Supporting Refugee and Asylum-seeking Parents to Respond to Their Children's Mental Health Needs



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Declaration

Some parts of this thesis have been published or submitted for publication.

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Chapter 5

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Artificial Intelligence (AI) Declaration

This thesis was prepared in accordance with the University's policy on the use of generative artificial intelligence (AI). AI tools were used to assist with coding and programming tasks and support refinement of written text. All research design, data collection, analysis, and the final content of this thesis are the work of the author, who takes full responsibility for its accuracy and integrity.

Declaration of Authorship and Contributions

The empirical chapters in this thesis report work undertaken as part of my doctoral research, for which I was the primary researcher and lead author. Across the programme, I led the study design, analyses, interpretation of findings, and drafting and revision of the empirical chapters, with conceptual, methodological and editorial guidance from my supervisors, Professor Cathy Creswell (CC), Professor Sarah Halligan (SLH) and Professor Lucy Bowes (LB). To date, one empirical chapter has been published in a peer-reviewed journal, one has been accepted for publication, and one is under peer-review. Where chapters are based on published or submitted manuscripts, they have been edited and reformatted for inclusion within the thesis.

For the electronic health record study (Chapter 2), I led the study design, development of the annotation and coding frameworks, data annotation, data management, analysis, interpretation and writing. Huilin (Angel) Chen and Dr En-nien (Ernie) Tu contributed to annotation of a proportion of the clinical records. Dr Andrey Kormilitzin provided natural language processing and programming support that enabled the clinical records to be processed and annotated. Hawa Hussain supported with data cleaning. Dr Carmen Chen provided clinical expertise and feedback on the interpretation of findings in relation to mental health service practice. My supervisors, CC, SLH and LB, contributed to the conceptual development of the study and provided iterative methodological and editorial feedback throughout its development.

For the qualitative studies (Chapters 3–6), I led the study design, data collection, management, analysis and interpretation, and the development and refinement of themes and conceptual frameworks. My supervisors CC, SLH and LB, contributed to study development, reflexive and analytic discussions, and review of the resulting chapters and manuscripts.

List of Abbreviations

ACRS: Afghan Citizens Resettlement Scheme

ADHD: Attention-Deficit/Hyperactivity Disorder

ARAP: Afghan Relocations and Assistance Policy

AWS: Amazon Web Services

BN(O): British National (Overseas)

CAMHS: Child and Adolescent Mental Health Services

CBT: Cognitive Behavioural Therapy

CFIR 2.0: Consolidated Framework for Implementation Research 2.0

CI: Confidence Interval

CPD: Continuing Professional Development

CRIS: Clinical Record Interactive Search

CUREC: Central University Research Ethics Committee

EHR: Electronic Health Record

EMDR: Eye Movement Desensitisation and Reprocessing

ESOL: English for Speakers of Other Languages

GP: General Practitioner

HIOWH: Hampshire and Isle of Wight Healthcare NHS Foundation Trust

IASC: Inter-Agency Standing Committee

ICD-10: International Classification of Diseases, Tenth Revision

IQR: Interquartile Range

MASH: Multi-Agency Safeguarding Hub

MHST: Mental Health Support Team

NET: Narrative Exposure Therapy

NOTTSHC: Nottinghamshire Healthcare NHS Foundation Trust

NHS: National Health Service

NICE: National Institute for Health and Care Excellence

NLP: Natural Language Processing

OHFT: Oxford Health NHS Foundation Trust

OR: Odds Ratio

PMTO: Parent Management Training–Oregon Model

PTSD: Post-Traumatic Stress Disorder

REC: Research Ethics Committee

RTA: Reflexive Thematic Analysis

SD: Standard Deviation

SEN: Special Educational Needs

SPARE: Strengthening Parenting Among Refugees in Europe

TAF: Team Around the Family

UASC: Unaccompanied Asylum-Seeking Children

UK: United Kingdom

UNHCR: United Nations High Commissioner for Refugees

UNICEF: United Nations Children's Fund

VDI: Virtual Desktop Infrastructure

VPRS: Vulnerable Persons Resettlement Scheme

WHO: World Health Organization

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Abstract

Background

Refugee and asylum-seeking children are at elevated risk of emotional and behavioural difficulties due to cumulative exposure to pre-migration trauma, forced displacement, and post-migration stressors. Despite documented vulnerability, engagement with specialist child and adolescent mental health services does not consistently reflect this level of need. Parents play a central role in regulating children's mental health and in mediating access to formal services; however, they frequently navigate these processes under conditions of structural strain and service constraint. Empirically grounded guidance on how best to support refugee parents in supporting their children's mental health remains limited.

Objective

To examine how the mental health needs of refugee and asylum-seeking children in the United Kingdom are recognised and addressed across family and specialist service contexts, and to identify how refugee parents can be most effectively supported in helping their children's mental health following resettlement.

Methods

I conducted a sequential programme of research comprising multiple methods, presented across five empirical chapters:

1. A retrospective analysis of electronic health records from three National Health Service (NHS) trusts to characterise the presenting problems and patterns of care for refugee and asylum-seeking children accepted for assessment by specialist Child and Adolescent Mental Health Services (CAMHS).
2. In-depth semi-structured interviews with 23 refugee and asylum-seeking parents of children aged 3–11 years, exploring their experiences and understanding of their children's mental health needs following resettlement, with particular attention to the challenges parents face in supporting their children within complex post-migration contexts.

3. Semi-structured interviews with 30 professionals and stakeholders across health, education, voluntary, and community sectors to examine conceptualisations of refugee children's mental health and service responses.
4. An integrative qualitative analysis of parent and stakeholder data to identify perspectives on effective support for refugee parents to help their children.
5. A further qualitative analysis using the Consolidated Framework for Implementation Research 2.0 (CFIR 2.0) to examine barriers and facilitators to implementing therapist-guided parent-led mental health support within UK statutory systems.

Results

Across the programme of research, children's mental health and the support available to them were closely linked to conditions of resettlement. Housing instability, disrupted education, family separation, language barriers and immigration uncertainty were identified as contributing to children's distress and constraining parents' capacity to respond and families' ability to access and engage with services. Although children reaching CAMHS typically had multiple documented mental health symptoms, care frequently relied on consultation, liaison and wider community or statutory support, whereas direct psychological intervention was relatively uncommon and specialist provision varied according to local service configuration and expertise. Stakeholders working at the interface between families and CAMHS described these wider systems of support as fragmented, difficult to navigate and, at times, mistrusted. Within these conditions, therapist-guided parent-led interventions emerged as one potentially promising avenue for extending psychological support to children through their parents. However, regardless of the intervention offered, findings from across the studies indicated that supporting parents to help their children appeared to require conditions that fostered trust, accommodated competing pressures on parental capacity, addressed language needs, provided relational support, and allowed organisational flexibility.

