

Mental health services designed for Black, Asian and Minority Ethnic (BAME) in the UK: a scoping review

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**Running title: Culturally-adjusted mental health support/services for Black, Asian and Minority Ethnic (BAME) in the UK:
a scoping review**

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Abstract:

Background and objective: Mental health disparities exist among Black, Asian and Minority Ethnic (BAME) populations. This scoping review aimed to provide an overview of mental health services designed for BAME population, both established UK BAME communities and refugee/asylum-seekers.

Methods: A range of electronic databases were searched for peer-reviewed studies conducted within past decade in the UK. Using the Arksey and O'Malley methodology, data were extracted, analysed and summarised.

Findings: A total of 13 papers were identified, mostly non-randomised community-based. Studies were very heterogeneous in terms of their sample and service provided. After initial appraisal, we presented a narrative synthesis. Overall, all studies reported positive mental health outcomes and beneficial effects.

Conclusion: Mental health services provided for BAME people, both established and refugee/asylum-seekers are feasible and improve engagement with the services and mental health outcomes. Initiatives are required to facilitate integration of these targeted services within mental health and community services for BAME in the UK.

Key words: Mental Health, BAME, BME, Mental Health Services, U.K, Minority Ethnic, Minorities

Introduction

Mental health disorders (MHDs) are a global public health concern and the United Nations and World Health Organization set goals and action plans to promote mental health and well-being (United nations, 2015, World health Organisation 2013). A systematic review and meta-analysis of 174 studies across 63 countries indicated that 20% of participants met the inclusion criteria for a common MHD within the last 12 months (Steel et al., 2014). This review reported that 29.2% of the respondents had experienced a common MHD at some point in their life course. The UK data shows an increasing trend for common MHD's since 1993, with one in six adults having symptoms of these conditions (baker 2018).

Poor mental health can have a huge impact at both a societal and personal level as globally 32% of all years lived-with-disability and 13% of disability-adjusted life-years are associated with MHD (Vigo et al., 2016). People with a mental illness compared to those without are also at a greater risk of unemployment (Evans-lacko et al., 2013) and excess morbidity and mortality (Wahlbeck et al., 2011; Chesney et al., 2014; Charlson et al., 2015; Saxena et al., 2018).

Mental health in migrants

Mental health disparities exist among Black, Asian and Minority Ethnic (BAME) populations. Meta-analyses have shown that although the risks are not equitably distributed within ethnicity groups and location, overall immigrants and their descendants are at a higher risk of psychotic disorders and non-affective disorders than majority ethnic groups in a given setting (Bourque et al., 2011; Jongasma et al., 2019). Evidence indicates that minority ethnicities have a poor engagement with mental health service with lower rates of initiation, retention and dropout from treatment (Interian et al., 2013; DeJesus et al., 2015; Dixon et al., 2016). This

suggests disparities in mental health care pathways among BAME and is attributed to a number of factors including perceived discrimination and prejudices (Henderson et al., 2013; Chen et al., 2014), unequal access to care (Penner et al., 2014; Kapke et al., 2016) as well as lack of resources to fund health services (Lillie & Hoffman 2005; Buchmueller et al., 2016). It also suggested that clinicians are less likely to have friendly conversation or involve BAME patients in their clinical decision-making (Harrison et al., 2004; Cooper et al., 2012), which to a great extent is linked to the knowledge that clinicians have about cultural beliefs and stigma/perceived illness causes in BAME patients (Cooper et al., 2003; McHugh et al., 2013). This leads to underutilisation of medical and psychological services in BAME (Armstrong et al., 2013; Schmitt et al., 2014). There are reports that ethnic minorities of Black African Caribbean and South Asians are less likely to be diagnosed with MHDs by their general practitioners in England (National Institute for Mental Health in England 2003).

Given the above background, it is very likely that BAME people become reluctant to ask for help from mental health services and present to services when in crisis. In fact, it is shown that there are disproportionate rates of admission of people from BME communities to the UK psychiatric inpatient units and also, compulsory detention of BME users in inpatient units (Department of Health 2005). Further reports indicate that poor relationships exist between psychiatric services and the community of Black/Black British and hence, they are far more likely to be detained under the mental health act and thus forcibly treated i.e. over four times more than that of White groups (NHS Digital 2019). A review of assessing poor engagement of African and Caribbean communities with mental health services has suggested that circles of fear stop Black people from engaging with services and that mainstream

services are experienced as inhumane, unhelpful and inappropriate for the community (The Sainsbury Centre for Mental Health 2002). The poor engagement of BAME people with mental health services indicates that there is a need to improve the accessibility and acceptability of the services to achieve integration within BAME communities (Bansal et al., 2014).

