UNIVERSITY OF AMSTERDAM

UvA-DARE (Digital Academic Repository)

Communication in refugee and migrant mental healthcare

A systematic rapid review on the needs, barriers and strategies of seekers and providers of mental health services

Krystallidou, D.; Temizöz, Ö.; Wang, F.; de Looper, M.; Di Maria, E.; Gattiglia, N.; Giani, S.; Hieke, G.; Morganti, W.; Pace, C.S.; Schouten, B.; Braun, S.

DOI
10.1016/j.healthpol.2023.104949

Publication date
2024

Document Version
Final published version

Published in
Health Policy

License
CC BY

Link to publication

Citation for published version (APA):
Krystallidou, D., Temizöz, Ö., Wang, F., de Looper, M., Di Maria, E., Gattiglia, N., Giani, S., Hieke, G., Morganti, W., Pace, C. S., Schouten, B., & Braun, S. (2024). Communication in refugee and migrant mental healthcare: A systematic rapid review on the needs, barriers and strategies of seekers and providers of mental health services. *Health Policy*, *139*, Article 104949. Advance online publication. https://doi.org/10.1016/j.healthpol.2023.104949

General rights
It is not permitted to download or to forward/distribute the text or part of it without the consent of the author(s) and/or copyright holder(s), other than for strictly personal, individual use, unless the work is under an open content license (like Creative Commons).

Disclaimer/Complaints regulations
If you believe that digital publication of certain material infringes any of your rights or (privacy) interests, please let the Library know, stating your reasons. In case of a legitimate complaint, the Library will make the material inaccessible and/or remove it from the website. Please Ask the Library: https://uba.uva.nl/en/contact, or a letter to: Library of the University of Amsterdam, Secretariat, Singel 425, 1012 WP Amsterdam, The Netherlands. You will be contacted as soon as possible.

UvA-DARE is a service provided by the library of the University of Amsterdam (https://dare.uva.nl)

Download date:24 Jan 2024

Health policy 139 (2024) 104949

Contents lists available at ScienceDirect

Health policy

journal homepage: www.elsevier.com/locate/healthpol

Communication in refugee and migrant mental healthcare: A systematic rapid review on the needs, barriers and strategies of seekers and providers of mental health services

Demi Krystallidou [a,*], Özlem Temizöz [a], Fang Wang [a], Melanie de Looper [b], Emilio Di Maria [c,d], Nora Gattiglia [e], Stefano Giani [f], Graham Hieke [a], Wanda Morganti [g], Cecilia Serena Pace [h], Barbara Schouten [i], Sabine Braun [a]

[a] School of Languages and Literature, Centre for Translation Studies, University of Surrey, Guildford, United Kingdom
[b] Tilburg Social and Behavioural Sciences, Centre for Care and Wellbeing (Tranzo), University of Tilburg, the Netherlands
[c] Department of Health Sciences, University of Genoa, Italy
[d] University Unit of Medical Genetics, Galliera Hospital, Genoa, Italy
[e] Department of Modern Languages and Cultures, University of Genoa, Italy
[f] University of Amsterdam, the Netherlands
[g] Department of Geriatric Care, Orthogeriatrics and Rehabilitation, Ente Ospedaliero Galliera Hospital, Genoa, Italy
[h] Department of Educational Sciences, University of Genoa, Italy
[i] Amsterdam School of Communication Research (ASCoR)/Centre for Urban Mental Health, University of Amsterdam, the Netherlands

ARTICLE INFO

Keywords:
Mental healthcare
Refugees
Migrants
Communication
Language barriers
Interpreting

ABSTRACT

Background: Migrants and refugees may not access mental health services due to linguistic and cultural discordance between them and health and social care professionals (HSCPs). The aim of this review is to identify the communication needs and barriers experienced by third-country nationals (TCNs), their carers, and HSCPs, as well as the strategies they use and their preferences when accessing/providing mental health services and language barriers are present.
Methods: We undertook a rapid systematic review of the literature (01/01/2011 – 09/03/2022) on seeking and/or providing mental health services in linguistically discordant settings. Quality appraisal was performed, data was extracted, and evidence was reviewed and synthesised qualitatively.
Results: 58/5,650 papers met the inclusion criteria. Both TCNs (and their carers) and HSCPs experience difficulties when seeking or providing mental health services and language barriers are present. TCNs and HSCPs prefer linguistically and culturally concordant provision of mental health services but professional interpreters are often required. However, their use is not always preferred, nor is it without problems.
Conclusions: Language barriers impede TCNs' access to mental health services. Improving language support options and cultural competency in mental health services is crucial to ensure that individuals from diverse linguistic and cultural backgrounds can access and/or provide high-quality mental health services.

1. Introduction

One billion people worldwide are living with a diagnosable mental health disorder, and in the first year of the COVID-19 pandemic, rates of common conditions such as depression and anxiety increased by more than 25% [59]. The rates of psychotic, mood and substance use disorders among migrants and refugees are similar to the rates in host countries although post-traumatic stress disorder is more common among refugees and asylum seekers. Also, the prevalence of depression among refugees more than five years after resettlement is higher than in the

* Corresponding author at: Centre for Translation Studies, School of Literature and Languages, Library and Learning Centre-3rd Floor, University of Surrey, GU2 7XH UK.
E-mail address: m21651@surrey.ac.uk (D. Krystallidou).

https://doi.org/10.1016/j.healthpol.2023.104949
Received 15 June 2023; Received in revised form 26 October 2023; Accepted 24 November 2023
Available online 28 November 2023
0168-8510/© 2023 The Authors. Published by Elsevier B.V. This is an open access article under the CC BY license (http://creativecommons.org/licenses/by/4.0/).

corresponding host country population [60]. Moreover, most migrants and asylum seekers living with mental health conditions do not have access to available care services, often due to a lack of capacity, limited accessibility, high costs or fear of stigma in the community [59]. In addition, different belief systems and the ability to recognise mental health issues influence migrants' and refugees' access to mental health services [59].

Previous reviews of the literature have identified barriers to access and use of mental health services among migrants and refugees, including problems with scheduling or restrictive timing of treatment, low social status, discrimination, and language and communication barriers [61–68].

Although the differences in the use of language about mental health issues across cultures [59] and language and communication barriers have been identified as factors affecting migrants' and refugees' ability to seek care, we still know little about the specific barriers to accessing mental healthcare that migrants and refugees experience when language barriers are present. Similarly, we know little about the communication needs of refugees, migrants, health and social care professionals (HSCPs) and the strategies currently used to overcome language and cultural barriers in seeking and providing mental health services. Considering the increasing number of migrants and refugees globally (including over 89.3 million displaced people) [69], as well as the urgent need for mental health support, many of them will require in a host country where language barriers are likely to occur, we highlight the need for addressing the above gaps in the literature and synthesising evidence that feeds into research, policy and practice. The findings of this review have informed the development of a cross-national survey and interview study with HSCPs, third-country nationals (TCNs) and language support providers within an EU-funded project that aims to facilitate access to and provision of mental health services.

This systematic rapid review aims to address the above gap in the literature and improve our understanding of the process of seeking, receiving and providing mental health services when language barriers are present. More specifically, the objectives of the review were to investigate the needs and preferences of HSCPs and vulnerable people who require or seek mental health support but encounter language barriers due to their limited proficiency in the language(s) of the host country (see working definition in "Methods"). We also sought to examine the difficulties experienced by these groups in seeking and/or providing mental health services when language barriers are present, as well as the strategies used to overcome language barriers and their perceived effectiveness. Equally important, we sought to identify the stage(s) in the help-seeking process and/or care trajectory at which language barriers become particularly manifest, and the strategies recommended in the literature to help people seeking mental health support and experiencing language barriers, as well as HSCPs overcome these barriers and address needs, as this is crucial to improving the provision of mental healthcare in linguistically and culturally diverse settings.

Although we acknowledge the diversity within the refugee and migrant population along with the unique challenges each sub-group may experience, it is beyond the scope of the study to cover sub-group specific challenges. Instead, this review focuses on the challenges arising from the inability to construct a shared understanding when language barriers are present. We examine communication difficulties arising from language discordance through the lens of linguistic vulnerability [82], which we posit lies at the core of the various types of vulnerability (e.g., cultural, structural) faced by refugees and migrants. Moreover, there appears to be a causal relationship between these vulnerabilities, as an inability to understand and communicate in the language of the host country is likely to lead to structural challenges and possible experience of discrimination.

2. Materials and methods

The protocol of this review was registered in PROSPERO; registration number: CRD42022318663. We drew on the updated PRISMA 2020 guidelines for reporting systematic reviews [70] (See Fig. 1 below). The review question (PICOS) was as follows:

(P): three main groups: a) vulnerable people who require or seek mental health support but face language barriers due to their limited proficiency in the language(s) of the host country (e.g., refugees, migrants, asylum seekers, displaced persons, stateless people, ethnic minorities). For convenience we adopt the broad term Third-Country Nationals (TCNs), which covers most of the above categories; b) carers (e.g., family/friends) of TCNs involved in mental healthcare pathways; c) health and social care professionals (HSCPs) providing care to TCNs on mental health issues in any clinical setting (e.g., psychiatrists, psychotherapists, psychologists, general/family practitioners, nurses, social workers);
(I): communication barriers experienced by the above participants in any spoken or sign language; communication strategies (including informal/professional/volunteer interpreters, health-/social care/ other professionals doubling as interpreters, (inter-)cultural mediators, physical/virtual dictionaries, audio-visual materials, apps, wearables providing translations, etc.) to overcome spoken or sign language barriers between the above participants; communication needs and/or preferences of TCNs and HSCPs of the above participants; barriers to accessing mental health services; barriers to/difficulties in accessing language support resources;
(C): linguistically and culturally discordant care seeking/provision of care in mental health settings; unsupported linguistically and culturally discordant care seeking/provision of care in mental health settings; supported linguistically and culturally discordant care seeking/provision of care in mental health settings;
(O): access to mental health services in terms of approachability, acceptability, availability, affordability, and appropriateness [71]; measurements of clinical outcomes (e.g., recurrence, severity, quality of life); adverse and/or unintended outcomes;
(S): original peer-reviewed articles, opinion/position papers, and meta-analyses written in English.

