Service providers’ perspectives on increasing access to psychological interventions for refugees from the Middle East

A thesis submitted to the University of Manchester for the degree of Doctor of Clinical Psychology (ClinPsyD) in the Faculty of Biology, Medicine and Health

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Thesis Abstract
This thesis has been completed as part of the examination process for the Doctor of Clinical Psychology (ClinPsyD) in the Faculty of Biology, Medicine and Health (Division of Psychology and Mental Health) at the University of Manchester. This thesis was focussed around the perspectives of service providers on the access to mental healthcare and parenting interventions for refugees from the Middle East. Paper 1 includes a meta-synthesis of primary qualitative research relating to service provider perspectives on refugees from the Middle East accessing mental healthcare in the context of displacement and resettlement. Paper 2 provides an empirical study which utilised a Thematic Analysis approach to analyse interviews that were done with service providers on perspectives on a Conversation Group for refugee families and complexities that would need to be taken into consideration for its implementation in resettlement contexts. The paper 3 comprises of the researcher’s insights and critical reflection on the process of conducting this research and with a focus on explaining decisions made and implications of the research.
Declaration

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The Author

Altaf Sumra was awarded with a BSc in Psychology from the University of Central Lancashire in 2010 and thereafter with a MSc in Health Psychology in 2011 and a Post Graduate Certificate in Primary Care Mental Health Practice in 2015 from the same institution. He worked as a Research Assistant conducting research in the cultural adaptation of psychological interventions for ethnic minority groups as part of Lancashire Care NHS Foundation Trust. He has also gained experience in working in Forensic settings as an Associate Practitioner and has been pursuing a career in Clinical Psychology through working through the Clinical Psychology Doctorate programme at the University of Manchester.

Acknowledgements

I would like to sincerely thank my research supervisors, Professor Rachel Calam and Dr Fiona Ulph, your guidance, motivation and hope helped pushed me through. This also extends to the programme team and personal tutors, James McManus, Dan Pratt and James Lea, you all helped me more than you can ever know. This research would also not be possible without the participants and organisations which kindly gave their time to take part in the study.

I would also like to thank my friends that helped provide a listening ear and support; Adam Desai, Adam Esa, Nadeem and Farah, I cannot thank you enough.

Last, but by no means least, I would like to say a heartfelt thank you to my wife Amna and my baby son Yusuf. Amna, your patience and perseverance is something which I aspire to, and Yusuf, I hope you read this one day and see that anything can be accomplished if you want it enough.
Paper 1: Service providers’ perspectives on access to mental healthcare for refugees from the Middle East across the journey: A meta-synthesis

Altaf Sumra, Fiona Ulph and Rachel Calam

The University of Manchester

Paper 1 was formatted according to the guidelines of the Journal of Social Science and Medicine (Appendix 1).

Some formatting amendments have been made to enhance the readability in this thesis. An example is that the relevant tables and figures have been inserted within the text and not presented separately.

Word count excluding tables, figures and references: 7531
Abstract
Displacement, as a result of forced migration has soared to unprecedented heights across the Middle East. Populations that have been forced to migrate suffer from a higher level of mental health issues and receive less support with their mental health needs. Understanding the perspectives of service providers is imperative as they are often found to be gatekeepers to the care refugees receive. This qualitative meta-synthesis aimed to 1) collate, review and then provide a synthesis of qualitative research findings around the views of service providers on the challenges and facilitators Middle Eastern refugees face when accessing mental healthcare; 2) to provide implications and recommendations for the practice of when working with refugee populations from the Middle East and to help assist in service development. There were seven primary research studies included within this synthesis and using Walsh and Downe’s (2005) method of meta-synthesis, results found five core concepts (service level: challenges related to the delivery of mental healthcare; life stressors affecting access to mental healthcare; culture, spirituality and religion; interpersonal healthcare interactions and communication; service level: facilitating mental healthcare access). The relationship between these concepts were described and the synthesis highlighted barriers and facilitators toward access to mental health services for refugees from the Middle East. Implications and recommendations for practice and research are discussed.

Key words: Qualitative, meta-synthesis, refugee mental health, Middle East
Introduction
Forced migration is currently at the highest reported on record with 65.6 million individuals from around the globe. Of these, 22.5 million individuals are refugees, 40.3 million are internally displaced people and 2.8 million are asylum seekers (United Nations High Commission for Refugees (UNHCR, 2016). Populations that have been forcibly displaced are often referred to as refugees and are defined as people who have migrated out of their country of origin for reasons of persecution and conflict and thereafter require international protection (UNHCR, 2018). Also considered within forcibly displaced populations are asylum seekers; defined as people who seek leave to stay in a country, and internally displaced populations, defined as people forcibly displaced from their home. However, internally displaced population remain within their original country and often stay in camp settings (Reed, Fazel, Jones, Panter-Brick & Stein, 2012). The term ‘refugee’ is to be used hereafter to describe the populations outlined above.

Refugee Journey and mental health
Refugee populations go through many stages as part of their journey from their home land to eventual resettlement (Williams, 2012). The main stages that are described as part of this are: pre-flight as a time when the conflict initially occurred; flight, and eventual resettlement (Williams, 2008). Prior to resettlement, the experiences that refugees endure in regards to war trauma and uncertainty, increase their vulnerability to developing mental health issues (Steel, Chey, Silove, Marnane, Bryant & van Ommeren, 2009). Even when the refugee has reached resettlement, issues like that of multiple losses, family separation, poor housing and issues with procedures relating to asylum processes can have an ongoing impact on their mental health (Porter and Haslam, 2005; Murphy, Rodrigues, Costigan & Annan, 2017) and subsequent integration into new surroundings (Schick, Zumwald, Knöpfli, Nickerson, Bryant, Schnyder et al, 2016). Furthermore, the additional pressure of having to adapt and acculturate to a new environment which has differing cultures, practices and health care systems to that of their original country of origin can be difficult to navigate (Williams, 2010).
Asylum seekers and refugees are deemed as vulnerable populations and a population in which many complexities arise in both physical and mental health (Robertshaw, Dhesi & Jones, 2018). Mental health issues can be described as psychological and emotional disturbances (WHO, 2004) and it has been reported that levels of anxiety, depression, phobias and post-traumatic stress disorder (PTSD) can be up to five times higher in refugee populations in comparison to the general population (Aspinall and Watters, 2014; Fazel, Wheeler & Danesh, 2005). Some reasons that have been put forward to explain the increase in psychological problems commonly refer to the trauma that is often witnessed and experienced by refugees during conflict and displacement from their home, and the stress associated with refugee camps like that of violence, overpopulation and lack of resources (Mckell, Hankir, Abu-Zayed, Al-Issa & Awad, 2017). Reviews and studies have found that the war and turmoil that has affected many countries in the Middle East have had a large impact on the mental health of refugees, with PTSD and depressive disorders amongst some of the most common mental health problems reported (Al-Ghawzi, A-Bashtawy, Azzeghaiby, & Alzoghaibi, 2014; Elbedour, Onwuegbuzie, Ghannam, Whitcome & Hein, 2007; Khamis, 2005).

Crisis in the Middle East

The Middle East represents a region with very significant numbers of refugees. There continues to be unrest across the Middle East with war and conflict on the increase. Individuals from the Syrian Arab Republic continued to be the largest forcibly displaced population at the end of 2016 (UNHCR, 2016). For every 1,000 people of the population in Syria, 650 have been forcibly displaced. Furthermore, other nations in the Middle East like that of Iraq and Palestine also have a large number of individuals that have been forced to migrate, with 5.3 million refugees registered to the United Nations Relief and Works Agency for Palestinian Refugees (UNRWA) (UNHCR, 2016). Furthermore, neighbouring countries like that of Lebanon and Jordan are places in which refugees were often hosted. In Lebanon, the population consists of every one in six people being a refugee and is one in every eleven in Jordan (UNHCR, 2017).
Middle Eastern refugees accessing mental health care

Refugees from the Middle East often struggle to gain appropriate access to the mental healthcare and support they require. Multiple reasons have been put forward for this, some concerning attitudes and beliefs, and some, more practical difficulties. The role of stigma and a lack of education are some reasons that have been proposed to potentially explain why there is such a disparity between these refugee populations receiving the care they require (Mckell et al, 2017; Ellis, Miller, Baldwin & Abdi, 2011). Furthermore, the stigma of accessing mental health services could affect marital prospects and could be misconstrued by the community in which they reside (Al-Krenawi & Graham, 2000; Hassan, Hassan, Ventevogel, Jefee-Bahloul, Barkil-Oteo & Kirmayer, 2016). The presence of barriers which often prevent these refugees from gaining the services they require can subsequently have a detrimental effect on the refugees’ mental health and wellbeing (Almazeedi and Alsuwaidan, 2014).

This is compounded by perspectives from individuals from the Middle East regarding mental health services. Mental health services have been found to be viewed in a negative light from these refugees and this mistrust can often lead to an underutilisation of them (Al-Krenawi & Graham, 2000). This mistrust can often stem from a belief that if services are accessed, then their religious faith and value system may fail to be seen as a source of healing for them (Al-Krenawi & Graham, 2000). Furthermore, even when refugees wish to access care related to their mental health, language differences can often cause difficulties due to emotions and feelings often being harder to articulate for this population in comparison to physical clinical symptomology (Jensen, Norredam, Priebe & Krasnik, 2013; Bischoff, Bovier, Isah, Françoise, Ariel & Louis, 2003).

Another issue is that mental health services in the Middle East are scarce with many countries having very little resource allocated to deal with mental health concerns (Okasha, Karam & Okasha, 2012). There are few trained mental health professionals and this is further compounded by many countries in the Middle East having no formal mental healthcare policy or specialist mental healthcare workforce (Okasha et al, 2012). Okasha et al (2012) estimated that post the 2011 Libyan civil war, per for every 100,000 of the population there was only approximately 0.2 psychiatrists, 5 psychologists, 0.05
psychiatric nurses and 1.5 social workers. Similarly, government expenditure on mental health provision has been reported to be estimated at just 2% in Egypt and Syria (WHO, 2011) and 5% in Lebanon (Yehia, Nahas, & Saleh, 2014). However, there is systematic review data which shows the efficacy and effectiveness of interventions such as Narrative Exposure Therapy (Tribe, Sendt & Tracy, 2017) and Cognitive Behaviour Therapy (CBT) (Stenmark, Catani, Neuner, Elbert & Holen, 2013) which shows the importance and effectiveness mental healthcare and intervention can have for these populations.

**Importance of gaining service provider perspectives**

Access to appropriate services is usually identified and sought through health professionals and service providers who often have the role of ‘gate keepers’ to care (Ingleby, 2004). Middle Eastern refugees have a high prevalence of mental health concerns and are less likely to receive support with their mental health needs in comparison to the general population (Aspinall & Watters, 2010). This highlights the importance of understanding the perspectives of service providers; individuals that are often the first means of contact for refugees (Starfield, 1994), and of synthesising their views on barriers and facilitators for refugees from the Middle East on accessing mental healthcare.

**The present review**

Currently, reviews in this area of research on service providers’ perspectives with refugees in and from the Middle East have focussed on the views of healthcare practitioners providing primary healthcare (Robertshaw et al, 2018) as opposed to a focus on mental healthcare. Some focus more specifically on refugees and displaced refugees in low and middle income countries globally. However, Middle Eastern refugees potentially form a distinct cultural group, with shared values and languages, which could then indicate fruitful areas for the development and provision of mental health support and services for this underserved population. There have been qualitative research studies that have been conducted in this area, which provides an opportunity to produce a
synthesis of the qualitative data that is present and allow the findings to be contextualised. The present meta-synthesis was produced in this regard and aimed to fulfil this need.

**Aims and research question**

The aims of this review were to 1) collate, review and then provide a synthesis of qualitative research findings around the views of service providers on the barriers and facilitators Middle Eastern refugees face when accessing mental health care; 2) to provide implications and recommendations for the practice of when working with refugee populations from the Middle East and to help assist in service development. In order to enhance the understanding of potential areas for development of service provision, perceived barriers and facilitators were central to this synthesis. The primary research question for this meta-synthesis was: What are service providers’ perspectives on access to mental healthcare for refugees from the Middle East?

**Method**

In this meta-synthesis of the literature the focus was on studies which utilised a qualitative research design. When attempting to gain an understanding of experiences and opinions on healthcare delivery, qualitative studies can provide the depth and detail of information required (Pope, Van Royen & Baker, 2002). Collating these studies and applying systematic procedures to identify, summarise and synthesise the results should further enhance the depth of knowledge in the topic area and produce inferences which are more generalisable than separate individual studies (Finfgeld-Connett, 2010; Harden, Garcia, Oliver, Rees, Shepherd, Brunton & Oakley, 2004).

Many methods have been proposed to allow for the synthesis of qualitative research (Ring, Ritchie, Manday & Jepson, 2010). The present meta-synthesis used the Walsh and Downe (2005) method of meta-synthesis for qualitative research which was based on the method initially proposed by Noblitt and Hare (1988). It is a method which is commonly
used to synthesise qualitative research (Khan, Bower and Rogers, 2007) and provides a level of interpretation to understand the data and for conclusions to then be drawn (Walsh and Downe, 2005). A synthesis of the existing literature related to mental health service provision for refugees of Middle Eastern origin was therefore undertaken. Of particular importance was the health professionals’ views and perceptions of the barriers and facilitators to improving access to appropriate mental healthcare for this underserved population.

**Search strategy and selection criteria**

A search strategy was developed which used key search terms (see table 1). Search terms were derived from the American PubMed mesh terms, the medical subject headings for scholarly databases. On examining the mesh key terms, a search strategy was formulated based on the relevant keywords and previous literature. Once an initial scope of the literature was carried out, the search terms were agreed by the authors of the review and inclusion and exclusion criteria were set for when reviewing the literature (see table 2).

