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Systematic Review

Factors That Affect Refugees' Perceptions of Mental Health Services in the UK: A Systematic Review

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Abstract

The UNHCR reported that over 123.2 million people were forcibly displaced worldwide by the end of 2024, with the mental health of refugees emerging as a critical issue. In the UK, asylum seekers and refugees make up around 13% of immigrants and the number is increasing year on year. The Immigration and Asylum Act 1999 aimed to ensure that most cases of asylum seekers would be decided fairly, and within six months. However, it has been argued that long wait times and systemic inequalities and inequities within the asylum system have contributed to heightened mental health problems among refugees even once they gain refugee status. The present study aimed to examine the factors that refugees perceive as limiting their ability and willingness to access mental health services in the UK. A systematic review of 15 relevant articles followed the guidelines of the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) statement. Results highlight intersecting perceived limitations to accessing mental health services, such as language difficulties, cultural disconnection regarding mental health including stigma and prejudice, mistrust of services as well as structural barriers including general service limitations and the involuntary transient nature of many refugees' lives. Policy recommendations emphasize integrating ethnic minority organizations into services, developing culturally adapted services that take into consideration the views of refugees, and ensuring holistic approaches to address socio-economic determinants.

Keywords: refugees; culture; trauma; language barrier; stigma; mental health services

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1. Introduction

The office of the United Nations High Commissioner for Refugees (UNHCR) reported that at the end of 2024, the number of refugees, asylum seekers, forcibly displaced and internally displaced persons around the world was estimated to exceed 123.2 million (UNHCR 2024). In the UK, asylum seekers and refugees make up around 13% of immigrants, which is not an insignificant proportion. Furthermore, the number of people applying for asylum in the UK rose from 103,00 in 2002 to 108,000 in 2024 (the highest annual number since records began in 1979) (Walsh and Jorgensen 2024), largely as a result of wars in Somalia, Afghanistan, Iraq, and the former Yugoslavia. A signatory of the 1951 United Nations Convention and Protocol Relating to the Status of Refugees (here after Refugee Convention), the UK Home Office will grant asylum to those meeting its criteria. The Home Office can also grant humanitarian protection or discretionary leave if people are

deemed to need protection even though they do not meet the criteria. Following the 1988 government White Paper Fairer, Faster, and Firmer, the Immigration and Asylum Act 1999 aimed to ensure that most cases of asylum seekers would be decided fairly, and within six months. However, the Nationality and Borders Act 2022 (c.36) granted new powers to limit eligibility for asylum status and reduced support for survivors of modern slavery unless they complied with State-set deadlines to disclose their abuse. This, amongst other pecuniary measures within the Act, has caused unnecessary delay and anxiety for those seeking refugee status (James and Forrester-Jones 2022).

The terms "migrant", "asylum seeker", and "refugee" tend to be used interchangeably by the media and policymakers to refer to the recent arrivals of people in Europe (UNHCR 2015). The UNHCR (Refugee Council 2017) defines several categories under the term 'persons of concern':

- *Migrants* are defined as people who 'choose to move not because of a direct threat of persecution or death, but mainly to improve their lives by finding work, or in some cases for education, family reunion, or other reasons. Unlike refugees who cannot safely return home, migrants face no such impediment to return. If they choose to return home, they will continue to receive the protection of their government.' (UNHCR 2015, p. 1).
- *Persons seeking asylum (often termed asylum-seekers)* are regarded as individuals who have sought international protection and whose claims for refugee status (as defined by the UN Refugee Convention) have not yet been determined. Since March 2013, the UK Home Office Immigration Enforcement and Visas and Immigration directorates have controlled asylum administration. According to Owers (2003), individuals may apply for asylum under the Refugee Convention, the European Convention of Human Rights 1953, or the Human Rights Act 1998.
- A *Refugee* is a person who '. . .owing to well-founded fear of being persecuted for reason of race, religion, nationality, membership of a particular social group or political opinion[1], is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it.' (Article 1A(2) UNHCR 1951, p. 14). What is commonly referred to as *refugee status* or 'legitimate refugee' (see Kirkwood et al. 2016) applies to those 'whose asylum application has been successful and who is allowed to stay in another country having proved [a 'well-founded fear'] they would face persecution back home' (Refugee Council 2005, p. 1). A person who has refugee status under the Refugee Convention in the UK is given five years leave to remain as a refugee. They can then apply for indefinite leave to remain (generally referred to as ILR or 'settlement'), gaining the right to live, study, and work in the UK permanently. After one year, they are eligible to apply for British citizenship. It is this latter group who was the focus of our systematic review.

International evidence suggests that adult refugees generally experience high rates of mental health problems[2] (Reavell and Fazil 2017; Blackmore et al. 2020), particularly post-traumatic-stress-disorder (PTSD) (Hsu et al. 2004; Li et al. 2016).

Fazel et al.'s (2005) systematic review of 20 studies across seven Western countries estimated that refugees were about ten times more likely to have post-traumatic-stress-disorder (PTSD) than non-refugees of the same age in those countries. Empirical studies and systematic reviews concerning the mental health of refugees across the globe have pointed to pre-migration traumas as the cause of their psychological problems. These include discrimination, conflict and violence, political persecution, and war (Bogic et al.

2015), which feature in the three countries (Syria, Afghanistan, and Somalia) from which over half of all refugees originate (see Abbas et al. 2018).

Other studies have highlighted 'flight' stressors such as escaping countries of origin, fear of not reaching another country and/or being sent home and living conditions in refugee camps (Shannon et al. 2015; Walther et al. 2020). Post-migratory impacts on mental health include spouse and family separation or loss, unsafe or problematic housing and lack of social protection (including cash benefits on arrival at host countries), poverty, isolation, loneliness, and inequitable access to mental health care and treatment (Paudyal et al. 2021; Sah et al. 2019; Vostanis 2014; Frissa et al. 2013; Watters and Ingleby 2004). Refugees have also been found to require psychological support to access education and employment opportunities that are difficult to navigate (see Simkhada et al. 2021; Alpak et al. 2015; Craig et al. 2009).

In the UK, the number of refugees has been increasing largely due to geopolitical conflicts including most recently the Russian invasion of Ukraine in 2022. The UNHCR (2022) has reported approximately 515,700 refugees living in the UK.

Despite refugee status affording adults the legal right to residency, further and higher education, work and access to the welfare system on the same basis as British citizens and permanent residents, Burnett and Peel (2001), Bhui et al. (2006), and Barnswell et al. (2025) assert that refugees in the UK still experience severe depression and PTSD compared with non-refugees, corroborating Bogic et al.'s (2015) international systematic review of studies across 30 countries and Fazel et al.'s (2005) systematic review of seven countries. Bhui et al. (2006) reported that refugees and asylum seekers in London experienced suicidal ideation because of experiences of war, torture, family loss, loneliness, and having fled their country. However, despite evidence that psychological interventions help reduce PTSD symptoms (Nosè et al. 2017), UK mental health services remain poorly resourced and characterized by extended wait-times and inequalities (Lowther-Payne et al. 2023). Furthermore, significant disparities in accessing adult mental health services in the UK for asylum seekers and refugees have been indicated (see Pollard and Howard's (2021) scoping review and Lowther-Payne et al.'s (2023) systematic mapping review). Krystallidou et al.'s (2024) international systematic rapid review (including nine studies from the UK) focused on language barriers to accessing mental health services.

However, like Krystallidou et al.'s review, which covered a wide range of participant views including migrants, asylum seekers, displaced persons, stateless people, ethnic minorities, informal carers, and health and social care professionals, we found that previous systematic reviews based in the UK, including Lowther-Payne et al. (2023), Nosè et al. (2017), Close et al. (2016) and the scoping review by Pollard and Howard (2021), tended to conflate asylum seekers with refugees, or included migrants rather than focusing on the situations and views of people who had refugees status.

In this paper, we present the results of a systematic review exploring the factors refugees themselves perceived as limiting their ability and willingness to access mental health services, thus avoiding the dilution of their voices by other actors. By concentrating our review on UK studies only, we offer a context-specific synthesis and policy-relevant perspective, which also seeks to corroborate previous study assertions that adult refugees experience high rates of mental health problems (particularly post-traumatic-stress-disorder [PTSD]) and are therefore in need of particular mental health services in the UK.