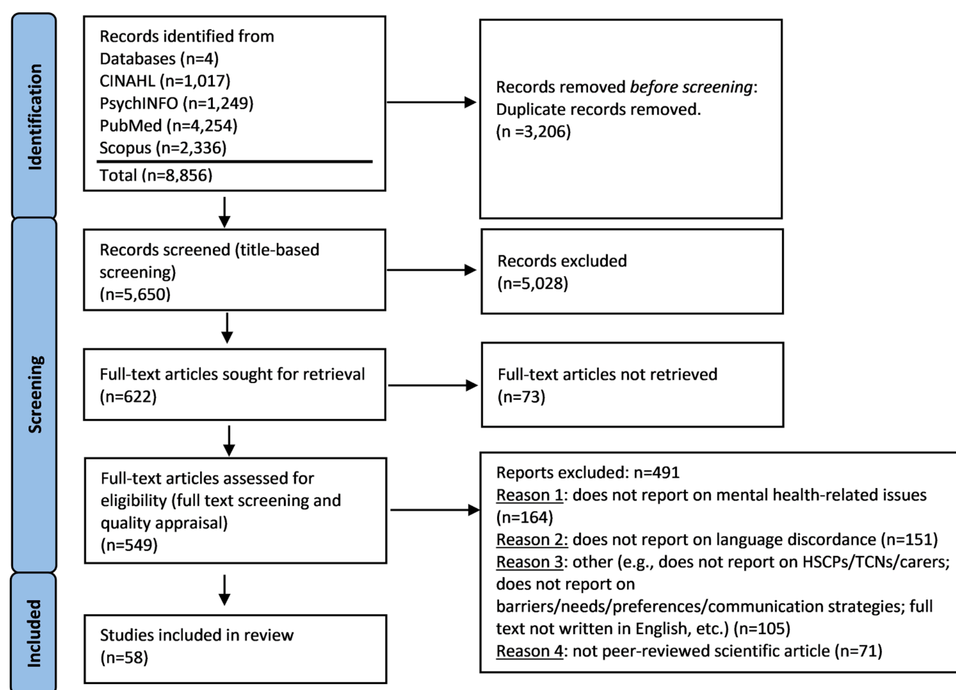

Fig. 1. Review process and selection of studies according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA).

We also consulted narrative and systematic reviews, which we inspected for relevant references.

2.1. Search strategy and study selection

A systematic electronic search of the literature was conducted in PubMed, CINAHL, PsychINFO, and Scopus for publications in English from 01/01/2011 to 09/03/2022 (see Fig. 1). The search strategy (see Annex) was built around four constructs: TCNs, language barriers, mental health, and healthcare, and was developed by a librarian with experience in systematic reviews. Search terms were combined using the Boolean operators AND (between constructs) and OR (within constructs). Constructs 3 (mental health) and 4 (healthcare) were linked with OR. EndNote was used to remove duplicates.

To expedite the review process, eight independent reviewers applied the inclusion and exclusion criteria and performed title-only screening of studies identified in the search [72]. Title screening was performed in Rayyan and was supported by the use of 45 relevant keywords taken from our search strategy. Eligible studies had to meet at least one of the P (opulation) and at least one of the I (ntervention) criteria listed above. Papers were excluded if they did not report on any of the above criteria, or if they reported on communication/language difficulties other than language discordance, such as language disorders (e.g., aphasia), or if they reported on cultural discordance without reference to language discordance. Eligible papers were then reviewed in Rayyan by five pairs of independent reviewers who applied the eligibility criteria to the full papers and reached a consensus through discussion. All reviewers were instructed by the first author on how to apply the eligibility criteria. In case of disagreement, the full text was reviewed by the first author, who made the final decision to include or exclude the paper.

2.2. Data extraction and quality appraisal

Data were extracted from the eligible papers by three pairs of independent reviewers. A data extraction sheet was developed and piloted for the purpose of this review, which allowed the reviewers to extract information on the study design, sample size, HSCP/TCN demographics, communication and language support needs, communication and language support difficulties, strategies used to overcome language barriers, the effectiveness of strategies, preferences, recommended communication and language support strategies, and stage(s) at which language barriers have a noticeable impact on communication. Each pair of reviewers discussed their extracted data, reached a consensus, and the extraction sheets from all pairs were merged into a single sheet by the lead author, who verified the validity of the extracted data by revisiting the full text and making adjustments when needed.

To assess the quality of the included studies, we used the quality appraisal checklist by Theys et al. [73], which was developed according to the Cochrane Handbook guidelines [74] and was used in a previous systematic review on language barriers in healthcare. Five independent reviewers, who were briefed by the first author on the use of the appraisal checklist, assessed the findings, research design, sample coverage, data collection, data analysis, reporting, reflexivity, neutrality, ethics, and documentation of the research process in the included studies and reached consensus through discussion. For each study, a quality appraisal score was calculated by adding up the number of positively rated quality indicators, i.e., aspects of the research design that were sufficiently and adequately addressed in the study. Studies were included if they received a positive rating for at least 21 of the 42 items in the appraisal checklist.

3. Results

The results were synthesised by the lead- and second author. The included studies ($n = 58$) were conducted across different countries, the majority from the USA ($n = 18$), the UK ($n = 9$), Canada ($n = 8$), and Germany ($n = 5$). Other countries include Norway ($n = 3$), Switzerland ($n = 3$), Australia ($n = 2$), New Zealand ($n = 2$), Denmark ($n = 1$), Italy ($n = 1$), Japan ($n = 1$), the Netherlands ($n = 1$), Spain ($n = 1$), Sweden ($n = 1$), Turkey ($n = 1$), and one study across 16 European countries covering more than 85% of the EU population ($n = 1$) (Table 1). While some of the studies use either quantitative ($n = 9$) or mixed methods ($n = 8$), the majority employ qualitative methods ($n = 41$). The size of the participant groups varies depending on the study scale and the methodology ranging from 4 [15] to 1328 (828 in the treatment group and 500 in the control group) [23]. The participant profiles vary depending

Table 1
Study Characteristics.

Author Year Country of origin [Study no]	Study design	Sample size	Main reported barriers to access (TCNs & Carers)/to provide (HSCPs) mental health services
Jang Y. et al. 2013 USA [1]	Evaluation of tele-counselling program conducted via videoconferencing (4 weekly sessions)	14 Korean patients with depressive mood (≥ 65 years-old) 4 New York-based Korean mental health counsellors	• Low proficiency level in the host language
Moskö, M.O. et al. 2013 Germany [2]	Survey questionnaire	485 outpatient psychotherapists	• Linguistic and cultural challenges in conducting psychotherapy with TCNs • TCNs' inability to communicate in the host language and/or other widely spoken European languages
Sandhu, S. et al. 2013 UK [3]	Interview	48 mental healthcare workers from 16 European countries	• Complications with diagnosis • Difficulty in developing trust • Increased risk of marginalisation • Mismatch between the language capabilities of the HSCPs and TCNs hampering diagnosis
Singer, R. R. and Narra P.T. 2013 USA [4]	Interview	13 White, European American clinicians (30 - 85 years old)	• HSCPs' lack of cultural knowledge to provide care for TCNs • Perceived systemic barriers such as limitations of particular interventions • Lack of time to comprehensively address TCNs' needs • Mismatch between the language capabilities of the HSCPs and TCNs
Brisset, C. et al. 2014 Canada [5]	Self-reported survey questionnaire	113 family physicians providing mental health care, and mental health workers, including social workers, psychologists and nurses	• Limited access to linguistic resources
Orijako, O. E. Y. and So, D. 2014 USA [6]	Archival data from the New Immigrant Survey, Interviews	Sub-Saharan African sample of 669 adults	• Low proficiency level in host language • Level of education
Liu, C.H. et al. 2015 The Netherlands [7]	Semi-structured in-depth interviews	23 Chinese people living in NL who know other Chinese people with mental health problems, but don't experience mental health problems themselves.	• Low proficiency level in host language • Stigma • Negative attitudes • Lack of knowledge about healthcare system
Ferrari, M. et al. 2016 Canada [8]	Quantitative Post-intervention Exit Surveys, Qualitative Interviews	74 clients and 9 providers of a Toronto based Community Health Centre	• Linguistically discordant HSCPs and TCNs • Implications arising from the use of interpreters • TCNs' perceptions of mental health stigma • Vulnerable populations
Mutiso, V. et al. 2019 UK, Eastleigh Nairobi [9]	Qualitative, explorative	60 refugees (15 adult male, 15 female, 15 adolescent male and 15 adolescent female). 10 primary health workers and 10 religious leaders with 10 participants per group. 2 Somali refugee doctors running a psychiatric clinic in Eastleigh, UK	• Mismatch between terms in HSCPs and TCNs language/culture • Informal interpreter distortions • Informal interpreters' inability to understand medical terms • Informal interpreters' lack of privacy
Sah, L. K. et al. 2019 UK [10]	Qualitative	20 Nepalese-born women (≥60 years old)	• Insufficiency of language support hindering access • Relying on informal interpreters • Inability to express oneself in a foreign language
Salami, B. et al. 2019 Canada [11]	Qualitative, descriptive	53 immigrant service providers	• TCNs' unwillingness to seek professional mental health support • TCNs' unwillingness to report mental health issues • TCNs' distrust in professional interpreters • TCNs' fear of confidentiality breach • Carers' unwillingness to talk about mental health issues • Low proficiency level in host language
Tschirhart, N. et al. 2019 Norway [12]	In-depth individual interviews	14 Thai migrants (female)	• Low proficiency level in host language • Stigma about mental health • Limited knowledge of the host country's health system
Arafat, N.M. 2016 UK [13]	Qualitative approach	92 mental health service providers (psychiatrists, community mental health nurses, social workers, occupational health therapists, psychologists, and approved mental health professionals)	• HSCPs' lack of understanding TCNs' cultural perspective • Mismatch between terms in HSCPs and TCNs language/culture • TCNs' low literacy • Implications arising from the use of interpreters • TCNs' unwillingness to rely on professional interpreters • Unavailability of professional interpreters • Mismatch between terms in HSCPs and TCNs language/culture • Limited access to translated materials/resources • HSCPs' inability to brief interpreters

(*continued on next page*)

Table 1 (*continued*)