Once the search strategy had been developed, relevant truncations were utilised and synonyms obtained from various sources were input. The search was then deployed in the scholarly databases; CINAHL, EMBASE, Medline and PsychInfo. The databases were searched with no start date restrictions. Hand searches were also carried out in May 2018. Further grey literature was also searched using Open Grey, this was due to ensuring that any unpublished work had not been missed. A framework around the population, phenomena of interest and context (PICO) was utilised to help provide structure to the search strategy (see table 2). The method of ‘Preferred Reporting Items for Systematic Reviews and Meta-Analyses’ (PRISMA) (Moher, Liberati, Tetzlaff, & Altman, 2009) was utilised to illustrate the process of searching the literature and selection of papers for review (see figure 1).
Table 1 - Adapted PICo Search Tool

| Population | Service providers providing mental health care | health service or mental health services or nurs* or health care or psyc* or counsel* or psychotherap* or therapist or community worker or support worker or aid worker or case worker |
| Phenomena of Interest | Perspectives | Attitude* or perception* or belie* or mindset or opinion* or perspective* or position* or prejudice* or stance* or view |
| | | Barrier* or Hurdle or Obstacle or Obstruct* or refusal or Impedim* or Promot* or Facilitat* or Support* or Enabl* or Cause* or Reasons or challeng* |
| Context | Refugees | Refug* OR asylu* |
| Outcome | Qualitative research methods | exp Qualitative Research or qualitative or mixed method or experience |
### Table 2 - Selection criteria for inclusion and exclusion

<table>
<thead>
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<th>Inclusion:</th>
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<tr>
<td>1) Studies that are in the English language</td>
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<td>2) Qualitative methodology was utilised</td>
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<td>3) Original peer-reviewed research articles</td>
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<td>4) Studies which described health professionals’ views on mental healthcare</td>
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<td>5) Studies looking at perspectives to accessing mental health care for refugees that originate from the Middle East; as defined by the World Bank country definition (World Bank, 2018)</td>
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<td>6) Mixed method studies if the qualitative element could be extracted for the synthesis of the papers</td>
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<th>Exclusion:</th>
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<tr>
<td>1) Studies that are not in the English language</td>
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<td>2) Health professionals’ views on refugees on accessing primary healthcare that does not have a focus on mental health care</td>
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<td>3) Refugees that do not originate from the Middle East</td>
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<td>4) Studies that included immigrants or migrants as their sole participants</td>
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<td>5) Dissertations, literature reviews and book chapters</td>
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The initial search found 720 research papers which could possibly be included in the review once the duplicate papers were identified and removed. The included and excluded studies were then selected after the title and abstracts of the research papers were screened against the criteria set. At this point in the review, 687 studies were found to not be suitable and were excluded. Many of the research papers were excluded due to not being specifically about refugees from the Middle East. To ensure the screening process that was carried out was appropriate, an independent doctoral-level researcher was sought and 20% of the records were cross checked against the set selection criteria. The Kappa statistic was thereafter utilized to test for inter-rater reliability and the result
indicated a very high level of agreement \( k = 0.84 \) \( (p<0.001) \) (Cohen, 1960). Thirty-three research articles remained. The full texts for these papers were located and reviewed, 26 papers were thereafter excluded. Once the procedure outlined above was complete, a final set of seven research papers remained.

**Data extraction**

The data from the studies were extracted by hand by the researcher and by using Microsoft Excel. Study characteristics were extracted from the original paper using the following criteria; included methods/analysis, country study conducted in, participants, refugees’ countries of origin, aims and results/themes. Table 3 illustrates the data that was extracted.
<table>
<thead>
<tr>
<th>Authors</th>
<th>Methods/analysis</th>
<th>Country study conducted in</th>
<th>Participants</th>
<th>Refugees countries of origin</th>
<th>Aims**</th>
<th>Results/Themes</th>
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<tbody>
<tr>
<td>1 Mckell et al (2017)</td>
<td>Interviews / Thematic Analysis</td>
<td>Jordan (displacement context)</td>
<td>16 Healthcare professionals</td>
<td>Palestine</td>
<td>To identify the barriers of accessing and consuming mental health services for refugees from Palestine in refugee camps in Jordan and to formulate policy recommendations</td>
<td>Resource and financial deficits</td>
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<td>Stigma and religion</td>
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<td>Culture</td>
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<td>2 Mirdal et al (2012)</td>
<td>Interviews / Qualitative phenomenological approach</td>
<td>Denmark (resettlement context)</td>
<td>4 Clinical psychologists</td>
<td>Iraq, Lebanon</td>
<td>To study how refugees, therapists and interpreters perceive curative and hindering factors in psychological therapy</td>
<td>Importance of;</td>
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<td>Psychoeducative methods</td>
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<td>Cognitive interventions</td>
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<td>Practical help</td>
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<tr>
<td>3 El-Khani et al (2016) ¥</td>
<td>Interviews and Focus groups / Thematic analysis</td>
<td>Syria and Turkey (displacement context)</td>
<td>27 Refugees and 2 Professional aid workers (1 camp doctor and 1 local director of NGO)</td>
<td>Syria</td>
<td>Explore the parenting support needs of Syrian parents currently in refugee camps to understand the feasibility and value of intervention at this stage</td>
<td>Value of tailored, culturally sensitive support</td>
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<td>Value of simple interventions</td>
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<td>Limited mental health care resources and provision</td>
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<tr>
<td>4 El-Khani et al (2018) ¥</td>
<td>Interviews and Focus groups / Thematic analysis</td>
<td>Syria and Turkey (displacement context)</td>
<td>27 Refugees and 2 Professional Aid Workers (1 Camp Doctor and 1 Local Director of NGO)</td>
<td>Syria</td>
<td>Identify the parenting experiences of Syrian families living in refugee camps with a focus on understanding how their parenting had changed and the impact displacement had on this</td>
<td>Environmental challenges</td>
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<td>Child and parent specific challenges</td>
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<td>Lack of mental health care provision for this population</td>
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<td>Importance of parenting interventions</td>
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<td>Study</td>
<td>Methodology</td>
<td>Country (context)</td>
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<tr>
<td>5 Khawaja and Stein (2016)</td>
<td>Interviews / Thematic analysis</td>
<td>Australia (resettlement context)</td>
<td>7 Practitioners (3 Psychologists / 2 Psychiatrists / 1 Occupational Therapist and 1 Social Worker)</td>
<td>To understand the psychosocial issues of asylum seekers in the community and identify changes that should be made to existing mental health services</td>
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<tr>
<td>6 Dotevall et al (2017)</td>
<td>Interviews / Content analysis</td>
<td>Jordan (resettlement context)</td>
<td>8 Final year Nursing students with experience caring for refugees</td>
<td>To describe Jordanian Nursing students experience of caring for refugees with mental health problems</td>
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<tr>
<td>7 Khan et al (2017)</td>
<td>Interviews / Grounded theory</td>
<td>Canada (resettlement context)</td>
<td>22 (5 Legal Providers / 4 Mental Health Providers / 6 Advocates 5 Resettlement Workers / 2 Private Sponsors)</td>
<td>Explore providers’ perspectives on how they understand and promote the wellbeing on LGBT forced migrants and what challenges service providers face in promoting well-being to this population</td>
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</tbody>
</table>

*These research articles had data from the same set of participants’, but different aspects were reported

*Some of the studies included include refugee populations that are not eligible for the current review. They have not been included in the table.

** Aims have been taken directly from the research articles
Quality Appraisal

The method of critical appraisal to assess the quality of the papers that were included in this meta-synthesis were done by using the Critical Appraisal Skills Programme (CASP, 2017); a tool which is validated and has a checklist of 10 items to assess papers. Some of the domains which the CASP was used to assess were research aims, reflexivity and the value of the research. The CASP was scored via a system in which a ‘yes’ would achieve a score of 1 and a ‘no’ would get a score of 0 and there was also an option for ‘can’t tell’. In total, for each paper a score of 10 can be achieved (10 being the highest). In regards to the quality of each paper, a score of 8-10 would suggest it was of a high quality, a score of 5-7 would suggest an acceptable quality rating and any paper than obtained a score that was lower than 4 would suggest that the paper was not of a sufficient quality and would have therefore been removed from the current meta-synthesis. To ensure that this process was rigorous and reliable, all the papers that were included were also independently assessed by an independent researcher. There was a 100% concordance rate between the two ratings and a table highlighting the scores obtained for each paper and agreement between the rating can be seen in Appendix 2.

Synthesis approach

To analyse and synthesise the data an interpretive approach was utilised based on the method proposed by Walsh and Down (2005) which has been developed from the work by Noblitt and Hare (1988). Initially, to get a feel for the data and to enable concepts and similarities to emerge, each study was read several times. In line with Walsh and Downe’s (2005) method, data from the authors, in terms of their interpretation and direct quotations from participants in the data were sought and the concepts that emerged from the data were entered into a conceptual grid. Once all the concepts were collated the process of contrasting and comparing them had taken place which resulted in the development of a set of initial descriptive themes (n= 30). Thereafter, in line with Noblitt and Hare (1988) who further elaborate on this process and suggest at this stage a note is made of whether the themes are representative of data that is reciprocal or reputational to each other; this was done by the researcher. A refining process was then undertaken in which the initial themes were collated into more refined, analytic constructs and in line with Finlayson and Downe (2013), the process was continued until a saturation was
believed to have been reached. The first author (AS) conducted the initial stages of the synthesis and thereafter, several discussions with the other authors were held until theoretical saturation was believed to had been reached and this allowed the further refinement of themes to develop into the core concepts (see table 4). This was then expressed in a diagrammatic and written narrative.
<table>
<thead>
<tr>
<th>Initial description of themes</th>
<th>Refined iteration of themes</th>
<th>Core concepts</th>
<th>Referenced in papers</th>
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<tbody>
<tr>
<td>Not enough resources</td>
<td>Limited resources</td>
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<td>Not able to provide enough sessions</td>
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<td>Inadequate quality of mental health care</td>
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<td>Mental health care provided in poor/dirty environments</td>
<td>Mental health care provided in unsuitable environments</td>
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<td>Not enough emphasis put on mental health care</td>
<td>Mental health not seen as a priority</td>
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<td>Not the best time for accessing mental health care</td>
<td>Mental health care not prioritised</td>
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<td>Hearing bad news from country of origin</td>
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<td>Visa issues</td>
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<td>Threat of being sent back to country of origin</td>
<td>Uncertainty</td>
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<td>Job issues</td>
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<td>Cost of transport</td>
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<td><strong>Culture, spirituality and religion</strong></td>
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<td>Stigma around seeking support</td>
<td>Stigma around mental health and seeking support</td>
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<td>Sex/gender issues</td>
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<td>Social marginalisation</td>
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<td>Psychosomatic presentations</td>
<td>Mental health presentation</td>
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<td>Mental health understood through spirituality</td>
<td>Cultural explanatory models</td>
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<td>Spiritual healers accessed before mental health services</td>
<td>Role of spiritual healers</td>
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<td>Importance of religion</td>
<td>Impact of religion</td>
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<td>Importance of building rapport and trust</td>
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<td>Allowing time to talk</td>
<td>Allowing time to talk</td>
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<td>Practitioner positive traits (flexible / respectful / empathetic)</td>
<td>Positive ways of practitioner relating</td>
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<td>Shared hopes and goals</td>
<td>Collaborative working</td>
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<td>Use of interpreters</td>
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Mckell et al (2017)  
El Khani et al (2018)  
El Khani et al (2016)  
Gretty et al (2012)  
Khawaju and Stein (2016)  
Dotevall et al (2017)
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<th>Importance of flexibility in approaches</th>
<th>Importance of flexibility in approaches</th>
<th>Service level: Facilitating mental healthcare access</th>
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<td>Importance of multi-disciplinary care and holistic services</td>
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<td>Dotevall et al (2017)</td>
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Reflexivity
This synthesis adopted a constructivist approach (Charmaz, 2014) as this enabled the researcher to interact with the literature and utilise an interpretive stance. The first author (AS) is a South Asian male and is of the Muslim faith. He was born and raised in the Northwest of England, and has one child. The researcher has not worked with refugee populations and so did not share the same experiences that the research participants had experienced. This made it imperative for the researcher to be aware of and to get immersed in the data to allow appropriate interpretations to be made (Haynes, 2012) and to enable understanding of the data sets.

Results

Quality rating
All of the studies (n=7) that were included in this paper were assessed as being of high quality and therefore having a high level of both methodological quality and the research being at a low risk of bias. No papers were excluded from this synthesis on the basis of quality or bias.

The quality of the papers was consistently high, however, some issues were identified after conducting the CASP. The critical analysis of each paper was tabulated and can be found in Appendix 2, it highlights what each paper scored individually and also the concordance between each reviewer. In total, seven papers exploring service providers’ perspectives on access to mental health care for refugees from the Middle East were utilised for the synthesis.

Overview of studies
The studies included the views of 61 service providers from the seven individual research study articles and the views of these providers were focussed on refugees that originated from the Middle East. These refugees originated from different parts of the Middle East, namely; Palestine, Iraq, Lebanon, Syria, Iran and the Arabian Peninsula. Three of the studies focussed on the refugees that were in refugee camps and four of the studies were
focussed on when the refugees in the resettlement stage. The studies were conducted in different countries, including: Jordan (n=2), Syria and Turkey (n=2), Denmark (n=1), Australia (n=1) and Canada (n=1). The methods of data collection that were utilised by all the studies were semi-structured interviews, two of these studies also included focus groups as part of the study. The most common form of analysis found in the studies was that of Thematic Analysis (n=4). Other methods included Grounded Theory (n=1), Content Analysis (n=1) and a Phenomenological Approach (n=1). See table 3 For full details of each paper.

**Synthesis results**

Five core concepts were identified. Service level: challenges related to the delivery of mental healthcare and service level: facilitating mental healthcare access were found to directly affect mental healthcare access for these refugees from a service perspective. Life stressors affecting access to mental health care was a concept that was found to affect the service level factors. Furthermore, culture, spirituality and religion and interpersonal healthcare interactions and communication were themes that directly had an impact on mental healthcare access. This is depicted in figure 2 below. A narrative description and direct quotations from the data sets can also be found below.
Figure 2: Diagram representing the factors impacting providing mental health care to refugees from the Middle East

- Culture, spirituality and religion
- Service level: Challenges related to the delivery of mental healthcare
- Service level: Facilitating mental healthcare access
- Mental health care access and utilisation
- Interpersonal healthcare interactions and communication
- Life stressors affecting mental health service access
Service level: Challenges related to the delivery of mental healthcare

All the papers included in the review talked about the perspectives of service providers on the challenges that were present when attempting to provide mental health care for refugees from the Middle East. There were five key themes that were identified, however, one main theme which appeared consistently were aspects related to limited resources to deal with the burden of mental health difficulties within the refugee populations across pre and post migration contexts. Of note were factors related to the influx of refugees, there appeared to be a large amount of refugees in need of mental health support and not enough resources to see them all.

“I have too many patients in a day, often more than 80 a day. I don’t have enough time to talk” (Mckell et al, 2017)

“The demand is outstripping the supplier” (Khawaja and Stein, 2016)

This extends to when refugees have resettled into their host country, there appeared to be a need with refugees from the Middle East in regards to mental healthcare and is a need which is struggling to be met. There were not only a large amount of refugees to care for noted, but they were also described as being of high need. This can lead to a sense of hopelessness and an increased chance of developing mental health difficulties.