Conclusion

Effective mental health support for refugee and asylum-seeking children requires both appropriate psychological interventions and systems capable of delivering them within the realities of

resettlement. Supporting parents requires strengthening parental capacity alongside accessible specialist care, trusted relationships, language-responsive practice and coordinated community and statutory support. Refugee-responsive mental healthcare should therefore focus not only on what support is provided, but on creating the conditions that enable children and families to access, engage with and benefit from it. Future research should examine how evidence-based psychological interventions can be effectively implemented and sustained in the context of continuing adversity, and how wider resettlement conditions shape families' ability to access and make use of support.

Reflexivity Statement

As a researcher exploring psychological interventions for refugee children and families, I recognise that my positionality is not separate from the research process but actively shapes it. My lived experience of migration and resettlement informs how I understand displacement, adaptation, and the reconstruction of everyday life. This standpoint may heighten my sensitivity to the structural, cultural, and emotional dimensions of refugee experiences, particularly in relation to children's mental health and the central role of caregiving relationships.

I also acknowledge that this proximity to the research topic introduces particular assumptions and investments. My own experiences may lead me to privilege certain narratives of resilience, adaptation, or need, and to assume commonalities across refugee families despite the significant diversity in cultural, linguistic, and socio-political contexts. In addition, my belief in the importance of parental roles and psychological interventions may shape how I attend to, interpret, and prioritise participants' accounts. These perspectives are not neutral; they reflect specific values and ways of knowing that may both illuminate and constrain the analysis.

I have therefore approached this research with an ongoing commitment to critical reflexivity. This involves not only recognising potential bias, but interrogating how my positionality influences the questions I ask, the relationships I form with participants, and the meanings I construct from the data. I remain attentive to issues of power, particularly in representing the experiences of families whose voices are often mediated through research and clinical frameworks. To support this process, I have engaged in regular reflexive practice, including documenting assumptions, seeking critical dialogue with supervisors, and remaining open to interpretations that challenge my expectations.

By situating myself within the research in this way, I aim to balance the insights afforded by lived experience with methodological rigour and analytic transparency. This reflexive stance is intended to support the development of a nuanced, contextually grounded understanding of how refugee parents can be supported in addressing their children's mental health needs, while acknowledging the limits of my perspective.

Chapter 1: Introduction

1.1 Childhood in the Context of Forced Displacement

More than 117 million people were forcibly displaced worldwide in 2025 as a result of armed conflict, persecution, and human rights violations (UNHCR, 2026). While the majority of displaced individuals remain internally displaced or seek refuge in neighbouring low- and middle-income countries, high-income nations have experienced increasing numbers of refugee resettlements and asylum applications in recent years (UNHCR, 2026). Within these contexts, legal status is a central determinant of lived experience. Under international law, refugees are individuals granted protection in a host country on the basis of a well-founded fear of persecution, whereas asylum seekers are those awaiting formal determination of such claims (Tudor, 2022). These distinctions shape access to housing, education, employment, and healthcare, and therefore structure the social and economic conditions within which families experience resettlement (Migration Observatory, 2025).

Children comprise a substantial proportion of the forcibly displaced population, with around 40% under the age of 18 years (UNICEF, 2024). For many, displacement is not a single event but a prolonged and cumulative process unfolding across multiple stages of migration. Experiences of armed conflict, persecution, community disruption, and family separation may precede migration; periods of instability and transit may follow; and resettlement often introduces new structural stressors, including insecure housing, protracted asylum procedures, financial hardship, and social marginalisation (Bronstein & Montgomery, 2011; Scharpf et al., 2021).

These cumulative experiences reshape the relational and institutional contexts within which childhood develops. Rather than affecting children through isolated events, displacement can disrupt multiple interconnected systems, including education, social networks, caregiving relationships, and access to services (Betancourt et al., 2015; Block et al., 2014; Dryden-Peterson, 2016). For families navigating asylum systems, prolonged legal uncertainty may compound difficult material and social conditions, including financial hardship, housing insecurity and social isolation, contributing to psychological distress (e.g., van Eggermont Arwidson et al., 2022). Forced migration can therefore be

understood not only as exposure to traumatic events, but as sustained disruption to the ecological systems that support child development.

1.2 The UK Asylum and Resettlement Context

The UK's response to forced displacement is structured through a combination of asylum processes and 'safe and legal' humanitarian routes, including resettlement programmes, family reunion visas, and nationality-specific schemes (Home Office, 2026). These pathways confer differing legal statuses and entitlements, which shape access to services, stability of residence, and the conditions under which children and families experience arrival and integration. As such, experiences of displacement in the UK are shaped by policy frameworks that govern entry and access to support, which remain subject to ongoing change and variability (Home Office, 2026).

Within this context, 16,710 children aged 17 years or under sought asylum in the UK during 2025, including 3,598 unaccompanied asylum-seeking children (UASC), the majority of whom were aged 16-17 (Home Office, 2026). In parallel, substantial numbers of children have arrived through humanitarian routes; for example, since the Ukraine Family, Sponsorship and Extension Schemes opened in March 2022, 282,687 out-of-country visas have been granted, with children accounting for 26% of arrivals since 2022. Additional arrivals have occurred through nationality-specific and resettlement pathways, including schemes established in response to recent conflicts in Afghanistan (e.g., ARAP and ACRS) and Syria (VPRS), as well as longer-standing routes such as the British National (Overseas) (BNO) visa pathway. Together, these routes contribute to a diverse population of refugee and asylum-seeking children growing up in the UK (Home Office, 2026; Migration Observatory, 2025).

Despite differences in policy pathways and migration routes, cultural backgrounds and socio-political contexts, this thesis deliberately adopts a cross-contextual approach to refugee and asylum-seeking populations (hereafter 'refugee', except where distinctions in legal status or experience are relevant) in the UK. Existing literature has frequently focused on specific refugee subgroups, such as unaccompanied or asylum-seeking children (Ehntholt et al., 2018), or on particular national or conflict-affected populations, for example Syrian (e.g., Hazer & Gredebäck, 2023), Ukrainian (e.g.,

Silwal et al., 2026) and Afghan (e.g., Alemi et al., 2023) children and families. Such research provides important insight into the experiences shaped by specific cultural, political and displacement contexts, but may provide less insight into whether common processes operate across heterogeneous refugee populations. The focus on shared experiences was therefore an *a priori* decision, reflecting the aim of identifying processes relevant to supporting children's mental health across populations. This approach recognised that culture and migration pathways shape how these experiences are understood and navigated, while seeking to inform interventions relevant across populations and responsive to variation within the UK context.