Author Year Country of origin [Study no]	Study design	Sample size	Main reported barriers to access (TCNs & Carers)/to provide (HSCPs) mental health services
O'Mahony, J. and Clark, N. 2018 Canada [14]	Environmental scan, document analysis, grey literature search, mixed methods (questionnaires, open-ended interviews)	100 public health nurses and mental health professionals (questionnaire) 10 immigrant service providers, public health administrators, public health nurses, policy experts, and primary health care providers (interview)	• TCNs' fear of confidentiality breach • Gender-related issues through an interpreter of opposite sex • Need for culturally adapted translations • Limited access to professional interpreters
Brar-Josan, N. and Yohani S. C. 2019 Canada [15]	Qualitative, case study, semi-structured interviews	4 educational cultural brokers worked directly with refugee youth and had experience collaborating with a mental health practitioner in the context of providing services to refugee youth.	• Systemic and cultural barriers in accessing mental health services
Storck et al. 2018 Germany [16]	Questionnaires	Refugees: 75 children and 21 of their relatives	• Low proficiency level in host language
Chiang, S.Y. et al. 2019 New Zealand [17]	Qualitative, semi-structured interviews	11 Chinese sexual/gender minority participants (19-29 years old)	• Fear of 'losing face' • Unwillingness to disclose distress • Linguistically and culturally discordant HSCPs • Unethical conduct by the HSCPs • Lack of empathy by the HSCPs • HSCPs' being dismissive of TCNs' cultural heritage and gender minority status
Felsman et al. 2019 USA [18]	Cross-sectional, descriptive, mixed method	23 female refugees	• Cost of professional interpreting service • Scheduling interpreters to suit the TCNs' work schedules • Shortage of interpreters trained in mental healthcare
Melamed, S. et al. 2019 Switzerland [19]	Qualitative, semi-structured interviews	10 asylum-seekers residing in Switzerland	• Manager/social assistant in asylum homes as a mediator to access to mental healthcare • Fear of stigma • Lack of privacy in asylum homes • Use of interpreters
Doğan, N. et al. 2019 Türkiye [20]	Qualitative, semi-structured focus groups, phenomenological design	24 Syrian refugees (adults) in Turkey and diagnosed with mental disorders	• Inability to express oneself (in a foreign language) • Absence of language support hindering access • Unavailability of interpreters • Dissatisfaction with interpreters
Forrest-Bank, S.S. et al. 2019 USA, Tennessee [21]	Cross-sectional design, mixed method	14 providers of mental health/well-being services for refugee youth and families	• Fear of confidentiality breach when interpreter is from TCNs' community • HSCP/interpreter lack of understanding TCNs' cultural perspective • Lack of understanding legal obligation to provide language support • Poor quality of interpreter performance and implications arising from it • Need for in-person interpreters • HSCPs' lack of understanding legal obligation to provide language support
King, D. and Said, G. 2019 UK [22]	Cognitive behavioural informed group intervention	14 unaccompanied asylum-seeking young people	• Cost of interpreters • Employment of interpreters directly through the NHS Trust
Gonçalves, M. et al. 2013 USA [23]	Quantitative, longitudinal intervention	828 Portuguese-speaking patients in the intervention group; 500 in usual care group	Factors to increase the quality of care: • Use of interpreters • Use of culturally competent HSCPs • Linguistically and culturally concordance HSCPs • Ethnic-specific care • Use of linguistically concordant HSCPs
Asfaw, B.B. et al. 2020 Germany [24]	Qualitative, interview	10 licenced psychotherapists	• HSCP lack of awareness of regulations (not clear what regulations about) • HSCP capacity constraints (not clear this refers to time constraints, workload constraints, etc.) • HSCP lack of understanding TCNs' cultural perspective • TCNs' distrust in HSCPs • TCNs' unfamiliarity about host country's healthcare system • Need for linguistic support • Mismatch between terms in HSCPs and TCNs language/culture
Snowden, L.R. et al. 2011 USA [25]	Quantitative, quasi-experimental	247 primary language speakers of Vietnamese, Cantonese, Hmong and Cambodian (19–64 years old)	• Absence of language support hindering access

(*continued on next page*)

Table 1 (*continued*)

Author Year Country of origin [Study no]	Study design	Sample size	Main reported barriers to access (TCNs & Carers)/to provide (HSCPs) mental health services
Priebe, S. et al. 2011 16 European countries [26]	Structured interviews with open questions and case vignettes, qualitative	240 providers/mediators in primary care, emergency care and community mental healthcare (doctors, $n = 156$; nurses, $n = 44$, psychologists $n = 7$, physiotherapists $n = 4$, social workers $n = 3$, administrators/managers $n = 26$)	• Language barriers • Difficulties in arranging care for migrants without health care coverage • Social deprivation and traumatic experiences • Lack of familiarity with the health care system • Cultural differences, different understandings of illness and treatment • Negative attitudes among staff and patients • Lack of access to medical history
Kim, G. et al. 2011 USA [27]	Quantitative retrospective survey, (orally administered)	372 participants (249 Latinos: 82 Cubans, 45 Puerto Ricans, 58 Mexicans, 64 other Hispanics; 123 Asians: 34 Vietnamese, 25 Fillipinos, 38 Chinese and 26 other Asians)	• TCNs' unwillingness to report mental health issues
Bartholomew, T.T. et al. 2021 USA [28]	Qualitative, descriptive, phenomenological study	8 participants (2 clinical psychologists and a clinical health psychologist, 5 social workers or counsellors and 1 interpreter)	• Mismatch between terms in HSCPs and TCNs language/culture • Language barrier and implications arising from it
Benjamen, J. et al. 2021 Canada [29]	Mixed method, online survey and semi-structured interviews	77 HSCPs (qualitative) 11 HSCPs (qualitative)	• TCNs' inability of understanding HSCPs' instructions • TCNs' need for language support for TCNs trying to access mental health care services • TCNs' inability of setting up virtual care (phone-care cause information loss)
Bhandari, D. et al. 2021 Japan [30]	Qualitative	14 TCNs 21–47 years old	1. Need for language support for TCNs trying to access mental health care services 2. Absence of language support hindering access
Rayes, D. et al. 2021 Germany [31]	Qualitative (using a grounded theory approach)	17 TCNs (22–47 years old)	• TCNs more willing to work with linguistically and culturally concordant HSCPs • HSCPs empathise with TCNs
Simkhada, B. et al. 2021 UK [32]	Qualitative, in-depth interviews	21 participants (6 community mental health workers, 8 Iranians and 7 Nepali)	• Mismatch between terms in HSCPs and TCNs language/culture • Family involvement in treatment of mental health and implications arising from it • Fear of confidentiality breach • HSCPS' lack of understanding TCNs' cultural perspective and implications arising from it (preconceptions/ stereotyping) • TCNs' unwillingness to report mental health issues (fear, stigma) • Fear of stigma in relation to gender (more stigma in female refugees) • Need for equal access to mental healthcare for both genders • Language barrier and implications arising from it • Role of religious/spiritual factors mental health treatment preferred by TCNs • TCNs' reliance on family about mental health treatment and implications arising from it
Memon, A. et al. 2016 UK [33]	Qualitative	26 TCNs	• Inability to express oneself (in a foreign language) and implications arising from it • Inadequate interpreting service
Gartley, T. and Due, C. 2017 Australia [34]	Qualitative	7 participants (4 registered clinical psychologists, 3 registered social workers)	• Need for interpreters (in all stages, across sessions) • Interpreters' inability to explain cultural issues and the implications arising from it • Implications arising from use of informal interpreters (various levels of interpreters) • Interpreters can prevent building a relationship of trust between HSCP and TCN
Nithianandan, N. et al. 2016 Australia [35]	Qualitative	37 participants (24 HSCPs and 4 interpreters; 9 community representatives, pregnant women refugees)	1. Literal translation of screening tools is inadequate 2. Fear of confidentiality breach 3. Fear of stigma in relation to use of interpreters
Shannon, P.J. et al. 2016 USA [36]	Mixed method, participatory and action research	64 mental health providers	• HSCPs failing to book interpreters • Interpreters not showing up • Lack of understanding legal obligation to provide language support
Corrigan, P.W. et al. 2017 USA [37]	Qualitative, focus groups, action research	41 in total (11 mental health service providers, 22 consumers of mental health services and people with lived experience and 4 family members of consumers)	• Poor quality of interpreter performance

(*continued on next page*)

Table 1 (*continued*)

Author Year Country of origin [Study no]	Study design	Sample size	Main reported barriers to access (TCNs & Carers)/to provide (HSCPs) mental health services
Hansen, M.S. et al. 2012 USA [38]	Qualitative, in-depth interviews	19 Spanish speaking Latinos	• Communicating symptoms • Expressing need for mental healthcare • Understanding HSCPs' instructions
Saechao, F. et al. 2012 USA [39]	Qualitative	30 immigrants	• Need for language support for TCNs trying to access mental health care services
Jensen, N. K. et al. 2013 Denmark [40]	Qualitative, content analysis	9 General Practitioners	• Lack of interpreters and implications arising from it
Paudyal, P. et al. 2021 UK [41]	Qualitative, in-depth semi-structured interviews	12 refugees	• TCNs' distrust in professional interpreters • Fear of being misunderstood by HSCPs • TCNs' unwillingness to rely on professional interpreters • Mismatch between terms in HSCPs and TCNs language/culture • Language barrier hampering access to care • Poor quality of interpreter performance • Concerns about use of professional interpreters
Griffiths, G. and Tarricone, I. 2017 Italy [42]	Qualitative, semi-structured interviews	14 HSCPs (13 consultant psychiatrists and 1 psychiatry registrar)	• Inability to check adherence to treatment plan • Mismatch between terms in HSCPs and TCNs language/culture • Inability to establish rapport with HSCPs • Communicating symptoms • Unawareness of language support services • Poor quality of interpreter performance • Lack of funding for language support services
Mirza et al. 2017 USA [43]	Qualitative, video-recorded counselling sessions, audio-recorded post-session video elicitation interviews	6 refugees (3 Bhutanese and 3 Iraqi) 5 interpreters (2 Nepali and 3 Arabic)	• Inability to establish rapport with TCNs • Poor quality of interpreter performance • Inability to monitor TCNs' body language (due to distraction caused by simultaneous interpreting) • Interpersonal rapport in triadic interaction • Potential role conflict • TCNs' choice to communicate in a limited proficiency language despite the presence of interpreter • Interpreters' limited language proficiency
Mitschke, D.B. et al. 2017 USA [44]	Quantitative, group intervention, qualitative, semi-structured interviews	30 refugees	N/A
Pallaveshi, L. et al. 2017 Canada [45]	Cross-sectional qualitative, exploratory study	12 mental healthcare providers	• Mismatch between terms in HSCPs and TCNs language/culture • HSCPS' lack of understanding TCNs' cultural perspective • Inability to empathise with TCNs • Language barrier and implications arising from it • Poor quality of interpreter performance and implications arising from it • Unavailability of professional interpreters • Unawareness of how to use interpreter services • Fear of confidentiality breach when HSCP is from TCNs' community
Shrestha-Ranjit, J. et al. 2017 New Zealand [46]	Qualitative, exploratory, case study	52 participants [(32 Bhutanese women, 8 Bhutanese men); 12 HSCPs (5 nurses, 4 doctors, 3 midwives)]	• HSCPs' lack of understanding TCNs' cultural perspective and implications arising from it • Unavailability of professional interpreters in primary care settings • Implications arising from the use of informal interpreters • Lack of appropriate interpreting services • TCNs' low literacy • Use of informal interpreters
Weng, S.S. and Spaulding-Givens, J. 2017 USA [47]	Qualitative, semi-structured interviews	32 participants (carers of TCNs who, outside of their paid employment, were informally helping members of the Asian American community with their mental health needs.)	• TCNs' unwillingness to report mental health issues • Mismatch between terms in HSCPs and TCNs language/culture
Chao, Y.Y. et al. 2020 USA [48]	Mixed-method, explanatory sequential design, quantitative survey, qualitative semi-structured individual interviews	130 Chinese immigrants	• Mismatch between terms in HSCPs and TCNs language/culture • TCNs' unawareness of mental health condition • TCNs' unwillingness to report mental health issues