“One weekly session is not enough. Persons who are so heavily affected need more psychosocial support” (Mirdal et al, 2011)
“So there’s all those sort of things where they get a bit concerned about how they’re going to access services and help and how things aren’t changing and improving over time. Sometimes you get an increased sense of hopelessness I think, with services” (Khawaja and Stein, 2016)

A common issue within this core concept was that of mental health not getting enough attention and importance within both pre and post migration contexts. There were often opinions related to organisations having to focus on the physical means of the families and with competing demands existing, suggesting that it may be better to at times not go into in-depth psychological treatments. Sessions relating to mental healthcare were often delivered by individuals that were not adequately trained to do so and when sessions were provided they were so in environments that were often unsanitary (Dotevall et al, 2017).

“Of course there is a need [for parenting advice] but that is my opinion, others [organisations] will say they are not even getting the food they need and you want to tell them how to make them (the children) stop screaming at each other!” (El-Khani et al, 2018)

“In terms of dealing with other stuff they come to see us about, they’re not in a headspace to even get into that deeper stuff, they’re still trying to deal with the practical things they have to do to get through each day, and all of the different stresses around immigration, accommodation, finances” (Khawaja and Stein, 2016)
Service level: Facilitating mental healthcare access

Another theme which emerged through the papers was related to ways in which services and health professionals could adapt their approaches and provide suitable methods of care to refugee populations from the Middle East. Within the camp settings, papers described the impact of interventions that could be easily implemented and the impact that could have.

“Some projects arrive from well-wishers and donors, who want to do extravagant things, good things, but they simply won’t work, even if we had all the money in the world. But what we spoke about [providing parenting information to families] and how you sat with the mother, you asked her what she wanted, yes this is it. A big important idea, but carried out simply on the ground here” (El-Khani et al, 2018)

Throughout the papers a consistent element which emerged was the importance of culturally sensitive and adapted care for refugee populations. The impact of this was far reaching and the need for flexibility highlighted.

“It is the people from here [Canada]. It is the community organisations. It is the institutions, the decision makers, the commissioners, the lawyers. It is towards them that this education should be done in order for them to do what I call the cultural translation. The cultural translation responsibility should belong to local institutions and not to applicants” (Khan et al, 2017)
“We talked a lot about the differences in child rearing and how she should deal with the children when she was angry” (Mirdal et al, 2011)

“You have to adapt and do other things creatively, whether it’s art therapy or music therapy, or involving other more practical or sensory or other tangible modes to what you do” (Khawaja and Stein, 2016)

“We (service provider) went to a supermarket with him, just to teach him about what kinds of foods to buy” (Mirdal et al, 2011)

Finally, the need for multi-disciplinary working and holistic services was put forward as being an effective method for providing care for these populations.

“A lot of the cultures don’t separate the psych and the somatic, so they want holistic, they often want things presented in more physical terms” (Khawaja and Stein, 2016)

“We work as a team. The inter disciplinary work is very important. It would not be possible to provide treatment for PTSD without the other members of the team” (Mirdal et al, 2011)

**Culture, spirituality and religion**

Another key construct which followed was the impact of culture, spirituality and religion. This was a theme which resonated across both pre and post migration contexts. There was a common description of stigma around mental health issues and its subsequent impact on how individuals would be accepted within the wider community. The effects of
having a mental health issue were far reaching and one which could affect not only them but also their family as a whole.

“Many of them have these disorders hidden, which they do not like to admit for many reasons” (Mckell et al, 2017)

“Sometimes he (refugee asking the service provider) asks me: I'm have a disease, I'm crazy? Uh, I tell him no, that's not crazy, that's about crisis management” (Dotevall et al, 2017) (sic)

“They think if they seek this kind of assistance they will be considered majnoon [crazy], and disqualified totally from social acceptance... And his daughter and son will suffer. They think psychological disorders are genetic. So, the whole family could be disqualified from society” (Mckell et al, 2017)

"Many patients have stigma with depression and stress that this is not socially accepted in the community" (Dotevall et al, 2017)

Stigma around mental health issues were found to be relevant to both genders, however it was clear that women were perceived as being affected more by it. Having a mental health issue was controversial for a man, however they were described as still being accepted by the society, this was not the same for women. The responsibility of the woman was to cater for whole families and having a mental health issue was described as questioning her ability to do so and have an effect on her marriage and family image.
“She is married to one man, but she feels she is married to the whole family. She must care for all of them. She must care for his parents” (Mckell et al, 2017)

“No one will marry a girl if she is known to have had a mental illness. Mental health does not affect men as much – they can still marry. So it is more of a problem for women” (Mckell et al, 2017)

Religion and spirituality played a big role in the lives of many of the refugees from the Middle East and was seen as a form of solace and purpose, however, it was described as something that was misconstrued and something which acted as a barrier for them actively seeking and engaging with support with their mental health.

“There are proverbs in Christian and Islamic books that encourage people to look for treatment. A good believer will not wait” (Mckell et al, 2017)

“The child is a responsibility and something from God to cherish and do our best with and they feel they aren’t able to” (El Khani et al, 2016)

“They think I am sick, because I did something wrong and God wants to punish me, or that is my destiny. And if I go to seek treatment this is against God’s will” (Mckell et al, 2017)

Mental health was seen through many different perspectives and was often attributed to spiritual manifestations. Faith healers were often the first point of call when mental and physical health concerns emerged in refugees as it was believed to be a faster and more culturally appropriate care pathway.
"Health services vary across the cultures; people have different cultural explanatory models for different experiences. So what we might term health issues may be seen as a spiritual issue" (Khawaja and Stein, 2016)

As well as attributing mental health issues to spiritual manifestations, these refugee populations were also described to commonly present with psychosomatic concerns. This could be described as being linked to the stigma of having a mental health issue and one is which access and utilisation of mental health services in affected.

"they don’t necessarily conceptualise the difference between the two, there would be generalised anxiety, depression, insomnia, fatigue, not eating, bodily pains connected with depressive symptomatology as well” (Khawaja and Stein, 2016)

**Life stressors affecting mental health service access**

A further theme identified across the papers was that of external factors that either directly or indirectly affected the refugees access and subsequent utilisation of mental health services. Scarce resources and staff in local clinics often meant that refugees had to travel long distances as they are seen in outpatient appointments; with their mental health difficulties it often meant several follow up appointments which proved expensive and difficult to get to.

"Sometimes patients when they come here (Baq'a) they do not have 1JD (£0.95) for the bus, so they are walking great distances. Many cannot afford to come back for follow up appointments for mental health, so they give up. Mental health needs more follow up, more visits” (Mckell et al, 2017)
“We (service provider) have chronic financial resources; this is a real challenge”
(Mckell et al, 2017)

“They lived in a very little flat. It was a vicious circle. He was irritable, could not take the children’s noise. There was no place to go. Then they got more space and an extra room, and it makes a big difference” (Mirdal et al, 2011)

Through the papers was also a common description of the factors refugee families face when attempting to access mental healthcare in refugee camps. Even when refugee parents wanted to access support, they found external factors hindered them in that they had no where they could leave their children in which they felt comfortable and safe.

“The parents are in charge of providing everything the children need, this is making them so stressed, extremely stressed, what a huge responsibility [. . .] to feel completely out of control” (El-Khani et al, 2016)

“You have sleep issues, wetting of the bed, loud noises make them jump, they are very anxious and many don’t like to leave the parent’s side, we call them anxiety issues. A few kids also display characteristics that are younger than them” (El-Khani et al, 2016)

The feeling of uncertainty was often described by service providers about these refugee populations and this was often related to issues around obtaining a visa for some of the population but also around the uncertainty of what was happening in their country of origin and the plight of their loved ones who were still there. This affected both their uptake and engagement with mental health services.
“they may lose sense of self, sense of community, sense of belonging, all of those get lost. So I put it under the roof of existential crisis” (Regarding visa uncertainty) (Khawaja and Stein, 2016)

“When the situation in Iraq gets worse and he sees images of the war on TV, his symptoms get out of control” (Mirdal et al, 2011)

“All asylum seekers will look at you and say ‘Can you help me with my visa? Can you help me with my legal stuff?’ You say ‘No I’m a psychologist,’ and they say ‘Well what’s the good of you?” (Khawaja and Stein, 2016)

In line with this, issues with visas often affected job prospects in the new place of resettlement and this subsequently impacted the individuals’ finances overall. As well as finances, the impact can also be seen through described feelings of guilt and inadequacy. The importance of financial security can also be seen below.

“It is generally uplifting to work, but some of them are not able to carry out even simple jobs. They get very stressed, and they feel it as a defeat” (Mirdal et al, 2011)

(on receiving a pension) “It was not only an economic relief. It was also a confirmation that he had gone through torture, and that he was ill. It was a re-valuation of him as a person” (Mirdal et al, 2011)
Interpersonal healthcare interactions and communication

An important construct that was widely cited in papers related to resettled refugees was that of the interactions that the refugees had with mental health professions and service providers and its subsequent impact. Interestingly, this was a phenomenon which very rarely emerged in camp settings. This could be explained by lack of emphasis and services present in those settings on providing mental healthcare, however, this is not explicitly mentioned.

Practitioners who were self-reflective, gave importance to the therapeutic relationship and spent time on building trust and rapport with the refugees were seen positively through the papers that described this theme.

“We were equals. We were also on the same line politically. It was help, but also solidarity” (Mirdal et al, 2011)

“I am rigorously questioning myself and being reflective and using or questioning my own power and privilege, the way I present to them, the way I talk to them, the language I use, my own mistakes” (Khan et al, 2017)

Even when the individuals may not have specifically found the psychological support useful, the importance of the social contact was highlighted.

“She did not value the advice she received, she regarded the sessions as a social contact” (Mirdal et al, 2011).

The impact of interpreters within the mental healthcare encounter was consistent through the papers. Khawaja and Stein (2016) stated that between 90-100% of their
sessions with refugees included the use of an interpreter. There were many challenges that were described when including an interpreter within healthcare encounters and some of which included the interpreter not fully engaging themselves within the process and uncertainty around their competency and methods.

“It’s not just about can they interpret or not, do they know the language, or do they know their role versus my role, but also about mental health issues and being able to discuss those things in a culturally sensitive and appropriate way in terms of doing interventions” (Khawaja and Stein, 2016)

“We were not in synchrony. I cannot tell you what it was, but her tone of voice did not fit what she was supposed to translate” (Mirdal et al, 2011)

“A lot of the cultures of course, or languages rather, don’t have the breadth of terminology, words, particularly psychological states, they just don’t exist in the lexicon so the interpreter has to try to get that equivalency and try to capture the meaning of what the person is saying. That’s what we’re hoping they do but of course that doesn’t always happen” (Khawaja and Stein, 2016)

Discussion

This meta-synthesis served to provide the first synthesis of qualitative findings relating to service providers’ opinions on providing mental healthcare to refugees from the Middle East. Five core concepts were identified: service level: challenges related to the delivery of mental healthcare; life stressors affecting access to mental health care; culture, spirituality and religion; interpersonal healthcare interactions and communication and service level: facilitating mental healthcare access. These themes were conceptualised
within a framework which illustrated links between them and their relevant impact on access to mental healthcare for refugees from the Middle East.

Interpretation of findings

The current meta-synthesis findings show the complexities which arise when considering what Middle Eastern refugees go through when trying to access and thereafter utilise mental healthcare resources in both pre and post migration contexts. The findings are constant with other research conducted within this area (Porter and Haslam, 2005). Findings are also consistent with other meta-synthesis, like that of Robertshaw et al (2018) who looked at barriers and facilitators for refugees accessing primary healthcare. A key finding was highlighted around the importance of building a strong therapeutic relationship and allowing sufficient time in healthcare encounters. Refugees are classed as populations that are vulnerable (Aspinall and Watters, 2014) and may require this additional support to engage with and sufficiently utilise services (Duncan, 2015).

Culture and spirituality were important constructs which were highlighted in this synthesis. An individuals’ culture has been found to influence how they view and experience mental health issues within themselves and should therefore be acknowledged and incorporated within healthcare systems (Kirmayer, 2012). Furthermore, services that adapted their care to be more culturally sensitive have been found to have greater level of clinical effectiveness when compared to services without adaptation (Griner and Smith, 2006). These findings within the literature are consistent with findings from the current synthesis and emphasise an acknowledgement of the influence of culture and potential issues regarding stigma, spirituality and cultural understanding. This further highlights the importance of mental health services to provide holistic and culturally sensitive care.

Findings further demonstrated the significance of limited resources available to support the mental health of refugees and the high level of support that refugees require. This has been highlighted in previous research (Tobin and Murphy-Lawless, 2014) and furthermore by Robertshaw et al (2018). The difficulties with funding and allocation of resources in
this sector were found to affect the quantity and quality of care that could be provided was consistently reported by service providers and an important factor to be considered.

Through the analysis, there were some studies which were found that had some relevant findings and results which support what was found in the current qualitative meta-synthesis. Burck and Hughes (2018) conducted a recent study which focussed on setting up psychological interventions for refugees in a camp setting, many of which included refugees from the Middle East. Similarly, the importance of allowing time to build rapport and also the focus on resilience were found. The paper was however, not included in this synthesis as the method of analysis and data collection were not clear enough and so it did not fit the inclusion criteria. Furthermore, work conducted by Crowley (2005), who focussed on the mental health needs of asylum seekers in the United Kingdom similarly found and elucidated on post migration stressors including financial strain and the need to build rapport to enable engagement. This study was also not included in the current synthesis as the health professionals’ opinions that were sought on the refugees they had worked with were not specific enough on where the refugees originated from and therefore, did not fit the inclusion criteria for this synthesis.

Strengths and limitations

Overall the key strength of the current synthesis was that it examined an area which had not been investigated previously and provides a platform to increasing the evidence base for theory based research which informs mental healthcare in practice. A further strength of the current synthesis is that it included studies that were relevant to both camp and resettlement settings (pre and post migration) when considering barriers and facilitators to accessing mental healthcare for refugees from the Middle East.

Conclusions should also consider the possible limitations that were also encountered. One of the key limitations of the review was the limited number of studies found which met criteria and could be included. This could be representative of there being limited provision and resources allocated to mental health care for refugee in the Middle East as suggested by Okasha et al (2012) and could therefore impact the decision of refugees that
originate from there Middle East to access mental healthcare even when available and to adequately make use of these services.

This meta-synthesis focussed on qualitative research which specifically looked at the views of service providers. Service providers can often act as ‘gate keepers’ to the interventions which refugee populations are offered and so their views were important to ascertain to identify factors which can potentially affect access and utilisation of mental healthcare interventions for these populations. However, these views only account for one aspect when considering mental healthcare access. To gain further depth in understanding issues regarding access and utilisation of mental healthcare in refugee populations from the Middle East it would be beneficial to consider perspectives from research which directly sought views from the refugees themselves.