2. Method

Our systematic review was carried out in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Liberati et al. 2009). The PRISMA statement comprises a 27-item checklist designed to ensure transparency,

reproducibility, and comprehensive reporting in systematic reviews. Search engines included Google Scholar, EBSCOhost, PubMed, PsycINFO, and EBSCO as well as an array of search terms representing refugee and mental health were applied with Boolean operators (AND, OR) and an asterisk (*) to detect words with various endings. Search terms were broad so as to not miss relevant studies; terms for refugee/asylum seekers/migrants were conflated but which specifically discussed people with refugee status. Terms included Mental health AND refugee*, Mental health services AND stigma AND refugee*, Refugee* OR asylum seekers AND PTSD, Refugee* OR asylum seekers AND post trauma stress disorders, Mental Care AND refugee* OR asylum seekers (see Appendix A for the full search terms and database hit counts).

Hand searching of relevant journals including the Journal of Mental Health and the Journal on Migration and Human Security was also undertaken. The publication date was limited from January 2000 to August 2024, as the number of refugees who had entered the UK were particularly high in the early 2000s, peaking at 103,000 in 2002, due largely to conflicts in Afghanistan, Iraq, and Somalia (Home Office 2025) as well as the dictatorial regime in Zimbabwe (UKGOV 2004). In order to maximize our chance of gaining extant knowledge about the topic, we included a broad range of study types including quantitative, qualitative, mixed methods, and case studies.

Inclusion criteria:

- Empirical studies about mental health services for adult refugees with mental health problems and/or post-traumatic stress disorders (PTSDs).
- UK articles published from 2000 to 2024.
- Quantitative, qualitative, and mixed methods studies.

Exclusion criteria:

- Children and older (over 65 years) refugees; more than two-thirds of refugees arriving in the UK are over 18 years and less than 65 years (UNHCR 2022).
- Non-UK studies.
- Articles not written in English.
- Articles published before 2000.
- Non-empirical articles

2.1. Screening

All articles were originally screened by the first author based on their titles. A total of 9134 potential papers were initially identified, with 8612 removed based on title irrelevance. Abstract screening involving all three authors excluded a further 525 that did not meet our inclusion criteria.

2.2. Data Extraction

Full texts of 36 articles were read by all authors, and following a number of discussions, 21 were excluded, leaving 15 (two papers referred to the same study but offered different though relevant data and so both were included) for review (Figure 1). Study characteristics including authors, publication year, aims of study, sample size, participant socio-demographic data, methods, prevalence of mental health problems, and main findings were extracted from each included article. Discrepancies between authors were resolved by discussion.

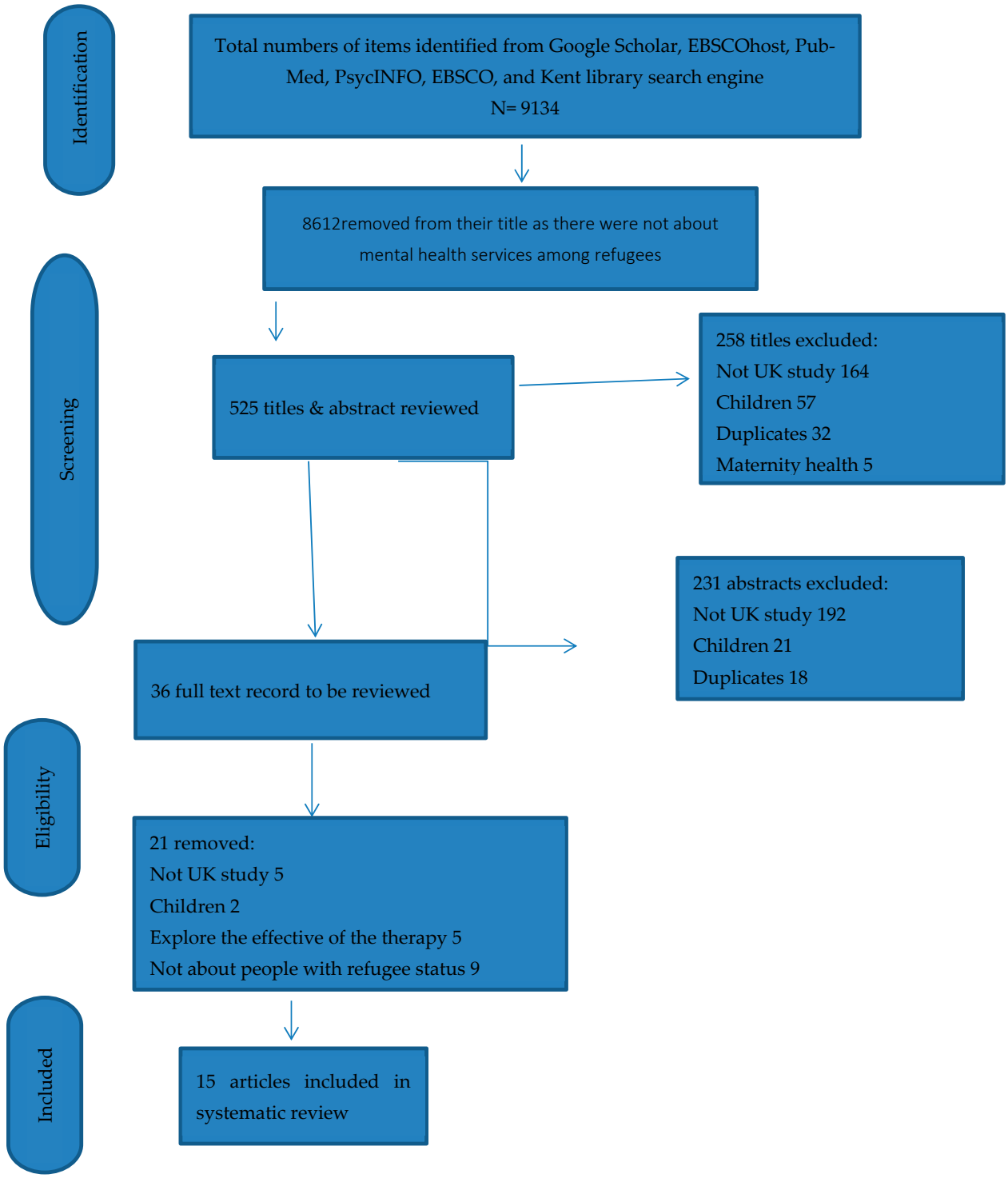

Figure 1. Search results.

2.3. Quality Appraisal

The methodological quality of all included studies was assessed using the Quality Assessment Tool for Studies with Diverse Designs (QATSDD) (Sirriyeh et al. 2011). This tool was specifically developed to appraise studies that employ a variety of methodological approaches and is particularly suited to reviews that integrate both qualitative and quantitative evidence. The QATSDD consists of 16 items, each scored on a 4-point Likert scale (0 = not at all, 1 = very slightly, 2 = moderately, 3 = complete), covering aspects such as clarity of aims, theoretical framework, appropriateness of research design, sampling strategy, representativeness, data

collection reliability, analytic rigor, ethics, and user involvement. The maximum possible score is 42 for single-method studies, and 48 for mixed-method designs.

To enable cross-study comparison, total scores were converted to percentages and categorized according to four levels of methodological quality: high quality (≥75%), good quality (50–74.9%), moderate quality (25–49.9%), and poor quality (<25%). The QATSDD has demonstrated reliability and validity in the original evaluation across disciplines such as psychology, sociology, and nursing. Interrater agreement between reviewers was high, and qualitative feedback from health researchers confirmed that the criteria were clear, comprehensive and usable across diverse study types. In this review, the QATSDD applied to the 15 included studies examined factors influencing the refugees' access to and experiences of health and mental health services in the United Kingdom. Any scoring discrepancies were discussed until consensus was reached. The included papers comprised a range of study designs including qualitative interviews (e.g., Paudyal et al. 2021; Linney et al. 2020), quantitative surveys (e.g., Turner et al. 2003; Bogic et al. 2012), mixed-method evaluations (e.g., Papadopoulos et al. 2004; Carswell et al. 2011), and descriptive service evaluations (e.g., Nyiri and Eling 2012).