Statistics show the population in the UK has becoming more ethnically diverse and the minority ethnic population has been growing since 1991 (Office for National Statistics 2011). Therefore it is necessary that the quality and effectiveness of mental health care services in ethnic minorities supported appropriately thus, contributing to a more productive economy and healthier society.

There is a gap in our knowledge of the studies that have provided accessible and acceptable mental health services for the UK BAME, for both established and refugee/asylum seeker. It is also important to note that the mental health needs of forced migrants communities i.e. refugees/asylum-seekers and established UK BAME communities and challenges faced by services in providing appropriate, accessible and acceptable services are different. Therefore this scoping review aimed to synthesise the evidence from a variety of targeted services in order to improve access and uptake of mental health services for BAME communities in the UK. It would also inform the scope and breadth of the designed mental health services for both established and refugee/asylum-seekers BAME in the UK. This provide updated information to the earlier reviews that have assessed improving therapeutic communications between BAME and limited only to the psychiatric professionals, in the UK and mostly USA (Bhui et al., 2015) and also experiences of BAME women on perinatal mental health services and help seeking behaviours in Europe (Watson et al., 2019).

Methods

This scoping review followed Arskey and O'Malley's (2005) framework. The review used an integrated approach, including both quantitative and qualitative studies to provide a stronger evidence-base (Pluye & Hong 2014).

Search strategy

A comprehensive search strategy was developed (Appendix 1), consisting of subject headings, keywords and related terms representing BAME, mental health and related services. The strategy was applied to the following databases: MEDLINE Complete, PsycINFO, SocINDEX with Full Text, CINAHL Complete, Scopus and ISI Web of Science. The search was conducted in April 2019 and the results were limited to studies conducted between 2009 and 2019. Inclusion criteria of the studies were identified as: peer-reviewed papers published since 2009, conducted in the UK only, had provided a type of mental health service i.e. improving access, uptake and acceptability of the mental health services for a BAME population in the UK, any UK BAME population i.e. established, refugee or asylum-seeker, either culturally sensitive or community-based and published in English. Studies were excluded if they had described the provision of service to non-BAME groups or were conducted outside the UK. Grey literature and books and/or book chapters were not included because of the scope of this review.

Screening of papers and data extraction

Eligible articles were identified through scanning the title and abstract and the full-text reviews were checked and confirmed by two authors (MV and BS). The reference lists of other reviews were also investigated to identify any additional articles. Data from the

included papers were extracted using a standardised charting form, capturing details on article type, service provided and its duration, the sample/population, comparators (if applicable), outcomes and the relevant key findings (quantitative, qualitative or both). One researcher (MV) extracted the data from all papers independently and all other authors contributed to 25% of data extraction. Any discrepancies were discussed within the team to arrive at a consensus.

Data synthesis

Descriptive statistics provide summaries of studies and their programme of research. Heterogeneities between the methods and reported outcomes in the included studies were examined as to whether it was possible to conduct meta-analyses. Narrative approach was used for all data.

Results

Electronic searches yielded a total of 2,777 records (Figure 1). After removal of duplicates and screening of title/abstract, 20 full text papers were assessed against inclusion criteria for this scoping review. Thirteen publications (Afuwepe et al., 2010; Amani 2012; Bhui et al., 2015; Chaudhry et al., 2009; Chiumento et al., 2011; Dura-Vila et al., 2012; Edge & Grey 2018; Fazel et al., 2009; Fazel et al., 2016; Hughes 2014; O'Shaughnessy et al., 2012; Rathod et al., 2013; Masood et al., 2015), each detailing a unique study were included (Table 1). Three studies were conducted as a Randomised Controlled Trial (RCT) (Afuwepe et al., 2010; Rathod et al., 2013; Masood et al., 2015), and the rest were non-randomised community-based studies, using either mixed methods, qualitative or quantitative (Table 1). Six studies targeted refugees and asylum seekers, mostly yet unsettled in the UK, focusing on school children (Chiumento 2011; Dura-Villa 2012; Fazel 2009; Fazel 2016; Hughes 2014) and pregnant women (O'Shaughnessy 2012) whilst the remainder were conducted in established UK BAME groups.