Furthermore, Thomas and Harden (2008) highlight that there is yet to emerge a method of synthesis for qualitative research studies that is universally accepted as a ‘gold standard’. The approach utilised in this current synthesis has commonly been used for synthesising qualitative research, however is still developing. When considering the process of collating papers for synthesis it is prudent to note the difficulty of attaining every possible research article of relevance solely through the method of looking through research databases. To overcome this, title and abstract searches were carried out as opposed to just searching the titles of papers and furthermore, hand searching and searching through grey literature was sought to ensure the likelihood of finding relevant papers was high. Cross checking of papers was carried out and the similarities of themes across the papers suggest theoretical saturation.

The studies included in this meta-synthesis were assessed as being of a high quality. However, considerations to be noted from the CASP (CASP, 2017) evaluative assessment showed that there appeared to be some limitations which should be acknowledged. Across several of the papers there appeared to be a lack of information regarding the relationship between the researcher and the participants and issues regarding reflexivity; this could suggest potential bias by the researcher in the included studies. Furthermore, although the included research articles did include relevant and adequate research designs and recruitment strategy, it was often found that a justification of why particular
research designs or the research participants that were used were not adequately described. These points should be noted as considerations when interpreting the results.

**Implications**

Supporting the mental health needs of refugees from the Middle East is a primary concern when considering global mental health (Yule, Dyregrov, Raundalen & Smith, 2013), this extends to refugees in both camp (El-Khani et al, 2018) and resettlement contexts (Murray, Davidson and Schweitzer, 2010). Inequalities exist when considering the scale of mental health issues refugees from the Middle East face and how often they receive support with these issues when compared to the general population (Fazel et al, 2005). Results from this synthesis support the assertion that greater resources should be allocated to these vulnerable populations, this would help bridge the gap between mental healthcare inequalities. As found in this synthesis, more culturally sensitive and holistic services would help provide greater mental healthcare for these populations.

Although culturally, it is appropriate for individuals to seek solace in religion and with religion being a key component of mental health, however, recommendations can be made that faith healers should work with professionals in providing adequate and appropriate treatment approaches for refugees. This is also supported by Mckell et al (2017). Furthermore, the synthesis also highlighted the significance of the use of interpreters and how common their presence is within mental healthcare encounters. To assist in its successful implementation within services, the importance of support for interpreters was considered to be important in helping prevent burnout and for training to be provide to ensure a high quality and standard is maintained.
Recommendations

In practice, services and professionals should be provided with adequate resources to allow them to work with refugee populations effectively. As part of this, where possible, training and support should be provided to support adapted services that take in consideration the refugees culture and spirituality. Furthermore, service providers of mental healthcare should ensure that time is provided in both the assessment and intervention stages when working with these refugee populations as this would hope to support a therapeutic relationship and rapport in which the individual is more likely to engage with services.

Considering the needs of service provision, commissioning bodies and policies should identify and acknowledge the pressing need that refugees from the Middle East face and in turn provide sufficient provision to enable high quality and culturally sensitive services to be developed and maintained. Future research in this area would benefit from more primary research articles on the opinions of service providers on refugees from the Middle East accessing mental health services and for research ensuring participants are adequately described to ensure replication and potential inclusion in future meta-syntheses and reviews.

Conclusion

This meta-synthesis illustrates the complex picture which emerges when considering providing mental healthcare to refugee populations from the Middle East. Many barriers and difficulties were highlighted, however, there were also many factors that were highlighted that can help improve access and utilisation of services. In particular, were findings related to the importance of considering the impact of culture and to have services that adapt and are sensitive to the needs of refugees. On a wider scale, considerations need to be made on the emphasis and messages being given to the importance and utility of providing mental health services to refugee populations from the Middle East. The findings from this will hope to inform service development in the field.
References


Paper 2: Maximising the accessibility of a brief parenting intervention for refugee families

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Paper 2 was formatted according to the guidelines of the Journal of Peace Psychology (Appendix 3).

Some formatting amendments have been made to enhance the readability in this thesis. An example is that the relevant tables and figures have been inserted within the text and not presented separately.

Word count excluding tables, figures and references: 6122
Abstract
Countries in the Middle East and surrounding areas are currently in crisis as a result of armed conflicts; violence is rife and instability within these regions is triggering continuing waves of displacement. Children remain the most vulnerable victims in conflict and parents and families have an important role in protecting their children’s mental health. The Conversation Group is a brief parenting intervention that was made up of a set of highly focused information for parents and caregivers in the form of a booklet and matching PowerPoint materials for a Conversation Group which can be led by non-experts. This study explored the opinions of service providers that work with refugees from the Middle East around the content of a Conversation Group and on how to best facilitate its access in resettlement contexts. In total, 13 qualitative, semi-structured interviews were conducted. All the interviews were recorded and transcribed verbatim and thematic analyses was used. The decision was made to focus the analysis on three core themes; 1) intervention specific feedback, 2) contextual factors of implementation and 3) Facilitators specific to intervention implementation. Common codes and themes were then located within the dataset and found intervention specific feedback to contain information on positive aspects of the intervention and suggestions for its adaptation. Furthermore, the contextual factors included themes relating to the complexity of group delivery, service pressures, client poverty and language barriers. In the final core theme, of facilitating factors specific to implementation, the themes of enabling access and promotion were found. The interviews and subsequent themes which came from the data highlighted that the content of the booklet was comprehensive, suitable for the study population and that there was a need for such interventions in resettlement contexts from provider perspectives. Furthermore, the results highlighted complexities which may arise when the intervention is implemented in group settings with considerations needing to be made regarding its location, language and attendees. The findings will hope to inform policy and practice to help guide services that support refugee families and their children in resettlement contexts and recommendations are also provided.

Key words: Middle Eastern refugees, thematic analysis, group interventions, service provider perspectives
Introduction

Refugee crisis in the Middle East

Countries in the Middle East and surrounding areas are currently in a state of crisis, violence is rife and instability within these regions are triggering further waves of displacement (UNHCR, 2018a). Occupants living within these regions often live in constant fear and uncertainty, with countries like Syria, Iraq and Yemen still suffering through waves of displacement (UNHCR, 2018b). Individuals from these regions continue to suffer the effects of the immediate difficulty but also from the multi-generational displacement which leaves the population and especially the children very vulnerable (UNICEF, 2015).

Refugee parenting

Children remain the most vulnerable victims in conflict and parents and families have the important role of protecting their children’s mental health when the children are forced to live through conflict zones and move through displacement to eventual resettlement. Trauma can overburden parents and cause conflicting relations among family members (Byrne & Riggs 1996). Song, Tol, and Jong (2014) found that war trauma may be transmitted to offspring via parenting practices that include severe parental emotional distress and parents who have Post Traumatic Stress Disorder (PTSD). Conversely, positive family relationships can help mitigate the impact of armed conflict (Panter-Brick, Goodman, Tol & Eggerman 2011) and more broadly, there have also been elements of parenting which have been linked to increasing the level of resilience in families and can encourage their children’s adjustment (Walsh, 2016).

Brief, accessible interventions

The protective function of positive family functioning for children, which has been identified in research on families in the Afghan context (Panter-Brick et al, 2011)
highlights a pressing need for easily accessible, brief and effective evidence-based parenting advice. The need is evident in resettlement contexts for interventions that can be used in low resource settings and delivered by non-specialists with minimal training.

Recent research conducted by El-Khani, Cartwright, Redmond and Calam (2016a) focused on the displacement phase of the refugee journey and involved parenting advice distributed via leaflets in bread wrappers. The parenting advice was based on initial work by El-Khani, Ulph, Peters & Calam (2016b) where refugee families’ views were sought on the type of parenting advice they would have found helpful. The feedback from parents when receiving this information highlighted that the information was well received and that families wanted more of it and with more detail; the Conversation Group was developed in response to this feedback. This indicated that brief psychological interventions are feasible and acceptable when considering interventions for families displaced by conflict. Furthermore, El-Khani et al (2016b) found that these refugees had a desire to understand ways in which they could best parent their children but were frustrated with not having the resources. Providing refugee families with support and interventions in pre as well as post resettlement can aid both the parents and their children’s mental health and wellbeing. A Conversation Group accompanied by a brief booklet has now been developed from the original materials to meet the needs families identified with the hope to facilitate conversation on these important topics when literacy may be limited in these populations. In this paper, opinions will be sought from service providers with a focus on resettlement contexts to assess its feasibility and acceptability in these settings.

Crisis events like that of conflict can have the impact of severely affecting a health systems’ ability to cater to the needs of vulnerable populations (WHO, 2012). Mental health systems are also affected and their ability to quickly respond to the needs of these vulnerable populations are not always adequate and so there is a need for intervention and advice which is evidence based as well as being easily accessible (Sijbrandij, Acarturk, Bird, Bryant, Burchert, Carswell & van Ittersum, 2017). The potential benefit of using brief
parenting interventions at different stages of the refugee journey is that it can have a huge impact on families in crisis requiring advice and, if the format is right, is able to be disseminated widely. Obtaining views and opinions from different individuals regarding its cultural relevance has also been found to be important to ensure interventions are effective and appropriate for the population they are being aimed at (Bernal, Bonilla & Bellido, 1995). Resettled refugees have differing needs in regards to their mental health literacy; furthermore, the need for adequate health promotion and early intervention to recognise this variability and address the gap between the mental health models the host country utilises and the resettled refugees own knowledge and belief systems (Yaser, Slewa-Younan, Smith, Olson, Guajardo & Mond, 2016).

It is imperative that agencies’ and practitioners’ opinions are sought on how to make resources and interventions accessible for the individuals they are intended for. This is important as they work closely with refugees and often have the key role of ‘gate keepers’ to the care that they receive (Ingleby, 2004).

**Aims of the present study**

The proposed study sought to explore the opinions of individuals working in services and nongovernmental organisations that worked with refugees from the Middle East. Views were explored around the content of a Conversation Group and how to best facilitate refugee families to access it in the context of resettlement. This would hope to enable recommendations to be produced on ways to facilitate access for the refugee populations from the Middle East and how to overcome potential barriers on its implementation. The Conversation Group was made up a set of highly focused information for parents and caregivers in the form of a booklet and PowerPoint materials for a Conversation Group which can be led by non-experts. The booklet is derived from previous work at the University of Manchester that was based on initial research carried out by El-Khani et al (2016b). The developed material included evidence based practical parenting advice that has been culturally adapted through research with refugee families and practitioners.
Method

Design

The study used a qualitative design, this approach enables an exploration of rich, explanatory data (Taylor, Bogdan, & DeVault, 2015). Thematic Analysis has been used in refugee research (Sideris, 2003) and involves the repeated reading of datasets to ensure familiarity and the emergence codes and themes. It was chosen as the analysis in the current study due to its ability to reliably represent respondents’ opinions and experiences and is known to provide insightful findings (Braun and Clarke, 2006).

Interview Schedule

The interview schedule (Appendix 4) was developed by the researcher with input from a Child and Family Clinical Psychologist and a qualitative expert who were the researcher’s supervisors. The interview schedule focussed initially on demographic details and detailed information on the participants past and current role with refugee populations. Thereafter, the interview schedule aimed to cover 2 main areas: the participants’ perspective on the conversation group content and ways to facilitate access to it and identify/overcome barriers to its implementation in resettlement contexts. The topic guide was developed with a focus on ensuring its sensitivity when being carried out with participants in interviews. The topic guide focussed on the professionals’ view of the Conversation Group content and not on any past trauma / experiences that they may have heard when working with refugees. The researcher had experience of conducting assessments and clinical interviews as part of their clinical training. The topic guide was piloted with one-to-one interviews with members of the research team.

Sampling

Research suggests that 12 interviews are sufficient to reach saturation and obtain an understanding of the experiences and perceptions of those interviewed when using
Thematic Analysis (Guest, Brunce & Johnson, 2006). Convenience sampling was utilised by the researcher and to ensure the individuals interviewed were diverse, after each interview the person that was being interviewed was questioned on who they felt were relevant organisations/individuals to approach and interview. Inclusion criteria are shown below in Table 1.

Participants that were identified as matching the inclusion criteria and were interested in partaking in the study were provided with an information sheet (Appendix 5) and had the opportunity to ask the researcher any questions they had. If they agreed to take part in the study, they were then also provided with a copy of the Conversation Group booklet. A day prior to the interviews taking place the researcher emailed the participant to kindly remind them of the upcoming interview and provided an electronic copy of the booklet in case they had misplaced the hard copy. The interviews were approximately 1 hour in length and were arranged at a time that was convenient to them. The interviews were conducted in a private room at the participants’ organisation or over a Skype voice call.

Table 1: Inclusion criteria

| - Professionals working in services and non-governmental organisations that work with refugee families. These families they are or have worked with should be from The Middle East; as defined by the World Bank country definition (World Bank, 2018) |
| - The professional must have worked with the family when they were in or have recently (within the last two years) gone through the process of resettlement |
| - Participants must also be willing to be audio recorded (to ensure accurate transcription of interviews) |
| - Participants must be able to understand the participation and consent sheets |
| - Participants must have the capacity to consent to take part in the study |
| - Participants must be able to understand and speak the English language |
Data generation

Refugee organisations in the UK and internationally were contacted by the researcher. The researcher explained the study to them and was then referred to the most appropriate member of staff. Thereafter the individuals were asked if they would like to take part in the current study. A date for the interview was scheduled and prior to the interview, the participants were asked if they had read and understood the information sheet and if so, were provided with a consent form to complete (Appendix 6).

Data analysis

Data emerging from the interviews were analysed using Thematic Analysis, this enabled the evaluation of participants’ opinions and perceptions of the intervention. This was carried out using the protocol suggested by Braun & Clarke (2006).

After the interviews were transcribed verbatim they were input into the NVivo programme for coding and analysis. The transcribed interviews were read several times to allow familiarity with the data set. Initially, the coding method which was used was line by line coding as this allowed the researcher to classify the initial codes that were data driven and thereafter the codes were then categorised into themes. The decision was made with the research team that the themes of interest were 1) intervention specific feedback, 2) contextual factors of implementation and 3) facilitators specific to intervention implementation.

Reflexivity

The researcher reflected on and considered their potential influence on the research process; an exercise which is found to be important when conducting qualitative research (Braun and Clarke, 2013). The researcher is a male of South Asian heritage and was born and raised in the UK. The researcher has one infant child and currently works for the National Health Service (NHS) as a Trainee Clinical Psychologist. The researcher had not worked within the area of refugee support prior to this project, however he shared some
commonalities with the health professionals in their roles with helping to support vulnerable, at risk populations. Any potential differences were reflected on and considered within a reflective journal and within supervision on any potential impact on interactions with participants.