Following appraisal, four studies were rated high quality, nine were good quality, and two were moderate quality. None were rated poor. Overall, most studies demonstrated strong alignment between the research aims and methods and robust analytic processes, with several explicitly reporting formal research ethics approval (e.g., Paudyal et al. 2021; Linney et al. 2020; Bogic et al. 2012; Carswell et al. 2011; Vincent et al. 2013; Green et al. 2012). Others (e.g., Warfa et al. 2006; Papadopoulos et al. 2003, 2004; McCrone et al. 2005; Turner et al. 2003; Palmer and Ward 2007; Nyiri and Eling 2012; Summerfield 2003; Harris and Maxwell 2000) described ethical considerations such as informed consent and confidentiality but did not specify formal review board approval. Common limitations included a lack of explicit theoretical frameworks, small or convenience samples reducing representativeness, and limited user involvement in the study design.

Table 1 presents the quality distribution of the included studies.

Table 1. The Quality Assessment Tool for Studies with Diverse Designs (QATSDD).

Author (Year)	Design	QATSDD %	Quality Category	Key Strengths (High-Scoring Items)	Main Limitations (Lower-Scoring Items)
Paudyal et al. (2021)	Qualitative (Syrian refugees)	76%	High	Clear aims; ethical procedures; strong data collection methods	Limited theoretical framework; small, gender-skewed sample
Linney et al. (2020)	Qualitative (community participatory)	81%	High	Participatory design; strong community engagement	Lack of explicit theoretical underpinning
Vincent et al. (2013)	Qualitative (therapy acceptability)	79%	High	Methodological transparency; ethics clearly addressed	Limited generalizability; small, selective sample
Bogic et al. (2012)	Quantitative (epidemiological survey)	86%	High	Large, representative sample; robust statistical analysis	Limited qualitative insight; cross-sectional design

Table 1. *Cont.*

Author (Year)	Design	QATSDD %	Quality Category	Key Strengths (High-Scoring Items)	Main Limitations (Lower-Scoring Items)
Nyiri and Eling (2012)	Service/clinic description	48%	Moderate	Practical relevance; service-based insights	Weak methodological detail; limited analysis
Green et al. (2012)	Qualitative (Kurdish interpreters)	74%	Good	Culturally grounded; clear ethical procedures	Small sample; limited triangulation
Carswell et al. (2011)	Mixed methods (post-trauma, service use)	71%	Good	Integration of quantitative and qualitative data	Limited theoretical framework; moderate sample size
Palmer and Ward (2007)	Qualitative (forced migrants in London)	69%	Good	Rich qualitative narratives; clear ethical considerations	Lack of analytic transparency; small scale
Warfa et al. (2006)	Qualitative (Somali refugees)	74%	Good	Cultural contextualization; rich qualitative data	Small, convenience sample; limited theoretical framework
McColl and Johnson (2006)	Qualitative (community project)	67%	Good	Community-based approach; clear aims	Limited analytic rigor; descriptive reporting
Papadopoulos et al. (2004)	Mixed methods (Ethiopian refugees)	74%	Good	Clear link between methods and aims; ethical approval obtained	Limited user involvement; descriptive analysis
Papadopoulos et al. (2003)	Mixed methods (Ethiopian refugees)	69%	Good	Innovative design; culturally relevant findings	Weak theoretical justification; non-random sampling
Summerfield (2003)	Clinical case reflection	52%	Moderate	In-depth clinical insight; contextually rich	Anecdotal; lacks systematic methodology
Turner et al. (2003)	Quantitative (Kosovan refugees)	71%	Good	Large sample; defined variables; ethics stated	Cross-sectional; limited cultural interpretation
Harris and Maxwell (2000)	Qualitative needs assessment (London refugee communities)	72%	Good	Comprehensive community involvement; culturally appropriate model; clear ethical framework	Limited generalizability; small N (71 participants across multiple groups); lacks theoretical depth

The integration of the QATSDD provided a robust methodological foundation for this review, allowing for a comprehensive and transparent evaluation of diverse refugee health studies. This strengthened the credibility of the synthesis and ensured that methodological

variability was appropriately accounted for in interpreting the factors affecting the refugees' access to and engagement with healthcare services in the UK.

2.4. Analysis

The 15 papers were subjected to thematic analysis as recommended by Thomas and Harden (2008), alongside Braun and Clarke's (2006) six-step framework to identify barriers as well as influences affecting the refugees' access to UK mental health services. Articles were repeatedly and independently read by all three authors. Initial descriptive codes were assigned to the finding's sections of each paper by the first and third author and then checked by the second author.

Once patterns and themes were identified across all of the studies, a discussion took place between all three authors with the themes refined and named based on their content until saturation of the themes had been achieved. Illustrative quotes were also agreed upon by all authors.

3. Results

The details of the 15 papers are shown in Table 2. The papers taken together reported findings using refugee samples from the Middle East (Syria, Iraq, Iran, Kurdistan), East Africa (Somalia, Ethiopia, Sudan, Congo), South Asia (Afghanistan, Nepal), and the Balkans (former Yugoslavia, Kosovo, Bosnia). Only a few studies included participants from other regions such as South America (Colombia). Nyiri and Eling (2012) only stated the origin of one refugee out of their sample of 112 participants, and Carswell et al. (2011) stated that their sample represented 24 countries across five continents (Middle East, Africa, Europe, Asia, and South America) but did not specify which countries. In total, the views of 1810 participants living in the UK were reported across the 15 papers.

Study locations were mainly concentrated in London (e.g., Carswell et al. 2011), East and South London (Warfa et al. 2006; McCrone et al. 2005); Brixton (Nyiri and Eling 2012), Waltham Forest (Harris and Maxwell 2000), with Palmer and Ward (2007) recruiting participants from 10 London boroughs. Linney et al.'s (2020) study was located in Bristol, and Paudyal et al.'s (2021) study was located in southeast England, whilst Vincent et al. (2013) stated that they recruited participants from both England and Wales. The other five studies did not name their specific UK locations.

A combination of purposive, convenience, and snowball sampling was used by most studies via specialist NGOs, charities, resource centers, cultural events, community organizations, language centers, advocacy groups, and refugee centers (Harris and Maxwell 2000; Paudyal et al. 2021; Linney et al. 2020; Bogic et al. 2012; Warfa et al. 2006; Palmer and Ward 2007; Turner et al. 2003). Papadopoulos et al. (2003, 2004) additionally used advertisements on Ethiopian radio stations. Other studies used NHS clinics and outpatient services offering specialist mental health treatments for PTSD (e.g., Vincent et al. 2013; Carswell et al. 2011; Green et al. 2012) or in the case of Summerfield (2003), the Bosnian participant was recruited through their psychiatric assessment at the Medical Foundation for the Care of Victims of Tortures, a medical charity offering clinical services.

The Refugee Council and legal practices and projects offering legal aid were also used as recruitment grounds for Nyiri and Eling (2012). Finally, McCrone et al. (2005) randomly sampled people with Somali names who were registered with local GPS. These potential participants were then verified as Somali by Somali researchers working on the project. This sample was supplemented with refugees living in refugee hostels, attending Somali cafes, mosques, and further education colleges.

Table 2. Characteristics of the included studies.

