional information and skills focused on working with young and/or traumatised children, or those who have limited existing skills (Dababnah)[107]
	Perceived quality of care was enhanced by positive relationships of trust and rapport between clients and healthcare providers. Clients consistently reflected on the value of having friendly and helpful staff and reported high levels of satisfaction (McBride)[157]
	Training for mental healthcare professionals indicated better understanding of several migration and refugee health-related topics, in particular the context and social situations of refugees in Sweden and the way in which migration experience, trauma and migration stress can affect the health of patients, and their families, 'I have got a better picture of the complexity of their situations, what they may have gone through … and health aspects …'. New knowledge and understanding was seen to promote empathy and change in attitudes and promote reflection, empowering professionals to be curious, courageous and stand up for certain values. Improved understanding of diverse cultural idioms of distress was also achieved and seen as knowledge to help navigate communication barriers and facilitate diagnostic evaluations (McDonald)[158] Intercultural mediators and therapists suggested more time was needed to offer psychoeducation, the importance of adapting the focus of sessions to meet the current need of a minors, and highlighted the prominent focus on continuous stressors in the treatment approach (Van Es)[161]
Patients as partners	
Behaviours	Health agency: the culturally adapted group psychological intervention led to participants enacting new skills and strategies in stress management and problem solving (Acarturk)[150] Adequacy: most transitioned well from holistic transitional care into universal primary health care. The small number that struggled indicated language as a barrier (McBride)[157] Participation in the school-based health and learning partnership programme led to more appropriate and efficient use of tertiary health services (Woodland)[175]
	Acceptability: the wellness programme proved acceptable and feasible, all parents stating that they found the programme worthwhile and would recommend to friends. The majority sustained attendance, including for Zoom 'refresher' sessions during the year after the initial programme (Rosenberg)[159] Trauma-focused treatment approach saw good engagement from unaccompanied minors and indicated that previous barriers to mental health care could be overcome with minors motivated for referral to formal mental health care following the programme (Van Es)[161]
	Most participants attending a psychosocial walk-in clinic stated that they would like to continue receiving therapeutic support in the future (Zehetmair)[162] Short group-based intervention delivered by a trained non-specialist female facilitator and local refugee interpreter, aimed at improving well-being and resilience, was a 'new and nice experience' for children, led to children learning positive things about themselves, how to deal with challenges and increased social connections (Foka)[110]
Health promotion	Acceptability: good acceptability of a trauma-informed wellness and physical education programme, feasibility and COVID-19 knowledge after participation also saw interest in other support, such as anger management (Rosenberg)[159] Participants gained knowledge of psychological problems and some prejudices relating to mental illnesses and the Dutch healthcare system were alleviated (Uitterhaegen)[160] Attendees at a psychosocial walk-in clinic appreciated learning stabilisation techniques and receiving medical reports (Zehetmair)[162]
Self-stigma	Small number reported internal barriers such as feelings of shame, fear of stigmatisation that might prevent them from seeking further mental health services in the future (Zehetmair)[162] Participants acknowledged the perceived value of a mobile mental health application and its potential to address distress among Syrian users, although not accepting the need for psychological aid was sometimes seen as a barriers to uptake of the programme 'The idea of going to a psychologist is a bit hard to accept for Syrians. Most people don't admit that a psychological illness is exactly the same as any other illness' (Burchert)[210]

Appendix 9 Map of players



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