**Ethical approval**

Ethical approval was granted by the University of Manchester ethics committee (Appendix 7).

**Results**

**Sample Characteristics**

Thirteen interviews were conducted. Participants varied in terms of their age (ages 31-74) and the sample included a mix of male (n=6) and female (n=7) participants. Participants were also from different ethnic backgrounds (White British n = 8, Black African n = 2, Pakistani n = 1, American n= 1 and Middle Eastern n = 1). All the participants had experience with working with refugees from the Middle East but varied regarding the amount of length of their experience from 3 months to 18 years. The individuals that were interviewed had different occupations and were at different levels in regards to their respective organisations (Volunteer n = 1, Support Worker n = 1, Project Officer n = 1, Refugee Accommodation Officer n = 1 Manager n = 6, Lead Consultant n = 1, Chief Executive Officer n = 2) (see Appendix 8 for table of participant identifiers and demographic details).
Results overview

The data driven codes that were formed were organised into three themes and were identified as: 1) intervention specific feedback, 2) contextual factors of implementation and 3) facilitators specific to intervention implementation.
Conversation group for refugee families

Theme 1: Intervention specific feedback
- Positive aspects of the intervention
- Recommendations for adaptation

Theme 2: Contextual factors of implementation
- Complexity of delivery in a group format
  - Service pressures
  - Client poverty
  - Language barriers

Theme 3: Facilitators specific to its implementation
- Enabling access
- Promotion
Theme 1: Intervention specific feedback

Positive aspects of the intervention

Participants described through their interviews the importance of the intervention and how it could facilitate conversations to take place around refugee parenting in resettlement contexts. Perspectives were also found around how this can prove to be a preventative measure to help buffer against mental health issues that may emerge. More specifically, many of the participants highlighted that the intervention shows its utility by being clear and specific to the population it is aimed for; as opposed to other services which are often provided for resettled refugees and are more broad and generic.

So anything for me [...] that is really targeted at the group of people that we work with is fantastic, so, erm, I’m very, very happy that something has been made that is so, so specific, erm, to our service users [refugees going through resettlement] (participant 1)

A common element throughout the interviews that was highlighted by the participants was how well the information in the booklet was structured and organised. The illustrations were often picked out as elements that made the booklet visually appealing and were depicted in a way which represented different cultures and religions.

The headings are big enough for me to find that, and then the way the bullet points are laid out, it’s more or less really a step by step sort of how to, and in my opinion, this is what’s the most important [referring to the layout of the booklet] (participant 9)

It seems to be an even representation, if every woman in this booklet was veiled, it would be seen as geared towards some religious gender, or at least, erm, religious, er, dialogue, trail of thought, less scientific, if that makes sense, and it’s just nice that it
touches on culture, but at the same time it’s realistic, ‘cos not all, erm, refugees are veiled, not all refugees are Muslim, so I found that the illustration was comfortable and kind of, almost neutral (participant 12)

As well as the content being appropriately structured it was also a common element through the interviews that the content was developed at an appropriate level to be delivered to refugees for them to understand the information without them having to invest large amounts of time looking through it; as long as the information was in a language they could understand. The booklet was described as “totally non-threatening” (participant 9) and something which included ideas which could be implemented into the individuals’ life.

They’re put in layman’s terms that people can understand, which is always helpful, erm, and I figure that a refugee, if this is translated, can follow, regardless of what educational level they’re at (participant 12)

There were several elements of the booklet which resonated with the participants that were interviewed. The most common across the data obtained was the advice pertaining to the importance of self-care for the refugee parents to allow them to best support their children and the focus on safety and the practical ways this could be implemented in their day to day lives.

**Recommendations for adaptation**

Participants often highlighted the usefulness and utility of the intervention but also commented on a need for more practical examples and tangible resources that could serve as templates for the refugees.
Maybe at the end of the session you can show an example of what a reward chart might look like, maybe, erm, or maybe do one together (participant 1)

All these points are very good, but how to implement? How to use them? If I am a parent, how to use it (participant 8)

This view was however, not unanimously felt through all the interviews. There were several other individuals that were interviewed that felt that there were enough practical suggestions provided in the booklet.

I like, I especially liked the, erm, suggestions, I think some of the recommendations and things that were, erm, in here, were very, very practical, and erm, and I think very easily doable in, in the context that many of the, er, refugees find themselves in. (participant 9)

The length of the booklet was also a topic that occurred frequently throughout the interviews. The majority of the participants felt the information that was presented was relevant and the booklet was appropriate in its length. However, some of the respondents felt that the booklet had too much information and suggested it contained too many points to consider.

I think it’s quite wordy, for some people, but I mean this is going to be like you say it’s going to be people that will, er, deliver this, erm, if you were giving this to refugee parents, it might be a little bit wordy (participant 3)
it’s very clean, very, very quick to get to and I don’t think there was anything in here that would not be, erm, useful and at the same time just enough, it wasn’t too much information, it wasn’t too little information it was just the right amount of information, it really is the need to know (participant 9)

As previously highlighted, the booklet was seen to be a resource that had utility and content that was relevant to refugee families. Although this was the case, the most frequent recommendations provided in the interviews centred around the reality of what to expect in terms of timescales for change, but also around the reality and re-emphasis on their current resilience and strengths that have helped them.

I think there needs to be more, er, .. erm .. you know .. a little bit more emphasis on resilience and strengths that they have, you know, I think we can quite frankly, I think, you know migrants, refugees and asylum seekers .. we can admire their resilience, you know, we can, you know, you can take inspiration from them (participant 7)

Theme 2: Contextual factors of implementation

Complexity of delivery in a group format

Having this intervention in the form of a group setting was something that was universally accepted by all the respondents as the best method for its implementation. Using the format of a group was something which was described as therapeutic and an environment in which learning could take place and normalisation occur.

[when asked if a group format is appropriate] Yes, that is really encouraging because people learn from each other and sometimes people obviously are more interested to listening to others and their experiences (participant 8)
When utilising a group format there was not much information gathered on the optimal size that would be recommended, however, one respondent did suggest smaller groups to allow space and more opportunities for individuals to discuss things if they wanted.

*I would go for as small a group as possible (later specified approximately 10 individuals) to make people feel as comfortable as possible about talking, I imagine, really people are going to start talking about sometimes really awful past experiences (participant 1)*

Regarding the implementation of the intervention in a group setting, the issue of gender often arose in relation to whether to have integrated or separate groups for males and females. There appeared to be varied responses to this across the interviews and no consensus to what the most appropriate grouping would be. However, the point of it being of importance to both parents was consistent with all the interviews and as one respondent explained, it can also include issues with childcare and practicalities.

*I think we should not .. er, not discourage males and females to be in the same group (participant 13)*

*If you could run sessions for fathers and then different ones for mothers, maybe that is an option I don’t know, in some ways I think it is better for them to learn the same thing at the same time but practically with children and childcare it may not be that they can both go, so yeah, so yeah there are gender issues around that (participant 10)*

All participants discussed the importance of the role of the facilitator that would deliver the groups. The interviewees preferred the facilitator to be someone that had some experience with running groups, as the interviewees described the possible issues which could emerge
through the discussion e.g. trauma. There were mixed responses gained in relation to whether the group should be facilitated by someone the community knew or if it could be delivered by someone the group did not know.

A skilled practitioner would possibly be able to pick up where there was a deeper concern (participant 2)

I think it needs to be somebody who they don’t necessarily already know. I know people often think oh it’s much better if you know the person, erm, but I don’t (participant 1)

Service pressures

Many of the interviews highlighted that a potential challenge of implementing this intervention could be due to limited resources in regards to mental health provision. Organisations may not be as willing to implement interventions of this nature due to the additional strain it would put on their time. The exception to this is if running the group would help fulfil other goals the organisation may have.

It’s just an additional piece of work that they’ll gonna do (sic), the only reason they’ll, they’ll bite your hand off is if they can see some, benefits, some spin offs that aids them as well as aids the client group, i.e., in order, by, by delivering this actually helps them achieve other goals as well. otherwise, why would they? Because they’re all trying to achieve something under limited resources (participant 5)

Yeah, the, the main obstacle is, you know, sort of fitting it into peoples’ (service providers) crowded, agendas (participant 7)
**Client poverty**

Interviewees highlighted that refugees going through resettlement after being displaced often meant that they may struggle with financial pressures. Additionally, as many of the interviews highlighted, the situation may often mean that the resettling refugees may not be able to work and not receive many or any benefits and so would struggle to travel to venues and may not, at times, have the means to support their families.

> Well if, if say, like some of them, if they are sort of in an asylum seeker situation or they’re waiting for benefits or any other reason, erm, sometimes they just don’t have the, the money to get a bus (participant 3)

> I thought that the bit about play was really important, but from my experience of going to visit families, they don’t have anything to play with … you know, they have very, very little in terms of material things, erm, from what I’ve seen, well from what I’ve asked … no toys, no books, no TV, no crayons, no pencils, no paper, no puzzles, no nothing (participant 2)

**Language barriers**

The issue of language was often talked about in the participant interviews regarding implementation of the intervention. Even though the refugees came from the Middle East interviewees explained that they can still often be found to be illiterate in their own languages and also that of English and so this can act as a barrier towards engaging with the intervention.

> One of the particular challenges that our clients have is that very few of them speak English and quite a number of them are illiterate in their own language (participant 10)
All of ours were in English (written support for refugees), and one of the things we found was it wasn’t accessible to everybody, er, and it was an issue (interview 11)

Furthermore, based on the complexity of language, a way to overcome this was to use interpreters. Interpreters ensure the message gets across to the recipient of the group, however, the importance of using professionals and not the children of the refugee parents were highlighted in some of the interviews as this can often cause a power differential between the child and their parent.

Being very, very careful about trying to use your children as interpreters for you […] I think children learn a lot of things that they shouldn’t learn, that they don’t need to know, some of the concepts that they’re trying to explain are too complicated for a child to understand, so much can be lost there in translation. The power dynamic between parent and child really shifts, erm, and I don’t think that’s healthy (participant 1)

Theme 3: Facilitators specific to intervention implementation

Enabling access

Consistent within all the data obtained was the view that incentives help towards enabling people to attend and access group interventions like the one in this study. Within this study population more specifically, the use of food was highlighted throughout and described as a way to give a sense of belonging and celebration of the individual and their individuality. Furthermore, reimbursing travel was also a common theme to assist access for refugees as they were described as a population which struggled with finances.

Food is always, always huge, so it was a way in, it was, er, it gave us the opportunity to engage, and also developed relationships and break down cultural barriers (participant 11)
So if they are having to travel in, would you want to be paying travel expenses for people to come along to a session (participant 1)

The participants commonly reported the importance of having a central location that was easily accessible and preferably already known by refugee populations to allow them to adequately get to the place where the sessions would be taking place and to feel safe and comfortable there.

Well, you know, again, access is important, so, you know, you know, it’s got to be central, er, where people can either walk to or use public transport (participant 5)

From the interviews it was also reported by the majority of the participants that to assist the intervention implementation the use of volunteers was important. Also, providing services like a crèche was described as being able to help refugee parents have the time and attention required to take part.

Promotion

The participants all had the opinion that in order to best facilitate the implementation of the intervention a settling in period would be initially required before it was offered and undertaken by refugees. They reported that in the initial period of settling in to a new culture and environment there is still feelings of uncertainty and so allowing a period of time to let them acculturate would be beneficial before the intervention’s implementation. The period of waiting for refugees to settle varied from one to six months.

I think there’s a bit of a shell shock period isn’t there, I think probably, erm, I think maybe the kind of facilities that we have at the moment are enough in those initial stages, just, I’m getting my children school and I’m going to meet some people and I’m getting English classes, and they’re taking us on a tour on Saturday morning round the town and, so I think after, I think a settling in period (participant 2)
After this period of settling in then to help facilitate access to the intervention the best method which was reported with all the interviews was to utilise and link with organisations that are already running in the local areas and also the use of word of mouth. Thus showing the importance of allowing refugees to embed themselves within the community.

Word of mouth, within the asylum community, is massive, everything’s word of mouth, so if you’ve got someone who’s familiar, they will, they will, you know, they will happily engage (participant 11)

Discussion

This qualitative research study provided an evaluation of a Conversation Group which was in the form of a booklet to refugee parents that originate from the Middle East. Furthermore, the study also looked at how it could be best implemented to have increased access to these refugee populations. The interviews and subsequent codes which emerged highlighted that the content of the booklet was very positive e.g. its structure and illustrations. However, when being implemented in a group setting considerations need to be made regarding its location, language and attendees.

Interpretation of findings

The results obtained reflected that there is a need for interventions which focus on refugee parenting and from the service provider perspective, that they can be implemented in resettlement contexts. Research conducted by El-Khani et al (2017) has already shown the feasibility and importance of parenting and caregiver interventions in humanitarian settings and this study has further shown the need of similar parenting interventions in resettlement contexts. The findings highlighted the importance of interventions that are tailored and specific to refugees. The topic of safety was specially focussed on as an important element of the intervention and one in which further practical examples could be given. This finding fits in with wider literature in the area as also found by Silove (1999) in the Adaption and
Development After Persecution and Trauma (ADAPT) model which emphasised several core psychosocial issues that affect individuals that have gone through war and displacement and systems of safety and security were paramount within this.

The booklet was described as having content which was comprehensive and detailed, however, one finding which came about from the data was the importance of resilience and strengths, the booklet could have possibly focussed on this more. The role of resilience is developing within the research literature and conversations that have more solution focussed elements to them have been found to help support individuals locate internal resources within them. They may already have these internal resources and this would help them move towards desired outcomes and it can be applied in multiple settings and contexts (Corcoran and Pillai, 2009).

The results also highlighted the complexities that can arise when attempting to implement group interventions with these refugee populations. Refugees that have undergone forced migration may have also witnessed social exclusion (Miller, Weine, Ramic, Brkic, Bjedic and Smajkic et al, 2002) and discrimination (Murray, Davidson & Schweitzer, 2010) and may therefore struggle to engage with services. Alongside this the current study also highlighted the linguistic challenges resettled refugees from the Middle East face and how this can act as a barrier to them accessing and subsequently effectively utilising services. The importance of culturally sensitive and adapted services has been highlighted in literature in this topic area (Kirmayer, 2012) and in line with findings from this study the use of group facilitators that have experience with working with refugee populations and the use of trained interpreters can help overcome this obstacle.