1.3 Refugee Child Mental Health: Elevated Risk and Heterogeneity

A substantial body of research demonstrates that refugee children experience elevated rates of mental health difficulties relative to host-country populations (e.g., Kien et al., 2019). In a meta-analysis of refugee and asylum-seeking children and adolescents, Blackmore et al. (2020) estimated pooled prevalence rates of 22.7% for PTSD, 15.8% for anxiety disorders and 13.8% for depression. For comparison, the nationally representative Mental Health of Children and Young People in England survey estimated prevalence rates of 0.6% for PTSD, 7.2% for anxiety disorders and 2.1% for depressive disorders among 5–19-year-olds in the general population (NHS Digital, 2018). Although methodological differences limit direct comparison, the markedly higher prevalence estimates reported among refugee children are consistent with wider evidence of increased vulnerability to mental health difficulties across diverse resettlement contexts (e.g., Blackmore et al., 2020). However, much of this evidence is derived from studies of school-aged children and adolescents, with comparatively limited research examining mental health in young children (Frounfelker et al., 2020).

Despite elevated risk, mental health outcomes among refugee children vary considerably across individuals and contexts. This variation reflects differences in exposure severity, time since resettlement, individual and family circumstances, host-country conditions, and methodological approaches (Blackmore et al., 2020; Fazel et al., 2012). Increasingly, a substantial literature has emphasised the role of post-migration stressors - such as housing instability, financial hardship, social

exclusion, and legal uncertainty - in shaping children's mental health trajectories following displacement (Scharpf et al., 2021; Tamming et al., 2026). As such, psychological vulnerability is better understood as a product of cumulative and interacting adversities across the migration trajectory, rather than exposure to discrete traumatic events alone (Miller & Rasmussen, 2017).

At the same time, elevated risk does not translate uniformly into persistent disorder. Many refugee children demonstrate remarkable resilience, particularly in the presence of stable caregiving relationships and supportive social environments (Masten & Narayan, 2012). From a family systems perspective, children's psychological functioning is embedded within patterns of relational stability and family adaptation to stress (Cox & Paley, 2003). However, displacement may alter family roles, increase parental strain, and constrain access to external supports, thereby influencing children's mental health both directly and indirectly.

Together, this evidence highlights both elevated vulnerability and considerable variability in mental health outcomes, yet these needs are not consistently reflected in patterns of service engagement.

1.4 The Gap Between Mental Health Need and Specialist Service Engagement

Despite evidence of elevated psychological vulnerability, refugee children appear to underutilise mental health services relative to their level of need, with lower utilisation compared with host-country peers across high-income contexts (Abou Seif et al., 2026; Kiselev et al., 2020; Satinsky et al., 2019). When support is accessed, entry may occur through crisis or emergency pathways rather than planned referral routes, suggesting delays and fragmentation in access to care (Abou Seif et al., 2026).

Multiple structural and systemic factors may contribute to this pattern. Refugee families frequently encounter barriers including language difficulties, lack of familiarity with referral systems, stigma, cultural barriers, distrust of institutions, and service accessibility (Bilican et al., 2025; Byrow et al., 2020; Colucci et al., 2015; Satinsky et al., 2019). These challenges intersect with service-level pressures within CAMHS, where rising demand and workforce constraints have led to high referral thresholds and extended waiting times (Children's Commissioner for England, 2021). Under such

conditions, it is possible that presentations that are less acute or less clearly aligned with diagnostic categories are less likely to progress to specialist intervention.

Although considerable attention has focused on barriers to accessing mental health services, evidence suggests that challenges continue after initial contact, influencing engagement, navigation and treatment within services (e.g., van der Boor & White, 2020). Refugee children's mental health difficulties are often embedded within complex migration histories and culturally shaped understandings of distress, while assessment frequently relies on caregiver report and interpreter-mediated communication (e.g., Cardoso Pinto et al., 2026). Consequently, whether children receive appropriate mental health support depends not only on access to services, but also on how their difficulties are recognised, interpreted and responded to across families, schools, primary care and specialist mental health services. At each stage, decisions are made about whether children's difficulties warrant further assessment, referral or intervention. Understanding these processes is therefore essential to explaining why many refugee children with substantial mental health needs remain unsupported despite increasing recognition of their vulnerability.

1.5 Parental Centrality Within a Family Systems Framework

Across childhood and adolescence, parents and carers (hereafter referred to as parents) occupy a central role in shaping, interpreting, and responding to children’s mental health, as well as mediating access to formal support. From a family systems perspective, child functioning is embedded within patterns of interaction, co-regulation, and shared adaptation to stress (Cox & Paley, 2003). Emotional regulation and coping capacities develop through ongoing caregiver–child exchanges, and stable caregiving relationships are among the most robust protective factors for children exposed to adversity (Masten & Narayan, 2012). Children’s mental health is therefore embedded within the functioning of the caregiving environment.

Parental wellbeing is closely associated with child mental health, with parental psychological difficulties associated with increased emotional and behavioural difficulties in children (Goodman et al., 2011; Nielsen et al., 2019; Sangalang & Vang, 2017; Scharpf et al., 2021). In contexts of forced migration, parenting often occurs under sustained structural strain, including ongoing stressors related

to instability and resettlement (Miller & Rasmussen, 2010). Despite these challenges, supportive caregiving relationships and adaptive family processes can remain important sources of resilience for refugee children and families (e.g., Betancourt et al., 2015). As consistent figures across displacement trajectories, parents play a central role not only in shaping children's emotional environments but also in mediating how difficulties are understood and addressed over time.

Parents also play an important role in shaping the pathway between children's experiences and formal support systems. They play an important role in determining whether behaviours are perceived as concerning, interpret their significance through cultural and experiential frameworks, and decide whether and how to seek support (Elias et al., 2025; Maddox et al., 2025; Sayal, 2006). In this way, parental interpretation and decision-making represent important mechanisms through which children's needs are translated into service engagement. This role may be particularly important where access to specialist support is constrained, and children depend on adults to recognise difficulties and navigate pathways to care. Strengthening parents' capacity to recognise and respond to children's difficulties may therefore represent one avenue for supporting refugee children's mental health, alongside efforts to improve the accessibility and responsiveness of formal services.

1.6 Aim and Research Questions

The preceding sections identify a central challenge. Refugee children experience elevated mental health vulnerability, yet engagement with specialist services does not consistently reflect this level of need. How children's difficulties are recognised and communicated may shape their pathway to support, with parents playing a pivotal role in translating need into help-seeking and service engagement. However, limited research has examined how parental experiences, professional perspectives, and service-level practices interact within the UK context to shape how children's needs are recognised and addressed.

