'My happiness, I can build it myself'

The Mental Health and Wellbeing of Asylum Seeking and Refugee Populations in High-Income Countries: A Capabilities Approach

Thesis submitted in accordance with the requirements of the University of Liverpool for the degree of Doctor in Philosophy

Institute of Primary Care and Mental Health

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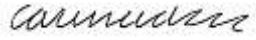
SIGNATURE 

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Abstract

The number of people who have been forcibly displaced is at an all-time high. Forcibly displaced individuals have often suffered acutely distressing experiences pre-migration, during their migration journeys, and post-resettlement in their host countries. Whilst there is a large research base which shows this can have a profoundly negative impact on their mental health and wellbeing, comparatively less research attention has been allocated to exploring indices of positive outcomes for this population. The aim of the current thesis was to understand the predictors of mental health and wellbeing of asylum seekers and refugees post-resettlement in high-income settings. Specifically, the research aimed to shed light on the barriers and facilitators that may hinder or promote positive mental health and wellbeing outcomes for these groups. The focus on positive outcomes allows a shift away from an exclusive focus on the presence or absence of psychopathology alone, to a more holistic consideration of what factors can bring vitality to an individual's lived experience post-migration.

During the initial phase of this thesis, two systematic reviews were carried out to identify existing research on barriers and facilitators of mental health and wellbeing in asylum seeking and refugee populations, including access to mental health services, and wider socio-cultural, political, and environmental factors that may impact on mental health outcomes and quality of life outside of formal healthcare. The findings of these reviews revealed that the bio-medical model may not be an adequate service model for meeting the mental health needs of forcibly displaced populations. Instead, more attention should be focused on non-health sector interventions that use more inclusive explanatory models of health and can increase access to care. Additionally, attention needs to be shifted towards the inclusion of social determinants of quality of life outside of formal healthcare systems.

Following on from these literature reviews, the Capability Approach (Sen, 1999) is proposed as a valuable theoretical framework that can inform the evaluation and assessment of mental health, wellbeing, and quality of life outcomes of migrant populations post-resettlement. A crucial argument of the Capability Approach is that wellbeing should be understood as the freedoms (or 'capabilities') individuals have to live the kind of life that they have reason to value. Central to this is the social climate into which migrants resettle. To explore this climate, a survey study was carried out to shed light on the perceptions of a sample of community members in the United Kingdom of the capability-based wellbeing of different migrant groups (refugees and economic migrants). The findings of this empirical study highlighted recognition

that refugees may have more limited capabilities in the United Kingdom and may not be achieving similar levels of the 'good life' as compared to economic migrants and British nationals.

To explore the lived experiences of refugees themselves and identify locally relevant dimensions of capability-based wellbeing, a series of focus groups were carried out with refugee women residing in the United Kingdom. An Interpretative Phenomenological Analysis was used, and the findings revealed three highly interconnected themes that were considered necessary to achieve a 'good life' post-resettlement namely *legal security*, *social cohesion*, and *personal agency*. These themes clearly confirmed that mental health status and access to formal health systems, whilst important, are not all that matters to mental health, wellbeing, and quality of life for forcibly displaced groups, rather broader social determinants need to be considered.

The themes that emerged through the qualitative analysis were subsequently aggregated into a capability-based wellbeing measure for migrant women in high-income settings. This measure was piloted on a sample of migrant women (refugees, asylum seekers and economic migrants) and validity and reliability analyses were carried out. A 17-item 'Good Life in the Community Scale' (GLiCS) with three meaningful subscales (i.e. (i) *access to resources,* (ii) *belonging and contributing,* and (iii) *independence*) was developed. The GLiCS demonstrated good internal consistency and construct validity. Furthermore, the findings of this study provide evidence of the validity and utility of operationalizing the Capability Approach for particular populations, and the relevance of developing a measure that speaks directly to the needs of migrant women post-resettlement specifically.

Overall, this thesis sheds light on the barriers and facilitators that are directly relevant to the mental health, wellbeing and integration of migrants in high-income settings, and develops an outcome measure inspired by the Capability Approach to assess migrant women's capability-based wellbeing post-resettlement.

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Table of Contents

List of Tables

List of Figures

Chapter 1: Introduction

Background

In today's world, there is an unprecedented level of human mobility. By the end of 2019, the estimated number of international migrants around the globe reached 272 million (United Nations High Commissioner for Refugees [UNHCR], 2019a). Of these, 79.5 million were forcibly displaced, including 26 million refugees and 4.2 million asylum seekers (UNHCR, 2019a). The continuation of population growth, increased connectivity, trade, rising inequality, conflicts, demographic imbalances and climate change indicate that this figure is likely to continue increasing over the next few decades.

Asylum seeker and refugee (AS&R) statuses are defined and determined by legal frameworks and are transitory categories in nature. An 'asylum seeker' is a person who is seeking international protection, but whose request for sanctuary is yet to be processed (UNHCR, 2019b). A 'refugee', according to the 1951 Refugee Convention[1], is anyone who, owing to a well-founded fear of persecution on the basis of race, religion, nationality, membership in a particular social group or political opinion, is outside of their country of origin or habitual residence, and is not able to receive protection from their country of origin (UNHCR, 2019b). Roughly 85% of the world's refugees are hosted by developing countries. However, in 2019 the majority of new asylum applications were made to high-income countries; with the United States of America being the world's largest recipient of applications followed by Peru, Germany, France, and Spain (UNHCR, 2019b).

In 2016, Europe confronted the largest single inflow of AS&R since World War II with individuals chiefly coming from Syria and other Middle Eastern countries (UNHCR, 2016). Oscillations in public opinion and government policies meant that many national border agencies attempted to stop and/or divert the influx of asylum-seeking people. This highlighted the lack of preparedness of countries to deal with a humanitarian crisis of this scale (UNHCR, 2016). Overarching measures implemented by the European Commission aimed at managing and responding to the humanitarian crisis included deterring the arrival of forcibly displaced people to the EU's external borders and approaches to responsibility sharing through

[1] The 1951 Refugee Convention is the key legal document that forms the basis of the work of the UNHCR. It defines the term 'refugee' and outlines the rights of the displaced, as well as the legal obligations of States to protect them and it is ratified by 145 State parties.

resettlement programs, policies of externalization (i.e. the EU-Turkey statement[2]). Furthermore, there was an additional introduction of trust funds to prevent forcibly displaced peoples' departure from their home and transit countries, and clarifications and adjustments were made with regards to who has a right to seek asylum through the introduction of new safe origin countries, defined as countries which are safe and therefore generally do not produce refugees (Niemann & Zaun, 2018). Individual governments also took different approaches to deter forcibly displaced persons, with some countries opening their doors (i.e. Germany) and others (i.e. Denmark) passing stricter laws to reduce numbers of displaced people arriving to settle down there (Tange, 2016). Even countries with low levels of migration such as Hungary launched a campaign to reduce the settlement of refugees which included moving refugee flows to the neighboring country, Slovenia (Trauner, 2016).

Public Perceptions and National Policies

Government policies ultimately set the context in which public attitudes towards migration are formed, including immigration, asylum, integration, economic and social policies (Dempster & Hargrave, 2017). As a result of restrictive policies, citizens of Western countries do not always perceive AS&R with compassion. Migration is rarely absent from the news and arouses political, social cultural and emotional responses that range from compassion to hostility, and racism. There is a pervasive rhetoric used across the EU of exclusion and fear of foreigners, combined with political demands for increasing border control on the international movement of people, especially of forcibly displaced groups (Bracey & Darius, 2020; Huysmans & Buonfino, 2008). Public perceptions often reflect a trade-off between the wellbeing of those who have fled their country and the wellbeing of citizens of the host country (Fakih & Marrouch, 2015; UN Secretary General, 2016). Consequently, the combination of beliefs that only a limited number of individuals are deserving of refuge, economic worries, and the need from governments to ensure voters that migration flows are under control, continues to feed into stricter refugee policies to deter, control and manage asylum flows (Stewart & Mulvey, 2013).

[2] The EU-Turkey Statement was agreed on the 18th of March, 2016 and sought to put an end to irregular migration from Turkey into the EU, improve living conditions for Syrian refugees in Turkey and open up organised, safe and legal channels to Europe for them.

According to a Standard Eurobarometer survey conducted in 2016, 39% of respondents considered immigration to be the most important issue facing the EU (Eurobarometer, 2018). A second poll on immigration and refugees conducted by IPSOS MORI across 22 countries worldwide found that almost 40% of respondents agreed with the closing of their borders to refugees. These views were particularly salient in the United States of America (54%), Italy (52%) and France (52%) (IPSOS MORI, 2016a). Perhaps these views are partially motivated by concerns around numbers of AS&R arriving; an EU survey conducted in 2017 across 28 members states highlighted that individuals overestimated the numbers of immigrants (regular and irregular) in their country, with a majority of respondents overestimating more than double the number of actual immigrants (European Commission, 2018). This was also found in a review conducted by Crawley and Macmahon (2016) which showed that people in the UK estimated 24% of the population to be immigrants, when in reality it is around 13%. Similarly, in both Germany and Sweden people believe that migrants make up nearly a quarter, whereas the real figures are 13% and 16% respectively (Crawley & Macmahon, 2016).

Other polls looking at public perceptions towards refugees across different countries specifically highlighted that 61% of respondents believe that terrorists pretend to be refugees to enter host countries and cause violence, and 51% stated that refugees come for economic reasons and as welfare tourists rather than being genuine refugees (N= 16,040; IPSOS MORI, 2016a). Furthermore, a Pew Research Center poll conducted across 10 EU countries, revealed that half or more of participants in five of the countries (Hungary, Italy, Poland, Greece and Spain) consider refugees to be a burden to host countries because they take jobs and access social benefits (N=500; Wike et al., 2016). This climate demonstrates strong negative perceptions towards AS&R groups, which incites discrimination and prejudice towards AS&R in various sphere of life, such as education, employment, healthcare, and housing (Murray & Marx, 2013; Riek et al., 2006; UNHCR, 2016).

Policy Impact on Mental Health and Integration

Public attitudes and restrictive policies applied to AS&R by host countries are crucial to the mental health of this population (Ellis et al., 2008; Mölsa et al., 2016; Silove, Ventevogel & Rees, 2017). Over the last two decades there has been an increase in epidemiological studies looking at AS&R mental health, and as a result multiple comprehensive systematic reviews have been carried out. One of the most frequently cited reviews was conducted in 2005 by Fazel and colleagues which found refugees to have high levels of comorbidity. The authors

reported the rates of post-traumatic stress disorder (PTSD) to be on average ten times more likely than for age-matched general populations (Fazel et al., 2005). Findings revealed multiple factors to be associated with poorer mental health outcomes, including demographic characteristics such as older age, being female, education; and post-migration stressors such as restricted economic opportunities, living in an institution, and continuing conflict in their country of origin. More recent reviews have reported similar findings. Steel et al. (2009) found both PTSD and depression rates to be around 31% in AS&R groups. Experiences of torture was the strongest predictor of PTSD, and for depression significant predictors included number of potentially traumatic events, time since conflict, reported torture, and residency status. A further review conducted by Priebe et al. (2016) found that the rates of depression and anxiety were similar to host populations, however rates of PTSD were higher in AS&R groups. They also reported socioeconomic conditions post-migration to be associated with increased rates of depression five years post-resettlement and brought to light the significant barriers to accessing mental health care for AS&R groups (Priebe et al., 2016). These reviews highlight large heterogeneity in findings between studies and reviews. However, despite this heterogeneity in findings, prevalence rates of PTSD still exceed the estimated 1.1% reported in non-displaced populations that participate in the WHO World Mental Health Surveys (Karam et al., 2014).

The research conducted to date has served to highlight the impact not only of pre-migration and during migration stressors, but also of post-migration stressors on mental health outcomes (i.e. Cleveland et al., 2013; Steel et al., 2002; Momartin et al., 2003; Steel et al., 2006; Schweitzer et al., 2006; Priebe et al., 2016). Restrictive policies, prolonged detention, uncertain legal status, limited access to services, reduced socio-economic opportunities, discrimination, and other post-migration stressors have been found to aggravate the effect of past traumas and can exacerbate symptoms of PTSD and depression (i.e. Steel et al., 2006, 2009; Reesp, 2003; Li et al., 2016; Fazel & Silove, 2006). Simultaneously, the UNHCR recognizes that although in high-income countries national health services are often available, they are not necessarily accessible or adapted to the needs of this particular group (UNHCR, 2021). These findings are consistent with ecological models of health in demonstrating the impact that the social environment post-resettlement exerts on the mental health and wellbeing of refugees (Silove et al., 2017), and highlight the need for further research into ways of supporting the mental health and psychosocial wellbeing of forcibly displaced populations.

Ultimately, confining AS&Rs to the margins of society denies them their human potential, and results in economic strain and social tension (UNHCR, 2016). The better approach is the inclusion of AS&R populations in all spheres of social, cultural, and economic life, as this

promotes social cohesion and allows them to make a positive contribution to the receiving countries (UNHCR, 2016). Work by social psychologists has built on the concept of integration as being the outcome of a process, arguing that over time migrant groups *and* host societies develop, change, and form new identities (Berry, 1997). Specifically, according to Berry (1997), integration is a form of acculturation which takes place when a person aims to both maintain their original culture whilst at the same time seeks to participate as an integral part of the larger social network, in this case in the host society. Berry highlights the central role of social networks in order to successfully integrate. Alternative forms of acculturation which may occur are *assimilation*, where migrant groups do not want to maintain their own cultural identity but do interact with the host culture; *separation*, when individuals hold on to their own culture but avoid interacting with the host community; and *marginalization* where individuals have no interest in maintaining their own culture, or in interacting with the host culture, therefore becoming excluded from society (Berry, 1997). These different forms of acculturation may be chosen, or imposed, if for example due to discrimination or harmful policies migrants are prevented from forming wider social networks (Berry, 1997).

Whilst a lot of research attention thus far has been allocated to pathology and negative mental health outcomes related to post-migration stressors and anti-integrative environments for AS&R groups, less research has focused on positive outcomes including protective factors of mental health, wellbeing, and quality of life (QoL) in these populations (van der Boor et al., 2020a). There has been a call within the research literature for further research on protective factors for mental health and indicators of QoL in AS&R groups (Giacco, 2020). Additionally, the UNHCR has called for the need to prioritize providing humanitarian assistance in ways that support the mental health and psychosocial wellbeing of refugees, asylum seekers, and other persons of concern (UNHCR, 2021). Specifically, they emphasize that attention must be paid to; (i) providing security, and access to basic needs and essential services (such as access to health care), (ii) using participatory approaches to plan, implement and monitor programs, (iii) taking into account age, gender and diversity, and (iii) using clear and two- communication systems with communities themselves, in order to support mental health and psychosocial wellbeing (UNHCR, 2021).

Capability Approach

The Capability Approach (CA) has emerged as a normative framework for social justice developed by Amartya Sen, which offers a broader informational space to measure, compare

and conceptualize wellbeing. This approach draws on a liberal philosophical framework which emphasizes the importance of the individual in terms of what they are able 'to do and to be', and to lead the kind of life that they value. The approach has commonly been referred to as an alternative to measurements of wellbeing based on income or social primary goods (Brighthouse & Robeyns, 2010).

Sen advocates that people's wellbeing and societal welfare should be assessed based on the notions of '*capabilities*' and '*functionings*' (Sen, 1985a, 1987). Capabilities are described as the real opportunities people have to live the kind of life that they have reason to value and demonstrates the ability of individuals to achieve meaningful outcomes for themselves and their families (Sen, 1999). Whereas functionings describe individual's aspects of achieved outcomes; what people choose to be and to do. These functionings can include 'being happy', but also many other intrinsic values such as being nourished, avoiding premature mortality, or being healthy (i.e., Kuklys, 2005). The CA has "resituated human beings, and their wellbeing as the end concerns of economic and social processes… founded on the intrinsic dignity of human freedom and people's ability to be subjects of their own lives" (Deneulin & McGregor, 2010, p.514).

The CA has had a significant and wide impact on public policy. It has contributed to the creation of the United Nations Human Development Index (Anand & Sen, 1995), the annual United Nations human development reports, and the World Bank project 'Voices of the Poor' (Narayan, 2000; Narayan et al., 2000). Furthermore, it influenced the UK government's national wellbeing program in 2011, and in France it prompted the development of the Commission on the Measurement of Economic Performance and Social Progress (Stiglitz & Sen, 2008). Based on this commission, the OECD developed the Better Life Index (2011) which is used to measure national wellbeing across member countries (OECD, 2013).

However, with a few exceptions (Avllsup, 2014; Josefsson, 2016; Risse, 2009), it has not been applied to understanding the experience of those involved in global migration, and even less in the context of forced migration despite it being highly relevant. Structural conditions shape capabilities and their exercise, therefore securing capabilities for individuals will require involvement from the state to provide political, economic, and material resources necessary to fully realise these capabilities (Briones, 2011; de Haas, 2014). As Doná (2002) asserted in relation to AS&R; "resettlement policies have an impact on how refugees adapt to host countries, how they are perceived by mainstream society and what opportunities they are given after their arrival in Europe" (p.45). As such, institutionalized social disintegration through policies of isolated accommodation, temporary refugee status, long-term reliance on welfare

systems and the lack of real long-term opportunities for social integration and meaningful occupation, will most likely result in a state where "individuals are unable to do what is necessary and meaningful in their live due to external restrictions" (Whiteford, 2000, p.200). These restrictions then limit their access to valuable functionings, capabilities, and freedoms that allow them to live a life that is valuable to them.

The CA has the potential to fill a theoretical gap in questions of AS&R mental health and wellbeing in the context of resettlement in high-income countries. This research takes Sen's conceptual framework of the CA as the foundation for developing an understanding of the barriers and facilitators to optimal mental health and wellbeing in AS&R groups post-resettlement.

Research aims and objectives

The primary aim of this research is to understand the barriers and facilitators to optimal mental health and wellbeing in AS&R populations post-resettlement, using a qualitative and quantitative mixed-methods approach.

In order to achieve this primary aim, this project sought to meet the following specific objectives:

i. **What are the known barriers that can limit access to mental health services in AS&R populations in high-income countries**? To answer this question a systematic review of existing literature will be presented that identifies barriers to accessing and negotiating mental health services for AS&R.

ii. **What are the known factors that can limit or enhance the quality of life of AS&R populations post-resettlement**? To answer this question a systematic review of existing literature will be presented that identifies factors associated with QoL in AS&R.

iii. **What are the community perceptions on capability-based wellbeing for different migrant groups in the UK?** To answer this question a quantitative empirical research project was conducted looking at the community perspectives on levels of capability-based wellbeing, what constitutes a 'good life', and discrimination for different migrant groups in the UK.

iv. **What constitutes a 'good life' for female refugees post-resettlement in the UK?**

To answer this question a qualitative focus group project was conducted with refugee women in the UK using a CA framework to understand what a 'good life' means to them.

v. **Is the 'Good Life in the Community Scale' (GLiCS), an outcome measure developed throughout this thesis, valid and reliable in assessing the mental health and wellbeing of migrant women in high-income countries?** To answer this question a quantitative empirical research project was carried out to develop the GLiCS measure and report on the preliminary assessment of the validity and reliability thereof using a pilot sample of migrant women.

Structure of the thesis

This thesis is composed of two literature reviews, three paper-style chapters which include chapter-specific literature reviews, a description of the methodology, results, and a discussion, and two bridging chapters. The thesis includes an overall final discussion which draws together and reflects on the findings of the thesis and concludes with a brief summary on recommendations.

In *Chapter 2* an outline is provided on what mental health relates to, together with a discussion on the need for a wider understanding of factors that may impact on the mental health and wellbeing of AS&R populations, including socio-cultural, political, and environmental factors in order to help advance the promotion of wellbeing outside of formal health services.

Chapter 3 provides an overview of barriers to accessing and negotiating mental health services in high-income countries through a systematic review of the literature. The Candidacy Framework (Dixon-Woods et al., 2006) is used to synthesize the qualitative findings.

Chapter 4 provides an overview of the literature on factors associated with QoL of AS&R in high-income countries. Specifically, this review synthesizes the literature on known factors which are associated with QoL in these populations and identifies the methodological strengths and weaknesses of the existing body of research.

Chapter 5 introduces the acculturation model (Berry, 1997) as a theoretical model to understanding mental health and wellbeing of AS&R populations. Furthermore, limitations of the model are discussed, and the CA (Sen, 1999) is proposed as an alternative model to inform

the evaluation and assessment of the mental health outcomes, wellbeing and quality of life of migrant communities post-migration.

Chapter 6 uses quantitative measures to explore community perspectives on wellbeing and what constitutes a 'good life' for refugees, economic migrants, and native citizens in the UK. The theoretical framework of the CA is used to analyze the cross-sectional data via an online survey.

Chapter 7 describes the use of qualitative methods to select the dimensions of mental health and wellbeing that are important for refugee women to live a 'good life' in the UK. The list of dimensions is derived through a series of focus group discussions analysed using an interpretative phenomenological analysis.

Chapter 8 describes the development and preliminary validation of the capabilities-based wellbeing measure for migrant women, through focus group discussions and a pilot study conducted on a representative sample across the UK, Northern Ireland, and New Zealand. An exploratory factor analysis will be carried out. Furthermore, internal consistency, convergent, and incremental validity checks will be conducted.

Chapter 9 presents a summary of the main findings and discusses limitations of the research overall. Furthermore, it proposes an agenda for future research and recommendations for policy and practice are discussed.

Chapter 2: Overview of mental health and wellbeing

2.1. Background

The potentially long-lasting effects of conflict on the mental health of AS&R has been extensively documented and poses a challenge for mental health services in countries of resettlement (Priebe et al., 2016). AS&R groups are exposed to risk factors for mental disorders before, during and after migration (Priebe et al., 2016). The prevalence rates of psychotic, mood, and substance use disorders are variable in the literature and are suggested to be similar to those in host populations (Priebe et al., 2016). However, rates of post-traumatic stress disorder (PTSD), depression and anxiety are reported to be higher (Lindert et al., 2009; Turrini et al., 2017; Uphoff et al., 2020). This is particularly the case in longitudinal studies; a systematic literature review conducted by Bogic et al. (2015) found that five years after resettlement, the rates of depression, anxiety and PTSD were higher in refugee populations as compared to host populations. Long-term studies suggest that the increase in mental disorders over time may be linked to post-migration stressors, particularly poor socioeconomic status, social isolation, and unemployment (Bogic et al., 2012, 2015; Priebe et al., 2016). Indeed, multiple studies have found post-migration stressors to have a negative impact on the mental health and wellbeing of AS&R groups, specifically prolonged detention, poverty, uncertainty regarding asylum outcomes, discrimination, violence, and disrupted social and cultural networks (Herrman, 2019; Li et al., 2016; Lund et al., 2018; Porter & Haslam, 2005; Miller & Rasmussen, 2010; Silove, 2012; Steel et al., 2009).

Despite the evidence for the mental health needs for AS&R populations, studies in several high-income countries suggest that these populations are less likely to access mental health services than their native counterparts, even when their experience of distress is equivalent or higher to host populations (DeShaw, 2006; Dyhr et al., 2007; Sandvik et al., 2012). There are concerns regarding the extent to which health services in host countries are indeed accessible and appropriate to address the needs of AS&R groups (Crosby et al., 2013; van der Boor et al., 2019). Given that the number of AS&Rs seeking refuge in high-income countries is increasing, the challenges and demands to healthcare systems is substantial both in terms of capacity to respond to increasing demands, and for the prevention of mental disorders on a societal level.

Simultaneously, research suggests that sociocultural factors also play an important role in mental health. Post-migration stressors can constitute a risk factor for mental illness, whilst on the other hand education, employment, and family welfare have been noted to have the

potential to reduce the burden of mental disorders amongst refugees by addressing upstream social determinants (Lund et al., 2018). These findings suggest that mental illnesses and mental health are strongly socially determined, therefore the promotion of mental health is unlikely to be successful by improved access to mental health services alone (Blas & Kurup, 2010; WHO, 2014; White & van der Boor, 2021). Rather a wider focus needs to be used that includes social, cultural, political, and environmental factors that may impact on the mental health and wellbeing of AS&R groups.

2.2. Explanatory models of illness

Perceptions of physical and mental wellbeing differ substantially across and within societies. The causal attributions of a specific episode of illness that are held by individual patients and practitioners are referred to as explanatory models of illness (Kleinman, 1980). Explanatory models of illness are predominantly culturally shaped and project personal and social meaning and understanding on the illness experience (Kleinman, 1980). The need for health services to pay attention to individual's explanatory models is reflected in research that shows that understandings of illness can affect coping (De Vaus et al., 2018), treatment preferences (Saravanan et al., 2007), compliance with treatment (Cooper et al., 2003), therapeutic relationships (McCabe & Priebe, 2004), willingness to access health services (i.e. Sandvik et al., 2012), and lifestyle changes required to manage the disease, amongst others (Petrie & Weinman, 2006; Hagmayer & Engelmann, 2014).

Several studies conducted by anthropologists and cross-cultural psychiatrists have explored conceptual models of symptoms of distress in different cultural contexts. For example, a review conducted by Patel et al. (1995) in Sub-Saharan Africa found that whilst psychotic illness was often recognized as 'madness', the conceptual models of neurotic illness differed from Western models, as they were often somatically defined and may not be considered as mental illness at all. Furthermore, they found that behavioral and somatic symptoms were much more emphasized than cognitive features (Patel et al., 1995). A more recent example is a study conducted by Karasz (2005) in which conceptual models of depression were compared between South Asian migrants and European Americans in the US. Findings highlighted that the South Asian sample largely identified depression in social and moral terms, whereas the European American samples' descriptions were more biology focused and described in terms of situational stress. These findings highlight that conceptual models of illness reflect people's cultural realities; therefore, consideration needs to be given to individual sociocultural realities in order to respond to peoples' illness and health needs.

In the case of AS&Rs, their mental health and wellbeing is increasingly being understood as an outgrowth of not only trauma but also the significant post-resettlement challenges including acculturative stress, social isolation, discrimination, and structural resettlement stressors (Ellis, 2019). Qualitative research into cross-cultural understandings of distress in AS&R groups highlight this combination of risk factors and stressors. For example, a study conducted with Vietnamese and East Timorese refugees found that participants described their distress as being embedded in pre-migration experiences, traumatic escapes and dislocation and alienation post-resettlement (Kokanovic et al., 2010). Another study exploring lay understandings of distress in Ethiopian and Somali refugee communities in Australia found that depression was often understood as an affliction that was collectively derived and experienced. Somali refugee communities in New Zealand described stressors such as issues with family reunification as a direct cause of mental illness, rather than war-related trauma (Guerin et al., 2004). Southeast Asian refugees in the USA described children's misbehavior and a lack of proficiency in the English language as causes of depression (Lee et al., 2010). Furthermore, Somali refugees' mistrust of the biomedical health sector in terms of confidence and expectations with regards to care, was reported in qualitative studies in both Sweden (Svenberg et al., 2011) and the USA (Scuglik et al., 2007). These studies represent a few examples which bring to the forefront the complexities of providing adequate care to AS&R groups that ensures their needs are met. Importantly, findings reveal that needs are not additive, rather they are very much interrelated and act across the different levels of AS&R socioecological environment. Researchers have called for the need to investigate appropriate assessment tools and interventions that incorporate and respond to these different needs AS&R groups may face (Ellis, 2019). Specifically, an overemphasis on examining pathology, mental illness, and distress, is a missed opportunity to understand the full picture, including the range of mental health outcomes experienced during resettlement. Research on adaptive, resilient, and positive outcomes will facilitate understanding on protective processes for mental health and wellbeing in AS&R populations.

The WHO defines health as; "a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity" (WHO, 2013). This definition recognizes mental health as being an integral component of health, including the understanding that the absence of mental illness falls short as a criterion to study mental health; rather high levels of wellbeing and an understanding of positive predictors of mental health are necessary as well (Keyes, 2002). To date, little research has focused on understanding the determinants, predictors, and adequate assessment methods of positive mental health outcomes in AS&R

populations. At the same time, recent systematic reviews clearly identify the comparative lack of intervention studies for AS&R populations measuring wellbeing and quality of life in both high-income and low and middle-income countries (Bosqui & Marshoud, 2018; Turrini et al. 2019). These reviews also highlight predominantly poor quality of evidence focused on understanding these concepts in AS&R populations.

As countries continue to resettle AS&Rs from areas of social and political unrest and/or violence, more research is needed to help understand trajectories and predictors of positive adaptation following resettlement outside of formal health services. Specifically, research that examines what biological, social, cultural, and psychological factors are associated with positive outcomes that can help increase the quality of life of AS&R groups following trauma and adversity is required. Increased understanding of such factors will help advance interventions and programs that promote wellbeing and successful integration amongst those that are struggling with mental illness and other adaptation challenges.

In order to address these concerns, a first systematic literature review is conducted in Chapter 3, which aims to understand the barriers AS&R populations face to accessing and negotiating formal mental healthcare services post-resettlement in high-income countries.

Published Chapter

1. Stage of Publication

   The paper presented in Chapter 3 has been published in a peer-reviewed journal. This chapter is presented as the authors' accepted for publication version of the paper.

2. Research paper title

   Barriers to Accessing and Negotiating Mental Health Services in Asylum Seeking and Refugee Populations: The Application of the Candidacy Framework

3. Peer-reviewed journal

   Journal of Immigrant and Minority Health

   DOI: https://doi.org/10.1007/s10903-019-00929-y

4. Citation

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5. Candidates' specific contribution

   The substantive contribution of Catharina van der Boor has been the conception and design of the research, conducting the literature review, carrying out the analysis and interpretation of the findings, writing the paper and doing critical revision.

6. Co-author declarations

   I give permission to Catharina van der Boor for including this research paper in her doctoral thesis.

   Name: Dr. Ross White

   

   Date: 23rd August 2021

Chapter 3: Systematic Review on barriers to accessing and negotiating mental health services in asylum seeking and refugee populations: The application of the Candidacy framework

3.1. Introduction

Asylum Seekers, Refugees and Mental Health

Increasing numbers of people are leaving their homelands because of human rights violations, persecution and conflict. By June 2018, there were an estimated 68.5 million forcibly displaced individuals worldwide of whom 3.1 million were classified as asylum seekers, and 25.4 million as refugees (UNHCR, 2019). The arrival of such high numbers of asylum seekers and refugees (AS&R) places substantial pressures on host countries and their services, including mental health (MH) care systems (Bradby et a., 2015; De Vito et al., 2015).

AS&R can be subject to pronounced stressors and adverse conditions pre-migration, during migration and/or post-migration (i.e. (IOM, 2013; Priebe, Giacco & El-Nagib, 2016; Ryan, Dooley & Benson, 2008). In light of potential exposure to these stressors, it is perhaps unsurprising that AS&R show higher rates of post traumatic stress disorder (PTSD) than host populations (Priebe et al., 2016; Bogic, Njoku & Priebe, 2015; Turrini et al., 2017). Indeed, PTSD rates have been noted to be almost 10 times more frequent in AS&Rs than in age-matched host populations (Fazel, Wheeler & Danesh, 2005). The literature shows there is high variability in the studied prevalence rates of mental disorders in AS&R populations, compared to host populations. Bogic et al. (2015) also found that refugee samples are likely to have high prevalence rates of depression, which often exceed those reported by samples in host nations. However, a review conducted by Priebe et al. (2016) concluded that the rates of mood, psychotic, and substance-use disorders found in AS&Rs groups are within the range of the rates present in host groups. Although the evidence base for prevalence rates varies, the literature shows that the exposure to adverse events can have a negative impact on the MH of AS&R. Given the high absolute numbers of AS&Rs moving across borders, this can constitute a significant challenge to healthcare systems in receiving countries.

The Candidacy Framework: 'Accessing' vs. 'Negotiating' Care

Research suggests that despite this increased vulnerability, there is often an underrepresentation of AS&Rs in the health care (HC) services (Derr, 2015; Thomson et al., 2015). Identified challenges to accessing services include social, linguistic, economic, clinical severity, and cultural differences in symptom presentation, as well as systemic discrimination (Derr, 2015; Kirmayer et al., 2007; Varvin & Aasland, 2009). There is also evidence that legal entitlement; formal access to care regulations and the migration process inhibit access in various high-income countries (De Vito et al., 2015). All individuals have a fundamental legal right to health and to access HC, which is represented both in international and European instruments, such as the European Charter of Fundamental Rights (Rechel et al, 2013). However, depending on migration status, migrants may have limited entitlements to HC due to national laws and policies (European Union Agency for Fundamental Rights, 2013). For example, the structure of health systems, which is determined by national policies, can determine the availability of services, the need for HC insurance and the extent of HC coverage, amongst others, which can all impact on the ability to access HC in subgroups of migrants (Wendt, 2009).

The candidacy framework (CF) was initially developed as a counter to existing ideas of 'access' that draw on data about service utilisation (e.g., number of consultations), but which often fail to capture the complex processes involved in navigating care and fails to account for those who do not seek or are refused services. Dixon-Woods and colleagues summarize *candidacy* as the ways in which eligibility for medical help and intervention is negotiated between individuals and HC services (Dixon-Woods et al., 2006). Candidacy can be understood as a dynamic and contingent process which is constantly defined and redefined through interactions between the individual and professionals. Therefore, people's previous interactions and experiences with HC services and professionals can also shape an individual's candidacy (Dixon-Woods et al., 2006). As such, an individual's identification of their 'candidacy' for accessing and negotiating HC services can be culturally, structurally and professionally constructed (Dixon-Woods et al., 2005a). This framework provides a means to explore these negotiations and how they can act as barriers to care (Dixon-Woods et al., 2006). The CF proposes seven overlapping stages two of which address immediate access (stage 1 and stage 2) and five which address negotiation (see Table 1).

Table 1. The seven stages of candidacy (Dixon-Woods et al., 2006)

Stages of Candidacy	**Description of Stages**	**Examples**
1. Identification of candidacy by the individual	Process through which individuals decide that they have a particular need and that assistance may be required.	Individuals' recognition of MH symptoms.
2. Navigation	Knowing how to make contact with appropriate services in relation to identified candidacy.	Being allowed time off work for appointments.
3. Permeability of services	Ease with which people can use services. Includes the level of explicit and implicit gate-keeping within a service and the complexity of its referral systems; in addition, it refers to the 'cultural alignment' between users and services.	Provision of translational services.
4. Appearing at services and asserting candidacy	The work that individuals must do to assert their candidacy in an interaction with a HC professional.	The service user feels taken seriously' – 'acknowledged' and/or 'understood'
5. Adjudications by professional	Refers to the judgments and decisions made by professionals which allow or inhibit continued progression of candidacy.	Being referred on to mental health services
6. Offers of, and resistance to, specific services	Emphasizes that follow-up services may be appropriately or inappropriately offered and that these may or may not be acted upon by service-users.	Refusal of offer of medication.

7. Operating conditions and local production of candidacy	Incorporates factors that influence decisions about subsequent service provision (i.e. the resources available for addressing candidacy) and the kinds of contingent relationships that develop between professionals and service-users over a number of encounters.	Adapting the frequency of consultations to the individual's needs.

The CF has thus far mainly been applied in populations whose entitlement to care is relatively stable and comprehensive. Mackenzie et al. have called for the exploration of candidacy in contexts where vulnerable individuals may be subject to compromised services (i.e. lack of citizenship or stigma) (Mackenzie et al., 2013). To date, only one study has specifically applied the CF to understanding the help-seeking trajectory of asylum seekers (Chase et al., 2017). The study found that asylum seekers' precarious migratory status constrained their candidacy for obtaining HC. Barriers included having misinformation about HC coverage, tiresome administrative procedures specific to asylum seekers, and long waiting times. The findings showed that migratory status and feelings of marginalization and insecurity that come from their migrant status, appeared to amplify the effects of the barriers to care and even minor difficulties to access could have dramatic effects on future help-seeking behavior (Chase et al., 2017).

The current review uses the CF to synthesize qualitative research findings investigating barriers to accessing and negotiating MH services for AS&Rs in high-income countries (HIC). The structure and delivery of HC services (including MH services) in HIC are comparatively well resourced and formalized. As such, the exclusive focus on including studies undertaken in HIC in the current review allowed for a fuller examination of barriers and facilitators relating to accessing and negotiating services than including studies conducted in low- and middle-income countries, where services may be non-existent, would have permitted. With HIC-based HC services and providers seeing increasing numbers of AS&R groups (WHO, 2017; Ledoux et al., 2018), there is also need for a more detailed understanding of the barriers to accessing specialist services in HICs. This review is the first to focus specifically on barriers to MH services for AS&R populations by using a CF. The findings of this review can be used to inform the design and delivery of forms of MH support for this underserved population in HIC of resettlement.

3.2. Methods

Search Strategy

The PsychINFO, Medline, Web of Science, SocINDEX and Embase databases were searched up to December 2018. Each search contained three segments; (1) asylum seekers, refugees and displaced persons, (2) MH services and MH problems and (3) candidacy, see "Appendix A" for an example of the full search strategy for the PsycINFO database. The search strategy used was adjusted to each database using the Kings College London library guide (Kings College London, 2019). Additionally, *reference chaining* was completed—a process by which academic papers that have cited an included study are electronically identified and screened for potential inclusion and the reference list of each included study are also searched for studies that could meet eligibility criteria for inclusion.

Screening and Selection

Two researchers (CB and FR) independently screened the titles and abstracts of all the articles, and the full texts of potentially relevant papers. This gave a moderate inter-rater reliability ($\kappa = 0.42$) (Landis & Koch, 1977). Discrepancies were discussed with CM and RW. All qualitative peer-reviewed publications in English exploring barriers faced by adult AS&Rs, or displaced persons to accessing MH services, mental HC delivery, or help-seeking behaviors in HIC were included. Displaced persons were included to ensure all forms of forced displacement were taken into account, including irregular migrants, provided the displacement took place in or to HIC. Books, chapters, dissertations, literature reviews, and theoretical texts were excluded. Articles focusing on individuals under the age of 18 years were also excluded. Studies were also excluded if they did not elicit primary data from participants.

Assessing Study Quality and Data Extraction

Each paper was individually assessed for quality by author CB using the Critical Appraisal Skills Program (CASP) tool for qualitative studies (Critical Appraisal Skills Programme, 2013). A data extraction form was used to summarize bibliographic information, study design, key findings, and limitations. The seven stages of the CF were included in the data extraction process to highlight which study addressed which stage. Author CB read each paper and conducted the data extraction, which was monitored by CM.

Data Synthesis

A two-stage *critical interpretive synthesis* (CIS) (Dixon-Woods et al., 2005b; Dixon-Woods et al, 2006) approach was used. In stage one '*First order* constructs (i.e. direct quotes used in the papers) and *second order* constructs (i.e. researchers' interpretations based on existing theories) were identified and merged across studies. This was done by initially extracting all the direct quotes which addressed the themes of accessing and/or negotiating HC from each paper. For example, a first order construct found in a paper published by Teunissen et al. (2014) was the quote: "*Yeah but we didn't knew that you can go to a GP with depression*" (p. 8). The quotes were put in a table together with the second order constructs provided by the original authors of the study. In this case, Teunissen et al. (2014) interpreted the quote as demonstrating a lack of recognition and trust of the GP being a doctor who could treat mental illness. The first and second order constructs were compared and contrasted across the different studies through which third order constructs emerged. In this example, the third order construct was 'understanding a new system'. This process was undertaken by author CB and peer-reviewed by a second researcher (CM).

In stage 2, evidence from across the studies including first, second and third order constructs were integrated into the synthesizing argument, namely the seven stages of the CF. In this example, the first, second and third order constructs mapped onto stage 2 (Navigation). This was peer reviewed by researcher CM and author RW. Overall, a deductive qualitative approach was used.

3.3. Results

Of the 1.296 articles identified through the systematic search, 23 met the full inclusion criteria and were included. Article selection is summarized in Figure 1.

The 23 studies that met the inclusion criteria were conducted in 8 different high-income countries (USA = 3; UK = 4; Canada = 8; Denmark = 1; Switzerland = 1; Australia = 3; Netherlands = 2; New Zealand = 1). Across these studies, 548 participants (Mdn = 21, IQR = 26) were recruited with a representation of 60 different countries of origin. Of 60 participants the specific country was not reported. A summary of the demographic characteristics is shown in Table 2.

Figure 1. PRISMA flow diagram of the literature search

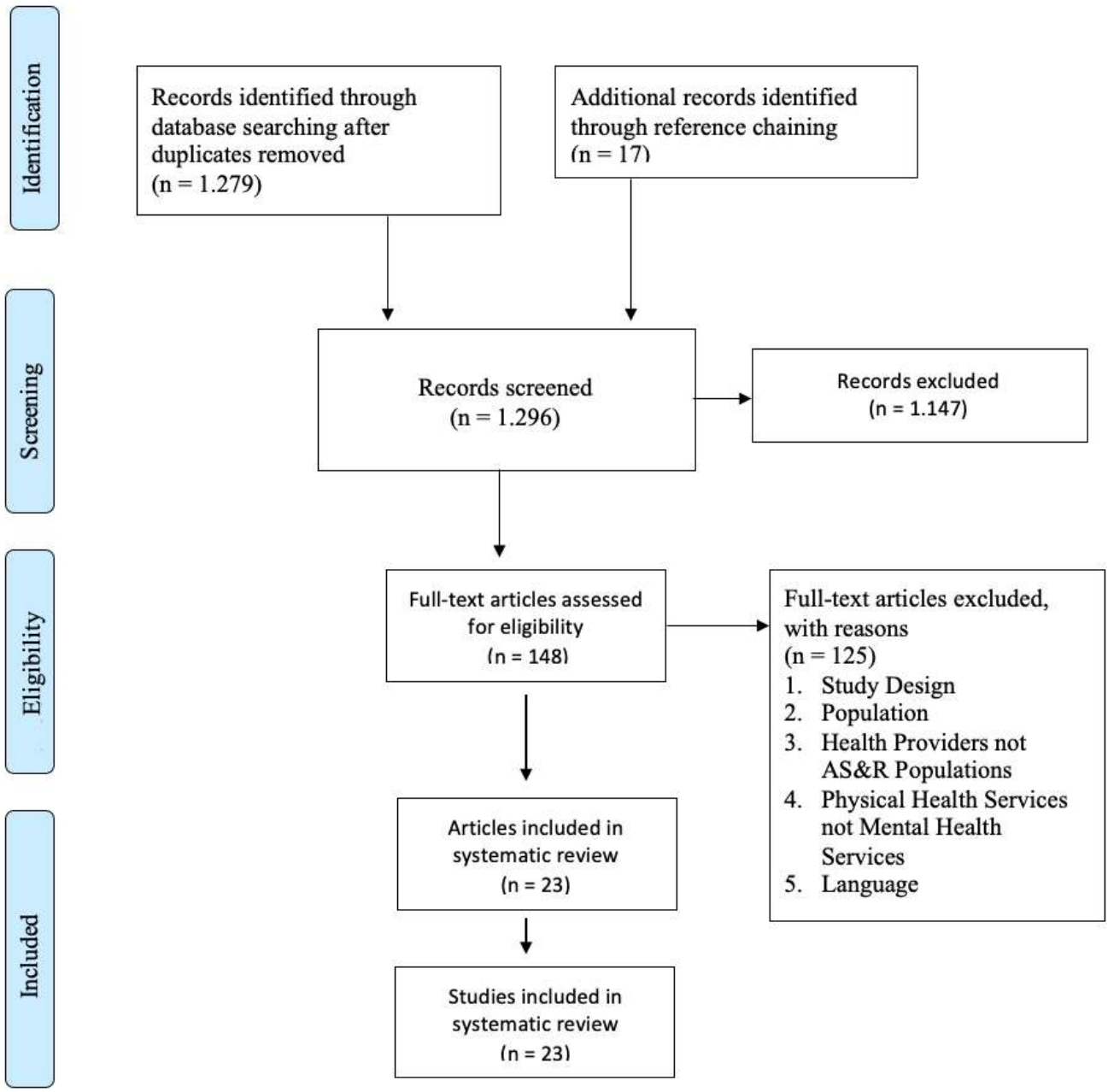

Table 2. Summary characteristics of studies included in the review

Study	Country Study Conducted	Participants	Recruitment	Type of Migrant	Country of Origin	Data Collection	Qualitative analysis
Ahmed et al. (2008)	Canada	10 Participants Age 20- 40 Gender: female	Purposive sampling	Refugees and asylum seekers	China (2), India (2), Pakistan (1), South America (3), Egypt (1), and Haiti (1).	Semi-structured interviews	Constant comparative method
Ahmed et al. (2017)	Canada	12 Participants Age 20-37	Purposive sampling	Refugees	Syria	Focus groups	Thematic content analysis
Asgary & Segar (2011)	United States of America	35 Participants Age > 40 years Gender: 30 male, 5 female	Purposive sampling	Asylum seekers	Cameroon (4), Chad (4), Guinea (4), Pakistan (3), Bangladesh (2), Congo (2), Kosovo (2), Senegal (2), Sierra Leone (2), Egypt (1), Eritrea (1), Ghana (1), India (1), Ivory Coast (1), Lebanon (1), Mali (1), Mauritania (1), Nepal (1), and Russia (1)	21 semi-structured interviews 5 focus groups	Comprehensive analysis, not specified further
Behnia (2003)	Canada	36 Participants Age 20-49 Gender: not specified	Purposive sampling	Refugees	Bosnia, Cambodia, El Salvador, Iran, and Somalia (numbers not specified)	Semi-structured interviews	Not specified

Campbell et al. (2014)	Canada	21 participants Average age 45.62 Gender: female	Purposive sampling	Refugees, Refugee claimants and undocumented migrants	Mexico (4), El Salvador (2), Colombia (3), Venezuela (4), Ecuador (2), Cuba (1), Dominican Republic (2), Costa Rica (2), South America (1)	Semi-structured interviews	Thematic content analysis
Chase et al. (2017)	Canada	25 participants Average age 36.7, minimum and maximum not provided Gender: 11 males, 13 females, one not specified	Purposive sampling	Asylum seekers	Sub-Saharan Africa (10), North Africa (3), the Middle East (3), South Asia (2), Southeast Asia (1), the Caribbean (5), and South America (1), individual countries not specified	Semi-structured interviews	Thematic content analysis
Djuretic et al. (2007)	United Kingdom	19 participants Age 20-69 years Gender: 7 male, 12 female	Purposive sampling	Refugees, asylum seekers	Croatia (3), Bosnia and Herzegovina (9), Serbia and Montenegro (4), Kosovo (1), Macedonia (1), Slovenia (1)	Focus groups	Thematic content analysis
Donnelly et al. (2011)	Canada	10 participants Age >18 years Gender: all female	Purposive sampling	Refugees	China (5), Sudan (5)	In-depth individual interviews	Framework analysis
Feldmann et al. (2007)	The Netherlands	36 participants Age 18-66	Purposive sampling and snowball sampling	Refugees	Afghanistan (36)	Semi-structured interviews	Comparative analysis

		Gender: 15 males, 21 females					
Jensen et al. (2014)	Denmark	5 participants[1] Age 26-50 years Gender: 3 males, 2 females	Purposive sampling	Refugees	Iran (1), Bosnia and Herzegovina (1), Iraq (2), Turkey (1)	Interviews	Thematic content analysis
Kahn et al (2018)[1]	Canada	7 participants Age 22-40	Purposive sampling	Forced migrants (legal status not specified)	Bahamas, Bangladesh, Iran, Lebanon, the Arabian Peninsula, and Ghana (numbers not specified).	In-depth interviews	Thematic content analysis
Leavey et al. (2007)	United Kingdom	9 participants Age 19-41 years Gender: 8 males, 1 female	Purposive sampling	Refugees and asylum seekers	Turkey (8), Cyprus (1)	In-depth interviews	Narrative analysis
Maier & Straub (2011)	Switzerland	13 participants Age 22-53 years Gender: 8 males, 5 females	Purposive sampling	Refugees and asylum seekers	Bosnia and Herzegovina (2), Kosovo (2),Turkey (Turkish) (1),Turkey (Kurdish) (1), Iran (Kurdish, (2), Afghanistan (2), Cameroon (1), Sudan (1), Chechnya (1)	Semi-structured interviews	Thematic content analysis
O'Mahony et al. (2012)	Canada	30 participants Age not specified Gender: females	Not specified	Immigrant (not specified) and refugees	Not specified	In-depth critical ethnographic interviews and field notes	Critical ethnography

Omar et al. (2017)	Australia	36 participants Age 18-60 Gender: males	Purposive sampling	Refugees	Somalia (17), Ethiopia (2), Djibouti (3), Eritrea (6), Saudi Arabia (5), Sudan (2), unknown (1)	Focus groups	Thematic content analysis
Palmer (2007)	United Kingdom	10 participants Age >18 years Gender: 7 males, 3 females	Snowball sampling	Refugees	Ethiopia (10)	In-depth semi-structured interviews	Thematic content analysis
Palmer & Ward (2007)	United Kingdom	21 participants Age 21-62 years Gender: 11 males, 10 females	Maximum variation sampling	Refugees and asylum seekers	Turkey (1), Bosnia and Herzegovina(1), Colombia (1), Democratic Republic of Congo (1), Ethiopia (3), Iran (3), Iraq (2), Kosovo (1), Russia (1), Rwanda (1), Somalia (5), Ukraine (1)	In-depth interviews	Thematic content analysis
Pavlish et al. (2010)	United States of America	57 participants Age 18-80 Gender: females	Purposive sampling	Refugees	Somalia (57)	Focus groups	Inductive coding
Piwowarczyk et al. (2014)	United States of America	48 participants Age 18-59 years Gender: all female	Convenience sample	Refugees and asylum seekers	Democratic Republic of Congo, Somalia (numbers not specified)	Focus groups	Grounded theory
Shrestha-Ranjit et al. (2017)	New Zealand	40 participants[1] Age 18-82 Gender: 8 males, 32 females	Not specified	Refugees	Bhutan (40)	Focus groups	Thematic content analysis
Russo et al. (2015)	Australia	38 participants	Purposive sampling	Refugees	Afghanistan (38)	In-depth interviews	Thematic content analysis

		Age > 18 years Gender: all female				and focus groups	
Teunissen et al. (2014)	The Netherlands	15 participants Age 21-73 years Gender: 9 males, 6 females	Purposive sampling	Undocumented migrants	Burundi (1), Dominican Republic (1), Egypt (1), Eritrea (1), Ghana (1), Morocco (1), Nepal (1), Nigeria (1), Philippines (2), Sierra Leone (1), Somalia (1), Surinam (1), Uganda (1), Zambia (1)	Interviews	Grounded theory
Valibhoy et al. (2017)	Australia	16 participants Age 18-25 years Gender not specified	Purposive sampling	Refugees	Iraq, Iran, Afghanistan, Sudan, Democratic Republic of Congo, Ethiopia, Tanzania, Ivory Coast, Pakistan (Numbers not specified)	In-depth individual interviews	Thematic content analysis

Note[1]: Only the answers of AS&R participants were included in this review

Table 3 provides an overview of which stage(s) of candidacy were addressed by each study. All studies addressed at least 2 stages, the *Identification of candidacy* (stage 1) was the most widely discussed by 20 studies and *Adjudications by Professionals* (stage 5) was the least commonly discussed, reported on by only 7 studies. Additional quotes to support the findings for each stage are included in Figure. 2.