Furthermore, the pressure services have in relation to resources allocated to the delivery of mental health care is scarce. Services were reported to already be stretched and even though group interventions like the one discussed in this study were thought to be useful, the acknowledgment of its delivery and implementation was discussed. A common finding
linked with this was the issue of client poverty and refugees struggling financially to get appointments and sessions. However, the findings from the study do suggest that to help enable access in these deprived settings, providing reimbursement and ensuring convenient and central locations for interventions help with its access and subsequent implementation, a finding also found by Robertshaw, Dhesi & Jones (2018).

A consistent finding was that of the benefit and utility of providing support for refugees in a group setting. The UNHCR (2018a) have provided some key steps and guidance for supporting refugees with mental health needs and psychosocial support and this also highlighted the benefits of group interventions to help the individual cope with their distress. Furthermore, group interventions help provide a source of external support for individuals and provide community healing (Kira, Ahmed, Mahmoud & Wasim, 2010). The current study further highlighted the need for individuals that would be facilitating the group intervention to have the ability and experience in leading such groups, this was also highlighted by the UNHCR (2018a) which indicated the need for training and ongoing supervision of workers in health that usually would deliver such interventions.

**Strengths and limitations**

This study utilised a qualitative methodology which allowed exploration of professionals views within the context of resettlement and is apt at obtaining diversity in different peoples’ experiences (Ungar, 2003). To ensure that the study population was varied, the researcher sought individuals from different settings and levels within their respective organisation. This enabled the study to have a wide range of views from professionals at both ground and service level. Furthermore, the sample size is adequate for thematic analysis and theoretical saturation was reached. The participants in the study population were considered to be a hard to reach group due to the limited amount of services operating, the high workload that practitioners had and professionals often being out of the country to respond to immediate refugee crises.
The aim of the study was to obtain insights into how to implement the Conversation Group in resettlement settings with a focus on its delivery and provision within services. This was done through the lens of service provider perspectives. It was important to obtain these views as service providers often act as 'gate keepers' to the mental health care interventions that refugees receive. However, a potential limitation to this is that by not obtaining views from refugee caregivers directly, there is the potential neglect of insights from the individuals that would use the intervention. Seeking their opinions could allow insights into how well it would be accepted and utilised in this study population. The researcher was aware of another study currently being conducted which looked at obtaining views from refugee caregivers from the Middle East on the potential use of the Conversation Group, therefore the current study aimed to focus solely on the intervention's implementation from a service level.

The Thematic Analysis approach was utilised for this study and has been utilised as a method of analysing qualitative data with other studies in the refugee literature (Khawaja, White, Schweitzer & Greenslade, 2008). The use of this approach was useful in extracting key themes which emerged from the interviews. However, this mode of analysis has some limitations. Holloway and Todres (2003) suggest that its ability to be flexible can be beneficial but can also result in a deficiency in coherence when identifying and elucidating themes. Furthermore, research utilising Thematic Analysis may also include researches conducting inter-rater reliability checks. This was not done in the current study, however, to ensure the analysis was comprehensive, the method of triangulation was used to compare themes found (Mays and Pope, 2000).

**Implications**

This study highlights the utility and need of brief, accessible parenting interventions for refugees in resettlement from service provider perspectives. This is in line with recent guidance on how to support children that have been through war and conflict, the recommendations suggest a focus on the caregivers’ mental health and psychosocial needs.
Identifying, developing and implementing support for refugees and their families is a global health concern (Yule, Dyregrov, Raundalen, 2013) and with refugees having an increased risk of mental health issues at the stage of resettlement there appears to be a need for interventions in this area (Murray et al, 2010).

The findings of this study suggest that greater provision should be provided to services attempting to implement psychosocial interventions for refugee populations. Considerations should also be made regarding the use of skilled and experienced group facilitators and around the complexity of running groups in resettlement contexts.

**Recommendations**

Future research could benefit from working with refugee families in more depth, this would allow more detailed discussion and opinions to be obtained on views on the best methods of how to implement and run group interventions in resettlement contexts. This study was focussed on service providers’ perspectives of refugees from the Middle East accessing mental health services in resettlement contexts. Future research would also benefit from obtaining views from professionals on the Conversation Group and its implementation within displacement contexts along with any potential barriers and facilitators that would emerge from implementing it in those low resource settings. In the current study data was collected on the two distinct settings of displacement and resettlement, however, the decision was made to focus on the resettlement context to allow a sufficient and detailed analysis.

**Conclusion**

This study provided an in-depth exploration of factors relating to the implementation of a brief parenting intervention for refugee families in resettlement contexts. The benefit of providing this support in a group setting was highlighted and recommendations for its
adaptation were suggested. Some of the key complexities were highlighted which may impact on its ability to be implemented within resettlement contexts and methods for its facilitation were given to help overcome these issues. Furthermore, services should ensure trained and skilled interpreters and group facilitators are utilised when delivering group interventions and considering the needs of service resources, commissioners should acknowledge the need for group interventions with these populations and provide funds to increase the amount of services that can run these interventions.
References


Critical Reflection

This critical reflection on the research aimed to provide an appraisal of the work that was completed and provide a background to the decisions made and reflections through the process. To help structure this critical reflection the initial part will focus on a rationale for why this project was chosen in the first place. Thereafter, Paper 1 (the meta synthesis) and then Paper 2 (the empirical paper) will be reflected on and with both papers the information and knowledge gained will be combined to assist in the development of implications for work in this area of research and practice. Thereafter any personal reflections will be discussed.

Rationale for conducting research in this area of study

The papers that were produced highlight the continued issue of war, violence and conflict that are resulting in record high levels of forced displacement (UNHCR, 2016). The Middle East is a region which either hosts resettled refugees or has countries which are in turmoil and are causing forced migration. There appeared to be literature on catering for the physical health of refugees from the Middle East and other countries (Robertshaw, Dhesi & Jones, 2018) but a limited focus appeared to be on their mental health and issues relating to them accessing and utilising such services.

Therefore, when initially planning and considering which area of study to focus on when developing a large scale research project these points were considered. Qualitative research methods were decided upon as a reliable method for undertaking research in this area to help capture rich detail and experiences from the individuals we were considering interviewing. Service providers and health professionals that deliver the care to the refugees were seen as an important demographic to obtain views from as they often act as ‘gatekeepers’ to the care that vulnerable populations receive (Ingleby, 2004), and so the researcher, with discussion from the research term, decided to obtain the views from this population.

The researcher has had an interest with working with marginalised populations and individuals of an ethnic minority. The researcher has worked in positions which entail
culturally adapting interventions and has been a part of special interest groups to help develop services to make them more culturally sensitive. The researcher has not, however, had a chance to work in the area of refugee populations and so was excited at this prospect and with the prospect of carrying out research that helps towards developing ‘practice based evidence’ and help services on the whole.

Paper 1

The research question

Through the scoping exercise using Google Scholar and research databases there appeared to be some literature relating to service providers’ views on Middle Eastern refugees and them initially accessing or utilising mental health care and services. There were not enough papers on the topic on either the context of displacement or resettlement and so refugee experiences of accessing mental health care across the journey were considered. There did not appear to currently be a synthesis present that collated and summarised these views in the literature. Once these findings came to light the researcher discussed them with the research team and it was considered appropriate and timely as an area that would benefit the literature and knowledge base around accessing mental healthcare for this undeserved population.

Method of synthesis

Within the realm of qualitative research there has still not been a recognised ‘gold standard’ by which the synthesising of qualitative research papers can be undertaken (Ring, Richie, Mandava and Jepson, 2011). With this being the case, the researcher considered and decided to choose a method of synthesis which would enable an interpretive focus to allow the possibility to not only compare and contrast but to also explore new knowledge which may emerge. Furthermore, the researcher wanted to utilise an approach that could adequately synthesise qualitative research articles that contained various methodology, albeit them all being of a qualitative nature. Based on this, the researcher decided to utilise
the method proposed by Walsh and Downe (2005) for synthesising qualitative research that was developed from the underpinnings of work by Noblitt and Hare (1998). It was able to adequately synthesise qualitative research that included methods that were heterogeneous and further accommodated the interpretive focus and exploration of unprecedented research should it emerge (Walsh and Downe, 2005).

Qualitative synthesis of research has important insights to help enhance research and knowledge in the area, however, there have been some criticisms. Bearman and Dawson (2013) discuss the issues around researchers assessing and synthesising qualitative data that has been reported by others. This could lead to some of the data being misinterpreted and also some of the depth of experiences that the participants have expressed may be missed. It would have been good practice to contact each of the study authors that had research included in the synthesis and obtained their views on the researcher’s summaries and understanding that were found, however, due to time resections this was not possible in the current synthesis. However, to overcome some of these issues the researcher ensured that each research article which was included in the synthesis was read on multiple occasions to assist in familiarising with the data presented. Furthermore, the findings were consistently compared against any themes that emerged and were indeed consistent with the findings originally obtained by the study authors. The researcher also worked closely with the research team and any themes that appeared and became apparent were first checked and discussed with them and further iterations were made as required.

Criteria for inclusion and exclusion

When considering criteria to set for the inclusion and exclusion of studies, the research question was kept in mind and considerations were made to ensure the criteria was not too narrow or ambiguous (Boland, Cherry and Dickson, 2017). As part of the synthesis the decision was made to not include certain populations. One such example is populations that were described as ‘migrants’ or ‘immigrants’ as with those populations there is an assumption of these populations not being forcibly displaced due to issues regarding war and conflict and were more closely aligned to students and economic migrants (Robertshaw, Dhesi and Jones, 2018). When considering papers to include in the synthesis there were
occasions in which papers that appeared appropriate and had findings which were important to note could not be included due to them not adequately specifying the refugee population being studied. An example of this would be the article by Crowley (2005). The findings were discussed in the discussion of the synthesis but to ensure the synthesis was systematic in its nature, it was not included in the final selection. Furthermore, primary research that was not written in the English language were also not included and so this may also need to be considered when assessing the results of the synthesis and its generalisability.

Search process

The search process in reviews require a thorough and rigorous process to ensure that all decisions made are clear and enough detail is produced to ensure replicability (Boland et al, 2017). At present there has not been an established method which ensures certainty of results in the search process and so to aid the process the use of PICO was utilised and was adapted to suit the current synthesis by focussing on the population, phenomena of interest and context. Using this process helped with the development of relevant search terms to locate relevant primary research and synonyms and truncations were used where required to help the process. Search terms were included to help maximise the possible number of research articles which could be found and thereafter the title, abstract and the full text of the article was searched through where required to ensure the search process was rigorous. This process also included the process of cross checking to ensure inter-rater reliability. The search terms were discussed and agreed upon with the research team and were developed considering terms used in other prominent, published systematic reviews and meta-syntheses in this topic area (Robertshaw et al, 2018; Tribe, Sendt and Tracy, 2017).

Quality appraisal

The CASP (CASP, 2017) was the quality appraisal tool that was selected to assess the papers in the meta-synthesis. This specific tool is often used to assess qualitative research and also provides a useful framework for appraising quality and also includes ‘anchors’ which can
help researchers that are new to qualitative research and to the process of quality assessment (Newton, Rothlingova, Gutteridge, LeMarchand & Raphael, 2012). To reduce the chance of bias, the first author and a colleague external to the project used CASP against the set of papers and a 100% agreement was found between the scores. The limited amount of articles to assess may have caused some bias as there was limited data to compare and contrast across the papers, however, the high level agreement shows good inter-rater reliability.

To date there still remains a lack of consensus around the use of quality appraisals tools in qualitative reviews (Tong, Flemming, McInnes, Oliver & Craig, 2012). The CASP appraisal tool was appropriate in this synthesis, however, an alternative consideration which could have been made would be to have based the appraisal more on how ‘thick’ the data and analysis was as opposed to the rigour of the studies. This method has been used recently in meta-syntheses (Knowles, Toms, Sanders, Bee, Lovell and Rennick-Egglestone et al, 2014) and was based on work from Atkins, Lewin, Smith, Engel, Fretheim & Volmink et al (2008) that found richer articles that had ‘thick’ analyses and data sets contributed the most to the analysis overall. The definition of thick data would be that the papers would use at least semi-structured interviews and with this at least a Thematic Analysis (Knowles et al, 2017).

**Limited number of eligible studies**

After rigorous searches were conducted there was a relatively small number of relevant primary research articles found. As discussed previously, one such issue is related to studies which were close to being included but could not due to not being specific enough in their description of refugee populations that views were being sought on. Additionally, this finding could also suggest the underdevelopment of research in this research area regarding the views of service providers in the form of qualitative primary research. In consideration of this, one possible method could have been to adopt a mixed method approach to inclusion. The rationale in the current review regarding the sole use of qualitative research was related to wanting to obtain a rich and in depth form of analysis to review and that qualitative research was more suited to obtain papers that the synthesis wanted to further explore.
Development of the Research Question

The research for the empirical paper followed on and was related to the meta-synthesis carried out in paper 1. The perspectives from service providers on access to mental healthcare for Middle Eastern refugees was found to be important and pertinent when considering issues regarding the barriers and facilitators for these populations gaining access to mental healthcare. Furthermore, with the development of a Conversation Group and accompanying booklet that was developed by the research team at the University of Manchester, views on its content and methods to increase its accessibility when implemented were valued.

The decision to focus on the views of service providers was, in part, developed through useful discussions with the research team which also included considerations regarding the researcher’s exploration of personal interests and strengths. Through these discussions an interest in connecting with people on a large scale and making links in the wider context in relation to work with refugee populations was found. Working with marginalised communities and ethnic minorities, as previously noted, has always been an interest of the researcher and coupled with the interest with wanting to understand how services worked in this area and how they could be adapted, meant a focus on service providers was what was needed.

The research project was initially going to focus solely on the Syrian population as their plight has been widely noted in the media and in research. However, through further exploration through organisations like UNHCR it appeared that there were also other areas in the Middle East that were suffering from forced displacement and many of the Syrian population were being displaced to neighbouring regions like Lebanon and Jordan (UNHCR, 2016). Additionally, when liaising with professionals that work directly with refugees this
point was raised and an emphasis on the Middle East as a whole for the implementation of the Conversation Group was preferred.

This started off the thought process and as a result changed the project to include individuals from the Middle East that were not solely from Syria. Furthermore, through discussion with the research team, the decision to focus on the Middle Eastern population was due to the benefit of studying a population that was relatively homogenous in terms of their refugee experiences and that the research team has experience with producing qualitative research with refugees from this region. This enabled the researcher to utilise the expertise and knowledge that was present within the team.