Article Title	Authors/Year of Publication	Study Location in UK	Aims	Sample Size (Gender) [Age]	Methods	Prevalence of Psychological Disorders	Findings
1. Qualitative study on mental health and well-being of Syrian refugees, and integration in the UK	(Paudyal et al. 2021)	Southeast England	To investigate the mental well-being of Syrian refugees	12 (3 women, 9 men) [18–79]	Qualitative in-depth semi-structured interviews	Not stated (for ethical reasons)	Syrian refugees face social integration challenges including accessing mental health services, cultural differences, and stigma around mental health and language.
2. "*Crazy person is crazy person. It doesn't differentiate*": an exploration into Somali views of mental health and access to healthcare in an established UK Somali community	(Linney et al. 2020)	Bristol	To discover UK Somali community beliefs and views about mental health problems, treatment, and access to medical services.	23 (12 men, 11 women)	Qualitative focus groups	Not stated	Participants discussed their lived experiences of mental health problems in relation to trauma from war and forced migration. Language, waiting times, mistrust of doctors linked to cultural beliefs were barriers to accessing healthcare.
3. Asylum-seekers' experiences of trauma-focused cognitive behavior therapy for post-traumatic stress disorder: A qualitative study	(Vincent et al. 2013)	England and Wales	To estimate the suitability of Trauma-focused CBT (TFCBT) for asylum seekers/refugees with PTSD	7 (6 asylum seekers, 1 refugee)	Qualitative semi-structured interviews	Post-traumatic stress disorder (PTSD)	Participants expressed their uncertainty about engaging in trauma-focused CBT (TFCBT); describing the treatment as very challenging, but helpful. Factors impeding uptake of treatment include fear of repatriation.
4. Factors associated with mental disorders in long-settled war refugees: refugees from the former Yugoslavia in Germany, Italy and the UK	(Bogic et al. 2012)	Germany, Italy, and UK (unknown)	To compare mental health problems across similar refugee groups resettled in different countries.	85 (302 in the UK) [18–65]	Quantitative instruments.	Major depression and anxiety disorder and post-traumatic stress disorder (PTSD)	Sociodemographic traits, war experiences and postmigration stressors are separately linked to mental health problems in long-settled war refugees.
5. A specialist clinic for destitute asylum seekers and refugees in London	(Nyiri and Eling 2012)	Brixton	To examine the challenges faced by asylum seekers and refugees in London in accessing physical and mental health care.	112 (61 male, 51 female)	Quantitative questionnaire	Depression, and post-traumatic stress disorder (PTSD).	Participants had encountered practical barriers to registering with general practices including reticence to request help, complex physical, psychological and social problems, long process of consultations, and language barriers.
6. Too close to home? Experiences of Kurdish refugee interpreters working in UK mental health services	(Green et al. 2012)	Unknown	To explore experiences of Kurdish refugee interpreters working in mental health services in the UK	(4 male–2 female)	Qualitative (semi-structured interview).	Not stated	Interpreters who were also refugees experienced ambiguous and complicated interactions with other professionals.
7. The relationship between trauma, post-migration problems and the psychological well-being of refugees and asylum seekers	(Carswell et al. 2011)	London	To explore the relationship between mental health problems of refugees and asylum seekers, to trauma, post-migration problems, and social support.	47	Quantitative standardized measures	Post-traumatic stress disorder (PTSD).	Clinical services need to respond more holistically to the PTSD and emotional distress of refugees who have suffered trauma and post-migration problems.

Table 2. *Cont.*

Article Title	Authors/Year of Publication	Study Location in UK	Aims	Sample Size (Gender) [Age]	Methods	Prevalence of Psychological Disorders	Findings
8. 'Lost': Listening to the voices and mental health needs of forced migrants in London	(Palmer and Ward 2007)	Ten boroughs in London	To explore the opinions of refugees and asylum seekers who have mental health problems	21 [21–65]	Qualitative semi-structured interviews.	Not stated	Forced migration including deculturation (due to the host country's alien culture), unemployment, and lack of social support leads to mental health problems. Holistic mental health services that include preventative, practical, and interventions are needed
9. Post-migration geographical mobility, mental health and health service utilization among Somali refugees in the UK: A qualitative study	(Warfa et al. 2006)	East and South London	To investigate the perspectives of Somali refugees on their geographical mobility, the relationship to mental health status.	21 (12 female–9 male) [19–65]	Focus groups	Depression and post-traumatic stress disorder (PTSD).	Refugees have trouble accessing adequate mental health care due to being moved from one location to another. There is a need for a national strategy to ensure services meet the needs of transient refugees.
10. Mental health needs, service use and costs among Somali refugees in the UK	(McCrone et al. 2005)	East and South London	To evaluate the mental health needs and service use among Somali refugees living in London.	143	Quantitative measures.	Not stated	Uptake of mental health services by Somali refugees is relatively low, reflecting their high geographical mobility, especially in the early part of the asylum seeking process.
11. Ethiopian refugees in the UK: Migration, adaptation and settlement experiences and their relevance to health	(Papadopoulos et al. 2004)	Unknown	To investigate the experiences of migration, among Ethiopian refugees and asylum seekers.	106 refugees	Qualitative open-ended semi-structured and semi-structured questionnaire.	Not stated	Belief that mental illness is due to supernatural and psychosocial causes. Although participants sought help from general practitioners, language barriers and poor understanding of the healthcare system precluded getting adequate care
12. The impact of migration on health beliefs and behaviors: The case of Ethiopian refugees in the UK	(Papadopoulos et al. 2003)	Unknown	To investigate the migration experiences of Ethiopian refugees in the UK, and the effects on their health views and activities	106 Ethiopian refugees and asylum seekers	Qualitative semi-structured and semi-structured questionnaire.	Not stated	Mental health services need to be holistic to address all refugees' needs including physical, mental, spiritual, environmental, and social-cultural. Although acculturation to Western medicine may have happened, Ethiopian beliefs about mental health have evolved over thousands of years within a complex society and are unlikely to disappear—this needs to be understood.
13. War, exile, moral knowledge and the limits of psychiatric understanding: A clinical case study of a Bosnian refugee in London	(Summerfield 2003)	Unknown	A study of a Bosnian refugee, a survivor of war	1 Bosnian refugee	Case study	Depression, and post-traumatic stress disorder (PTSD)	War victims may need intervention by experts as they try to re-establish their lives and need to be aware of the limitations to recovery techniques.

Table 2. *Cont.*

Article Title	Authors/Year of Publication	Study Location in UK	Aims	Sample Size (Gender) [Age]	Methods	Prevalence of Psychological Disorders	Findings
14. Mental health of Kosovan Albanian refugees in the UK	(Turner et al. 2003)	Unknown	To establish the frequency of mental health problems in Kosovan Albanian refugees in the UK	842 adults/[38.1]	Quantitative measures	Depression, anxiety, and post-traumatic stress disorder (PTSD)	Just under half of the sample had a diagnosis of PTSD and less than one-fifth had a major depressive disorder indicating refugee conflict survivor resilience. However, psychosocial interventions are likely to be an important part of treatment programs.
15. A needs assessment in refugee mental health project in northeast London: Extending the counselling model to community support	(Harris and Maxwell 2000)	Waltham Forest	To outline the model of care for refugee mental health needs in Waltham Forest.	71 refugees	Qualitative needs assessment	Not stated	The main focus of the role of the refugee support psychologist was in empowerment, training, reinforcement of refugee identity, and the supply of a one-to-one counselling/therapy service.

Apart from Nyiri and Eling (2012), Carswell et al. (2011), McCrone et al. (2005), Turner et al. (2003), and Bogic et al. (2012), who used quantitative questionnaires, scales, and inventories, six studies (Paudyal et al. 2021; Vincent et al. 2013; Green et al. 2012; Palmer and Ward 2007; Papadopoulos et al. 2003, 2004; Harris and Maxwell 2000) used semi-structured qualitative interviews. Linney et al. (2020) used focus groups and Summerfield (2003) used a case study of one participant from Bosnia.

Several studies highlighted the importance of language and cultural sensitivity in interviewing refugees. For example, Papadopoulos et al. (2004) trained their researchers to effectively interview Ethiopian refugees. While some studies used translators (Palmer and Ward 2007; Carswell et al. 2011), others (e.g., Vincent et al. 2013; Nyiri and Eling 2012) selected only English-speaking participants, which may have limited the depth of insights and validity (Papadopoulos et al. 2004). Only a few studies (Warfa et al. 2006; Papadopoulos et al. 2004) provided detailed demographic and health status data, which was noted as a gap in the broader literature. For example, Warfa et al. (2006) reported that their sample included 21 Somali refugees (12 women and 9 men) aged 19–65 years and presented data on post-migration mobility, mental health status, and service use patterns. The authors also discussed the relationship between frequent relocation, depression, and post-traumatic stress symptoms, highlighting both gender and age as relevant factors influencing well-being. Similarly, Papadopoulos et al. (2004) included 106 Ethiopian refugees and asylum seekers and described demographic variables such as age, gender, marital status, education, and length of residence in the UK, alongside health indicators like self-rated physical and mental health, and experiences of cultural adjustment. The study also noted how migration, adaptation, and settlement experiences affected the participants' psychological and social well-being, providing one of the most comprehensive demographic profiles among the reviewed papers.