Table 3. The stages of candidacy addressed by studies (N=23)

Article	Stage 1	Stage 2	Stage 3	Stage 4	Stage 5	Stage 6	Stage 7
Ahmed et al. (2008)	✓	✓		✓			✓
Ahmed et al. (2017)	✓	✓		✓			
Asgary & Segar (2011)	✓	✓	✓	✓			✓
Behnia (2003)	✓					✓	✓
Campbell et al. (2014)		✓	✓	✓		✓	✓
Chase et al. (2017)		✓	✓	✓	✓		
Djuretic et al. (2007)	✓	✓		✓	✓		
Donnelly et al. (2011)	✓	✓	✓	✓		✓	✓
Feldmann et al. (2007)				✓	✓	✓	✓
Jensen et al. (2014)	✓	✓			✓	✓	✓
Kahn et al. (2018)	✓	✓					✓
Leavey et al. (2007)	✓			✓		✓	
Maier & Straub (2011)	✓				✓	✓	✓
O'Mahony et al. (2012)	✓	✓				✓	✓
Omar et al. (2017)	✓	✓	✓				
Palmer (2007)	✓		✓				
Palmer & Ward (2007)	✓		✓	✓			✓
Pavlish et al. (2010)	✓		✓			✓	
Piwowarczyk et al. (2014)	✓					✓	
Shrestha-Ranjit et al. (2017)	✓		✓	✓	✓		
Russo et al. (2015)	✓	✓		✓			
Teunissen et al. (2015)	✓	✓	✓	✓		✓	
Valibhoy et al. (2017)	✓	✓		✓	✓	✓	✓

Stage 1= Identification of candidacy, Stage 2= Navigation, Stage 3= Permeability of services, Stage 4= Appearing at services and asserting candidacy, Stage 5= Adjudication by professionals, Stage 6= Offers of and resistance to specific services and Stage 7= Operating conditions and local production of candidacy

Identification of Candidacy

The identification of candidacy was dependent on two different third order constructs.

Identification of Symptoms as Medical

Different studies found that AS&Rs often did not seek medical help because they were not familiar with symptoms of mental illness, they did not consider the seriousness of their symptoms, or there was a cultural difference regarding the interpretation of symptoms. Traditional beliefs around symptoms being caused by supernatural forces such as cursing, witchcraft or evil spirits led many individuals to describe people with mental illness as deserving of their condition. Many studies also showed that individuals commonly believed the illness to be part of their destiny, therefore participants often relied on alternative forms of care and even described a lack of awareness of formal services to provide support.

"*Traditionally it is believed that diseases can be caused because of cursing, and by evil spirit and germs. The remedies are medicinal plants, praying, healers and taking tablets*." (Omar et al., 2017, p. 51)

Alternative forms of care were largely traditional practices, which were mentioned as a source of support and strength to deal with MH symptoms. These included healing through the church, herbal remedies, praying or going to ceremonies. Prayer was most commonly reported across studies as a valid coping method and a good alternative to formal care. Individuals mentioned prayer as bringing relief and calm, thus helping to cope with MH symptoms. Findings highlighted that traditional practices were mostly supported by older generations, with younger individuals at times preferring formal services in the country of resettlement. Family pressures influenced these decisions, as parents often pushed younger generations to use these practices despite the youngsters not believing in their effectiveness.

"*For our old generation, if someone is sick we quickly invite Sheikh to read Quran on him and I don't think that young people use Quran as a healing (...) as far as I know, some, their parents beg them to accept reading Quran on them...*" (Piwowarczyk et al., 2014, p. 384)

Other forms of care included relying on personal and easily accessible resources rather than seeking external help in dealing with stressful situations. Social networks from the country of origin were seen as a valid form of counselling, specifically accessing shared environments

that held a common language, culture, and history. One individual explained; "*Counsel in each other. Look to friends, family, religious leaders*" (Behnia, 2003, p. 212). These ideas mostly emerged amongst individuals who were not familiar with or distrusted the local HC system, with distrust often stemming from alternative ideas around the causation of illness and other barriers discussed in stage 2 (navigation). These findings highlight that although individuals may identify their candidacy; they are often choosing not to access formal services.

Social Barriers

Social barriers to identifying candidacy included stigma and privacy concerns surrounding MH. Stigma emerged both from the individuals themselves and from the environment and was often embedded in preconceived ideas of what individuals with mental illness are like. At times, the individuals appeared to internalize the stigma as shame, hindering the willingness to ask for help for fear of social stigma. The environment also discouraged individuals from seeking care particularly family pressures and gender hierarchy influenced whether entitlement and need for help was recognized or not. For example, at times male domination situated women in a socially vulnerable position, thereby hindering timely identification of candidacy. There were also worries around confidentiality, given that if services were accessed, confidentiality could not be ensured which may lead to further stigmatization from the community.

"I don't use mental health professional. In my culture going to a professional like a psychologist and psychiatrist is stigmatized. It is associated with mental health problem and craziness." (Asgary & Segar, 2011, p. 12)

Navigation

Using services was dependent on three different third order constructs.

Structural Barriers

Location of the medical center, inability to pay for transport, cancelling work for the appointment, and finding someone to look after the children, were all found to be structural barriers to navigating HC systems. Preoccupations with medical expenses interfered substantially with seeking care and choice of service, especially when host countries required medical insurance. Participants also felt that providers often did not understand their situation

in terms of economical options of paying for treatment and some voiced their mistrust of Western biomedicine altogether stating that providers are only after money.

"I just got this temporary job and my boss would not allow me to leave to see doctor" (Teunissen et al., 2014, p. 515)

Understanding a New System

The ability to navigate a new and unfamiliar system was mostly dominated by a lack of knowledge about the right to medical HC and where and how to attain it. There were notions that initially participants believed they were entitled to certain forms of HC but were unclear on the scope and duration of the coverage. AS&Rs who had arrived individually or did not speak the local language described it as a time-consuming process to understand routes to accessing primary care. Specifically, understanding the 'gatekeeper' role of primary care services. Furthermore, many AS&Rs reported not being familiar with the actual role of MH professionals, nor what symptoms could be treated. Participants addressed the need for information to be made available when arriving to the host country, specifically which services exist and what they charge.

"*Yeah but we didn't knew that you can go to a GP with depression, we didn't know that.*" (Palmer, 2007, p. 8)

Fear of Unknown Consequences

Fear of unknown consequences to accessing services was common. There was a pervasive fear of approaching authority of any kind and facing legal consequences. Personal safety was often chosen over health, especially with undocumented migrants. Preoccupation existed around health-care-related bills and fear regarding inability to pay and consequently being reported to authorities. Additionally, there was a fear that receiving a MH diagnosis would result in separation from family or children.

"I also had the fear that if I talked to someone that people will come and take my daughter from me because I thought I was going crazy." (Russo et al., 2015, p. 6)

Permeability of Services

Often influenced by the previously mentioned barriers, some individuals delayed seeking medical help until reaching a crisis point and thereby accessing urgent care. This was particularly the case for undocumented migrants. This delay was at times also influenced by previous experiences, where individuals described a substantial gap between initial refusals and further help-seeking behavior. Initial refusals influenced the permeability of services in that participants felt they were not taken seriously when reaching out for help. If past experiences were positive, individuals were more willing to establish their candidacy again.

'If I get sick I pop pills and wait. And when I say pills I mean over the counter shit, not prescriptions. If it gets really bad then I have to decide if I think I will die. If I think I will, I go to Emergency. If I don't then I wait in pain. Why do you ask me about family doctors? Walk-in-clinics? Are you kidding? I have no papers.' (Campbell et al., 2014, p. 171)

Economic worries also restricted permeability, and many individuals described learning about their entitlements on a trial and error basis: *"... I do not know [if it will be covered] until I try, when I go*" (Chase et al., 2017, p. 54). The willingness to do so was described as dependent on whether it was themselves or their children who were in need of care, with there being less hesitation when it concerned a child.

Continuity of care, sub-specialties, and preventive care were largely unknown or unavailable to users. Importantly, they often depended on a range of support services such as non-governmental organizations to access care and be referred to specialist care. Additionally, there also appeared to be cultural norms which influenced whether services were seen as permeable. Evidence showed issues with religion, language, and expectations on what would happen if they did, for example many participants expressed that they believed that going to the doctor is what makes you sick therefore staying away keeps you healthy. These barriers highlight the lack of knowledge and therefore the lack of permeability of specialist services for AS&Rs.

Appearances at Health Services

Barriers when appearing at services were linguistic; attitudes and perceived discrimination; and cultural competency.

Linguistic Barriers

Language was a major obstacle when appearing at health services, with a lack of adequate translation services, particularly for uncommon languages, found across studies. This was often linked to fear, as inability to communicate with providers led to uncertainty around outcomes. Confidentiality was a big issue, as worries were voiced regarding official interpreters and their role in the community. Furthermore, studies found concerns around interpreters them omitting material, interpreting inaccurately, hindering interpersonal dynamics, giving opinions, or even passing judgment. Alternatively, family members were sometimes used for translational purposes, but this brought up issues of confidentiality of its own.

"If you speak with a psychiatrist, you would speak normally, but if there is an interpreter as a mediator, and this person might speak about what you said, and now like you have told your story to this and may be this mediator will tell everybody in Canada." (Ahmed et al., 2007, p. 8)

Attitudes and Perceived Discrimination

Studies reported that the attitudes and perceived discrimination at HC services led to feelings of rejection, especially when participants felt their concerns were not taken seriously, were disregarded by HC professionals, or they felt they were treated differently from the national citizens. This was mostly prominent when participants felt they received hostile attitudes when they used their immigration papers or lacked insurance.

"For me, it's moral torture.... Sometimes I pray God to give us good health, me and my children, because I know so well what I will face in clinics or in hospitals.... You feel worth less than others, as if you don't have the same rights as the other person." (Chase et al., 2017, p. 55)

A sense of discriminatory attitudes also occurred when there was a cultural misalignment in terms of the symptomology description. Some individuals found it difficult to talk about their experiences or feelings with someone unfamiliar to them, therefore resorting to the use of subtle terms to describe symptoms. Individuals felt that this sense of unease lead some HC providers to conclude that the situation was not serious, or they focused on a different illness altogether. One study highlighted a service user who described feelings of embarrassment when during his first visit the practitioner had begun to ask 'inappropriate' questions relating

the HIV/AIDS and tuberculosis, which were not the reason for the visit (Palmer, 2007). This led to feelings of discrimination, as the individual felt these questions were only due to his immigration status.

Cultural Competency of HC Provider

Several studies discussed how care conflicted with cultural practices of the individuals, and this was identified as a point of contention in their appearance at services. For example, many AS&Rs were unaccustomed to verbalizing personal experiences and emotions. One study highlighted an individual who had experienced 'spiritual energies' since he was seventeen and viewed his problems mostly in religious terms (Omar et al., 2017). He indicated that he would not discuss these issues with English doctors as they would not understand these terms and spiritual beliefs— "*they are only interested in symptoms*." (Leavey et al., 2007, p. 264). This was highlighted as feelings of judgment from the providers for wanting to adhere to their own traditions. It was considered important that health workers recognized these beliefs as being legitimate and culturally significant.

Adjudications by Professionals

Findings showed that once AS&Rs had asserted their candidacy by presenting to health services, the professional judgements made regarding their candidacy strongly influenced subsequent access to services. AS&Rs highlighted a lack of resources and inconsistencies between providers. Providers were often perceived as overwhelmed with few options for referring clients who required continuing MH care. Programs designed for AS&Rs often lacked funding or were oversaturated with long waiting times. This resulted in concerns about timely access to a specialist's opinion. It was however generally recognized that severe conditions were referred more quickly. Respondents also mentioned complex referral processes and eligibility criteria for accessing MH services leading to negative experiences and absence of clear guidance as to how to navigate the system.

"doctors at [A] they suggested [B]. I contacted [B] and then they couldn't do help much. Then I was transferred to [C] and from there to [D] so it's like a little tour." (Valibhoy, Kaplan, Szwarc, 2017, p. 29)

Service users also described experiences of being turned away from the service if they were not assessed to be ill enough when they reached out for help. The lack of referrals led to feelings

of rejection by the system and AS&R experienced that they often had to rely on other people to negotiate contact with the services on their behalf in order to be taken seriously.

Cultural concerns with regards to adjudication also emerged. For example, concerns regarding whether HC providers in the country of resettlement were familiar with the common diseases in their countries of origin. Another example that arose was the feeling amongst participants that an illness should be treated in the early stages rather than waiting to see the symptoms develop *"they let your illness become very old here"* (Feldmann et al., 2007, p. 522). This was further underscored by the idea that health services may lack staff that is knowledgeable and sensitive to the particular needs of AS&R populations.

Offers and Resistance

This stage was dominated by concerns over an excessive focus on medication. Experiences of emphasizing watchful waiting approaches and simple self-medication, was perceived by some as revealing a lack of interest in them and their circumstances. Simultaneously, when prescribed medication, there was a lack of understanding what it was for and worries around consequences such as addiction, side effects, or medication leading to worsening of the problem emerged across studies. Mostly, these findings suggested a lack of communication between the provider and patient regarding the purpose of the medication.

"Sometimes I see these pills... I mean I don't think that these pills are good. They make me numb. Sometimes I decide to give up. I decide to skip taking them to see what would happen." (Leavey et al., 2007, p. 263)

A few individuals in the studies described their statements and behaviors as being exaggerated to fit within a particular illness framework, making it more difficult for them to come to terms with their diagnosis and accept treatment offers. The lack of acknowledgement of the individuals' perspective towards treatment and their past experiences led to patients feeling detached from their treatment course. In some cases, this resulted in individuals reducing or discontinuing their medication without the involvement of the health professional. This was at times also influenced by the environment including family and clergy, who even if the medications were prescribed sometimes discouraged the individual from taking them. Often this was prioritized over treatment, and the disparity between lay beliefs and Western understanding of MH created a clash of understanding between the service user and the system.

"*If a doctor says you need medication, and the pastor says no. You won't take it*" (Behnia, 2003, p. 212)

Issues around the economic burden of medication also emerged as a reason for resistance and discontinued treatment. Out-of-pocket payment proved to be challenging especially for those who do not have the finances to cover food and housing expenses.

Operating Conditions and the Local Production of Candidacy

The relationship with the individual provider was highlighted as being essential to the continued use of services. Specifically, trust, rapport and respect in the relationship were key, and suggested that satisfaction with operating conditions and production of candidacy were very person dependent and could take years before they found a provider with whom they developed a deeper connection.

"*Sometimes they were asking very like personal questions that I didn't like...The journey that we had, like how many days were you in the boat, and I never want to think about it... [later] People are different, like we have saying; ''jungle has dry and wet—some trees are alive, some trees are dead, and they are different.'' And people are the same; some people like to talk about their selves, their families, and some people want to keep a secret.*" (Valibhoy et al., 2017, p. 32)

There were also instances in which individuals had not been able to build this relationship which often led to discontinuing the care. The main reason for this was providers not meeting expectations or not being adequately responsive to needs. A need for awareness of the individuals' cultural background, previous experiences, and understanding how the individual made sense of their illness was very salient. Findings showed the need for practitioners to avoid assumptions and learn from the patient as an individual in order to accommodate nuances in ethnic and religious identities. For example, one female refugee who had previously been incarcerated in Iraq highlighted her distress upon being in a closed ward showing the need for providers to understand the individual's past: *"And the door was shut. It was a closed ward. It comes to my mind again, how we were in prison in my country. The door was shut. It was very difficult.*" (Jensen et al., 2014, p. 9749).

Lastly, studies reported accounts of professionals being out of reach due to a lack of time giving rise to feelings of neglect, unworthiness, and frustration in patients. Furthermore, the flexibility

of services to respond to individual needs was highly valued. This included adapting the frequency of consultations to personal preferences or maintaining contact with the provider whilst waiting to access specialized treatment.

"*he was not helpful or he was just not getting us... I felt he was being disrespectful... we were new to the country and... we had to travel by train then take a tram and sometimes we might be a bit late, but he wasn't understanding one bit."* (Valibhoy et al., 2017, p. 35)

Figure 2. Key Thematic Quotations

Identification of Candidacy

1) **Identification of symptoms as medical**

"the people from the developing countries… many people cannot realize it (…) for some people, they have very limited education or knowledge, they won't see the seriousness of the mental illness." (Donnelly, 2002, p.283)

"Most are religious with much emphasis on prayer. Ethiopians are not serious about depression or sophisticated sickness. We believe in religion and holy water as a cure" (Omar et al., 2017, p.52)

2) **Social barriers**

"Psychiatric problems are not accepted, if you have psychiatric problems it is because you are a bad person or 'crazy" (Behnia, 2003, p.212)

"Then, my family all gathered (…) everyone got upset . . .. They did not want to accept it. They said no such thing could happen." (Leavey et al., 2007, p.265)

Navigation

1) **Structural barriers**

"*…even when I ask with the doctor that 'can I have on this time on this day', they say 'no no', or something like I have to follow their schedule, but I have work!"* (Palmer, 2007, p.7)

"I just pray all the time that I don't fall sick… because if it happens that I really have to go to the hospital, I don't know how I'm going to do that" (Teunissen et al., 2014, p.514)

2) **Understanding a new system**

"When I first came here and didn't have anybody, I had no clue what the Primary Care Trust is or Mental Health Trust, or Hospital Trust. Back home it's all in one – health service and you know it is health service and hospitals." (Djuretic, Crawford & Weaver, 2007, p.753)

"... an asylum seeker or a refugee ... has many things to do. One cannot master everything at the same time" (Chase et al., 2017, p.54)

3) **Fear of unknown consequences**

"If I need to get healthcare I risk being reported by the doctor and deported back to Venezuela.My safety has to take precedent over my health. When you are an illegal, those two things are mutually exclusive entities." (Campbell et al., 2014, p.170)

Permeability of Services

"Many people are afraid to go to doctor because they don't know if they will be arrested or reported. Only emergency is ok" (Teunissen et al., 2014, p. 511)

"The main problem is that for Ethiopians, mental health services are unreachable. They don't understand the culture, they don't engage, they don't have a full of mental health so they think services are for others not them.' (Omar et al., 2017, p.48)

"A lot of [Somali] people think that if they go to the doctor, it's what makes you sick so staying away from the doctor makes you pretty healthy." (Palmer & Ward, 2007, p.355)

Appearances at Services

1) **Linguistic barriers**

"I asked for painkillers but he (the doctor) gave me pills instead for depression. I don't think he understand my problem or what I tell him. No interpreter to help me. He gave me the pills for the wrong thing, but at least they help me relax and sleep." (Campbell et al., 2014, p.172)

"Interpreters take time and then maybe he doesn't say exactly what you feel. For example he might say that I feel mad when I feel depressed. It's not good for confidentiality as they talk too much in the community." (Palmer & Ward, 2007, p.206)

"It is very difficult to find Fulani translation. She [the interviewee] has to have her kids or her husband translate for her. . . . When it is private stuff, she would like

someone else. Or if it is medical terms, she's not sure whether her kids or her husband understand" (Teunissen et al., 2014, p.514)

2) **Attitudes and perceived discrimination**

"They don't pay much attention to immigrants, see us fast just to finish and don't listen. They know we don't have documentation so can't complain." (Teunissen et al., 2014, p.509)

3) **Cultural competency of HC provider**

"I felt like I was judged by my doctor...I wanted to do things according to my tradition but I was expected to do things differently." (Russo et al., 2015, p.6)

"I was like, 'am I supposed to tell you, I don't want to tell you, can I tell you, is it okay?' (…) it felt very different, and very um, unusual for me because I'm not used to showing and telling my feelings." (Valibhoy et al., 2017, p.28)

Adjudications

"So, every time we go to the hospital, it's stress, because I wait, I bring my son again, and at the last minute we receive a negative answer ...." (Chase et al., 2017, p.54)

"I have had these problems since about the second month after I arrived in Switzerland. I kept explaining to the staff at my accommodations that I had certain experiences earlier, and they simply said, "Yes." Later, I went to the doctor and he wrote a report to the Federal Office [of Migration]. Yet I heard nothing and didn't know what to do. I then got an appointment at the district hospital and had surgery for my shoulder, for my clavicle. I explained my problems to the surgeon in the hospital, and then he organized an appointment with a psychiatrist. I talked to this man and he referred me to this clinic, and so I finally arrived here" (Maier & Straub, 2011, p.242)

Offers and Resistance to Specific Services

"My husband stopped me from taking medication. He said, "If you start on medication, it's a slippery slope ... once you enter into that vicious circle you never come out" (O'Mahoney, 2005, p.741)

"My mom had to take pills once for the brain that were very expensive. Ten tablets were almost $200. I'm not saying that you can't find a way to pay the money but sometimes people just can't get the money and you feel like they're saying, 'oh ya whatever - die', you know." (Asgary & Segar, 2011, p.171)

Operating Conditions and the Local Production of Candidacy

> *''it just takes time to um, basically see if you can trust the person.'* (Valibhoy et al., 2017, p.34)
>
> *"But as time went on, I gradually understood that this is it—the power and energy that I am given. What I am suffering from cannot be properly cured by medication. It is more the psychiatrist who gave me back the joy of life."* (Maier & Straub, 2011, p.240)

3.4. Discussion

3.4.1. Main Findings

The current review used the candidacy framework (CF) to synthesize qualitative findings relating to barriers to accessing and negotiating MH services for AS&R in high-income countries. Comparatively more data was available in the papers about barriers to access than on barriers to negotiating services once accessed. This could be an artefact of the fact that barriers to accessing services mean that a small number of respondents can comment on issues relating to negotiating services, or that this has been less of a focus of research conducted to date. Nonetheless, findings show there are many barriers which affect the process of establishing candidacy for care which affirm the harmful consequences of barriers including delays in receiving treatment, feelings of social exclusion and mistrust.

Access to Services

The identification of candidacy (stage 1) was dominated by issues relating to the interpretations by AS&Rs of symptoms and social barriers. The data showed that AS&R recognize their symptoms as requiring help, however they often turn to informal services. Previous evidence has suggested that traditional explanatory models of health held by ethnic minority groups can impact on their help seeking behavior from Western HC services. This may be attributable to different explanatory models regarding MH, specifically different holistic beliefs about causality that do not correlate with the western medical model (Knifton et al., 2010). Certain beliefs about causality can lead directly to shame and stigma, such as MH problems as punishment for wrong-doings (Karim et al., 2004), as God's will, and as black-magic, jinn or possession by spirits (Ciftci, Jones & Corrigan, 2013; Joel et al., 2003). On the other hand, in a qualitative study conducted on a Thai Muslim community, family and key stakeholder

participants rejected the idea that schizophrenia had stigma since the illness was Allah's will (Vanaleesin, Suttharangsee & Hatthakit, 2007). Consequently, individuals may choose to access more traditional and faith-based healing practices (Hills et al., 2013), as was found in the current review. Access to services may not be sufficient, it must be accompanied by efforts to increase MH literacy for communities and training for traditional and faith-based healers to improve referral pathways to formal services and decrease stigma.

The concerns over structural barriers (i.e. fear of financial contribution) and unknown consequences (i.e. legal repercussions) to accessing services found in stage 2 (*navigation)* suggest that there is a clear need to provide more knowledge on available services and entitlements to care in this population across Western countries. The unknown consequences of accessing services combined with an inherent lack of trust in public organizations and/or fear of being reported to authorities can make it particularly challenging for individuals to trust HC systems especially during the asylum process (Hebebrand et al., 2016). Their migratory status has the potential to perpetuate social dependence and economic marginalization (Portes & Rumbaut, 2001) and therefore hindering their assertion to candidacy and accessing health services.

Negotiating Services

The negotiation stages highlighted the dynamic nature of the system and more specifically the constant negotiation between service users and HC providers. Overall, service- level responsiveness was inadequate with waiting lists, eligibility criteria, and continuity of care being described as common and distressing. The findings suggest that power distributions were asymmetrical at times between HC providers and AS&R including the enforcement of dominant values onto services users and perceived discrimination.

Theorists commenting on the difference between illness and diseases have emphasized 'illness' as the individual's lived experience of symptoms and disability; and 'disease' as the HC provider's representation of the disorder after having reworked the person's account into a medical framework (Kleinman, 1980, Turner, 1996). Understanding how individuals create meaning in their illness can largely influence care and increase diagnostic validity (Bäärnhielm & Scarpinati, 2009; Lupton, 2012). This calls for the need for culturally competent care, which exists when providers are knowledgeable of the potential and actual factors that can influence their interaction with service users and have training to address the cultural divide (McKeary

& Newbold, 2010). However, dominance of the bio-medical model may fail to adequately acknowledge the social and cultural basis of MH. Providers can be influenced by stereotypes and potentially homogenize this population into a single pathologized identity, or lack training to identify symptoms unique to other cultures (Gavagan & Brodyaga, 1998). Therefore, providers must constantly reflect on their own values, attitudes and behaviors that could be influencing the relationship and can both directly and indirectly create barriers to care (Donnelly, 2002; Hart & Mareno, 2014; Yakushko & Chronister, 2005).

Language was flagged as a major barrier throughout the current review. In terms of access, individuals were scared providers would not speak their language or understand their symptoms. In terms of negotiating the system, language existed as a barrier throughout the stages. The lack of competent interpretation was said to complicate the encounter and translational services were often not available for comparatively rarely spoken languages and dialects. When this occurred, providers often used family members as translators, which highlight suboptimal standards as this has implications for potential bias in the interpretation, and reduced willingness on the AS&Rs' behalf to open up. MH providers themselves have also reported similar issues including lack of access to or poor-quality interpretation services in research (Dauvrin et al., 2012; McColl & Johnson, 2006). This has been found to impact empathetic responses, decrease rapport, service user satisfaction and has shown to increase medical error in previous research (Reko et al., 2015; Wong et al, 2006). The sensitive nature of AS&Rs' experiences demands highly competent interpretation services therefore there is a need to train clinicians systematically in the efficient use of interpreters, cultural brokers and cultural formulations as has been highlighted previously (Kirmayer et al., 2003; Brendler-Lindqvist, Norredam & Hjern, 2014). Additionally, interpreters may require additional training to work with AS&R and clinicians in what may be challenging consultations. Piacentini et al. (Piacentini et al., 2019) have previously highlighted the need for more training measures that move beyond diversity and/or race awareness, and which use a more holistic approach to understanding how different social identities and multi-dimensional markers of difference come to be produced and reproduced in interpreter-mediated healthcare encounters with migrant populations. They argue that these social identities and markers of difference include language, culture, ethnicity, age, gender, and also immigration status. Therefore, interpreters need to be aware how these variables intersect specifically with language.

The use of the CF as synthesizing argument for CIS has proven to be a useful way to conceptualize barriers and underlying constructs that influence access and negotiation. Using a systematic review to bring this knowledge together has allowed us to cast the net wide and integrate findings from different global settings into new evidence-based knowledge.

3.4.2. Recommendations for Improving Practice

Moving forward, a holistic approach incorporating input from a range of stakeholders is needed to address the barriers found in this review, including the work of academics; policy makers and HC providers who all need to acknowledge the impact of country of origin, language, culture and status on MH service provision. Most importantly, the idea that 'one size does not fit all' should be at the forefront. Once service users have accessed mainstream health services, simple referral processes and provision of adequate information can facilitate treatment, for example through websites (Brendler-Lindqvist et al., 2014, Hebebrand et al., 2016). Furthermore, sensitivity trainings, hiring professionals who share the persons' ethnicity or language, and improvement of interpretation services are needed. Additionally, interpreters may require additional training to work with AS&R and clinicians in what may be challenging consultations. Piacentini et al. (2019) have previously highlighted the need for more training measures that move beyond diversity and/or race awareness, and which use a more holistic approach to understanding how different social identities and multidimensional markers of difference come to be produced and reproduced in interpreter-mediated healthcare encounters with migrant populations. They argue that these social identities and markers of difference include language, culture, ethnicity, age, gender, and also immigration status. Therefore, interpreters need to be aware how these variables intersect specifically with language. Most importantly, AS&Rs need to be engaged as stakeholders and stand at the center of finding solutions to achieving accessible and negotiable services.

There is also a need for qualitative research into displaced populations' barriers to HC in low and middle-income countries. This review focused on high-income countries but can be seen as examples of the types of issues that local MH services should be exploring with their own AS&R communities. The CF has thus far only been used in high-income settings, therefore future research should investigate the suitability of using the CF in low and middle-income settings where more macro level barriers to care may exist. Lastly, this review only considered barriers to access and negotiation rather than including facilitators. There is a need for future reviews to address facilitators that can increase contact with services.

3.4.3. Strengths and Limitations

This review was the first to focus specifically on barriers to MH services for AS&Rs by using a CF. The use of qualitative research afforded opportunities for the personal experiences of AS&Rs to be explored in depth. Given the cultural diversity of the sample, these findings appear to be generalizable for AS&Rs who migrate to Western countries despite varying national policies and HC systems in their countries of resettlement.

Regarding the CIS, accessing first order constructs (i.e. participants in the research) was not possible as the data included in the primary studies had already been preselected from initial datasets. For this review, second order constructs (i.e. researchers' interpretations of these views based on theories) were arguably more representative of the overall findings relating to barriers. This made it difficult to distinguish the influence of authors' perspectives in terms of personal background or theoretical standpoints. Additionally, the use of translators in the studies entails a potential omission of information and/or errors in the translation process, which makes this distinction complicated. The strength of CIS is that it can link the emerging synthetic constructs surrounding barriers to access and negotiation to the chosen synthesizing argument of candidacy. This theoretical framework further allowed the transition from simply describing the barriers to understanding the multidimensional nature thereof.

In terms of generalizability, all studies included were based in high-income countries. Given that the majority of the world's AS&R live in low and middle-income countries (UNHCR, 2017), this limitation highlights the importance of further research concerning barriers to accessing and negotiating care for AS&Rs in low and middle-income settings.

3.5. Conclusion

The findings of this review reflect a rich experience of barriers to accessing and negotiating MH services for AS&Rs. By doing so it has begun to unpack and differentiate the unique barriers to MH care faced by these groups, as opposed to a more broadly defined 'immigrant' or 'foreign-born' population. The use of the CF provided a theoretical framework to understand the interrelated barriers, which exist at different stages. Reduced access ultimately leads to decreased health status and increased suffering amongst a population at elevated risk of experiencing MH difficulties. The CF has proven to be effective for gaining insight into barriers and the necessary refocusing of future research, policy and practice to ameliorate these

barriers. The bio-medical model may not be a sufficient service model for meeting AS&R MH needs, with more focus needed on non-health sector interventions with more inclusive explanatory models.

Foreword Chapter 4

The findings of the qualitative systematic literature review investigating the barriers to accessing and negotiating mental health services for AS&R populations conducted in Chapter 3 higlighted that a bio-medical model of health may not be an adequate service model for meeting the mental health needs of forcibly displaced populations. Instead, more research attention should be focused on non-health sector interventions that use more inclusive explanatory models of health, including broader socio-ecological determinants of mental health and wellbeing. By understanding trajectories and predictors of positive adaptation following resettlement, access to appropriate care and support can be increased, including support outside of formal health services. Increased understanding of such factors will help advance interventions and programs that promote wellbeing and successful integration amongst those that are struggling with mental illness and other adaptation challenges.

Chapter 4 provides an overview of the literature on physical, psychological, social and environmental factors associated with QoL of AS&R in high-income countries. Specifically, it synthesizes the literature on known factors which are associated with QoL in these populations and identifies the methodological strengths and weaknesses of the existing body of research.

Published Chapter

1. Stage of Publication

   The paper presented in Chapter 4 has been published in a peer-reviewed journal. This chapter is presented as the authors' accepted for publication version of the paper.

2. Research paper title

   Systematic review of factors associated with quality of life of asylum seekers and refugees in high-income countries

3. Peer-reviewed journal

   Conflict and Health

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5. Candidates' specific contribution

   The substantive contribution of Catharina van der Boor has been the conception and design of the research, conducting the literature review, carrying out the analysis and interpretation of the findings, writing the paper and doing critical revision.

6. Co-author declarations

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   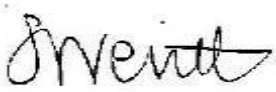

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Date: 23rd August 2021

Chapter 4: Systematic review of factors associated with quality of life of asylum seekers and refugees in high-income countries

4.1. Introduction

Background

The number of forcibly displaced persons in 2018 exceeded 70.8 million worldwide (UNHCR, 2019c). Within this displaced group, the estimated number of people awaiting a decision on their application for asylum was 3.5 million, and an estimated 25.9 million individuals were recognized as refugees (UNHCR, 2019c). High income countries on average host 2.7 refugees per 1000 of population (UNHCR, 2019c). The stressful experiences that many asylum seekers and refugees (AS&R) are exposed to during forced migration, and during resettlement in host countries, can have a profound impact on their mental health (MH) including high rates of depression, anxiety and posttraumatic stress disorder (Turrini et al., 2017). However, comparatively less research attention has been allocated to exploring other indices of MH such as quality of life (QoL) in AS&R populations.

Quality of Life

QoL has been implicated in MH status. It is defined as an "Individuals' perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns" (WHO, 1997, p.1). As such, QoL is a broad ranging and multidimensional concept which includes an individual's subjective evaluation of their physical health, psychological state, level of independence, social relationships, personal beliefs and their relationship to their environment (WHO, 1997).

Whilst there is growing consensus over the multidimensionality of QoL, little research has focused on understanding the specific predictors and correlates thereof. This is specifically the case with regards to AS&R populations, despite the existing evidence base for their high risk of developing mental disorders. The WHO estimates the prevalence of mental disorders, including depression, anxiety, post-traumatic stress disorder (PTSD), bipolar disorder and schizophrenia, in conflict-affected settings to be 22.1% at any time point in the populations assessed (Charlson et al., 2019). Evidence has shown that for AS&R the effects of war-related events may persist for years and have been associated with lower QoL even when hostilities

have ended (Akinyemi et al., 2012; Matanov et al., 2013). Akinyemi et al. (2012) noted that QoL, together with occupational status, were the biggest threats to the mental health of refugee populations and called for attention to the overall QoL in order to support their long-term mental health. Similarly, Matanov et al. (2013), found that traumatic war events were directly associated with lower QoL in war-affected communities in the Balkan countries, and experiencing more migration-related stressors was linked to lower QoL in refugee populations who had resettled in Western Europe. Simultaneously, the lack of studies evaluating the efficacy of interventions for increasing QoL in AS&R populations (Bosqui & Marshoud, 2018, Turrini et al., 2019) has been noted. Improving understanding about predictors and correlates of QoL in AS&R populations will be important for guiding the foci of these interventions, and more broadly informing policies in high-income countries to support the local settlement, integration and long-term mental health of AS&Rs.

The current paper is the first to systematically review evidence relating to predictors and correlates of QoL of AS&Rs living in high-income countries. The specific aims of the review were to: 1) understand what factors are associated with QoL in AS&R populations; 2) identify the methodological strengths and weaknesses of the research investigating QoL

4.2. Methods

4.2.1. Literature Search

Fourteen databases were systematically searched. A search strategy tailored to the aims of the review was applied to each database using the Kings College London library guide (Kings College London, 2021). See appendix B for the list of databases which were searched and the full search strategy. Reference chaining was also carried out and five experts in the field of mental health of refugee populations were independently consulted to ensure the final list of included papers was exhaustive.

4.2.2. Eligibility

All quantitative peer-reviewed publications in English, Spanish or Dutch (languages spoken by the authors of this review) which used measures based on the four WHOQOL domains (WHO, 1998), explored predictors and correlates of the QoL of adult AS&R populations

residing in a high-income country (as classified by the World Bank[3]) at the time that the search was conducted were included. The exclusion of grey literature was used as a form of minimal quality assurance. Longitudinal evaluations of interventions were also excluded if a cross-sectional analysis between QoL and other variables were not performed at baseline. The search of databases was conducted up to the 5th of May 2020, and any studies that met inclusion criteria were included in the current review. Furthermore, additional papers identified through expert consultation were included.

CB and RA independently screened the titles and abstracts for inclusion. Articles rated as possible candidates by either CB or RA were added to a preliminary list. Working independently and in duplicate, both reviewers inspected the full texts of the preliminary list for inclusion. A consensus meeting was subsequently held between CB and RA and remaining discrepancies were resolved through discussion with the research team.

4.2.3. Data Extraction and Quality Appraisal

For each included study, CB extracted information on the publication year, country of publication, settings, populations, study design, assessment measures and key findings, which was peer-reviewed by RW. Once the data was extracted, CB rated the quality of each individual study and RA peer reviewed the quality appraisal for a quarter of the studies.

4.2.4. Data Synthesis and Analysis

A narrative synthesis approach was used to analyze the data. The WHOQOL Group developed a conceptual framework for QoL that incorporates four domains (WHO,1998): physical, psychological, social relationships and environment. To support efforts to synthesize the research findings of the studies included in the current review, these four domains were used to group predictors and correlates of QoL investigated in the studies. Two authors (CB and RW) independently mapped the various correlates investigated in the studies onto these four domains, discrepancies were resolved through discussion.

Consideration was given to conducting a meta-analysis. Five studies reported significant relationship between QoL and the correlates in terms of a correlation coefficient (an r statistic)

[3] Further information on the classification of countries per income can be found at: https://datahelpdesk.worldbank.org/knowledgebase/ articles/906519

and the statistical significance of this coefficient. Meta-analysis of correlation coefficients is methodologically complex due to the bounded nature of these statistics (i.e. that they can only take values between: −1 and+1) and furthermore, correlation coefficients were not reported with a measure of precision such as a confidence interval which would be required for meta-analysis (Field, 2001; Hedges & Olkin, 2014). Similarly, five studies also reported the relationship between QoL and the variables in terms of t-statistics and corresponding p-values. Such statistics do not have an associated measure of precision and therefore cannot be combined within meta-analysis.

The only amenable statistical measure for meta-analysis to represent the relationship between QoL and the predictors were regression (beta) coefficients with accompanying confidence intervals. These were reported in 52% of studies. These act as continuous data and theoretically, synthesis of such data may be possible within a 'prognostic review' framework (Riley et al., 2019). However, across the studies, the predictors included within regression models to examine the effects of these predictors on QoL varied widely. Therefore, due to anticipated very large heterogeneity originating from the wide range of predictors included within regression models (see Figure 3), meta-analysis of these beta-coefficients was deemed to be potentially misleading and therefore inappropriate.

Instead, further consideration of the direction, strength and consistency of the correlates of overall QoL has been undertaken for the studies included in this review which reported correlational analysis. Cohen's (Cohen, 2013) conventions were used to interpret the effect sizes; positive large correlation (>0.50 to +1.00), positive moderate correlation (0.30 to 0.50) and positive small correlation (<0.30). Negative large correlation (<−0.50 to −1.00), negative moderate correlation (− 0.30 to 0.50) and negative small correlation (> − 0.30). Positive correlations indicate a relationship between two variables in which both variables move in the same direction (i.e. if mental health increases, QoL increases), whereas negative correlations indicate a relationship whereby both variables move in opposite directions (i.e. if depression decreases, QoL increases). Figure 3 provides a representation thereof.

The quality of the cross-sectional studies was assessed using the Appraisal tool for Cross-Sectional Studies (AXIS tool) (Downes, Brennan, Williams & Dean, 2016). Longitudinal studies were assessed using the Critical Appraisal Skills Programme (Critical Appraisal Skills Programme, 2018). The quality of the studies was independently rated by CB. Additionally, RA rated a quarter of the cross-sectional studies (N = 5) and longitudinal studies (N = 2) in

order to ensure a quality check was carried out. There was high agreement regarding quality assessment; items that were rated differently were resolved through discussion.

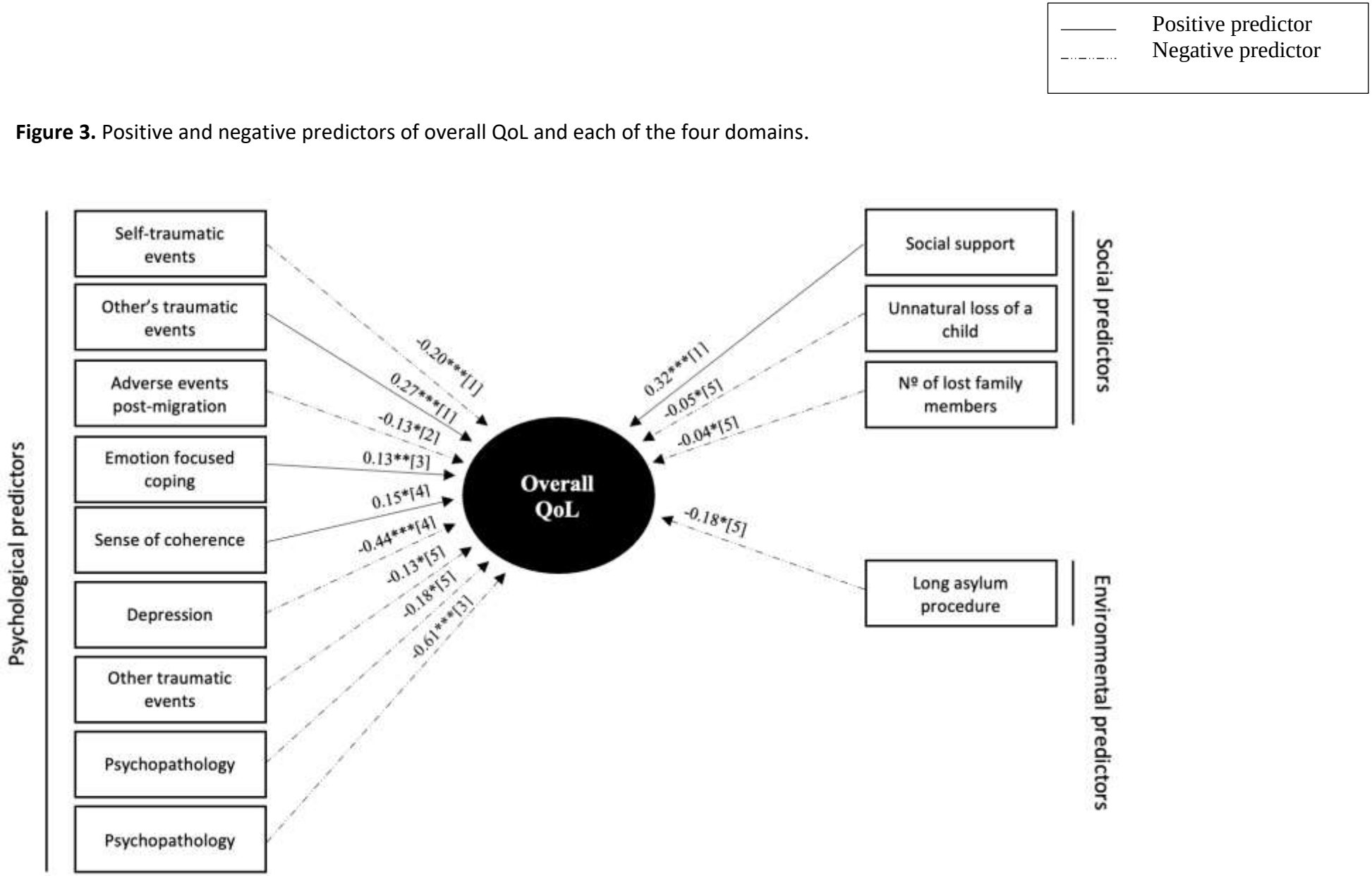
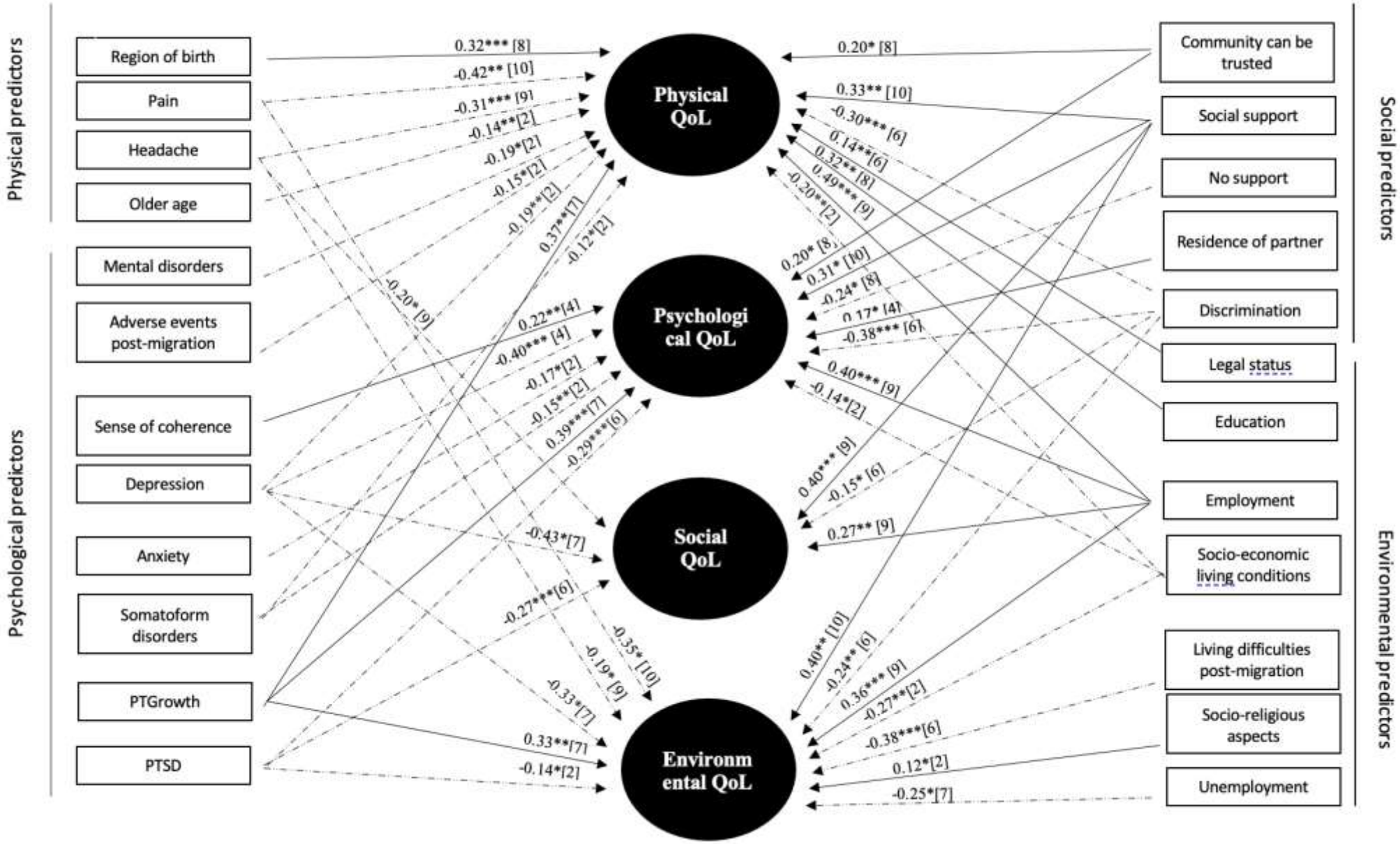


Figure 3. Positive and negative predictors of overall QoL and each of the four domains.

*Gender and time have not been included in the figure. Where multiple studies reported the same predictor only the study with the strongest predictor is reported in the figure.
***p<001, **p<.01, *p<.05



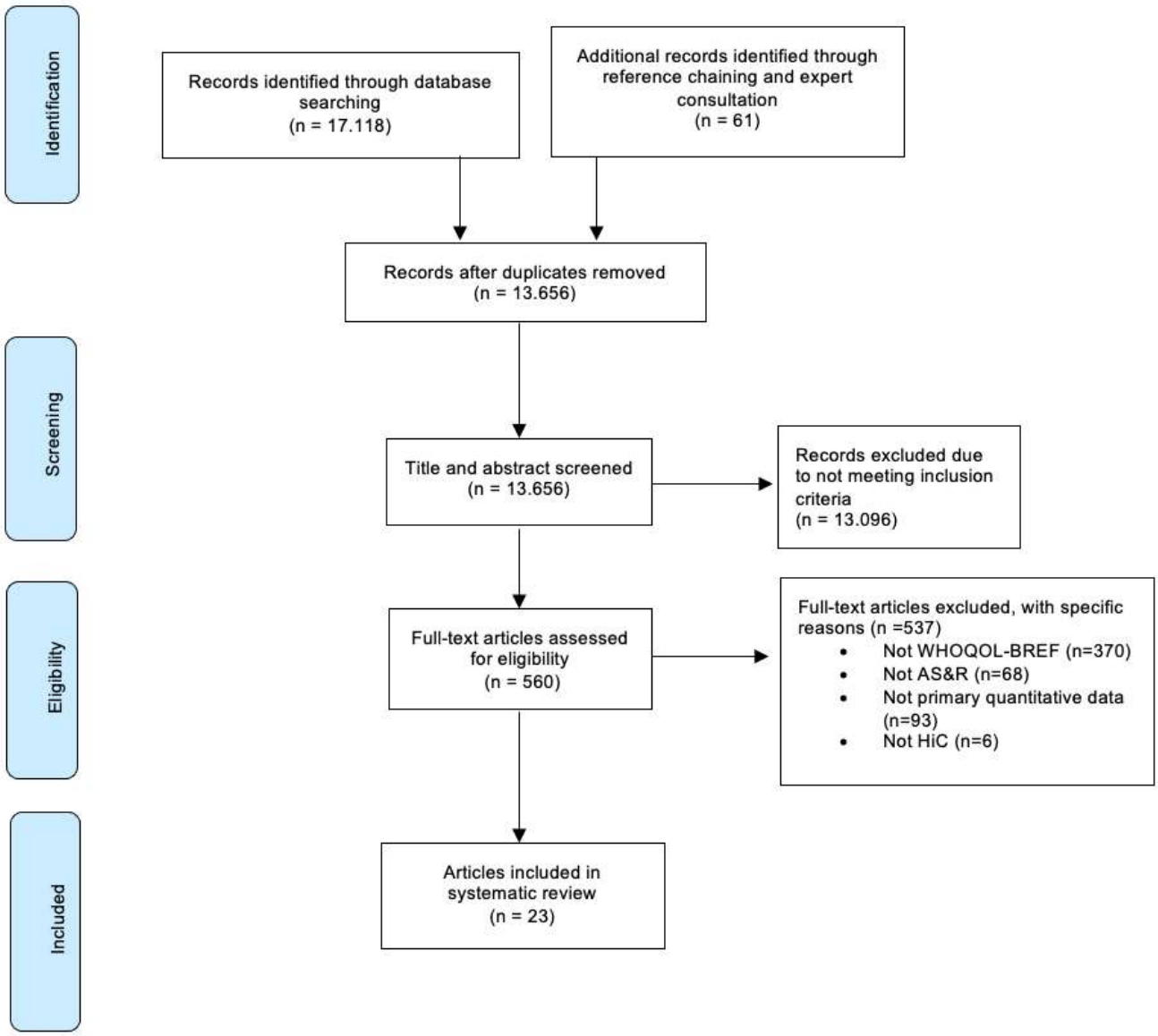
*Gender and time have not been included in the figure. Where multiple studies reported the same predictor only the study with the strongest predictor is reported in the figure.
***p<001, **p<.01, *p<.05

[1] Regev & Slonim-Nevo (2019), [2] Laban et al. (2008), [3] Huijts et al. (2012), [4] Georgiadou et al. (2020), [5] Hengst et al. (2018), [6] Slonim-Nevo et al. (2015), [7] Teodorescu et al. (2012), [8] Correa-Velez et al. (2020), [9] Carlsson et al. (2006b), [10] Carlsson et al. (2006a)

4.3. Results

The search identified 13.655 articles of which 23 met the inclusion criteria. Article selection is summarized in the PRISMA diagram presented in Figure 4.