This thesis conceptualises the gap between mental health need and service engagement not solely as an issue of access, but as a process of translation through which children's difficulties must be recognised, interpreted, and legitimised across family and service systems. The aim of this thesis is therefore to develop a multi-level understanding of how refugee children's mental health needs are

recognised, interpreted and addressed, and how refugee parents can be supported to respond to these needs.

A sequential, multi-method design was adopted, with methods selected to address distinct but connected aspects of the overarching aim. Chapter 2 used electronic health records to establish how refugee children's mental health needs and treatment pathways were documented within specialist services. Chapters 3 and 4 then used qualitative interviews and Reflexive Thematic Analysis (RTA) to explore patterns of meaning within parents' and stakeholders' experiences and perspectives that could not be captured through clinical records alone. These interview datasets were subsequently revisited to address different, more applied questions. In Chapter 5, template analysis enabled existing evidence and insights from the preceding studies to inform the initial analytic structure, while retaining flexibility for participants' accounts to challenge, refine and extend it. Chapter 6 used template analysis informed by the Consolidated Framework for Implementation Research 2.0 (CFIR 2.0) to examine barriers and facilitators to implementing therapist-guided parent-led interventions, providing an established framework while retaining flexibility in how these were represented within the developing template. Together, this sequence enabled different dimensions of the same rich interview datasets to be examined using analytic approaches suited to each research question, while maintaining conceptual and methodological continuity across the programme.

I address these aims through the following research questions:

Chapter 2: For refugee children assessed within UK specialist CAMHS, what are the recorded presenting problems and what treatment pathways are offered?

Chapter 3: How do refugee parents experience and manage the mental health needs of their children aged 3-11 years following resettlement in the UK?

Chapter 4: How do stakeholders across relevant sectors conceptualise and respond to child mental health problems among refugee families?

Chapter 5: What do parents and stakeholders identify as effective and acceptable ways to support refugee parents in managing their children's mental health needs?

Chapter 6: What are the barriers and facilitators to implementing a therapist-guided parent-led intervention for refugee children's mental health needs?

Chapter 2: Identification and Treatment Within Specialist Services

2.1 Background

Chapter 1 reported on wider literature that has established that refugee and asylum-seeking children experience elevated mental health vulnerability, yet engagement with specialist services does not consistently correspond to this level of need. International evidence suggests both lower use of outpatient specialist mental health services and lower receipt of guideline-concordant treatment among refugee children compared with non-refugee peers (Abou Seif et al., 2026; Sengun Filiz et al., 2026). Yet, while epidemiological studies have established elevated rates of emotional and behavioural difficulties (Blackmore et al., 2020; Fazel et al., 2012), far less is known about how these vulnerabilities present and are addressed once refugee children reach specialist services. One of the few UK studies to examine refugee children within specialist mental health services compared 30 refugee children attending a single London child psychiatry clinic with matched non-refugee immigrant and White British clinical controls (Howard & Hodes, 2000). Refugee children experienced greater adversity and different referral pathways, but did not differ from comparison groups in the likelihood of receiving individual or family-based psychological treatment or premature treatment dropout. However, this small, single-site study was conducted in a specialist setting more than two decades ago, and contemporary evidence on how refugee children present and are treated within routine CAMHS remains limited. Prevalence estimates alone do not indicate which difficulties reach specialist services, how they are conceptualised, or what forms of intervention are delivered. Without empirical examination of current service practice, it is difficult to determine how mental health support for refugee families might be strengthened. Understanding how documented vulnerability is translated into clinical categorisation and treatment is therefore essential to interpreting the broader need–support gap.

Mapping current service responses serves several purposes. First, it describes the mental health presentations and diagnoses documented among refugee children who access specialist CAMHS, providing insight into how these difficulties are recognised and managed in routine clinical practice. Second, it examines whether treatment pathways differ according to age, gender,

immigration status and accompanied versus unaccompanied status, identifying potential variation in care within the CAMHS population. Third, it characterises treatment pathways, including psychological therapies, pharmacological interventions, parent-focused support and adaptations to routine care. Together, this approach moves beyond documenting access to specialist services to examine how refugee children's mental health needs are recognised and addressed within routine CAMHS.

Such analysis is particularly important in the context of constrained CAMHS capacity, where demand frequently exceeds available resources (Children's Commissioner for England, 2021; Valentine et al., 2024). Understanding how services respond to those who are able to access care is therefore a priority for policy and commissioning. The use of routinely collected electronic health records enables examination of real-world clinical practice at scale, providing broader coverage of routine service activity than is typically possible with smaller, researcher-recruited samples. It also allows multiple components of care (e.g., referral routes, diagnostic pathways, interventions, and outcomes) to be examined within a single dataset. This approach can identify barriers documented among children who reach specialist services, highlight potential missed opportunities for earlier identification (e.g., in schools or primary care) and reveal how services may already be adapting to meet the needs of refugee populations.

This chapter therefore addresses the first research question of the thesis by examining what mental health difficulties are identified among refugee children who access specialist mental health services in the UK and what treatments are offered in response. Using routinely collected electronic health record data from three NHS mental health trusts in England, the study characterises presenting problems, referral characteristics, treatment modalities, and documented outcomes within routine practice, and explores variation across demographic and migration-related subgroups.

By establishing how needs are currently recognised and responded to within specialist services, this chapter provides an empirical anchor for the subsequent qualitative exploration of parental and stakeholder perspectives. It addresses the service-level dimension of the overarching thesis aim and creates the foundation upon which questions of parental support, system alignment, and intervention development can be meaningfully examined.

2.2 Methods

Study Design

I conducted a multicentre retrospective cohort study using de-identified electronic health record (EHR) data accessed via the Clinical Record Interactive Search (CRIS) system at three NHS mental health trusts in England: (a) Oxford Health NHS Foundation Trust (OHFT), (b) Nottinghamshire Healthcare NHS Foundation Trust (NOTTSHC), and (c) Hampshire and Isle of Wight Healthcare NHS Foundation Trust (HIOW). Sites were selected pragmatically based on data availability and feasibility. Additional trusts were approached through Akrivia Health, but two further applications could not proceed because of data availability and software constraints. Data were accessed through the Akrivia Health Data Research Platform (Akrivia Health, Oxford, UK) under NHS service agreements.