(*continued on next page*)

Table 1 (*continued*)

Author Year Country of origin [Study no]	Study design	Sample size	Main reported barriers to access (TCNs & Carers)/to provide (HSCPs) mental health services
Harris, S.M. et al. 2020 Norway [49]	Semi-structured interviews, hermeneutic phenomenological qualitative method	15 General Practitioners	• Mismatch between terms in HSCPs and TCNs language/culture • TCNs' unawareness of mental health condition • TCNs' unwillingness to report mental health issues • TCNs' unfamiliarity with HSCPs' roles • TCNs' unawareness of mental health condition • HSCPs' not having been trained to communicate with TCNs • Poor quality of interpreter performance • Professional interpreters' lack of medical training • TCNs' distrust in professional interpreters • Culturally adapted translations of screening tools • Diagnostic tests through interpreters • Interpreters can prevent building a relationship of trust between HSCP and TCN
Kiselev, N. et al. 2020a Switzerland [50]	Quantitative	867 psychiatrists and psychotherapists working in outpatient settings	• Lack of funding for language support services • Unawareness of how to use interpreter services
Kiselev, N. et al. 2020b Switzerland [51]	Cross-sectional, qualitative design, in-depth interviews	19 participants (5 Syrian refugees, 5 healthcare providers 4 other stakeholders)	• TCNs' low literacy • Language barrier and implications arising from it • Mismatch between terms in HSCPs and TCNs language/culture • Unfamiliarity with Latin alphabet
Tulli, M. et al. 2020 Canada [52]	Qualitative descriptive study, semi-structured interviews	18 carers (immigrant and refugee mothers of children with mental health issues)	• Inability to find information about healthcare system • Language barrier impeding access to care • Inability to communicate with healthcare providers • Inability to understand medical terminology • Feeling isolated, feeling unheard by service providers • Stigma • Racism/ discrimination • Financial strain
Boettcher, V.S. et al. 2021 Germany [53]	Structured interviews, quantitative	177 TCNs (refugees)	• Lack of information about mental health • Language barriers impeding access to care
Disney, L. et al. 2021 USA [54]	Qualitative, electronic interviews in the form of an online survey	17 HSCPs (clinicians and case workers)	• Lack of non-verbals during e-consultations constituting obstacles to effective telemental health • E-consultations through interpreters are challenging • Securing interpreters for e-consultations is more difficult than for on-site consultations • Few resources and low technological literacy impeding TCNs' use of e-consultations • Language issues
Khanom, A. et al. 2021 UK [55]	Qualitative, participatory, focus groups	57 TCNs and HSCPs (Asylum seekers, refugees, support workers and volunteers)	• Language barrier and implications arising from it • Dissatisfaction with interpreters • Unavailability of professional interpreters • Informal interpreters' inability to understand medical terms • Use of informal interpreters and the implications arising from it
Kour, P. et al. 2021 Norway [56]	Qualitative, explorative, descriptive, focus groups.	19 HSCPs (psychiatrists, psychologists, specialist nurses, general nurses, social workers)	• Language barrier and implications arising from it • Poor quality of interpreter performance • TCNs' fear of confidentiality breach • Need for language support for TCNs trying to access mental health care services • 5. Language barrier and implications arising from it
Nejati, S. et al. 2022 Sweden [57]	Qualitative, semi-structured interviews	17 participants (8 TCNs - female patients and 9 HSCPs - care managers)	• Language barrier and implications arising from it • Inability to express oneself • Lack of privacy when using interpreters
Collazos, F. et al. 2021 Spain [58]	Quantitative, descriptive, cross-sectional, exploratory	467 TCNs (patients visiting emergency rooms - 400 foreign-born and 67 native-born patients as a control group)	• HSCPs' lack of understanding TCNs' cultural perspective • Language concordance and (nearly) cultural concordance are more likely to ensure TCNs' involvement in care plan (no coercive treatment) • HSCPs' failing to perceive culture as an important aspect in psychosis diagnosis • Language and culture influence the HSCP-TCN relationship • HSCPs' poor understanding of TCNs' symptomatology due to language and cultural

(*continued on next page*)

Table 1 (*continued*)

Author Year Country of origin [Study no]	Study design	Sample size	Main reported barriers to access (TCNs & Carers)/to provide (HSCPs) mental health services
			barriers leading to psychosis diagnoses (due to HSCPs' understanding of TCNs' "strange" behaviour • TCNs' failing to express themselves accurately due to language/cultural barriers resulting in misdiagnosis

on the aims. Some studies only include TCNs ($n = 24$), while others focus solely on HSCPs ($n = 24$) or both TCNs and HSCPs ($n = 8$), or only on carers ($n = 2$). Furthermore, the participants' profiles and backgrounds differ according to the TCN groups' characteristics in the countries where the studies were conducted. (See Table 1 below)

We have organised the findings according to the three main categories of participants (TCNs, carers and HSCPs), their communication needs and difficulties, and the language support options they use to overcome language barriers when seeking or providing mental health services.

3.1. Third-Country Nationals (TCNs)

3.1.1. TCNs' communication needs and difficulties

Several studies report that TCNs have difficulty accessing mental health services [10,15,20,21,25,30,50], mainly due to language barriers and lack of language support [10,20,21,25,30,50]. Language barriers are likely to occur at all stages of the disease and treatment trajectory [3, 22,26,32,35,36,38,42,43,46,49,54–56], as well as at the (pre-)care seeking stage [29,30,32,42,44,45,47,48,53]. In addition, language barriers are likely to affect low-level follow-up (e.g., booking appointments) [36,42,45], which, in turn, may affect TCNs' adherence to the care plan [38,42].

There is also evidence that TCNs may be reluctant to seek professional mental health support and discuss mental health issues with HSCPs [11,14,17,19,27,32] due to fear of stigma [8,17,19,32] or lack of privacy and/or potential invasion of privacy (e.g., in asylum homes) [19]. One study found that TCNs are more likely to rely on family support for mental health issues [32]. There is also some evidence that TCNs are unaware of the mental health issues they may be experiencing [48].

Those who seek and receive professional support for mental health report mental/emotional symptoms, related to diagnoses such as PTSD [9,16], as well as physical [9] and behavioural [16] symptoms. They experience difficulties in reporting symptoms, often due to the language barrier between them and HSCPs [17,21,58] and the implications of this [7,10,17,20,21,30,33,36,38,39,42,48,51,53,56,58]. As a result, HSCPs are likely to misunderstand the TCNs' symptomatology, which is likely to lead to misdiagnosis (e.g., psychosis diagnoses due to HSCPs' poor understanding of TCNs' symptomatology and therefore viewing TCNs' behaviour as 'strange', 'strangeness' being expressed and interpreted differently across cultures and languages [58]). TCNs often struggle to accurately express themselves [58] and their need for mental health support [38], not only because of their limited proficiency in the host language [7,10,20,33,51] but also because of a mismatch between the terms and constructs used by HSCPs and those used in the TCNs' language and culture [21,41,42,48,51].

Other difficulties include TCNs' inability to establish rapport with HSCPs [42] (which may ultimately affect their relationship with HSCPs [58], mainly due to the language barrier and sometimes low levels of literacy in their native language [46,54]), and their inability to navigate the host country's healthcare system and ways of seeking and receiving professional support for mental health issues [7,48,49]. In addition, although not explicitly linked to the language and cultural discordance between TCNs and HSCPs, the literature reports that TCNs sometimes experience inappropriate behaviour from HSCPs [17,31,42] (e.g., unethical behaviour, lack of empathy, rejection of TCNs' cultural heritage [17,31]) or have negative attitudes towards the host country's healthcare system [7] (e.g., due to inaccessibility of mental health services or language support options).

Finally, there is a need for (in-person) [21] language and cultural support for TCNs with limited proficiency in the host language at different stages of the care-seeking/receiving process (e.g., attempts to access mental health services [14,29,30,34,39,46,56], including making appointments [36,53] and being referred to specialist mental health services [30,39,56]).

3.1.2. Language support options used by TCNs

One of the most commonly reported language support options in relation to TCNs' mental healthcare is the use of interpreters [18,21,22, 23,27,29,33,35,36,45], both in person (i.e., physically co-present in the consultation room with the TCN and HSCP) [21,22,36,45,56] and remotely (usually via telephone) [6,22,56,58]. Although the use of professional interpreters is associated with perceived effectiveness [50], the literature also reports on the frequent unavailability [18,20,21,45, 46,55] and lack of well-trained professional interpreters [21] in mental health communication [18], TCNs' dissatisfaction with the poor quality of interpreter performance [1,10,18,21,37,45,46,50,54], lack of privacy [57], fear of stigma [35] and breach of confidentiality [32,34,35,45], especially when the interpreter or the HSCP are members of the same community as the TCN [21,45].

Evidence suggests that TCNs are often unaware of the availability of professional interpreting services or how to access and use them [50] and are often unwilling to rely on professional interpreters [10,11,21, 41]. Instead, they are likely to seek support from bilingual or linguistically and culturally concordant mental health professionals (i.e., HSCPs who share the same linguistic and cultural background as TCNs) [17,23, 27,31,32,36,45,48] or even rely on traditional healers [32], either within the host country or by travelling back to their home country [32]. There is also a strong preference among TCNs to rely on family and friends, instead of seeking professional mental healthcare support services, who often also act as informal interpreters [10,32,46,48,57]. However, when acting as informal interpreters, family and friends are usually unable to understand medical terms and therefore struggle with the translation process [9,55]; their use is also associated with an increased lack of privacy [9]. Also, TCNs are more willing to work with linguistically and culturally concordant HSCPs [17,23,27,31,32,36,45, 48] than seeking professional language support.