The study by Hughes (2014) has conducted their intervention in mothers of refugee background whose children had behavioural problems and high absence rates from school. Fazel et al. (2009) primarily conducted a quantitative study with refugee children in Oxford and in their most recent paper (Fazel et al., 2016); they reported the qualitative follow-up findings of refugee children ≥ 16 yrs across three UK cities, who had initially participated in their intervention study. The study by Masood et al., (2015) was initially conducted as an exploratory RCT in a PhD project, testing the feasibility and acceptability of a culturally-adjusted CBT in British South Asian women with postnatal depression. This study (Masood et al., 2015) reported a wide range of views and experiences of 17 women post-intervention and also a summary of quantitative findings in the intervention arm. Most studies were conducted in

London (Afuwepe et al., 2010; Bhui et al., 2015; Chiumento et al., 2011; Hughes 2014) and the majority had assessed mental health problems in general (Table 1).

Studies were very heterogeneous in terms of their design, sample i.e. type and size and services provided and hence, no meta-analyses were possible and all results are narratively described (Table 2). Overall, the results from all studies; quantitative, qualitative or combined, showed improvements in mental health outcomes in participants post intervention and one study only (Bhui et al., 2015) reported the cost-benefit outcomes of an intervention in relation to care and consultation in service users (SUs). The duration of interventions in most studies was very diverse. The three RCTs were 3-months (Afuwepe et al., 2010; Masood et al., 2015) and 4-5months (Rathod et al., 2013) and all reported significant improvements in mental health status of participants post intervention (Table 2).

In some of the included studies, participants were selected from different groups. For example one study had two levels: training community figures from the Nepali's community in mental health first aid and also surveying a cross section of a local Nepali community to assess perception and awareness of local mental health services (Amani 2012). In this scoping review only the results for the community health ambassadors have been presented since there was no report on evaluative research of their work with the Nepali population. Two other studies also assessed the views of both SU and clinical staff (Bhui et al., 2015) and SUs, caregivers and professionals (Edge & Grey 2018) again only the results for the SUs have been reported.

Most studies were very small such as Chaudhry and colleagues (2009) with originally only 55 eligible women and of the first consecutive 18 who agreed to participate, 8 women dropped out before the start of intervention, one attended only one session and only nine women attended most or all of the sessions. In addition some studies employed a range of interventions in their study sample such as the Haven project conducted by Chiumento and colleagues (2011) whereby different groups of refugee children benefitted from several interventions: a psycho-educational and psychodrama group; art psychotherapy group; combining art psychotherapy and psychodrama; a horticultural group of local and refugee/asylum-seeking children; girls engaged in art psychotherapy; a mixed group of refugee and local children who came together to make a film about how to overcome bullying and racism and a collaboration with The Reader Organisation. Only the results of two of the intervention groups have been reported in their paper.

Discussion

This scoping review, including 13 citations of peer-reviewed papers in English, provided an insight into the mental health services designed for BAME in the UK. The studies included a range of migrants, from UK BAME established to refugees and asylum-seekers. Regardless of the mixed samples and services provided, positive improvements in mental health outcomes were reported in all studies by participants post intervention. The majority of the included studies were non-randomised community-based and three were identified as RCT (Afuwepe et al., 2010; Rathod et al., 2013; Masood et al., 2015). It is important to note that good engagement with the provided mental health services were reported in the majority of the included studies. This has mostly been evident for refugee and asylum-seekers from BAME communities since lack of knowledge about available services as well as barriers for accessing were present. It was identified that acceptable mental health services are key challenges within this community of migrants. For example, women included in the Tree of Life intervention (Hughes 2014) indicated that the group has helped them a lot, they do not feel as alone and have found themselves. In the studies conducted by Fazel et al. (2009) and Fazel et al. (2016), children stated that the sessions have been very useful, it was good to be listened to and discuss things they could not tell to their parents and other people around them. Furthermore, the Haven project (Chiumento et al., 2011) through the collaborations made with school staff helped refugee children, who were removed from school and placed in detention centre, to support their educational and emotional needs throughout their time in detention and also, later returning to school. The studies that were conducted in a school setting for refugee/asylum-seeker children used a multi-approach service model (Table 2) including variety of psychological therapies for the individual and included, where appropriate, support for the family and his/her