CRIS provides secure access to routinely collected secondary mental healthcare data, including structured fields (e.g., demographic information and referral sources) and unstructured free-text clinical documentation such as assessment summaries, correspondence and progress notes. These clinical records contain detailed information on presenting symptoms, clinical history, treatment provision, medication use and recorded outcomes (https://crisnetwork.co/). Although structured diagnostic fields are available within CRIS, these were not routinely completed within the participating services and therefore diagnoses were extracted from free-text clinical documentation.

Supported by a multidisciplinary team, I used NLP-assisted processing of free-text records to facilitate the manual extraction of presenting problems, referral information, treatments, adaptations and outcomes; procedures are described below. The study period spans clinical notes from August 2011 to April 2026, with coverage varying by trust: OHFT (December 2011–April 2026), NOTTSHC (May 2016–May 2024), and HIOW (August 2011–April 2026). For OHFT, an initial extract covering records to August 2022 was subsequently updated to include data to April 2026. The final dataset includes information from 226 patients contributing to 14,850 distinct clinical documents. The study protocol and predefined analytic approach were preregistered on the Open Science Framework: https://osf.io/ef89p.

Cohort Selection

Eligibility Criteria

The study cohort was identified by NHS trust teams at each participating site according to predefined inclusion criteria. The cohort comprised refugee and asylum-seeking children and young people aged under 18 years, whose referrals were accepted for CAMHS assessment during the study period. The individual child was the unit of analysis. Where children had multiple CAMHS referrals or episodes of care during the study period, information across these contacts was synthesised into a single child-level analytical record, capturing presenting difficulties, referrals, interventions and outcomes across the child's documented CAMHS pathway.

Children were included in the refugee/asylum-seeking cohort if their records contained documentation of immigration status identified through a predefined free-text keyword search (including terms such as "refugee", "asylum", "asylum seeker", and "unaccompanied minor"). Records identified through keyword screening were manually reviewed to confirm eligibility. Refugees and asylum seekers were combined for primary analyses; where data permitted, exploratory summaries are presented separately for these groups.

Following screening and eligibility assessment, 183 children were included from Oxford Health NHS Foundation Trust, 35 from Nottinghamshire Healthcare NHS Foundation Trust, and 8 from Hampshire and Isle of Wight Healthcare NHS Foundation Trust (where a number of otherwise eligible records were excluded following routine information governance review; see Appendix A). These exclusions did not alter the study eligibility criteria or analytical approach but reduced the number of participants available for analysis from this site.

Data Extraction and Annotation

All processing of clinical free text was conducted within the secure Akrivia Health analytical environment, accessed through Amazon Web Services (AWS) Virtual Desktop Infrastructure (VDI), in accordance with applicable data-governance requirements (see Ethics and Governance). Python 3.10 scripts were used to prepare documents for annotation and export the resulting annotations. The

Prodigy annotation interface (version 1.11.14) was used to display documents and record manual text-span annotations.

Data were extracted from structured EHR fields and free-text clinical documentation, including assessments, correspondence, care plans and progress notes. Free-text clinical notes were first screened to identify potentially relevant documents using wildcard searches for predefined keywords (“asyl*”, “refug*”, “unaccompanied minor”). Matched documents were then manually reviewed against the inclusion and exclusion criteria described above. An annotation schema was developed to capture text spans corresponding to each target concept (e.g., presenting problems, treatments and outcomes, as defined below in section “Measures”). Concepts were operationalised as labelled text spans. Using the Prodigy annotation interface, annotators manually highlighted relevant spans and assigned predefined category labels. The annotation format permitted overlapping or nested spans where more than one concept occurred within the same passage.

Three annotators underwent structured training using a standardised set of records to support consistent application of the coding schema. In addition to myself, the annotation team included ET, a child and adolescent psychiatrist, and HC, a doctoral researcher with extensive experience working with clinical record data. Disagreements were resolved through discussion and, where necessary, adjudication by an additional reviewer. No automated information-extraction model was trained or used to assign labels; all text spans used in the analyses were identified and labelled manually by human annotators. The final annotations were exported into a structured tabular format for contextual review and statistical analysis.

Measures

Coding of Analytical Variables

Annotated text spans were subsequently mapped into predefined analytical variables using coding frameworks developed specifically for this study. The frameworks provided operational definitions and decision rules for classifying presenting mental health problems, diagnoses, treatments, treatment adaptations, treatment outcomes, referral sources and reasons treatment was not received. Initial coding informed iterative refinement of the analytical framework to ensure categories

adequately reflected the clinical records, after which all annotated data were reviewed and mapped to the final coding framework. Where multiple references to the same construct occurred across a child's electronic health record, information was synthesised at the patient level using predefined coding rules. Coding frameworks are provided in the Appendix (Tables B1–B6). Annotated spans were interpreted within their surrounding clinical context before being mapped to child-level analytical variables. Presenting-problem categories were coded according to the definitions and decision rules in the final coding framework. Treatment and outcome information frequently required interpretation across multiple documents and was therefore manually re-reviewed against each child's clinical record to verify coding in context and resolve ambiguities arising from individual text spans.

Sociodemographic and Referral Characteristics

Demographic variables included age at first recorded CAMHS referral, gender, ethnicity, immigration status (e.g., refugee or asylum seeker) and accompanied versus unaccompanied status, where recorded. Referral source (e.g., general practitioner, school or social care) was extracted from structured fields, while the individual or organisation identifying concerns about the child's mental health (e.g., parent, teacher or social worker) was extracted from free-text clinical documentation.

Presenting Mental Health Problems

Presenting problems were identified from free-text clinical documentation and reflected documented symptoms rather than formal diagnoses. These were mapped to categories within the Current View Tool framework (Jones et al., 2013), which captures provisional problem descriptions, complexity factors and contextual problems. Provisional problem descriptions were coded as binary indicators (present/absent) and were not mutually exclusive; children could contribute to more than one category. As the Current View Tool did not fully capture all clinically relevant presentations identified in this cohort, additional neurodevelopmental and transdiagnostic symptom categories were developed and applied alongside the existing framework (Appendix Table B6).

Diagnoses were extracted only where a formal mental health diagnosis had been explicitly documented and were mapped to ICD-10 categories. Previously documented neurodevelopmental diagnoses made by overseas services were retained where explicitly recorded, whereas overseas

mental health diagnoses were excluded because clinical presentation may change over time. Screening measures and symptom descriptions were not used to assign or derive diagnoses.