3.2. Health and social care professionals (HSCPs)

3.2.1. HSCPs communication needs and difficulties

The HSCPs need to communicate with the TCNs at different stages of the care process about different topics, such as assessment of symptoms [35], health screening [16,18], diagnostic and evaluation processes [16], perinatal screening, post-partum depression [14], and during psychiatric hospitalisation and referrals [36]. Moreover, communication needs arise for HSCPs when they educate TCNs about the host country's healthcare system and the relevant roles of the HSCPs [35].

Several studies report that HSCPs have difficulties in their interactions with TCNs when providing mental health services [2,3,40,42,43,45,49,54], mainly due to language and cultural discordance between HSCPs and TCNs [8,9,11,13,24,28,32,40,45,49,51,56,57]. The lack of training of HSCPs to communicate with TCNs stands out as a prominent factor [4,13,24,32,45,46,49,58], which leads to a lack of understanding of the TCNs' cultural perspective by the HSCPs [4,13,24,32,45,46,58], as well as the emergence of preconceived ideas and stereotypes about TCNs [32]. Other factors related to HSCPs include lack of support in dealing with refugee migrants [46], capacity and workload constraints of HSCPs [24], lack of regulations regarding care/communication with TCNs, and lack of awareness among HSCPs (i.e., it is largely the responsibility and initiative of psychotherapists to obtain information and strengthen their cross-cultural therapy skills) [24]. In addition, HSCPs are reported to be unaware of the available language support services [42], the legal obligation to provide language support [21,36], and the requirement to brief interpreters [13] when this service is available.

There are also systemic barriers experienced by HSCPs, such as unavailability of, or limited access to, professional interpreters [9,13,14,40,45,46], lack of time to fully address TCNs' needs [4], and lack of funding for language support services [42]. Even when the presence of interpreters is secured, HSCPs are concerned about the poor quality of the interpreter's performance and the resulting implications [21,42,43,45,49,56], such as the limited language proficiency of interpreters [43] and their lack of training in mental healthcare communication, which makes it difficult for them to present medical symptoms in a coherent way and may affect the consultation outcomes [49].

The literature frequently highlights that HSCPs need access to interpreting services provided by well-trained professional interpreters to overcome language barriers between them and the TCNs [14,21,22,28,29,34,35,36,46,51]. Other needs include culturally adapted translations/interpreting [14] and the use of same-sex interpreters according to the patient's condition [34]. Several studies emphasise the importance of HSCPs' cultural awareness, training, support, and competence [24,28,32,42,46] as well as the awareness to work skilfully with interpreters [28], for HSCPs to offer an effective service to TCNs.

Difficulties in using interpreters [8,13,14,34,43,56] can arise when the interpreter is of the opposite sex to the TCN [14], when interpreters are unable to explain cultural issues [34], when HSCPs are unable to monitor the body language of TCNs (due to overlapping speech and use of non-verbal cues during simultaneous interpreting) [43], when there is a potential role conflict between interpreters and HSCPs/TCNs [43], and when the interpersonal rapport and trust between the HSCPs and TCNs is undermined in interpreter-mediated interaction [34,43,49]. Furthermore, using family members or friends as informal interpreters has been reported to lead to problems [9,11,34,46], such as distortion of meaning (e.g., misinterpretation of symptoms) [9] and poor interpreting performance [46,55], as well as perceived risks, such as TCNs' fear of stigma [14].

3.2.2. *Language support options used by HSCPs*

One of the most common language support options reported by HSCPs in the provision of mental health services to TCNs is the use of professional interpreters [13,18,22,25,28,35], both in person [5,36,40,42] and remotely [57]. HSCPs using interpreters report reducing the content/information in their communication with TCNs to account for the time required for interpreting [22,43]. When the use of professional interpreters is not an option, HSCPs rely on informal interpreters [5,9,14,40,42]. This may include the use of children as interpreters for low-level follow-up [40]. Linguistically and culturally concordant cultural mediators are also reported to provide formal and informal support [15]. There are also situations where HSCPs refer TCNs to linguistically and culturally concordant HSCPs, rather than using a third person (such as an interpreter or cultural broker) to mediate the communication [1,25,36,40,42,57]. Other language support options reported by HSCPs include the use of simplified language [22,43], bilingual staff members [5], linguistically capable staff at key points of contact [25], translated/multilingual information materials and telephone menus [5,25], a 24-hour toll-free linguistically competent telephone [25] and tele-counselling programmes [1]. Moreover, HSCPs use visual aids [5,43] such as signs/instruction posters, automatic translation of prescriptions [5], Google Translate [57], self-located online multilingual resources, such as multilingual healthcare websites [5], multilingual electronic systems [16], interactive, touchscreen-based self-assessment tool for common mental disorders provided in TCNs' and the host countries' languages [8] and translated screening tools [35]. HSCPs also report asking TCNs clarification questions, encouraging them to provide examples and using visual aids [43]. Evidence furthermore suggests that HSCPs work with the wider community [57] to establish connections and credibility with TCNs [4] and reach out to culturally competent voluntary support services [42], locally provided mental health and community services [18], and social services that connect immigrants [45].

In terms of HSCPs' perceptions of these strategies, the use of professional interpreters is associated with increased effectiveness and efficiency [28,35,43] as they enable the disclosure of relevant information during HSCP-TCN encounters [28], facilitate rapport by relating to both TCNs and HSCPs [43], and enhance the quality of the therapeutic session by attending to the smallest nuances [43]. In-person interpreters are preferred to remote interpreters [11] and the use of in-person interpreters has been found to improve access to mental health services [11]. Consecutive interpreting is preferred by HSCPs over simultaneous interpreting, as it allows HSCPs to better focus on the TCNs and to distinguish the body language of the TCN from that of the interpreter [43]. Despite the effectiveness associated with professional interpreters, there are some implications associated with their use, such as fear of breach of confidentiality [9,11], poor quality of interpreter performance due to poor language skills [21], incomplete or inaccurate interpretation [13,42] or potential introduction of the interpreter's own political agenda or bias into the communicative situation [34]. The literature also reports that HSCPs are more likely to perceive the use of linguistically concordant HSCPs (i.e., HSCP who share a language with the TCN) as more effective than interpreters [13] because of their ability to educate, advocate, build trust and bridge the communication barriers with TCNs.

3.3. *Carers (of TCNs)*

3.3.1. *Carers' communication needs and difficulties*

The literature on the communication needs and difficulties of carers is limited compared to that for HSCPs and TCNs. Evidence suggests that carers have difficulty finding information about the healthcare system, communicating with healthcare providers, and understanding medical terminology [52] due to language barriers, all of which hinder their access to mental healthcare. There is also evidence that carers of TCN minors have difficulty communicating with HSCPs when asked to complete assessment forms and self-report questionnaires [16]. Like TCNs, carers may be reluctant to talk about mental health issues [11].

3.3.2. *Language support options used by carers*

When they have access to mental healthcare, carers are usually unaware of how to use interpreters [50,52]. In terms of the effectiveness of the strategies they use to overcome the language barrier, carers are reported to favour the use of culturally adapted translation of screening tools [16] and language-concordant carer/TCN and HSCP scenarios, as this increases the involvement of carers in the communicative situation [52]. The use of informal interpreters is associated with poor quality outcomes [47], but carers also express concerns about the use of professional interpreters [52].

3.4. Preferences to overcome the language barrier

3.4.1. Third-Country Nationals (TCNs)

TCNs prefer better and more accessible interpretation and translation services [21,30,50,57], especially in-person [21,30] and funded [30,50] professional interpreting services. They also prefer the translation of mental health-related written information [55] that is available in audio version or on a website rather than in leaflets [35]. TCNs favour an increase in linguistically and culturally concordant HSCPs [7,31,33,35] and an expansion of culturally competent multidisciplinary mental health services [35]. They also call for more support from educational institutions or workplaces [7,44,55] for the provision of language and literacy education [44] by bilingual language teachers who are proficient in both the TCNs' and the host country's languages [44], as well as courses and drop-in sessions organised by NGOs [55]. Despite the implications of informal interpreters reported by both TCNs and HSCPs [9,14,46,55], TCNs still rely on and prefer informal interpreters (e.g., family members) [57]. They also prefer gender concordance with HSCPs [35], support group sessions rather than individual mental health sessions [44], a participatory model of mental health programme development involving TCNs in the development phase [44], and the active involvement of all interlocutors in the clinical encounter [57].

3.4.2. Health and social care professionals (HSCPs)

HSCPs prefer to use professional interpreting services [34,40] provided by well-trained interpreters [11,13] who have received in-house training on mental health awareness [13]. HSCPs also prefer interpreters who do not interfere with HSCPs' role in the communicative situation [34]. They prefer having the translation of written information in the mother tongue of the patient [57], culturally adapted translations of screening tools [35], and guidance on translating the assessment tools to ensure validity [49]. HSCPs support the expansion of linguistically and culturally concordant HSCP teams [13,35,57] and culturally competent multidisciplinary mental health services [35], and they ask for more funding for language support services [46]. They also prefer that TCNs enhance their host language and culture-related knowledge [10,42,45] through education about the system and services [45] and opportunities to build confidence in using the host-country language, especially for women [10]. HSCPs also value receiving education about cultural competence [45] and support the provision of integrated care, particularly for refugees, that covers all costs and resources [46].

3.4.3. Carers

The provision of culturally adapted mental health services and education for the TCN community on mental health issues are among the suggestions reported by carers to achieve more effective TCN—HSCP encounters where language barriers exist [47].

4. Discussion

The purpose of this review was to identify the language needs and preferences of TCNs, their carers and HSCPs, and the difficulties they experience when seeking or providing mental health services while language barriers are present. We also sought to identify the stages in the help-seeking process and/or care trajectory at which language barriers become manifest, and the strategies used by TCNs, carers and HSCPs to overcome language barriers and address needs in order to improve the provision of, and access to, mental healthcare in linguistically and culturally discordant settings.

The synthesised evidence is primarily based on qualitative studies, as the number of high-quality quantitative studies on this topic remains limited. This aligns with previous review findings (see e.g. [60]). Our findings lend support to previous research that has provided evidence of the importance of proficiency in the language(s) of the host country in relation to mental health outcomes for TCNs [75]. They also highlight the disparity in knowledge about language support between TCNs, HSCPs and service agencies that support migrant health [78]. Our findings suggest that language barriers and lack of language support options impede TCNs' access to mental health services and that there is a strong need for language support. This corroborates findings from recent reviews on migrants' and refugees' health status and healthcare [77] and on mental health care utilisation and access in Europe [80]. If language support is not provided, language barriers are likely to become manifest at all stages of the care pathway, as well as in the preliminary stages of information- and care-seeking, and adherence to care plans. Unaddressed language barriers at early stages of the information- and care-seeking process can have a detrimental effect on the identification and early diagnosis of mental health issues, which in turn can affect the subsequent stages of the care pathway.