Whilst refugees in the reviewed studies clearly encountered many pre-, transitional and post-migration difficulties precipitating mental health difficulties, they generally felt thwarted from accessing mental health services in the UK, as discussed below.

3.1. Prevalence of Psychological Disorders

Seven of the included studies indicated that depression and PTSD were the most common mental health problems faced by refugees and asylum seekers, with seven reporting particularly high levels of PTSD; Bogic et al. (2012) found positive correlations between PTSD and older age, a lower level of education, and more traumatic experiences. Two studies (Bogic et al. 2012; Turner et al. 2003) also reported a range of anxiety disorders experienced by refugees, who were also found to have higher percentages of serious mental health problems compared with the general population (Palmer and Ward 2007).

McCrone et al.'s (2005) study of Kurdish and Somali refugees also found that there were higher rates of physical health and social needs in this group of individuals compared with the local population. Unmet social needs may lead to or exacerbate mental health problems (see Forrester-Jones and Grant 1997; Forrester-Jones et al. 2018, 2024).

A number of studies (Paudyal et al. 2021; Bogic et al. 2012; McColl and Johnson 2006) found that many of their participants encountered post-migration distress while living in the UK, which negatively impacted their mental health. Stressors included discrimination, poverty, social isolation, separation from family, poor housing, and uncertainty about asylum applications. Similarly, Paudyal et al. (2021); Carswell et al. (2011) and Warfa et al. (2006) suggested that socio-economic status, including unemployment, financial problems, loss of community, and limited social networks as well as nostalgia for the homeland, all led to mental distress.

3.2. Factors Which May Affect Individuals' Access to Mental Health Services

All of the reviewed studies showed that accessing mental health services was far from easy for refugees due to a number of interrelated reasons, as outlined in the three major themes below:

3.2.1. Theme One: Stigma and Cultural Beliefs About Mental Health Problems

This theme represented the beliefs of refugees concerning mental health problems, which in turn influenced their perceptions about accessing mental health services in the UK. The theme entailed three subthemes: mental health stigma, lack of trust, and bravado as a counterbalance to the first two perceptions.

Subtheme 1. Mental health stigma: defined as "an attribute that is deeply discrediting" (Goffman 1963, p. 4). Affinity bias (a tendency to seek out people who look and think similar to oneself) occurs in most societal groups, especially in unfamiliar environments (Hobbs and Souter 2020). Communities of refugees based on, among other things, language and situation, were therefore not uncommon in the studies we reviewed (e.g., Paudyal et al. 2021; Linney et al. 2020; Warfa et al. 2006). These groups also appeared to act as communities of reference, in which shared cultural beliefs tended to stigmatize mental health problems, attributing pejorative labels to it such as 'crazy', as quoted by participants in Paudyal et al. (2021, p. 5):

> *Back in Syria, people are used to or have the assumption that people who go to psychiatrists have something wrong in their brains, crazy or something*. (Participant 9, man)

And in Linney et al. (2020, p. 8), whose participants demonstrated how cultural stigma generalizes all forms of mental health problems under one negative label:

> *Crazy person is crazy person. It doesn't differentiate—whether it is depression or schizophrenia, it is all the same.* (Participant 2, Somali community, UK).

Other cultures, such as Ethiopian, attributed mental health problems to supernatural or psychosocial causes:

> *. . .when someone is depressed in Ethiopia, people say it is an illness caused by Satan*. (070 male: 206) Papadopoulos et al. (2004, p. 66)

Such closely held values meant that those within the group who were suffering from mental health problems avoided services for fear of being stigmatized by their own communities, as exemplified by the following quote from Paudyal et al. (2021, p. 5):

> *[. . .] so the majority of Syrian people are coy of going to the doctor or are not used to this habit, because we don't have something like that in Syria.* (Participant 9, man).

Similarly, in Palmer and Ward's (2007) study, two participants said:

> *. . .If someone is stressed, they say [In Ethiopia] 'Waa waa she' which means mad. It is quite extreme, there is nothing in between. Stress is less than mad but Somalians talk about being mad.* (Somali male, p. 205).

> *Inside Somalia people are crazy but they don't have depression. They (Somali community) didn't know about depression. . ..I didn't want to publicize. Depression doesn't mean anything in Somalia.* (Somali male, p. 205).

The cultural stigmatization of mental health problems was also a feature of Linney et al.'s (2020, p. 8) study:

> *It's embarrassing for the families to admit we need help.* (Male, FG2, P4).

> *There are so many people amongst Somali community, it's a really big taboo subject*. (Female, FG1, P3)

These quotes demonstrate binary understandings of mental health that consider people to be either 'sane' or 'mad'. The cultural stigmatization of mental health problems caused many of the refugees from 11 countries in Harris and Maxwell's (2000) study to resort to hiding themselves from others rather than risk being viewed as 'not coping' with their situation. However, isolation and loneliness due to 'cultural bereavement' (Eisenbruch 1990) (loss of familiar social structures, family, cultural norms and values, social- and self-identity), whilst being a natural response to a current situation, can lead to mental health problems if supports are unavailable to buffer the loss. In Paudyal et al.'s (2021) study, refugees from Syria discussed how separation from home and loved ones could lead to poor mental health:

> *Any news that you hear about the country, whether it's small or big news, it hurts and disturbs the person's mental state, so you fine us happy for their happiness and sad for their sadness or their suffering*. (Participant 8, man; p. 3)

> *If a person could see his children. . .like for one of our children to come, we probably would not need a psychiatric doctor. . .you know? Isn't this, right*?. (Participant 5, woman; p. 3)

Despite mental health generally being perceived as a taboo subject across the study participants, there were signs that some refugees had accepted a broader perception, with over half of the 12 participants from Syria in Paudyal et al.'s (2021) study believing that taboos about mental health should be broken, with four revealing that they had attended a UK mental health clinic, one stating:

> *It is necessary to resort to psychiatric medicine. . .psychiatry is a normal thing and healthy [. . .] we have a misconception about it likes it's for crazy people or so. . .no, no. On the contrary, it's something healthy and a person must resort to it whenever he feels the need to speak to someone.* (Participant 7, man).

Subtheme 2. Lack of trust in UK mental health services and reliance on traditional healers: helped perpetuate refugees' negative beliefs that they could be helped psychologically. Although Linney et al. (2020, p. 9) reported that women in their sample were more likely to trust UK health services than men, one female participant stating:

> *We don't have, not that many barriers affecting with the health services. Whatever the problem we have in mind, the first person to contact will always be the GP.* (Female, FG3, P2).

Participants in general across studies tended to perceive such services as being ignorant of their own cultural traditions and habits and therefore their own beliefs about how mental health problems arose. This was found to be the case even when interpreters were present in mental health programs:

> *No one would understand what we went through, and the situation like you would. . .who did not witness it won't sympathize, yes, so it's hard for me to go and explain my mental status to a doctor, it's better to explain to God.* (Participant 11, man) (Paudyal et al. 2021, p. 5)

Most of the refugees who participated in the reviewed studies came from countries where traditional healers and/or elders and religious leaders played an important role in relation to health including mental health. They therefore felt more confident dealing with people who were from their own cultural background, Harris and Maxwell (2000, p. 209) stated that traditional support could be found in the UK:

> *There are also non-religious ceremonies, like the Saar ceremony used in Somalia or the rituals used by the Poosary spiritual healer amongst Tamils, in which the sufferer must*

> *dance and sing out the spirit or djinn inside them. Both the Sheikhs (Somalia) and Hojas (Turkey), who use the Quran against evil spirits, can be found in the UK.*

This meant that in the eyes of many refugees, there was no need for mental health services offered by the UK, with a Somali participant in Linney et al.'s (2020, p. 8) study stating:

> *We felt like NHS do not understand what we want, we sent my [family member] back home and he's ok, thanks God.* (Male, FG2, P4).