**Use of Thematic Analysis**

The Thematic Analysis method (Braun and Clark, 2006) was utilised for this study and through this method the familiarisation of the data and subsequent coding and organisation of themes were undertaken. There are several methods of analysis which can be used when analysing qualitative studies, some of which including Grounded Theory (Glaser and Strauss, 2017) and Interpretive Phenomenological Analysis (IPA) (Smith, 2010). Grounded Theory is often used when there is a focus on the development of theory and in the current study there was already a question which was established and so in this regard Thematic Analysis seemed more appropriate to use. IPA is a methodology which may have been considered to be utilised for the current study, however, IPA has a focus on exploring the in-depth lived experiences of individuals and is often done with a relatively small number of participants. With the current study obtaining a relatively large sample for interviewing and with the focus of the interviews being on the barriers and facilitators of refugees accessing a Conversation Group, Thematic Analysis was deemed most appropriate as the research methodology.
Recruitment and study sample

The researcher utilised several different sources to undertake the successful recruitment of study participants. Prior links that had been established with the research team were sought and the use of convenience sampling was employed. To supplement this approach, the researcher contacted several charities and non-governmental organisations and often stumbled across the recruitment of professionals in unlikely scenarios e.g. at a barbeque that was organised by a collaboration between a mosque, church and charity organisation. The recruitment was difficult to start with, however, once the first few interviews had taken place the recruitment became easier as many of the interviewees recommended other individuals which they felt could provide a good insights and information required for the study. There were, however, some occasions in which interviews had to be continuously rescheduled due to how busy the service providers were in relation to them having to actively leave the country and assist in supporting refugees as part of their work.

Service providers were not recruited via NHS organisation as few NHS services cater solely for refugee populations. When refugees are seen in NHS services it is often in the context of psychotherapeutic help which the refugee family/individual may access once settled in the country for a few years. Additionally, there appeared to be a sufficient number of participants to take part in the study from charities, the council and existing national and international links. In relation to the sample size, 13 semi-structured interviews were conducted and included an array of individuals from different ethnicities, organisations and roles within their respective organisations. Research suggests that 12 interviews are enough for data saturation to be reached and a sufficiently in-depth account of an individuals’ experiences when using the Thematic Analysis method as was used in the current study (Guest, Brunce and Johnson, 2006).

Interviewing

Considering the qualitative methodology of the study, the interviewing of professionals was a key component. There were many considerations that had to be taken into account to
ensure the interviews were successful and delivered to a good standard. Interviews require the facilitator to be flexible, and in a relatively short period of time, build a rapport with the person (Charmaz, 2014). The researcher had not had previous experience in interviewing individuals as part of a research project; however, did have experiences gained through clinical training. These experiences provided the researcher with skills on how to guide conversations and to also ensure the participant felt as though and were provided with a space to talk about their experiences. This did, however, also bring up some interesting reflections within the researcher and on their tendencies to interview in a method which they would utilise in a more therapeutic context. This is something which can happen when Clinical Psychologists that are trained and used to conducting therapeutic input with patients and are then conducting research interviews. To assist in overcoming this, guidance from research supervisors who have many years of experience in qualitative methodology was sought through supervision and in-depth practice interviews to help the researcher reflect on these tendencies and methods to overcome and adapt interview practice.

A further reflection was considered based on the length of some of the research interviews. Some of the research interviews were longer than anticipated and this could have been for a number of reasons. One such reason could reflect the amount of experiences the participants had and wanted to share. On the other hand, it was also worth considering the possibility that the topic guide could have included too many questions and the researcher could also have been more directive with when to move on with certain questions. The researcher felt that learning was cemented in the area of interviews by having the opportunity to provide supervision and support to a Masters student who was starting her journey with qualitative methodology and required some guidance on how to conduct research interviews. This was a great learning opportunity and was positively received from the student.

**Decision to focus on the resettlement context**

This paper was also initially planning to focus on gaining perspectives from service providers on Middle Eastern refugees access to and implementation of the Conversation group in both displacement and resettlement contexts. A wealth of data was collected via the semi-
structured interviews on the two distinct settings, however, the decision was made to focus on the resettlement context to allow a sufficient and detailed analysis on the setting as to focus on both contexts proved to be too large a study to be completed in the time frame allocated for this research. The findings that were obtained in relation to the Conversation Group and its implementation within displacement contexts will be analysed and described in a separate report.

**Implications of papers 1 and 2**

As was found when conducting the meta-synthesis, there appeared to be very little in terms of primary research articles that looked at parenting groups and interventions with refugees from the Middle East. The mental health and well-being of the care givers of refugee children have been highlighted as an area of need (Save the Children, 2018) and providing this support has been recognised globally as a matter of priority (Yule, Dyregrov, Raundalen & Smith 2013). The meta-synthesis in Paper 1 highlighted the range of factors which contribute to refugees from the Middle East accessing mental healthcare and many themes were found. The synthesis highlighted the importance of considering factors like that of a lack of service provision whilst catering for refugees with complex needs. On the other hand, it also had implications for services as it highlighted the need for adapted, culturally sensitive mental healthcare which considered the individuals’ spirituality as well as their often deprived and uncertain living situations. Furthermore, the importance of the healthcare encounter was discussed with services needing to allow time for refugees to suitably build rapport and trust.

Many of these concepts were also found in paper 2 where the empirical paper looked more specifically at a Conversation Group for refugee families from the Middle East. The study showed the effectiveness of brief, accessible interventions that can be implemented in low resource settings with little training required to facilitate its running. It was further highlighted that thought needs to be considered when running groups in regards to the gender split and considerations for locations that are easily accessible for refugees that were often described as having financial difficulties.
Personal Reflections

Qualitative Research

Doing this research project was the first time I have conducted research with a qualitative methodology and through wider reading I was aware that qualitative research has, at times, been criticised for issues regarding its subjectivity (Mays and Pope, 1995). This was, therefore, something that required some thought and consideration. Supervision was a method which I utilised in this regard to help me reflect on my own processes and ideas and how they may interact with the questions I ask and information I focussed on during research interviews; something which I felt was in the process of already being developed whilst training to be a Clinical Psychologist.

A suggestion which was made early on in my research journey by the research team and supervisors was to keep a reflective journal. This proved to be very useful and was done throughout the research process. Keeping a research journal with reflections, ideas and thoughts on all areas of the research helped me to consider my reactions and assumptions and its potential influence on the research process. It was also a useful tool when searching through and attempting to analyse numerous datasets and interviews. It was a skill and tool which I hope to continue implementing in both my clinical practice and research endeavours.

Working with service providers

Working closely with service providers that had a variety of positions, from volunteers to individuals at the service level was something that I thoroughly enjoyed and learned a lot from. I was astounded by the way many of them were managing with the scarce resources they had and with the high amount of refugees they had to support. Through their narratives and the many examples, the service providers gave, I felt like I obtained a sense of what their job entailed and what it takes to support some of the most vulnerable in
society. These experiences have allowed me to consider working in this area in some capacity once qualified as a Clinical Psychologist.

Personal resonance and impact

Working on this research project produced some reflections and enabled some conversations which I had not had with myself and others previously. I reflected on my own journey and that of my parents when first coming to the UK. My parents were born in a part of the world where there was persecution and a place where difficulties were rife and so to provide a better life for their family they migrated to the UK. When talking to them I realised the acculturation process they went through; from difficulties with navigating the school systems to having to struggle to find work in their fields of speciality. I don't believe I can truly understand what it must feel like to be forcibly displacement due to war and conflict, however, reflecting on these experiences allowed me to gain an insight into the challenges of acculturating to new environments.

Furthermore, the impact and relevance of the work which is being carried out had an impact very early on. The BPS as part of the Clinical Psychology Forum had a special edition on minority groups and a paper was sent for publication which was accepted on reflections of the research process and insights gained from working within the area of refugees and mental health (Sumra and Baess, 2017). As well as this, the information and knowledge gained from this research project is hoped to be shared with organisations both nationally and internationally once in a format which is ready to be disseminated to help co-ordinate the dissemination of mental health materials to refugees in need of it.

Summary

In summary, working on and completing a large scale research project was an experience which allowed me to develop in many areas of research and life. Completing such a task whilst working concurrently on clinical placements and having a baby boy was difficult given the limited time frame in which the work was to be completed. There were bumps along the
way with challenges I faced with health issues but the overcoming of obstacles is what makes this feat all the more worthwhile. This highlighted an important issue in that of self-care. Self-care was very important in helping me stay healthy both mentally and physically.

I believe I was able to sufficiently fulfil the aims of the project on the whole and I feel the qualitative methodology was the most appropriate method of analysis to gain an insight into the views and perspectives of service providers. Also the knowledge that was gained can be of use to research in this area and assist in the production of recommendations for research, clinical practice and service development. The process started from an interest in wanting to support and understand ethnic minorities and marginalised populations and completing this project has highlighted how much of an important topic this is. Furthermore, the importance of cultural sensitivity and the complexities that are present when working with refugees and vulnerable populations in society should be taken into consideration.
References


Tong, A., Flemming, K., Mclnnes, E., Oliver, S., & Craig, J. (2012). Enhancing transparency in reporting the synthesis of qualitative research: ENTREQ. BMC medical research methodology, 12(1), 181.


Appendices

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GUIDE FOR AUTHORS – Journal of Social Science and Medicine

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2) Systematic reviews and literature reviews of up to 15000 words including abstract, tables, figures, references and (printed) appendices as well as the main text.

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4) Submitted or invited commentaries and responses debating, and published alongside, selected articles (please select the article type 'Discussion' when submitting a Commentary).

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• E-mail address

• Full postal address

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All necessary files have been uploaded:

Manuscript:

• Include keywords

• All figures (include relevant captions)

• All tables (including titles, description, footnotes)

• Ensure all figure and table citations in the text match the files provided

• Indicate clearly if color should be used for any figures in print

Graphical Abstracts / Highlights files (where applicable)

Supplemental files (where applicable)

Further considerations

• Manuscript has been 'spell checked' and 'grammar checked'

• All references mentioned in the Reference List are cited in the text, and vice versa

• Manuscript does not exceed the word limit

• All identifying information has been removed from the manuscript, including the file name itself

• Permission has been obtained for use of copyrighted material from other sources (including the Internet)

• Relevant declarations of interest have been made
• Journal policies detailed in this guide have been reviewed

• Referee suggestions and contact details provided, based on journal requirements

For further information, visit our Support Center.
### Appendix 2: CASP quality rating scale

<table>
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<th>Study</th>
<th>CASP (10 items)</th>
<th>Quality Score</th>
<th>Independent Rater Score</th>
<th>Agreement on scores and quality</th>
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<td>Mirdal et al (2012)</td>
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Appendix 3 - Instructions for Authors – Journal of Peace Psychology

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Authors should supply a shortened version of the title suitable for the running head, not exceeding 50 character spaces.

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Prepare manuscripts according to the Publication Manual of the American Psychological Association [6th edition]. Manuscripts may be copyedited for bias-free language (see Chapter 3 of the Publication Manual).

Review APA's Checklist for Manuscript Submission before submitting your article.

If your manuscript was mask reviewed, please ensure that the final version for production includes a byline and full author note for typesetting.
Double-space all copy. Other formatting instructions, as well as instructions on preparing tables, figures, references, metrics, and abstracts, appear in the *Manual*. Additional guidance on APA Style is available on the [APA Style website](https://apastyle.org).
Appendix 4: Topic guide

Project Title: Maximising accessibility of a conversation group for refugee families.

Interview Key:

All information in bold with speech marks is read to the participant or asked as a question.

Linked research questions are identified and presented in capitalised italic form.

Instructions are presented in [italicised square brackets].

Question-specific and general prompts are presented in [square brackets].

Introduction:

Just so you know before we start there is some information I need to go through with you.

“Thank you for taking the time today to talk with me. Your experience and views are really important and we want to hear your opinions as people that work in the field.

I am going to be asking you some questions about the conversation group content and how its access can be maximised in refugee families that have been in a refugee camp / resettled, based on your experiences of working with refugee families.

I’m going to talk as little as possible so that I can just listen to what you have to say. Sometimes I might ask you to repeat or explain something. That may be because the recorder may not pick up everything you say otherwise. We can stop at any time if you like or move on to the next question and you can ask me questions at any time”.

“Have you any questions before we start?”

One criticism of research is that sometimes people just talk to similar people we want to information about you and your role and so we can ensure we are getting varied people to interview.
1. **Background questions:**

1.1 Gender?
1.2 Age?
1.3 How would you self-identify your culture/ethnicity?
1.4 Qualifications?
1.5 Current job title?
1.6 Organisation?
1.7 Length of time in this role?
1.8 Can you tell me about your role with refugee parents/caregivers?
1.9 How much face to face contact does the role involve with refugee parents?
1.10 Previous experience with refugee populations?
1.11 How much experience do you have with refugee parents when refugee’s have been displaced (left their country and lived in refugee camps)?
1.12 How much experience do you have with refugee parents during resettlement?
1.13 What brought you to work with refugee populations?

[Generic prompts: can you tell me more about that?]

*[information gained will inform questions asked in 2.1 and 2.2]*

2. **Conversation group content:**

1. **Conversation Group Content**

1.1 “What is your overall view of conversation group content”
1.2 “What elements did you find would be helpful for refugee parents?”
1.3 “Were there any elements you felt could be adapted to have greater effect?”
1.4 “What are your views on the relevance of the cultural/religious aspects of the conversation group content?”
1.5 “What are your views on it being delivered in a group setting?”
1.6 “How is it best to promote the conversation group?”
1.7 “Where is it best to promote the conversation group?”
1.8 “When is it best to promote the conversation group?”
1.9 “Who are the best people to promote the conversation group?”
1.10 [Generic prompts: can you tell me more about that? Why do you describe it as {use metaphor/simile/ phrase that interviewee used}? Can you give me an example?]

2.1 Ways in which uptake can be facilitated when refugees leave their country:

“I am going to ask you about two time points in the refugee parent/caregiver’s parenting experience.

First, I want us to talk about a family who have just left their country and their potential use of the conversation group. Thereafter, we will talk about the conversation groups use once a family have arrived in the place of resettlement.

“In your experience of working with refugee families how could the conversation group access be maximised during the time when they have left their country?”

2.1.1 “Ways in which to best facilitate its access?”

2.1.2 “Potential obstacles that we need to be aware of?”

2.1.3 “How could potential obstacles be overcome”

2.1.4 “Can you tell us about your experience of a similar initiative and how you promoted its access and overcome any obstacles?

[Generic prompts: can you tell me more about that? Why do you describe it as {use metaphor/simile/ phrase that interviewee used}? Can you give me an example?]

2.2 Ways in which uptake can be facilitated when refugees go through resettlement:

“In your experience of working with refugee families, how could the conversation group access be maximised once they have resettled?”

2.2.1 “Ways in which to best facilitate its access?”
2.2.2  “Potential obstacles that we need to be aware of?”