Figure 4. *PRISMA flow diagram of article selection*



4.3.1. Study Characteristics

A total of twenty-three studies met the inclusion criteria. Seventeen studies were conducted in Europe, two in Australia, two in Israel, one in the USA and one in Japan. Four studies used the same dataset, therefore there were two repeat samples. Sample sizes ranged from 22 to 663 (Mdn = 119, IQR = 222), with a total sample of 3817 across studies including 2138 males, 1516 females, and 163 not specified. Studies that used the same dataset were only counted once. Eleven of the studies recruited individuals from a medical setting, and the rest were recruited from support agencies, reception facilities (N = 5), community events (N = 4) or other (N = 3). Seventeen studies reported cross-sectional data and six were longitudinal studies including one case control design. All studies used the WHOQOL-100, WHOQOL-BREF or the EUROHIS-QOL measures (see Table 4).

The WHOQOL-100 is the QoL questionnaire developed by the WHO (WHO, 1995). It consists of 100 items, and each item is measured from on a 1 to 5 Likert scale. The internal consistency of the Danish version was high (Cronbach's $\alpha = 0.97$), with a test-retest reliability of 0.70 (Bech, 2001). Furthermore, it has been validated in refugee populations (De Vries & Van Heck, 1994).

The WHOQOL-BREF is the abbreviated version of the WHOQOL-100 (WHO, 1998) and contains 26 questions. The internal consistency of the WHOQOL-BREF was high (Cronbach's $\alpha = 0.86$), and demonstrated discriminant and construct validity (i.e. Sreedevi, Cherkil, Kuttikattu, Kamalamma & Oldenburg, 2016). It has also been validated in refugee populations (Redko, Rogers, Bule, Siad & Choh, 2015). Lastly, the EUROHIS-QOL (Schmidt, Mühlan & Power, 2006) is an 8-item index which is based on the WHOQOL-100 and WHOQOL-BREF. Each item is measured using the 1 to 5 Likert scale. It has demonstrated high internal consistency (Cronbach's $\alpha = 0.80$), and satisfactory convergent and discriminant validity (Schmidt et al., 2006).

Table 4. Summary table of the selected articles including study site, country of origin, sample size, type of migrant, study design, assessment tool

Study	Country in which the Study was Conducted	Migrant Country of Origin	N	Type of Migrant	Study Design	Recruitment Site	Self-Rating Scale for QoL	Other validated Assessment Measures	Summary of Significant Associations with QoL	Non-significant Associations with QoL (p>.005)
Carlsson et al (2010)[a]	Denmark	Iraq, Iran, Afghanistan	45	Refugees	Longitudinal	Rehabilitation and research center for torture victims	WHOQOL-Bref (WHOQOL Group, 1998)	HTQ, HSCL-25, HDS	• WHOQOL Environment Time (Baseline vs. 9-month follow-up)(p=.029) • WHOQOL Environment Time (Baseline vs. 23-month follow-up)(p=.017)	• No significant difference between baseline and 9 month, or 23 month follow-up for WHOQOL Physical, mental or social.
Carlsson, Mortensen & Kastrup (2005)[a]	Denmark	Iraq, Iran, Afghanistan	55	Refugees	Longitudinal	Rehabilitation and research center for torture victims	WHOQOL-Bref (WHOQOL Group, 1998)	HTQ, HSCL-25, HDS	• Changes in mental health ○ Evaluation of improved mental health (vs. those evaluating no improvement) during treatment had higher health-related quality of life in the 'mental' domain (t=2.46, p=.017) • Those with the lowest baseline QoL showed the largest increase in QoL.	• No significant changes over time for the WHOQOL domains. • The Spearman rank correlations between years from exposure to torture and baseline scores were nonsignificant for all QoL domains • The Spearman rank correlation between total number of treatment sessions and difference scores was low and nonsignificant for all QoL domains • Expressing expectations to improve during treatment was not associated with changes in QoL domains
Carlsson, Mortensen & Kastrup (2006)	Denmark	Iraq, Iran, Afghanistan, other (not specified)	63	Refugees	Cross-Sectional	Rehabilitation and research center for torture victims	WHOQOL-Bref (WHOQOL Group, 1998)	HSCL-25, HDS, HTQ	• Overall variance accounted for by the regression model was not reported • WHOQOL Physical ○ Occupation (β =0.23, p<.05)	• Number of years since last exposure to torture was not associated with QoL • Age and proficiency in Danish were not

									○ Social relations (β =0.33, p<.01) ▫ Pain (β =-0.42, p<.01) • WHOQOL psychological ○ Social relations (β =0.31, p<.05) • WHOQOL Social ○ Social relations (β =0.39, p<.01) • WHOQOL Environment ○ Social relations (β =0.40, p<.01) ▫ Pain (β =-0.35, p<.05)	significant associated with QoL Regression (Model 2) • Education, torture, or having been on the run were not significantly associated with any of the QoL domains • Occupation was not significantly associated with mental, social or environmental QoL • Pain was not significantly associated with mental or social QoL
Carlsson, Olsen, Mortensen & Kastrup* (2006)	Denmark	Iran, Iraq, Lebanon	139	Refugees	Longitudinal	Rehabilitation and research center for torture victims	WHOQOL-Bref (WHOQOL Group, 1998)	HTQ, HSCL-25	• Overall variance accounted for by the regression model was not reported • WHOQOL Physical ○ Pain upper extremities (β =0.20, p<.05) ○ Employment (β =0.49, p<.001) ▫ Headache (β =-0.31, p<.001) • WHOQOL Mental ○ Social relations (β =0.21, p<.05) ○ Employment (β =0.40, p<.001) • WHOQOL Social ○ Social relations (β =0.40, p<.001) ○ Employment (β =0.27, p<.01) ▫ Headache (β =-0.20, p<.05) • WHOQOL Environment ○ Social relations (β =0.24, p<.01) ○ Employment (β =0.36, p<.001)	Regression (Model 2) • Education, marked mood shifts, and years in Denmark were not associated with any of the QoL domains • Pain in upper extremities was not associated with mental, social or environmental QoL • Headache was not associated with mental QoL • Social relations was not associated with physical QoL

									▫ Headache (β =-0.19, p<.05)	
Correa-Velez, Green, Murray (2020)	Australia	Africa, South Asia, Middle East, West Asia, South East Asia	104	Refugees	Cross-Sectional	Agency involved in refugee resettlement	WHOQOL-Bref (WHOQOL Group, 1998)	HTQ, PMLD, SASCAT	• Regressing WHOQOL Physical domain on predictor variables was significant (r^2=.30, p<.001) ○ Region of birth (Africa) (β=0.32, 95% CI= [5.44, 19.83], p=.001) ○ Education (2y/3y) (β=0.32, 95% CI= [3.80, 16.94], p=.002) ○ Community can be trusted (β=0.20, 95% CI= [.79, 12.49], p=.027) • Regressing WHOQOL Psychological domain on predictor variables was significant (r^2=.19, p=.008) ○ Community can be trusted (β=0.20, 95% CI= [.33, 13.02], p=.039) ▫ Number of people no support (β=-0.24, 95% CI= [-5.80, -.57], p=.018)	• Age, Children (1 or more), English skills and trauma types were non-significant predictors of the physical domain • Age, region of birth (Africa), children (1 or more), education (2y/3y), English skills, and trauma types were non-significant predictors of the psychological domain • The hierarchical logistic regression predicting overall QOL found no significant associations
Correa-Velez, Barnett, Gifford & Sackey (2011)*	Australia	Sudan, Burma (Myanmar), Iraq, Burundi, the Democratic Republic of Congo, Rwanda, Liberia, Afghanistan, Congo-Brazzaville, Iran, Tanzania, Uganda	233	Refugees	Cross-Sectional	Community	WHOQOL-Bref (WHOQOL Group, 1998)	HSCL-25, HTQ, Items to assess use of Health Services & Medication	• WHOQOL Environment ▫ Living in regional areas (OR=0.4, 95% CI= [0.2, 0.9], p<.05)	• Area of settlement did not predict significant poorer QoL in the physical, mental or social domain

Georgiadeu et al. (2020)	Germany	Syrian	119	Refugees	Cross-sectional	Registry	WHOQOL-Bref (WHOQOL Group, 1998)	ETI, PHQ-9, GAD-7, SOC-13, F-SozU,	• WHOQOL Psychological Married with partner in Germany scored higher than married without partner in Germany, t(117)=2.91, p=.004 • WHOQOL Social Married with partner in Germany scored higher than married without partner in Germany, U=-3.02, p=.002 • WHOQOL Environment Married with partner in Germany scored higher than married without partner in Germany, t(117)=2.27, p=.025. • WHOQOL Overall Married with partner in Germany scored higher than married without partner in Germany, t(117)=2.78, p=.006. • Regressing overall QoL on predictor variables was significant (r^2=.66) ○ Sense of coherence (β=0.15, 95% CI= [-0.00, 0.33], p=.049) ○ Social support (β=0.25, 95% CI= [0.15, 0.46], p<.001) ▫ Depression (β=-0.44, 95% CI= [-1.52, -0.61], p<.001) • Regressing WHOQOL psychological domain on predictor variables	• No significant differences in WHOQOL Physical (married with partner vs. married without partner) • Sex, age, residence of partner, residence of minor child, anxiety, number of traumatic events, trauma inventory, and satisfaction with marriage were non-significant predictors of overall QoL • Age accommodation, residence of minor child, anxiety, number of traumatic events, trauma inventory, and satisfaction with marriage were non-significant predictors of WHOQOL psychological.

									was significant (r^2=.61) ○ Gender (β=0.15, 95% CI= [0.32, 11.04], p=.038) ○ Residence of partner (β=0.17, 95% CI= [1.39, 13.95], p=.017) ○ Sense of coherence (β=0.22, 95% CI= [0.07, 0.47], p=.008) ○ Social support (β=0.17, 95% CI= [0.04, 0.41], p=.016) ▫ Depression (β=-0.40, 95% CI= [-1.66, -0.56], p<.001)	
Ghazinour, Richter & Eisemann (2004)	Sweden	Iran	100	Refugees	Cross-Sectional	Half were recruited as outpatients at a psychiatric clinic and half were recruited as interested volunteers.	WHOQOL-100 (WHOQOL, 1997)	CRI, ISSI, BDI, SCL-90	• Gender: Males reported lower overall QoL (t=-2.99, p=.004) than females • Males reported lower levels of Independence (Psychological domain), (t=-2.00, p=.049) than females • Males reported lower social QoL than females (t=-2.40, p=.018) • Males reported lower environmental QoL (t=-2.06, p=.043) • Males reported lower spirituality (psychological domain) (*t=-2.82, p=.006*) • Having a BDI score below the mean and having been in the army showed the highest significant	• Gender: no significant differences found for physical health or psychological health • No significant correlation was found between spirituality (psychological domain) and adequacy of attachment (social support scale)

									overall QoL $F(19,70)=60.06$, $p<.001$ • Sense of coherence, coping resources, and social support had various significant relationships with QoL (see paper for details)	
Hengst, Smid & Laban[b] (2018)	Netherlands	Iraq	294	Asylum Seekers	Cross-Sectional	Central Organ of Asylum (COA)	WHOQOL-Bref (WHOQOL Group, 1998)	HTQ, PMLP, WHO-CIDI, BDQ	• Mediation model of psychopathology, disability and quality of life $\chi^2(12)=10.52$, $p=.570$ ▫ Unnatural loss of a child (β=-.05, 95% CI=[-.44, -.03], $p<.05$) ▫ Nº of lost family members (β=-.04, 95% CI=[-.01, .00], $p<.05$) ▫ Other traumatic events (β=-.13, 95% CI=[-.06, -.02], $p<.05$) ▫ Long asylum procedure (β=-.18, 95% CI=[-.66, -.13], $p<.05$) ▫ Psychopathology (β=-.33, 95% CI=[-.42, -.20], $p<.05$)	• Age, female sex, education level and postmigration stressors were not significantly associated with QoL • Unnatural loss of family, unnatural loss of friends, witnessing the loss of family or friend, number of lost children, and number of lost friends were not significantly associated with QoL
Huijts, Kleijn, van Emmerik, Noordhof, and Smith (2012)	Netherlands	38 different countries in the Middle East, former Yugoslavia, or other regions of which 50 were Asian, 35 African, and 4 South American.	335	Refugees	Cross-Sectional	Foundation Centrum '45, a specialist institute for diagnosis and treatment of posttraumatic stress.	WHOQOL-Bref (WHOQOL Group, 1998)	COPE-EASY-32, HTQ	• Regressing overall QoL on predictor variables was significant (r^2=.42, $p<.05$) ○ Social Support Seeking (β =0.12, 95% CI=[.03, .21], $p<.05$) ○ Emotion-Focused Coping (β =0.13, 95% CI=[.04, .23], $p<.01$)	Subgroup analysis of regression • Males: emotion-focused coping, was not significantly related to QoL • Females: social support seeking was not significantly related to QoL Multigroup analyses • No significant differences found

									▫ Self-reported PTSD (β =-0.61, 95% CI=[-.68, -.54], p<.001) • Post-hoc analyses revealed that emotion-focused coping and social support seeking differed per country of origin, and per gender.	regarding length of stay in the Netherlands.
Jesuthasan et al.* (2018)	Germany	Afghanistan, Syria, Iraq, Somalia, Iran, Eritrea	663	Refugees + European Reference Sample	Cross-Sectional	Shared reception facilities	EUROHIS-QOL questionnaire (Schmidt et al., 2006)	HTQ, HSCL-25, ICSEY	• Female refugees rated their overall QoL significantly lower than the EU reference simple, t(5508)=16.9, p<.0001 • Residence and mission in a war zone, and being sick without any access to health care significantly affected all four domains of QoL • Near death experience affected physical and psychological domains. • Aggression from family members affected the physical and social domain • Forced isolation affected the physical, psychological, and environmental domains. • Within Group (Refugees) Predictors: Regressing overall reduced QoL on socio-demographic and traumatic predictor variables (Overall variance accounted for by the regression model was not reported)	• Having had sexual contacts as a minor did not signfiicantly correlate with overall QoL • No significant association was found between near death experience and the social and environmental domains • No significant association was found between aggression from family members and the psychological and environmental domains • No signiciant association was found between forced isolation and the social domain.

									A) Reduced QoL • Age>30 (OR=1.6, 95% CI=[1.2-2.3], *p*=.004) • Near-Death Experience (OR=1.7, 95% CI= [1.2, 2.4], *p*=.001) • Mission/Residence in War Zone (OR=0.7, 95% CI=[0.5-1.0], *p*=.04) • Attack by Family Member (OR=2, 95% CI= [1.3, 3.1], *p*=.001)	
Kinzie et al. (Kinzie et al., 2012)	USA	Ethiopia, Somalia, Iran and Afghanistan	22	Refugees	Longitudinal	Refugee psychiatric clinic	WHOQOL-BREF (WHOQOL Group, 1998)	HTQ, SDS, CES-D	• WHOQOL Physical ○ Time (baseline vs. 1-year follow-up) (p<.001) • WHOQOL Psychological ○ Time (baseline vs. 1-year follow-up) (p<.001) • WHOQOL Environment ○ Time (baseline vs. 1-year follow-up) (p=.004)	None reported
Laban, Gernaat, Komproe & de Jong (2007)[b]	Netherlands	Iraq	294	Asylum Seekers *Group 1*: living in the Netherlands <6 months *Group 2*: living in the Netherlands for at least 2 years.	Cross-Sectional	Agency for the reception of asylum seekers	WHOQOL-Bref (WHOQOL Group, 1998)	PMLP, WHO-CIDI, Physical Health Rating	• Overall QoL group 1 vs. group 2 (*p*<.0005, Z(294)=-5.29) with group 2 scoring lower than group 1 • Perceived QoL General Health group 1 vs. group 2 (*p*=.017, Z(294)=-2.39) with group 2 scoring lower than group 1.	None reported

Laban, Komproe, Gernaat & de Jong (2008)[b]	Netherlands	Iraq	294	Asylum Seekers *Group 1*: living in the Netherlands <6 months *Group 2*: living in the Netherlands for at least 2 years.	Cross-Sectional	Agency for the reception of asylum seekers	WHOQOL-Bref (WHOQOL Group, 1998)	HTQ, PMLP, WHO-CIDI	• Overall QoL was significantly lower in group 2 Z(294) = −5.29, p=.0005 • WHOQOL physical was significantly lower in group 2, t(292) = 3.21, p=.001 • WHOQOL psychological was significantly lower in group 2, t(292) = 2.33, p=.020 • WHOQOL environment was significantly lower in group 2, t(292) = 5.26, p=.001 • Regressing overall QoL on predictor variables was significant (r^2 = 0.13, p<.001) ▫ Long Asylum Procedure (β=-0.17, p<.01) ▫ Adverse life events after arrival in the Netherlands (β=-0.13, p<.05) • WHOQOL Physical (r^2=.31, p<.01) ▫ Adverse life events after arrival (β=-0.15, p<.05) ▫ Depression (β=-0.19, p<.01) ▫ Somatoform disorders (β=-0.12, p<.05) ▫ One or more psychiatric disorders (β=-0.19, p<.05) ▫ Older age (β=-0.14, p<.01)	• WHOQOL social was not significantly different between group 1 and group 2. Regression • Psychopathology and socio-economic living conditions were not associated with overall QoL • Anxiety disorders, PTSD, long asylum procedure, adverse life events after arrival, and family issues were not associated with physical QoL • Having one or more psychiatric disorders, depressive disorders, a long asylum procedure, adverse events after arrival and family issues were not associated with psychological QoL • Psychopathology, adverse events after arrival, family issues and socioeconomic living conditions were not associated with social QoL • One or more psychiatric disorders, depressive disorders, anxiety disorders, somatoform disorders, long asylum procedure, adverse events after arrival, and family issues were not associated with environmental QoL

    - Socio-economic living conditions (β=-0.20, p<.01)
- WHOQOL Psychological (r^2=.18, p<.01)
    - Self-reported PTSD (β=-0.17, p<.05)
    - Somatoform disorders (β=-0.15, p<.01)
    - Socio-economic living conditions (β=-0.14, p<.05)
    - Anxiety (β=-0.17, p<.05)
- WHOQOL Social (r^2=.12, p<.01)
- WHOQOL Environmental (r^2=.15, p<.01)
    - Socio-religious aspects (β=0.12, p<.05)
    - Self-rated PTSD (β=-0.14, p<.05)
    - Socio-economic living conditions (β=-0.27, p<.01)

Lee et al. (2009)	Japan	North Korea	81	Refugees (resettled in Japan vs. resettled in South Korea)	Cross - sectional	Support center	WHOQOL-Bref (WHOQOL Group, 1998)	BDI	• Resettled in Japan vs. Resettled in South Korea
									  • Overall QOL (p<.05), Korea scoring higher
									  • WHOQOL Physical (p<.05), Korea scoring higher
									  • WHOQOL Mental (p<.01), Korea scoring higher
									  • WHOQOL social (p<.05), Korea scoring higher
									• WHOQOL environment (p<.001), Korea scoring higher
										None reported

Leiler et al. (2019)	Sweden	Afghanistan, Syria, Iraq, Iran, Eritrea, Somalia	510	AS&R	Cross-sectional	Housing facilities	WHOQOL-BREF (WHOQOL Group, 1998)	PHQ-9, GAD-7, PC-PTSD	• WHOQOL Physical
									  ▫ Depression (r=-0.58, p<.001)
									  ▫ Anxiety (r=-0.52, p<.001)
									  ▫ PTSD (r=-0.36, p<.001)
									• WHOQOL Psychological
									  ▫ Depression (r=-0.38, p<.001)
									  ▫ Anxiety (r=-0.32, p<.001)
									  ▫ PTSD (r=-0.21, p<.001)
									• WHOQOL Social
									  ▫ Depression (r=-0.37, p<.001)
									  ▫ Anxiety (r=-0.37, p<.001)
									  ▫ PTSD (r=-0.27, p<.001)
									• WHOQOL Environment
										No significant differences found between asylum seekers and refugees neither in the domain scores nor in overall QoL score.

									▫ Depression (r=-0.34, p<.001) ▫ Anxiety (r=-0.33, p<.001) ▫ PTSD (r=-0.23, p<.001)	
Löfvander, Rosenblad, Wiklund, Bennström & Leppert (2014)	Sweden	Somalia, Iraq, Syria	66 pairs of refugees and matched Swedish born	Refugees	Longitudinal Case-Control	Asylum and integration healthcare center	WHOQOL-Bref (WHOQOL Group, 1998)	GHQ-12, GAF	• Between Groups (Men) ○ Psychological (Baseline; *p*=.020) ○ Social Relations (Baseline; *p*=.002, 6 Months *p*<.001, 12 Months *p*=.001) • Between Groups (Women) ○ Social Relations (6 Months; *p*=.030) • Between Groups (Mixed) ○ Psychological (Baseline; *p*=.004, 6 Months; *p*=.025, 12 Months; *p*=.041) ○ Social (Baseline; *p*=.002, 6 Months; *p*<.001, 12 Months; *p*=.001)	Between groups (men) • No significant differences for physical QoL or environmental QoL at any timepoint. • No significant differences at 6-months or 12-months for psychological QoL. Between groups (women) • No significant differences for physical, psychological or environmental QoL at any timepoint. • No significant differences at baseline or at 12 months for social QoL Between groups (mixed) • No significant differences for physical or environmental QoL at any timepoint
Regev & Slonim-Nevo (2019)	Israel	Sudan	300	AS&R	Cross-sectional	Community	WHOQOL-Bref (WHOQOL Group, 1998)	HTQ, PCL-C, BSI, MSPSS	• Overall model for WHOQOL was significant (r^2 = 0.07, *p*<.001) ○ Social support (*β*=0.32, *p*<.001) ○ Other's traumatic events (*β*=0.27, *p*<.001)	• Length of stay was not a significant predictor of QoL

									▫ Gender *(β*=-0.32, *p*<.001) ▫ Self-traumatic events *(β*=-0.20, *p*<.001)	
Slonim-Nevo (2015)	Israel	Sudan	340	AS&R	Cross-sectional	Community	WHOQOL-Bref (WHOQOL Group, 1998)	HTQ, Language proficiency in Hebrew, PMLD, perceived discrimination, PCL-C, BSI, AIS, CSQ, FAD, MSPSS	• Overall model for WHOQOL Physical was significant (r^2 = 0.32, *p*<.001) ○ Legal status *(β*=0.14, *p*<.01) ▫ PTSD *(β*=-0.40, *p*<.001) ▫ Perceived discrimination *(β*=-0.30, *p*<.001) • Overall model for WHOQOL Psychological was significant (r^2 = 0.31, *p*<.001) ▫ PTSD status *(β*=-0.29, *p*<.001) ▫ Perceived discrimination *(β*=-0.38, *p*<.001) • Overall model for WHOQOL Social was significant (r^2 = 0.12, *p*<.001) ▫ PTSD *(β*=-0.27, *p*<.001) ▫ Perceived discrimination *(β*=-0.15, *p*<.05) • Overall model for WHOQOL Environment was significant (r^2 = 0.25, *p*<.001) ▫ Perceived discrimination *(β*=-0.24, *p*<.001) ▫ Post-migration living difficulties *(β*=-0.38, *p*<.001)	• WHOQOL Physical ○ Gender ○ Post-migration living difficulties • WHOQOL psychological ○ Gender ○ Legal status ○ Post-migration living difficulties • WHOQOL Social ○ Gender ○ Legal status ○ Post-migration living difficulties • WHOQOL Environment ○ Gender ○ Legal status ○ PTSD diagnosis

Stammel et al. (2017)	Germany	Iran, Chechnya, Turkey, Syria, Kosovo, Afghanistan, Iraq, Other countries of the russian Federation, Armenia, Kenya, Angola, Chile, Lebanon	76	AS&R	Longitudinal	Center for torture victims	EUROHIS-QOL (Schmidt et al., 2006)	MINI, PDS, HSCL-25, SCL-90-R	• Multilevel analysis revealed QoL increased significantly after an average of 14 months of treatment (Pseudo R^2= .14, β=0.42, 95% CI [0.29, 0.55], p<.001).	• Not specified
Teodorescu, Siqveland, Heir, Hauff, Wentzel-Larsen & Lien (2012)	Norway	Eastern Europe, Africa, Middle East, Far East, Latin America	55	Refugees	Cross-Sectional	Hospital outpatient department	WHOQOL-Bref (WHOQOL Group, 1998)	LEC, CAPS, SCID-PTSD, MINI, IES-R, HSCL-25, PTGI-SF	• Bivariate correlations • WHOQOL Physical ○ Posttraumatic growth (r_s=.51, p<..001) ▫ Weak social network (r_s=-.35, p<.01) ▫ Poor social integration (r_s=-.32, p<.05) ▫ Unemployment (r_s=-.34, p<.05) ▫ Posttraumatic stress (rs=-.45, p<.01) ▫ Depression (r_s=-.59, p<.001) • WHOQOL Psychological ○ Posttraumatic growth (r_s=.58, p<..001) ○ Physical QoL (r_s=.73, p<.001) ▫ Weak social network (r_s=-.53, p<.001) ▫ Poor social integration (r_s=-.37, p<.01) ▫ Unemployment (r_s=-.31, p<.05) ▫ Posttraumatic stress (r_s=-.53, p<.001)	Correlations • Non-significant correlations reported between age and physical, psychological, social, environmental and overall QoL. • Non-significant correlations reported between gender and physical, psychological, social, environmental and overall QoL. • Non-significant correlation reported between overall QoL and unemployment Regression model • Posttraumatic stress symptoms did not significantly predict any of the four domains of QoL • Gender did not significantly predict physical, psychological or social QoL.

- Depression (r_s=-.58, p<.001)
- WHOQOL social
  - Posttraumatic growth (r_s=.41, p<.01)
  - Physical QoL (r_s=.46, p<.001)
  - Psychological QoL (r_s=.54, p<.001)
  - Weak social network (r_s=-.61, p<.001)
  - Poor social integration (r_s=-.48, p<.001)
  - Unemployment (r_s=-.37, p<.01)
  - Posttraumatic stress (r_s=-.45, p<.01)
  - Depression (r_s=-.54, p<.001)
- WHOQOL environment
  - Posttraumatic growth (r_s=.49, p<.001)
  - Physical QoL (r_s=.48, p<.001)
  - Psychological QoL (r_s=.53, p<.001)
  - Social QoL (r_s=.62, p<.001)
  - Weak social network (r_s=-.56, p<.001)
  - Poor social integration (r_s=-.40, p<.01)
  - Unemployment (r_s=-.38, p<.01)
  - Posttraumatic stress (r_s=-.38, p<.01)
  - Depression (rs=-.51, p<.001)
- Overall QoL

- Depressive symptoms did not significantly predict physical QoL
- Posttraumatic growth did not significantly predict social QoL
- Unemployment did not significantly predict physical, psychological or social QoL

- Posttraumatic growth (r_s=.47, p<.001)
- Physical QoL (r_s=.62, p<.001)
- Psychological QoL (r_s=.71, p<.001)
- Social QoL (r_s=.39, p<.01
- Environmental QoL (r_s= .48, p<.001)
- Weak social network (r_s=-.39, p<.01)
- Poor social Integration (r_s=-.38, p<.01)
- Posttraumatic stress (r_s=-.65, p<.001)
- Depression (r_s=-.70, p<.001)

- Regression
- WHOQOL Physical (ΔR^2=0.49, F (4,46)=13.15, *p*<.001)
  - Posttraumatic growth (β=0.37, 95% CI=[.04, 16.22], *p*<.01)
- WHOQOL Psychological (ΔR^2=0.56, F (4,46)=17.97, *p*<.001)
  - Posttraumatic growth (β=0.39, 95% CI=[9.18, 16.37], *p*<.001)
  - Depression (β=-0.31, 95% CI=[9.18, 16.37], *p*<.05)
- WHOQOL Social (ΔR^2=0.34, F (4,46)=7.51, *p*<.001)
  - Depression (β=-0.43, 95% CI=[11.21, 21.41], *p*<.05)

									• WHOQOL Environmental (ΔR^2=0.38, F (4,46)=8.79, p<.001) ○ Posttraumatic growth (β=0.33, 95% CI=[11.28, 18.86], p<.01) ▫ Depression (β=-0.33, 95% CI=[11.28, 18.86], p<.05) ▫ Gender (β=-0.26, 95% CI=[11.28, 18.86], p<.05) ▫ Unemployment (β=-0.25, 95% CI=[11.28, 18.86], p<.05)	
Trilesnik et al. (2019)	Germany	Not specified	133	Refugees	Cross-sectional	Psychosocial counseling centers	WHOQOL-BREF (WHOQOL Group, 1998)	WEMWBS, HSCL-25, HTQ, SCL-90 , PMLDC,	• Post-migration living difficulties and overall WHOQOL (r=-.54, p<.001)	• No significant difference between post-treatment and pre-treatment levels of wellbeing.
Von Lersner et al. (2008)	Germany	Bosnia, Serbia, Kosovo, Iraq, Turkey	100	Refugees (Stayers vs.returnees)	Cross-sectional	Refugee centres, language schools and doctors' offices.	EUROHIS-QOL (Schmidt et al., 2006)	PDS, MINI,	• Stayers ○ Healthy participants vs. those with mental disorder(s) (t (37.4) = 5.65, p < .01) with healthy participants having higher QoL ▫ Age and QoL (r =-.39, p < .05)	• No significant difference in returnees between mentally healthy participants and participants with at least one mental disorder on QoL

[a, b]Same dataset has been used although they addressed different research questions. *Discrepancy exists between how the study used the measure and what the purpose of the measure was intended to be. AIS= Anger idioms scale. BDI= Beck Depression Inventory. BDQ= Brief Disability Questionnaire. BSI= Brief Symptom Inventory. CAPS= Clinician Administered PTSD Scale. CES-D= Self reported depression scale. CIDI= World Health Organization Composite International Diagnostic Interview. CRI= Coping Resources Inventory. CSQ= Culture shock questionnaire. ETI= Essen Trauma Inventory. FAD= Family assessment device. GAD-7=General anxiety disorder. GAF= General Activity Functioning Assessment Scale. GHQ-12= General Health Questionnaire. HDS= Hamilton Depression Scale. HSCL-25= Hopkins Symptoms Checklist. HTQ= Harvard Trauma Questionnaire. ICSEY= International Comparative Study of Ethno-Cultural Youth Questionnaire. IES-R= Impact of Event Scale-Revised. ISSI= Interview Schedule of Social Interaction. LEC= Life Events Checklist. MINI= International Neuropsychiatric Interview 5.0.0. MSPSS=Multidimensional scale of perceived social support. NA=Not Assessed. PC-PTSD= Primary care PTSD screen. PCL-C= PTSD checklist civilian version. PDS= Post traumatic Stress Diagnostic Scale. PHQ-9=Patient health questionnaire. PMLP= Post Migration Living Problems. PTGI-SF= Posttraumatic Growth Inventory Short Form. SASCAT= Short version of the adapted social capital assessment tool. SCID-PTSD= Structural Clinical Interview for DSM-IV-TR PTSD Module. SCL-90= Symptom Checklist. SDS=Sheehan Disability Scale. SOC-13= Sense

of Coherence Scale. F-SozU=Social support questionnaire. WEMWBS=Warwick Edinburgh Mental Wellbeing Scale. WHOQOL-BREF= World Health Organization Quality of Life-Bref. QLQ= Quality of Life Questionnaire.

- Main findings relevant to SWB and/or QoL
  - Negative Predictor
  - Positive Predictor

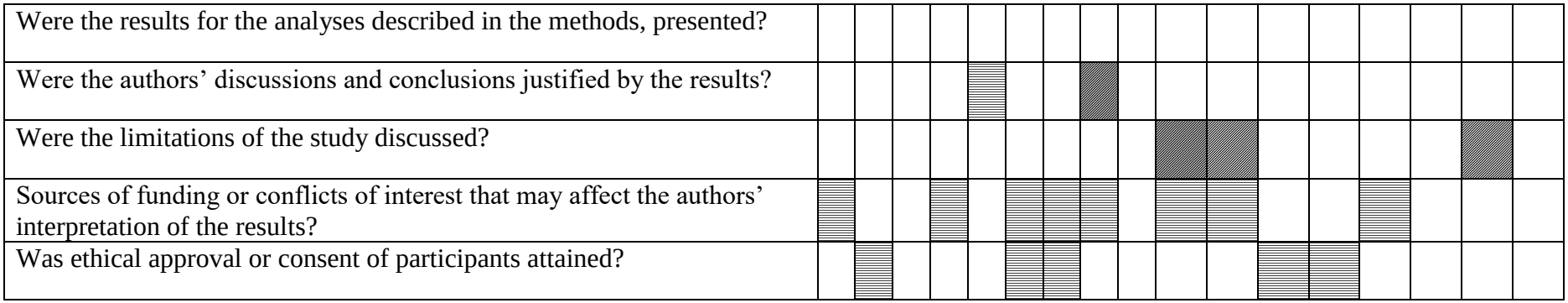
4.3.2. Quality of Cross-Sectional Studies

None of the seventeen cross-sectional studies met all 20 quality criteria of the AXIS tool, and although all of the cross-sectional studies met over half of the quality criteria, only 12 met 75% or more of these criteria. The study with the highest quality rating met nineteen of the quality criteria (Correa-Velez et al., 2011) and the study with the lowest quality rating met eleven of the quality criteria (Ghazinour et al., 2004). The quality assessment of each cross-sectional study can be found in Table 5.

Many methodological weaknesses were noted. Firstly, sample size justification (i.e., power calculation) was only reported by one study (Trilesnik et al., 2019). Five studies were unclear regarding sample selection, and one study was unclear regarding taking the sample frame from an appropriate population base (Ghazinour et al., 2004). Secondly, there were significant concerns regarding response bias as eight studies did not make a clear attempt to quantify the level of non-responders. Thirdly, five studies were unclear on standards used for determining statistical significance and/or precision estimates in their results section. This was due to insufficient detail regarding data management, significance levels, effect sizes and/or confidence intervals. Lastly, eight studies did not clearly report sources of funding and/or conflicts of interest. Five studies were not clear on whether ethical approval or consent had been obtained.

Table 5. Quality assessment of the included cross-sectional studies using the AXIS tool

Axis tool items	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
Aims/objectives of the study clear																	
Appropriate study design																	
Was the sample size justified?																	
Target/reference population clearly defined																	
Was the sample frame taken from an appropriate population base?																	
Was the selection process likely to select subjects/participants that were representative of the target/reference population?																	
Were measures undertaken to address and categorize non-responders?																	
Were the outcome variables measured appropriate to the aims of the study?																	
Were the risk factor and outcome variables measured correctly using instruments/measurements that had been trialed, piloted or published previously?																	
Is it clear what was used to determine statistical significance and/or precision estimates?																	
Were the methods sufficiently described to enable them to be repeated?																	
Were the basic data adequately described?																	
Does the response rate raise concerns about non-response bias?																	
If appropriate, was information about non-responders described?																	
Were the results internally consistent?																	



1=Carlsson et al. (2006), 2= Lee et al. (2009), 3=Correa-Velez et al. (2020), 4= Correa-Velez et al. (2011), 5=Georgiadou (2020), 6=Ghazinour et al. (2004), 7=Hengst et al. (2018), 8=Huijts et al. (2012), 9=Jesuthasan et al. (2018), 10=Laban et al. (2007), 11= Laban et al. (2008), 12=Leiler et al. (2019), 13=Regev et al. (2019), 14=Slonim-Nevo et al. (2015), 15=Teodorescu et al. (2012), 16=Trilesnik et al. (2019), 17=Von Lersner et al. (2008)

☐ Quality met
▨ Quality not met
▤ Unclear

4.3.3. Quality of Longitudinal Studies

Table 3 provides details about the quality of the longitudinal studies. Five studies clearly defined their primary outcome, one did not (Kinzie et al., 2012). Five also used validated measures, one did not (Carlsson et al., 2005). All of the studies identified confounding factors, however two did not take them into account in the analysis, and two studies were unclear. Overall, a range of follow-up periods were used; 6- months, 7-months, 9-months, 12-months, 14-months, 23-months and 10-years.

The two biggest limitations were that all studies lacked statistical precision (e.g., failing to state the confidence intervals or effect size), and the results cannot be applied to the local population as studies were conducted on very specific samples. There was a shortage of detail regarding follow-up assessments – three studies did not provide enough information on non-responders (Carlsson et al., 2005; Carlsson et al., 2006b, Löfvander et al., 2014). All but one (Stammel et al., 2017) study did not clearly report effect sizes, variance accounted for by regression models, and/ or the confidence intervals for the results. The quality assessment of each individual longitudinal study can be found in Table 6.

Table 6. Quality Assessment of the Included Longitudinal Studies using the CASP Tool

CASP Tool	Carlsson et al. (2006) *Baseline vs. 9-month follow-up*	Carlsson, Olsen, Mortensen & Kastrup (2006) *10-year follow-up*	Carlsson et al. (2005) *Baseline vs 9 month vs. 23 month follow-up*	Kinzie et al. (2012) *Baseline vs-12 month follow-up* [34]	Löfvander et al. (2014) *Baseline, 6- and 12-month follow-up* [39]	Stammel et al. (2017) *Baselinve vs. 7 months vs. 14 months* [42]
Did the study address a clearly focused issue?	Yes	Yes	Yes	No	Yes	Yes
Was the cohort recruited in an acceptable way?	No	Yes	Yes	Yes	Yes	Yes
Was the exposure accurately measured to	Cannot tell – no control group	Cannot tell – no control group	Yes	Cannot tell – no control group	Yes	Cannot tell – no control group

minimise bias?						
Was the outcome accurately measured to minimise bias?	Yes	Yes	Yes	Yes	Yes	Yes
Have the authors identified all important confoundin g factors?	Yes	Yes	No	Yes	Yes	Yes
Have they taken account of the confoundin g factors in the design and/or analysis?	No	No	Cannot tell	Cannot tell	Yes	Yes
Was the follow up of subjects complete enough?	Yes	Yes	Yes	Yes	Cannot tell	Cannot tell
What are the results of this study?	After a mean of 8 months of multidisciplina ry treatment, mental symptoms and health-related quality of life did not change	The level of emotional distress was high at follow-up. Social relations and unemployme nt at follow-up were important predictors of mental health symptoms and low health-related quality of life.	Reduction in trauma /depressio n (baseline >23month) means. Minimal differences due to low effect sizes. Interventio n not effective.	There were significant changes between means on the WHOQOL physical, mental and environment al domains after 1 year.	New immigrants did not have inferior physical or psychologic al health, quality-of-life, wellbeing or social functioning compared with their age- and sex-matched Swedish born pairs during a 1-year follow-up.	Quality of life increased significantly after an average of 14 months of treatment.
How precise are the results?	Cannot tell	Cannot tell	Cannot tell	Cannot tell	Cannot tell	Good

Do you believe the results?	Cannot tell	Cannot tell	Yes	No, more information is required	Cannot tell	Yes
Can the results be applied to the local population ?	No	No	No	No	No	No
Do the results of this study fit with other available evidence?	Yes	Yes	Cannot tell	Cannot tell	No	No
What are the implications of this study for practice?	When planning health-related and social interventions an increased focus is needed on the present exile situation, e.g., social relations, occupation and resources available in the present situation.	Post migratory factors, such as social relations and occupation, are important for mental health and health-related quality of life. For the clinician dealing with severely traumatized refugees, it is important to be aware of a possible chronic condition.	Long-term follow-ups should be included in randomized trials focusing on the effects of different treatment approaches, including the appropriate length of treatment.	The results can have implications for the treatment of torture survivors.	General screening in unselected settings of refugees and new immigrants seems to be of little value. Clinical consultations in selected cases are to be preferred, adopting a holistic practical approach in patient and family-focused care.	It provides evidence for the efficacy of multidisciplinary treatment, more research needed.

4.3.4. Overall Quality of Life (oQoL)

All WHOQOL-BREF domains positively correlated with each other (Teodorescu et al., 2012). There was evidence of differences in oQoL according to the time that had passed since arriving in the host country – Two studies, using the same sample, found that asylum seekers who had recently resettled (< 6 months) rated their oQoL higher than those who had lived in the host country for at least 2 years (Laban et al., 2007; Laban et al., 2008). Simultaneously, Stammel et al. found that refugees' oQoL increased after 14 months of multidisciplinary treatment.

In terms of physical correlates, significant gender differences were found - males reported lower oQoL than females (Ghazinour et al. 2004), and Regev et al. (2019) found gender to be a significant negative predictor of oQoL, however the coding of variables was not reported. When compared to a non-refugee EU sample, a female refugee sample rated their oQoL significantly lower (Jesuthasan et al., 2018). Being older (>30 years) predicted lower oQoL (Jesuthasan et al., 2018) and was a negative correlate of oQoL (Von Lersner et al., 2008).

Psychological associations with lower oQoL included, self-rated PTSD (Huijts et al., 2012), posttraumatic stress (Teodorescu et al, 2012), depression (Georgiadou et al., 2020; Ghazinour et al., 2004; Teodorescu et al., 2012) and having one or more mental disorders, including depression, anxiety, PTSD and somatoform disorders (Hengst et al., 2018). Furthermore, experiencing the following adverse events was negatively associated with oQoL; near-death experiences (Jesuthasan et al., 2018), self-traumatic events (Regev et al., 2019), forced isolation (Jesuthasan et al., 2018), adverse events post-resettlement (Laban et al. 2008), and other traumatic experiences (Hengst et al., 2018; Regev et al., 2019).

When compared to individuals with a mental disorder, healthy individuals reported higher oQoL (Von Lersner et al., 2008). Sense of coherence was positively associated with oQoL (Georgiadou et al., 2020, Ghazinour et al., 2004), with males reporting a significantly lower sense of coherence than females (Ghazinour et al., 2004). Exposure to other people's traumatic events (Regev et al., 2019) and posttraumatic growth (Teodorescu et al., 2012) were positive predictors of oQoL; and coping strategies (Ghazinour et al., 2004; Huijts et al., 2012), availability and adequacy of attachment (Ghazinour et al., 2004) correlated with increased oQoL. According to one study, coping strategies only led to an increase in oQoL for females (Huijts et al., 2012). Exposure to other people's traumas was interpreted by the authors as potentially providing validation for people's own experiences (Regev et al., 2019).

Weak social networks and poor social integration were social correlates of low oQoL (Teodorescu et al., 2012). Specific events that predicted lower oQoL included the unnatural loss of a child (Hengst et al., 2018), attacks by family members[4] (Jesuthasan et al., 2018), and number of lost family members (Hengst et al., 2018).

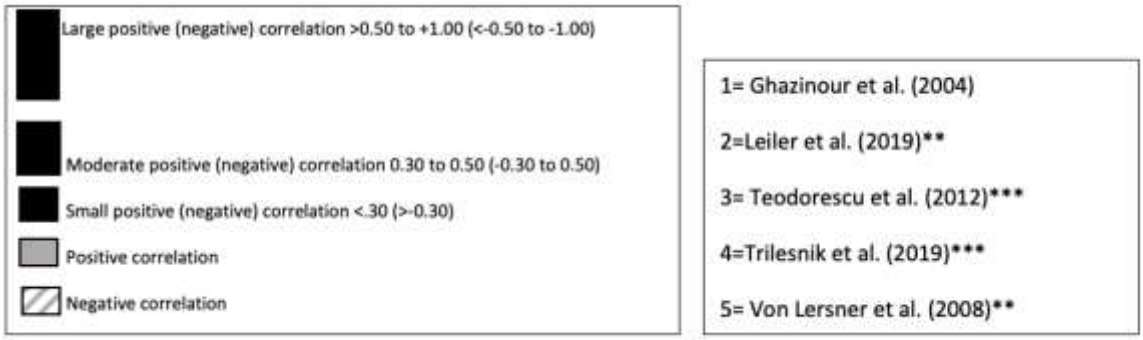
[4] This terminology was replicated from the study itself, the authors of the study do not specify what is meant specifically with this term.

Positive social predictors of oQoL focused on having social support (Georgiadou et al., 2020; Huijts et al., 2012; Regev et al., 2019). Additionally, social integration (Ghazinour et al., 2004) and having a spouse in the host country (Georgiadou et al., 2020; Jesuthasan et al., 2018), were associated with higher oQoL. One study suggested that social support was only a significant predictor for males (Huijts et al., 2012).

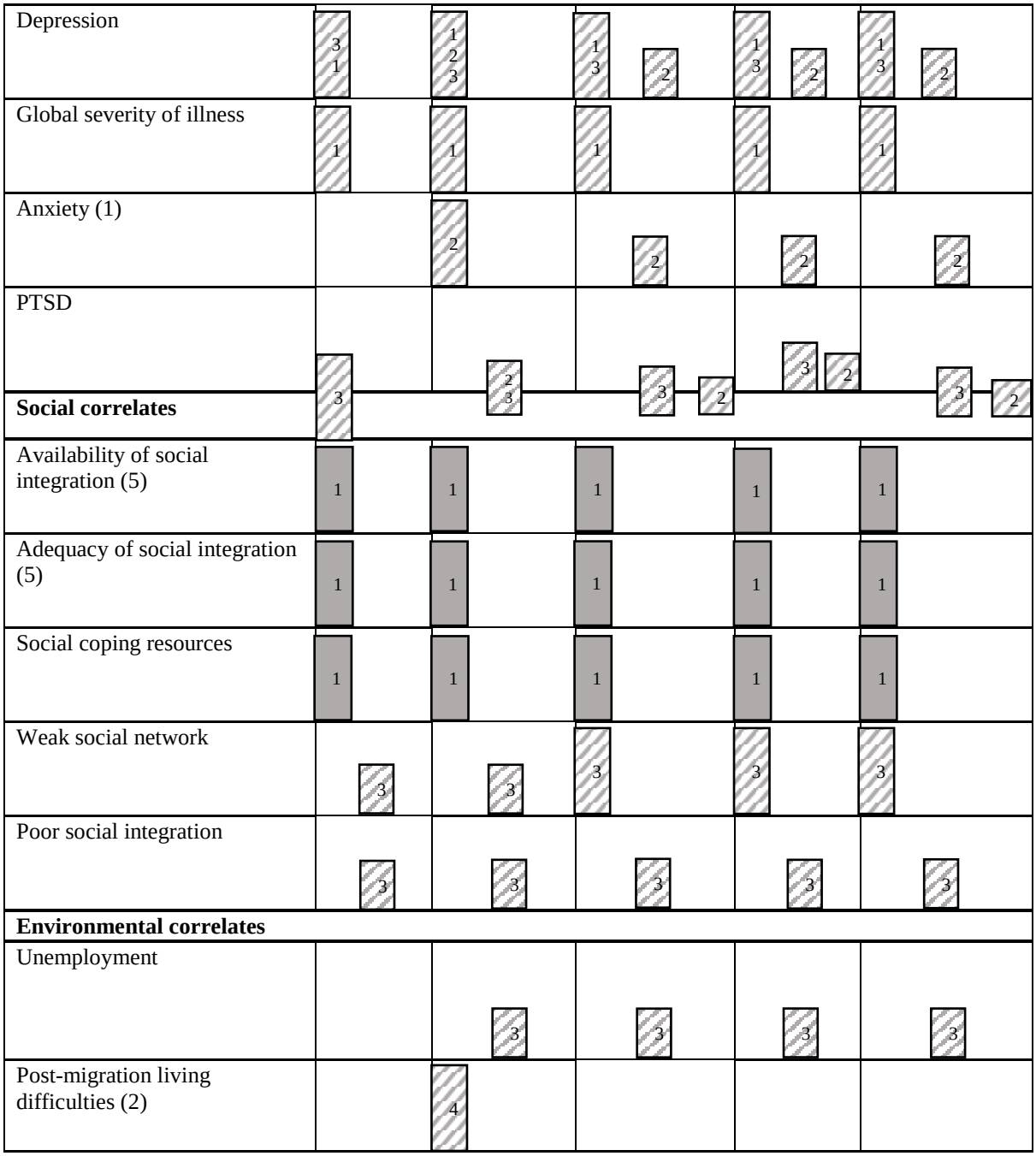
Three of the environmental predictors that were investigated predicted low oQoL; prior mission/residence in a war zone (Jesuthasan et al., 2018), being sick without access to healthcare and long asylum procedures (Hengst et al., 2018; Laban et al., 2008). Post-migration living difficulties negatively correlated with oQoL (Trilesnik et al., 2019). Similarly, one study found that North Korean refugees resettled in South Korea vs. those resettled in Japan had higher QoL, which the authors interpreted as being due to difficulties adapting to a new culture (Lee et al., 2009). No positive predictors or correlates of eQoL were found.

The consideration of the direction, strength and consistency of the correlational analyses of the correlates of oQoL reported across studies is summarized in Figure 5. For oQoL, both the strongest positive and negative correlations were found by Ghazinour et al. The strongest positive correlate found was between physical coping resources and psyQoL ($r = 0.82$, $p < .001$) and the strongest negative correlation found was between depression and psyQoL ($r = -0.86$, $p < .001$) (Ghazinour et al., 2004). However, this study reported the lowest quality of the 23 studies included. The majority of strong positive correlations found for oQoL were mental correlates.

Figure 5. A harvest plot indicating the positive and negative correlations of overall QoL and the four QoL domains. All findings are from cross-sectional studies.



	Overall QoL	Physical QoL	Psychological QoL	Social QoL	Environmental QoL
Physical correlates					
Age	5				
Physical coping resources	1	1	1	1	1
Psychological correlates					
Posttraumatic Growth	3	3	3	3	3
Individual's orientation to see life as comprehensible	1	1	1	1	1
Individual's orientation to see life as manageable	1	1	1	1	1
Individual's orientation to see life as meaningful	1	1	1	1	1
Availability of attachment	1	1	1	1	1
Cognitive coping resources	1	1	1	1	1
Emotional coping resources	1	1	1	1	1
Spiritual coping resources	1	1	1	1	1
Adequacy of attachment	1	1	1	1	1


Depression
Global severity of illness
Anxiety (1)
PTSD
Social correlates
Availability of social integration (5)
Adequacy of social integration (5)
Social coping resources
Weak social network
Poor social integration
Environmental correlates
Unemployment
Post-migration living difficulties (2)

4.3.5. Physical Quality of Life (pQoL)

Laban et al. (Laban et al., 2008) found that asylum seekers who had recently resettled (<6months) rated their pQoL higher than those who had lived in the host country for at least 2 years (Laban et al., 2008). On the other hand, Kinzie et al. (2012) reported pQoL improved over time (1year) for refugees who were undergoing treatment. Older age was a negative predictor of pQoL (Laban et al, 2008). Negative Physical correlates of pQoL in AS&R were physical pain (Carlsson et al., 2005) and headaches (Carlsson et al., 2006b). The only positive Physical predictor found was region of birth, specifically being African was a positive predictor of pQoL (Correa-Velez et al., 2020).