circle of network. This approach has important implications for BAME people who may experience inequalities in accessing mental health services due to perceived discrimination and systemic and cultural barriers (Basnal et al., 2014; Chen et al., 2014; Cooper et al., 2003). It is noteworthy that the forced to flee population and in particular children have potentially been exposed to traumatic experiences prior and during their migration to the resettlement country and thus, are at increased risk of developing psychological problems (Reed et al, 2012; Fazel et al., 2012). This scoping review suggests that schools can be an appropriate place to address the psychological as well as social and emotional needs of these children and their families. A systematic review of school-based interventions for improving mental health and/or social-emotional functioning among refugee and asylum-seekers students showed that overall school-based interventions could be effective in reducing students' trauma-related symptoms where more consistent outcomes have been evident for particular types of intervention such as cognitive behaviour therapy (Sullivan & Simonson 2016). Further research have also emphasised the robust role that schools could have as a setting for implementation of trauma-focused practices in children (Zakszeski et al., 2017; Franco 2018). In the UK, due to issues related to settlement, the Refugee Community Organisations (RCOs) would seem to be the only available point of engagement with mental health services for refugees and asylum-seekers, which makes the role of schools even more pertinent for mental health services within this population. Seven of the included studies used culturally-adapted and community services for the UK established BAME populations (Afuwepe et al., 2010; Amani 2012; Bhui et al., 2015; Chaudhry et al., 2009; Edge & Grey 2018; Rathod et al., 2013; Masood et al., 2015). The focus of these studies had been on reducing stigma, promoting good mental health and also, providing acceptable and

effective mental health services for BAME e.g. adapted cognitive behaviour therapy. All provided evidence that the designed services could have beneficial effects within UK established BAME groups. Whilst there are a variety of components and frameworks for culturally-adapted mental health services, communication styles between clinicians and ethnic minorities could be a basic foundation for improving participation and treatment continuation in BAME (Aggarwal et al., 2016). It is reported that the nature of care pathways for Black people can negatively impact the outcome of treatment and willingness to engage with mainstream services and therefore, practical steps by creating culturally sensitive services should be encouraged, in order to improve early access in non-stigmatising or generic community settings for Black service-users (Sainsbury Centre for Mental Health 2002). Adapted CBTs are also a feasible approach in Improving Access to Psychological Therapy services and can provide effective and well-received treatments for depression and anxiety disorders in BAME (Sidhu & Begum 2017).

Overall, with the increasing number of migrants worldwide, particularly refugees and asylum-seekers, the case for culturally-adapted treatments for MHDs in ethnic minorities has been raised in a number of studies where it could facilitate mental health literacy and in improving access to health care systems and the care they receive (Penka et al., 2012; Mederoise & Lotufo-Neto 2014; Sumin et al., 2016). Systematic reviews of culturally-adapted psychotherapies, mainly by infusing specific cultural values and cognitive-behavioural strategies, versus un-adapted treatments for a number of MHDs have shown that these therapies are beneficial for psychological functioning and boost seeking and treatment behaviours in ethnic minorities (Benish et al., 2011; Kalibatseva et al., 2014).

Strengths and limitations

This scoping review is snapshot of the mental health services designed for BAME people in the UK in the last decade. Differences exist between the current scoping review and earlier reviews (Bhui et al., 2015; Watson et al., 2019) in terms of the inclusion of studies where the first (Bhui et al., 2015) included only studies that were designed to improve therapeutic communications for BAME patients receiving specialist psychiatric care and the latter (Watson et al., 2019) has assessed experiences and perceptions of perinatal mental health and related services amongst BAME women in Europe. The current review adds to our evidence-based knowledge from the studies that have designed and provided accessible and acceptable mental health services for the UK BAME, established and refugee/asylum-seekers.

Generalisability of the findings is limited due to the small scale of studies and wide-range of designed services. Also because of time limitations and the quality of the papers, we only included peer reviewed journal articles. Also, we did not assess the quality assessments of the included papers due to this being a scoping review.

Concluding remarks and implications for research

This scoping review provided the fundamental evidence that mental health services designed for BAME people, both for established and refugees/asylum-seekers are feasible and it could be said that this frequently labelled a hard-to-reach group of people are, in reality, seldom-heard. The settings of mental health services in many of the included studies have been community locations and schools which highlights the importance of services working outside of clinics and the traditional routs and thus not

carrying the related stigma. There is a need for more research to demonstrate the effectiveness of BAME specific services and indicate the place that these services can have in mainstream mental health services. Initiatives are also required to facilitate integration of these targeted services within mental health and community services.