2.2.3  “How could potential obstacles be overcome”

2.2.4  “Can you tell us about your experience of a similar initiative and how you
promoted its access and overcome any obstacles?

[Generic prompts: can you tell me more about that? Why do you describe it as
{use metaphor/simile/ phrase that interviewee used}? Can you give me an example?]

3. Concluding the interview:

3.1  “Are there things we haven’t talked about that you think it’s important for us to
know from your experience of working with refugee families?”

[Generic prompts: can you tell me more about that? Why do you describe it as
{use metaphor/simile/ phrase that interviewee used}? Can you give me an example?]

3.1.1  “Do you have any questions for me at all?”

[Give debrief information here]

[End interview: thank participant]
APPENDIX 5: Participant information sheet

MAXIMISING ACCESSIBILITY OF A CONVERSATION GROUP FOR REFUGEE FAMILIES

Participant Information Sheet

You are being invited to take part in a research study as part of a postgraduate student project for the Doctorate in Clinical Psychology. Before you decide whether you would like to take part in the study it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information sheet carefully and discuss it with others if you wish. Take time to decide whether or not you wish to take part. Thank you for reading this.

Who will conduct the research?
The study will be conducted by Altaf Sumra, Trainee Clinical Psychologist under the supervision of Professor Rachel Calam, and Dr Fiona Ulph at the School of Health Sciences, The University of Manchester, Second Floor, Zochonis Building, Brunswick Street, Manchester, M13 9PT.

Title of the research
Maximising accessibility of a conversation group for refugee families.

What is the aim of the research?
There are many families across the world forced to leave their homes and country of origin due to conflict. Some families resettle in more stable countries such as the UK. Adapting to life in a new country, in addition to coping with traumatic events and distressing experiences that may have occurred can make it particularly difficult for families. Getting the right kind of support to do this is important for the wellbeing of both parents and their children. From talking to refugee parents we have established that help and advice on how to care for children through conflict and displacement and into resettlement is much needed. Our research team have developed a conversation group with an accompanying booklet that provides practical advice and guidance to provide
psychological information to help parents. Now, we are seeking the views of people who work with refugees to find out their opinions on the conversation group’s content and ways to increase it access.

**Why have I been asked to take part?**
You have been asked to take part because you are a professional who works with refugee families that have fled their country due to conflict and have gone through displacement / recent resettlement. We are interested in understanding your perspectives on the conversation group and ways in which its access can be maximised.

**What would I be asked to do if I took part?**
If you decide to participate in the study, we will arrange an appointment with you at which we will interview you for approximately 45 minutes, which will be audio-recorded. You will receive a copy of the conversation group content a week prior to the interview to have some time to have a look at it before the interview.

We will also ask whether you give permission for us to re-contact you in the future for other research studies our research team is conducting. If you agree to this you may be contacted by a researcher from the team if we are doing other projects that you may be interested in taking part in. If this was the case, we would talk to you about the project, and you would be free to agree to take part or not, without giving a reason. We would not contact you within the first 3 months after you have taken part in this project. You will be free to change your mind and ask us not to contact you at any time.

**What are the risks of taking part?**
There are no more than minimal risks associated with this research. We will ask you questions about the conversation group for refugee parents and ways to helps its facilitation in refugee populations. If, however, you do not feel comfortable answering any of the questions in the interview, you do not have to. However, if through responding to interview questions you find that you become upset due to the topic being discussed, the interview will be stopped and only continue if you wish it to. If after the interview you would like to discuss any issues further, we would talk with you about whether there is someone local to you who could help support you further.
What happens to the data collected?
The data collected will be stored confidentially at The University of Manchester. The interviews will be used to widen our knowledge and help to develop further research about parenting in refugee families. The findings of the study will also be communicated to academics, refugee organisations and health and educational professionals and services to help in the future provision of parenting support to families. Anonymised interview transcripts (with no identifying information) may be shared with other researchers known to the research group for research or teaching purposes.

Will my data be confidential?
Yes, all data collected will remain confidential at all times. A research identification number will be assigned to you and your name will not be used. Your data, including audio-recordings, will be kept confidentially and securely using your identification number in password-protected electronic files and on paper in locked filing cabinets in a confidential research facility at The University of Manchester. Any audio-recordings will be typed up as anonymised transcripts with any identifiable data being removed. Once the project is complete the audio files will be deleted, however all other anonymised data will be kept for a minimum of five years, and may be used for further research or secondary data analysis. The only people who will have access to your individual identity and your data are the research team. Future researcher can apply to have access to the anonymised data sets by applying to the University of Manchester. With your permission we may use direct quotes from your interview, but your name will not be used and therefore you will not be personally identified and will remain anonymous.

Do I have to take part?
You are not obliged to participate in this study. If you decide to take part and subsequently change your mind, either before you start the study or during, you can withdraw without giving your reasons.

What happens if I do not want to take part or if I change my mind after taking part?
It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part and then at a later time decide that you would not like us to use your data, you can withdraw your data any time up until the data has been transcribed and fully anonymised. You can withdraw your data without giving a reason and without detriment to yourself.

**What is the duration of the research?**
The interview will last up to 45 minutes. We will book an appointment to speak with you for up to 60 minutes to allow time to obtain consent from you and give you the opportunity to ask any further questions you might have before being interviewed.

**Where will the research be conducted?**
The study will take place at your work place, at a higher education institute or over the telephone / Skype.

**Will the outcomes of the research be published?**
When we have seen all participants taking part in the study, we will provide you with a summary of what we have found out. The results from the research may be presented at national and international conferences and may be published in academic journals. They will also be used as part of an educational project (Doctorate in Clinical Psychology). The results may be presented to refugee organisations and agencies and other health and educational professionals and services and a report containing the results may be provided to them. You will not be personally identified in any reports or publications of the research.

**Who has reviewed the research project?**
The project has been reviewed and approved by the Division of Psychology and Mental Health Research Ethics Committee at the University of Manchester. The Committee has confirmed that they think the research is ethical and safe to do.

Contact for further information
For any further information about the study please contact altaf.sumra@postgrad.manchester.ac.uk. The main study supervisor is Professor Rachel Calam (rachel.calam@manchester.ac.uk).

What if something goes wrong?
If you have a concern about any aspect of the study, you should speak to the research team. You can also contact Rachel Calam by phone on 0161 306 0403 or by email rachel.calam@manchester.ac.uk. You can also contact Fiona Ulph: Fiona.ulph@manchester.ac.uk, and Altaf Sumra: altaf.sumra@postgrad.manchester.ac.uk.

If there are any issues regarding this research that you would prefer not to discuss with members of the research team and/or you would like to make a formal complaint about the conduct of the research, please contact the Research Governance and Integrity Team by either writing to 'The Research Governance and Integrity Manager, Research Office, Christie Building, The University of Manchester, Oxford Road, Manchester M13 9PL', by emailing: Research.Complaints@manchester.ac.uk, or by telephoning 0161 275 7583 or 275 8093.
Appendix 6: Participant consent form

MAXIMISING ACCESSIBILITY OF A CONVERSATION GROUP FOR REFUGEE FAMILIES:
CONSENT FORM

If you are happy to participate please complete and sign the consent form below

Please initial
box

1. I confirm that I have read the attached information sheet on the above project and have had the opportunity to consider the information and ask questions and had these answered satisfactorily.

2. I understand that my participation in the study is voluntary and that I am free to withdraw at any time up until the point the data has been transcribed and fully anonymised without the need to give a reason and without detriment to any services.

3. I understand that the interviews will be audio-recorded.

4. I agree to my data being retained indefinitely for further research and/or secondary data analysis related to the parenting experiences and support needs of refugee parents. This includes anonymised data being shared with other researchers working with the research group for research or training purposes.

5. I understand that my name will not be used and I will not be personally identified in any reports or publications of
the research. I agree to the use of anonymous quotes from the interview.

6. I agree to my contact details being securely stored and being re-contacted by a member of the researcher in the future (after a minimum of 3 months). I understand that I am free to withdraw this consent at any time.

7. I agree to take part in the above project.

<table>
<thead>
<tr>
<th>Name of participant</th>
<th>Date</th>
<th>Signature</th>
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<table>
<thead>
<tr>
<th>Name of person taking consent</th>
<th>Date</th>
<th>Signature</th>
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</thead>
</table>
21st November 2016

ALTAF SUMRA
Clinical Psychology, 2nd Floor Zochonis Building
University of Manchester
M13 9PL

Dear Altaf

Research Subcommittee – 21st November 2016

Thank you for submitting your revised proposal to the Research Subcommittee meeting on 17th November 2016. The committee were satisfied that the revisions made were appropriate and in accordance with the feedback from that meeting and you may now proceed with your research as set out in your revised proposal.

For the purposes of ethical scrutiny by relevant NHS and/or University bodies, this letter may be taken as confirmation that your research proposal has been independently reviewed and that it is considered to meet necessary scientific and methodological standards.

On behalf of the Research Subcommittee, we wish you good luck with your research work.

Yours sincerely

[Signature]

Dr Anja Wittkowski
Senior Lecturer in Clinical Psychology
Panel B Chair, Research Sub-Committee

cc: Supervisors: Rachel Calam, Fiona Ulph
Tutors: Dan Pratt, James McManus
## Appendix 8: Participant identifiers and demographic details

<table>
<thead>
<tr>
<th></th>
<th>Participant Details</th>
<th>Job Title</th>
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<tbody>
<tr>
<td>1</td>
<td>Female, 31 years old, White British, MSc level educated, 6 years’ experience with refugees from the Middle East in resettlement in the UK, UK based interview</td>
<td>Job title – Project manager at refugee charity</td>
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<tr>
<td>2</td>
<td>Female, 56 years old, White British, Post Graduate level educated, 4 years’ experience with refugees from Middle East (Iraq, Syria) in resettlement, UK based interview.</td>
<td>Job title- lead consultant for new arrivals and gypsy Roma traveller children (council)</td>
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<td>3</td>
<td>Female, 45 years old, White British, Diploma level educated, 3 months experience with resettled refugees from middle east (Iraq, Iran, Syria), UK based interview,</td>
<td>Job title- Wellbeing and Outreach support worker</td>
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<tr>
<td>4</td>
<td>Female, 38 years old, White British, Degree level educated, 4 years’ experience with resettled refugees from Middle East, UK based interview,</td>
<td>Job title- health and well-being lead nurse and health and wellbeing and inclusion team lead nurse</td>
</tr>
<tr>
<td>5</td>
<td>Male, 53 years old, Black African Caribbean, Diploma level educated, 10 years’ experience with refugees from Middle East, UK based interview,</td>
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<tr>
<td>Job title - Asylum and Refugee temporary accommodation housing officer (council)</td>
<td>6) Female, 39 years old, Black African, Degree level educated, 6 years’ experience with refugees from the Middle East, UK based interview,</td>
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<tr>
<td>Job title – Volunteer</td>
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<tr>
<td>7) Male, 64 years old, White British, Masters level educated, 9 years’ experience with refugees going through resettlement (lots of varied experience- more strategic level) UK based interview</td>
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<td>Job title- Chief executive officer of a voluntary sector charity</td>
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<tr>
<td>8) Male, 61 years old, British Pakistani, Masters level educated, 8 years’ experience with refugees from Middle East in resettlement (Iran, Iraq, Syria), UK based interview (was previously an asylum seeker)</td>
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<tr>
<td>Job title – Project officer</td>
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<tr>
<td>9) Female, 53 years old, American, Phd level educated, 12 years’ experience with refugees from Middle East and in the middle east mainly in conflict zones, Middle east based interview,</td>
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<tr>
<td>Job title – Learning programme manager</td>
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<tr>
<td>10) Male, 47 years old, White British, Degree level educated, 18 years’ experience of refugees from the Middle East in resettlement,</td>
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<td>Job title- Service Manager</td>
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<tr>
<td>11) Male, 44 years old, White British, Masters level educated, 6 years’ experience with refugees from the Middle East, UK based interview</td>
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<tr>
<td>Job title- manager for children and young people’s services (strategic level)</td>
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<tr>
<td>12) Female, 42 years old, Middle Eastern, Phd level educated, 10 years’ experience with refugees from the Middle East, UK based interview</td>
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<tr>
<td>Job title – Psychological therapist and founder/chair of refugee charity</td>
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<tr>
<td>13) Male, 74 years old, White British, Degree level educated, 12 years’ experience with refugees from predominantly from the Middle East,</td>
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<tr>
<td>Job title- regional programme manager for Middle East and Africa (previous country director of refugee charity)</td>
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I: when you said there was quite a few things that you liked, you mentioned that you like the pictures and the font, could you say a little bit more about what you like about them?

P10: yes so I thought the pictures were obviously very people related which is what it is about so that is good. There is different scenarios of whether it is a female with one child or well there's quite a good mix of things it is not noticeably representative of a particular culture so there is one with a head scarf and stuff so it is quite mixed up which is good. I do like the clear titles and bullet points as well I think as we mentioned there is one that does seem a bit longer and more like a paragraph under ‘safety’ but generally I do think it is really good. Particularly it guides, the headings guide you through a process really so ‘thinking about yourself’ and then ‘your child’ and then some of the key issues. There isn't actually a sort of contents so one possibility might be to have some kind of diagram that almost talks you through where you are going but yeah I just thought it was very well written and yeah very clear what was being said really so yeah I really like that.

I: is that terms of the language?

P10: yeah in terms of the language, well both really, in terms of the language I thought each point was quiet clear with what was trying to be said and like I said I'm not an expert in the actual content but I thought it seemed to make sense and I think people would resonate with how it says this is what it likely to be happening for your child and this is what you could potentially do to support them with it so I really like that.

I: so you feel as though the group setting might be quite a good thing for this kind of stuff?

P10: yes I do

I: You mentioned quite a few different points on kind of, how is it best to promote the group? So far I remember you mentioning that you have to phone them and maybe
have to pick them up and do that kind of thing. What other kind of things do we have to do to make sure it is best promoted?

P10: yeah so one of the advantages of the groups we work with is that obviously we work very intensely with them and they have one to one case worker who can promote things but thinking about more generally if you're not running a program like that I think word of mouth is always the best way of trying to encourage people to attend these sort of events and so links with refugee community organisations and religious and faith groups that can be ambassadors for it really or talk a little bit about it and sometimes if you co-run a session with a community group in particular if it is within their venue somewhere where they are used to coming for ESOL classes or other events so they are familiar with the premises and they trust the people that are running it with you we found it helpful to bring in other people into our sessions rather than encourage them to go so for example the police have come in and talked about things, where as we wouldn’t have taken them to necessarily to access those other things so that can help.