Negative Psychological predictors of pQoL included diagnoses of depression (Laban et al., 2008), somatoform disorders (Laban et al, 2008), PTSD (Slonim-Nevo et al., 2015), having one or more mental disorders (Laban et al, 2008) and adverse life events post-migration (Laban et al, 2008). Negative correlates of pQoL found were similar; depression (Ghazinour et al., 2004; Leiler et al., 2019; Teodorescu et al., 2012), anxiety (Leiler et al., 2019) and PTSD (Leiler et al., 2019; Teodorescu et al., 2012). Contrarily, coping strategies (Ghazinour et al., 2004), availability and adequacy of attachment (Ghazinour et al., 2004), were correlated with increased pQoL (Teodorescu et al., 2012). Posttraumatic growth was a positive predictor of pQoL (Teodorescu et al., 2012).

One study reported on negative social predictors of pQoL and found that perceived discrimination (Slonim-Nevo et al., 2015) negatively predicted pQoL. Weak social networks (Teodorescu et al., 2012) and poor social integration (Teodorescu et al., 2012) were negatively correlated with pQoL. Positive social predictors were having social relations (Carlsson et al., 2006a; Carlsson et al., 2006b) and feeling that most people in the community can be trusted (Correa-Velez et al., 2020). Additionally, social integration was positively correlated with pQoL (Ghazinour et al., 2004).

Living conditions post-resettlement, specifically socioeconomic conditions (Laban et al., 2008) was a significant negative environmental predictor of pQoL. Unemployment was significantly negatively correlated with pQoL but was not a significant predictor (Teodorescu et al., 2012). Being employed (Carlsson et al., 2006a; Carlsson et al., 2006b) and having completed either secondary or tertiary education (Correa-Velez et al., 2020) were significant environmental predictors of in- creased pQoL (Carlsson et al., 2006a; Carlsson et al., 2006b). Additionally,

legal status increased pQoL, with refugees reporting higher pQoL than asylum seekers (Slonim-Nevo et al., 2015). Lastly, place of resettlement was significant, as one study found that North Korean refugees resettled in South Korea vs. those resettled in Japan had higher QoL, which the authors interpreted as being due to difficulties adapting to a new culture (Lee et al., 2009).

4.3.6. Psychological Quality of Life (psyQoL)

Differing results were found for asylum seekers and refugees on psyQoL over time. Laban et al. (Laban et al., 2008) found that asylum seekers who had recently resettled (< 6 months) rated their pQoL higher than those who had lived in the host country for at least 2 years (Laban et al, 2008), whereas Kinzie et al. (Kinzie et al., 2012) reported psyQoL improved over time (1-year) for refugees who were undergoing multidisciplinary treatment (Kinzie et al., 2012). Group comparisons over time between refugees and a non-migrant sample also showed that refugees scored significantly higher on psyQoL outcomes at baseline, 6 months and 12 months (Löfvander et al., 2014).

The only physical predictor for psyQoL was gender, with males reporting higher psyQoL overall (Georgiadou et al., 2020). Males also reported lower levels of independence and spirituality than females, which belong to the psychological domain (Ghazinour et al., 2004).

Psychological predictors found to decrease psyQoL were depression (Georgiadou et al., 2020; Teodorescu et al., 2012), anxiety (Stammel et al., 2017), PTSD (Laban et al., 2008; Slonim-Nevo et al., 2015), and somatoform disorders (Laban et al., 2008). Negative correlates for psyQoL found were similar; depression (Ghazinour et al., 2004; Leiler et al., 2019; Teodorescu et al., 2012), anxiety (Leiler et al., 2019) and PTSD (Leiler et al., 2019; Teodorescu et al., 2012).

Psychological correlates for an increased psyQoL were self-evaluations of improved MH during treatment (Carlsson et al., 2005), coping strategies (Ghazinour et al., 2004), and availability and adequacy of attachment (Ghazinour et al., 2004). Sense of coherence and posttraumatic growth (Teodorescu et al., 2012) positively predicted psyQoL (Georgiadou et al., 2020).

Negative social predictors reported were perceived discrimination (Slonim-Nevo, 2015), and number of key persons who provide no support (Correa-Velez, 2020). Having a weak social

network and poor social integration negatively correlated with psyQoL (Teodorescu et al., 2012). Findings on positive social predictors relevant to psyQoL highlighted the importance of social support (Carlsson et al., 2006a, Carlsson et al., 2006b; Georgiadou et al., 2020), feeling that most people in the community can be trusted (Correa-Velez et al., 2020), and having one's spouse in the host country (Georgiadou et al., 2020). Additionally, social integration (Ghazinour et al., 2004) positively correlated with psyQoL.

The only significant negative environmental predictor of psyQoL was poor socioeconomic living conditions post-resettlement (Laban et al., 2008). Unemployment was a negative correlate (Teodorescu et al., 2012). Lastly, place of resettlement was significant as one study found that North Korean refugees resettled in South Korea vs. those resettled in Japan had higher QoL (Lee et al., 2009).

4.3.7. Social Quality of Life (sQoL)

There were two physical correlates of sQoL - having headaches predicted lower sQoL (Carlsson et al., 2006b), and Gender. Löfvander et al. (2014), noted that whereas the male refugees had higher sQoL compared to Swedish born controls (matched for age and gender) at the three assessment points (baseline, 6 months and 12-month follow-up), female refugees had significantly higher sQoL relative to Swedish born matched controls at baseline assessment only. Another study reported males had lower sQoL than female refugees (Ghazinour et al., 2004).

Negative psychological correlates of sQoL reported were; depression (Ghazinour et al., 2004; Leiler et al., 2019; Teodorescu et al, 2012), anxiety (Leiler et al., 2019), PTSD (Leiler et al., 2019) and post-traumatic stress (Teodorescu et al., 2012). PTSD (Slonim-Nevo et al., 2015) and depression (Teodorescu et al., 2012) were negative predictors of sQoL. Availability and adequacy of attachment (Ghazinour et al., 2004), and coping strategies (Ghazinour et al., 2004) were positively correlated with sQoL, and posttraumatic growth positively predicted sQoL (Teodorescu et al., 2012). Perceived discrimination (Slonim-Nevo et al., 2015), was a significant negative social predictor of sQoL. Simultaneously, weak social network (Teodorescu et al., 2012), and poor social integration (Teodorescu et al., 2012) were negatively correlated with sQoL. Social integration (Ghazinour et al., 2004) and being married with a spouse in the host country (Georgiadou et al., 2020) were positively correlated with sQoL, and social relations (Carlsson et al., 2006a; Carlsson et al., 2006b), positively predicted sQoL.

Employment was the only environmental predictor found to increase sQoL (Carlsson et al., 2006b), and unemployment was found to decrease sQoL (Teodorescu et al., 2012). Additionally, one study found that North Korean refugees resettled in South Korea vs. those resettled in Japan had higher QoL, which the authors interpreted as being due to difficulties adapting to a new culture (Lee et al., 2009).

4.3.8. Environmental Quality of Life (eQoL)

Three studies revealed the eQoL increased over time for refugees, after 9-months (Carlsson et al., 2010), 12-months (Kinzie et al., 2012) and 23- month follow-up (Carlsson et al., 2010). Laban et al. (Laban et al., 2008) found that asylum seekers who had recently resettled (< 6 months) rated their eQoL higher than those who had lived in the host country for at least 2 years (Laban et al., 2009).

In terms of negative physical predictors of eQoL, studies reported on the presence of pain (Carlsson et al., 2006a) and headache (Carlsson et al., 2006b). Gender was also a predictor of eQoL; however, the authors did not specify how gender was coded (Teodorescu et al., 2012). However, Ghazinour et al. (2004), found that males reported lower eQoL than females.

The negative psychological predictors of eQoL were self-rated PTSD (Laban et al., 2008), and depression (Teodorescu et al., 2012). Negative correlates found were similar; depression (Ghazinour et al., 2004; Leiler et al., 2019), anxiety (Leiler et al., 2019) and PTSD (Leiler et al., 2019) negatively correlated with pQoL. Positive psychological correlates of eQoL were coping strategies (Ghazinour et al., 2004), availability and adequacy of attachment (Ghazinour et al., 2004). Posttraumatic growth was a positive predictor of eQoL (Teodorescu et al., 2012).

Perceived discrimination (Slonim-Nevo et al., 2015), was a significant negative predictor of eQOL. Poor social integration and having a weak social network (Teodorescu et al., 2012) were negatively correlated with eQOL. The significant positive social predictor identified for eQOL was having social relations (Carlsson et al., 2006a; Carlsson et al., 2006b). Social integration (Ghazinour et al., 2004) positively correlated with eQoL and having one's spouse in the host country was associated with higher eQoL, as compared to not having one's partner in the host country (Georgiadou et al., 2020).

The negative environmental predictors found comprised socio-economic living conditions post resettlement (including living in regional areas as opposed to central areas) (Correa-Velez et

al, 2020; Laban et al., 2008), post-migration living difficulties (Slonim-Nevo et al., 2015), unemployment (Teodorescu et al., 2012), and socio-religious aspects, such as a lack of contact with people of the same religion (Laban et al., 2008). The significant positive environmental predictor of eQoL was being employed (Carlsson et al., 2006b). Additionally, place of resettlement was found to be significant in two studies; Correa-Velez et al. (2011) found that living in regional areas was a positive predictor of eQoL, and Lee et al. (2009) found that North Korean refugees resettled in South Korea vs. those resettled in Japan had higher QoL.

4.3.9. Differences Between Asylum Seekers and Refugees

Sixteen of the included studies focused on refugees, three on asylum seekers and four used mixed samples or terminology. Only nine studies (39.1%) gave the specific criteria used to define their sample as either a refugee or asylum-seeking population (i.e. by law). This is important as some studies used mixed terminologies or did not distinguish between the two. Given that asylum seekers and refugees constitute different populations with different needs, this distinction is important. Only two studies specifically compared asylum seekers to refugees (Leiler et al., 2019; Slonim-Nevo et al., 2019). Leiler et al. (2019) found no significant differences between them on any of the four QoL domains nor in oQoL. Slonim-Nevo (2015) did find that having a legal status positively predicted pQoL.

Similarly, long asylum procedures were found to be a negative predictor for oQoL by all three studies that focused exclusively on asylum seekers (Hengst et al., 2018; Laban et al., 2007; Laban et al., 2008). However, Laban et al. (2008) did not find long asylum procedures to be a significant predictor for pQoL specifically. Furthermore, for asylum seekers, QoL did not appear to improve over time whereas for refugees findings suggest that it does.

4.4. Discussion

To date, there has been a paucity of efforts to synthesize evidence relating to predictors and correlates of QoL of AS&Rs. The current review sought to address this gap, so that policy makers and organizations working to support AS&Rs in high-income countries can be guided by an improved understanding about what enhances the lived experience of AS&Rs. Key findings across the various forms of QoL (overall, physical, psychological, social and environmental) were that having established social networks and social integration were associated with higher QoL, whereas having mental disorders (i.e. PTSD or depression) was

strongly associated with reduced QoL. Physical predictors and correlates were the least reported.

Psychological predictors and correlates (including the presence of mental disorders) of QoL were the most extensively studied and reported across studies. The predictors and correlates of QoL noted in the current review can be compared with predictors of common mental disorders (CMD) identified in previous reviews. For example, Bogic et al. (2015) found that poor post-migration socio-economic status including unemployment, low income, poor host language proficiency and lack of social support were each associated with depression experienced by war-affected refugees. These findings overlap with those found in the current review. However, there were also important points of distinction; the current review showed that having a spouse was positively associated with increased QoL, whereas Bogic et al. (2015) did not find any consistent association between marital status and mental disorders. Furthermore, this review showed that positive coping strategies were highly associated with increased QoL, whereas Bogic et al. (2015) indicated that these factors had not been assessed in studies exploring mental disorders experienced by war-affected refugees. To ensure that AS&Rs are afforded the opportunity to enjoy full and meaningful lives, it will be important to understand and address not only factors associated with mental disorders, but also those uniquely associated with QoL.

The associations that QoL had with various social factors and environmental factors, point to the value of extensive integration programs that include housing and employment assistance (Valenta & Bunar, 2010). Unfortunately, however, in many high-income countries, AS&Rs face social exclusion, restricted employment opportunities, and/or below average earnings (Phillimore & Goodson, 2006). The current review highlighted that having weak social networks, and poor social integration were both moderately correlated with lower overall QoL. Those involved in developing migrant integration policies need to be cognizant of the associations that QoL have with various aspects of the socio-ecological context that AS&Rs live in. Most European governments and other OECD countries outside Europe have imposed employment bans or time constraints to asylum seekers entering the labor market (OECD, 2016; ECRE, 2016). Although asylum policies vary by country, region, and even over time within a country, such policies generally lead to long waiting periods in which asylum seekers find themselves in a legal and social limbo, without the ability to work and integrate. Research has shown that longer waiting times to obtain a refugee status strongly reduces employment integration of refugees (i.e. Bloch, 2002; Hainmueller, Hangartner & Lawrence, 2016; Warfa

et al., 2012) and can also reduce social integration (i.e. Bakker, Dagevos & Engbersen, 2014; Phillimore, 2011). Therefore, the findings of the current review should be considered by policymakers as being consistent with a need to reduce asylum procedure times, in order to promote socio-economic integration, reduce the risk of marginalization and mental ill-health, and overall increase the QoL of AS&R populations. The discourse must shift from a narrative regarding AS&R as being a burden on society to seeing their support as an investment in the social and economic framework of the host country.

Regarding methodological quality, studies had moderate to good quality overall with more recent publications generally scoring higher on quality assessment. There was a tendency to recruit opportunistic samples through health centers, which may have resulted in a bias towards AS&R who were already seeking care and with greater support systems rather than more marginalized individuals. This limits the generalizability of findings. Evidence of basic design flaws, and the predominance of cross-sectional methodologies were important limitations of the available evidence base. Moving forward more transparency is required regarding sampling procedures and non-responders. Furthermore, authors need to clearly state sources of funding and possible conflicts of interest that may have led to outcome bias.

4.4.1. Future Research and Implications

The current review has highlighted a need for research to further explore factors positively associated with QoL. Mixed-method approaches may be used to allow for a qualitative exploration of context and culture, together with a quantitative prediction. Longitudinal studies aimed at exploring causal relationships that variables (including mental disorders) potentially have with QoL are required. Specifically, more research is needed on environmental and physical correlates and predictors of QoL. Clinical trials of interventions conducted with AS&R populations that employ instruments assessing QoL as primary outcomes is required. This is a particularly worthy area of research focus in light of the fact that many people opt not to engage with treatments for mental disorders owing to the stigma that it can bring (Corrigan, Druss & Perlick, 2014).

4.4.2. Limitations of this review

The exclusion of grey literature may have introduced a publication bias into the findings presented in the current review. However, the peer review process for journal submission was

used as a form of minimal quality assurance for the studies included in the review. Similarly, the exclusion of articles that were not written in a language spoken by the authors (English, Spanish or Dutch) may have introduced a language bias. These decisions were made due to authors' language proficiency and a lack of time to arrange translating resources. Therefore, publications on other languages should be considered an area for future research.

The samples of the included studies varied significantly with respect to country of origin, time since resettlement, year and country of study publication. However, this reflects the reality that AS&Rs populations tend to be very diverse in terms of their personal circumstances. Furthermore, studies recruiting AS&Rs in low- and middle-income countries were excluded given that this review aimed to support efforts to provide further evidence to guide health and social care policy that could inform the support of AS&R in high-income countries. As the majority of the world's AS&R live in low- and middle-income countries (UNHCR, 2019c), this limitation highlights the importance of further research concerning the factors influencing AS&Rs' QoL in low and middle-income settings. The analyses used in the studies included in the current review do not permit causal relationships to be inferred. Finally, there was heterogeneity in the measures of QoL used and this limited efforts to synthesize the findings. Consideration was also given to conducting a meta-analysis but given the large heterogeneity of available data, a meta- analysis was deemed inappropriate.

4.5. Conclusion

In summary, this review expands knowledge on the predictors and correlates of QoL in AS&R populations. The findings highlight that there are significant physical, psychological, social and environmental predictors and correlates that affect QoL in AS&Rs. Overall, the majority of strong positive correlations found for oQoL were MH related correlates. Positive MH is a key determinant for good integration (Robila, 2018; Schick et al., 2016), and good integration is a determinant of good MH (Haasen, Demiralay & Reimer, 2008). Efforts to develop and deliver interventions to support AS&Rs need to be aware of QoL as an important outcome and target important determinants thereof.

Foreword Chapter 5

The findings of the systematic literature reviews conducted in Chapter 3 and Chapter 4 reveal the need to conduct research beyond formal healthcare systems and negative mental health outcomes in order to better understand factors that can promote positive mental health and wellbeing outcomes for AS&R populations. The findings in both these reviews highlight the influence of the broader socio-ecological realities of AS&Rs, and findings in Chapter 4 reveal that social networks and integration specifically were central to achieving higher QoL.

In order to understand how social determinants may influence mental health and wellbeing outcomes, in Chapter 5 the role of the host society in determining the social climate into which migrants resettle is discussed. The acculturation model (Berry, 1997) is proposed as a helpful theoretical model that can aid a broader understanding of mental health and wellbeing of AS&R groups. Potential limitations of the acculturation model are discussed, and the Capability Approach (CA, Sen, 1999) is proposed as a framework that can complement efforts to enhance understanding about issues of candidacy and the development of the acculturation model.

Chapter 5: Enhancing Capabilities

5.1. Acculturation and Integration

Migrant integration has gained prominence on the global agenda with the arrival of the 2030 Sustainable Development Agendas aim to 'leave no one behind' (United Nations General Assembly, 2015). Of particular relevance to the aim of integration is *Goal 16* which seeks to 'Promote peaceful and inclusive societies for sustainable development, provide access to justice for all, and build effective, accountable and inclusive institutions at all levels' (United Nations General Assembly, 2015). The aim of this chapter is to discuss the multidimensional nature of the integration of migrants into host countries and the different factors that can influence integration for economic migrants and forcibly displaced populations specifically.

A large part of research on migrant settlement has looked at different aspects of how newly arrived migrants build a life in their host country. Migrant adaptation to their new circumstances is frequently termed 'acculturation', which can be defined as the process of change that results from contact between groups and individuals of different cultures (Redfield, Linton & Kerskovits, 1936). Early research conceptualized acculturation as a unidimensional model, more commonly referred to as the 'assimilation model', which postulates that the strengthening of one culture (i.e., the dominant culture of the host society) requires a weakening of another culture (i.e., heritage culture), requiring a high degree of adaptation by migrants and a low degree of accommodation by the receiving society (Gordon, 1964).

The nature of acculturation, however, has changed over time for at least two reasons. Firstly, technological advancements have allowed individuals to maintain contact with their countries of origin, and secondly, the increased volume of migration across the globe has provided opportunities for displaced populations of similar cultural backgrounds to concentrate in host countries making the retention of the heritage culture a more viable component of acculturation (Schwartz et al., 2006). Furthermore, there has been an increased recognition of the impact of the sociocultural context into which individuals migrate on the integration process, specifically how well an acculturating individual is able to manage daily life in their new cultural context (Berry, 2005; 2006; 2008). As a result, acculturation has more recently been reconceptualized as a bidimensional process whereby migrants develop relationships with the new culture and maintain their original culture (Berry & Sam, 1997).

Berry proposed four potential acculturation strategies that may occur when two cultures meet: *assimilation*, *separation*, *marginalization*, and *integration* (Berry, 2009). Each of these strategies provokes reflection from the perspective of migrants on two issues; (i) to what extent

they wish to maintain their own culture, and (ii) to what extent they want to adopt the dominant culture of the host society. The first of these, *assimilation,* reflects the leaving behind of one's own culture in order to adopt the new one. *Assimilation* was historically expected of people changing cultures, for example, during colonialism and the slave trade era (Montiel, 1977; Rowley, 1973). To a great extent, national migration policies today are still informed by expectations of assimilation, with policies often reflecting expectations of migrants to embrace the receiving society's national identity and values (i.e., Haslam & Holland, 2012). According to this model, individuals who do not adopt the host countries' dominant culture can become either *separated*, by adhering to their own culture, without adopting the host culture, or *marginalized*, by abandoning their own culture without taking on the host culture. The fourth strategy, *integration,* involves keeping the heritage culture whilst also adopting the dominant culture of the host society. Berry states that the most positive acculturation strategy both in terms of society as a whole and in terms of individual mental health and wellbeing is *integration* (Berry, 1997).

Although experiences of migration are highly varied and some migrants benefit more than others, research shows that the acculturation strategies can impact on mental health and wellbeing. For example, work by Nakash et al. (2015) examining Eritrean and Sudanese asylum seekers in Israel found that *assimilation*, as assessed by the Bicultural Involvement and Adjustment Scale (Szapocznik, Kurtines & Fernandez, 1980), was related to increased levels of depression. Similarly, both *separation* and *marginalization*, have been associated with negative mental health outcomes in migrant populations, such as depression (Sawikar & Hunt, 2005), as assessed by the Acculturation Inventory (INVACC, Sawrikar & Hunt, 2005), and lower self-esteem (Virta et al., 2004), assessed using four 5-item scales based on Berry's model of acculturation. The four scales assessed attitudinal aspects of the four acculturation strategies in five life domains: marriage, cultural traditions, language, social activities, and friends (Virta et al., 2004). On the other hand, *integration* has been found to dissipate the adverse effects of culture shock in migrant populations and can lead to better psychological outcomes including lower rates of anxiety (Nguyen & Benet-Martínez, 2013), depression (i.e., Virta et al., 2004), and somatic symptoms (Nguyen & Benet-Martínez, 2013). *Integration* is also associated with the least amount of social difficulties (Berry, 2003) and stress (Berry, 2005) as it allows migrants to use resources such as language, social networks and access to employment to gain stability during the adaptation process (Berry, 2005).

5.2. The Legal Context of Integration

Depending on the sociopolitical context in which migrants arrive, acculturation strategies may be chosen, or they may be imposed contingent upon laws, policies, and the willingness of the host society to engage with newcomers. As noted by Portes and Rumbait (2006), government policy constitutes the first step to integration because it directly dictates the probability of successful migration into the host country and forms the legal framework for socio-economic opportunities. These opportunities are often linked to migrants' legal status which determines their residency rights as well as their access to central sectors such as employment, education, and health (Lomba, 2010; Strang & Ager, 2010), which have been identified as means and markers of integration (Strang & Ager, 2010).

This is particularly important when considering the integration opportunities and outcomes of different migrant groups (Becker & Ferrara, 2019). Economic migrants generally relocate based on relative opportunities available in the new country, as compared to their country of origin. This is conditional on obtaining the right to enter the country either through a work visa or law on free mobility of labor (Brell, Dustmann & Preston, 2020). Thus, they are generally able to plan and prepare for the migration journey and are likely to have access to resources to help them settle (Castles et al., 2002). In contrast, forced migration is driven primarily by experiences of conflict, persecution, natural/manmade disasters, human trafficking, and others (Reed, 2018). As such, AS&R are generally more constrained in their choice of relocation (Dadush & Niebuhr, 2016) and resettle with less locally applicable human capital, including speaking the local language and job skills, than economic migrants (Brell et al., 2020). Forced migrants may also face legal barriers to accessing the labor market whilst their asylum claim is being made (Allsopp et al., 2014), which has a long-term negative impact on their economic outcomes (Fransen et al., 2018). Lastly, national policies also dictate where forcibly displaced groups are housed upon arrival to their host country, commonly in disadvantaged and dispersed neighborhoods (i.e., Bakker et al., 2016; Phillimore & Goodson, 2006; Stewart, 2012), with a lack of access to social support, refugee support, and employment (Zetter et al., 2005). Consequently, their agency, socioeconomic living standards, and their ability to contribute to their host society can be significantly compromised. These dissimilarities must be taken with caution, as many economic migrants have been found to face similar hardships upon arrival as AS&Rs (Migreurop & Clochard, 2009).

National migration laws generally take one of two approaches to integration. Firstly, it can recognize that a secure legal status is a means to advance integration and a precarious legal

status constrains integration (Groenendijk, 2004). Alternatively, national laws can stipulate that integration is a condition that needs to be met for admission, legal residency, and/or citizenship to be granted (Erdal & Oeppen, 2013; Morokvasic & Catarino, 2006). Numerous high-income countries have adopted the latter strategy, whereby new migrants are required to either pass tests on language skills and socio-cultural knowledge, and/or take part in training programs which focus on language and cultural knowledge gain (Joppke, 2007). Such strategies highlight the importance that different governments may place on specific indicators of integration, such as language acquisition (Joppke, 2007). In the UK for example, citizenship can only be achieved through a demonstration of knowledge of, and embeddedness within, the 'British way of life'. As such, obtaining citizenship requires learning British values, taking language classes, a 'Life in the UK' test, and taking a citizenship oath. These political decisions are grounded in the governments' need to be perceived as being in control of migration levels and community cohesion (Erdal & Oeppen, 2013).

Multiple issues have been noted with this approach. Firstly, it suggests that integration is an outcome rather than a process, and this outcome is dependent on obtaining citizenship. This is problematic – obtaining citizenship implies having equal rights as natives, however, it does not imply migrants are able to exercise these rights equally (Spencer, 2006). For example, on the one hand gaining a right to work might help forcibly displaced populations to develop social connections which are key to integration, on the other hand, obtaining this right does not change non-legal barriers to employment, such as discrimination (i.e., Abdelkerim & Grace, 2012; Bloch, 2002). Furthermore, this approach conceives integration as an aim to be accomplished by the migrant alone, rather than a two-way process. A one-way view of integration affirms an asymmetric understanding of social process whereby structures, such as integration policies and requirements, are fixed (Strang & Ager, 2010; Phillimore, 2011).

5.3. The Role of the Host Society

Prevailing attitudes, stereotypes, and perceptions among members of the host society are instrumental to determine the social climate into which migrants resettle (Phelps, Ommundsen, Türken, & Ulleberg, 2013; Segovia & Defever, 2010). Previous literature shows that positive integration is more likely to be achieved in contexts where the host society is characterized by a positive multicultural ideology, low levels of discrimination and prejudice, positive mutual attitudes between different cultural groups, and a sense of identification with the larger society

by all individuals (Berry, 2005, 2006, 2008). On the other hand, societies characterized by antimigrant sentiments, support for far-right wing political ideologies, spatial segregation of migrants, and socioeconomic exclusion can reduce the likelihood of successful integration. Such contexts can make it a highly stressful adaptation process, whilst simultaneously reducing migrant opportunities overall (Garcés-Mascareñas & Penninx, 2016; Lajevardi et al., 2020; Rudmin, 2006). Ultimately, where the burden of finding avenues for participation in society falls solely on migrants there is an increased risk of integration becoming a "watered down form of assimilation" (Castles et al., 2002; p.116). Promoting understanding and seeking strategies to foster positive relations between migrants and host societies is imperative to supporting integration efforts and achieving positive outcomes.

To continue building on the acculturation framework, it is important to consider some of the criticism it has received over the last few decades. Firstly, although the acculturation model provides a framework for structural analysis, it does not consider individual differences such as personality, self-esteem, and coping (AbiHanna, 2014; Lazarus, 1997), instead it considers acculturation strategies to be universal across groups (AbiHanna, 2014). Secondly, the model assumes a single monolithic and monocultural majority society exists into which migrants acculturate (Horenczyk, 1997). This is particularly relevant in today's world as host societies are often highly multicultural. In 2019 an estimated 26% of Germany's population was foreign-born (Destatis, 2019), and the UK's foreign-born residents made up 14% of the population (Vargas-Silva & Rienzo, 2020). As such, migrants may choose to adopt the norms of multicultural neighborhoods, or specific cultural clusters, rather than adopt the values and norms of the dominant culture. Lastly, there is a lack of recognition within this model that the social practices of migrants are increasingly multi-sited and embedded in transnational social spaces (Levitt & Schiller, 2004). The realities of these transnational processes and attachments imply that acculturation cannot be understood as a choice between adopting a new 'national' culture or rejecting it (Korac, 2009), instead it suggests that it is a multidimensional process which may fluctuate over time and space. Consequently, it is important to consider how relevant and appropriate these models of thinking are for guiding acculturation policy and practice.

We contend that there is a need to further explore and develop the acculturation model. We propose the use of the Capabilities Approach (CA) which is a human development approach that centers around individual freedoms to engage in forms of being and doing that are valuable to them. The approach has gained currency in a range of areas and disciplines, and has been

influential in international policy, for example, contributing to the development of the United Nations Human Development Index. The use of the CA in research related to migrant populations remains limited (e.g., Briones, 2009; Clarke, 2014), specifically in the area of integration. However, we propose that it can be a valuable framework that provides scope for understanding how different factors can impact on individuals' experiences post-migration, and what support is required for communities to achieve positive outcomes that are valuable to them.

5.4. Migration and the Capability Approach

The CA is a "broad normative framework for the evaluation and assessment of individual wellbeing and social arrangements, the design of policies, and proposals about societal change" (Robeyns, 2006 p. 352). Initially proposed by Amartya Sen during the Tanner Lecture on Human Values with his essay titled '*Equality of What?'* (Sen, 1979), the CA advocates that people's wellbeing and larger societal welfare need to be assessed in the space of the real opportunities ('capabilities') people have "to live the kind of life they value and have reason to value" (Sen, 1999, p.18). The CA offers a way of evaluating social arrangements and exploring the factors that may influence the choices individuals have to derive benefits from resources, which can allow them to expand their capability sets and live a life that is valuable to them (Sen, 1992). The framework has been developed over the last few decades and has been used to study poverty, human development, societal wellbeing, and justice. A key characteristic of the CA is its broad interdisciplinary nature and the prevalence of theoretical and conceptual analysis in contrast to empirical modelling.

The CA speaks directly to the specific areas of critique of the acculturation model that have been highlighted in this chapter. Firstly, the CA contends that social arrangements should aim to expand people's capability sets; ergo their freedoms to promote or achieve their own valuable 'beings and doings' (Alkire & Deneulin, 2009). These freedoms should not be theoretical or legal, rather they are the set of real opportunities that an individual can choose to pursue. Sen argues that such freedoms have intrinsic as well as instrumental value, as a 'good life' needs to be one of genuine choice (Sen, 1996). The expansion of people's capabilities and freedoms has the power to cultivate empowerment, responsibility, informed public action, and ultimately, development (Alkire & Deneulin, 2009). Capabilities therefore offer a lens through which to examine the real freedoms and opportunities that exist for migrant groups to live a life that is valuable to them within their host society.

Secondly, the CA is acutely attuned to the individual, social, political, legal, and further context in which an individual must navigate choice (Brighouse & Robeyns, 2010). It recognizes that factors can exist at different levels of a person's social environment (i.e., the individual, interpersonal, community, institutional system levels) which can impact on the individual's ability to convert available resources into capabilities. Consequently, different individuals may require different resources to achieve similar outcomes (Brighouse & Robeyns, 2010; White & van der Boor; 2021). For example, the capability to enter paid employment will be different for an economic migrant with a strong social network and an asylum seeker, who may be limited in terms of legal access, whereas refugees may be concerned about the impact on their migration status (see Chapter 3). The CA can therefore be used to understand what resources are available to different migrants within their social environment, and how these resources interact with the person's capabilities and freedoms to engage in functionings that are important to them (White & van der Boor, 2021).

Lastly, the CA gives a central role to the ability of people to be agents of their own lives. According to the CA, individuals should not be considered passive objects of social welfare provision, rather they should be seen as active subjects (Alkire, 2009; Sen, 1985a). This is described in terms of 'agency', which refers to a person's ability to pursue and achieve goals that they have reason to value. The opposite of an individual who has agency is a person who is forced, oppressed or passive (Sen, 1999). For example, a female asylum seeker's agency in relation to seeking employment would be impeded by legislation that prevents asylum seekers from gaining employment in that country. Agency is important in "assessing what a person can do in line with his or her conception of the good" (Sen, 1985b, p.206). Furthermore, the CA advocates that individuals and communities should be empowered to define their own local priorities as well as choose the best means to meet these.

Ultimately, our understanding of issues such as supporting the wellbeing of migrants and promoting positive outcomes including social cohesion can be greatly enriched by focusing on the enhancement of capabilities of community members (migrant and host). The CA recognizes the multi-dimensional nature of wellbeing, individual diversity, and the central role of human agency and allows for a person-based understanding of the experience of migrants by situating the person in the particularities of their social environment (White & van der Boor, 2021). The CA is therefore offered as an approach that can complement the narrower focus on notions of integration, marginalization, assimilation, and separation, to inform the evaluation and assessment of the mental outcomes, wellbeing and quality of life of migrant communities post-migration.

Foreword Chapter 6

In Chapter 5, the bidirectional nature of integration was discussed and the need to consider the sociopolitical environment into which migrants arrive. It has been recognized that the social environment and public perceptions into which migrants resettle is an important area of research (Dempster & Hargrave, 2017). Additionally, understanding attitudes and perceptions of the general population towards migrants can be helpful in understanding how integrated a nation might be. In order to explore public perceptions of host communities, in Chapter 6 a quantitative cross-sectional survey design is used to explore host community perspectives on capability-based wellbeing of different migrant groups in the United Kingdom.

Chapter 6: Quantitative exploration of the Host Societies' perspectives on capability-based wellbeing and what constitutes a 'good life' for different migrants in the United Kingdom

6.1. Introduction

Migrant Categories

Over the last few decades, there has been extensive political and social debate in the United Kingdom (UK) around migration and asylum, with challenges of integration and social inclusion being issues of concern for many political leaders.

Under the 1951 Refugee Convention, a refugee is defined as an individual who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion (Refugee Convention, 1951). On the other hand, an asylum seeker is someone whose request for sanctuary has yet to be processed (United Nations High Commissioner for Refugees [UNHCR], 2021). Asylum seekers and refugees (AS&R) are distinct migrant categories to economic migrants (EM), as EM leave their country of origin of their own volition for economic reasons and/or to seek material improvements to their livelihoods (UN, 2006). EM are generally able to plan their journey and have resources to help them settle down upon arrival (Castles et al., 2002), in contrast to AS&R who often are unable to plan. Overall, EM and AS&R are entitled to the same universal human rights and fundamental freedoms, however there are specific international protections that are afforded to AS&R (UNHCR, 2016). In the year ending 2019, The UK offered asylum, humanitarian protection, or alternative forms of resettlement to 19,480 individuals (Home Office 2019b), and an estimated 18% of the UK workforce was born abroad (The Migration Observatory, 2021)

The Social and Political Postmigration Context

The social and political environment into which migrants (AS&R and EM) arrive and settle has been highlighted as a key determinant of their overall health, wellbeing and quality of life outcomes (Chen et al., 2017; Giacco, Laxham & Priebe, 2018; Rapp et al., 2019; van der Boor et al., 2020a). A recent systematic review conducted by Giacco et al. (2018) revealed that poor social integration and difficulties in accessing care contribute to higher rates of mental

disorders in the long-term for refugees, including post-traumatic stress disorder, and depressive and anxiety disorders. Similarly, a qualitative six-year follow-up study conducted on female Iranian immigrants in Sweden illustrated the complex relationship between wellbeing, health and the host environment as participants identified discrimination as "the greatest threat to their health", and this remained consistent over time (Sharareh et al., 2007, p.349). On the other hand, participants considered being integrated as being good for their health (Sharareh et al., 2007). Similarly, research conducted on EM post-resettlement has highlighted that they too often face discrimination, exploitation, and psychosocial problems upon resettlement which can impact on their mental health (Kofman et al., 2009; Mock-Munoz de Luna et al., 2015).

However, important differences also exist between the mental health outcomes of AS&R and EM. In a meta-analysis conducted by Lindert et al. (2009), both depression and anxiety rates were found to be double as high for refugees as compared to EM. A more recent study conducted in Switzerland by Heeren et al. (2014) found that resident status was significantly associated with mental health outcomes. Specifically, asylum seekers, refugees, and illegal migrants show higher rates of psychiatric morbidity post-migration as compared to EM and residents. This difference was found to be consistent across trauma specific as well as trauma unspecific symptoms. The authors concluded that the sociopolitical living conditions of different migrant groups are linked to their mental health outcomes. Indeed, it has been recognized more widely that the social environment and public perceptions into which migrants resettle is an important area of research (Dempster & Hargrave, 2017). The aim of the current study is to shed light on the public perceptions towards migrant groups in the UK.

Literature examining public attitudes towards migrant populations in the UK has shown clear trends of generally negative feelings and attitudes towards newly arrived migrants. The Ipsos Mori Issues Index showed that in 2015, 'immigration as an issue' in the UK rose to its highest level ever recorded (Duffy et al., 2015). Since then, public opinion polls highlight that immigration consistently ranks in the top five 'most important issues' (Blinder & Allen, 2020). However, views are divided as 39% of respondents considered that the level of immigration should stay the same, whilst 44% said they would like immigration to be reduced (Blinder & Allen, 2020). There is also strong evidence that people's attitudes vary by migrants' ethnicity, social class, skill-level, legality, region and country of origin, with consistent opposition towards undocumented migrants and AS&R, when compared to other migrants such as EM or students (Ford, 2011; Blinder, 2015; Adida et al., 2016; Hainmueller & Hopkins, 2014). These figures suggest that migrants may be settling into environments that are becoming less welcoming and increasingly challenging at the social level, which may be driven by

governmental policy and rhetoric around migration (Crawley & McMahon, 2016; Dempster & Hargrave, 2017).

In addition to the political environment into which migrants arrive, measuring attitudes and perceptions of the general population towards different migrant categories can be helpful in assessing how integrated a particular nation is. Work by social psychologists, in particular Berry (1994, 1997), builds on the idea of integration as a two-way process whereby both migrant groups and host societies need to adapt for new identities to emerge. However, to date most research has focused on integration from the perspective of the migrants, with very limited research being done on the host societies' understanding and perceptions of the post-resettlement realities of different migrant groups. As stated by Casey (2016); "understanding opinions on specific social and ethical issues could give an insight into fundamental divergences in opinion which are driving integration – or segregation- within the population" (p.64-65). Engaging effectively with public attitudes towards different migrant categories requires understanding of the real-world concerns and perceptions around which attitudes may be formed. The current study adopts a Capability Approach (CA; Sen, 1993) to gain insight into public perceptions of different migrant groups in the UK.

The Capability Approach

There is a growing interest in using Sen's CA as a conceptual framework to capture different dimensions of wellbeing (i.e., Nussbaum, 2011). The CA postulates that a 'good life' is one in which a person has the freedom to achieve the forms of 'beings and doings' that they have reason to value in life (Sen, 1993). It differs from the literature on subjective wellbeing as the CA offers a much broader informational space to assess the situation of an individual, including a focus not only on outcomes but also on agency and a person's substantive opportunities (Binder, 2014).

One of the important distinctions made within the CA is that between freedom (also referred to as capability) and achievement (functionings). Sen describes *functionings* as "the particular beings or doings a person enjoys at a given point in time" (Alkire, 2005, p.2). *Capability* on the other hand, refers to the: "alternative combinations that are feasible … to achieve. Capability is thus a kind of freedom: the substantive freedom to achieve alternative functioning combinations (or, less formally put, the freedom to achieve various lifestyles)." (Sen, 1999, p.75). Capability therefore refers to the option, the possibility, the liberty, the ability etc., or the *freedom*, to achieve what is valuable. These genuine freedoms can be influenced by internal

factors (i.e., being able to speak the language of the host country) and by external factors such as migration policies imposed by governments or negative attitudes from others in society.

A significant advantage of the CA lies in its focus on opportunities rather than on resources. To date, migration studies have largely been concerned with resource-based metrics such as economic means or social capital (Eichsteller, 2021). These resource-based outcome metrics largely place responsibility on the individual migrant and suggest that by making resources available (i.e., housing or employment), individuals can successfully assimilate or adapt (Eichsteller, 2021). The CA takes on a different approach; firstly, it recognizes that not everyone has the same needs (Burchardt & Hick, 2016) thereby acknowledging that different migrants will require different forms of support rather than a 'one-size fits all' approach. Secondly, it recognizes that individuals may face systemic barriers that frame a person's agency, such as discrimination or negative perceptions from the host society. This can limit their capability set and put them at a significant disadvantage (Burchardt & Hick, 2016). Sen states that in order to assess the 'good life' it is necessary to reflect the environment in which the individual exists. As Eichsteller (2021) describes; "in the context of migration, this includes the expectations of multiple reference groups, including the receiving and sending communities as well as the migrant groups themselves, with an added value attached to individual choices." (p. 176).

To consider what capabilities may be important for individuals, Martha Nussbaum (2000) proposed a list of 10 central capabilities that she claimed sustain human life and dignity: Life; Bodily Health; Bodily Integrity; Senses, Imagination and Thought; Emotion; Practical Reason; Affiliation; Other Species; Play; and, Control Over One's Environment. The express intention of this list is that these should provide the basis for "constitutional principles that should be respected and implemented by the governments of all nations" (Nussbaum, 2000a, p.5). Although this list has been debated, particularly with regards to the domains that should be included, its contents overlap with multiple other lists on human development and wellbeing (for a review see Alkire, 2005). As such, it is considered to be a relatively comprehensive list of central human capabilities (Simon et al., 2013).

The current chapter explores the potential utility that applying the CA might have for better understanding community perspectives on post-resettlement levels of wellbeing (measured by capabilities), of different migrant groups in the UK, as compared to a non-migrant control condition (a British national). This study was guided by three research questions:

(i) *To what extent does a UK community sample consider refugees and EM to have the freedom to achieve capability-based wellbeing considering the unique set of circumstances that their migration status gives each of these groups in the UK?* We hypothesized that there would be a difference in the community perceptions of levels of capability-based wellbeing depending on migration status, with refugees being perceived as having lower levels of wellbeing as compared to both EM and the British national condition.

(ii) *To what extent does a UK community sample consider refugees, EM and British nationals to live a 'good life' in the UK?* We hypothesized that refugees would be perceived as having less of a 'good life' as compared to the EM and British national conditions.

(iii) *Does the community perceive different types of migrants to face different levels of discrimination as compared to the British national condition?* We hypothesized that the participants would estimate that both refugees and EM face higher levels of discrimination in the UK than British nationals, and that the reasons for discrimination would differ per migrant group.

6.2. Methods

Participants

A convenience sample was recruited through social media platforms (Facebook, Twitter, Reddit) and posters with a QR code were distributed across the University of Liverpool campus between February and March 2020 (see Appendix C). To complete the survey, participants were required to be an English language speaking UK resident, and have access to the online survey. The sample was recruited between the 3rd of February and the 16th of March 2020. Participation was on a voluntary basis and participants were not given an incentive for completing the survey. All potential participants who indicated they considered themselves to be an EM (N=6), or a refugee (N=2) were excluded. A further two participants who chose 'prefer not to say', and three with responses to that question missing were also excluded. An *a priori* sample size calculation using G*Power 3.1 revealed that to achieve adequate power (1-β=0.95) at level α=.05 a minimum sample size of 252 participants was required. The final sample size was 364.

Materials and Measures

Three vignettes were constructed describing a 30-year-old female residing and working in Birmingham, UK as a waitress. Vignettes varied only on the basis of nationality and migration status (refugee/EM/British national). In order to create the vignettes, published peer-reviewed articles that had used a vignette experiment to research different aspect of migration were reviewed (i.e. Kootstra, 2016; Terum, Torsvik & Overbye, 2017). This review gave insight into which variables to include and which ones to change within each vignette. The vignettes were then drafted in consultation between authors CB and RW:

- Condition 1 (Refugee): *Fatima is a 30-year-old female resident in Birmingham with Eritrean parents. She fled her country and applied for asylum in the UK 5 years ago. After spending two years in the asylum process, she got her refugee status. Since then, she has been working as a waitress in Birmingham. Fatima lives on her own but has some cousins who live in London. She is single and has no children.*
- Condition 2 (Economic Migrant): *Sabryna is a 30-year-old female resident in Birmingham with Jamaican parents. She holds a visa and moved to Birmingham from Jamaica 5 years ago to look for employment. Sabryna has been working as a waitress in Birmingham for four years now. She lives on her own, but she has some cousins who live in London. She is single and has no children.*
- Condition 3 (British national): *Sara is a 30-year-old female resident in Birmingham with English parents. She was born in London but moved to Birmingham twelve years ago. Sara has been working as a waitress in Birmingham for ten years now. She lives on her own and all her relatives live in London. Sara is single with no children.*

Participants were asked to fill in the survey according to their perceptions on the capabilities the individual presented in the vignette has in the UK.

The 16-item Oxford capabilities questionnaire -mental health (OxCAP-MH; Simon et al., 2013) was adapted (AOxCAP-MH) to capture different dimensions of capability-based wellbeing within the conceptual framework of the CA, across the three conditions (refugee/EM/British national). The original OxCAP-MH questionnaire is a wellbeing questionnaire developed within the conceptual framework of the CA. It was developed in the UK as a self-report measure for individuals with a severe mental illness (Simon et al., 2013). The measure is based on Nussbaum's list of 10 central human capabilities (Nussbaum, 2001) and the 16 items cover: overall health, enjoying social and recreational activities, losing sleep over worry, friendship and support, having suitable accommodation, feeling safe, likelihood of

discrimination and assault, freedom of personal and artistic expression, appreciation of nature, self-determination and access to interesting activities or employment (Simon et al., 2013). The measure has previously shown good internal consistency (Cronbach's alpha 0.79; Vergunst et al., 2017). In this study, the adapted version (AOxCAP-MH) also demonstrated good internal consistency (McDonald's ω=0.86).

For the current study, the wording of the questionnaire was adapted to allow the participant to complete the measure in relation to the experience of the character featured in the vignette. For example, if the original item stated, '*are you able to meet socially with friends or relatives*?' this was adapted to '*do you think that Fatima/Sabryna/Sara would be able to meet socially with friends or relatives*?'. See Appendix D for the AOxCAP-MH. Two of the items ('*Does the health of Fatima/Sabryna/Sara affect their daily activities compared to most people their age*?' and '*Do you think Fatima/Sabryna/Sara would be able to meet socially with friends and relatives*?') were dichotomously coded (yes/no) and then converted into a 1 to 5 scale for scoring purposes as suggested in Simon et al. (2013). All the other items were scored on a 5-point Likert scale. Items 2, 4, 5, 6, 9, 10, 11, 12, 13, 14, 15 and 16 were reverse coded. The original OxCAP-MH is scored on a 16-80 scale, and the scores are standardised to a 0–100 scale, with higher scores indicating better capabilities. Scores are standardised using the formula: 100 × (OxCAP-MH total score – minimum score)/range (Vergunst et al., 2017). This standardization method was also used for the AOxCAP-MH.

To address research question 2, participants were asked to give an overall rating regarding to what extent they expected the individual in the vignette to be living a 'good life'[5] in the UK with '10' being the best, and '0' being the worst.

Lastly, one of the items (item 8a) of the AOxCAP-MH focuses on reasons for discrimination and is not included in the total score (Vergunst et al., 2017). In the current study, this item was used to address the third research question. Eight potential reasons for discrimination were offered; race/ethnicity, gender, religion, sexual orientation, age, health or disability (incl. mental health), 'I don't think she will be discriminated against', and 'other'. Participants were able to choose more than one reason. Furthermore, a textbox was provided in which participants could write alternative perceived reasons for discrimination not included in the provided list.

[5] This question was replicated from Greco et al. (2015)

Procedure

The landing page for the online Qualtrics platform was a participant information sheet (see Appendix E) describing the nature of the study after which participants were asked to complete the consent form (Appendix F). Participants were then asked questions regarding their demographics and employment status. Subsequently, Qualtrics randomly assigned participants to one of the three conditions: the vignette featuring the refugee, EM, or British national. Depending on the condition they got assigned to, they were presented with one of the three vignettes and asked to fill in the survey including the AOxCAP-MH along with the individual question on the 'Good Life'. Participants were thanked for their time.

Ethics

This research was granted ethical approval by the Health and Life Sciences Research Ethics Committee of Psychology, Health and Society (approval reference number: 4314) at the University of Liverpool.

Statistical Analysis

To address research question one, a one-way between-subjects ANOVA was conducted to analyze the effect of condition on the AOxCAP-MH score of participants. A second one-way between-subjects ANOVA was run to analyze the difference between conditions in response to the 'good life' question (research question 2). A Levene's test was used to check the assumption of equal variances before running both the between-subjects ANOVAs.

For research question three, a non-parametric Kruskal-Wallis H test was conducted to compare the overall effect of condition on the total number of perceived reasons for discrimination in refugee, EM and British national conditions. Additionally, each of the potential reasons for discrimination contained a binary category of 'yes'/'no'. A binary logistic regression was run to predict group membership ('yes'/'no') for each of the eight reasons for discrimination, across the three conditions. A significance level of $p<.05$ was set for all inferential tests conducted. The data were analyzed using SPSS version 25.0.

6.3. Results

Participant characteristics are provided in Table 7.

Table 7. Socio-demographic characteristics of participants

	N=364
Female (Male)	65% (35%)
Age	M=30.81, SD=13.70
Ethnicity	
English/Welsh/Scottish/Northern	326 (90%)
Irish/British	4 (1%)
Irish	-
Gypsy or Irish Traveller	17 (5%)
Other white background	1 (0%)
White and Black Caribbean	-
White and Black African	3 (1%)
White and Asian	5 (1%)
Indian	2 (1%)
Pakistani	-
Bangladeshi	3 (1%)
Chinese	-
Other Asian background	-
African	-
Caribbean	-
Arab	1 (0%)
Other	-
Prefer not to say	2 (1%)
No response	
Employment Status	
Full time student	122 (33%)
Employed	211 (58%)
Unemployed	21 (6%)
Retired[a]	10 (3%)
No response	-

Perceptions of Capability-Based Wellbeing

A one-way between-subjects ANOVA was conducted to compare the effect of condition (refugee/EM/British national) on the perceptions of capability-based wellbeing using the AOxCAP-MH survey. Levene's test was significant, suggesting the assumption of homogeneity of variance was not met ($F(2, 336)=4.24$, $p=.015$). Therefore, a Welch's adjusted F ratio was used. There was a significant main effect of condition on the AOxCAP-MH score; $F(2, 223.71)=11.63$, $p<.001$, $\eta p^2=.06$. Tamhane's adjusted post-hoc tests demonstrated a significant difference between the refugee (M=54.47, SD=12.44), and EM condition (M=60.01, SD=13.27, $p=.003$), with the refugee condition scoring lower. There was also a significant difference between the refugee and British National condition (M=61.59, SD=9.98, $p<.001$), with the refugee condition scoring lower on perceived wellbeing. No significant

difference was found between the EM condition and the British national condition in perceived wellbeing.