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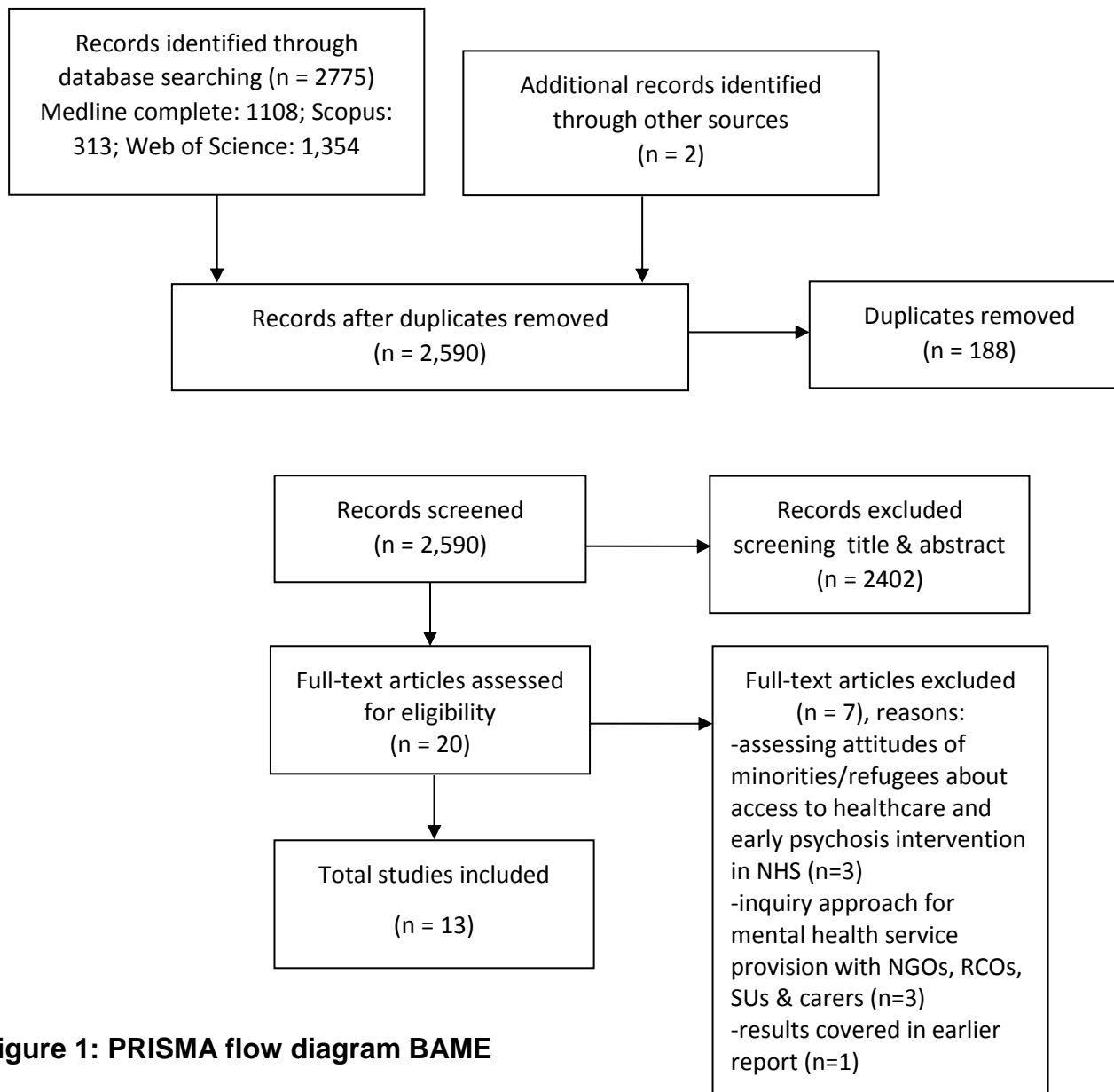