Treatment Variables

Treatments were identified from free-text clinical documentation and categorised using a predefined coding framework. Treatment receipt was first coded as a binary variable (received/not received). Among children who received treatment, treatment modalities were classified as direct psychological treatment (e.g., cognitive behavioural therapy), parent treatment, parent-mediated treatment, family therapy, psychotropic medication, other medication prescribed to manage symptoms relevant to mental health that did not constitute psychotropic medication, psychoeducation, professional consultation and liaison, other clinical support (such as occupational therapy), social prescribing, and referral to another service/team. For children not receiving treatment, documented reasons (e.g., treatment not indicated, awaiting assessment, declined treatment and service limitation) were extracted. Treatment modalities and documented reasons for not receiving treatment were not mutually exclusive. Treatment adaptations were extracted where explicitly documented and classified as interpreter support; translation or language adaptations (e.g., translated written materials); cultural or religious adaptations (e.g., gender-concordant clinicians); service delivery adaptations (e.g., home- or school-based appointments); treatment delivery adaptations (e.g., modified session structure); and cross-country or international liaison (Appendix Tables B1–B6).

Outcomes

Treatment outcomes were identified from narrative clinician documentation within free-text clinical records. Outcomes were coded at the child level using the most recent documented evaluation of treatment during the study period. Outcomes were classified as positive effect, mixed effect, no effect, negative effect, or outcome could not be determined (Appendix Tables B1–B6). Outcome evaluation was undertaken only for interventions where an individual treatment response could reasonably be assessed. Professional consultation and liaison, referral to other services, signposting and other indirect interventions were classified as CAMHS interventions but were not considered evaluable treatment outcomes. Where outcomes were unable to be determined, the documented reason

(e.g., treatment ongoing, treatment not commenced, treatment discontinued, transfer of service or insufficient documentation) was also recorded.

Statistical Analysis

All analyses were conducted using R (version 4.6.1). Categorical variables are presented as frequencies and percentages, and continuous variables as means (standard deviations) or medians (range) where appropriate. Missing data arose primarily from incomplete routine clinical documentation and were not imputed. Descriptive analyses report the extent of missingness where relevant, while inferential analyses were conducted using complete cases for the variables included in each analysis. To examine differences in treatment according to patient characteristics, treatment receipt, treatment modalities, reasons treatment was not received were compared across age group (≤11 years; >11 years), gender (male/female), immigration status (refugee/asylum seeker), and accompaniment status (accompanied/unaccompanied). Parent treatment, parent-mediated treatment, and family therapy were combined into a single parent or family-focused intervention category because of small cell counts and conceptual overlap. Group differences were assessed using Pearson's chi-square tests. Expected cell counts were examined for each comparison and were ≥5 for all analyses. All statistical tests were two-sided. Odds ratios (ORs) with 95% confidence intervals (CIs) were reported to describe the magnitude and precision of associations. For the pre-specified subgroup analyses, Bonferroni correction was applied to account for multiple comparisons (32 tests), with statistical significance defined as $p < .0016$.

Ethics and Governance

This project was conducted in accordance with the ethical and governance requirements across all participating trusts. Approval to access and analyse pseudonymised patient data was obtained from the relevant Research and Development departments and CRIS oversight committees at OHFT, NOTTSHC, and HIOW. The CRIS database operates under generic Research Ethics Committee (REC) permitting the secondary use of anonymised electronic health records for approved research. As the present study was conducted within these existing governance frameworks, separate REC approval was not required.

2.3 Results

A total of 226 refugee and asylum-seeking children and young people were identified (Table 2.1). Hereafter, 'children' refers to the full cohort of children and young people unless specific age groups are stated. The cohort was predominantly male (70.8%), with a mean age at first CAMHS referral of 12.6 years (SD = 3.6); 64.2% were aged over 11 years. Over half were recorded as asylum seekers (53.5%), and two-thirds were accompanied by a parent or carer (67.7%). Participants originated from a wide range of countries and regions, with Afghanistan, Syria, Ukraine, Iran, Sudan and Iraq representing the most common countries of origin (Appendix Table C1).

Table 2.1

Demographic Characteristics of the Study Cohort

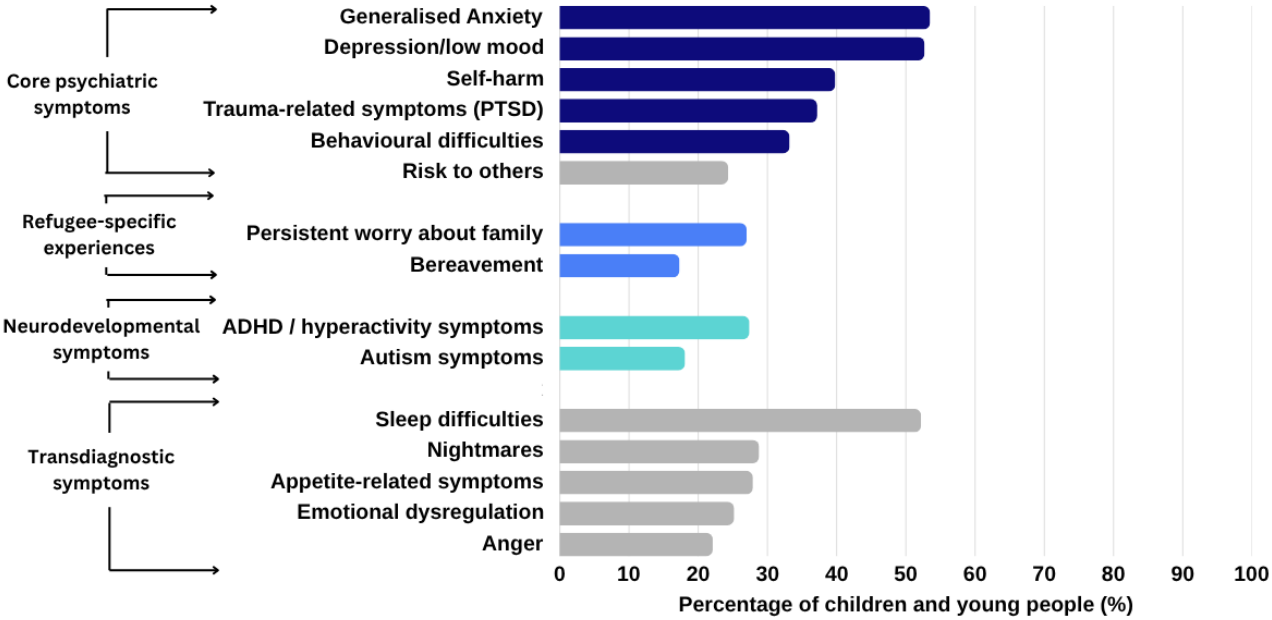
Characteristic	***n* (%) or *M* (*SD*)**
Total	226 (100.0)
Gender	
Male	160 (70.8)
Female	66 (29.2)
Age at first referral, years (n = 222)	12.58 (3.55)
Range	4 –17
Age group	
≤ 11 years	76 (33.6)
> 11 years	145 (64.2)
Unknown	5 (2.2)
Ethnicity	
White	29 (12.8)
Black	23 (10.2)
Asian	37 (16.4)
Mixed	17 (7.5)
Other	72 (31.9)
Unknown	48 (21.2)
Immigration status	
Asylum seeker	121 (53.5)
Refugee	91 (40.3)
Unknown	14 (6.2)
Accompaniment status	
Accompanied	153 (67.7)
Unaccompanied	69 (30.5)
Unknown	4 (1.8)