Perceptions of the 'Good Life'

A one-way between-subjects ANOVA was run to compare the effect of condition (refugee/EM/British national) on the overall rating of the 'good life' using the question '*to what extent do you think Fatima/Sabryna/Sara is living a 'good life' in the UK*? Levene's test was not significant (F(2, 358)=.44, p=.645). There was a significant main effect of condition on the overall rating of the 'good life'; F(2, 358)=3.40, p=.035, ηp^2= .02. Fisher's least significant difference (LSD) adjusted post-hoc tests showed a significant difference between the refugee (M=5.42, SD=1.64) and the EM condition (M=5.87, SD=1.62, p=.031), and the British national condition (M=5.92, SD=1.70, p=.022) with the refugee condition scoring lower on the perceptions of the 'good life' in both instances. There was no significant difference between the EM and the British national condition (p>.05).

Perceptions of Discrimination

The total number of perceived reasons for discrimination across conditions was non-parametric (Skewness statistic=1.22, SE= .13), therefore a Kruskal Wallis H test was conducted to compare the effect of condition (refugee/EM/British national) on the total number of perceived reasons for discrimination.

The Kruskal Wallis H indicated a significant difference in the medians, $\chi^2(2, N=364) = 26.89$, p<.001, with a mean rank of 213.35 for the refugee condition, 181.32 for the EM condition and 145.42 for the British national condition. Follow-up Mann-Whitney U tests were conducted to evaluate pairwise differences among the three groups. Participants in the refugee condition were perceived to have more reasons for discrimination than those in the EM condition (*U*=6762.50, *p*=.003, *r=.18),* and compared to those in the British national condition (*U*=4437.50, *p*<.001, *r* =.31). Additionally, participants in the EM condition reported a higher number of reasons for discrimination experienced by the character in their vignette than those in the British national condition (*U*=5226, *p*=.001, *r* =.21).

A binary logistic regression was run for each of the individual reasons for discrimination to predict the odds of participants saying yes or no to the individual reasons for discrimination based on migration status (refugee/EM/British national). Odds ratios revealed that participants

in the refugee condition were 50 times more likely to say that the individual in the vignette would be discriminated against on the basis of race/ethnicity (p<.001), and 13 times more likely to give religion as a reason for discrimination (p<.001) as compared to the British national condition. Similarly, participants in the EM condition were 35 times more likely to say that the individual would be discriminated against on the basis of race/ethnicity (p<.001) than those in the British national condition. Additional significant findings are reported in Table 8.

Table 8. Binary logistic regression on perceived reason for discrimination across conditions with British national as reference category

	Conditions			
	Refugee		Economic Migrant	
Perceived reasons for discrimination	*b* (SE)	OR [95%CI]	*b* (SE)	OR [95%CI]
Race/Ethnicity	**3.92 (.41)*** **	50.40 [22.45, 113.15]	**3.55(.38)*** **	34.80 [16.63, 72.83]
Gender	**-.58 (.28)***	.56 [.33, .96]	-.33 (.28)	.72 [.42, 1.24]
Religion	**2.55 (.41)*** **	12.76 [5.74, 28.38]	.45 (.46)	1.57 [.64, 3.85]
Sexual Orientation	**-1.53 (.49)** **	.22 [.08, .56]	**-1.53 (.49)** **	.22 [.08, .56]
Age	**-1.51 (.53)** **	.22 [.08, .62]	-.41 (.39)	.66 [.31, 1.43]
Health or Disability (Including Mental Health)	-.45 (.45)	.64 [.26, 1.54]	-.69 (.48)	.50 [.20, 1.28]
I Don't Think She Will be Discriminated Against	-.07 (.57)	.93 [.30, 2.86]	-.66 (.66)	.52 [.14, 1.89]
Other Reason for Discrimination	**-1.50 (.41)*** **	.22 [.10, .50]	**-1.19 (.38)** **	.31 [.15, .64]

Numbers in bold indicate significance

*** p<.001, **p<.01, *p<.05

Lastly, participants were given the option to provide additional reasons for discrimination which were not included in the list. Socioeconomic status was the most commonly reported additional reason for discrimination across the conditions, with responses including “job role”, “wealth/class”, “socio-economic status” and “job”. Secondly, migration status was reported as alternative reason for discrimination, with respondents providing answers including “refugee status”, “asylum seeker”, and “immigration status” as reason for discrimination. See Table 9 for all qualitative responses provided.

Table 9. Qualitative responses given for perceived reasons for discrimination per condition

Condition	**Qualitative Responses**
Refugee	‘Refugee status’ ‘Refugee’ (x2) ‘Asylum seeker’ ‘It could be anything, looks/attitude/etc’ ‘Dress’ ‘Job role’ ‘There are a lot of negative sentiments against migrants’
Economic Migrant	‘Wealth/class’ ‘Immigration status’ ‘Socio-economic class’ ‘Anything the deters from the stereotypical 'normal' white male (in society's view). Hair colour, hair style, clothes, make up, tattoos, piercings, shoes, height, weight’
British National	‘Job, choice of habitation’ ‘Work’ ‘Single parent’ ‘Economic status’ ‘Class’ ‘I don't know enough about Sarah to make this judgement’

6.4.Discussion

Main Findings

In the midst of negative attitudes in the UK being directed towards migrant populations, there is a need for theoretically informed approaches to explore the extent to which members of the general public are able to recognize the adverse impact that migration can have on peoples' wellbeing and their risk of facing discrimination post-resettlement. This is the first study to focus on community perceptions of the levels of capability-based wellbeing of different migrant populations upon resettlement in a high-income setting, the UK. Specifically, an adapted version of a validated measure of capability-based wellbeing (as assessed by the OxCAP-MH measure) was used to explore the perceptions of a UK community sample randomly allocated to assess the wellbeing of hypothetical vignettes relating to the experience of a EM, a Refugee or a British National.

Firstly, we hypothesised that there would be a difference in the perceptions on overall levels of wellbeing depending on migration status, with refugees being perceived as having lower levels of capability-based wellbeing as compared to both the EM and the British national condition. This hypothesis was partially supported as participants perceived the levels of wellbeing of refugees to be lower than both those in the EM condition and in the British national condition, but no significant difference was found between EM and the British national condition. Secondly, it was hypothesized that refugees would be perceived as having less of a 'good life' as compared to EMs and British nationals. This was also partially supported, as the 'good life' was perceived to be significantly lower for refugees as compared to both groups, however no difference was found between the perceived levels of wellbeing or rating of the 'good life' of EM and British nationals.

Findings indicate that the sample recognized that refugees may have more limited capabilities post-resettlement in the UK and may not achieve similar levels of the 'good life' as compared to EM and British Nationals. These findings seem to correspond with one of the few studies that have explored the experiences of refugee populations in the UK specifically. In a qualitative study conducted by Phillimore (2011), interviews were conducted with 138 refugees living in Birmingham (UK). Participants reported being aware that they are perceived as a problem by society, experience harassment and/or discrimination, social isolation, and housing segregation (Phillimore, 2011). The findings by Phillimore (2011) provide evidence that many refugees face specific post-resettlement stressors in the UK which can influence their freedom of choice, their ability to integrate, and limitations to their real opportunities for self-

development and agency. Similarly, another qualitative study conducted with 24 asylum seekers and refugees in Scotland found that experiences of the asylum system, both alone and in combination with other sources of vulnerability including racism, poverty, and language barriers, had a negative impact on the physical and mental health of these groups which continued even once the refugee status was granted (Isaacs et al., 2020). Evidence for the impact of post-migration stressors on mental health and wellbeing have been replicated in a multitude of other studies across the globe (i.e., Li et al., 2016; Wu et al., 2021). The findings from the current study reflect an understanding and recognition from a sample of the host population that refugees who resettle in the UK may face significant barriers to flourishing as defined by Nussbaum's (Nussbaum, 2000) ten central capability domains and how these were assessed by the AOXCAP-MH.

On the other hand, the lack of significant differences between levels of both perceived wellbeing and a 'good life' for EM and British Nationals are not in line with self-report studies conducted with EM. Previous research suggests that whilst many EM improve their material wellbeing (Abramitzky et al., 2012; Clemens et al., 2008; McKenzie et al., 2010), the cross-sectional evidence on the effect of economic migration on subjective wellbeing and quality of life is ambiguous. For example, two studies conducted by Bălţătescu (2005, 2007) found that when comparing the self-assessed life satisfaction of EM to host societies across Europe, EM are on average less happy than natives (Bălţătescu, 2005, 2007). To a certain extent, these previous findings may be explained by the evidence that shows that EM can also face discrimination, exploitation, and psychosocial problems (Kofman et al., 2009; Mock-Munoz de Luna et al., 2015), factors which could contribute to a widening of inequalities between EM and the host population (Simon et al., 2015). This is particularly relevant given the 'spike' in racial attacks as a consequence to the racially divisive climate created both during the Brexit referendum debate and in the subsequent divisive policies and programmes implemented by successive governments (Burnett, 2017). Although the current findings shine a light on the understanding of potential difficulties refugee populations may face in the UK, they also reflect a lack of recognition by the host population that EMs may similarly face barriers to wellbeing as compared to the host population.

In the context of the CA, wellbeing is understood as the real freedom to achieve those beings and doings that individuals have reason to value (Nussbaum, 2003). It is known that structural conditions (i.e., government policies, negative attitudes about migration held by the host society, resources available within the community) shape capabilities, therefore securing

capabilities for individuals, including refugee groups and EM, requires responsibility of individuals, states, and communities (Briones, 2011; Eichsteller, 2020; de Haas, 2014). The involvement of the state is required to provide the political, economic, social, and material resources necessary to expand capabilities and act as an enabler of quality of life (Briones, 2011, de Haas, 2014). One of the ways in with the UK government has acknowledged the multidimensionality of wellbeing is through the UK Home Office's revised Indicators of Integration Framework (2019b). This framework recognizes the integration and wellbeing of migrant populations to be a shared responsibility between local and national government, migrants, and members of the receiving community. Part of this collective responsibility then, includes understanding by the host community of the lived experiences, practical information for daily living, customs, and cultural values, etc. of different migrant groups in the UK. The findings in this chapter indicate more efforts are required to build empathy for both refugees and EM in the host population to promote integration and the expansion of capabilities of migrant communities in the UK. After all, integration is defined as a two-way process.

One way of working towards this is by promoting interpersonal contact between migrant communities and the host community. From previous literature it is known that direct intergroup contact is one of the most effect ways to reduce stereotyping, prejudice and intergroup conflict (Pettigrew & Tropp, 2006; Pettigrew, 216). In a recent meta-analysis which looked at the impact of direct and indirect contact interventions, the authors noted that contact meetings, cooperative learning, and extended contact programs are successful at reducing ethnic prejudice. Importantly, the findings from the meta-analysis revealed that the impact of programmes were consistent over time (Lemmer & Wagner, 2015). Furthermore, the meta-analysis highlighted that the contact interventions not only improved attitudes towards those involved in the programs, their effects also extended to outgroups as a whole (Lemmer & Wagner, 2015). Therefore, promoting intergroup contact through interventions and programs can be an important step towards building empathy towards different migrant groups. Specific examples of successful interventions included in the meta-analysis were those that facilitated cooperative learning (e.g. Cook, 2000) wherein participants from different ethnic backgrounds are asked to work together on a common learning objective that does not relate to interethnic relations. Another example of interventions included were extended contact interventions (e.g. Cameron et al., 2006). These involve provision sources (books, pictures, stories, films) that showcase positive relations between at least one member of one's own ethnic group and members of an ethnic outgroup (i.e. refugees, Cameron et al., 2006). Other studies have also looked at the impact of vicarious contact through the media. For example, in one study, a

version of Sesame Street was designed to present positive intergroup contact between Israelis and Palestinians, with a particular focus on mutual understanding and respect. The findings revealed that following the Sesame Street show led to more positive and prosocial reasoning when thinking about other's intentions (Brenick et al., 2007). This example is also useful when considering the role the media can play on promoting empathy. This is particularly important in the context of the UK, as multiple research papers have highlighted the negative impact of the discourse around migration in the UK press (i.e. Blinder & Jeannet, 2017; Pruitt, 2019; Taylor, 2014). Although changing the media narrative altogether may not be plausible, the study by Brenick et al. (2007) offers promise for media interventions that may help counteract the general negative discourse and move towards more positive outcomes.

The current study provided support for the third hypothesis – the community sample estimated that both refugees and EM face more forms of discrimination in the UK than British nationals overall. For refugees, the most common perceived reasons for discrimination were race/ethnicity and religion, which were both perceived to be higher as compared to British nationals. Previous research has shown that religiously and culturally distinct Muslim immigrant minorities are regarded as more problematic by Western societies than other ethnic minority groups (Bansak et al., 2016; Saggar, 2009). A longitudinal research by Collyer et al. (2018) looked at the integration of resettled refugees in the UK. Two hundred and eighty refugees were interviewed over a five-year period. Many reported having faced racist abuse in the UK, ranging from verbal attacks to physical assaults (Collyer et al., 2018). The majority of respondents also considered the overall atmosphere towards migrants in the UK in general, and the attitudes towards refugees in particular, to have become increasingly negative (Collyer et al., 2018). Similarly, a survey conducted in the UK by Opinium showed that ethnic minorities in Britain are facing rising and increasingly overt racism in light of Brexit (Booth, 2019). Specifically, minority ethnic women reported a sizeable increase, with 74% stating they had faced racial discrimination in the year leading up to 2019, compared with 61% in the latter half of 2016 (Booth, 2019). Given that levels of discrimination around ethnic minorities appear to be increasing in the UK, and the current study suggests that the community recognizes that refugees and EM are more likely to face discrimination than their British counterparts, there is a need for a sharpened focus on human rights, injustice and discrimination as actually experienced by different migrant groups in the UK. As higher rates of discrimination correlate negatively with psychological wellbeing (Jasinskaja-Lahti et al., 2006), research should aim to increase knowledge about interventions that can reduce said discrimination to increase social cohesion in the UK. This is particularly relevant given that the findings in the current study

suggest that participants recognise the increased levels of discrimination for different migrant groups.

Implications and Future Research

Wellbeing is a key determinant for good integration (Robila, 2018), and good integration is a key determinant of wellbeing (i.e., Herrero, Fuente & Garcia, 2011). In line with the Home Office's Indicators of Integration Framework (2019b), integration of migrant communities should be considered a shared responsibility between the migrants and host communities. This shared responsibility is deemed important to ensure migrants can access work, education, health, etc. which are important for their integration and wellbeing (Ndofor-Tah et al., 2019). Attempts to speak to public attitudes regarding different migrant groups can only succeed if interventions engage with people's real-world understandings and concerns. The findings of the current study indicate that a UK based community sample recognises that migrant populations experience different forms of discrimination and that the challenges they face can impact on their wellbeing. This demonstrates that there is empathy for the experiences of migrant populations, which can help create a basis for dialogues and initiatives aimed at supporting migrant populations and associated integration.

Strengths and Limitations

The current paper is the first to shed light on a UK community sample's perception of the levels of wellbeing of different migrant groups across the UK. The first strength of this paper was the use of a vignette experimental design to look at perceptions about capability-based wellbeing, perceptions around achieving a 'good life', and the risk of discrimination. Using three different research questions facilitated engagement with three differing aspects of life experience, giving insight into specific areas that may require further research.

Nonetheless, there were a number of limitations to this study. Firstly, the OxCAP-MH measure was designed as a self-report measure rather than a measure of perceptions about others. Therefore, it has not previously been validated in this context or used for proxy reporting. However, the response rate and the findings of the current study suggest that this was a valid form of use for the measure which represents a promising new way of measuring wellbeing in different populations. Secondly, the vignettes were not pilot tested prior to being used. Pilot testing the vignettes would have given helpful insight into the adequacy of using the different

ethnicities and names that were chosen, and whether these might have an effect on participants beyond those that we aimed to measure. Therefore, the lack of pilot testing was a third limitation of this study, as the subtle differences between the three vignettes may have influenced participant responses beyond what we aimed to test (migrant category). However, the differences in country of origin between conditions was done to reflect the reality of the UK as EM and refugees most commonly come from different countries. Thirdly, given the opportunistic sampling methods, it is possible that participants of the current study did not have sufficient information on the different migrant populations, which could have diminished their ability to provide proxy estimates for these different groups. Thirdly, the design was cross-sectional, and therefore it is difficult to derive causal relationships from this data (Setia, 2016). As such, future studies should consider using a longitudinal design.

Future research should build on the strengths and limitations of this study to gain a more comprehensive understanding of areas which require intervention within the UK community. Furthermore, research working directly with migrant groups using a CA framework to understand wellbeing is required.

6.4.Conclusion

Attempts to speak to public attitudes towards refugees and migrants can only succeed if they engage with people's real-world understandings and concerns around migration. The current paper aimed to engage with British citizen's perceptions of capability-based wellbeing of different migrant groups across the UK using the theoretical framework of the CA. Findings revealed that participants recognised that refugees may have more limited capabilities in the UK and may not be achieving similar levels of the 'good life' as compared to EM and British nationals. Furthermore, refugees and EM were perceived to face higher levels of discrimination as compared to the control group. The results showcase the validity of using the AOxCAP-MH as a measure that can be used in the 'third person' to provide proxy estimates of capability-based wellbeing for people other than the person completing the measure. The findings highlight a need for targeted initiatives and dialogues aimed at discussing and addressing challenges to migrant wellbeing and sources of discrimination within the British community.

Foreword Chapter 7

In Chapter 6, the perceptions of a UK community sample of different migrant groups' capability-based wellbeing was measured. In order to move towards an understanding of self-reported levels of capability-based wellbeing of migrant women, in Chapter 7 we explore important capabilities post-resettlement for refugee women in the UK.
An understanding of valuable dimensions of the 'good life' can help inform the development of more nuanced approaches to assessing their capability sets post-migration.

In particular, Chapter 7 describes the use of qualitative methods to select the dimensions of mental health and wellbeing that are important for refugee women post-migration in the UK. The list of dimensions is derived through a series of focus group discussions in which the concept of a 'good life' is discussed. The findings are analyzed using an interpretative phenomenological analysis.

Published Chapter

1. Stage of Publication

   The paper presented in Chapter 7 has been published in a peer-reviewed journal. This chapter is presented as the authors' accepted for publication version of the paper.

2. Research paper title

   'Good life is first of all security, not to live in fear': a qualitative exploration of female refugees' quality of life in the United Kingdom

3. Peer-reviewed journal

   Journal of Ethnic and Migration Studies

   https://doi.org/10.1080/1369183X.2020.1852074

4. Citation

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5. Candidates' specific contribution

   The substantive contribution of Catharina van der Boor has been the conception and design of the research, data collection, data analysis, interpretation of findings, writing the paper and doing critical revision.

6. Co-author declarations

   I give permission to Catharina van der Boor for including this research paper in her doctoral thesis.

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   Signature: 
   Date: 29 August 2021

   Name: Dr. Ross White

   Signature: 

   Date: 23rd August 2021

Chapter 7: 'Good life is first of all security, not to live in fear': a qualitative exploration of female refugees' quality of life in the United Kingdom

7.1. Introduction

Background

The UK has seen an increase in asylum applications in recent years. By the end of 2019, the UK received 35.566 asylum applications, and 20.703 were offered protection in the form of grants of asylum, humanitarian protection, alternative forms of leave and resettlement (Home Office, 2019a). Once a positive asylum decision is reached, new refugees are granted five years of limited leave to remain, with permission to access employment, welfare benefits, education and access to the National Health Service (Doyle, 2014).

Despite gaining access to different areas of support, these five years constitute a period of uncertainty as the Home Office reserves the right to review an individual's case at any point (Home Office, 2017). Research into the first year of being granted refuge reveals delays in receiving essential documents for identification, welfare support, risk of destitution and challenges accessing employment and education (Doyle, 2014; Rowley, Morant & Katona, 2020).

At the end of the 5-year period, refugees must apply for indefinite leave to remain (ILR) in order to stay in the UK. In 2019, there was a 9% decrease in ILRs being granted for refugees (Home Office, 2020). Once individuals hold ILR for 12 months, they can apply for citizenship if they meet the necessary requirements (Home Office, 2018). Researchers note that these restrictive policies hinder AS&R's capacity to rebuild their lives post-resettlement (Grace, Nawyn & Okwako 2018; Refugee Council 2017), stating that this temporary status is 'not compatible with the desire to have active citizens engaged in all aspects of economic, social and political life' (Stewart & Mulvey 2014, 1034).

Indeed, previous research has indicated that AS&R face socioeconomic challenges, isolation, loss of life projection and decreased health after gaining ILR (Khawaja et al. 2008; Rowley, Morant & Katona 2019). Similarly, the uncertainty of protracted asylum processes has been linked to decreased wellbeing (Walther et al., 2020). For example, a qualitative study conducted in the UK using a Capabilities Approach (CA) framework to understand

unaccompanied migrant's conceptualisations of wellbeing revealed high levels of anxiety surrounding the uncertainty of legal situations and indefinite waiting periods (Chase, 2020).

Female Refugees

Particular concerns have been raised regarding the needs of female AS&Rs (UNHCR, 2016). In the UK, a significant proportion of refugee women have experienced violence and remain vulnerable upon resettlement (Dorling, Girma & Walter 2012). Research shows clear gender differences in accessing education, training, employment, general health, budgeting, housing and language proficiency, with women generally faring worse than men (Cheung & Phillimore 2017). Additionally, Carswell, Blackburn, and Barker (2011) found post-migration stressors in the UK to be significantly associated with post-traumatic stress disorder and emotional distress. However, research looking at positive mental health outcomes remains scarce. Systematic reviews looking at the mental health of AS&R populations clearly identify the comparative lack of intervention studies measuring wellbeing and quality of life (QoL) in high, low and middle-income countries (Bosqui & Marshoud 2018; Turrini et al. 2019). These reviews also highlight predominantly poor quality of evidence regarding wellbeing and QoL in AS&R. Furthermore, a review on the impact of migration on refugee women suggested that migration can bring about positive changes, such as freedom, equity and greater opportunities (Shishehgar et al., 2017). Identifying factors that can promote the mental health and wellbeing of refugee women is important to enable positive resettlement.

Applying the Capability Approach in the Context of Refugees

There is growing interest in using Sen's CA to assess QoL and evaluate social policies (Sen, 1993). A crucial normative argument of Sen's approach is that a 'good life' should concern people's capabilities – the freedom and opportunities 'to be' and 'do' what an individual value (Sen, 1985b). Sen argues that freedoms have intrinsic and instrumental value; "The 'good life' is partly a life of genuine choice, and not one in which the person is forced into a particular life — however rich it might be in other respects" (Sen, 1985b; p. 70). Consequently, Sen deliberately refrained from providing a universal list of capabilities, stating that different capabilities are relevant to different contexts, and can be influenced by personal, social and environmental conditions (Stiglitz, Sen, & Fitoussi 2009). In order to choose a list of relevant capabilities that are worth promoting, one must go beyond theory and include local consensus

building through discussion (Sen, 2004). Therefore, a bottom-up approach is preferred to determine the relevant capabilities for different groups and contexts.

To date, few studies have attempted to measure capabilities, with the majority doing so by reference to the researchers' own values or using existing datasets (Robeyns, 2006). One focus group study did develop an index of capabilities for women in Malawi using a bottom-up approach which proved to be a valid and reliable measure of QoL (Greco, Lorgelly & Yamabhai, 2016). This provides evidence for the feasibility of developing a list of capabilities directly from people's voices and that group dynamics are an appropriate participatory method for defining and measuring challenging concepts.

A similar bottom-up approach to Greco, Lorgelly, and Yamabhai (2016) was used in the current research, while incorporating a new method – an interpretative phenomenological analysis (IPA). IPA is a phenomenological, hermeneutic method concerned with "the detailed examination of personal lived experience, the meaning of experience, and how participants make sense of that experience" (Smith, 2011; p.9). This entails a 'double hermeneutic' process where the researcher interprets the participant's interpretation of their experience (Smith, Flowers & Larkin, 2009). IPA is considered particularly useful for examining complex, ambiguous and emotional topics (Smith & Osborn, 2015). The aim of the current paper was to conduct an IPA using a CA framework to explore what constitutes a 'good life' for female refugees post-resettlement in the UK.

7.2. Methods

Study Design

Sen (2005) argues that developing a list of capabilities must depend on the process of public reasoning which is specific to the context to which the list aims to speak. For this reason, a qualitative design was used; four focus groups (FG) were conducted in Liverpool. Although IPA is traditionally used for in-depth semi-structured interviews, its techniques have previously been applied to FG (Smith, Flowers, & Larkin, 2009). In the particular context of FG, the double hermeneutic within IPA becomes a multiple hermeneutic, as the researcher interprets the participants' interpretation of their experience, with the additional task of understanding participants' interpretation of other people's experiences through interaction within the group (Tomkins & Eatough, 2010).

Participants and Recruitment

Sixteen women took part in four FG, which on average lasted 1h (Table 10). Data for IPA are obtained from purposive, homogenous samples (Smith, 2017). The four homogenous elements in the current study were: (1) having a 5-year refugee status, (2) being female and (3) being able to converse comfortably in English.

Table 10. Demographic characteristics of participants per focus group

Group	Length of focus group	Country of origin	Months since receiving refugee status
Focus group 1 (FG1)	47 minutes	Azerbaijan	13
		Azerbaijan	11
		Azerbaijan	11
		Cameroon	2
Focus group 2 (FG2)	53 minutes	Sudan	48
		Syria	32
		Pakistan	29
		Sudan	3
Focus group 3 (FG3)	1h 8 min	Iran	24
		Uganda	7
		Iran	2
		South Sudan	1
Focus group 4 (FG4)	1h 15 min	Nigeria	28
		Sierra Leone	15
		Sierra Leone	32 (estimate)
		Nigeria	32 (estimate)

For recruitment purposes, author CB contacted gatekeepers of community organisations working with refugee women in Liverpool. Three different approaches were used; (i) visiting drop-in sessions for direct recruitment, (ii) gatekeeper referrals, for individuals who met the inclusion criteria and (iii) snowball sampling. Composition details of each group can be found in Table 10. Seven women were unable to participate due to the timing of the FG and one FG was cancelled as the level of English was not sufficient.

Data Collection

Data collection took place from July to December 2019. A pilot FG was conducted at the University of Liverpool (UoL), with a sample of non-refugee women to test the duration and flow of the interview schedule. No changes were made, and data were not included for analysis.

The interviews were conducted by author CB; a female PhD researcher in her mid twenties. Prior to data collection, CB received training on conducting focus group interviews and building rapport with participants. An early termination protocol was in place in the case that a participant(s) should get distressed (see Appendix G). This protocol was not used during the study. Three of the FG took place at the organisation of recruitment, and one at UoL upon the participants' interest in visiting the campus. Travel costs were reimbursed. Ethical approval was granted by UoL's Health and Life Sciences Research Ethics Committee of Psychology, Health and Society (approval reference number: 4701).

A participant information sheet (see Appendix H) and advertisement (Appendix I) were given prior to the FG explaining the purpose, voluntary nature, data handling, anonymity, confidentiality, and information on support agencies available in the region. This was verbally repeated at the start of the FG. Written and verbal consent was given (see Appendix J). One participant was illiterate; therefore, a witnessed mark was provided.

All FG were in English and digitally recorded. To ensure anonymity, each participant was asked to provide the name or pseudonym to be used during the recording. Not all participants chose a pseudonym; therefore, pseudonyms used in this paper were chosen by author CB. Group discussions were facilitated by a moderator (CB) and a facilitator.

A semi-structured topic guide was used with open-ended questions based on Greco et al. (2015)'s work (Appendix K). The open-ended nature of the questions was chosen to encourage participants to come up with their own capability dimensions, as described by Sen (2005). Discussions started with an open exploration on the meaning of a good life (what does the term 'good life' mean to you?). When discussions around a topic drew to a natural close, probes were used to introduce specific questions regarding dimensions and valued choices. The topic guide was discussed with each of the gatekeepers prior to the FG. Sen also states that there is a need to understand the importance of the different capabilities included in the list (Sen, 2005). Therefore, participants were invited to write down the three most important dimensions to

living a good life in the UK. Participants were verbally debriefed, and a copy of the debrief information was provided for participants to take home (Appendix L).

Data Analysis

Bracketing

Prior to data collection and throughout the analysis, bracketing was carried out by author CB through a reflexive journal. Bracketing is a methodological procedure of phenomenological inquiry that requires deliberate putting aside of one's own beliefs and prior knowledge about the phenomenon under investigation before and throughout the phenomenological investigation (Carpenter, 2007).

Analysis

IPA has two complementary commitments; the phenomenological requirement to understand and 'give voice' to the experiences and concerns of the participants, and the interpretative requirement which aims to contextualise and 'make sense' of these experiences from a psychological point of view (Larkin, Watts & Clifton, 2006). In the current study, the phenomenological requirement led the development of the themes, described in the results section, and the interpretative requirement allowed these themes to be interpreted in the context of the CA framework, presented in the discussion.

Audio recordings were transcribed verbatim and analysed by CB. In order to make sense of IPA's multiple hermeneutic circle for FG, transcripts were parsed twice: (i) for group-level patterns and dynamics and (ii) for individual accounts (Smith, 2004). For the analysis of both the group-level and individual accounts empirical IPA guidelines (Tomkins & Eatough, 2010) were used, which are described below.

In the first step, standard IPA procedures were used (Smith, Flowers, & Larkin, 2009). Transcripts were read and re-read at the group-level, and preliminary notes were written including exploratory, linguistic and conceptual comments by CB (Table 11).

Provisional themes were selected by prevalence and representativeness (Smith, 2011), and organised into a hierarchy including 'subordinate' themes' which were given a title to capture

the emergent themes underneath. A table was produced showing each subordinate theme, emergent themes, and supporting quotes per group (Smith & Eatough, 2007).

To ensure that the process was iterative, the analytical loop was revisited for each participant within the FG, as suggested by Tomkins and Eatough (2010). Following individual level iterative interpretations, amendments were made to the group-level themes. For example, the theme social impact on emotions was changed to social cohesion in FG1. Final themes with supporting quotes were peer-reviewed by three researchers who were distinct from the FG moderator and facilitator: a doctoral student, research associate and an associate professor of clinical psychology (RW).

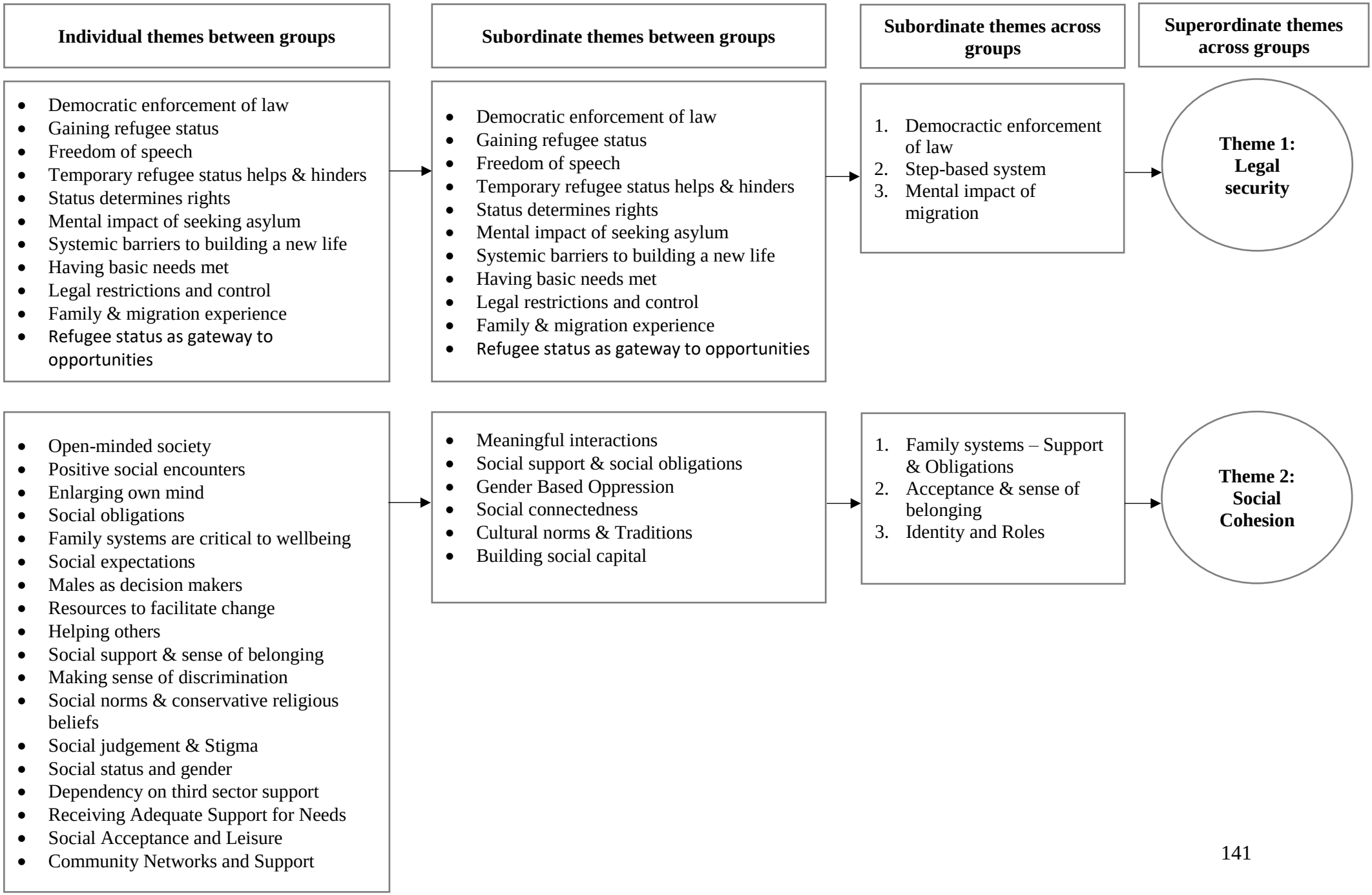
Themes were compared and contrasted across groups. Overlapping 'subordinate' themes were clustered into 'superordinate' themes. In order to create 'subordinate' themes that were relevant across the groups, the emergent and 'subordinate' themes for each FG were revisited once more engaging in the hermeneutic circle (see Figure 6).

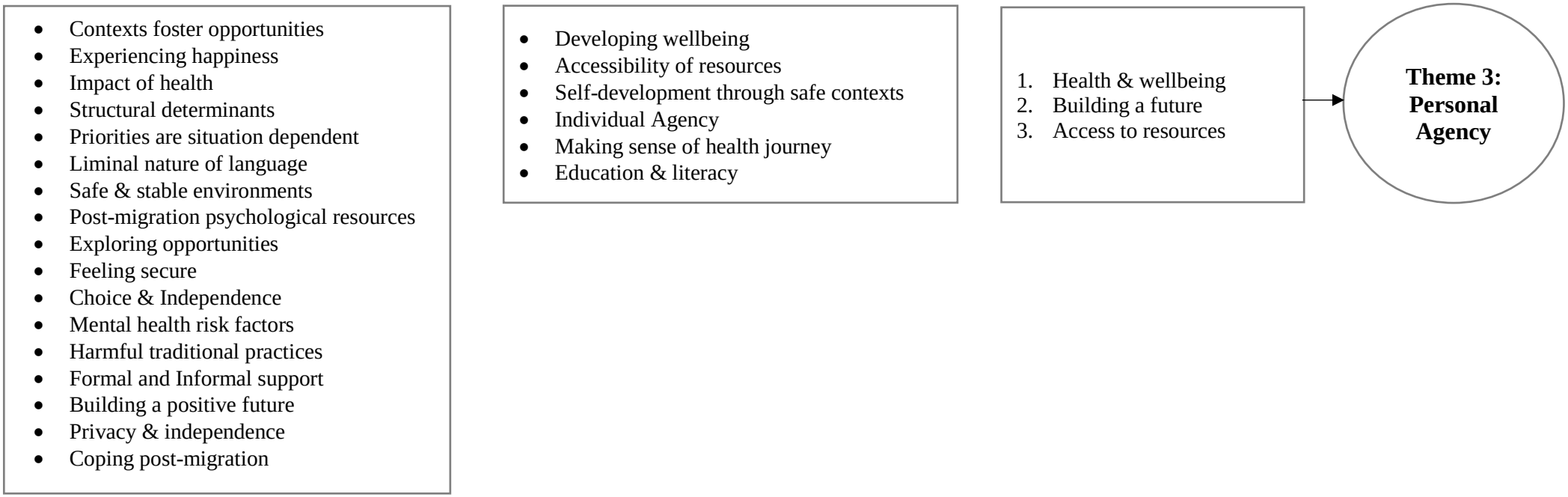
Table 11. Excerpt of preliminary analysis

Emergent themes	Transcript excerpt FG2 (unedited)	Preliminary notes
Males as decision makers	Jamal: *I all time, any woman I say 'you can do this course, this course is too easy you can try this thing you know', 'no, my husband say I can't do these things'. Why you… everything in the life 'my husband says that, my husband say I can't do this, my husband…', why he should decide about you? You have a life. You should to live this life, not anyone live or tell you how you live this life.* Fatima: *Because I think, because the Culture, Jamal.* Jamal: *Yes* Fatima: *the culture uh in our country, different.* Jamal: *Yes, but we are here. We are now in this culture.*	'any woman' – applicable to all women Encouraging higher pursuits Disagreement – husband is decision maker 'why you' – questioning Expression of judgement Female agency & empowerment 'You' - generic to women 'I think' – personal narrative 'our country' – group membership Discrepancy 'but'

	Fatima: *Still the culture…[laughs] inside…* Jamal: *Yes, not easy to change the culture. I'm sure not easy.*	New culture implies possibility for change in gender expectations 'culture inside' – the culture is carried within Agreement

Figure 6. Development of superordinate themes through cross group analysis




Contexts foster opportunities
Experiencing happiness
Impact of health
Structural determinants
Priorities are situation dependent
Liminal nature of language
Safe & stable environments
Post-migration psychological resources
Exploring opportunities
Feeling secure
Choice & Independence
Mental health risk factors
Harmful traditional practices
Formal and Informal support
Building a positive future
Privacy & independence
Coping post-migration
Developing wellbeing
Accessibility of resources
Self-development through safe contexts
Individual Agency
Making sense of health journey
Education & literacy
1. Health & wellbeing
2. Building a future
3. Access to resources
Theme 3: Personal Agency

7.3. Results

Four FG were conducted. Participants' demographics can be found in Table 10. There was a powerful sense of shared and overlapping experiences between the participants within their groups. This was evoked through detailed accounts of their experiences pre and post-migration. Overall, emotive language was used when describing personal experiences of migration, as these were often described in terms of the emotional impact thereof. The value of using FG was reflected in the different turns the conversation took through interactions. For example, in Table 11, Zahra describes frustrations towards encounters of a lack of female agency and the impact this has on women's lives. Fatima attributes this lack of agency to culture, highlighting the varying extent to which discrepancies between the women's own culture and host country's culture were perceived as an important issue.

Participants contributed issues related to membership of different groups, including being a refugee, female, from a particular culture or religion. In Table 11, Zahra refers to 'our culture', including both her own (Sudanese) and Fatima's (Syrian), both distinctive to the UK. Participants used a collective voice to describe experiences that were common to other group members (i.e. the asylum process). However, personal accounts linked to individual experiences were distinguished through the use of statements including 'in my opinion', 'I think', or 'to be honest'. This would not have been necessary in one-on-one interviews and stood out against times were experiences were described without such reservations.

The Meaning of 'Good Life'

Three superordinate themes were identified to achieve a 'good life' in the UK; (i) legal security, (ii) social cohesion, and (iii) personal agency.

Legal security 'All our dream is to get paper' (Fatima, FG2)

Legal security is necessary to achieving a good life through a democratic enforcement of law, going through the step-based system, and the mental impact of migration.

Democratic enforcement of law. Participants described the government's role in enforcing democracy through the protection of equality and advancement of basic human rights, often described through a comparison between pre-and post-migration experiences.

> Adila: when I got my status [refugee status] after that I have problem as well. I have a lot of paperworks, official things, of course. But I can solve it I learn a lot of things. I learn my law in this country, it gives me a lot of opportunity in the future. If I hmm ... if ... if some things happens for my official things uh I remember when I did some things I need this law, ehm ... and I know my rights. I know my rights. But ehm ... in my country it's not this. You have official law and unofficial law as well and it's so different (...) government eh who they control our country and our people, they are not democracy people.They are not hmm ... good mind people, I think so. That's why we are so hmm ... suffered from them. (FG1, Azerbaijani)

When living under a totalitarian system of rule in their country of origin, citizens are deprived of autonomous decision making. There is recognition that governments should have good intentions ('good minded people') and accountability to the law ('You have official law and unofficial law'). A lack thereof leads to suffering within society.

Safeguarding freedom of speech was identified as imperative to achieving a good life. Previous experiences of censorships were contrasted with newfound freedom of speech in the UK, including freedom of religion. Some described a transition period, where the fear of government and/or social reprisal remained even post-migration. Participants across groups highlighted their relief at being able to enjoy these freedoms:

> Amaya: And I can share my idea. I can go anyone else and I for example as a voluntary is I can talk without think how if I talk, something right for me? Wrong for me? Not. I can place Instagram and Facebook, without any, any, scared I can use. I can evangelize in here, no it's, you can't, you can't imagine how I feel happy when I write about Jesus and I public, I send public. (FG3, Iranian)

> Zahra: Sometimes a lot of people in Syria saw my photo on Facebook and contact with my mom, 'how your.... Uhh how she can put these photo on Facebook?' [](FG2, Syrian)

> Fatima: Yes, not allowed to put your photos or pictures in the Facebook (FG2, Sudan)

> Sevinc: Yeah uhm here uhm I ... , I achieved two free speak. One; uhm free speak politics, free speak my ideas ... things ... . But second; free speak in my house. In my family. For me, [laughs] twice, double, double freedom. (FG1, Azerbaijani)

This highlights the long-term impact of having lived in a repressed state and the happiness that stems from being able to have these freedoms.

Step-based system. To achieve a good life, the different stages of the step-based system to achieving legal security must be considered. Each step of the process brings new priorities, struggles, rights and freedoms. Those who are detained are considered to have neither basic human rights nor freedoms ('That's why detention centers are worse than prisons. People in detention centers prefer to be in prison' – Mirembe, FG3, Ugandan). The asylum system was described as confusingly complex and controlling, and external help was required to navigate it. There was also a recognition that basic human rights are protected once the asylum claim is made.

An explicit distinction was made between gaining basic human rights and gaining freedom; freedom was described as having similar rights to British citizens, facilitating the ability to pursue individual goals beyond having basic needs met:

> Mirembe: [...] if you are not in detention centers, home office provide you the basic human rights. [...] I know in my time we were given at least an accommodation, we were given maybe like five pounds a day for food, and then maybe you had access like maybe to charities and maybe parcels and you know clothes, and things, a few things, like basic human rights. [...] if you are good in your status [refugee status] you have the freedom maybe to like travel, to work, you know? To do things that the citizens will do as well. (FG3, Ugandan)

This was echoed by Fatima (FG2), who described achieving similar rights to be dependent on obtaining citizenship:

> Fatima: Yeah, now I think about these five years, after that I think ... but now I can do everything for my children and for myself. I can go to university, I can improve my English, I can join in the university, I do everything I want to do. After five years uh think about that. (FG2, Sudanese)
>
> Zahra: I think after one year you will start to thinking 'I just want to have ... British citizen' (FG2, Syrian)
>
> Fatima: No, I'm not thinking about passport or like that no. (FG2, Sudanese)

> Zahra: I start thinking about that because when you have a passport, British passport, you will feel more free. You don't ... you can travel to any place. You don't need visa in any place. (FG2, Syrian)

Fatima's experience highlights a hesitation to plan past the 5-years. There is a sense of temporariness which she wants to make the most of. On the other hand, Zahra has set a clear goal to obtain a British passport, linked to feeling secure and guaranteeing a safe future for her daughter.

Mental health impact of migration. Long and complex asylum procedures led to periods of uncertainty and stress, described as 'being stuck in limbo' (Mirembe, FG3). The asylum system was 'painful', 'stressful' and 'depressing'. This was exacerbated by pre-existing mental health conditions; two participants (FG4) described suicide attempts during this time. Mariam (FG3) described the inability to accept the migration as a cause for depression. Difficulties coping with moving was contrasted with the rational expectation of the impact of migration, as indicated by repetition of the word 'should'. There is a clear understanding that coping takes time:

> Safie: But I think because a long time we live in our country when you ... when we moving...we can't accept everything. [...]. Because after moving we should to change everything and we should to start from zero. That's very difficult for us. And it's need ... need take time. All the people, not all the people, more the people has a problem for mentally depression. For example, myself or my mother, for one year we used tablet for depression and we couldn't do anything. Nothing. Just sit at home and crying. (FG3, Iranian)

Social support is a mediating factor for stress during this time. In line with this narrative, being granted refugee status was described as being "a weight off your shoulders" (Esther, FG1, Cameroonian), and providing a sense of certainty which gave space to develop forward-looking abilities 'but now, after I get paper, now I am happy and start thinking about the future' (Fatima, FG2, Sudanese). One woman described her mental improvement upon gaining refuge:

> Yoruba: [...] now I would say I have freedom. I have freedom. I live life to the fullest. The way I want to live my life, I feel happy. I go out for shopping, and it helps my

wellbeing. It helps my mental health, after I got my asylum. It helps my mental health. (FG4, Nigerian)

Social cohesion 'healthy atmosphere is like wherever no one can judge you' (Zainab, FG2, Pakistani)

Achieving a good life is dependent on social cohesion, described in terms of family systems – support and obligations, acceptance and sense of belonging, and identity and roles.

Family systems – support and obligations. Supportive family systems facilitate adaptive coping in the UK through emotional and/or economic support, and guidance. Having left family behind was experienced as initial barrier to adaptation across three groups, both in terms of the women's own experience, and also for their children:

> Fatima: Maybe also hard for my, our children uh....to forget our country because community, their family, cousins and like that. Uhm ... I need also to support my children to forget this community and uh ... (FG2, Sudanese)
>
> Moderator: To forget?
>
> Fatima: Not forget, not forget at all, but at least ... not thinking (FG2, Sudanese)
>
> Zainab: These memories, you know? (FG2, Syrian)
>
> Fatima: Yeah no thinking more about the past life where we are in our country and with their family and uh ... to ... to ... interact with the new community here. (FG2, Sudanese)

Women recognise the necessity of coping with the past to adapt to their new situation and feel a sense of responsibility for providing emotional support to their children to cope with the impact of social losses during migration.

Children were described as a source of happiness and obligations. Provision for children is considered a priority which affects choice making, which impacted particularly on single primary caregivers. For example, Zahra, a single mother from Syria, described overriding her own emotional preference of returning to Syria in favour of staying in the UK to ensure a positive future for her daughter "I prefer to come back to Syria. Now I can't because it's war

and I can't take my daughter to Syria. Uhhh ... don't have any future, don't have any education." (FG2). Similarly, the lack of family and social support to care for children in the UK implied own goals were set aside in favour of the children's wellbeing and safety;

> Zainab: But all of these things when you've got kids and you are single, there is some hurdles as well. You can't get like straight through. Like I want to join uni, last year as well, I go through all the paperwork and all that ... and fees was accepted and all that but there is no one else. As I told you, I am alone there, there is no one else. So I couldn't find out any child minder as well, because [location] is quite rough area. (FG2, Pakistani, emphasis in the original)

Repetition of 'there is no one else' evokes a sense of isolation and lack of support. Later on, Zainab describes financial difficulties to be a contributing factor to her inability to find quality childcare arrangements; "So struggling, struggling with money wise as well and so many other factors when you go for childcare".

Acceptance and sense of belonging. Feeling accepted and having a sense of belonging within the community was described through positive interactions with other community members and honed a sense of solidarity and altruism. Amaya (FG3) explained this:

> Amaya: But that time when people start to help you, as a simple ... just smiling or just, nothing, you know? It makes you [think] 'okay, no no they like me'. I'm not ... is look like 'no they don't want'. It's very good, very good things. And yeah that is opportunity because after that you think you have to be more and more useful. If I was in my country, never ever I been thinking that. Really, to be honest. Because all the time they hurt me. (FG3, Iranian)

As part of feeling accepted, the need exists to live in an open society free from social judgement. Pre-migration experiences included feeling judgement on the basis of sexuality (FG1), mental health (FG4) and social norms regarding religion and/or gender (FG2 and G3), which contrasted with experiences post-migration:

> Esther: I think my partner, she makes me happy [...] and I think the reason is because we are totally free and don't have any worries about not being judgmental towards us or something like that. (FG1, Cameroonian)

In FG4, charities were named as crucial for building social capital and finding others who have been through similar journeys. There was also a sense of dependency on these organisations for carrying out tasks such as going to appointments, accessing healthcare, medication, or finding accommodation, particularly for women who lack other forms of social support;

> Yoruba: You know is like coming out from a dark. That's the way I see it; coming out from the dark going to the light. You know ... it refresh you when you go out with a group like that. You interact, you see places, you know it helps your wellbeing. So ... that's the support they really give to me. (FG4, Nigerian)

Furthermore, participants described social erosion through experiencing discrimination and 'othering' on the basis of (i) refugee status, and/or (ii) ethnicity. A refugee status was described as problematic for accessing basic commodities such as accommodation or opening a bank account: 'All the people said 'you are refugees' and 'you're not working' we can't give you any house.' (Safie, FG3, Iranian). Ethnic discrimination was reported by two women from South Sudan and Nigeria. Unpleasant experiences included physical attacks, comments regarding physical appearance, and discrimination when applying for jobs. Notable was the discrepancy regarding these experiences;

> Amaya: my friends tell me 'no, UK people are racist'. I thought I never ever I didn't see. Really I didn't see. All the time I'm out and I talk but I never see look like. Maybe this is your mind. And this, this is very good things because you feel 'yeah, this is my country'. (FG3, Iranian)

> Mariam: [...] and in terms of just being here with the society or with the community what she [Amaya] mentioned about racism and all that I feel like people who ... I did experience to be honest sometimes. (FG3, South Sudan)

The interaction highlights opposite experiences. Amaya describes feeling completely accepted ('yeah, this is my country'), to the point where she sees discrimination as something which might be imagined. Whereas Mariam faces discrimination on the basis of race, highlighting significant differences possibly dependent on country of origin.

Identity and roles. Participants talked about tensions in relation to their identity and roles as women both within their own cultural communities, and with the host populations. In their own

cultural communities, experiences of gender inequality were largely on the basis of cultural norms and traditions, which were described as all-encompassing and difficult to change;

> Mariam: So in my opinion like a good life is first of all security, not to live in fear in terms of general in the country or war or if it's even more serious in terms of the concept [traditions] because like in, when there is war you know that there is killing. You have to run away but the concept that is already been there is hard to fight because it has been there for generations. (FG3, South Sudanese)

Distinguishing between the impact of physical danger from war, and the mental impact of traditions, Mariam emphasises that the impact of harmful traditions can be more severe than living through a war ('if it's even more serious'). The intergenerational component of traditions requires hard work to create change ('hard to fight') and were described as continuing in the UK, resonating with the quotes highlighted in Table 11.