Similarly, Nyiri and Eling (2012, p. 600) stated that one participant at a London clinic expressed that:

> *It takes so long to see a doctor, and when you do, they don't understand what I mean. So why should I go again?*. (Participant 3, man)

Subtheme 3. Bravado. Perhaps as a partial antidote to frustrations of perceiving the UK NHS mental health services as not being appropriate to their needs, refugees reported using a form of bravado—appearing 'strong' as a coping strategy—to help reduce their own feelings of anxiety and depression. This was also recognized as a cultural trait in studies, since vulnerability is not always expressed easily within some cultures. For example, in Papadopoulos et al. (2004), one refugee stated:

> *If you show weakness, people will look down on you. So, I keep everything inside and just pretend I am strong.* (Participant, Ethiopian refugee in the UK, p. 67).

Paudyal et al. (2021) reported that religious ideologies and faith as well as other self-help mechanisms (which could be encapsulated as a kind of bravado whereby individuals articulated 'I am alright as I have my faith') also played a significant role for people who had experienced trauma, with many depending on religious practices to help their own healing. Two refugees in their study said:

> *My mental state is better when I recite the Quran, I continue to do it, it provides comfort for me. . .Reciting the Quran is a comfort for me. . ..Sometimes I listen to it on the phone, and this is honestly a comfort for me* (Participant 11, man, p. 5)

> *I go to the sea and sit by the seaside, and I express my concerns to the sea, I speak to it. I go to the park, I try to get away from people* (Participant 8, man, p. 5)

Similarly, Papadopoulos et al. (2004) highlighted the practice of hobbies, such as reading, writing, or playing a musical instrument, being utilized rather than requesting help from mental health services, thus avoiding stigmatization, with one refugee stating in Papadopoulos et al. (2003, p. 217):

> *When I play my instrument, I feel at peace, I don't think about my problems.* (Ethiopian refugee, man)

Finally, Turner et al. (2003) argued that the trait of resilience in the face of adversity plays an important part in relation to the development of mental health problems, finding that just under half of their Kosovan Albanian refugee sample had a diagnosis of PTSD, and less than one-fifth had a major depressive disorder. The following quote from a refugee in Paudyal et al.'s (2021, p. 5) study corroborated this idea of resilience and self-help:

> *The person is his own doctor. Whatever happens to you, support or help, if you were not helping yourself from the inside, you won't be able to succeed. You must keep combating in this life, there is no other way* (Participant 1, woman)

Nevertheless, Turner et al. (2003) maintained that many individuals, especially newly arrived refugees, often have serious psychological difficulties for which appropriate and effective treatment services are needed.

3.2.2. Theme Two: Cultural Barriers

This theme reflects the central role of culture including language and communication in shaping refugees' access to mental health services.

Subtheme 1. Language barriers.

Refugees frequently reported difficulties in expressing their psychological distress due to limited English proficiency, a lack of appropriate terminology in their own languages, and mistranslations by interpreters. These issues often led to frustration, misunderstandings, and a sense of alienation.

Communication between services and refugees was generally found to be problematic in most of the reviewed studies, especially for refugees who did not speak English and struggled to provide details about their symptoms:

> *You can't seek help outside and you don't know how to approach that person who is not in your language speaking.* (Female, FG1, P1) (Linney et al. 2020, p. 9)

Refugees from a number of studies also reported that they found it difficult to understand UK medical terminology (e.g., Linney et al. 2020; Paudyal et al. 2021; Palmer and Ward 2007) or even talk about such a sensitive topic, as one refugee stated:

> *I think that's the biggest thing, the language, because medical terminologies you know are very difficult, especially psychological ones [. . .] the language.* (Participant 7, man) (Paudyal et al. 2021, p. 5).

Additionally, Palmer and Ward (2007) found that many refugees in London were reluctant to seek mental health support through interpreters due to fears regarding confidentiality within their own communities, while Green et al. (2012) observed that the interpreters themselves struggled to translate distressing material accurately, with one Kurdish interpreter explaining:

> *You have to translate pain into another language—sometimes the meaning changes completely.* (Green et al. 2012, p. 232).

Paudyal et al. (2021, p. 5) also highlighted the mistakes that could be made due to language misunderstandings, leading refugees to feel frustrated. For example:

> *For the translation I think it's not very helpful, sadly. . .I mean every expression or word I give out has a certain feeling to it, and for a translation it might not give out the proper meaning, or it won't come out the intended way, I believe.* (Participant 12, man).

The provision of specialist interpretation services was therefore deemed to be very important (Paudyal et al. 2021; Linney et al. 2020; Warfa et al. 2006; Papadopoulos et al. 2004; Palmer and Ward 2007; Green et al. 2012; Carswell et al. 2011).

Subtheme 2. Perceptions that mental health services lacked cultural awareness of refugees intersecting difficulties.

A lack of cultural awareness of the intersectional determinants of mental health affecting refugees by health professionals was also cited as a problem in the reviewed studies. For instance, practitioners might consider physical symptoms such as headaches, dizziness, poor sleep, and weakness as psychosomatic (Summerfield 2001). This could result in inappropriate diagnoses and insufficient or inappropriate care. McCrone et al. (2005) found that these negative perceptions prevented Somali refugees from asking for help, as many believed their distress would not be understood by professionals. For instance, several participants expressed a preference for consulting religious or community leaders rather than healthcare staff, reflecting differing cultural understandings of mental health and healing. Papadopoulos et al. (2004) similarly noted that the beliefs of Ethiopian refugees about the causes of mental illness were shaped by spiritual and social explanations rather than biomedical models, leading to mismatched expectations by UK professionals.

Paudyal et al. (2021) reported that some Syrian refugees felt judged or misunderstood by clinicians unfamiliar with their cultural backgrounds, while Linney et al. (2020) highlighted that Somali participants viewed Western mental health services as dismissive of faith-based coping strategies. Warfa et al. (2006) also described how cultural differences in symptom expression, such as using physical descriptions of distress rather than emotional ones, often led to misdiagnosis or inappropriate treatment. As one participant explained in Papadopoulos et al. (2004, p. 68):

> "*When I talk about my pain, they think it is in my body, but it is in my heart.*" (Ethiopian refugee, woman).

This lack of cultural awareness often led refugees to perceive UK mental health services as alien or unresponsive to their needs, reinforcing stigma and discouraging engagement.

3.2.3. Theme Three: Structural Barriers to Accessing Mental Health Care

Two significant structural barriers that impacted refugees' perceptions of accessing mental health services in the UK were found. The first was how refugees experienced what they perceived as the bureaucratic and authoritative nature of mental health services; the second was the involuntary transient nature of the refugees' lives.

Subtheme 1. The bureaucratic process of accessing mental health services

As already discussed, refugees were often found to be reluctant to enter mental health arenas for multiple reasons including the confusion of services due to language barriers and the fear of being stigmatized by their own communities. This extended to those in need of trauma-focused cognitive behavior therapy for PTSD, with Vincent et al. (2013, p. 585) reporting that all but one of their participants shared that they were desperate or had reached "rock bottom" before they could contemplate engaging in therapy:

> PS2: *I was really getting at the end of my rope. I was, I was tired of, sort of, like fighting to be alive [. . .] I was really, really close to just ending everything.*

Nevertheless, a lack of knowledge about how to access mental health systems could thwart access, with some refugees in Linney et al.'s (2020, p. 9) study saying that they did not know their way around the UK health system, one even stating:

> *It's always good to seek help but we don't know how to and that's the main thing.* (Female, FG1, P2)

Another refugee talked about how the GP system worked in the UK to exacerbate their lack of trust:

> *Every time you make an appointment you see a different GP which is a big problem.* (Female, FG3, P4)

Being passed from one unit to another combined with long waiting times before gaining treatment was not an uncommon issue, as a refugee in Nyiri and Eling's (2012, p. 600) study mentioned:

> *Even when we manage to register, it feels like the system is not for us. We are always sent from one place to another.* (Participant 4, man).

Similarly, a Somali refugee in McCrone et al.'s (2005, p. 355) study said:

> "*Even if you are sick, the system makes you wait and wait. By the time help comes, you feel worse.*" (Somali refugee, male participant).