Presenting Mental Health Needs

Most children had multiple mental health symptoms documented, with a median of 7 distinct presenting symptom categories per child across their complete CAMHS record (IQR = 4-10, range = 0 - 30). Generalised anxiety (53.5%), depression/low mood (52.7%), self-harm (39.8%) and trauma-related symptoms (37.2%) were the most frequently documented mental health presentations (Figure 2.1). Refugee-specific experiences were also frequently recorded, particularly persistent worry about family members remaining overseas (27.0%) and bereavement (17.3%). Common transdiagnostic indicators included sleep-related difficulties, with sleep disturbance documented for around half of the children (52.2%) and nightmares for over one quarter (28.8%), alongside appetite-related symptoms (27.9%), emotional dysregulation (25.2%) and anger (22.1%). Neurodevelopmental concerns were also documented, including attention/hyperactivity difficulties (27.4%), autism-related symptoms (18.1%) and broader neurodevelopmental symptoms (15.9%). The complete distribution of presenting symptoms is provided in Appendix Table D1.

Figure 2.1

Common Presenting Mental Health Symptoms and Difficulties Among Refugee and Asylum-seeking Children



Documented Mental Health Diagnoses

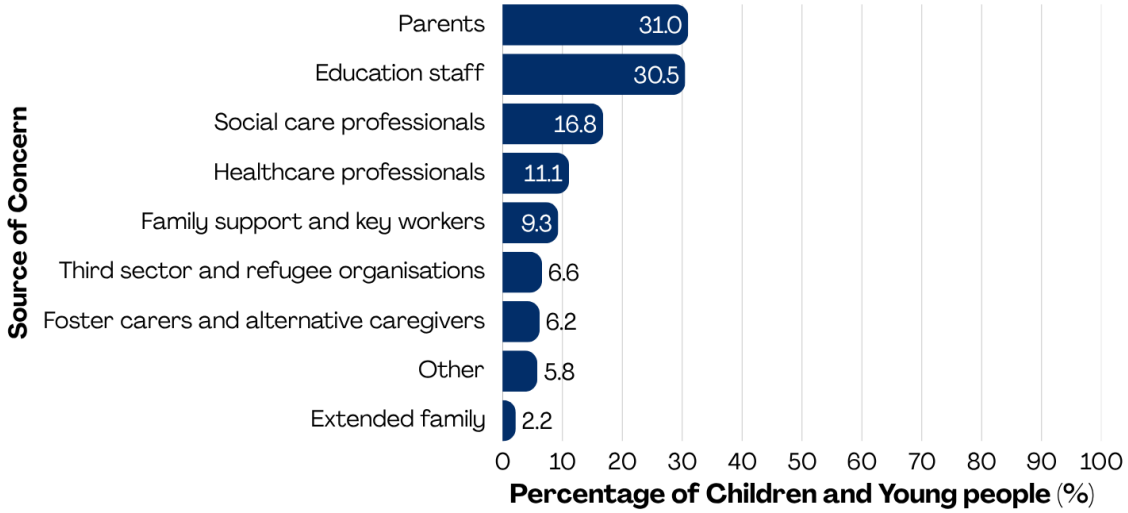
Only 36 children (15.9%) had at least one documented diagnosis, with a median of one diagnosis among those diagnosed (range = 1- 4). Autism spectrum disorder and attention-deficit/hyperactivity disorder were the most frequently documented diagnoses (6.6% each). Of the 36 children with a documented diagnosis, at least 12 (33.3%) had been diagnosed prior to arrival in the UK. Clinical records documented requests to verify overseas diagnoses and obtain translated clinical documentation before ongoing management could continue (e.g., "...if these are not in English, please can we kindly ask that these are translated"). Other records described uncertainty regarding the recognition of previous diagnoses within UK services, with several children undergoing reassessment before ongoing management or prescribing could continue, resulting in delays or interruptions to medication while specialist review was awaited. In contrast, relatively few mental health diagnoses were recorded despite the high frequency of documented mental health symptoms. The complete distribution of diagnoses is presented in Appendix Table E1.

Sources of Concern Prompting CAMHS Referrals

A median of one individual or service was documented as having raised concerns about each child's mental health (range = 0–7). The most common individuals or organisations identifying concerns were parents (31%), education staff (30.5%) and social care staff (16.8%) (Figure 2.2).

Figure 2.2

Documented Sources of Concern About Children's Mental Health



Referral Sources

Structured referral information was available for 222 children (98.2%) and missing for four (1.8%). Among children with available data, there was a median of two referrals (range = 1–11), originating from a median of one referral source type (range = 1–6). Most children (63.5%) had a single referral source; 36.5% had referrals from multiple sources (Table 2.2). General Practitioners (GP) were the most common referral source (39.6%), followed by social services (24.3%) and referrals from other CAMHS or mental health services (23.9%).

Table 2.2

Documented Referral Sources to CAMHS

Referral source	***n***	**%**
Healthcare services		
General Practitioner (GP)	88	39.6
Other CAMHS/Mental Health Service	53	23.9
Other NHS service	28	12.6
Emergency Department/Acute services	20	9.0
Education		
School/Education	40	18.0
Social care and justice		
Social Services	54	24.3
Justice System	9	4.1
Other		
Service/Agency (non-NHS)	21	9.5
Self-referral (young person/carer/relative)	15	6.8

Mental Health Treatment

Overall, 116 children (51.3%) received at least one documented CAMHS intervention at any point during their CAMHS care (Table 2.3). However, despite the majority of children presenting with emotional difficulties (for which evidence-based interventions often involve psychological interventions delivered to the child; e.g., NICE, 2013, 2018, 2019), only 46 children (20.4%) received any one-to-one therapeutic intervention delivered directly to the child. These psychological interventions ranged from stabilisation and supportive work (e.g., emotion regulation, coping skills

and play therapy) to evidence-based psychological interventions, including Eye Movement Desensitisation and Reprocessing (EMDR) and, less frequently, Narrative Exposure Therapy (NET) and Cognitive Behavioural Therapy (CBT). Therapeutic work involving parents or carers was even less common: 11 children (4.9%) received treatment mediated through a parent or carer, psychological treatment delivered directly to a parent or carer was documented for 11 (4.9%), and family therapy for two (0.9%). Parent-mediated work involved supporting parents to implement strategies targeting their child's difficulties, for example around sleep, eating, anxiety and coping. Treatment delivered directly to parents included parent support or therapeutic groups, such as anxiety and post-diagnostic groups and a Compassion After Trauma group. Psychotropic medication was documented for 24 children and adolescents (10.6%), including antidepressant, antipsychotic and ADHD medication, while other medication, predominantly for sleep difficulties (e.g., melatonin), was documented for 16 (7.1%).