Traditions appear to have a two-fold influence on individuals. Firstly, social status was described as dependent on meeting social expectations. Secondly, it shapes one's identity and self-concept. Social status was impaired when women chose not to meet expectations including female genital mutilation (FGM), staying in abusive marriages, or choosing education over marriage and having children. Consequently, many women described losing their community, facing social judgement, stigma and ostracisation.

> Amaya: It's freedom, freedom for man. Not for woman. And women afraid about the man. You know it's completely your, your uhm ... your situation in the society is down. Finish. (FG3, Iranian)

The legal and cultural environment in the UK facilitates empowerment through access to resources including women's rights, studying, employment, housing and access to income. However, in order to access these resources, women need to overcome personal and cultural (of which family members can be enforcers) constraints based on internalised beliefs around gender appropriate behaviour, as described earlier.

Tensions between participants and the host community occurred too; for example, Zainab (FG2, Pakistani) described being housed in a community with no mosque or access to halal food meaning extensive travelling was required to practice her religion. This highlights a lack

of cultural empathy in the placement of housing of refugee women, and a restriction of basic capabilities.

Personal agency 'My happiness, I can build it myself' (Amina, FG2, Sudanese)

Developing a sense of personal agency was dependent on health and wellbeing, building a future and having access to resources.

Health and wellbeing. Physical and mental health are necessary for wellbeing. Women described the achieved freedom to exercise and take care of one's physical health in the UK. In FG4, the harmful practice of FGM was discussed, the consequences of which were still being felt today. The ability to access healthcare and feel confident in the service provision was described in two of the groups (FG3, FG4).

> Mariam: here if you are sick, or if you have anything, you can go to the walk-in center, you are free to do that. And also you feel comfortable, confident having capable people to take care of you for whatever disease that you got. (FG3, South Sudanese)

The term commonly used across groups to describe mental health was 'having peace of mind', including being free from worries, feeling safe, feeling in control over personal matters, and seeing others happy.

> Leyla: there is just some moments you see like that you look around and you see everyone happy it kind of like makes you happy inside as well, it's kind of sunshine inside [laughs]. (FG1, Azerbaijani)

Being able to relax, carry out leisure activities and having access to peaceful environments, including green spaces, was important and often dependent on support organisations. Overall, there was recognition that without happiness and wellbeing, one cannot achieve a good life.

> Mirembe: [...] for me, like happiness crowns it all because well you might have everything else but if you not happy within yourself and maybe you don't find happiness from what you are experiencing or the freedoms and the life you have then I don't think it's a happy life, you know? (FG3, Ugandan)

Building a future. There is a need for a safe and stable environment where one is able to be free and independent to pursue goals and ensure a future for their children. Examples emerged across all groups:

> Fatima: Peace first. After that, after me and my children and me uhh ... in peace and safe. I think ... I can do everything if I find myself in peace. Yeah. (FG2, Sudanese)

> Safie: And I know that here is the safe place for me. After that we should determine how we want to do. (FG3, Iranian)

> Yoruba: I thank God for this country. They give you the opportunity to become who you want to become. (FG4, Nigerian)

Within safe and stable environments, women cherished the ability to explore different opportunities and work towards a positive future. There was recognition (Amaya, FG3; Yoruba, FG4) that opportunities are provided by the government, but the decision then lies within oneself to pursue them;

> Yoruba: So, life yeah is you have opportunity in the UK. A lot of opportunity is there for you if you want to make use of it, you make use of it. It's left for you, by the government the opportunity there for you. So for to better your life and to help your wellbeing. (Nigerian, FG4)

Achieving personal agency to make these choices requires a journey of self-discovery and self-development. Two participants (FG2, FG3) described the arrival to the UK as the start of this journey. For some, lack of family guidance was an important part of this, as it forces independent choice making. Others attributed this development to obtaining a refugee status, as it facilitates independence; ability to make informed choices, carrying out tasks, and having access to one's own resources.

> Fatima: now I am very happy in the UK. Especially after I got my paper [refugee status]. I can uhm..., improve my English, I can...because I am PhD holder in Psychology uhmm...I can go to university and work in university and achieve my goal. (FG2, Sudanese)

Access to resources. Access to government provided resources is a foundation for security, shelter and livelihood;

> Zahra: Yes, me, I all time thinking if I was in Syria I have family, but if the women divorce her husband no one will give her any money, no one will give her any house, no one will give her anything [...].Here, I don't have this problem. I have my home, because the city council give a lot of people houses, and I have my benefit. That's make me feel more safe. I can feel safe. (FG2, Syrian)

Housing was discussed in three of the groups. In FG4, three participants had experienced destitution in the UK, which significantly impacted on their mental health. Mariam (FG3) highlighted her own difficulties in finding a house upon gaining her refugee status:

> Mariam: I think if uhm...for the refugee has a more house, it's very better because when they arrived here that big problem is house for them. And when they say 'you are refugee and you don't have any job here' it will be our confidence come down and that's has a lot effect in our mind, our ... we will be stress, we can't continue normally. (Iranian)

For participants who had experienced difficulties in obtaining accommodation, finding housing represented a transition into a better life.

Lastly, women across all four FG recognised the importance of education. Education creates a pathway to dignity, empowerment and economic opportunity – an enabler to become who you want to become. One illiterate participant described her experience and motivation for learning to read and write, based on the ability to obtain privacy, and not be dependent on the welfare system:

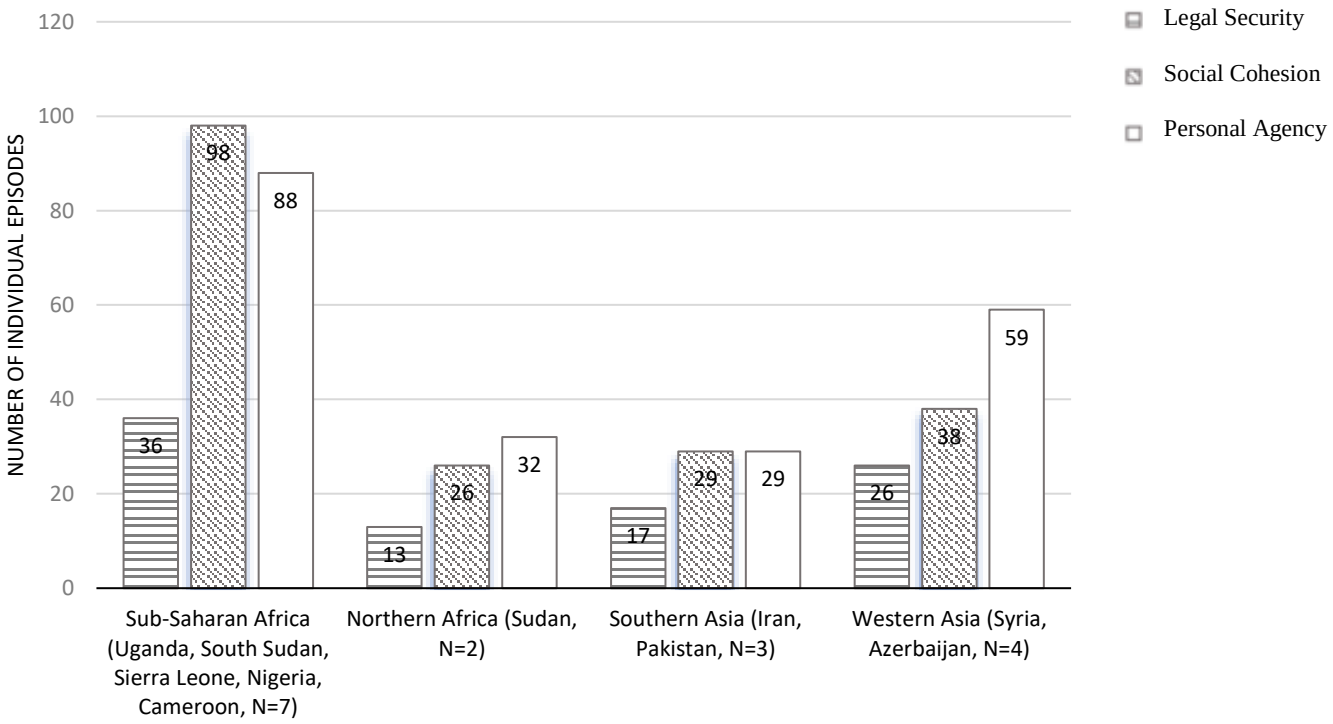
> Kadie: Because my children have the education, me now if they come out I say 'please can you read this for me?' I want to read it for myself. I want to have my own private for myself. My children don't have to know everything about me. (FG4, Sierra Leonean)

> Kadie: I find myself in ESOL (English for speakers of other languages) to just go for it, because I want to do something for myself. I don't want to depend on all times the benefit, benefit, no. I want to do something for my life. (FG4, Sierra Leonean)

Thematic representation across geographical regions

All three themes were represented across four of the WHO Sustainable Development Goals (2017) regional groupings; Sub-Saharan Africa, Northern Africa, Southern Asia and Western Asia (Figure 7). The Sub-Saharan African region was the most represented through the individual episodes provided by participants across groups, however, almost half (44%) of the participants came from this region. The Northern African region was the least represented, with also the lowest number of participants. Personal agency was the most prominent theme (total episodes = 208), followed by social cohesion (total episodes = 179) and legal security (total episodes = 92).

Figure 7. Number of individual episodes per superordinate theme across the WHO regional groupings



Written dimensions

The additional exercise through which participants were asked to provide the most important dimensions to achieving a 'good life' in the UK and the ranking thereof further support the themes found through the IPA analysis (Table 12). One participant did not participate.

Table 12. A ranking of the three most important dimensions to having a 'good life' in the UK transcribed verbatim from the post it notes.

	P1	P2	P3	P4
FG1	1. Being free and confident in your own skin (freedom) 2. Being able to have hope and outlook for your own future (hope for your future) 3. Find happiness around you and within yourself	1. Security life in here 2. Freedom for woman 3. What does it mean to be happy for me … ☺	1. To be freedom 2. To meet different people and culture 3. Good education	No response
FG2	1. When I have freedom to do what I want 2. When I achieve my dreams me and my daughter. To do my masters with (women rights) 3. When the war finish in Syria and see my family	1. seeing my kids in a happy way with offering every things to them 2. Health and wellbeing 3. Improving my language & start work	1. Peace 2. Studying 3. Work	1. Positive behavior 2. Confidence 3. Self esteem
FG3	1. Safe and security life 2. Free to speak my opinion and do my believes without scary 3. Good job	1. Good health 2. Basic human rights 3. Freedom	1. Freedom 2. Good job 3. Healthy	1. To be able to follow my passion 2. Security and basic needs 3. Independent
FG4 - *delivered orally*	1. Education make me happy. 2. With this car I have make me happy for life 3. Having a house	1. Good health 2. Family 3. Money	1. Children 2. Mental Health 3. Being in Liverpool	1. God and going to church 2. Family 3. Having a house

7.4. Discussion

Main Findings

The aim of this research was to shed light on what a 'good life' means to refugee women in the UK. An IPA approach using the CA framework was used. A number of strengths and limitations should be highlighted. In terms of strengths, the CA has a competitive advantage over other frameworks for three main reasons. Firstly, it moves away from a disempowering or pathologising protection model for refugees, by placing refugees in the centre as effective agents in their own welfare. Secondly, it recognises diversity and the potential complexity of different circumstances (Dean, 2009). Applying it in the context of refugee women allows us to consider the responsibility national bodies have towards migrant groups. Lastly, the CA works from an ontological position that the improvement of people's lives is driven by the improvement of individual rights and freedoms. Therefore, it avoids utilitarian arguments that could be used to justify the exclusion or marginalisation of specific populations, such as refugees (Landau, 2008).

In terms of limitations, those who had not received a 5-year status (e.g., still seeking asylum) or had been granted ILR were excluded as they were likely to face different challenges and hold a different perspective on what a 'good life' means to them. Additionally, the language of the FG was limited to English, given the heterogeneity of languages spoken by potential participants. There was a strong belief that including multiple interpreters would restrict the flow of the conversation. Consequently, this led to the exclusion of some women. Furthermore, women who did not speak sufficient English were also considered to face different challenges than those who do. Previous literature has shown that refugees with poor language skills are most at risk of exclusion and long-term dependency (Morrice et al., 2019). Future research should consider focusing on refugee women who do not speak the language of the host country to establish whether there is a difference in what dimensions emerge as being important. Additionally, a similar project could be conducted with asylum seekers to determine what they anticipate prior to receiving their refugee status. Lastly, given that the FG moderator (author CB) also developed the IPA themes, this may have introduced a bias. To mitigate this, firstly bracketing was carried out by CB (Smith, Flowers & Larkin, 2009). Secondly, IPA considers that the researcher forms part of the participant's meaning making process throughout the interview and analysis stages (Smith, 1995). Therefore, a research audit trail was created to ensure transparency of this process (Smith, Flowers & Larkin 2009) through reflexive journaling, taking notes on the margins of the transcripts, and showcasing theme development in Figure 6. Thirdly, triangulation was carried out at different timepoints during the analysis between authors CB and RW, to ensure validity (Yardley, 2008). Final themes were reviewed

by two additional independent researchers (Yardley, 2008). The findings of the research are discussed below.

Three highly interconnected superordinate themes emerged; legal security, social cohesion and personal agency. The narrative around what a 'good life' means to refugee women highlights the importance of having basic needs satisfied as a stepping stone towards more complex freedoms such as exploring one's agency, gaining a sense of belonging, and developing a future.

Legal security was discussed in terms of democracy and how the different stages of the step-based migration system act as barrier or facilitator to the expansion of individual capabilities. For example, having the freedom to work after gaining a refugee status was recognised as an important capability.

According to Sen, political freedoms and civil rights facilitate the 'informed and unregimented formation of our values [through] openness of communication and arguments'. Freedom of speech, public discussion and democratic choice are required to achieve 'a proper understanding of what economic needs are' and "express publicly what we value and to demand that attention be paid to it" (Sen, 1999; p.152). Therefore, democracy plays a fundamental role in increasing both individual and collective capabilities, that enable free choice. The role of governing institutions should be to promote resources and reforms that increase freedom to make choices (Sen, 1999). Women in the current study recognised the freedoms a democratic government is able to give; however, these freedoms are dependent on migration status. Being in detention and going through the asylum process were described as 'unfree' living conditions, where one's welfare and capability to act is highly dependent on government structures. Whereas the certainty of receiving the 5-year status enabled them to rapidly expand their material capabilities such as gaining an income.

The findings highlight that gaining a refugee status does not guarantee prosperity for nonmaterial objectives such as helping others or gaining a sense of belonging. This disparity has previously been noted by Landau (2008), who stated that by linking protection to agency and freedom, the CA first addresses the need for basic capabilities required to sustain life and avoid poverty, while they provide the basis to achieving 'higher-order' capabilities related to personal fulfilment and human dignity. In this study, participants described a 'good life' to be dependent on gaining a refugee status, suggesting that this may constitute a basic capability for

refugee women in the UK. After which, higher-order capabilities can be pursued (i.e. education).

The value of social cohesion for human development has been stressed across different disciplines (Putnam, 2000), and social networks are robust predictors of subjective wellbeing and QoL (van der Boor et al., 2020a). Current findings highlight the importance of interactions with family and communities to achieve a 'good life'. Social capital was specifically relied on both for emotional and practical support. Key to this was the need to live a life free from social judgement and discrimination.

Positive relationships between integration and social networks within and between communities have been previously noted in the UK (Cheung & Phillimore, 2017). Social networks enable access to welfare services, financial and emotional support and reduce isolation and depression (Cheung & Phillimore, 2017; Spicer, 2008). This was echoed in our study; there was a reliance on social networks to access services. Although this highlights the central role of social support networks, it also suggests poor accessibility of resources and support from governing bodies. One concern discussed by participants is the inability for some women to access social networks due to cultural factors or restrictions within the home (i.e. restrictions from male family members). This requires future research. Culture and gender sensitive policies are needed to ensure support is provided to both males and females to adjust to the new legal and social context.

The need for social cohesion is also recognised in the UK Home Office's revised Indicators of Integration Framework (2019b). Integration must be seen as a process of mutual accommodation, which requires a means of social connection between refugees and the host society (Home Office, 2019b). Current findings bring to the front issues of discrimination highlighting a need for interventions focused on the community, to ensure civil society plays a role in creating conditions which are conducive to positive integration and social cohesion. These may include interventions to reduce anti-migrant sentiment and changes in media narratives around migration with more focus on the benefits and positive impact migrants have on society.

Receiving a refugee status was considered the starting point of being able to enjoy one's agency. According to the CA, agency is qualified and constrained by conversion factors; namely personal, environmental and social characteristics which inhibit or encourage the

transformation of resources into functionings (Robeyns, 2005). In the current study, personal characteristics identified were the need for physical and mental wellbeing. Environmental characteristics included the ability to enjoy leisure activities, having easy access to resources and the location of housing. Social characteristics included government policies, which facilitate or restrict agency through legal rights. Furthermore, findings highlight intersecting, overlapping and mutually constitutive barriers that arise from structural inequalities such as the refugee status, gender, race, primary caregiver and religion. Intersectionality as a concept and theoretical framework was first developed as a means of exploring overlapping experiences of oppression and marginalisation faced by African American women due to their race and gender (Crenshaw, 1989). It has since then been used in studies on forced displacement, recognising that such experiences are framed by a range of intersecting identity markers (i.e., gender, ethnicity, religion) and power structures (i.e. patriarchy, xenophobia, Islamophobia) (i.e., Fiddian-Qasmiyeh et al., 2014). The current findings reveal refugee women are at risk of different forms of structural inequality throughout their journeys to securing protection, including discrimination on the basis of name, religion and ethnicity; and patriarchal power structures both within the family and larger society.

To remove barriers preventing refugee women from living a 'good life' in the UK, policies must recognise how gender is compounded by inequalities based on previously described intersecting identity markers. To ensure policies adequately address needs and expand capabilities, it is critical refugee women are equally represented at all levels of decision-making and become an active part of the process of structuration. Specifically, their combination of cultural knowledge and personal experience can guide improved use of resources and service provision at all levels (UNGA 2016).

A practical implication of this study is the support that the findings provide for the need to ensure a more humane migration process focused on safeguarding the specific needs of refugee women exists. The findings also suggest the need for targeted policies and community-focused interventions that foster positive integration and help women build social networks within their communities. Lastly, the findings can inform the development of a comprehensive outcome measure for the evaluation of capabilities in this population.

7.5. Conclusion

The current study was the first to use a participatory approach and IPA analysis to research what constitutes a 'good life' for female refugees who hold a 5-year refugee status in the UK. The three core themes of legal security, social cohesion and personal agency suggest that refugee women face specific barriers to expanding their capabilities. These three core themes should provide a basis to inform the development of more nuanced approaches to assessing, monitoring and measuring QoL and wellbeing of female refugees in high-income countries which can be used to evaluate policies aimed at improving wellbeing and integration for refugee women.

Foreword Chapter 8

Chapter 7 described an empirical qualitative study in which we explored what a 'good life' means to refugee women who have migrated to the UK. The three core themes that emerged (legal security, social cohesion and personal agency) highlighted two main things; firstly, the need to take a more holistic approach to understanding mental health and wellbeing in migrant populations. Secondly, it showcases the importance of moving away from a predetermined list of universal capabilities. Instead, the findings suggest different capabilities are relevant to different contexts and can be highly influenced by personal, social and environmental factors, as previously described by Stiglitz and colleagues (2009).

In Chapter 8, the qualitative findings from Chapter 7 are used to inform the development of a capability-based wellbeing measure that speaks to the specific capabilities dimensions that were found in Chapter 7. A preliminary validation of this capability-based outcome measure is conducted.

Published Chapter

1. Stage of Publication

   The paper presented in Chapter 8 has been submitted to a peer-reviewed journal and is currently under review. This chapter is presented as the authors' submitted for publication version of the paper.

2. Research paper title

   The Development and Validation of the 'Good Life in the Community Scale' (GLiCS): A Validation Study with Women Migrants Living in High Income Countries

3. Peer-reviewed journal

   BMC Public Health

4. Citation

   N/A

5. Candidates' specific contribution

   The substantive contribution of Catharina van der Boor has been the conception and design of the research, data collection, data analysis, interpretation of findings, writing the paper and doing critical revision.

6. Co-author declarations

   I give permission to Catharina van der Boor for including this research paper in her doctoral thesis.

   Name: Dr. Paul Christiansen
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   Date:31/08/21

   Name: Prof. Paul Anand
   Signature: *Paul Anand*
   Date: 2 September 2021

   Name: Dr. Ross White

   Date: 23rd August 2021

Chapter 8: The development and validation of the 'Good Life in the Community Scale' (GLiCS): a preliminary validation study with women migrants living in high-income countries

8.1. Introduction

Background

Increasing numbers of people are leaving their country of birth because of conflict, poverty, unemployment, or in search of higher quality of life. The *International Organisation for Migration* (IOM) estimated that as of June 2019, the number of international migrants was almost 272 million globally (IOM, 2020). Although migration is not a recent phenomenon, research into its impact on wellbeing and quality of life remains relatively sparse (Turrini et al., 2019; van der Boor et al., 2020a). Whilst many migrants have experienced multiple forms of trauma and life-threatening situations prior to, and during, the process of migration (Priebe et al., 2016), more recently research attention has also recognized that the living conditions and post-migration stressors experienced in the settlement environment can exert an important influence on their mental health and wellbeing (i.e., Li et al., 2016; Morgan, Melluish & Welham, 2017). Post-resettlement conditions have been suggested to be at least of equal importance for the mental health and wellbeing of migrants as pre-migratory conditions (Porter & Haslam, 2005; Chu et al., 2013; Schweitzer et al., 2011), including both forcibly displaced (i.e., asylum seekers and refugees, Chen et al., 2017; Gleeson et al., 2020; Jannesari et al., 2020), and non-forcibly displaced migrants (i.e., economic/labor migrants, Sangalang et al., 2018).

In particular, the United Nations High Commissioner for Refugees (UNHCR) underlines that some migrant subgroups are more disenfranchised than others, i.e. those with intersecting identities that may infer additional disadvantage including women/girls, children, persons with disabilities, sexual minorities, and elderly men (UNHCR, UNFPA & WRC, 2016; UNHCR, 2021). The intersecting challenges, such as challenges related to gender, immigrant status and forced migration, might add up or even mutually reinforce each other (Liebig & Tronstad, 2018), which can present multiple challenges to individuals' overall integration, wellbeing, and ability to live a full life post-resettlement (i.e., Liebig & Tronstad, 2018, Phillimore, 2011; Quinn, 2014; Strang & Quinn, 2019).

To date, few assessment instruments have been developed to quantitatively measure the mental health status of migrant populations specifically. The majority of tools that have been developed have focused on (i) specific subgroups of migrants, most commonly asylum seekers and refugees, and (ii) measuring pre-migration sources of trauma and distress (i.e., The Harvard Trauma Questionnaire, Mollica et al., 1992), or post-migration stressors and risk factors for mental ill-health (i.e., The Post-Migration Living Difficulties Scale; Silove et al., 1998; the Refugee Post-Migration Stress Scale, Malm et al., 2020), rather than positive mental health and/or wellbeing outcomes. There have been a number of calls in the literature to move away from the focus on psychopathology, and instead move towards broader outcomes relevant to psychosocial functioning in migrant groups (Bosqui & Marshoud, 2018; Turrini et al., 2019; White & van der Boor, 2021). It is argued that the dominant focus on trauma and distress overlooks other aspects of migrants' mental health and wellbeing, for example relationships, sense of meaning (Slobodin & de Jong, 2015) and sense of belonging (Giacco, Laxham & Priebe, 2018). This aligns with the recognition that mental health and wellbeing are not simply the absence of disease but instead encompass a wider understanding of what brings vitality into a person's lived experiences, and that high levels of wellbeing and an understanding of positive predictors of mental health are necessary as well (WHO, 2013; Keyes, 2002). As such, assessing levels of positive mental health and/or levels of wellbeing and identifying factors associated with higher levels of mental health and wellbeing has been highlighted as a research need (Keyes, 2002; du Plooy, Lyons & Kashima, 2020).

A recently conducted study used a participatory research approach to develop a wellbeing scale for a sample of newly resettled refugees from Myanmar and Bhutan in the USA (Martin-Willett et al., 2019). The scale was developed in the context of an agricultural program aimed at strengthening health and improving wellbeing. The initial scale was composed of three subscales namely, (i) somatic experience, (ii) occupational balance, and (iii) social inclusion/self-identification. The authors acknowledged that "future iterations of survey development could include a factor analysis to measure the fit of a latent variable of wellbeing to the selected survey items, or correlation with similar, existing measures" (Martin-Willet et al., 2019, p. 27). It is likely that assessment instruments of this kind could be beneficial for guiding policy, monitoring wellbeing, and identifying areas that require further support and attention for specific migrant groups post-resettlement.

The Capability Approach

Sen's CA (1980) is widely regarded to be of substantive importance for the conceptualization of multidimensional wellbeing (Atkinson, 1999; Jenkins & Miclewright, 2007). The CA holds that the wellbeing of a person ought to be assessed in the space of capabilities; the abilities to achieve the 'beings and doings' that they have reason to value in life (Sen, 1980). From a CA perspective, human wellbeing depends on what resources enable people to do and to be. The ability to convert resources (e.g., social networks or education) into what people consider to be a *good life* varies and can include both health and non-health related variables like empowerment, relationships, participation, housing, and legal status (Stiglitz, Sen & Fitoussi, 2009). As such, the CA not only assesses a person's current circumstances, it also includes a focus on outcomes, agency, and the individual's substantive opportunities to achieve wellbeing (Binder, 2014).

The relevance and utility of applying the CA in the context of migration has been highlighted in a recent theoretical commentary by White and van der Boor (2021). The authors proposed the CA as a helpful framework to elucidate a focus on what living well means to migrant groups, understand what resources are available to these groups, and how these resources might interact with the persons' capabilities and freedoms to engage in valuable functionings (White & van der Boor, 2021). Factors operating at different levels of an individual's social environment including their microsystem (i.e. factors that directly affect the individual), mesosystem (i.e. factors that impact on the social experience of the individual), exosystem (i.e. factors that are experienced by those in the person's social networks) and the macrosystem (i.e. factors that operate at an institutional level) were highlighted as important when formulating an understanding of migrants' experiences (White & van der Boor, 2021). The authors concluded that individual choices, resources, and entitlements will be highly influenced by people's migration status (Eichsteller, 2020; White & van der Boor, 2021).

Significant attempts have been made to create evaluative tools and measures that are based on the CA. For example, the '*Human Development Index*' published by the United Nations Development Program (UNDP, 1990) is grounded in the understanding of development as a process of expanding individuals' choices and opportunities. More recently, the *Oxford Poverty and Human Development Initiative* developed a specific poverty measure (Alkire & Foster, 2011). Furthermore, the Organisation for *Economic Co-operation and Development's* (OECD) developed the *Better Life Index,* which was launched in 2011 and aimed to measure

the national wellbeing of OECD member countries (OECD, 2013). However, there has been concern about the lack of available data relating to people's actual capabilities, rather than the outcome of these capabilities (i.e., their functioning) (Anand et al., 2009, for a review see Robeyns, 2006). Anand et al. (2009) developed a list of over sixty capability indicators which could be used to generate information about an individual's capabilities. This capability list was reduced and refined by Lorgelly et al. (2008) into an 18-item capability wellbeing index (OCAP-18) and was validated for use in public health evaluations in Glasgow, UK with members of the public. Subsequently, Simon et al. (2013) adapted the OCAP-18 to create the OxCAP-MH; 16-item capability informed wellbeing measure for mental health research. The OxCAP-MH allows for the identification of capability domains most affected by mental illness and was validated on a sample of adults who had been involuntarily treated in hospital. To date, however, the CA has not been used to operationalize a measure of wellbeing for migrant populations.

A key objective of this paper is to describe the development of the 'Good Life in the Community Scale' (GLiCS) which was developed using the CA (Sen, 1980) as a guiding framework and coproduced with members of migrant populations in the United Kingdom (UK). To develop the items on the GLiCS, qualitative data collected in a previous study that explored what constitutes a 'good life' for female refugees in the UK from the perspective of the CA was used (van der Boor et al., 2020b). Specifically, the wording used by the participants to describe each domain relevant to achieving a 'good life' was extracted from the transcripts and used to create an initial draft of 88 individual items.

In line with previous research that has highlighted the importance of liaising with experts by experience in the development of assessment instruments (Rubio et al., 2003; US Department of Health and Human Services, 2009;), the current paper describes a multi-phase approach using the initial 88 items as a starting point in the development of the GLiCS involving women with a lived experience of migration and/or supporting migrants. In addition, this paper also provides a preliminary assessment of the psychometric properties of the GLiCs.

8.2. Methods

The current study used a mixed-methods approach and was composed of two phases: (i) Phase I: the refinement of the items of the GLiCS through consultation with women with a lived experience of migration and/or supporting those who do, and (ii) Phase II: the validation of the GLiCS. Ethical approval was granted by the Health and Life Sciences Research Ethics

Committee of Psychology, Health and Society (approval reference number: 7561) at the University of Liverpool.

Phase I: Refinement of the 'Good Life in the Community Scale'

The initial pool of items (GLiCS v0.1) which was developed by the lead author from the data gathered in a previous focus group study (van der Boor et al., 2020b) was refined and checked for content validity through consultation with a *migration expert advisory panel*. This six-person panel consisted of four women who had experience of going through the asylum process and gaining a refugee status in the UK, and two female experts working with migrant women in the UK. The choice to include both members of the target population and experts working with migrant women was in line with suggestions made by Vogt and colleagues (2004) to include "consultation with experts and members of the population" (p.232) when assessing content validity. Similarly, Rubio et al. (2003) emphasized the need to use a panel of experts who can provide constructive feedback on the quality of the measure, and objective criteria with which to evaluate each item. Recruitment to the panel was targeted to individuals who had previously been involved in the qualitative focus group study either by aiding recruitment or as participants themselves (van der Boor et al., 2020b), and who have expressed a willingness to continue to be involved in the research. Participation was on a voluntary basis.

The six members recruited for the *migration expert advisory panel* were invited to participate via e-mail. The e-mail highlighted that following on from the previous study (van der Boor et al., 2020b), a wellbeing measure had been drafted and they were invited to individually review the 88 items and provide written feedback. Upon agreeing to participate, a participant information sheet (Appendix M) and consent form (Appendix N) were sent. Following the provision of written consent, each participant received a copy of the GLiCS (v0.1; consisting of 88 items) via e-mail (see Appendix O) and were asked to provide written feedback. The form contained three statements for each individual item; (i) this item is clearly understandable to refugee women (ii) this item is relevant to the wellbeing of refugee women (iii) if not, how can the item be amended to ensure that it is clear and/or relevant? Questions (i) and (ii) were answered on a 5-point Likert scale (1 - Strongly agree, 2- Agree, 3- Not sure, 4- Disagree, 5- Strongly Disagree). Question (iii) required a written response from participants. Additionally, participants were asked whether there were any additional questions or areas of wellbeing which should be included. Two participants did not complete the full Likert scales due to them

having limited time but provided written feedback on the items they considered needed changing. Following this feedback, an online discussion was hosted for debrief purposes.

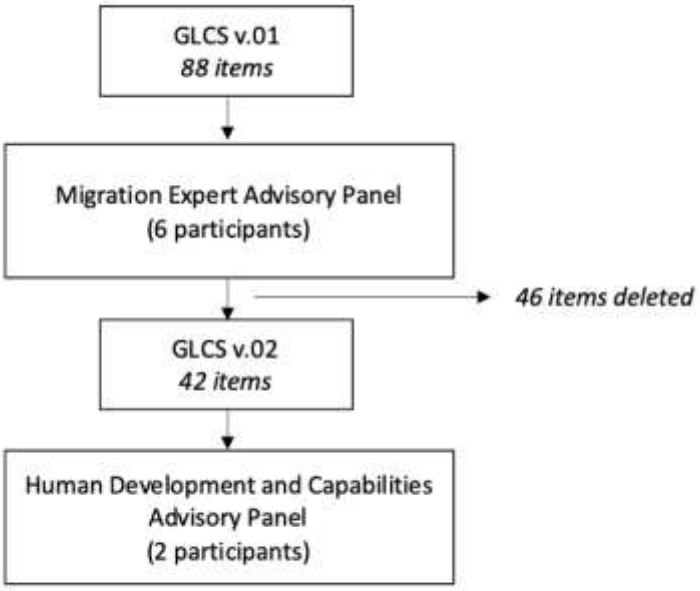
Based on the feedback provided, all the items which obtained a relevance score of four or higher from any one reviewer was deleted. The only item exempt from this process of deletion was item '*I am able to do things to help me achieve a good level of mental health, for example talking about my worries or taking time to relax'* as this was a key theme that emerged from the previous research (van der Boor et al., 2020b). This led to a revised GLiCS (v0.2) of 42 items (see Figure 8).

The GLiCS (v0.2) was then shared with two researchers belonging to the *Human Development and Capabilities Network*[6] (HDCA) who have previous experience in developing capability-based measures. The HDCA is a global community of academic and practitioners that seeks to build an intellectual community around the ideas of human development and the CA and relate these ideas to the policy arena. These two researchers were contacted via e-mail and asked to review the list of items and suggest written amendments and/or refinements regarding the perceived clarity, relevance, and the wording of each of the items in the context of measuring capabilities. The wording of specific items was adjusted according to the feedback collected. This resulted in GLiCS (v0.3).

Consistent with the approach taken by Lorgelly et al. (2008), Simon et al. (2013) and others in the development of their capability-informed assessment instruments an 'equal weights approach' was used in the current study, whereby each item of the GLiCS received an equal rating. The equal weights approach has previously been adopted in the development of the Human Development Index (Anand & Sen, 2000), the Human Poverty Index and the Gender-related Development Index (UNDP, 2013), the OECD Better Life Index (OECD, 2013), the OPHI Multidimensional Poverty Index (Alkire & Foster, 2011), the OCAP-18 (Lorgelly et al., 2008), and the OxCAP-MH (Simon et al., 2013).

[6]HDCA website: https://hd-ca.org

Figure 8. Diagrammatic representation of item deletion of the GLiCS.



Phase II: Factor Analysis and Validation

In Phase II, an exploratory factor analysis of the GLiCS (v.03) was carried out and a preliminary investigation of validity and internal consistency was conducted to determine whether the GLiCS is adequately able to measure capabilities in a sample of migrant women.

Design

This study used a cross-sectional design. Data was collected between August 2020 and March 2021. Participants were invited to complete the study on the online Qualtrics platform or verbally via a telephone consultation with author CB.

Participants

An initial validation of the GLiCS measure was conducted with a mixed group of females who identified as being a refugee, asylum seeker or economic migrant. The inclusion of three different migrant categories provided an opportunity to assess known groups validity; the ability a measure has to discriminate between groups likely to differ on the variables of interest (Davidson, 2014).

A sample of adult woman (≥18 years) who identified as a refugee (definite leave to remain or settled status), asylum seeker or economic migrant living in the UK, New Zealand, or the Republic of Ireland who speak English were recruited to complete the survey. These countries were included due to the available networks of the researchers on the project. Three participants did not give full consent (see Appendix P for Participant Information Sheet and Appendix Q for consent form), two stated they were male, two participants confirmed they were not refugees, asylum seekers or economic migrants and were excluded, and one reported they did not live in a country relevant to this study, therefore these participants' data were deleted. Demographic questions were asked at the beginning of the survey (see Table 13). The final sample consisted of 109 women.

Table 13. Sociodemographic characteristics of sample (N=109)

Characteristics	Sample (N=109)
Migration status	
Refugee	41(38%)
Asylum Seeker	19 (18%)
Economic Migrant	48 (44%)
Not stated	1 (0%)
Age	M=34, IQR=28 - 40
Country of Origin	
Spain	17 (16%)
The Netherlands	13 (12%)
Iran	10 (9%)
Syria	9 (8%)
Pakistan	7 (6%)
Turkey	6 (6%)
Afghanistan	5 (5%)
Kurdistan	4 (4%)
Nigeria	4 (4%)
Cameroon	2 (2%)
Venezuela	2 (2%)
Sierra Leone	2 (2%)
Egypt	2 (2%)
Iraq	1 (1%)
Sudan	1 (1%)
Poland	1 (1%)
Colombia	1 (1%)
Saudi Arabia	1 (1%)
Uganda	1 (1%)
East Africa	1 (1%)

Guatemala	1 (1%)
Bangladesh	1 (1%)
Missing	17 (16%)
Children	
Yes	60 (55%)
No	49 (45%)
Employment status	
Yes, regular employment	40 (37%)
Yes, in voluntary/protected/sheltered work	14 (13%)
No	55 (50%)
Housing	
Homeless or 24h supervised	2 (2%)
Sheltered or supported accommodation	27 (25%)
Independent accommodation	80 (73%)
Living situation	
Living alone	35 (32%)
Living with partner or family	74 68%)

Recruitment

Three different recruitment strategies were used; (i) advertisements inviting eligible people to take part in the research were disseminated online via dedicated social media sites (Twitter, Facebook, charity websites). The advertisement included a link and a QR code which could be scanned to access the measure online via the Qualtrics platform (see Appendix S), (ii) service providers within organizations supporting migrants in the UK were asked to circulate information about the research project to potential participants, using the advertisement or a recruitment video in which author CB provided a verbal explanation of the study. Forty-five organizations/individuals agreed to disseminate the project via their networks. Lastly, (iii) every participant was invited to share the survey with other women in their networks who met the inclusion criteria. All participants were given the opportunity to enter a randomized draw to win one of four Amazon vouchers, three of which were worth £50 and one worth £100. Four randomized numbers were drawn from an online number generator[7].

Measures

Objective Social Outcomes Index (SIX, Priebe et al., 2008*):* The SIX is a brief index used for benchmarking social outcomes by capturing objective information about an individual's social

[7] Online number generator: https://numbergenerator.org/randomnumbergenerator/1-100#!numbers=3&low=1&high=99&unique=true&csv=&oddeven=&oddqty=0&sorted=false&addfilters=

situation in three domains: employment, living situation and social contacts (Priebe et al., 2008). The instrument scores from 0 to 6 with higher scores indicating better outcomes. The SIX was used to test for convergent validity with the GLiCS (v0.3). The internal consistency for the SIX on the current study was ω =0.44. The low internal consistency in the current paper may be because the questions on the SIX are commonly collected as part of socio-demographic characteristics of participants, and do not test a construct per se (Priebe et al., 2008). See Appendix T.

Good Life in the Community Scale (GLiCS v0.3): the GLiCS (v0.3) is a 42-item measure which assesses whether migrant women judge their individual capabilities to be satisfied or deprived in the context of the UK. It contains forty-two items, and equal weights were assigned to each potential level of answers on a 5-point Likert scale; (1) strongly disagree, (2) somewhat disagree, (3) undecided, (4) somewhat agree, (5) strongly agree.

Oxford Capabilities questionnaire – mental health (OxCAP-MH, Simon et al., 2013*):* The OxCAP-MH is a wellbeing questionnaire developed within the conceptual framework of the CA. It was developed in the UK as a self-report measure for individuals with a severe mental illness (Simon et al., 2013). It consists of 16 items rated on a 1-5 scale where higher scores indicate better capabilities. The OxCAP-MH was used to test for convergent validity with the GLiCS (v0.3). The OxCAP-MH demonstrated good internal consistency in the current study (McDonald ω =0.86). See Appendix U.

WHO-5 wellbeing index (WHO-5, WHO, 1998): The WHO-5 is a measure of wellbeing that owes its development from items of the Zung scales for depression, distress and anxiety (Zung, 1965) as well as from the General Health Questionnaire (Golderberg, 1988) and the Psychological General Well-Being Scale (Dupuy, 1971). A key point of departure from these previous scales is that WHO-5 (WHO, 1998) only contains positively phrased items e.g. 'I have felt cheerful and in good spirits'. The WHO-5 is comprised of 5 items rated on a 6-point Likert scale (i.e. 5- all the time, to 0-at no time). The WHO-5 was used to test for convergent validity with the GLiCS (v0.3). The WHO-5 demonstrated high internal consistency (McDonald ω =0.95) and has been validated in a variety of settings. See Appendix V.

Analysis

A mean imputation was carried out for three participants who had missing data for a maximum of two answers on the GLiCS. Participants with missing data on the WHO-5 and the OxCAP-MH were excluded from the analyses.

As the GLiCS data were ordinal (scored on a five-point Likert scale), a parallel analysis was conducted using the simulated polychoric correlation matrix to identify the number of likely components in the data. Following this, an exploratory factor analysis (EFA) was conducted on the polychoric matrix in RStudio version 1.3.1093 using the Lavaan package to produce the GLiCS (v1.0).

The internal consistency of the GLiCS (v1.0) and each of the subscales was estimated by computing McDonald's ω. To test the convergent validity, correlation analyses were performed to examine the associations between the GLiCS (v1.0) and theoretically related measures of wellbeing (WHO-5) and QoL (OxCAP-MH). Furthermore, the convergent validity was tested by investigating the correlations of the GLiCS (v1.0) with the SIX (Priebe et al., 2008), as objective social outcomes such as employment and social contact would theoretically increase individuals' capabilities. Finally, the incremental validity was tested using a hierarchical regression analysis to ascertain the effect of age, migration status, objective social outcomes, OxCAP-MH and GLiCS (v1.0) on levels of wellbeing (WHO-5 wellbeing index; WHO, 1998). The known groups validity was tested by running a simple one-way between subjects ANOVA to test the effect of migrant status on the GLiCS (v1.0) and the OxCAP-MH.

8.3. Results

Factor structure

Parallel analysis of the 42 item GLiCS (v0.3) suggested there were up to six underlying factors, this was used as an upper limit to the number of factors when exploring the structure in the EFA. The Kaiser-Meyer-Olkin measure suggested the sample was adequate (KMO=0.50) and Bartlett's test of sphericity demonstrated that correlations between the items were large enough for EFA (χ^2 (861) =6887.394 , p <.001). The sixth factor identified by the parallel analysis had a substantially lower Eigenvalue and had one/no items loading onto it (see below).

Factor one had an Eigenvalue of 5.82 (variance explained=14%), factor two Eigenvalue=4.91 (variance explained=12%), factor three Eigenvalue=5.29 (variance explained=13%), factor four Eigenvalue=5.10 (variance explained=12%), factor five Eigenvalue=3.32 (variance explained=8%), factor six Eigenvalue=1.57 (variance explained=4%). Therefore, a five-item solution was retained. As factors were expected to be correlated, an oblique rotation was applied (Fabrigar et al., 1999). Only items with a clear loading of .40 or higher were included (Hinkin, 1995, 1998). Additionally, only cross loadings of less than .25 were used unless the item had a cross loading bigger than .60 (Davies et al., 2021; Kiffin-Petersen & Cordery, 2003). See appendix W for the factor loadings of each item of the GLiCS (V0.3).

We found six items loaded onto factor one, six items on factor two, five items on factor three, one item on factor four, and no items loaded onto factor five. A factor with fewer than three items is considered weak and unstable (Costello & Osborne, 2005), therefore factors four and five were deleted and a three-factor solution was retained. The resulting 17-item GLiCS (v1.0) demonstrated good internal consistency (McDonald's ω = 0.91). Each of the three factors constituted a meaningful subscale; (i) *access to resources*, (ii) *belonging and contributing,* and (iii) *independence;* each of which also demonstrated good internal consistency (see Table 14). See Appendix X for the full measure.

Table 14. Factor structure of the GLiCS (v1.0)

Scale item	Rotated factors		
	Access to Resources	Belonging and Contributing	Independence
I am able to get sufficient money to meet my basic needs (through employment or benefits)	**0.87**	0.23	-0.04
I am able to buy essential items for myself when I want to, for example clothes, toiletries or things for my home	**0.90**	-0.02	0.06
I am able to access the kind of food that I would like to eat	**0.80**	-0.03	-0.07
I am able to access internet when I need to, for example on my phone or on a computer	**0.61**	-0.19	0.34

I am able to access courses to help build my skills and talents, for example art classes or dance classes	**0.55**	0.14	0.16
I am able to choose which city and neighborhood I want to live in	**0.58**	0.18	0.06
I am able to learn about my rights in this country, for example through support organisations	0.17	**0.48**	-0.06
I am able to feel I am a valued member of the community here	0.11	**0.46**	0.01
When people around me are feeling sad, I feel able to support them and make them feel more positive	0.05	**047**	0.9
I am able to rely on local organizations or charities for support with carrying out important tasks, for example paying bills or working through migration documents.	0.10	**0.58**	-0.01
I am able to build a good life in this country	0.04	**0.79**	0.08
I feel happy about being in this country	-0.02	**0.78**	-0.24
I am able to read and write in the language of this country	0.27	-0.06	**0.65**
I am able to speak the official language(s) spoken in this country	0.16	-0.06	**0.62**
I am able to access green spaces in this country, for example parks or the countryside	-0.17	0.20	**0.51**
I am able to be involved in the decisions that affect my life, for example getting married or having children	0.13	-0.03	**0.59**
I am able to have my own privacy and keep information for myself if I want to, for example I can keep my bills and letters to myself.	0.06	0.04	**0.63**

McDonald's Omega	0.94	0.86	**0.82**

All significant loadings in bold.

Convergent validity

The convergent validity of the GLiCS (v1.0) was tested using the WHO-5 (WHO, 1998), the OxCAP-MH (Simon et al., 2013) and the SIX (Priebe et al., 2008). The overall scores for each measure can be found in Table 15. The GLiCS scores were correlated with wellbeing (WHO-5), capability-based wellbeing (OxCAP-MH), and with the SIX. Each of the subscales of the GLiCS were also correlated with the WHO-5, OxCAP-MH, and Six except subscale 2 which was not correlated with the SIX. For correlations see Table 16.

Table 15. The mean scores for each of the measures included in the analysis

Measure	Mean (SD)
SIX	3.67 (1.4)
OxCAP-MH	66 (123.20)
WHO-5	10.23 (6.55)
Total GLiCS	71.17 (12.33)
Subscale 1: Access to Resources	22.13 (6.94)
Subscale 2: Belonging and Contributing	22.86 (4.59)
Subscale 3: Independence	21.95 (3.30)

Table 16. The correlations between each of the scales and subscales used to test convergent validity.

Variables	1.	2.	3.	4.	4.	5.	6.
1. SIX	-						
2. OxCAP-MH	0.40*	-					
3. WHO-5	0.43*	0.54*	-				
4. Total GLiCS	0.56*	0.67*	0.61*	-			
5. Subscale 1: Access to Resources	0.64*	0.55*	0.51*	0.90*	-		
6. Subscale 2: Belonging and Contributing	0.18	0.46*	0.47*	0.72*	0.43*	-	

7. Subscale 3: Independence	0.42*	0.57*	0.47*	0.70*	0.53*	0.30*	-

*p<.001

Incremental validity

To test the incremental validity of the GLiCS (v1.0), a hierarchical regression was run to analyze the effects of age, migration status (refugee, asylum seeker or economic migrant), SIX, OxCAP-MH and GLiCS on levels of wellbeing (WHO-5). Age, migration status and SIX were entered into step one of the model. At step 2, the OxCAP-MH was added, and the GLiCS was entered in step three. Variance inflation factors suggested multicollinearity was not a concern. The final regression model was significant and explained 42.7% of variance (F(5, 85)=14.39, p<.001). Including the GLiCS (v1.0) at step three accounted for an additional 5.8% of variance in the model. Age, migration status and objective social outcomes (SIX) were not significant predictors of wellbeing (WHO-5). The OxCAP-MH (β=.25, p=.025) and GLiCS (β=.36, p=.003) were significant positive predictors of wellbeing. See table 17.

Table 17. Hierarchical regression to test the effects of age, migration status, SIX, OxCAP-MH and GLiCS on levels of wellbeing (WHO-5).

Variable	Cumulative		Simultaneous	
	R^2 Change	F-Change	β	p
Step 1	.24	9.18***		
Age			-.04	.667
Migration Status			.18	.050
Step 2	.16	22.36***		
SIX			.05	.652
OxCAP-MH			.25	.025
Step 3	.06	9.61**		
GLiCS			.36	.003

***p<.001, **p<.01

Lastly, a simple one-way between subject ANOVA was run to test the effect of migrant status (refugee, asylum seeker, economic migrant) on the GLiCS (v1.0) as a form of known groups validity (Davidson, 2014). The assumption of homogeneity of variances was not met (p<.001) therefore a Welch test was conducted. Welch's test revealed a significant effect of migrant status on capability-based wellbeing (F(2, 47.77)=26.92, p<.001). Tamhane's *post hoc* tests

revealed a significant difference between economic migrants (M=77.08, SD=7.99) and both refugees (M=69.29, SD=13.90, p=.007) and asylum seekers (M=60.00, SD=9.00, p<.001).

There was also a significant difference between asylum seekers and refugees (p=.009) with asylum seekers fairing worst on the GLiCS (v1.0) of all three groups followed by refugees and economic migrants respectively. These findings indicate that the GLiCS (v1.0) shows known groups validity for different migrant groups. The mean score on each of the three scales for each migrant group can be found in Table 18.

To determine whether this validity also exists for the OxCAP-MH, a simple one-way between subjects ANOVA was run to test the effect of migrant status (refugee, asylum seeker, economic migrant) on the OxCAP-MH. This analysis also revealed a significant effect of migrant status ($F(2, 95)=8.01$, p=001, $\eta_p^2=.14$). Fisher's Least Significant Difference *post hoc* test revealed a significant difference between refugees (M=62.37, SD=13.71) and economic migrants (M=71.32, SD=12.22, p=.002), with refugees scoring lower. There was also a significant difference between asylum seekers (M=59.38, SD=9.2) and economic migrants (p=.001), with asylum seekers scoring lower. No significant difference was found between the refugee and asylum-seeking groups (p=.421).

Table 18. Means and standard deviations for each subscale of the GLiCS depending on migration status

	Migrant Status		
Subscales	Asylum Seeker	Refugee	Economic Migrant
Subscale 1: Access to Resources	14.68±6.57	21.29±7.08	25.85±3.75
Subscale 2: Belonging and Contributing	21.26±5.08	22.80±5.11	23.44±3.80
Subscale 3: Independence	19.74±3.94	21.07±3.46	23.50±1.91

8.4. Discussion

Findings

To date, few assessment instruments have been developed to quantitatively measure the mental health status of migrant populations specifically. The majority of tools that have been

developed have focused on particular subgroups of migrants and/or on sources of trauma and distress. Simultaneously, a number of calls have been made to broaden the focus on negative mental health outcomes to also focus on psychosocial wellbeing and consideration of what factors may bring vitality to a person's lived experiences (Bosqui & Marshoud, 2018; Turrini et al., 2019; White & van der Boor, 2021). The primary aim of this study was to coproduce a capability-based wellbeing measure for migrant women in high-income settings, and conduct a preliminary validation thereof. An assessment instrument of this type can facilitate the measurement of capabilities of migrant women, which can have important implications for monitoring their mental health and wellbeing, better understanding predictors of positive outcomes, and identifying areas that require further support and attention.