Whilst long waiting times and lack of continuity in seeing the same GP are not extraordinary to refugees, the societal stigmatization and discrimination they face in their everyday lives (see Paudyal et al. 2021; Linney et al. 2020; Warfa et al. 2006) mean that it is understandable that refugees might perceive doctors' surgeries with distrust—especially since they often

view the GP as an authority figure. According to Linney et al. (2020, p. 11), this perception and fear of authority relates "to previous adverse experiences with people in positions of power" in their home countries, with three participants in their study stating:

> *We don't like the police because they intimidate you, they put you down for no reason and health services same as that.* (Male, FG2, P4).

> *There are not many, there's nowhere to turn other than locally, apart from going to your doctors which is a part of what we are so afraid of.* (Male, FG2, P4).

> *Your GP who will later on section your driving license for God's sake if you tell them, you haven't slept the last few days.* (Male, FG2, P4).

Palmer and Ward (2007) also noted that refugees in London described the referral system as confusing and alienating, with one participant reporting that repeated assessments and paperwork made them feel "passed around without help". Paudyal et al. (2021, p. 6) found that Syrian refugees often perceived NHS systems as overly bureaucratic and impersonal, with cultural expectations of care differing significantly from UK practices.

> *When you go to the doctor, you don't know who you will see, and they don't know you or what happened before. It feels like starting again every time.* (Participant 8, male).

They also noted that refugees often relied on informal advice networks for help navigating the NHS:

> *It's better to ask another Syrian because they know how to get appointments; the doctors don't have time,* (Participant 5, woman).

Warfa et al. (2006) echoed these issues, observing that Somali refugees associated delays in care and lack of continuity with feelings of discrimination and social exclusion. Collectively, these findings demonstrate how systemic inefficiencies intersected with cultural misunderstanding to reinforce the refugees' sense of exclusion from mental health support structures.

Subtheme 2. Involuntary transience of the refugees' lives.

Refugees frequently move around the UK (McCrone et al. 2005). Reasons vary (e.g., to gain employment, move to better housing, overcrowding, avoiding racism in a particular area and/or discrimination regarding employment and educational opportunities). These moves are normally unplanned and chaotic (Warfa et al. 2006). Forced moves (due to temporary housing policies in the UK) are perhaps the most difficult for refugees to cope with, one refugee in Warfa et al.'s (2006, p. 509) study stating:

> *Let me give you an example. My family and I myself moved a number of times. It is different when the housing officers said 'this family moved voluntarily'. I do not move voluntarily and I know a lot of people and a lot of families in different boroughs who change addresses because they have to. I myself did four times within three years until eventually I got a place of my own. And I didn't mean to move, I hate to move, but I had to.* (Male, professional).

The transient nature of the refugees' lives (unless they were ensconced within a close-knit cultural community, as found in Harris and Maxwell's (2000) study) impacted access to and continuity with GP and mental health services. There was a sense that individuals would have to 'start all over again' with the tiresome process of trying to explain their symptoms without interpreters who did not know them or understand the nuances of their culture. It is therefore unsurprising that most studies in our review reported an unmet need for psychological support amongst refugees (McCrone et al. 2005; Nyiri and Eling 2012; Carswell et al. 2011; Papadopoulos et al. 2004; Palmer and Ward 2007; Harris and

Maxwell 2000; Paudyal et al. 2021; Linney et al. 2020; Vincent et al. 2013; Bogic et al. 2012; Green et al. 2012; Summerfield 2003; Turner et al. 2003).

4. Discussion

The review included 15 studies from the UK, relating to many different communities and services. The studies emphasize that refugees struggled to access mental health services. Even when they did access them, the refugees were unsure whether the services understood their particular trauma-induced experiences or understood that symptoms related to past sufferings were a logical and normal reaction to highly traumatic experiences and the need to reassert the clients' strengths (Vincent et al. 2013); this latter point corroborates the findings of James and Forrester-Jones (2022). Anxiety about the safety of family members left behind may be one of the most stressful factors for refugees, but our review indicates that few mental health services seriously considered this important variable (Carswell et al. 2011; Turner et al. 2003).

This review confirmed that one of the biggest obstacles to accessing mental health services in refugee populations is language barriers (Paudyal et al. 2021), exacerbated by the limited availability of professional interpreters in general and the lack of well-trained professional interpreters in mental health communications in particular. Poor quality interpretation can lead to frustration and a fear of the potential lack of confidentiality (Simkhada et al. 2021), especially when the translator belongs to the same community as the refugee (Krystallidou et al. 2024). Thus, staff with bilingual expertise and an understanding of cultural backgrounds are very important in the provision of good care in mental health services (Krystallidou et al. 2024; Simkhada et al. 2021).

This systematic review also underlines how conceptualizations of mental health in refugee communities may differ from those of wider society, potentially affecting the services provided by GPs and health professionals (Linney et al. 2020). This adds to the complexity of diagnosing mental health problems in clinical settings and may influence the recorded prevalence rates among refugees from diverse cultural backgrounds. Refugees should not be considered as a uniform group, and these challenges all involve avoiding a universal description of mental disorders (Giacco and Priebe 2018). To improve the awareness of the mental health service requirements for refugees, a more holistic understanding of mental health needs is required including addressing the intersectional effects of issues such as accommodation, unemployment, poverty, lack of income, and transient housing (Linney et al. 2020).

Turrini et al. (2019) discussed the efficacy of psychosocial interventions in improving mental health outcomes among asylum seekers and refugees. They indicated that specific types of interventions such as cognitive-behavioral therapy and narrative exposure therapy demonstrated remarkably promising results in reducing symptoms of trauma, depression, anxiety, and PTSD. Understanding the acceptability of interventions is crucial for ensuring their feasibility and cultural appropriateness within diverse refugee populations.

Recent international socio-political crises suggest that the desire to escape war and torture (see Summerfield 2003) will continue to result in increasing numbers of refugees and the demand for mental health services. Moreover, at present, there may be an underuse of these services by refugees who may delay seeking help (as indicated by McCrone et al. 2005), but with time, these issues may ease and referrals may increase (Close et al. 2016). Consequently, there is a need for longitudinal studies to track the changes in health status for refugees over time, qualitative inquiries to explore the lived experiences of refugees in greater depth, comparative analyses across different refugee populations and host countries, and the evaluation of interventions aimed at addressing the mental health disparities faced by refugees (Papadopoulos et al. 2004; Sen et al. 2018).

The UK government also needs to make sure that health and social care policies that emphasize the importance of practitioner understanding of the cultural beliefs of mental health clients are underpinned by adequate funding. UK mental health services remain poorly resourced and are characterized by extended wait-times (Lowther-Payne et al. 2023). The collaboration of services with ethnic minority organizations and local refugee groups could help to develop more culturally sensitive services (McColl and Johnson 2006; Papadopoulos et al. 2004). Indeed, in Linney et al.'s (2020, p. 8) study, Somali refugees suggested that:

> *it would make sense if you could talk to some Somali person who could understand you rather than going to your GP*. (Male, FG1, P4)
>
> *Mental health team to recruit an elderly, an elderly person who understands the culture of the community*. (Male, FG2, P3)

Arafat (2016) argued that it is imperative to acknowledge and understand that the presentation of mental health symptoms may be different across minoritized communities. Community integration, acculturation, and psychological distress are some of the key benefits of increased collaboration. When such interventions are co-produced in participatory research involving refugees and the civil society organizations that support this population, they are naturally culturally responsive and can therefore address issues relative to different ethnic needs during the resettlement process (Mahon 2022).

Comparison with International Systematic Reviews

Our UK-focused synthesis aligns with, but also diverges from, findings reported in systematic and scoping reviews conducted in other high-income settings. Reviews covering refugees and first-generation migrants across Europe and beyond consistently identified language barriers, stigma, limited cultural competence in services, and post-migration stressors as primary obstacles to mental healthcare access (Close et al. 2016; Bogic et al. 2015; Watters and Ingleby 2004). Canadian reviews similarly documented structural and cultural barriers, and emphasized the role of culturally safe, community-embedded delivery models to mitigate them (Thomson et al. 2015). Australian qualitative syntheses echo these access constraints, adding the importance of trust and confidentiality concerns when using interpreters (Blignault et al. 2008).