Figure 1: PRISMA flow diagram BAME

Table: 1: Summary of main characteristics of the included studies

Main study characteristics	No. studies	References
Study design		
Randomised Controlled Trial (RCT)	3	Afuwepe et al., 2010; Rathod et al., 2013 [*] , Masood et al., 2015 ^{**}
Non-Randomised study design	10	Bhui et al., 2015; Chaudhry et al., 2009; Chiumento et al., 2011 Dora-Vila et al., 2012; Fazel et al., 2009 Amani 2012; Edge & Grey 2018; Fazel et al., 2016; Hughes 2014; O'Shaughnessy et al., 2012
• Mixed method (quantitative and qualitative)	3	
• Quantitative	2	
• Qualitative	5	
Targeted study sample		
Black, Asian, Minority Ethnic (BAME), settled in the UK	8	Afuwepe et al., 2010; Amani 2012; Bhui et al., 2015; Chaudhry et al., 2009; Edge & Grey 2018; Hughes 2014; Rathod et al., 2013; Masood et al., 2015
BAME, refugees and asylum seekers with uncertain residency status	5	Chiumento et al., 2011; Dora-Vila et al., 2012; Fazel et al., 2009; Fazel et al., 2016; O'Shaughnessy et al., 2012
Location		
London	4	Afuwepe et al., 2010; Bhui 2015; Dura-Vila et al., 2012; Hughes 2014
Hampshire	2	Amani 2012; Rathod et al., 2013
Manchester ^{***}	3	Chaudhry et al., 2009; Edge & Grey 2018; Masood et al., 2015
Liverpool	2	Chiumento et al., 2011; O'Shaughnessy et al., 2012
Oxford & Multi-site: Oxford, Glasgow, Cardiff	2	Fazel et al., 2009; Fazel et al., 2016
Type of mental health studied		
Schizophrenia	2	Edge & Grey 2018; Rathod et al., 2013
Anxiety and/or depression disorders	2	Afuwepe et al., 2010; Chaudhry et al., 2009
Mental health problems, in general	7	Amani 2012; Bhui et al., 2015; Chiumento et al., 2011; Dura-Vila et al., 2012; Fazel et al., 2009; Fazel et al., 2016; Hughes 2014
Perinatal mental health	2	O'Shaughnessy et al., 2012, Masood et al., 2015

Table 2: Overview of studies included in the scoping review and their findings

Reference	Location & study setting	Sample size & study population	Duration and details of intervention	Summary of findings
Afuwepe 2010	London, statutory agencies, local Black community organisations, self-referrers & referred from non-statutory organisations	40, Black African or Black Caribbean origins, born in sub-Saharan Africa or the UK with at least one parent from sub-Saharan or Caribbean	3-months; Rapid Access (RA as intervention) vs. Standard Access (SA as control): Needs-led stepped-care approach by community health workers & experienced therapist. Practical advice/assistance, advocacy for social needs, health education, mentoring, brief CBT and brief solution focused therapy	-Mean GHQ-28 scores improved post intervention in both groups (SA group: 14.10 vs. 12.25; RA group: 18.30 vs. 8.06) with greater improvements in intervention arm (RA) -RA group was significantly less severely depressed compared to control group at 3 months (95% CI=0.07-4.32, p=0.04) -Trend for RA group demonstrating better outcomes on the anxiety and insomnia sub-scale. -RA better improvement in the overall mental health component score on SF-36 (p=0.02).
Amani 2012	Rushmoor, Nepali community Hampshire	7 community figures local Nepali community	2-weeks mental health first aid training for being community health ambassadors (CHAs); who led comprehensive mental health promotional campaign, by face-to-face interactions, posters, leaflets and digital media	-Positive feedback by CHAs: improved confidence and knowledge on mental health; being able to signpost people to mental health services; improved relationships with family members & friends -Comprehensive mental health promotional campaign also raised awareness of mental health services in Nepali community and videos were popular
Bhui et al., 2015	London Tower Hamlets; East London NHS referrals from: community; Assertive Outreach Team, Community Mental Health Teams & Home Treatment Team	46 SUs, Asian or Asian British Pakistani or Bangladeshi, Black/Black British, Caribbean, African and Somali, Mixed White and Black Caribbean & other ethnicity (94%)	18-months, adapted CCS model; to work at multiple levels of service provision & commissioning to structural and individual determinants of health inequalities. Worked closely with local mental health teams to provide cultural consultation, promote social inclusion, recovery-oriented care and mental health care for BME service-users	-Only 15 people completed FU, trends suggested average CORE-10 scores did improve (baseline vs. F-U mean= 23.5 (SD=11.3) vs. 20.8(SD=11.8). -Level of service receipt & costs significantly reduced, with significant reduction in A & E, psychiatrists and CPNs/case managers. -Average length of total face-to-face contact for full cultural consultation was 6.86 h, costing £37.32/h. Improvement in outcome found for GAF scale, suggest average cost associated with an improvement in one point on GAF=£20.15 per SU. -Intervention reduced costs of care by £497.15 per SU. -Qualitative: talking to cultural consultant was helpful as they felt listened to & not judged and helped them to identify what was going.
Chaudhry 2009	Manchester; community centre	9, persistently depressed women of Pakistani origin living	10 weekly sessions development of informal networks, engaging participants in social	All women attended at least 6/10 sessions. -Post-intervention: reduction in mean Self Reporting Questionnaire (SRQ) score (15 (SD=3.08) vs. 11.7 (SD=5.95),