The study was divided into two phases. In phase I, an 88-item version of the *Good Life in the Community Scale* (GLiCS v0.1) was reduced and refined to a 42-item version (v0.2) through consultation with a migration expert advisory panel made up of refugee women who had experienced the asylum system, women working with migrant populations, and two researchers with previous experience of developing a capabilities-based outcome measure. In phase II, a parallel analysis and EFA were carried out, which suggested a three-factor solution for the GLiCS (v1.0; henceforth referred to as 'the GLiCS'). Each of these three factors constitutes a GLiCS subscale: *Access to resources* (6 items), *Belonging and contributing* (6 items), and *Independence* (5 items).

The preliminary validation of the GLiCS showed promising psychometric properties including high internal consistency and good convergent validity. The concurrent validity of the GLiCS was tested through a correlation analysis with the SIX. A moderate positive correlation was found, providing evidence for the concurrent validity. Incremental validity was assessed by determining whether the GLiCS significantly increased the amount of variance in wellbeing scores beyond that of the SIX and the OxCAP-MH (controlling for age and migration status). This was indeed the case. Furthermore, preliminary evidence of known groups validity was obtained for the GLiCS, as the measure revealed significant difference between the different migrant groups. Unlike the GLiCS, the OxCAP-MH did not discriminate between refugees and asylum seekers in terms of levels of wellbeing, may suggest the GLiCS is a more appropriate instrument for measuring capability-based wellbeing of migrant women in high-income settings. Overall, the GLiCS demonstrated good preliminary psychometric properties in the current sample.

Adding to the work of Lorgelly et al. (2008), Greco et al. (2015) and Simon et al. (2013), the development of the GLiCS provides further evidence of the feasibility of operationalizing the CA for the assessment of wellbeing. Importantly, the GLiCS is the first measure to be developed to measure capabilities in migrant populations. We believe that the three subscales that emerged from the data in the current study highlight the need to look across the different strata of the ecological model initially proposed by Bronfenbrenner (1979). Bronfenbrenner proposed an ecological theory of human development which placed individuals within multiple interacting systems including intra-individual, interpersonal, and larger social systems. These systems have previously been applied to understanding the mental health of migrant groups (i.e. Babatunde-Sowole et al., 2016; Drozdek, 2015; Miller & Rasmussen, 2016). In the current study, the three scales highlight how a myriad of factors at different levels of the social environment of migrant women in the UK might affect their capabilities. When linking these subscales to Bronfenbrenner's' ecological model, the Access to Resources scale relates primarily to larger social systems, as the items within this subscale are influenced by the setting the individual finds themselves in (i.e., item 5; '*I am able to access courses to help build my skills and talents, for example art classes or dance classes*'). The *Belonging and Contributing* subscale speaks chiefly to the interpersonal system, i.e., pertaining to the social connections the individual can make within their community (i.e., item 2; '*I am able to feel I am a valued member of the community here'*). Lastly, the *Independence* subscale seems to relate to the intra-individual system i.e., the items speak to the person's individual circumstances, sense of autonomy and agency (i.e., item 1. '*I am able to read and write in the language of this country*'). As such, the subscales of the GLiCS can help to shed light on what capabilities are being satisfied and/or deprived across the different levels of female migrants' ecology post-migration. Moving forward, this could help inform interventions and forms of support aimed at increasing wellbeing in these populations. This was recently discussed in more detail in a commentary on enhancing the capabilities of forcibly displaced populations (White & van der Boor, 2021).

The development and preliminary factor exploration of the GLiCS can have important implications for policy and practice. Firstly, organizations (including non-governmental organizations and charities) supporting migrant women in high-income countries may benefit from using the GLiCS, as it can draw attention to specific issues that need to be addressed to support migrant wellbeing. It can also provide valuable information for advocacy efforts aimed at developing and amending policy and legislation relating to migration. Secondly, clinical services engaged in supporting the mental health and wellbeing of migrant women could

benefit from using the GLiCS as an outcome measure to move beyond psychopathological outcomes and draw a more holistic picture of the individuals' lived experience.

Strengths, Limitations and Future Directions

A major strength of this study is that it reports on the empirical development and preliminary factor analysis of the first CA-specific psychometric scale to be developed for and validated in a migrant population. At each stage of the assessment instrument's development (including the previous qualitative work; van der Boor et al., 2020b) there was extensive involvement of experts by experience to ensure coproduction was facilitated. Following their participation, a number of participants provided positive feedback via e-mail to state that they had enjoyed participating and found the research highly relevant. A second strength of the study is the approach taken in the preliminary analyses. In previous studies researchers have erroneously used factor analyses developed for *interval-level* data, when the construct itself is *ordinal* in nature. To overcome this specific statistical challenge, the current study used a polychoric correlation matrix (Kolenikov & Angeles, 2004).

However, there are some limitations to the current study. The limited sample size means the study was significantly underpowered, and there is an increased likelihood of errors of inference regarding the factor structure of this scale (Costello & Osborne, 2005). Best practice methods for EFA suggest a 10:1 subject to item ratio for EFA. This would suggest that for our initial 42-item GLiCS, a sample size of 420 was required. Given the challenges related to recruiting migrant women during the COVID19 pandemic, this desired sample size was not reached. As such, the conclusions presented here present a first insight into this particular dataset, and may not be generalizable beyond the current sample. Nonetheless, the EFA is designed and intended to be exploratory therefore the three-factor GLiCS presented in the current study can be used as a basis to conduct further analyses including confirmatory factor analysis, test-retest validity, and other latent variable modelling techniques that may help verify the proposed factor structure. This should also include exploring the association between the GLiCS with mental illness measures such as the Patient Health Questionnaire (PHQ-9, Kroenke & Spitzer, 2002) and/or the Generalized Anxiety Disorder measure (GAD-7, Spitzer, Kroenke & Williams, 2006).

Beyond the limited sample size, the sample was also limited in terms of its representativeness of different migrant categories. This was particularly a concern for the EM given that the majority of EMs included in the sample came from the Netherlands and Spain. A recent report

published by the Migration Observatory (Fernández-Reino & Rienzo, 2020) reported that workers from the EU-14 countries are more likely to be in high-skilled employment in the UK than those from new EU member states (EU-8 and EU-2), who are more likely to be in low-skilled occupations. For future research it would be valuable to include a question on type of job and income level particularly for EM, to ensure a representative sample is achieved for this group, and includes EM in jobs classified as lower skilled.

Furthermore, the reliance on online recruitment due to the COVID19 national restrictions potentially excluded participants that do not have access to the internet and/or a smartphone. It is possible that these participants may have more limited capabilities and face more significant barriers to achieving high levels of wellbeing than those represented in the current sample. Similarly, the focus on participants who speak English excluded people from the current study. A future direction for the current research could be to translate the measure into other languages (e.g., Arabic) for use with participants who do not have a strong command of the English language. This could provide important insights into groups who may have more limited capabilities post-resettlement due to language barriers. Overall, the GLiCS should be subject to replication studies using diverse and representative samples.

8.5. Conclusion

Our preliminary investigation into the psychometric properties of the GLiCS provides support for the internal consistency, validity, and utility of the assessment instrument for assessing postmigration capability-based wellbeing for migrant women in high-income country settings. This is the first CA informed wellbeing scale to be developed and validated for use with migrant populations specifically. The three subscales found in the GLiCS ('*accessing resources*', '*belonging and contributing*', and '*independence*') highlight the different capability domains that are most relevant for migrant women to achieve high levels of wellbeing. The findings of this study provide further evidence of the merit, feasibility, and validity of operationalizing the CA for particular populations, and for applying the approach to outcome measures. The findings also highlight the relevance of developing a measure that speaks directly to the needs of migrant women in high-income settings.

Chapter 9: Discussion

9.1. Background

According to the World Health Organisation (WHO) estimates, there are roughly 272 million international migrants around the world, of which 82.4 million are forcibly displaced including asylum seekers and refugees (AS&R) (WHO, 2020). Migrants are a heterogenous population and depending on the reason for migration their experiences pre-, during migration and post-migration can vary considerably. In the case of AS&R, exposure to potentially traumatic events in their country of origin and during displacement can have a significant impact on their mental health and wellbeing (Bogic et al., 2015; Priebe et al., 2016). Furthermore, experiences post-migration determined by new social, economic, and political conditions in destination countries can also result in a high number of risk factors for developing mental illness (Beiser & Hou, 2016; Jannessari et al., 2020; Priebe et al., 2016). For example, a recent systematic review and meta-analysis looking at the post-resettlement mental health of refugees in high-income countries found that 13% were diagnosed with anxiety disorders, 30% with depression disorders, and 29% with post-traumatic stress disorders (Henkelmann et al., 2020). There has, however, been a comparative lack of research focusing on wellbeing and quality of life (QoL) in migrants, particularly for forcibly displaced populations (Turrini et al., 2019; van der Boor et al., 2020a).

The aim of the current thesis was to move away from a focus on psychopathology and instead shed light on supporting optimal mental health and wellbeing outcomes in AS&R populations post-resettlement in high-income settings. The thesis started with an exploration of barriers to accessing and negotiating formal mental healthcare systems for AS&R. Subsequently, an exploration was conducted beyond formal healthcare services to understand what broader socio-ecological factors contribute to mental health and wellbeing in these populations. The Capability Approach (CA; Sen, 1999) was proposed as a theoretical framework that can guide the understanding of the real opportunities that AS&R groups have to live a 'good life'. Qualitative methods were used to explore the 'beings and doings' that are valuable to AS&R post-migration. This informed the development of the *Good Life in the Community Scale* (GLiCS), which is a capabilities-based wellbeing measure for assessing the experience of migrant women post-resettlement in high-income countries.

This research was guided by the following set of research questions:

vi. What are the known barriers that can limit access to mental health services in AS&R populations in high-income countries?
vii. What are the known factors that can limit or enhance the QoL of AS&R populations post-resettlement?
viii. What are the community perceptions of the levels of capability-based wellbeing for different migrant groups in the UK?
ix. What constitutes a 'good life' for post-resettlement female refugees in the UK?
x. Is the 'Good Life in the Community Scale' (GLiCS), an outcome measure developed throughout this thesis, valid and reliable in assessing the mental health and wellbeing of migrant women in high-income countries?

The first question is addressed in Chapter 3, the second in Chapter 4, the third in Chapter 6, the fourth in Chapter 7 and the fifth in Chapter 8.

9.2. Main Findings

The first aim of this body of research was to understand the barriers that exist for AS&R populations in high-income countries that can limit their access to and navigation of formal mental health services. A systematic review of qualitative studies was conducted using the *Candidacy Framework* (Dixon-Woods et al., 2006) as a guiding framework (see Chapter 3). The findings revealed that the two main barriers to establishing candidacy for healthcare services for AS&R groups were narrowly identifying their symptoms as requiring medical attention and the social barriers they faced from their environments. Once candidacy was established, individuals reported multiple barriers to using services which included structural barriers (i.e., location of the medical service, having to cancel work to attend a medical service), understanding a new system, fear of unknown consequences (i.e., potential medical bills), the permeability of services, linguistic barriers, attitudes and perceived discrimination, cultural competency of healthcare providers, and other forms of multiple barriers. The findings from this review affirm the harmful consequences of barriers to mental health services including delays in receiving treatment, feelings of social exclusion, mistrust, and discrimination (van der Boor et al., 2019). Notably, the findings highlight that the bio-medical model may not be an adequate service model for meeting the mental health needs of AS&R groups. Instead, more attention should be focused on non-health sector interventions that use more inclusive explanatory models of health and can increase access to care.

Previous research has also highlighted that the global burden of mental disorders is unlikely to be relieved by improved access to mental health services alone (Blas & Kurup, 2010; WHO, 2015; Lund et al., 2018). Rather social determinants are increasingly recognized as being central to health, and there is growing acceptance by researchers and practitioners that there is a need to understand how social and institutional contexts shape people's lives and impact on their health and wellbeing (Lund et al., 2018).

To explore these wider determinants of mental health and wellbeing of AS&R populations, a second systematic review was conducted in Chapter 4 which focused on quantitative studies. The aim was to understand trajectories and predictors of QoL in AS&R populations in high-income countries. These were considered within the domains of QoL established by the WHO; overall, physical, psychological, social, and environmental QoL. The empirical quantitative evidence included in this review firstly confirmed that psychological predictors and correlates of QoL (e.g., depression, anxiety) were the most extensively reported across studies. This highlights that there is a preoccupation with psychopathological factors within the literature and their impact on QoL. Secondly, the review confirmed that social determinants are highly relevant to increasing QoL outside of formal healthcare systems. Specifically, the most prominent determinants found in the literature were interpersonal variables, such as having an established social network, social integration, and not facing discrimination. Environmental factors largely focused on socioeconomic conditions, including employment and post-migration living difficulties (van der Boor et al., 2020a). There was proportionately less focus on these predictors and moving forward, more research attention needs to be given to understanding the role of environmental factors in mental illness and health of AS&R. Further research will allow for a broader focus to be applied when considering how best to manage and prevent mental illness and mental health within this population. A wider focus is needed within policies and interventions to address the multidimensional ways in which structural factors, policies and contexts impact on the health and wellbeing of forcibly displaced populations. This requires understanding and acknowledgment of the range of socio-ecological determinants that affect QoL and operate to either facilitate or hinder access to resources and experiences that foster mental health and wellbeing post-migration.

The importance of policies and contexts aiming to improve opportunities for social participation of migrants has been the focus of documents at all institutional levels (Hunter et al., 2009; Rechel et al., 2013). This is because social participation has been found to impact

not only on individual health outcomes, but also on the experiences of settlement (i.e., discrimination, access to resources; Li et al., 2016; Na & Hample, 2016). Integral to both the experiences of settlement and social participation is the concept of integration. Integration, as a two-way process between migrants and host societies, is explored in chapters 5 and 6 of this thesis. In Chapter 5, we first illustrated how acculturation is conceptualized in the literature with a focus on Berry's (1980, 1997) bidirectional model of acculturation. According to this model, migrants and host community members can favor one of four types of acculturation which include integration, assimilation, separation, and marginalization (Berry, 1980; 1997). The model of acculturation highlights the importance of the systemic/macro-level context (e.g., government policies and legislation) into which migrants arrive, as this can influence whether acculturation strategies are freely chosen or imposed on the individual. In this chapter, three main points of criticism were noted for the acculturation model; firstly, that it considers acculturation to be universal across groups and so does not consider individual differences (e.g., personality, coping strategies). Secondly, it assumes a single monolithic and monocultural majority society exists. Thirdly, there is a lack of recognition within this model that the social practices of migrants are increasingly multi-sited and embedded in transnational social spaces (i.e., encompassing those who migrate and those who stay behind). The process of acculturation is clearly a dynamic and complex process and there is a need for conceptual models that can enrich our understanding of what factors are important and contribute to this process.

The CA, which centers around individuals' freedoms to engage in forms of being and doing that are valuable to them is proposed as a framework that can complement efforts to enhance understanding about issues of candidacy and the development of the acculturation model. It offers a lens through which to evaluate social arrangements, mental outcomes, wellbeing and ultimately the QoL of migrant communities' post-migration. The CA considers QoL in terms of the freedoms people have to enjoy valuable activities and states (Sen, 1087). Specifically, it argues that QoL should be considered and measured in terms of functionings and capabilities, rather than resources or utility; 'The central feature of well-being is the ability to achieve valuable functionings. The need for identification and valuation of the important functionings cannot be avoided by looking at something else, such as happiness, desire, fulfilment, opulence, or command over primary goods' (Sen, 1985a, p.200). In this way, functionings refer outcomes or states that are valuable both objectively, and to the person concerned. Capability refers to the combinations of functionings (achievements) a person can achieve (Sen, 1992), and

therefore reflect not only the functionings a person chooses but also captures the unchosen alternatives that may exist. This allows consideration for whether a person had the real opportunity of achieving a particular functioning, even if they did not choose it (Sen, 1985). As such, a persons' QoL should be considered in the space of both their functionings and capabilities.

The CA differs from the traditional approach to measuring QoL which usually focuses on the resources people have; with the most common resource measure being monetary indicators of income or consumption (Alkire & Foster, 2007). Non-monetary resources are usually measured by assets, and/or access to public services (e.g. education, water, health) in order to ascertain levels of QoL (Alkire & Foster, 2007). A resource-based approach to measuring QoL is appealing as it suggests each person is free to use their resources in a way that is important to them. However, whilst resources are essential to promoting QoL, it is important to note a few limitations to using such an approach alone (Alkire & Foster, 2007). Firstly, resources are required to enable people to do things that they value, but resources are not intrinsically valuable. For example, for one individual owning a motorcycle may be important to their QoL as it enables them to transport themselves. However, to another individual who does not own a driver's license, does not have access to safe roads, or is not physically healthy, owning a motorcycle would not necessarily promote their QoL in any significant way. Similarly, two people may have access to the same quantity and quality of food, but if one is sedentary and the other is a professional athlete, their nutritional status would vary significantly. As such, QoL is arguably more about what resources enable people to do (their functionings), rather than the resources in and of themselves (Sen, 1987). Therefore, measures of what resources enable people to achieve in terms of functionings may provide a more direct indication of a persons' QoL.

Alkire and James (2007) point out three relevant features of the CA for QoL. Firstly, instead of focusing only on material resources or emotional states, the CA includes all outcomes that are of intrinsic importance to the individual. It does not categorically exclude any outcomes a priori, rather it takes into consideration the aim of the research, the context, data analysis and data available. As such, it may be applied differently in different contexts, and the specific purpose of the operationalisation or application of the CA provides essential parameters to the set of potentially relevant capabilities and functionings.

Secondly, the application of the CA allows diversity in terms of the types of measures that can be used to measure capabilities and functionings. For example, because it is based on a wide conceptual framework, it can be used to inform measures of extreme deprivation, but equally

it can be used to measure levels of wellbeing. Lastly, the CA is flexible to different types of data and data analyses, including qualitative, quantitative and mixed-methods research (Alkire & James, 2007).

In Chapter 6, the utility of applying the CA to understanding community perspectives on post-resettlement levels of wellbeing of different migrant groups in the UK was considered. The literature suggests that female migrants tend to fare worse than males and are at a higher risk for developing mental health issues (Hollander, Bruce, Burstrom & Ekbald, 2011; Porter & Haslam, 2005). This gender disparity has been associated with a higher exposure to human rights violations, factors linked with the asylum process, and higher social isolation post-displacement for female migrants (Hollander et al., 2011). The methodology used in Chapter 6 incorporated an experimental design whereby participants recruited from a UK community sample were randomly assigned to assess the wellbeing (using an adapted version of a capability-based wellbeing measure; the AOxCAP-MH (Simon et al., 2013)) of one of three different vignette characters who identified as one of the following: a refugee, economic migrant or a British national. Findings revealed that participants from the UK community sample recognised that refugees may have more limited capabilities in the UK and may not be achieving similar levels of the 'good life' as compared to economic migrants and British nationals. Furthermore, refugees and economic migrants were perceived to face higher levels of discrimination as compared to British nationals. In Chapter 8, the OxCAP-MH was completed by a sample of participants who identified as refugees, asylum seekers or economic migrants. Similar to the perceptions of a UK community sample (Chapter 6), refugees scored significantly lower on the OxCAP-MH than economic migrants. The overlap in findings between the UK community perceptions and migrants' appraisals seem to suggest that the sample that participated in this research has a fair understanding of the challenges that migrant women can face and that these challenges are experienced on different levels of scale depending on migration type and status. These findings suggest that there is a need to further understand what drives opposition to migration in the UK, and more specifically why there can be a lack of empathy and compassion towards migrant groups in the popular press. Understanding this better could generate innovation in interventions aimed at supporting settlement. It is important to recognise that this sample was limited and therefore is not necessarily representative of the general population, as individuals who support decreased migration or anti-migrant sentiments may have been more reluctant to participate in a study on migration. Future research that aims to understand general perceptions towards different

migrant groups should aim to include a question that measures participants' sentiments towards migrants more broadly and what sources of information the participants use to form these sentiments. In terms of the self-reported levels of capability-based wellbeing of different migrant groups, it is necessary to further explore the capabilities that are important to these groups to determine how to best measure their capability sets post-migration.

Sen argues against a fixed predefined list of capabilities that cannot be adapted to different contexts, times, and societies (Sen, 2005). Instead, he argues that developing a list of capabilities must depend on the process of public reasoning which is specific to the context to which the list aims to speak (ibid). Every person may aspire to lead and enjoy a good life, but what does a 'good life' mean to women who have sought refuge in a high-income country? Contrary to other research that used either a predefined list (Anand & van Hees, 2006), or created lists based on researchers' own values or data availability (Chiappero-Martinetti, 2000; Klasen, 2000), the current thesis aimed to develop a list of capabilities using a 'bottom-up' inductive approach intended to elicit refugee women's values and perceptions about what a 'good life' means to them.

In Chapter 7, focus group discussions with refugee women residing in Liverpool were used to shed light on perceptions and determinants of what it means to live a 'good life' in the UK. The participants had all been through the asylum process and had received a temporary leave to remain status (i.e., permission to remain for up to 5 years during which time an application to have indefinite leave to remain can be considered). Three main themes emerged from the data as being important to living a 'good life' in the UK: *legal security*, *social cohesion*, and *personal agency*.

Having *legal security* was described as feeling protected by the law and was defined through the subthemes of experiencing a democratic enforcement of law by the government, the step-based system to achieving legal security in the UK, and the mental impact of migration. *Social cohesion* was described as feeling connected to other members of society. For this to be successful, participants described the central role of family systems as sources of support and obligations, the need for feeling acceptance and a sense of belonging, and attention be paid to their identity and roles as women both within their own cultural communities, and within their new social context. Lastly, having *personal agency* was defined as being able to control one's own thoughts, feelings, and actions. This could be achieved through health and wellbeing,

being able to build a future in the UK, and having access to resources which constitutes the foundation for security, shelter, and livelihoods.

The different capability dimensions revealed in this study clearly confirm that mental health status and access to formal health systems, whilst important, are not all that matters to mental health, wellbeing, and QoL. It reveals that wellbeing is influenced by personal, interpersonal, and institutional factors. This was previously discussed in a commentary published by White and van der Boor (2021), in which the authors recognized that factors that impact on mental health and wellbeing may operate across different strata of forcibly displaced people's social environment. As such, to foster capability development, interventions should aim to work across different layers of migrants' social environments. Furthermore, it lends support for Sen's (2005) argument against using a univariate measure of wellbeing (Stiglitz et al., 2009). Instead, it has been suggested that wellbeing measures need to be developed for the specific context in which the population-concerned are living their lives (Sen, 2005; Greco, 2015). Such a measure must move beyond a focus on basic needs to specifically assess the real opportunities and freedoms that migrant women experience post-resettlement.

In Chapter 8, the qualitative dimensions that emerged in Chapter 7 were used to generate items that were aggregated into a single measure; the *Good Life in the Community Scale* (GLiCS). This chapter reports on the development and preliminary validation of the GLiCS as a CA-informed measure of the wellbeing of women who have experienced migration (including refugees, asylum seekers and economic migrants) to a high-income setting. Although the findings in this chapter were preliminary and exploratory in nature, the GLiCS is the first measure that has been developed to quantitatively measure the wellbeing of migrant women.

Using a multi-phase empirical process (that included consultation with experts by experience and an exploratory factor analysis) a 17-item scale with three meaningful subscales (i.e. (i) *access to resources*, (ii) *belonging and contributing*, and (iii) *independence*) was developed. The GLiCS showed good internal consistency for both the overall scale and each of the three subscales. The convergent validity was tested using the theoretically related measures of wellbeing (WHO-5; WHO, 1998), a capability-based measure of wellbeing (OxCAP-MH; Simon et al., 2013) and with objective social outcomes (SIX; Priebe et al., 2008). The GLiCS demonstrated good convergent validity with each of these scales. Lastly, incremental validity was evidenced through a three-step hierarchical regression whereby the GLiCS accounted for a significant amount of additional variance in wellbeing of migrant women after controlling

for age, migration status, objective social outcomes (SIX) and the existent capability-based measure of wellbeing (OxCAP-MH). The findings of this study provide evidence of the validity and utility of operationalizing the CA for particular populations, and the relevance of developing a measure that speaks directly to the needs of migrant women post-resettlement specifically. It also provided preliminary evidence that the GLiCS is capable of measuring capabilities that are relevant to migrant women beyond those measured by the OxCAP-MH.

Overall, this thesis has demonstrated that the provision of mental health and psychosocial support must go beyond improving access to formal healthcare systems, and instead should also aim to understand and address wider social determinants of mental health and wellbeing. Ultimately, efforts to assess and support wellbeing need to address the real needs of the people it intends to serve. The CA has proven to be a helpful framework to elucidate what living well means, what resources are available and how these resources might interact with migrants' capabilities and freedoms to engage in valuable functionings post-resettlement in high-income settings.

9.3. Limitations

This thesis had a number of limitations, which are discussed in more detail at the end of each of the empirical chapters (chapters 2, 4, 6, 7 and 8). Firstly, an important limitation that both the systematic reviews (chapter 3 and 4) had in common was that grey literature was excluded. In the context of research on AS&R health, it is possible that relevant research studies may remain unpublished or disseminated by means other than peer-reviewed journals. Instead, it is possible that relevant research may have been published in government reports, news articles, and non-governmental organization publications. Therefore, there may have been an important publication bias in Chapters 2 and 4, which needs to be considered when interpreting the findings. Secondly, the review conducted in Chapter 4, only included studies that used measures based on the WHO QoL measures, including the WHOQOL-100 (WHO, 1995), WHOQOL-BREF (WHOQOL Group, 1998), and the EUROHIS-QOL measure (Schmidt et al., 2006). These measures have been widely tested for reliability and validity; however, it may have created a bias in the factors that arose as having an impact on QoL.

In Chapter 6 a cross-sectional research design was used to evaluate the perceptions of UK citizens of capability-based wellbeing of different migrant groups in the UK. There are commonly two main concerns expressed with the use of cross-sectional study designs; (i) common method variance (variations in response caused by the instrument) and, (ii) the

inability to draw causal conclusions due to the lack of temporal elements in the research design that could indicate temporal precedence (Spector, 2019). Given these limitations, there needs to be caution when interpreting the associations and direction thereof within the findings of Chapter 6. For example, it may be that plausible alternative explanations exist for these findings such as a general lack of understanding of different migrant statuses amongst the general public, and the access to different resources they may have upon resettlement. Additionally, it may be the case that individuals who are ambivalent about migration might have been less likely to participate, therefore we cannot claim that the sample is representative. A further limitation of Chapter 6 was that an adapted version of the OxCAP-MH measure (Simon et al., 2013) was used. The OxCAP-MH was originally developed and validated for the self-assessment of capability-based wellbeing of individuals with a severe mental illness in the UK. In Chapter 6, the AOxCAP-MH was used to measure perceptions of capability-based wellbeing for different migrant groups in the UK. Therefore, it was the first time this measure was used to assess the participants' perceptions about another person's wellbeing using a third-person narrative. McDonald's Omega for the AOxCAP-MH in the sample was good (McDonald ω =0.86), indicating good internal consistency. The original OxCAP-MH was later used in Chapter 8, for the self-assessment of capability-based wellbeing in different migrant groups.

Thirdly, several limitations were reported in Chapter 7, wherein qualitative focus groups were conducted to explore refugee women's own perceptions of what a 'good life' means to them post-resettlement. As the data were collected in focus group settings, the data was liable to social desirability bias. Social desirability bias refers to the tendency to present oneself and one's context in a way that will be perceived as being socially acceptable in a group context, but not truly reflective of one's reality (Bergen & Labonté, 2020). In Chapter 7, social desirability bias may have occurred with regards to the other members of the focus group and/or towards the researcher. Several steps were taken to mitigate this. Firstly, to ensure participants truly consented to participating in the research, consent was requested at two different timepoints –it was requested verbally when the project was explained individually, and a second time in writing at the start of the focus groups. At both timepoints, the research was explained. Secondly, by ensuring the focus groups took place in a safe, secure, and private location that the individuals agreed to, there was no risk for the focus groups being heard by external members. Thirdly, given that all the members in the focus group, including the researchers, were female, this enabled women to speak freely about very personal topics such as female genital mutilation which may not have arisen in the presence of men. Lastly, Mackenzie et al. (2007) state that for qualitative research with vulnerable groups to be ethical,

social researchers should aim to conduct research that not only identifies problems but that also helps to promote autonomy and build capacity. The women that participated in the focus groups verbally stated that they found it helpful and empowering to discuss this topic with other women from different cultures, and to realise how similar many of the experiences were.

Furthermore, recruitment for the empirical study described in Chapter 8 was carried out during the COVID-19 pandemic. This had two major consequences. Firstly, it meant that recruitment had to be conducted online, which implies that those who did not have access to support organisations, or the internet more broadly, were unlikely to hear about the research and be able to engage with it. This was somewhat mitigated through the inclusion of the option to complete the survey via the telephone, however, recruitment for this method was limited and most responses were collected through the online weblink. Secondly, charities across the UK raised concerns more broadly regarding the halt to face-to-face drop-ins for migrant support during the national lockdowns as this had big implications for staying in contact with individuals and providing necessary support in general (InfoMigrants, 2020). Given that charities were faced with these difficulties when providing services, this also impacted on their ability to support the recruitment for this research project. This is very likely to have had an impact on the sample size, as under non-pandemic circumstances the researcher would have been able to engage with face-to-face group activities that could have aided further recruitment to the project. Consequently, the sample size in Chapter 8 was significantly underpowered. In a paper published by Costello and colleagues (2005), the impact of different sample sizes was explored when conducting EFA. Using the dataset from the National Education Longitudinal Study, they analysed the structure of Marsh's Self-Description Questionnaire (Marsh, 1990) using different sample to item ratios (2:1, 5:1, 10:1 and 20:1). The findings revealed that larger sample sizes produce more accurate solutions. When a 2:1 sample to item ratio was used, only 10% of the samples produced correct solutions (identical to the population parameters). Additionally, they found that almost two of thirteen items on average were misclassified on the wrong factor in the smaller samples (Costello et al., 2005). In Chapter 8, the sample to item ratio was 2.60:1, suggesting a high likelihood for error. Given that EFA is intended to be exploratory, Chapter 8 offers a first insight into this particular dataset. The findings should not be generalised beyond this sample.

Lastly, it is important to recognize that the qualitative data on which the GLiCS was based, was collected prior to the global pandemic. Therefore, it is possible that the priorities and capabilities of migrant women in high-income countries may have changed as a result of the COVID-19 pandemic. The psychometric properties of the GLiCS described in Chapter 8

suggest that this is a valid and internally consistent measure for the sample in which it was tested. Pandemics and associated lockdowns lead to heterogenous effects on different groups and populations, with vulnerable groups being likely to bear disproportionate burdens, exacerbating pre-existing inequalities (Venkatapuram, 2020). Experts have noted that the CA offers significant intellectual and practical analytical tools that should be used by policy makers to support the response and rebuilding phases of the COVID-19 pandemic, which should center around respecting the capability claims of every individual in society (venkatapuram, 2020). The GLiCS can help shed a light on the specific areas of capabilities that may require attention to increase the wellbeing of migrant women post-pandemic.

9.4. Future research

Future research should seek to conduct a confirmatory factor analysis of the GLiCS and determine its test-retest reliability. If this research supports the psychometric properties of the GLiCS, the assessment instrument could be used for evaluating the impact of resettlement and/or wellbeing interventions for migrants in high-income settings. This may provide insights into the benefits of interventions that go beyond health and basic resources, and instead provide a more holistic evaluation of wellbeing.

The methodology that was used in the current thesis to develop a new capability-based wellbeing measure can also be used to adapt this measure to different groups. For example, future research might develop assessment instruments (or indeed adapt the GLiCS) for assessing the wellbeing of male migrants, different age groups, or migrant women in low and middle-income settings. Additionally, longitudinal research designs may be used to see how capabilities change as individuals go through the asylum process and gain a refugee status within specific contexts. This would shed light on how capability priorities and freedoms may change over time.

A further area for future research would be to explore the relationships between the capabilities identified in this thesis and specific functionings. Within the CA, the distinction between capabilities and functionings is between the effectively possible (capabilities) and the realized outcome (functionings). This would include understanding the freedoms and opportunities that migrants have to lead the kind of life that they have reason to value, and subsequently assess the functionings they end up with in their lives post-resettlement.

Lastly, there is a need to develop datasets that facilitate a focus on the intersectionality between gender, migration, ethnicity, religion, and others. To make use of such datasets, clearly defined and measurable indicators of mental health and wellbeing are required. This thesis offers a

good starting point for what indicators of mental health and wellbeing might look like for migrant populations who have resettled in high-income settings.

As highlighted throughout, such indicators will be context dependent. The CA can be a useful framework for informing research into indicators as it allows us to go beyond benchmarks usually associated with integration such as accessing the labor market. Instead, it recognizes that what a person requires will depend on the opportunities and barriers that they are facing in efforts to enhance their capabilities. Cohort studies should be utilized to measure the impacts of integration policies and to help identify these opportunities, barriers, and specific areas of disadvantage. However, these research efforts should be cognizant of migrants' potential suspicion of researchers' intentions as a barrier to overcome.

9.5. Recommendations for policy and practice

Governments in countries hosting migrants have an important responsibility to ensure their migration policies protect human rights and are consistent with international law, in addition to being sensitive to the specific needs of particular groups that may be at risk (including women, children, and others). The negative impact of migration policies has been widely discussed in previous research and throughout this thesis. The current thesis highlights different factors that can influence post-resettlement stress and risk factors for mental health, which can potentially be avoided and/or mitigated. We propose that a more holistic view is required when looking at the resettlement of refugees and other migrants, with a particular focus on fostering positive outcomes for these groups.

The current thesis has repeatedly highlighted the importance of the social environment into which newcomers migrate. Existing reports and research evidence has demonstrated that xenophobic and racist responses to refugees and migrants appears to be reaching new levels of frequency and public/social acceptance (United Nations, 2016). This climate can incite discrimination against AS&R and other migrants in different spheres of life including employment, health, and housing. With the aim of combating such views, AS&R and other migrants need to be included in all spheres of social, cultural, and economic life within their host society. Such an inclusion can help individuals achieve their full human potential, and consequently would allow them to positively contribute to their receiving countries.

The tone of public discourse on migrants, could be shifted from one of threat and 'othering' to one of international solidarity. Recognition of international solidarity includes awareness and appreciation of the positive contributions that migrants can make to their host society.

Importantly, such efforts need to directly address the fears and concerns of the host society, and awareness should be created through real facts, rather than misinformation.

National governments must work towards achieving collective outcomes for migrants and host communities over multi-year periods. Specifically, broader research has highlighted that personal contact can significantly reduce prejudice (Ha, 2010), and the importance of feeling accepted is also echoed by the refugee women who participated in Chapter 6. Programs that enable direct contact between host communities and migrant groups can help bring to the front the positive contributions made by migrant groups to the host society. For example, networking initiatives within the community can include community gardening, group walks, volunteering, and other forms of civic participation. Another way of shifting the narrative from burdens to assets is by showcasing success stories of individual empowerment and positive contributions migrants have made to the host society. This can simultaneously have a positive impact on other migrants, as success stories can be empowering and can act as role models. It is important to recognize that COVID-19 and the subsequent bans on social gatherings have hampered initiatives and socialization opportunities for migrants and the host community alike, which results in a depravation of important inclusion opportunities. As such, it is key that governments and policymakers support local efforts, community initiatives and other non-governmental organizations to maintain their activities amidst COVID-19 restrictions. In particular, economic support, human resources, and intelligence more broadly are required.

The current thesis also highlights the need for governments to promote enabling policies that allow equal opportunities for migrant women, as a particularly disadvantaged group, to access different settlement support services. The Canada-EU migration platform on the integration of migrant women[8] recommends implementing enabling policies rather than separate policies which target migrant women specifically, as separate policies risk stigmatizing women and may suggest that gender characteristics are responsible for lower integration into the host society (Desiderio et al., 2020). Examples of enabling policies might include alleviating obstacles related to childcare responsibilities and facilitate access to transportation. To ensure policies are effective in enabling equal opportunities, there is a need for migrant women to become more involved in policy and settlement design and implementation. As it currently stands, policies affecting migrant women's resettlement and integration is largely developed

[8]As part of the Migration Platform launched in 2016, the EU and Canada organized a series of events and discussions looking at the integration of migrant women on both sides of the Atlantic.

by non-migrant women and men who are often far removed and disconnected from the realities of migrant women (Desiderio et al., 2020). Consequently, a recommendation moving forward is to enhance representation of migrant women in policy making to ensure the policies align with the realities and needs of the women themselves. For this to become a reality, there needs to be equal opportunities for civic participation and access to public office and civil service.

Lastly, policymakers, researchers and activists recognize and advocate for the need of a rights-based approach to frame the debate surrounding migration and development (Basok & Piper, 2012; Battistella, 2009; Taran, 2009). There is an opportunity to use the human development framework of the CA to contribute to the debate surrounding the connections between migration and development and advance a rights-based approach within migration governance on a global scale (White & van der Boor, 2021). The CA provides an opportunity to develop national and international policy instruments that place human rights at the center of each of the stages of the migration process, including post-resettlement realities. Policy and research efforts in post-migration settings should focus on the social and structural factors that can shape social justice outcomes for different categories of migrants, with at the center, consideration for what people are actually able to do and to be.

9.6. Implications for Health Systems

The findings of this thesis also have implications for health and social service delivery. The systematic review presented in Chapter 3 details specific practical barriers to healthcare delivery that require attention such as the location of services and the need for available and culturally relevant translators. Beyond practical measures, to ensure AS&R are afforded the opportunity to enjoy healthy and meaningful lives, the findings of this thesis stress the need to look beyond psychopathology outcomes, and include outcomes that focus on mental health, wellbeing and QoL. As such, services and interventions should include measures of wellbeing alongside currently used measures of psychopathology. Health systems should also include more holistic forms of assessment and support that speak to the socioecological environment of the individual, which may include insights into social connections and support systems, legislative assistance, the legal status of individuals and their levels of agency. This will provide a more holistic picture of the individuals' lived experience and will be valuable when interpreting their health history and treatment needs. For this to be successful, familiarity with wellbeing measures is needed from the provider, knowledge about entitlements around available services is required, and coordination between different services that can provide

support to AS&R groups is essential. AS&Rs themselves should also become familiar with these areas so that they can hold healthcare providers accountable and ensure holistic care is provided.

9.7. Conclusion

This thesis contributes to the knowledge on barriers and facilitators that are relevant to the mental health and wellbeing of migrants in high-income settings. The focus on positive outcomes throughout this thesis contributes to the literature that promotes a shift towards holistic considerations of what may bring vitality to migrants' individual lived experience post-migration.

The findings from this thesis highlight that in order to promote positive mental health and wellbeing outcomes in AS&R populations, there is a need to move away from a predominant focus on a bio-medical model of mental health and wellbeing. Instead, there is a need to more holistically acknowledge the social and cultural determinants that impact on their access to formal healthcare but also those that can foster mental health and wellbeing beyond formal services.

Throughout this thesis, the CA approach is proposed as a valuable framework that can inform the broader evaluation of mental health, wellbeing and quality of life outcomes post-resettlement. It helps guard against interventions and measures that focus on distress and disorders rather than more holistic outcomes, and does so by promoting a multisectoral, coordinated activity that considers factors across the social environment.

In the current theses, the CA was used to explore both the social climate into which migrants resettle, and their own perspectives around what a 'good life' post-migration means to them. The findings overall showcase that there is recognition that certain migrant groups (i.e. refugees) may face more limited capabilities, and may not be achieving similar levels of the 'good life', when compared to others. The exploration of the lived experiences of refugees themselves highlighted that core domains to living a good life are having legal security, social cohesion, and personal agency. These findings confirm that mental health status and access to formal services, whilst important, are not all that matters to mental health, wellbeing, and quality of life for forcibly displaced groups. Indeed, broader social determinants need to be considered.

Finally, this thesis outlined the development and preliminary exploration of a capability-based wellbeing measure for migrant women; the GLiCS. The preliminary findings showed

promising results for the use of the GLiCS, and confirms the relevance of developing a measure that speaks to the socio-ecological needs of migrant women post-resettlement specifically.

In conclusion, an overemphasis on the biomedical model is a missed opportunity to understand the full picture of mental health and wellbeing of forcibly displaced populations. Research on more holistic adaptive, resilient, and positive outcomes will facilitate understanding on protective processes and shed light on support mechanisms and interventions that can aid the mental health and wellbeing in AS&R populations.

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Appendices

Appendix A: Search Strategy for PsycINFO

1. "Political Asylum" OR "Refugees" OR "Asylum Seeking" OR “Displaced Person”
2. (Asylum N2 Seek*) OR (refuge*) OR (displaced N1 person*) OR (Political N1 Asylum)
3. S1 OR S2
4. "Community Counseling" OR "Community Mental Health" OR "Community Psychology" OR "Mental Health" OR "Mental Health Services" OR "Community Mental Health Services" OR "Community Psychiatry"
5. (Communit* N1 counsel*) OR (Communit* mental N1 health) OR (Communit* N4 psych*) OR (Mental N1 health) OR (Mental N1 health N1 service*) OR (mental health OR Psycholog*) N4 (service* OR cent* OR care)
6. "Adjustment Disorders" OR "Affective Disorders" OR "Anxiety Disorders" OR "Dementia" OR "Dissociative Disorders" OR "Eating Disorders" OR "Impulse Control Disorders" OR "Mental Disorders due to General Medical Conditions" OR "Neurosis" OR "Personality Disorders" OR "Pseudodementia" OR "Psychosis" OR "Behavior Disorders" OR "Borderline States" OR "Brain Disorders" OR "Chronic Illness" OR "Comorbidity" OR "Conduct Disorder" OR "Emotional Adjustment" OR "Emotional Disturbances" OR "Memory Disorders" OR "Organic Brain Syndromes" OR "Perceptual Disturbances" OR "Personality Processes" OR "Sleep Disorders" OR "Suicide" OR "Thought Disturbances" OR "Mental Disorders"
7. "Adjustment N1 Disorder*" OR "Affective N1 Disorder*" OR "Anxi* N1 Disorder*" OR "Dementia" OR "Dissociative N1 Disorder*" OR "Eating N1 Disorder*" OR "Impulse N1 Control N1 Disorder*" OR "Mental N1 Disorder* due to General N1 Medical N1 Condition*" OR "Neurosis" OR "Personality N1 Disorder*" OR "Pseudodementia" OR "Psychosis" OR "Behavi* N1 Disorder*" OR "Borderline N1 Stat*" OR "Brain N1 Disorder*" OR "Chronic* N1 Ill*" OR "Comorbid*" OR "Conduct N1 Disorder*" OR "Emotional N1 Adjustment" OR "Emotion* N1 Disturb*" OR "Memory N1 Disorder*" OR "Organic N1 Brain N1 Syndrome*" OR "Perceptual N1 Disturbance*" OR "Personality N1 Process*" OR "Sleep N1 Disorder*" OR "Suicid*" OR "Thought N1 Disturbance*" OR "Mental N1 Disorder*"
8. (4 OR 5)
9. (6 OR 7)
10. (8 AND 9)

11. "Help Seeking Behavior" OR "Self-Referral" OR "Health Care Seeking Behavior" OR "Health Care Utilization" OR "Treatment Barriers" OR "Health Care Delivery" OR “Candidacy”
12. (Acces* OR Util*) OR (navigati* of service*) OR (Candida*) OR (Help N1 Seeking N1 Behavi*) OR (Health N1 Care N4 Seek* N2 Behavi*)
13. (11 OR 12)
14. (3 AND 10 AND 13)

Appendix B: Database Search Strategy

The databases searched were Medline, PsycINFO, CINAHL, Cochrane Library, Health Technology Assessment, National Health Service Economic Evaluation, Educational Resource Index and Abstracts, BiblioMap, Scopus, Social Sciences Citation Index, Evidence Aid, DARE, Web of Science and PubMed) up to 5th of May, 2020. The Scopus database enabled searching Embase articles not indexed in the previous databases.

Search Strategy

Concept	Keywords	Controlled Vocabulary	Example database PsycInfo
• Asylum seekers • Refugees • Political asylum • Political refugees • Adults	Asylum Seeker Refugee Political asylum Political refugees Adults	Asylum Seeker Seekers, Asylum Refugee Stateless people Political asylum Political refugees Adult	• Asylum Seekers OR Refugees OR political asylum OR political refugee • asylum N2 seek* OR refuge* OR Seeker*, Asylum OR political N2 asylum OR political N2 refuge* • Adult*
• Quality of Life • Wellbeing	Wellbeing Subjective wellbeing Psychological wellbeing Emotional wellbeing Quality of life Life quality Life satisfaction	Wellbeing Subjective wellbeing Psychological wellbeing Emotional wellbeing Quality of life QoL Life quality Health-related quality of life Life satisfaction Satisfaction with life	• Wellbeing OR Subjective wellbeing OR Psychological wellbeing OR Emotional wellbeing OR Quality of life OR QoL OR Life quality OR Health-related quality of life OR Life satisfaction OR Satisfaction with life • Well N2 being OR Subjective N3 well N2

			being OR Psychological N3 well N2 being OR Emotional N3 well N2 being OR Quality N3 of N3 life OR QoL OR Life N2 quality OR Health N2 related N5 quality N3 of N3 life OR Life N3 satisfaction
• Predictive Terms	• Predictor • Correlation • Determinant	• Predictor • Correlation • Determinant	• predictor OR correlation OR determinant • predict* OR correlat*OR determin*

Appendix C: Participant Advertisement

Version 3- 1st of December, 2018

UNIVERSITY OF LIVERPOOL

PARTICIPANTS NEEDED – What Constitutes a 'Good Life'?

We are looking to recruit participants for an online study looking into what constitutes a 'good life' in the UK. If you are an adult (>18) who lives in the UK and have 10 minutes to spare, please consider filling it in: Link to Survey

Thank you!

Appendix D: Adapted Oxford Capabilities Questionnaire -Mental Health

Condition 1 (refugee) = Fatima age 30
Condition 2 (economic migrant) = Sabryna age 30
Condition 3 (British national) = Sara age 30

1. Do you think the health of Fatima/Sabryna/Sara in any way limits her daily activities, compared to most people her age? (*always/most of the time/some of the time/hardly ever/never)*

2. Do you think that Fatima/Sabryna/Sara would be able to meet socially with friends or relatives? (*always/most of the time/some of the time/hardly ever/never)*

3. In the past 4 weeks, how often do you estimate that Fatima/Sabryna/Sara has lost sleep over worry? (*always/most of the time/some of the time/hardly ever/never*)

4. In the past 4 weeks how often do you estimate that Fatima/Sabryna/Sara has been able to enjoy recreational activities? (*always/most of the time/some of the time/hardly ever/never*)

5. How suitable or unsuitable do you think Fatima/Sabryna/Sara's accommodation that you imagine her to live in would be for her current needs? *(very suitable, fairly unsuitable, neither suitable nor unsuitable, fairly unsuitable, very unsuitable)*

6. Please indicate how safe you think Fatima/Sabryna/Sara would feel walking alone in the area near the home that you imagine her to live in: *(very safe, fairly safe, neither safe nor unsafe, fairly unsafe, very unsafe)*

7. Please indicate how likely you believe it to be that Fatima/Sabryna/Sara will be physically assaulted in the future (including sexual and domestic assault): *(very likely, fairly likely, neither likely nor unlikely, fairly unlikely, very unlikely)*

8. How likely do you think it is that Fatima/Sabryna/Sara will experience discrimination? *(very likely, fairly likely, neither likely nor unlikely, fairly unlikely, very unlikely)*

   8.a. On what grounds do you think it is likely that Fatima/Sabryna/Sara will be discriminated against? Race/ethnicity, Gender, Religion, Sexual orientation, Age, Health or disability (including mental health)

9. Please indicate how strongly you agree or disagree with the following statements: *(5 point scale: Strongly agree to Strongly disagree)*

   a. Fatima/Sabryna/Sara is able to influence decisions affecting her local area

   b. Fatima/Sabryna/Sara is free to express her views including political and religious views

   c. Fatima/Sabryna/Sara is able to appreciate and value plants, animals and the world of nature

   d. Fatima/Sabryna/Sara respects, values and appreciates people around her

   e. Fatima/Sabryna/Sara finds it easy to enjoy the love, care and support of her family

   f. Fatima/Sabryna/Sara finds it easy to enjoy the love, care and support of her friends

g. Fatima/Sabryna/Sara is free to decide for herself how to live her life

h. Fatima/Sabryna/Sara is free to use her imagination and to express herself creatively (e.g. through art, literature, music, etc.)

i. Fatima/Sabryna/Sara has access to interesting forms of activity (or employment)

*To what extent do you think Fatima/Sabryna/Sara is living a 'good life' in the UK? (10 being the best and 0 being the worst)

Appendix E: Participant Information Sheet (Version 3 – 6th of December)

Participant information sheet

The 'Good Life' in the UK.

You are being invited to participate in a research project on what constitutes a 'good life' in the UK. Before you decide to do so, it is important that you understand the purpose of the research and what it will involve. Please take your time to read the following information carefully and discuss it with others if you wish. Feel free to ask any questions if anything is not clear or you would like more information. You are free to decide whether or not you would like accept this invitation and should only agree to take part if you would like to.

What is the aim of the research?
This research project aims to examine your perceptions on what constitutes a 'good life' in the UK.

Why have I been invited to take part?

We are looking to recruit volunteers who:

- *Speak fluent English*
- *Are over 18 years of age*
- *Have access to the online survey*

If you meet these criteria, then you are eligible to take part in this research.

Do I have to take part?

You are under no obligation to take part in this research; this is completely your choice. If you do decide to take part you will be able to keep a copy of this information sheet and you should indicate your agreement to the online consent form. Also, you are free to withdraw at any time during the study without giving any reason or explanation.

What will happen to me if I take part?

If you decide to take part in this research, you will be asked to complete a brief online survey regarding your views on what constitutes a 'good life' in the UK. You will also be asked some demographic information regarding your age and ethnicity.

What are the possible disadvantages/risks of taking part?

Participating in the research is not anticipated to cause you any disadvantage or discomfort. Overall, the potential physical and/or psychological harm or distress will be the same as any experience in everyday life.

What are the possible benefits of taking part?

Participating Taking part will help promote understanding about what constitutes a good life for people living in the UK.

What if I am unhappy, or there is a problem?

If you are unhappy, or if there is a problem, please feel free to let us know by contacting Catharina van der Boor (C.Van-Der-Boor@liverpool.a.uk). If you have a complaint which you feel you cannot come to us with then you should contact the Research Governance Officer on 0151 794 8290 (ethics@liv.ac.uk). When contacting the Research Governance Officer, please provide details of the name or description of the study (so that it can be identified), the researcher(s) involved, and the details of the complaint you wish to make.

How will my data be used?