While linguistically and culturally concordant HSCP-TCN communication (e.g., HSCP and TCN sharing the same language and culture) is preferred by both TCNs and HSCPs, it is not always achievable, and communication mediated by language support options is required in most instances. When this is the case, systemic (e.g., lack of funded interpreter services), as well as interpersonal (e.g., role conflict between HSCPs and interpreters) and intrapersonal (e.g., fear of stigma, trust in family, lack of specific knowledge and skills) factors contribute to a fragmented landscape of language support options used by TCNs and HSCPs in relation to mental health issues. The above factors have also been documented in reviews and primary studies addressing TCNs' needs and barriers to access from angles other than communication [77,78,80,81].

When language support is required, HSCPs have a strong preference for professional interpreting services. However, even where professional interpreters are available, supply does not always meet demand. Both the need for and the unavailability of professional interpreters can make it difficult for HSCPs to organise follow-up appointments and thus affect work dynamics and the treatment process [13]. At the same time, the literature also points to problems arising from the use of interpreters and/or from current interpreter provision. For example, evidence suggests that interpreters may sometimes distort the intended meaning of HSCPs, may not always interpret non-verbal communication, may exclude HSCPs from the communication process and may not always be able to cope with chaotic mental health environments [13]. Whilst professional interpreters ensure communication in HSCP-TCN encounters, these difficulties have led to a perception that interpreters with a combination of language/interpreting skills and training in mental healthcare communication are needed [13]. Furthermore, although the use of professional interpreters is generally perceived as facilitating the establishment of trust between TCNs and HSCPs [49], there are also indications that it can sometimes hinder this [13,49].

While it is recognised that language support should not be approached in a one-size-fits-all manner and that a context-sensitive and person-centred approach should be promoted and applied, the literature suggests that both TCNs and HSCPs are not always aware of the types, affordances, implications and risks of different types of language support.

5. Implications for policy

Our results highlight a lack of knowledge, skills and appropriate attitudes among HSCPs when communicating through language support. To the need for the development of cultural and structural competency in Health Sciences education, as defined by Metzl and Hansen [79], we add the need for developing competence in linguistically mediated communication. The linguistic diversity among TCNs and the diversity of their lived experiences need to be reflected in the healthcare workforce with visible representation of TCNs' communities. Policy-makers should adopt a systems thinking approach and view the process of seeking, accessing and providing mental health services in situations of language discordance not in linear terms, but as complex systems. This entails looking beyond individual variables and

considering how desired and unexpected outcomes emerge from constantly adaptive interactions between people with different lived experiences, organisational structures, healthcare systems, physical, economic, socio-cultural environments, technology, etc.

At the level of intervention development, ensuring the provision of language support options, combined with early information and counselling interventions, and health promotion targeted at TCNs and carers upon arrival in the host country can be one of the ways to implement more effective mental health interventions for TCNs. In this way, TCNs would be more likely to seek mental health services at an earlier stage, make better use of the services, and act as educators in their own communities, fostering more meaningful relationships between communities and healthcare systems and thus contributing to the early identification and treatment of mental health problems among TCNs. Interventions of this kind need to be theoretically underpinned, informed by the latest available evidence and stakeholder experience, as well as being the product of co-creation involving TCNs, carers, HSCPs and language support providers. For such interventions to be cost-effective, they must be delivered in an appropriate manner, as poorly delivered interventions can both increase costs and worsen health [76].

There is a need for more nuanced understanding of the needs, barriers and preferences of sub-groups within the TCNs and HSCPs groups. Research funders can encourage more primary community-based participatory research that utilises more refined population categories.

Lastly, the increase in global migration and forced displacement along with high prevalence of mental health disorders among TCNs require that the social determinants of health are adapted for TCNs in such a way that language skills are not seen merely as part of individual lifestyle factors, but as an underlying factor permeating all social determinants of health.

6. Limitations

This study has several limitations. First, we only reviewed papers published in English and within a specified publication period, from 01/01/2011 to 09/03/2022. Second, our review only provides an overview of the needs, preferences and difficulties of TCNs, carers and HSCPs, but does not make any contextual distinctions between interventions within mental healthcare. A different type of review (realist review) would be required to understand the impact of context on the way stakeholders approach language support options in mental healthcare, and the mechanisms that drive change and lead to specific outcomes (both intended and unintended). Third, although we sought to include relevant papers of high quality, we may have excluded papers that provided relevant information only because they scored lower in the quality appraisal stage.

Finally, although our aim was to identify the needs, preferences and difficulties of three different groups, including users and providers of mental health services (TCNs, carers, HSCPs), it was not always clear in the literature whether the needs, preferences and difficulties of these groups were reported by members of these groups with first-hand experience (e.g., TCNs reporting difficulties they had experienced) or by members of another group with indirect experience (e.g., HSCPs reporting difficulties they thought TCNs were likely to experience). A recent review has highlighted that indeed a top-down approach of evaluation of migrants' needs is mostly used and that studies reporting on barriers and needs voiced by migrants themselves is largely missing [77]. Making a clear distinction at the level of agency (i.e., who experienced what) when reporting the above could benefit future research and help us to improve our understanding of primary and secondary experiences and guide the development of future interventions. Lastly, we were not always able to distinguish between professional and informal interpreters, as several studies did not provide clear information on that.

7. Conclusion

This review sought to identify the language needs and preferences of TCNs, carers and HSCPs, as well as the challenges faced by these groups in accessing or providing mental healthcare in the presence of language barriers.

The findings of this review point to the convergence and interconnectedness of barriers, needs and preferences, as expressed by and/or reported in the literature with regard to TCNs, carers and HSCPs while seeking and/or providing mental health services.

Both TCNs and carers encounter barriers at the preliminary stages of the care seeking trajectory (i.e., seeking mental health services, finding information). At the stage of TCN—HSCP communication, both TCNs and HSCPs experience similar difficulties reporting/eliciting information and establishing rapport with each other. There seems to be a strong preference among TCNs and HSCPs for monolingual communication, which ideally stems from the linguistic and cultural concordance between them. However, when this is not possible, as is often the case, both sides require language support and have a strong preference for high-quality professional interpretation and translation services. In addition, both sides, including the carers of TCNs, recognise the value of cultural adaptation at the level of provision of health services.

While the main barrier to accessing mental health services for TCNs is the linguistic and cultural discordance between them and the healthcare system in the host country, a combination of *systemic, interpersonal* and *intrapersonal* factors, as shown above, contribute to a fragmented landscape of language support options, affecting ultimately the quality of communication between TCNs and HSCPs and, in turn, the uptake and quality of service provision and mental healthcare among TCNs.

In conclusion, the review highlights the need for in-person language and cultural support at different stages of the care-seeking process, culturally adapted mental health education for TCNs, carers and HSCPs, and increased funding for language support services. Improving language support options and cultural competency in mental health services is essential to ensure effective communication and improve access to mental health services. Although the use of professional interpreters is a commonly reported and preferred language support option, the literature highlights the frequent unavailability and lack of well-trained professional interpreters in mental health communication.

Annex

Search Strategy.

Author contribution

All authors except Graham Hieke contributed to the study conception and design. Demi Krystallidou led the methodology and coordinated the review process. Material preparation, data collection, and/or analysis were carried out by all authors except Graham Hieke who joined the project team later. The first draft of the manuscript was produced by Demi Krystallidou, Özlem Temizöz, and Sabine Braun. All other authors commented on earlier versions of the manuscript and approved the final manuscript.

Compliance with ethical standards

Ethics Approval: Not needed.
Consent to Participate: Not applicable.
Consent for Publication: Not applicable

Funding information

This project was funded by the European Union Asylum, Migration and Integration Fund [Award No:101038491].

Data availability statement

Not applicable.

Declaration of Competing Interest

No potential conflict of interest was reported by the authors.

Acknowledgment

The authors would like to thank Patricija Monkevičiūtė for her contribution during the data extraction process.

Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.healthpol.2023.104949.