		in the UK	contacts and linking with mental health services	paired t test=0.039). -Post-intervention, two women had no depressive disorder and three reduced suicidal ideation.
Chiumento 2011	Liverpool; referrals from schools, with high numbers of refugee children primarily made by teachers, different agencies including GPs & other statutory & voluntary services	44; vulnerable refugee and asylum seeking children	Weekly and as long as demanded; various therapeutic supports based on specific modalities: art psychotherapy, psychodrama, horticulture. All interventions aimed at child to gain locus of control over troubling symptoms and symptom relief	-Strengths and Difficulties Questionnaire (SDQ) scores indicated five out of six showed an improvement. -Pre-intervention SDQ scores registering abnormal or borderline on social and emotional disturbance, becoming positive scores in the post-intervention measures. -Narrative feedback from kids: very positive
Dura-Vila 2012	London Westminster; primary & secondary school and voluntary homeless family service	102; Young refugees (3-17 years old (44% from Middle East, 27% African, 22% European & 7% elsewhere) Majority were BAME: 71%	3-years non-consecutive; variety of flexible treatment and management options including liaison with other agencies, problem-solving, direct therapeutic work, individual psychotherapy, supportive treatments, family therapy, cognitive work addressing issues of loss. With interpreters, also training teachers/other staff in recognition and management of children's psychological distress, and appropriate referral to specialist mental health services	-Post-intervention, data was not available for all participants. In those cases with available outcome data, young people benefitted significantly from treatment in all ratings. Therapists believed 3/4 children's wellbeing improved with one quarter either staying the same in terms of their difficulties or getting worse. Parents and teachers SDQ scores improved with community intervention. -According to teachers, young people showed improvement on Total Problem Scores (p=0.010), Hyperactivity Scores (p=0.015) & Peer Problem Scores (p=0.017). -According to parents, improvements in Total Problem Score (p=0.006), Hyperactivity Score (p=0.000) & Conduct Problem Score (p=0.043).
Edge 2018	Manchester, Community locations and NHS mental health care setting Northwest England	10 service-users; African-Caribbean aged ≥18 years living SUs, diagnosed with schizophrenia + family, caregivers and advocates and health care professionals	No mention; Culturally appropriate and acceptable version of extant evidence-based, CBT of Family Intervention (CaFI), a study website was also developed	-Qualitative: all participants agreed that culturally appropriate 'talking treatment' was desirable, that the extant FI model had good face validity. -Suggestions to improve model: i) to add items for African Caribbean SUs and their families such as experiences of racism and discrimination and alternative conceptualizations of mental health and illness (including beliefs about the role of spirituality); ii) emphasis was placed on developing a new ethos of delivery, called 'shared learning', acknowledging that power imbalances are likely to be magnified where delivery of interventions involves White therapists and Black clients; iii) cultural competence was regarded as fundamental for successful