All the information collected during the course of the research will be anonymous as you will not be asked to write any personal information that will make you identifiable such as name or email. The results from this research may be posted online for other researchers to use (i.e., uploaded to the Open Science Framework).

The University processes personal data as part of its research and teaching activities in accordance with the lawful basis of 'public task', and in accordance with the University's purpose of "advancing education, learning and research for the public benefit.
Under UK data protection legislation, the University acts as the Data Controller for personal data collected as part of the University's research. The project coordinator acts as the Data Processor for this study, and any queries relating to the handling of your personal data can be sent to Catharina van der Boor (c.van-der-boor@liverpool.ac.uk).

Further information on how your data will be used can be found in the table below.

How will my data be collected?	Via the online survey.
How will my data be stored?	Your data will be stored on a password protected platform at all times.
How long will my data be stored for?	10 years
What measures are in place to protect the security and confidentiality of my data?	It will be password protected and will only be accessible to the research team.
Will my data be anonymised?	Yes
How will my data be used?	It will be analysed to produce original research results.
Who will have access to my data?	The project coordinator, project supervisor and student investigators will have access to your data.
Will my data be archived for use in other research projects in the future?	Yes
How will my data be destroyed?	Your data will be deleted after 10 years in line with the University of Liverpool's data management policy.

What will happen if I want to stop taking part?

You are under no obligation to take part in this research. If you do decide to take part, you are free to withdraw at any moment, without giving any reason or explanation.
Data collected up until the period you withdraw will not be used and discarded.

Will my taking part be covered by an insurance scheme?

Participants taking part in any research which has been approved by the University Of Liverpool are covered by the University's insurance scheme.

Who has ethically reviewed the project?

This project has been ethically approved by the Health and Life Sciences Research Ethics Committee (Psychology, Health and Society) at the University of Liverpool.

Who can I contact if I have any further questions?

Project Coordinator: Catharina Van Der Boor Email: C.Van-Der-Boor@liverpool.ac.uk
Thank you for taking your time to read this.

Appendix F: Participant Consent Form (version 4 – 6th of December, 2018)

1. I confirm that I have read and have understood the Participant Information Sheet for the current study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

   (Yes/no)

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my rights being affected. In addition, should I not wish to answer any particular question or questions, I am free to decline.

   (Yes/no)

3. I understand that, under the Data Protection Act, I can at any time ask for access to the information I provide and I can also request the destruction of that information if I wish.

   (Yes/no)

4. I agree to take part in the above study.

   (I give my consent/I do not give my consent)

Appendix G: Early Termination and Distress Protocol

Early Termination Protocol (version 1 – 9th of April, 2019)

This protocol is to be used if one of the participants gets distressed and the focus group needs to be terminated early.

1. If a participant gets distressed, Catharina van der Boor will take the participant aside and initiate the distress protocol. In the case that the focus group takes place online due to the COVID-19, a 'breakout room' will be used on the Zoom platform to take the participant aside from the rest of the group. The rest of the participants will be encouraged to take a comfort break in the meantime.
2. Once the distress protocol has been followed through and the principal investigator (Ross White) has been informed of the situation, the moderator (CvdB) will return to the focus group and commence the early termination of the focus group.
3. The rest of the participants will be told the following:

Thank you for taking the time to participate in our discussion group on the suitability of the RE-CAP measure. I have decided to terminate this focus group discussion on the basis that we do not want to cause you any form of distress or discomfort.

I want to ensure that you are adequately supported and that the focus group of today does not cause you any distress. Please be reminded that there are support agencies that are available to you and that you can contact should you feel the need to. The contact information of some of these can be found on the debrief sheet. We will go through this list together now.

If you have any remaining questions or if there is anything you would like to discuss please do not hesitate to contact me at c.van-der-boor@liverpool.ac.uk.

4. Before the participants leave, Catharina van der Boor will check that they all have a copy of the debrief sheet (version 1 -25th of February) to take with them which contains the contact information of some support organisations in Liverpool.

Distress Protocol (version 2 – 9th of April, 2020)

(Adapted from: Burke-Draucker, C., Martsolf, D.S. & Poole, C. (2009). Developing Distress Protocols for Research on Sensitive Topics. *Archives of Psychiatric Nursing, 23(5),* 343–350 343.)

Indications of Distress During Focus Group	Follow-up Questions	Participant Behaviour/Response	Acute Emotional Distress / Safety Concern? (Y or N)	Imminent Danger (Y or N)
Indicate they are experiencing a high level of stress or emotional distress, OR exhibit behaviours suggestive that the discussion is too stressful such as uncontrolled crying, incoherent speech, indications of flashbacks, etc	1. Stop the focus group and take the participant aside 2. Offer support and allow the participant time to regroup 3. Assess mental status: *a) Tell me what thoughts you are having.* *b) Tell me what you are feeling right now.* *c) Do you feel you are able to go on about your day?* *d) Do you feel safe?* 4. Determine if, in the moderator's opinion (CvdB), the person is experiencing **acute emotional distress beyond what would be normally expected in a focus group about a sensitive topic.**			
Indicate they are thinking of hurting themselves	1. Stop the focus group 2. Take the individual aside 3. Express concern and conduct a safety assessment *a) Tell me what thoughts you are having.* *b) Do you intend to harm yourself?* *c) How do you intend to harm yourself?* *d) When do you intend to harm yourself?* *e) Do you have the means to harm yourself?* 4. Determine if, in the moderator's (CvdB) opinion, the person is **an imminent danger to self**			

Indicate they are thinking of hurting others	1. Stop the focus group 2. Take the individual aside 3. Express concern and conduct a safety assessment *a) Tell me your thoughts you are having.* *b) Do you intend to harm someone else? Who?* *c) How do you intend to harm him/her/them?* *d) When do you intend to harm him/her/them?* *e) Do you have the means to harm him/her/them?* 4. Determine if, in the moderator's (CvdB) opinion, the person is an **imminent danger to others.**			
Indicate that there health and safety is being endangered by other people.	1. Stop the focus group 2. Take the individual aside 3. Assess danger from other person *a) How might you be in danger?* *b) Who is it that is intending to harm you?* *c) Does the person intending to do harm have knowledge of your movements and/or information on where you stay?* 4. Determine if, in the moderator's (CvdB) opinion, the health and safety of the person is in imminent danger from others.			

Actions for Moderator and/or Facilitator of Focus Groups:

1. If a participant's distress reflects an emotional response reflective of what would be expected in a focus group about a sensitive topic, offer support and extend the opportunity to: a) stop participating in the focus group; b) regroup; c) continue.
2. If a participant's distress reflects acute emotional distress or a safety concern beyond what would be expected in a focus group about a sensitive topic, but NOT an imminent danger, take the following actions:
    a) Encourage the participant to contact her General Practitioner for follow-up
    b) Provide the participant with contact details for agencies who can offer mental health-related advice (Mind, Mental Health Foundation) and support (Samaritans, Freedom From Torture, British Red Cross) to refugees.
    c) Notify Principal Investigator of the recommendations given to the participant.

3. If a participant's distress reflects an imminent danger to themselves, take the following actions:
    a) Make an appoint with the person's GP on their behalf and make sure that they can get to this appointment.

b) Immediately notify the principal investigator of actions taken.

4. If the participant presents as being an imminent danger to others, take the following actions:
    a) Contact local police and request their assistance
    b) Immediately notify the principal investigator of actions taken.
5. If the participant indicates that their health and safety is in imminent danger:
    a) Contact local police and request their assistance
    b) Immediately notify the principal investigator of actions taken.

The list of contact people/organisations for addressing

concerns about mental wellbeing will include:

a) Their GP

b) Contacting the: *Asylum Help UK* - Telephone: 0808 8000 630

c) **CDS Housing Association** (for Floating Support) - CDS deliver a floating support service to people granted asylum who are living in Liverpool. Telephone: 0800 169 2988

Shelter Merseyside - Shelter is the Housing and Homelessness Charity. Stanley Building, 2nd floor, 43 Hanover Street, Liverpool, L1 3DN. General opening hours Monday to Friday 9am - 5.00pm. Tel: 0344 515 1900

d) **British Red Cross** Refugee Support and Restoring Family Links Team in Merseyside – Help for vulnerable people in crisis. Bradbury House, Tower Street
Brunswick Business Park, Liverpool, L3 4BJ. Refugee Support team - Tel: 0151 702 5067

e) **Freedom from Torture.** 1st Floor North Square 11-13 Spear Street Manchester M1 1JU. -Tel: 0161 236 5744

f) **Mind** - offering information on types of mental health problems, where to get help, treatments and advocacy. Tel- *0300 123 3393*

g) **Samaritans** - offering support for people experiencing feelings of distress or despair. Samaritans offer a 24-hour confidential helpline Phone: 116 123

Appendix H: Participant Information Sheet

Participant Information Sheet (version 5 – 16th of April, 2019)

You are being invited to participate in the group discussion to talk about what a good life in the UK means to you. Before you decide to do so, it is important that you understand the purpose of this project and what it will involve. Please take your time to read the following information carefully and discuss it with others if you want to. Feel free to ask any questions at any time if something is not clear or you would like more information. You are free to decide whether or not you would like to accept this invitation and should only agree to take part if you would like to.

Title of the Research

Selecting Capabilities to Assess what Constitutes a 'Good Life' in Female Refugees in the United Kingdom

What is the aim of the research?

We want to understand your ideas on what a good life means to you in the UK. We aim to do this by holding a group discussion in which you will be asked to tell us your ideas on what is needed to live a 'good life'. We will also ask you about what dimensions or areas have specifically been important to you to live a good life since you have come to the UK.

Why have I been invited to take part?

We have asked you to take part in this discussion if you are:

- Female
- A refugee
- Speak English

Do I have to take part?

No, you do not have to take part in this discussion; this is completely your choice. If you agree to take part and then decide later on that you do not want to take part anymore then you are free to leave at any time without giving a reason or explanation.

What will happen to me if I take part?

You will join a group discussion with other women to talk about what a good life means to you.
It will be an open discussion, so you will be free to give your thoughts and opinions as you like.

What will you do with my data after the discussion?

Everything that is discussed during the group discussion will be confidential. The discussion will be voice recorded but this recording will be stored safely with password protection and will only be available to the members of the research team.

Once we have collected and analyzed the data, we will write up the findings from what has been discussed in the groups. This will be completely anonymous. The findings may be disseminated in the form of a publication in an online peer-reviewed journal or a conference presentation. For this purpose, we may use anonymized quotes of the discussion. However, we will only use your quotes if you give consent to this.

Further information on how your data will be used can be found in the table below:

How will my data be collected?	Group discussion
How will my information be stored?	The discussion will be audio recorded and will be uploaded to a secure university of Liverpool server which is password protected. We will also store it on an encrypted data stick.
How long will my data be stored for?	10 years
Will my data be kept anonymous?	Yes, the data will be anonymized – your name or other identifying information won't be associated with it, and no-one outside the research team will have access to your personal information
How will my data be used?	The purpose of this piece of work is to listen to what your experiences have been and we will use the information to understand what is important to you to achieve a 'good life' in the UK.
Who will have access to my data?	The research team
Can I access my information?	We cannot give you access to the recordings because we want to keep the information from all the members in the group safe. However, our findings will be summarized in a brief one-page summary which we will make available to you through your support organization once the study is done.

If you have any questions about this, please contact Carine van der Boor (+44 (0)151 794 6705)

What will happen if I want to stop taking part?

You are free to stop participating at any point without having to give a reason or explanation. You can request to withdraw your data at any point up to the commencement of the analysis.

What are the anticipated benefits of taking part?

Participating will help promote understanding of what is important to you to achieve a 'good life' in the UK.

What are the anticipated risks of taking part?

It may be that some of the issues discussed can cause some distress or bring back memories. We will make sure to support you if this happens and discuss options with you that can provide further support after the group discussion.

Who has ethically reviewed the project?

This project has been ethically approved by the Health and Life Sciences Research Ethics Committee (Psychology, Health and Society) at the University of Liverpool.

Who can I contact if I have any further questions?

Lead student investigator: Carine van der Boor
Email: C.Van-Der-Boor@liverpool.ac.uk
Telephone number: (+44 (0)151 794 6705)

Thank you for taking your time to read this.

Support Agencies in Liverpool:

British Red Cross Refugee Support and Restoring Family Links Team in Merseyside.

Tel - 0151 702 5067

Mind offering information on types of mental health problems, where to get help, treatments and advocacy. Tel - *0300 123 3393*

Asylum Link Merseyside some of the services they provide are casework, destitution, immigration advice, English classes, meals, clothing and social. Tel - 0151 709 1713

Samaritans UK offering support for people experiencing feelings of distress or despair. Samaritans offer a 24-hour confidential helpline Phone: 116 123

Appendix I: Participant Advertisement

What does a 'good life' in the UK mean to you? (version 4 – 9th of April, 2019)

Are You:

Female?

A temporary refugee?

An English speaker?

We want to hear your experiences on what a good life means to you. We want to have a group discussion on the topic of a good life in the UK. This group discussion will last a maximum of two hours and will take place at [insert location]. We will make sure we find a time that is convenient to you, refreshments will be made available to all during the group discussion and we will also cover your travel costs to ensure you can come and join the discussion.

If you are interested in participating in this group discussion, or would like more information, please contact:

Carine van der Boor

c.van-der-boor@liverpool.ac.uk

+44 (0)151 794 6705

Appendix J: Participant Consent Form

Consent Form and Information Sheet (version 4, 9th of April, 2019)

Title of the research

Selecting Capabilities to Assess what Constitutes a 'Good Life' in Female Refugees in the United Kingdom

Write your initials in each box if you agree with what is written
Leave blank or put a cross if you do not agree, or if you are not sure
It's ok to ask questions or to ask for help completing the form!

1. I have read and have understood the Participant Information Sheet [Date:], or it has been read to me. I have had time to think about the information and ask questions which have been answered. ☐
2. I understand that taking part in the study means I will be part of a group discussion which will be voice-recorded. ☐
3. I understand that this is completely voluntary and I can stop taking part any time I want to without having to give a reason. ☐
4. I understand that I do not have to answer any questions I do not want to ☐
5. I understand that I can ask to see the information I have given, and I can ask Carine van der Boor to delete this information at any time up to the commencement of the analysis. ☐
6. I understand that anonymous quotes from the discussion might be used and published online. I give my consent for you to use my quotes. ☐
7. I understand that everything I say will be kept in a safe place and only the research team will be able to access it. ☐
8. I agree to take part in this group discussion. ☐

Please sign your name below if you understand what has been talked about in this form and if you **consent** to take part in the research project.

Date: Name of Participant:

Date: Name of Researcher:

Appendix K: Focus Group Topic Guide

Version 3 – 9th of April, 2019

Introduction

CvdB will welcome everyone to the focus group discussion and thank all the participants for coming in. She will introduce herself as the moderator and she will introduce CY as the facilitator. CvdB will describe both of their roles and reasons for being there – the role of the moderator (CvdB) is to run the focus group and ensure the smooth running of the discussion, managing the group process and dynamics, introducing relevant issues and ideas and ensuring the objectives of the focus groups are addressed. The role of the facilitator (CY) is to provide support with the group task and to take notes during the discussion. For example, CY will note down who is speaking when so that we can review this when listening back to the recordings. The facilitator is not responsible for the content and the outcomes of the group discussion.

CvdB will then briefly remind the participants that the aim of the focus group is to discuss what a good life in the UK means to them. Following this, CvdB will go through the participant information sheet again, highlighting the independence of the research project from governing bodies and community organization and reminding the participants of what the study will be used for. The participants will also be given the opportunity to ask any remaining questions regarding the information given before the discussion starts. If everything is clear, the group will move on to the consent forms for which a signature is required. If the participant is not able or not confident in writing, they will be given the option to give consent through a witnessed mark. The moderator (CvdB) will be responsible for supporting the participant who provides the witnessed mark and she will sign the consent form to indicate that she has witnessed the marking.

When consent has been taken, CvdB will cover the ground rules of the focus group. These will include the need to allow everyone the opportunity to speak, individuals need to be respectful of each other's contributions and everything that is said needs to be kept confidential and in this room. In order to ensure confidentiality, CvdB will then ask participants to write down a pseudonym on the folded paper in front of them and explain that this pseudonym will be used throughout the discussion.

Questions to guide the discussion

What does the term good life mean to you? For example, being sufficiently nourished can be an important basic need that needs to be met to achieve a 'good life' but we can also think of more complex things such as feelings.

What are important and valuable dimensions or areas of our lives that make the life good?
What are important and valuable dimensions or areas of our lives that make the life bad?
What opportunities, freedoms and choices do you value?
How do these differ from your expectations? Especially concerning the choices and opportunities you might have.

Sticky note exercise – Participants will be given sticky notes and asked to write down the three most important dimensions or areas to having a good life in the UK and rank them in order of importance. They will be offered assistance by the moderator (CvdB) or the facilitator (CY) if they do not feel comfortable writing. The initials of the individual (CvdB or CY) who has offered support to the participant with writing will be noted on the sticky note.

Conclusion

What did you think of this focus group process?

Summarize, ask if anything was missed, promise to provide a summary of research findings, thank the group for their participation and remind them of the debrief.

Appendix L: Debrief Form

Debrief form (version 3- 11th of February 2019)

Thank you for participating in our discussion group on what constitutes a 'good life' in the UK for female temporary refugees. Just as a reminder, your data will be stored on a secure server of the University of Liverpool which is password protected. Your data will be anonymised and will only be accessed by the research team. It is important to understand that you can withdraw your data at any point until we start the analysis, without having to explain why you want to withdraw from the study. If the study is published, we will make sure it is made available to you through the organisation through which we have contacted you today.

Do you have any further questions?

If you have any questions in the future, please contact me at c.van-der-boor@liverpool.ac.uk

Support Agencies in Liverpool:

British Red Cross Refugee Support and Restoring Family Links Team in Merseyside. Tel - 0151 702 5067

Mind offering information on types of mental health problems, where to get help, treatments and advocacy. Tel - *0300 123 3393*
Asylum Link Merseyside some of the services they provide are casework, destitution, immigration advice, English classes, meals, clothing and social. Tel - 0151 709 1713
Samaritans UK offering support for people experiencing feelings of distress or despair. Samaritans offer a 24-hour confidential helpline Phone: 116 123

Appendix M: Participant Information Sheet

FOCUS GROUP PARTICIPANT INFORMATION SHEET

Version 2 – 19th of April 2020

You are being invited to be a part of a focus group discussion to assess the content validity of a new measure of well-being (RE-CAP) designed for refugee women in the UK. Before you decide to do so, it is important that you understand the purpose of the project and what it will involve. Please take your time to read the following information carefully and discuss it with others if you wish. Feel free to ask any questions if anything is not clear or you would like more information. You are free to decide whether or not you would like accept this invitation and should only agree to take part if you would like to.

What is the aim of the project?

The aim of this research project is to discuss the content validity of a new measure of well-being (RE-CAP) which has been designed specifically for refugee women in the UK.

Why have I been invited to take part?

You have been invited to take part in this project because you either have been through the asylum system yourself, or you are an expert working with refugee women in the UK.

Do I have to take part?

You are under no obligation to take part in this project; this is completely your choice. If you do decide to take part you should indicate your agreement in the consent form. Also, you are free to withdraw at any time during the discussion without giving any reason or explanation.

What will happen to me if I take part?

If you decide to take part in this project, you will join a group discussion to discuss the new mental health and well-being measure for refugee women in the UK (RE-CAP). During this group discussion, you will be asked to review the list of items of the RE-CAP measure and to provide feedback on each item. You will have as much time as you need to complete this exercise and you are free to leave any particular question that you do not wish to respond to blank.

Following the completion of the exercise we will hold an open group discussion in which you will be given the chance to discuss any feedback or comments you may have with the rest of the group. This discussion will not be recorded but notes will be taken regarding the content of the discussion. You do not have to participate in the discussion if you do not want to and you are free to leave at any point without having to give a reason.

We will not ask you to provide any identifiable information throughout, and we will save your answers anonymously. Therefore, it will not be possible to withdraw your data after the end of the focus group. Should you wish to withdraw your data before the end of the focus group you can make this known to Catharina van der Boor and your data will not be saved.'

What are the possible disadvantages/risks of taking part?

It may be that some of the items discussed can cause some distress or bring back memories of personal experiences if you have been through the asylum process yourself. We will make sure to

support you if this happens and discuss options with you that can provide further support after the group discussion.

What are the possible benefits of taking part?

Taking part will help in the development of a measure of well-being which specifically aims to measure well-being in refugee women in the UK.

What if I am unhappy, or there is a problem?

If you are unhappy, or if there is a problem, please feel free to let us know by contacting Catharina van der Boor (c.van-der-boor@liverpool.ac.uk). If you have a complaint which you feel you cannot come to us with then you should contact the Research Governance Officer on 0151 794 8290 (ethics@liv.ac.uk). When contacting the Research Governance Officer, please provide details of the name or description of the study (so that it can be identified), the researcher(s) involved, and the details of the complaint you wish to make.

How will my data be used?

All the information collected during the discussion will be anonymous as you will not be asked to write any personal information that will make you identifiable such as name or email address.
Your feedback will be used to adjust the RE-CAP measure, and this process will be anonymously described in any future publications or conference presentations.

The University processes personal data as part of its research and teaching activities in accordance with the lawful basis of 'public task', and in accordance with the University's purpose of "advancing education, learning and research for the public benefit."

Under UK data protection legislation, the University acts as the Data Controller for personal data collected as part of the University's research. The project coordinator acts as the Data Processor for this study, and any queries relating to the handling of your personal data can be sent to Catharina van der Boor (c.van-der-boor@liverpool.ac.uk).

Further information on how your data will be used can be found in the table below.

How will my data be collected?	Via a survey and group discussion.
How will my data be stored?	Your data will be stored on a password protected platform at all times.
How long will my data be stored for?	10 years
What measures are in place to protect the security and confidentiality of my data?	It will be password protected and will only be accessible to the research team.
Will my data be anonymised?	Yes
How will my data be used?	Your responses to the questions will be used to improve and refine the RE-CAP measure.
Who will have access to my data?	Only the research team will have access to your data.
Will my data be archived for use in other research projects in the future?	No.

How will my data be destroyed?	Your data will be deleted after 10 years in line with the University of Liverpool's data management policy.

What will happen if I want to stop taking part?

You are under no obligation to take part in this research. If you do decide to take part, you are free to withdraw at any moment, without giving any reason or explanation.

Who has ethically reviewed the project?

This project has been ethically approved by the Health and Life Sciences Research Ethics Committee (Psychology, Health and Society) at the University of Liverpool.

Who can I contact if I have any further questions?

Project Coordinator: Catharina Van Der Boor
Email: c.van-der-boor@liverpool.ac.uk

Chief Investigator: Dr. Ross White

Email: rgwhite@liverpool.ac.uk

Thank you for taking your time to read this.

Appendix N: Consent Form

FOCUS GROUP PARTICIPANT CONSENT FORM

Version 1 – 25th of February, 2020

Research project: Focus group discussion to assess the content validity of a new measure of well-being (RE-CAP) designed for refugee women in the UK.

Please write your initials in each box if you agree with what is written. Leave blank or put a cross if you do not agree, or if you are not sure. Please ask questions or ask for help completing the form if you need to

9. I have read and have understood the Participant Information Sheet [Version 1, 25th of February, 2020]. I have had time to think about the information and ask questions which have been answered. ☐
10. I understand that taking part in the project means I will be part of a focus group discussion. ☐
11. I understand that this is completely voluntary and I can stop taking part any time I want to without having to give a reason. ☐
12. I understand that I do not have to answer any questions I do not want to ☐
13. I understand that all the information I give will be kept anonymous and in a safe place. I understand that only the research team will be able to access it. ☐
14. I agree to take part in the focus group discussion ☐

Please sign your name below if you understand what has been talked about in this form and if you **consent** to take part in the research project.

Date: Name of Participant:

Date: Name of Researcher:

Appendix O: GLiCS Exercise

Version 0.1 of focus group exercise (version 1-9th of March, 2020)

Please read the following list of items and provide an answer for each item. If you consider an item to be unclear or irrelevant to measure well-being in refugee women then please provide a suggestion as to how the item can be amended, or whether it should be deleted altogether.

Item	**Respondent's Feedback**		
Secure Legal Status	Please circle how much you agree or disagree with the statement		
	This item is clearly understandable to refugee women	This item is relevant to the well-being of refugee women	If not, how can the item be amended to ensure that it is clear and/or relevant?
(1) I am able to progress plans to clarify my legal status, for example getting settled status or applying for a passport	Understandable: 1. Strongly agree 2. Agree 3. Not sure 4. Disagree 5. Strongly Disagree	Relevant: 1. Strongly agree 2. Agree 3. Not sure 4. Disagree 5. Strongly Disagree	Amendment:
(2) I am able to enjoy opportunities until I apply for a passport here	Understandable: 1. Strongly agree 2. Agree 3. Not sure 4. Disagree 5. Strongly Disagree	Relevant: 1. Strongly agree 2. Agree 3. Not sure 4. Disagree 5. Strongly Disagree	Amendment:
(3) My immediate family members have the appropriate approvals to travel in and out of this country at the current time	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(4) I have the appropriate approvals to travel in and out of this country at the current time.	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:

(5) At the current time I am free to do the same things host citizens do	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(6) There are family members that I still want to have the opportunity to be reunited with.	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(7) I am able to feel physically safe in this country	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(8) I am able to sleep peacefully through the night in this country	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(9) I am able to adhere to my cultural beliefs and practices in this country	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(10) I feel protected by political institutions (such as the government) in this country	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(11) I feel that my basic human rights are being respected in this country	Understandable:	Relevant:	Amendment:

	1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	
(12) I am able to learn about my rights in this country	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(13) I am comfortable using public resources when I need help, for example calling the police or an ambulance	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(14) I am able to express my opinions and take part in the decisions that affect my life 1.	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(15) I am able to post what I want on social media, for example on Facebook, Instagram or Twitter	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(16) I feel free to choose whether I want to practice a religion and am able to decide what religion I want to practice	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(17) I am able to freely express my ideas and opinions	Understandable: 1. Strongly disagree 2. Disagree	Relevant: 1. Strongly disagree	Amendment:

	3. Undecided 4. Agree 5. Strongly agree	2. Disagree 3. Undecided 4. Agree 5. Strongly agree	
Accessibility of Resources			
(18) In my current situation, I am able to access paid employment if I want to	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(19) I am able to access the same work opportunities in this country as other people do (male or female)	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(20) I am able to access employment that reflects the qualifications I have	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(21) I am able to access my own money when I need to	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(22) I am able to buy essential items for myself when I want to, for example clothes or things for my home	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(23) I am able to access the kind of food that I would like to eat	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided	Relevant: 1. Strongly disagree 2. Disagree	Amendment:

	4. Agree 5. Strongly agree	3. Undecided 4. Agree 5. Strongly agree	
(24) I am able to buy healthy food and have a balanced diet	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(25) I am able to do the grocery shopping that I need	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(26) I am able to access affordable healthcare in this country	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(27) I am able to access healthcare services that are safe and effective	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(28) I am able to access affordable medication when I need it	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(29) I am able to access educational opportunities in my current situation	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree	Amendment:

		5. Strongly agree	
(30) I am able to access free courses in this country, for example language classes, art classes or dance classes	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(31) I am able to do educational courses that can help me to share my ideas with other people	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(32) I am able to read and write in the language of my host country	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(33) I am able to speak the official language(s) spoken in this country	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(34) I am able to improve my language skills in the official language(s) of this country if I want to	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(35) I am able to receive support from local authorities and government agencies to access appropriate accommodation	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:

(36) I am able to make plans to own my own residence in the future	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(37) I am able to have a say in which city and neighborhood I want to live in	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(38) I am able to use appropriate transportation to travel to the places that I wish to go to in this country, for example buses, trains, trams, etc.	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
Social support and integration			
(39) When people around me are feeling sad, I am able to make them feel more positive by offering support	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(40) I feel that my host society is tolerant, open and accepting of different people's views	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(41) I am able to contribute to discussions an/or plans aimed at rebuilding society in my country of origin	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:

(42) I feel able to make friends and interact in my host community	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(43) I my current situation I feel that I am able to be a valued member of the community	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(44) I am currently able to spend time with people from my own cultural background	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(45) In my host country I am able to meet and interact with people from different cultures	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(46) In this country I am able to educate others about my cultural beliefs and practices	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(47) I am able to feel respected and accepted by people from my host community	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(48) I have the same opportunities to employment as citizens of this country	Understandable:	Relevant:	Amendment:

	1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	
(49) I am able to look after my family members who are in this country or those who remain in my country of origin	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(50) In my current situation I am able to feel supported by my family members	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(51) I am currently able to receive support from a partner or significant other	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(52) I am able to receive support from friends in this country	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(53) I feel able and free to choose my own friends	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(54) I am satisfied with the opportunities that exist for migrants to support their children to integrate into their new setting	Understandable: 1. Strongly disagree 2. Disagree	Relevant: 1. Strongly disagree	Amendment:

	3. Undecided 4. Agree 5. Strongly agree	2. Disagree 3. Undecided 4. Agree 5. Strongly agree	
(55) I am satisfied with the opportunities that exist for migrants to be able to provide for their children	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(56) I am satisfied with the opportunities that exist to support migrants to access affordable childcare	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(57) I am satisfied with the support networks that migrants have to look after their children, for example family, friends or neighbor	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(58) I am satisfied with the opportunities that exist for migrants to see their children happy in this country	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(59) I am satisfied with the opportunities that exist for migrants to give their children a good education in this country	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(60) I am satisfied with the opportunities that exist for migrants to see that their children are able to think about a future in this country	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided	Amendment:

	5. Strongly agree	4. Agree 5. Strongly agree	
(61) I am able to get support from local organizations or charities to build a life in this country, for example support with meeting new people, making plans, getting used to a new system	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(62) I am able to rely on local organizations or charities for support with carrying out important tasks, for example paying bills, working through migration documents, etc	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
Personal well-being			
(63) I am able to exercise control over my living circumstances e.g. being able to live by myself if I want to.	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(64) My age does not impact on me doing the things that matter to me.	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(65) I am able to make my own informed choices regarding big life transitions, for example getting married or having children	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(66) In my current situation I have the freedom to make my own decisions	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree	Amendment:

		5. Strongly agree	
(67) I am able to have the same status and respect as other members (male or female) of my household	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(68) I am able to voice my opinions in my household and these opinions are respected	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(69) I am free to choose what clothes I want to wear	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(70) I am able to make my own choices and these choices are respected by other people living this country	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(71) I am currently able to achieve a good level of physical health	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(72) I am able to do things to help me establish a good level of physical health, for example going to the gym, going for a walk, dancing	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:

(73) I am currently able to achieve a good level of mental health	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(74) I am able to do things to help me establish a good level of mental health, for example talking to someone when I feel sad, or doing activities which make me happy	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(75) I am able to feel good and confident about myself	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(76) In my current situation I am able to feel free from emotional worry, stress and anxiety	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(77) I am able to have a balance in my day to day routine	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(78) I am able to live a happy life	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:

(79) I am able to access green spaces in this country e.g. parks or the countryside	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(80) I am able to enjoy leisure activities, for example going for walks, going to the cinema, visiting tourist attractions or listening to music	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(81) I am able to access a place of worship if I want to e.g. a church, mosque, synagogue, etc	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
Hope for the future			
(82) I am able to plan for my future in my current environment	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(83) I feel confident that I will be able to achieve goals that I set.	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(84) I am now able to have hope for the future	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
Independence			

(85) I have the opportunity to be independent and autonomous in this country	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(86) I am able to have my own privacy and keep information for myself if I want to	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(87) I am able to build a good life in this country	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:
(88) I feel able to fulfill my potential in this country	Understandable: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Relevant: 1. Strongly disagree 2. Disagree 3. Undecided 4. Agree 5. Strongly agree	Amendment:

Are there any additional questions or areas of well-being which you think we might have missed and should be included?

Appendix P: Participant Information Sheet GLiCS

Participant information sheet

(version 2 – 19th of April, 2020)

We are asking whether you would like to take part in a research study. Before you decide if you would like to join in, it is really important that you understand why the study is being done, what the study is about, and what it will mean if you take part. So please read this page and think about the information carefully.

If something doesn't make sense or you have more questions send us an email (c.van-der-boor@liverpool.ac.uk) and we can discuss your questions with you.

Why is this study being done?

- This study is being done so that we can understand your well-being in the United Kingdom.
- You have been invited to take part because you are an adult woman (18 years or older) who has a refugee status in the United Kingdom (either definite leave to remain or settled status).
- You would be one of at least 440 women helping us with this study

Do I have to take part?

No, it is completely your choice. You are also free to stop taking part at any time during the research without having to give a reason. If you do complete the survey, the data you give us will be kept anonymous so it will not be possible for us to delete this data at a later time.

What will happen if I take part?

1. *If you want to take part in the research, we will ask you to give your consent on the next page.* **Consent means you agree and are happy to take part in the research.**
2. *Then we will ask some questions about you. For example, how old you are and where you are from. It is okay if you don't want to give us this information.*
3. *Next, you will be asked some questions about your mental health and your well-being in the UK.*

4

When you have finished, we will thank you for taking the time to help us with the research. We will ask if you would like to help us again in a few weeks, but you don't have to do this if you don't want to.

Do I have to take part in this research?

No, it is completely your choice. You are also free to stop taking part at any time during the research without having to give a reason.

Is there anything I should be worried about if I take part in this study?

Some of the questions might feel difficult to answer or may be upsetting. If you think participating may upset you then please consider not taking part. If you do want to take part, *just answer the questions as openly and honestly as you can.* We want to make sure we are supporting you as best as possible so we have included some information on organizations which you can contact if you think you need some extra help or support after doing this study.

It is also important to know that this research is not linked to your migration status or case with the Home Office. *All the information collected from this study is anonymous, which means that your name won't be used and no one will be able to know you filled in this survey.*

You can also always e-mail the researcher; Catharina van der Boor (c.van-der-boor@liverpool.ac.uk, if you have any questions.

Will the study help me?

No not directly, but the information you give us might help us support refugee women in the United Kingdom better in the future.

What will you do with my information?

There are very strict laws in the United Kingdom to make sure that your personal information is protected and kept safe at all times. This research project is being carried out by the University of Liverpool who acts as a 'Data Controller' for any personal information that is collected in this research project. The project coordinator, Catharina van der Boor, acts as a 'Data Processor' for this study, so if you have any questions about what will happen with your personal information you can e-mail Catharina (c.van-der-boor@liverpool.ac.uk).

Here is a summary of what we will do with the information you give us:

How will my information be collected?	We will collect your information from the questions we ask about you and your mental health and well-being
How will my information be saved?	Your information will be saved on a password protected computer. If you fill in the information on a paper sheet then we will save it in a drawer with a lock on it. Only the members of the research team will have the key to open the lock.
How long will my information be saved for?	We will save your information for 10 years
How can you make sure my information is safe and confidential?	We will keep your information protected by a password on a computer, and in a drawer with a lock on it. Only the members of the research team can see your information.
Will my information be anonymised?	Yes, no one will know the information you have given belongs to you. We will not ask for your name, and you will be given a number which will be used instead.
How will my information be used?	We will use your information together with the information other women have given to the same questions to understand the mental health and well-being of women who are refugees in the UK. When the study has finished we will present the results to other researchers and organizations that work with refugee women.
Who will have access to my information?	Only the research team will have access to your information.
Will my information be used in other research projects in the future?	No.
How will my information be destroyed?	Your information will be deleted after 10 years.

Has someone checked that this research is okay?

Before research goes ahead it is checked by a Research Ethics Committee. This is a group of people who make sure that the research is OK to do. This study has been looked at by the Health and Life Sciences Research Ethics Committee (Psychology, Health and Society) at the University of Liverpool.

Who can I contact if I have any further questions or if there is a problem?

Tell us if there is a problem and we will try and sort it out straight away.
You can e-mail us with any questions.

Project Coordinator: Catharina Van Der Boor

Email: C.Van-Der-Boor@liverpool.ac.uk

Chief Investigator: Dr. Ross White

Email: rgwhite@liverpool.ac.uk

Thank you for taking the time to read this – please ask any questions if you need to.
If you think you could benefit from some additional support, consider contacting:
Your general practitioner
Samaritans: Confidential support for people experiencing feelings of distress or despair.
Phone: 116 123 (free 24-hour helpline)
Website: www.samaritans.org.uk
Shelter: Shelter is a housing and homelessness charity.
Phone: 0808 800 4444
Website: https://www.shelter.org.uk
British Red Cross: support with the urgent needs such as food parcels and vouchers, toiletries, baby
items, etc. Depending on where you live they may be able to offer advice on benefits, health care, adjusting to life in the UK, emotional support, family reunification, etc.
Phone: 0344 871 11 11
Website: https://www.redcross.org.uk/get-help/get-help-as-a-refugee

If you need support in other areas, you can access other resources through this website:
https://www.ljmu.ac.uk/microsites/resources-for-professionals-who-support-asylum-seekers-and-refugees/resources

Appendix Q: Consent form GLiCS

PARTICIPANT CONSENT FORM
(version 1, 25th of February, 2020)

Research project: *Mental health and well-being of migrant women in the UK*

1. I have read and have understood the Participant Information Sheet [Version 1, 25th of February, 2020], or it has been read to me. I have had time to think about the information and ask questions which have been answered.

   Yes

   No

2. I understand that taking part in the study means I will be completing a survey on mental health and well-being.

   Yes

   No

3. I understand that this is completely voluntary and I can stop taking part any time I want to without having to give a reason.

   Yes

   No

4. I understand that I do not have to answer any questions I do not want to
   Yes

   No

5. I understand that everything I say will be kept in a safe place and only the research team will be able to access it.

   Yes

   No

6. I agree to take part in the survey.

   Yes

No

Please sign your name below if you understand what has been talked about in this form and if you **consent** to take part in the research project.

Date: Name of Participant:

Date: Name of Researcher:

Appendix R: Debrief Form GLiCS

(version 1 – 19th of April, 2020)

Thank you very much for taking the time to fill in this online survey.

Aim of this study

The aim of this study is to understand the well-being and mental health of women who hold a refugee status in the UK.

Confidentiality

We would like to remind you that the data you have given us today will be kept anonymous and can only be accessed by the research team.

Mental health and well-being

We understand that some of the questions which we have asked you today might have been upsetting. In order to make sure that you are adequately supported we want to provide every participant in this study with a list of resources that are available to you across the UK, should you decide you need assistance at any time. If you think you could benefit from support in any of the areas which have been discussed today, please see the information below pertaining to resources and sources of support. If you continue to feel distressed, we would also advise you to contact your NHS General Practitioner to seek support.

Support organizations:

Samaritans: Confidential support for people experiencing feelings of distress or despair.
Phone: 116 123 (free 24-hour helpline)
Website: www.samaritans.org.uk

Shelter: Shelter is a housing and homelessness charity.
Phone: 0808 800 4444
Website: https://www.shelter.org.uk

British Red Cross: support with the urgent needs such as food parcels and vouchers, toiletries, baby items, etc. Depending on where you live they may be able to offer advice on benefits, health care, adjusting to life in the UK, emotional support, family reunification, etc.
Phone: 0344 871 11 11
Website: https://www.redcross.org.uk/get-help/get-help-as-a-refugee

If you need support in other areas, you can access other resources through this website:

https://www.ljmu.ac.uk/microsites/resources-for-professionals-who-support-asylum-seekers-and-refugees/resources

Contact information

If you have any outstanding questions or concerns regarding this research, its purpose or

procedures please feel free to contact Catharina van der Boor (c.van-der-boor@liverpool.ac.uk)

Appendix S: Advertisement GLiCS

Version 1 – 25th of February, 2020

PARTICIPANTS NEEDED

Well-being in refugee women

We are looking to recruit women who hold a refugee status in the UK for an online study looking at mental health and well-being.
Are you:

- An adult woman? (>18 years)
- Do you have a refugee status?
  (definite leave to remain OR settled status?)
- Do you live in the UK?

Then please consider filling in our online survey:

(web link) (QR code)

Thank you!

Appendix T: Objective Social Outcomes Index

Objective Social Outcomes Index

Priebe, S., Watzke, S., Hansson, L., & Burns, T. (2008). Objective social outcomes index (SIX): a method to summarise objective indicators of social outcomes in mental health care. *Acta Psychiatrica Scandinavica*, *118*(1), 57-63.

1. Employment

   None (0)
   Voluntary/protected/sheltered work (1)
   Regular employment (2)

2. Accommodation

   Homeless or 24 h supervised (0)
   Sheltered or supported accommodation (1)
   Independent accommodation (2)

3. Partnership/family

   Living alone (0)
   Living with a partner or family (1)

4. Friendship

   Not meeting a friend within the last week (0)
   Meeting at least one friend in the last week (1)

Appendix U: Oxford Capabilities Questionnaire - Mental Health

Simon J, Anand P, Gray A, Rugkåsa J, Yeeles K, and Burns T. Operationalising the capability approach for outcome measurement in mental health research. *Soc Sci Med.* 2013 Dec;98:187–196. DOI:10.1016/ j.socscimed.2013.09.019

This questionnaire asks about your overall quality of life.

7. Does your health in any way limit your daily activities, compared to most people of your age? (always, most of the time, some of the time, hardly ever, never)
8. Are you able to meet socially with friends or relatives? (always, most of the time, some of the time, hardly ever, never)
9. In the past 4 weeks, how often have you lost sleep over worry? (always, most of the time, some of the time, hardly ever, never)
10. In the past 4 weeks, how often have you been able to enjoy your recreational activities? (always, most of the time, some of the time, hardly ever, never)
11. How suitable or unsuitable is your accommodation for your current needs? (very suitable, fairly suitable, neither suitable nor unsuitable, fairly unsuitable, very unsuitable)
12. Please indicate how safe you feel walking alone in the area near your home: (very safe, fairly safe, neither safe nor unsafe, fairly unsafe, very unsafe)
13. Please indicate how likely you believe it to be that you will be assaulted in the future (including sexual and domestic assault): (very likely, fairly likely, neither likely nor unlikely, fairly unlikely, very unlikely)
14. How likely do you think it is that you will experience discrimination? (very likely, fairly likely, neither likely nor unlikely, fairly unlikely, very unlikely)
15. On what grounds do you think it is likely that you will be discriminated against? (race/ethnicity, gender, religion, sexual orientation, age, health or disability (incl. mental health)
16. Please indicate how strongly you agree or disagree with the following statements:

    (strongly agree, agree, neither agree nor disagree, disagree, strongly disagree)

    9a. I am able to influence decisions affecting my local area

    9b. I am free to express my views, including political and religious views

    9c. I am able to appreciate and value plants, animals and the world of nature.

    9d. I respect, value and appreciate people around me.

    9e. I find it easy to enjoy the love, care and support of my family and/or friends.

    9f. I am free to decide for myself how to live my life

    9g. I am free to use my imagination and to express myself creatively (e.g. through art, literature, music, etc.).

    9h. I have access to interesting forms of activity (or employment).

Appendix V: WHO-5 Wellbeing Index

World Health Organization. (1998). WHO (Five) well-being index (1998 version). *Available at: www. who-5. org*.

WHO (Five) Well-Being Index (1998 version)

Please indicate for each of the five statements which is closest to how you have been feeling over the last two weeks. Notice that higher numbers mean better well-being.

Example: If you have felt cheerful and in good spirits more than half of the time during the last two weeks, put a tick in the box with the number 3 in the upper right corner.

	Over the last two weeks	All of the time	Most of the time	More than half of the time	Less than half of the time	Some of the time	At no time
1	**I have felt cheerful and in good spirits**	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
2	**I have felt calm and relaxed**	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
3	**I have felt active and vigorous**	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
4	**I woke up feeling fresh and rested**	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
5	**My daily life has been filled with things that interest me**	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0

Scoring:

The raw score is calculated by totalling the figures of the five answers. The raw score ranges from 0 to 25, 0 represent- ing worst possible and 25 representing best possible quality of life.

To obtain a percentage score ranging from 0 to 100, the raw score is multiplied by 4. A percentage score of 0 represents worst possible, whereas a score of 100 represents best possible quality of life.

Interpretation:

It is recommended to administer the Major Depression (ICD-10) Inventory if the raw score is below 13 or if the patient has answered 0 to 1 to any of the five items. A score below 13 indicates poor wellbeing and is an indication for testing for depression under ICD-10.

Monitoring change:

In order to monitor possible changes in wellbeing, the percentage score is used. A 10% difference indicates a significant change (ref. John Ware, 1995).

Appendix W: Factor Loadings of items GLiCS (V0.3)

Scale item	Factor loadings				
	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5
1. I am able to feel physically safe when I walk around in my neighbourhood	0.23	0.30	-0.09	0.43	0.08
2. I am able to adhere to my cultural beliefs and practices in this country, for example practicing my religious beliefs or celebrating important festivities	0.16	-0.02	-0.14	0.75	0.01
3. I feel protected by political institutions in this country, for example the government or the legal courts	-0.01	0.41	-0.01	0.49	-0.30
4. I feel that my basic human rights are being respected in this country	0.15	0.33	0.03	0.43	-0.13
5. I am able to learn about my rights in this country, for example through support organisations	0.17	0.48	-0.06	0.19	-0.10
6. I am comfortable using public resources when I need help, for example calling the police or an ambulance	-0.18	0.29	0.49	0.29	-0.07
7. I am able to freely express my ideas and opinions	0.09	0.11	0.28	0.58	0.11
8. I am able to post what I want on social media, for example on Facebook, Instagram or Twitter	0.06	-0.05	0.28	0.59	-0.02
9. I am able to get sufficient money to meet my basic needs (through employment or benefits)	0.87	0.23	-0.04	-0.07	-0.10
10. I am able to buy essential items for myself when I want to, for example clothes, toiletries or things for my home	0.90	-0.02	0.06	-0.05	0.02
11. I am able to access the kind of food that I would like to eat	0.80	-0.03	-0.07	0.26	0.06
12. I am able to access internet when I need to, for example on my phone or on a computer	0.61	-0.19	0.34	0.18	0.10
13. I am able to use a mobile phone when I need to, for example to make an appointment or to contact friends and family	0.47	-0.13	0.48	0.21	-0.01
14. I am able to access courses to help build my skills and talents, for example art classes or dance classes	0.55	0.14	0.14	0.16	-0.14
15. I am able to access language classes in this country	0.17	0.14	0.26	0.23	-0.35
16. I am able to read and write in the language of this country	0.27	-0.06	0.65	-0.23	-0.07
17. I am able to speak the official language(s) spoken in this country	0.16	-0.06	0.62	-0.11	-0.08
18. I am able to receive support from local authorities and government agencies to access appropriate and safe accommodation	0.27	0.37	0.25	0.08	-0.50
19. I am able to choose which city and neighborhood I want to live in	0.58	0.18	0.06	0.16	0.08
20. I am able to use appropriate transportation to travel to the places that I wish to go to, for example a bicycle, buses, trains, trams, etc.	0.36	-0.13	0.36	0.28	-0.11
21. I am able to feel I am a valued member of the community here	0.11	0.46	0.01	0.20	0.13

22. In this country I am able to share information with other people about my cultural beliefs and practices, for example my language, my religion, or music from my country.	0.16	0.23	0.18	0.34	0.28
23. I am able to live freely without facing discrimination from other people in society	0.06	0.25	0.16	0.40	0.10
24. I am able to receive support from friends in this country, for example help accessing information	0.23	0.24	0.32	0.17	0.17
25. When people around me are feeling sad, I feel able to support them and make them feel more positive	0.05	0.47	0.09	0.09	0.17
26. I am able to rely on local organizations or charities for support with carrying out important tasks, for example paying bills or working through migration documents.	0.10	0.58	-0.01	0.07	-0.12
27. I am able to exercise control over my living circumstances, for example being able to live by myself if I want to	0.39	0.49	0.19	-0.14	0.05
28. Within my community, I am treated with equal respect and consideration compared to others (male or female)	0.33	0.01	0.23	0.09	0.29
29. I feel that my ideas and opinions are heard and valued by people that are important to me, for example my partner, parents or children	0.54	0.04	-0.07	0.05	0.52
30. I am able to choose what clothes I want to wear	0.48	0.05	0.12	0.01	0.29
31. I am able to do things to help me achieve a good level of mental health, for example talking about my worries or taking time to relax	0.15	0.28	0.41	0.14	0.15
32. I am able to access professional support for my mental health if I need to, for example going to my GP or getting support from an organization	0.01	0.41	0.30	0.12	-0.05
33. I am able to live a happy life with levels of stress that feel manageable to me	0.20	0.51	0.22	-0.13	0.35
34. I am able to access green spaces in this country, for example parks or the countryside	-0.17	0.20	0.51	0.18	0.18
35. I am able to enjoy leisure activities, for example going for walks, listening to music or visiting tourist attractions	-0.04	0.34	0.39	0.21	0.30
36. I am able to access a place of worship if I want to for example a church, mosque, synagogue, a temple etc.	0.02	0.17	0.15	0.38	0.35
37. I feel confident that I will be able to achieve goals that I set for myself	0.06	0.48	0.48	-0.05	0.15
38. I am able to be independent and free in this country	0.05	0.37	0.40	0.15	0.17
39. I am able to be involved in the decisions that affect my life, for example getting married or having children	0.13	-0.03	0.59	0.23	0.07
40. I am able to have my own privacy and keep information for myself if I want to, for example I can keep my bills and letters to myself.	0.06	0.04	0.63	0.24	0.00
41. I am able to build a good life in this country	0.04	0.79	0.08	-0.02	-0.08
42. I feel happy about being in this country	-0.02	0.78	-0.24	0.15	0.02

Appendix X: Good Life in the Community Scale

Subscale 1 – 'Access to Resources' (Scale: strongly disagree, somewhat disagree, undecided, somewhat agree, strongly agree)

1. I am able to get sufficient money to meet my basic needs (through employment or benefits)
2. I am able to buy essential items for myself when I want to, for example clothes, toiletries or things for my home
3. I am able to access the kind of food that I would like to eat
4. I am able to access internet when I need to, for example on my phone or on a computer
5. I am able to access courses to help build my skills and talents, for example art classes or dance classes
6. I am able to choose which city and neighborhood I want to live in

Subscale 2 – 'Belonging and Contributing' (Scale: strongly disagree, somewhat disagree, undecided, somewhat agree, strongly agree)

1. I am able to learn about my rights in this country, for example through support organisations
2. I am able to feel I am a valued member of the community here
3. When people around me are feeling sad, I feel able to support them and make them feel more positive
4. I am able to rely on local organizations or charities for support with carrying out important tasks, for example paying bills or working through migration documents
5. I am able to build a good life in this country
6. I feel happy about being in this country

Subscale 3 – ' Independence' (Scale: strongly disagree, somewhat disagree, undecided, somewhat agree, strongly agree)

1. I am able to read and write in the language of this country
2. I am able to speak the official language(s) spoken in this country
3. I am able to access green spaces in this country, for example parks or the countryside
4. I am able to be involved in the decisions that affect my life, for example getting married or having children
5. I am able to have my own privacy and keep information for myself if I want to, for example I can keep my bills and letters to myself