References

[1] Jang Y, Chiriboga DA, Molinari V, Roh S, Park Y, Kwon S, Cha H. Telecounseling for the linguistically isolated: A pilot study with older Korean immigrants. Gerontologist 2014;54(2):290–6. https://doi.org/10.1093/geront/gns196.
[2] Mösko MO, Gil-Martinez F, Schulz H. Cross-cultural opening in German outpatient mental healthcare service: An exploratory study of structural and procedural aspects. Clin Psychol Psychother 2013;20(5):434–46. https://doi.org/10.1002/cpp.1785.
[3] Sandhu S, Bjerre NV, Dauvrin M, Dias S, Gaddini A, Greacen T, Ioannidis E, Kluge U, Jensen NK, Lamkaddem M, Puigpinós I Riera R, Kósa Z, Wihlman U, Stankunas M, Straßmayr C, Wahlbeck K, Welbel M, Priebe S. Experiences with treating immigrants: A qualitative study in mental health services across 16 European countries. Soc Psychiatry Psychiatr Epidemiol 2013;48(1):105–16. https://doi.org/10.1007/s00127-012-0528-3.
[4] Singer RR, Tummala-Narra P. White clinicians' perspectives on working with racial minority immigrant clients. Prof Psychol Res Pract 2013;44(5):290–8. https://doi.org/10.1037/a0034299.
[5] Brisset C, Leanza Y, Rosenberg E, Vissandjée B, Kirmayer LJ, Muckle G, Xenocostas S, Laforce H. Language Barriers in Mental Health Care: A Survey of Primary Care Practitioners. J Immig Minor Health 2014;16(6):1238–46. https://doi.org/10.1007/s10903-013-9971-9.
[6] Orjiako OEY, So D. The role of acculturative stress factors on mental health and help-seeking behavior of sub-Saharan African immigrants. Int J Cult Ment Health 2014;7(3):315–25. https://doi.org/10.1080/17542863.2013.797004.
[7] Liu CH, Meeuwesen L, Van Wesel F, Ingleby D. Why do ethnic Chinese in the Netherlands underutilize mental health care services? Evidence from a qualitative study. Transcult Psychiatry 2015;52(3):331–52. https://doi.org/10.1177/1363461514557887.
[8] Ferrari M, Ahmad F, Shakya Y, Ledwos C, McKenzie K. Computer-assisted client assessment survey for mental health: Patient and health provider perspectives. BMC Health Serv Res 2016;16(1). https://doi.org/10.1186/s12913-016-1756-0.
[9] Mutiso V, Warsame AH, Bosire E, Musyimi C, Musau A, Isse MM, Ndetei DM. Intrigues of Accessing Mental Health Services Among Urban Refugees Living in Kenya: The Case of Somali Refugees Living in Eastleigh, Nairobi. J Immig Refugee Stud 2019;17(2):204–21. https://doi.org/10.1080/15562948.2018.1433904.
[10] Sah LK, Burgess RA, Sah RK. Medicine doesn't cure my worries': Understanding the drivers of mental distress in older Nepalese women living in the UK. Global Public Health 2019;14(1):65–79. https://doi.org/10.1080/17441692.2018.1473888.
[11] Salami B, Salma J, Hegadoren K. Access and utilization of mental health services for immigrants and refugees: Perspectives of immigrant service providers. Int J Ment Health Nurs 2019;28(1):152–61. https://doi.org/10.1111/inm.12512.
[12] Tschirhart N, Straiton M, Ottersen T, Winkler AS. Living like i am in Thailand": Stress and coping strategies among Thai migrant masseuses in Oslo, Norway. BMC Women's Health 2019;19(1). https://doi.org/10.1186/s12905-019-0836-9.
[13] Arafat NM. Language, culture and mental health: a study exploring the role of the transcultural mental health worker in Sheffield, UK. Int J Cult Ment Health 2016;9(1):71–95. https://doi.org/10.1080/17542863.2015.1112419.
[14] O'Mahony J, Clark N. Immigrant Women and Mental Health Care: Findings from an Environmental Scan. Issues Ment Health Nurs 2018;39(11):924–34. https://doi.org/10.1080/01612840.2018.1479903.
[15] Brar-Josan N, Yohani SC. Cultural brokers' role in facilitating informal and formal mental health supports for refugee youth in school and community context: a Canadian case study. Br J Guid Counsel 2019;47(4):512–23. https://doi.org/10.1080/03069885.2017.1403010.
[16] Storck M, Christians G, Möller B, Dugas M, Soto-Rey I. Conducting a Multilingual Study Researching Traumatised Refugees Utilizing a Patient-Reported Outcome System. Stud Health Technol Inform 2018;253:109–13. https://doi.org/10.3233/978-1-61499-896-9-109.
[17] Chiang SY, Fenaughty J, Lucassen MFG, Fleming T. Navigating double marginalisation: migrant Chinese sexual and gender minority young people's views on mental health challenges and supports. Culture, Health and Sexuality 2019;21(7):807–21. https://doi.org/10.1080/13691058.2018.1519118.
[18] Felsman IC, Humphreys JC, Kronk R. Measuring Distress Levels of Refugee Women to Enhance Community-Based Psycho-social Interventions. Issues Ment Health Nurs 2019;40(4):310–6. https://doi.org/10.1080/01612840.2018.1543744.
[19] Melamed S, Chernet A, Labhardt ND, Probst-Hensch N, Pfeiffer C. Social Resilience and Mental Health Among Eritrean Asylum-Seekers in Switzerland. Qual Health Res 2019;29(2):222–36. https://doi.org/10.1177/1049732318800004.
[20] Doğan N, Dikeç G, Uygun E. Syrian refugees' experiences with mental health services in Turkey: "I felt lonely because I wasn't able to speak to anyone. Perspect Psychiatr Care 2019;55(4):673–80. https://doi.org/10.1111/ppc.12400.
[21] Forrest-Bank SS, Held ML, Jones A. Provider Perspectives of Services Addressing the Mental Health Needs of Resettled Refugee Youth. Child Adolesc Soc Work J 2019;36(6):669–84. https://doi.org/10.1007/s10560-019-00602-1.
[22] King D, Said G. Working with unaccompanied asylum-seeking young people: Cultural considerations and acceptability of a cognitive behavioural group approach. Cognitive Behaviour Therapist 2019;12. https://doi.org/10.1017/S1754470X18000260.
[23] Gonçalves M, Cook B, Mulvaney-Day N, Alegría M, Kinrys G. Retention in mental health care of Portuguese-speaking patients. Transcult Psychiatry 2013;50(1):92–107. https://doi.org/10.1177/1363461512474622.
[24] Asfaw BB, Beiersmann C, Keck V, Nikendei C, Benson-Martin J, Schütt I, Lohmann J. Experiences of psychotherapists working with refugees in Germany: a qualitative study. BMC Psychiatry 2020;20(1). https://doi.org/10.1186/s12888-020-02996-0.
[25] Snowden LR, Masland MC, Peng CJ, Wei-Mien Lou C, Wallace NT. Limited English proficient Asian Americans: Threshold language policy and access to mental health treatment. Soc Sci Med 2011;72(2):230–7. https://doi.org/10.1016/j.socscimed.2010.10.027.
[26] Priebe S, Sandhu S, Dias S, Gaddini A, Greacen T, Ioannidis E, Kluge U, Krasnik A, Lamkaddem M, Lorant V, Riera RP, Sarvary A, Soares JJ, Stankunas M, Straßmayr C, Wahlbeck K, Welbel M, Bogic M. Good practice in health care for migrants: Views and experiences of care professionals in 16 European countries. BMC Public Health 2011;11. https://doi.org/10.1186/1471-2458-11-187.
[27] Kim G, Aguado Loi CX, Chiriboga DA, Jang Y, Parmelee P, Allen RS. Limited English proficiency as a barrier to mental health service use: A study of Latino and Asian immigrants with psychiatric disorders. J Psychiatr Res 2011;45(1):104–10. https://doi.org/10.1016/j.jpsychires.2010.04.031.
[28] Bartholomew TT, Gundel BE, Kang E, Joy EE, Maldonado-Aguiñiga S, Robbins KA, Li H. Integrating Cultural Beliefs About Illness in Counseling With Refugees: A Phenomenological Study. J Cross-Cult Psychol 2021;52(8–9):705–25. https://doi.org/10.1177/00220221211038374.
[29] Benjamen J, Girard V, Jamani S, Magwood O, Holland T, Sharfuddin N, Pottie K. Access to refugee and migrant mental health care services during the first six months of the covid-19 pandemic: A canadian refugee clinician survey. Int J Environ Res Public Health 2021;18(10). https://doi.org/10.3390/ijerph18105266.
[30] Bhandari D, Kotera Y, Ozaki A, Abeysinghe S, Kosaka M, Tanimoto T. COVID-19: challenges faced by Nepalese migrants living in Japan. BMC Public Health 2021;21(1). https://doi.org/10.1186/s12889-021-10796-8.
[31] Rayes D, Karnouk C, Churbaji D, Walther L, Bajbouj M. Faith-Based Coping Among Arabic-Speaking Refugees Seeking Mental Health Services in Berlin, Germany: An Exploratory Qualitative Study. Frontiers in Psychiatry 2021;12. https://doi.org/10.3389/fpsyt.2021.595979.
[32] Simkhada B, Vahdaninia M, van Teijlingen E, Blunt H. Cultural issues on accessing mental health services in Nepali and Iranian migrants communities in the UK. Int J Ment Health Nurs 2021;30(6):1610–9. https://doi.org/10.1111/inm.12913.
[33] Memon, A., Taylor, K., Mohebati, L.M., Sundin, J., Cooper, M., Scanlon, T., & De Visser, R. (n.d.). Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: a qualitative study in Southeast England. https://doi.org/10.1136/bmjopen-2016.
[34] Gartley T, Due C. The Interpreter Is Not an Invisible Being: A Thematic Analysis of the Impact of Interpreters in Mental Health Service Provision with Refugee Clients. Australian Psychologist 2017;52(1):31–40. https://doi.org/10.1111/ap.12181.
[35] Nithianandan N, Gibson-Helm M, McBride J, Binny A, Gray KM, East C, Boyle JA. Factors affecting implementation of perinatal mental health screening in women of refugee background. Implementation Science 2016;11(1). https://doi.org/10.1186/s13012-016-0515-2.
[36] Shannon PJ, Vinson GA, Cook TL, Lennon E. Characteristics of Successful and Unsuccessful Mental Health Referrals of Refugees. Administration and Policy in Mental Health and Mental Health Services Research 2016;43(4):555–68. https://doi.org/10.1007/s10488-015-0639-8.
[37] Corrigan PW, Torres A, Lara JL, Sheehan L, Larson JE. The Healthcare Needs of Latinos with Serious Mental Illness and the Potential of Peer Navigators. Administration and Policy in Mental Health and Mental Health Services Research 2017;44(4):547–57. https://doi.org/10.1007/s10488-016-0737-2.
[38] Hansen MC, Cabassa LJ. Pathways to depression care: Help-seeking experiences of low-income Latinos with diabetes and depression. J Immig Minor Health 2012;14(6):1097–106. https://doi.org/10.1007/s10903-012-9590-x.
[39] Saechao F, Sharrock S, Reicherter D, Livingston JD, Aylward A, Whisnant J, Koopman C, Kohli S. Stressors and barriers to using mental health services among diverse groups of first-generation immigrants to the United States. Commun Ment Health J 2012;48(1):98–106. https://doi.org/10.1007/s10597-011-9419-4.
[40] Jensen NK, Norredam M, Priebe S, Krasnik A. How do general practitioners experience providing care to refugees with mental health problems?. A qualitative study from Denmark. 2013. http://www.biomedcentral.com/1471-2296/14/17.