Compared with these international reviews, several UK-specific differences emerged from our analysis:

Waiting times and system navigation: While long waits appear across all settings, UK studies more frequently emphasize the protracted access routes and complex eligibility/registration steps in primary care that can delay referral to psychological therapies (e.g., Nyiri and Eling 2012; McColl and Johnson 2006). In Canadian and some European contexts, co-located primary care and settlement services were more commonly described as mitigating such delays (Thomson et al. 2015; Watters and Ingleby 2004).

Interpreter dynamics: International reviews recognize interpreter-related issues, but this UK evidence highlights specific concerns about confidentiality and role of conflict when interpreters are drawn from the same local community, sometimes deterring help-seeking, as also found by Simkhada et al. (2021). Alternatively, interpreters unfamiliar with local dialects spoken within particular communities often got it wrong, according to the participants in the studies reviewed, with information becoming lost in translation, thereby causing more struggles and stress. Australian work reports similar concerns but with greater emphasis on the need for the availability of professional interpreter pools (Blignault et al. 2008).

Conceptualizations of distress: UK studies (e.g., Linney et al. 2020; Summerfield 2003) describe somatized or culturally embedded expressions of distress that can clash with

diagnostic conventions in general practice. European comparative work underscores the same phenomenon but often reports more established cross-cultural training infrastructures in specialist services (Watters and Ingleby 2004).

Post migration stressors within the welfare context: UK studies show that precarious immigration status, poverty, and housing problems as well as transient and precarious living situations all affect refugees' mental health, similar to findings in Europe and Canada. However, this review highlights that in the UK, having to involuntarily move from one area of the UK to another (a country that is characterized by many counties with distinct dialects, norms, and traditions) are particularly linked to worsening mental health and avoiding services (Carswell et al. 2011; Paudyal et al. 2021; McCrone et al. 2005; Warfa et al. 2006).

Taken together, these comparisons strengthen the generalizability of our findings across high-income host countries while highlighting UK-specific leverage points—particularly around primary-care gateways, interpreter arrangements, and asylum-linked stressors—that should inform domestic policy.

5. Policy and Practice Implications for the UK and Recommendations

Building on the UK-specific gaps identified above and lessons from comparable international reviews, we recommend the following:

- Professional, trauma-informed interpreting: There is a need to commission regional pools of professionally trained mental-health interpreters with clear confidentiality protocols, independent of local community pressures (Simkhada et al. 2021; Krystallidou et al. 2024; Summerfield 2003; Vincent et al. 2013).
- Co-locate and integrate access points such as the establishment of one-stop "health and settlement" hubs, which could be co-located with primary care, legal aid signposting, and psychological therapies, in areas of high refugee settlement. This approach is supported by evidence from Canadian and European practice (Thomson et al. 2015; Watters and Ingleby 2004).
- Embed bilingual health navigators/cultural brokers within GP practices serving asylum hotels and dispersal accommodation to accelerate registration and referral (McColl and Johnson 2006; Nyiri and Eling 2012).
- Commission culturally adapted and scalable therapies: Scale TF-CBT/NET groups with adaptations to language, idioms of distress, pacing, and inclusion of family/faith-sensitive social and nature components (Nosè et al. 2017; Vincent et al. 2013).
- Making services visibly safe and stigma-reducing such as by holding sessions in neutral community venues (libraries, faith-neutral centers) and providing groups tailored by language, where relevant, that is mindful of the particular challenges in the UK around privacy and visibility within close communities (Linney et al. 2020; Simkhada et al. 2021).
- Addressing post-migration stressors alongside therapy as "therapy-plus" pathways allows clinicians to trigger rapid practical support for housing, asylum advice, and income insecurity. These factors are repeatedly linked to poorer mental health and disengagement and need to be addressed at the same time as therapy (Carswell et al. 2011; Paudyal et al. 2021; Bogic et al. 2015).

6. Strengthening Generalizability

The UK findings, alongside the international syntheses, confirm that the barriers (language, stigma, cultural mismatch, post-migration adversity) are very important and indicate that many recommendations will transfer across high-income host countries. However, UK-specific bottlenecks around GP registration, interpreter arrangements, and refugee-linked uncertainty warrant tailored commissioning and service design. Future

research should include cross-country comparative evaluations of co-located access hubs, interpreter-clinician training, and adapted TF-CBT/NET, with mixed-methods process evaluations to capture cultural fit and implementation feasibility.

Limitations

Although the studies involved many different UK refugee communities, most samples were drawn from specific countries, communities, or clinical settings, and therefore these findings should not be assumed to represent all refugees in the UK. The number of studies (n = 15) reviewed was small, largely due to the fact that in the process of reading the full text of papers under consideration, we found that many of them had conflated refugees with asylum seekers or migrants (e.g., Simkhada et al. 2021; Pollard and Howard 2021; Nosè et al. 2017; Close et al. 2016) and focused on settings such as immigration detention centers or mental health inpatient units (Sen et al. 2018; Bhui et al. 2006, respectively). Such settings differ substantially from community-based contexts, which were the primary focus of the present review. In addition, studies relying solely on clinical records without reporting the participants' perspectives (e.g., McColl and Johnson 2006) were excluded, as they did not provide qualitative or self-reported data relevant to our research question. We did note though that those that were excluded from our systematic review indicated similar mental health difficulties confounded by social determinants that the refugees experienced; there was no evidence to suggest that having refugee status abated mental health problems or issues of accessing mental health services.

The included studies had small numbers of participants and recruitment strategies were variable, so there may be a bias in particular participant groups. This could have influenced the results and conclusions. Since the studies were all in the UK, our review reflects the circumstances that people face in seeking care in one jurisdiction, and may not translate to other countries. However, our findings offer in-depth insights into how one country treats refugees in terms of mental health care, which can be lost in broader multiple-country systematic reviews.

7. Conclusions

This review demonstrates the need for mental health services that are tailored not only to the needs of refugees in accordance with complex histories of flight, but also that ease their pathway and access to services. Pivotal to improved access is the provision of language interpretation, cultural awareness, and an understanding of the issues that refugees may have faced and are coping with. Barriers to accessing care, such as stigma, lack of trust, ignorance, or the desire to appear resilient, are also common in the general population. Nevertheless, these challenges are often compounded for refugees by displacement, cultural disconnection, and precarious socio-legal status. We argue that the only way the situation can be improved for refugees is if clinical and professional mental health practitioners and services embed their policies and practice with insider information about what does and does not work. Creatively and authentically involving refugees in clinical practice and service training will go some way to help.

Relevance to Clinical Practice

Our review highlights key factors affecting UK refugees' access to mental health care and provides important insights for clinical practice. Clinical health and social care providers need to work together to consider how cultural beliefs about mental health can be better understood and collaborate with refugee groups to develop culturally sensitive services. Trained interpreters and bilingual clinicians are also essential. Moreover, effective mental health care for refugees should consider broader social determinants such as immi-

gration status, housing, unemployment, and poverty. In clinical practice, these findings emphasize the importance of culturally sensitive, linguistically accessible, and holistic mental health services tailored to the diverse needs of refugees.

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Appendix A. Full Search Strings and Database Hit Counts

The following full search strings were used across databases:

- Google Scholar: "Mental health AND refugee* AND (UK OR 'United Kingdom')" → 4337 hits;
- EBSCOhost: "Mental health services AND stigma AND refugee* OR asylum seekers" → 1245 hits;
- PubMed: "Refugee* OR asylum seekers AND PTSD OR post-traumatic stress disorder AND (UK OR Britain)" → 2133 hits;
- PsycINFO: "Refugee* OR asylum seekers AND post-traumatic stress disorders AND (United Kingdom OR UK)" → 876 hits;
- EBSCO: "Mental health care AND refugee* OR asylum seekers" → 543 hits.

After screening, a total of 15 studies were included in the final review (see the PRISMA flow diagram, Figure 1).

Notes

[1] Note that people who flee their homes due to famine or flooding or environmental disaster are not regarded as fearing persecution for any of the Convention reasons.

[2] The papers we reviewed used a wide range of terms such as mental health needs, conditions, and disorders. Following the preferences of UK charities Mental Health Foundation and Mind as well as recent empirical work by Forrester-Jones et al. (2024), we use the term mental health problems.

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