				therapeutic engagement and outcomes
Fazel 2009	Schools in Oxford with high number of refugee & asylum seeking children, arrived within last 5yrs from countries with on-going conflicts (one school=4-8yrs; one middle school=9-12yrs; one secondary school=13-19yrs).	47; refugee children from primary and secondary schools; 69 eligible children, 47 (65%) participated in study.	As demanded; Weekly consultations with mental health key worker and link teacher about individual children with psychological difficulties. Treatment options included: family work (with/without child); individual therapy (psychodynamic, supportive); or group work (for children/adolescents or parents) with additional in-home and crisis intervention work.	-At the end of study, refugee children continued to have significantly higher SDQ total ($p = 0.011$), emotional symptom ($p < 0.001$) and peer problem ($p = 0.002$) scores. -Assessing specific effectiveness of intervention, hyperactivity scores decreased significantly in refugee group (Mean [SD] change $-0.96(2.40)$ versus $-0.10(1.98)$; $t = 2.12$, $p = 0.037$) with suggestion of effect in emotional symptoms score (Mean [SD] change $-0.72 (2.63)$ vs. $0.03 (2.02)$; $t = 1.73$, $p = .088$).
Fazel 2016	Schools in Glasgow, Cardiff, Oxford	40; refugee and asylum seeking young adults (>16yrs) discharged from school-based mental health service for refugee children	Varied; specialised services for refugees collaborating with key school staff and interpreters & local child and adolescent mental health services (CAMHS) and the young people received individual, family or group interventions – or combination.	-Thematic analysis: impressions of being seen by mental health team in school; impression of therapeutic intervention received; contact with family; and ethical issues. -Many of young people interviewed longed for acceptance: by their peers, by society and by immigration determination process. All described events where their peers had embraced them in friendship, highlighting importance of adjustment for new arrivals, and social recognition as essential aspect of child's socialisation. -Teachers considered good referrers: they know students well, are aware of bullying in class and might be able to detect change in mood of students. They could encourage young person to attend appointments.
Hughes 2014	London, Camden	9 mothers; school for mothers and two more sessions for their children, secondary schools with Congolese, Afghani, Arabic-speaking & Horn of Africa refugee children	Workshops using a Tree of life approach on which people are invited to map their histories, lives. Tree of life need to be shared with their family	Qualitative: were generally positive -Those who took part in Tree of Life groups highlighted how people experienced them as not only positive and reinforcing of their identity and their resources, but also transforming of aspects of their lives.
O'Shaughn	Liverpool;	4-12 mothers & their	Not mentioned; social/practical	-Session-by-session questionnaire showed that group helped

essy 2012	Alder Hey Children's NHS Foundation Trust	babies (7 mothers & babies attended for a significant portion or all sessions); West African women, pregnant/with baby <=6months & high-risk asylum-seeking	support alongside a specialist therapeutic mother-infant group with infant massage, guided video feedback and parent-infant group activities	them to understand their baby (96%) & felt better (76%). -Thematic analysis: Being/talking together versus being alone; experience of feeling safe; Learning about motherhood/parenting; Mother and baby relationship; Un-storied narratives. -CARE-Index analysis (5 mother/babies: 2 mothers had positive change in quality of relationship, two mother/babies remained borderline & 1 mother remained in good enough range.
Rathod 2013	Hampshire (2-sites: (Southampton/Portsmouth) and London	35 (16 Int. vs. 17 control), two were lost to follow-up; minorities-with-a-diagnosis of schizophrenia group, 18-65yrs old	Between 16-20weeks; Culturally adjusted Behavioural Therapy (CaCBT) as intervention vs. Treatment as Usual (TAU) 16 sessions of CaCBTp by trained CaCBTp therapists, from 40min to 1.5 h and settings varied based on participants preferences	-Intervention group showed statistically significant reductions in symptomatology on overall Comprehensive Psychopathological Rating Scale (CPRS) scores, CaCBTp Mean (SD)=16.23 (10.77), TAU=18.60 (14.84); p=0.047, with a difference in change of 11.31 (95% CI: 0.14 to 22.49); Schizophrenia change: CaCBTp=3.46 (3.37); TAU= 4.78 (5.33) diff 4.62 (95% CI: 0.68 to 9.17); p=0.047 and positive symptoms (delusions; p=0.035, and hallucinations; p=0.056). -At 6 months follow-up, Montgomery-Asberg Depression Rating Scale (MADRAS) change=5.6 (95% CI: 2.92 to 7.60); p=0.001. Adjustment made for age, gender & antipsychotic medication. Overall satisfaction was significantly correlated with number of sessions attended (r=0.563; p=0.003).
Masood 2015	Manchester and Lancashire	83 (42 Int. vs. 41 control), British South Asian women living with their babies and over 16yrs old 17 women participated in the qualitative analysis post-intervention	12 weekly group sessions over 3-months; intervention consisted of two phases: a) interviews with women to explore their experiences with postnatal depression and type of help they would find acceptable, b) culturally-adapted CBT based manualised intervention to target their needs	-Women in intervention group who attended at least four sessions showed greater reductions in their Hamilton score from baseline to follow-up (r=0.35, p=0.048) -In general, women found the intervention acceptable and they experienced an overall positive change in their attitudes, behaviour, and increased self-confidence.

*indicates where the sample has been recruited from