[41] Paudyal P, Tattan M, Cooper MJF. Qualitative study on mental health and well-being of Syrian refugees and their coping mechanisms towards integration in the UK. BMJ Open 2021;11(8). https://doi.org/10.1136/bmjopen-2020-046065.
[42] Griffithhs G, Tarricone I. The provision of mental health services to immigrants and refugees in Italy: the barriers and facilitating factors experienced by mental health workers. J Psychopathol 2017;23:79–86.
[43] Mirza M, Harrison EA, Chang HC, Salo CD, Birman D. Making sense of three-way conversations: A qualitative study of cross-cultural counseling with refugee men. Int J Intercult Relat 2017;56:52–64. https://doi.org/10.1016/j.ijintrel.2016.12.002.
[44] Mitschke DB, Praetorius RT, Kelly DR, Small E, Kim YK. Listening to refugees: How traditional mental health interventions may miss the mark. International Social Work 2017;60(3):588–600. https://doi.org/10.1177/0020872816648256.
[45] Pallaveshi L, Jwely A, Subramanian P, Malik MO, Alia L, Rudnick A. Immigration and Psychosis: an Exploratory Study. J Int Migrat Integrat 2017;18(4):1149–66. https://doi.org/10.1007/s12134-017-0525-1.
[46] Shrestha-Ranjit J, Patterson E, Manias E, Payne D, Koziol-McLain J. Effectiveness of Primary Health Care Services in Addressing Mental Health Needs of Minority Refugee Population in New Zealand. Issues Ment Health Nurs 2017;38(4):290–300. https://doi.org/10.1080/01612840.2017.1283375.
[47] Weng SS, Spaulding-Givens J. Informal Mental Health Support in the Asian American Community and Culturally Appropriate Strategies for Community-Based Mental Health Organizations. Human Service Organizations Management, Leadership and Governance 2017;41(2):119–32. https://doi.org/10.1080/23303131.2016.1218810.
[48] Chao YY, Seo JY, Katigbak C, Chang YP. Utilization of Mental Health Services Among Older Chinese Immigrants in New York City. Commun Ment Health J 2020;56(7):1331–43. https://doi.org/10.1007/s10597-020-00570-2.
[49] Harris SM, Binder PE, Sandal GM. General Practitioners' Experiences of Clinical Consultations With Refugees Suffering From Mental Health Problems. Front Psychol 2020;11. https://doi.org/10.3389/fpsyg.2020.00412.
[50] Kiselev N, Morina N, Schick M, Watzke B, Schnyder U, Pfaltz MC. Barriers to access to outpatient mental health care for refugees and asylum seekers in Switzerland: The therapist's view. BioMed Central Ltd. 2020;20(1). https://doi.org/10.1186/s12888-020-02783-x.
[51] Kiselev N, Pfaltz M, Haas F, Schick M, Kappen M, Sijbrandij M, De Graaff AM, Bird M, Hansen P, Ventevogel P, Fuhr DC, Schnyder U, Morina N. Structural and socio-cultural barriers to accessing mental healthcare among Syrian refugees and asylum seekers in Switzerland. Eur J Psychotraumatol 2020;11(1). https://doi.org/10.1080/20008198.2020.1717825.
[52] Tulli M, Salami B, Begashaw L, Meherali S, Yohani S, Hegadoren K. Immigrant Mothers' Perspectives of Barriers and Facilitators in Accessing Mental Health Care for Their Children. J Transcult Nurs 2020;31(6):598–605. https://doi.org/10.1177/1043659620902812.
[53] Boettcher VS, Nowak AC, Neuner F. Mental health service utilization and perceived barriers to treatment among adult refugees in Germany. Eur J Psychotraumatol 2021;12(1). https://doi.org/10.1080/20008198.2021.1910407.
[54] Disney L, Mowbray O, Evans D. Telemental Health Use and Refugee Mental Health Providers Following COVID-19 Pandemic. Clin Soc Work J 2021;49(4):463–70. https://doi.org/10.1007/s10615-021-00808-w.
[55] Khanom A, Alanazy W, Couzens L, Evans BA, Fagan L, Fogarty R, John A, Khan T, Kingston MR, Moyo S, Porter A, Rhydderch M, Richardson G, Rungua G, Russell I, Snooks H. Asylum seekers' and refugees' experiences of accessing health care: a qualitative study. BJGP Open 2021;5(6). https://doi.org/10.3399/BJGPO.2021.0059.
[56] Kour P, Lien L, Kumar B, Nordaunet OM, Biong S, Pettersen H. Health Professionals' Experiences with Treatment Engagement Among Immigrants with Co-occurring Substance Use- and Mental Health Disorders in Norway. Substance Abuse: Research and Treatment 2021;15. https://doi.org/10.1177/11782218211028667.
[57] Nejati S, Svenningsson I, Björkelund C, Hange D. How can a care manager at the primary care centre support foreign-born female patients suffering from common mental disorders? – An interview study. Scand J Caring Sci 2022;36(2):456–67. https://doi.org/10.1111/scs.13060.
[58] Collazos F, Malagón-Amor Á, Falgas-Bague I, Qureshi A, Gines JM, del Mar Ramos M, McPeck S, Hussain I, Wang Y, Alegría M. Treating immigrant patients in psychiatric emergency rooms. Transcult Psychiatry 2021;58(1):126–39. https://doi.org/10.1177/1363461520916697.
[59] W.H.O.. World mental health report: transforming mental health for all. executive summary. In World Health Organization; 2022. Licence: CC BY-NC-SA 3.0 IGO.
[60] Priebe S, Giacco D, El-Nagib R. Public health aspects of mental health among migrants and refugees: a review of the evidence on mental healthcare for refugees, asylum seekers, and irregular migrants in the who european region. Copenhagen: WHO Regional Office for Europe; 2016 (Health Evidence Network (HEN) Synthesis Report 47).
[61] Hendrickx M, Woodward A, Fuhr DC, Sondorp E, Roberts B. The burden of mental disorders and access to mental health and psychosocial support services in Syria and among Syrian refugees in neighbouring countries: A systematic review. J Public Health (UK) 2020;42(3). https://doi.org/10.1093/pubmed/fdz097.
[62] Dickson K, Bangpan M. What are the barriers to, and facilitators of, implementing and receiving MHPSS programmes delivered to populations affected by humanitarian emergencies? A qualitative evidence synthesis. Global Mental Health 2018;5. https://doi.org/10.1017/gmh.2018.12.
[63] Kantor V, Knefel M, Lueger-Schuster B. Perceived barriers and facilitators of mental health service utilization in adult trauma survivors: A systematic review. Clin Psychol Rev 2017;52:52–68. https://doi.org/10.1016/j.cpr.2016.12.001.
[64] Mangrio E, Sjögren Forss K. Refugees' experiences of healthcare in the host country: a scoping review. BMC Health Services Research 2017;17(1). https://doi.org/10.1186/s12913-017-2731-0.
[65] Duden GS, Martins-Borges L, Rassmann M, Kluge U, Willecke TG, Rogner J. A qualitative evidence synthesis of refugee patients' and professionals' perspectives on mental health support. Commun Psychol Glob Perspect 2020;6 (2–1):76–100.
[66] Lebano A, Hamed S, Bradby H, Gil-Salmerón A, Durá-Ferrandis E, Garcés-Ferrer J, Azzedine F, Riza E, Karnaki P, Zota D, Linos A. Migrants' and refugees' health status and healthcare in Europe: A scoping literature review. BMC Public Health 2020;20(1). https://doi.org/10.1186/s12889-020-08749-8.
[67] Prady SL, Endacott C, Dickerson J, Bywater TJ, Blower SL. Inequalities in the identification and management of common mental disorders in the perinatal period: An equity-focused re-analysis of a systematic review. PLoS One 2021;16(3): e0248631. 15.
[68] Ahmadinia H, Eriksson-Backa K, Nikou S. Health-seeking behaviours of immigrants, asylum seekers and refugees in Europe: a systematic review of peer-reviewed articles. J Document 2022;78(7):18–41. https://doi.org/10.1108/JD-10-2020-0168.
[69] United Nations High Commissioner for Refugees [UNHCR]. (2021). Global Trends. Retrieved from: https://www.unhcr.org/figures-at-a-glance.html (Last accessed 25/10/2022).
[70] Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, Shamseer L, Tetzlaff JM, Akl EA, Brennan SE, Chou R, Glanville J, Grimshaw JM, Hróbjartsson A, Lalu MM, Li T, Loder EW, Mayo-Wilson E, McDonald S, Moher D. The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. In The BMJ 2021;372. https://doi.org/10.1136/bmj.n71.
[71] Sheath D, Flahault A, Seybold J, Saso L. Diverse and complex challenges to migrant and refugee mental health: reflections of the M8 Alliance expert group on migrant health. Int J Environ Res Public Health 2020;17(10):3530.
[72] Rathbone J, Albarqouni L, Bakhit M, Beller E, Byambasuren O, Hoffmann T, Scott AM, Glasziou P. Expediting citation screening using PICo-based title-only screening for identifying studies in scoping searches and rapid reviews. Systematic Reviews 2017;6(1). https://doi.org/10.1186/s13643-017-0629-x.
[73] Theys L, Krystallidou D, Salaets H, Wermuth C, Pype P. Emotion work in interpreter-mediated consultations: A systematic literature review. In Patient Education and Counseling; 2020;103(1):33–43. https://doi.org/10.1016/j.pec.2019.08.006.
[74] Higgins JPT, Thomas J, Chandler J, Cumpston M, Li T, Page MJ, Welch VA. Cochrane handbook for systematic reviews of interventions. In Cochrane Handbook for Systematic Reviews of Interventions 2019. https://doi.org/10.1002/9781119536604.
[75] Bamford J, Fletcher M, Leavey G. Mental Health Outcomes of Unaccompanied Refugee Minors: a Rapid Review of Recent Research. In Current Psychiatry Reports 2021;23(8):46. https://doi.org/10.1007/s11920-021-01262-8.
[76] Cohen JT, Neumann PJ, Weinstein MC. Does Preventive Care Save Money? Health Economics and the Presidential Candidates. N Engl J Med 2008;358(7). https://doi.org/10.1056/nejmp0708558.
[77] Lebano A, Hamed S, Bradby H, et al. Migrants' and refugees' health status and healthcare in Europe: a scoping literature review. BMC Public Health 2020;20:1039. https://doi.org/10.1186/s12889-020-08749-8.
[78] Kalich A, Heinemann L, Ghahari S. A Scoping Review of Immigrant Experience of Health Care Access Barriers in Canada. J Immigrant Minority Health 2016;18:697–709. https://doi.org/10.1007/s10903-015-0237-6.
[79] Metzl Jonathan M, Hansen Helena. Structural competency: theorizing a new medical engagement with stigma and inequality. Soc Sci Med 2014;103:126–33.
[80] Satinsky Emily, et al. Mental health care utilisation and access among refugees and asylum seekers in Europe: a systematic review. Health Policy 2019;123(9):851–63.
[81] Pollard T, Howard N. Mental healthcare for asylum-seekers and refugees residing in the United Kingdom: a scoping review of policies, barriers, and enablers. Int J Ment Health Syst 2021;15:60. https://doi.org/10.1186/s13033-021-00473-z.
[82] Määttä SK, Puumala E, Ylikomi R. Linguistic, psychological and epistemic vulnerability in asylum procedures: An interdisciplinary approach. Discourse Studies 2021;23(1):46–66. https://doi.org/10.1177/1461445620942909.