More commonly, CAMHS intervention comprised of professional consultation and liaison (34.5%), referral to another service or team (29.2%) and 'other' clinical support (19%), which predominantly involved safety planning following self-harm, and crisis telephone support. Professional consultation and liaison primarily involved schools, social workers and other professionals supporting the child's care, while referrals commonly involved internal CAMHS teams, neurodevelopmental services, social care, community organisations and voluntary sector services. Signposting frequently directed families to refugee-specific organisations, schools and community mental health resources.

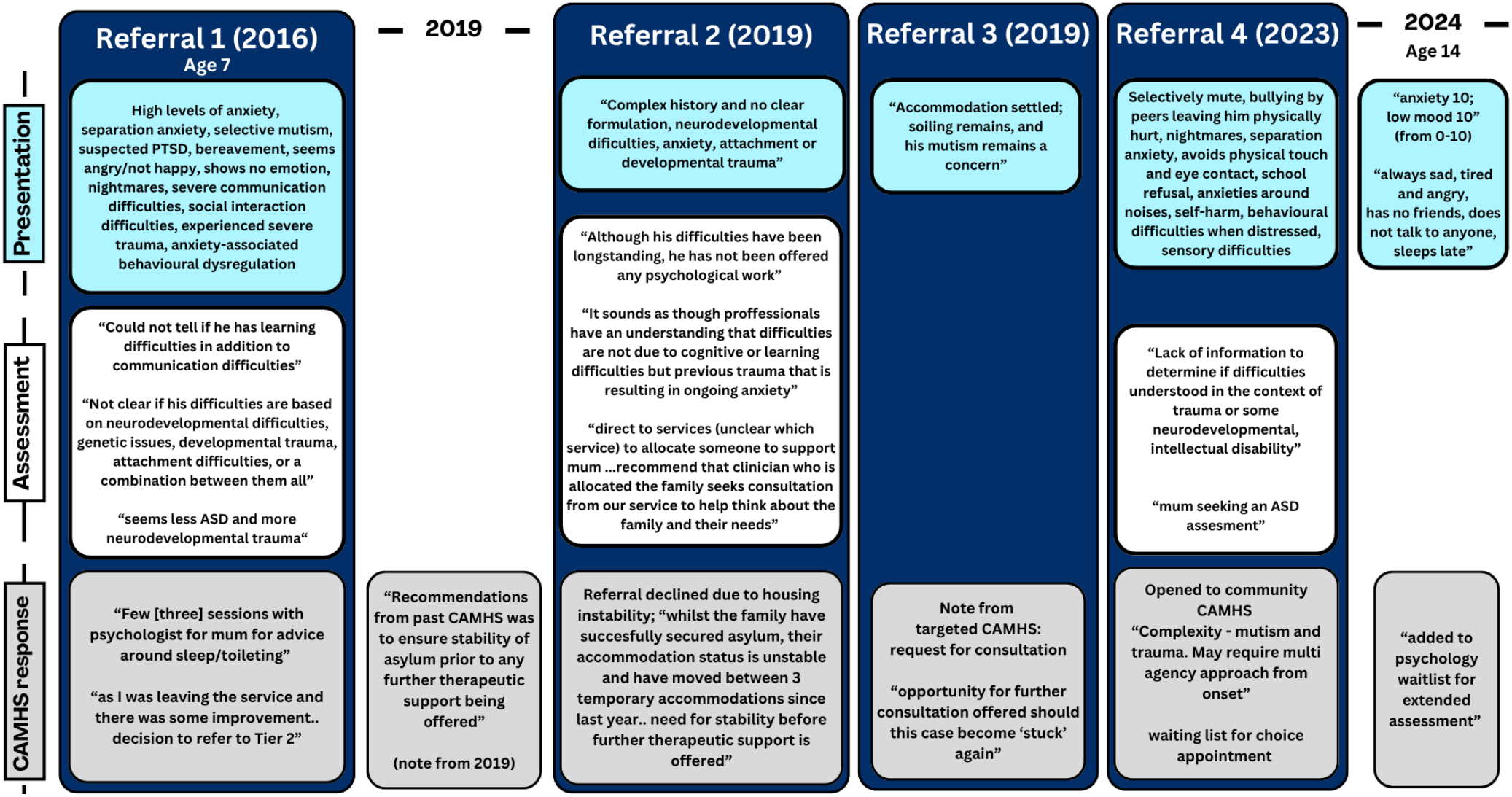
Among the 109 children without documented treatment by the end of the study period, the most frequently recorded reason was that treatment was considered 'not indicated' (47.7%). In most such cases, clinicians contextualised children's emotional and behavioural difficulties as understandable responses to war, displacement and ongoing resettlement and recommended wider psychosocial support rather than CAMHS treatment. Accordingly, signposting was documented for 43.1% of children who received no treatment, most commonly to refugee-specific organisations, schools and community resources; signposting alone was not classified as treatment received.

Across the whole cohort (N = 226), clinical records also documented factors influencing treatment provision (Table 2.4). In contrast to Table 2.3, which reports reasons among children with no documented treatment, Table 2.4 captures factors affecting treatment provision at any point across the CAMHS pathway, including among children who subsequently received treatment. The most frequently documented factors were treatment being considered ‘not indicated’ (35.4%), patient (or their parents) declining treatment (17.7%) and non-attendance or discontinued engagement (13.3%). Among children who disengaged from or declined treatment, clinicians frequently documented reluctance to revisit traumatic experiences. Separately, for 17 patients (7.5%), a lack of stability was explicitly documented as a reason for not providing psychological intervention at any stage of care. This could overlap with treatment being recorded as ‘not indicated’, while other children subsequently received treatment as their care pathway progressed. Figure 2.3 illustrates one child’s pathway through CAMHS, demonstrating how repeated referrals and continuing instability could extend across several years.

Clinical records also highlighted language barriers limiting parents' participation in parenting programmes and engagement with written resources. Other families expressed reluctance to engage with statutory services because of fear or mistrust. Service limitations were explicitly documented for 14 children (6.2%) and included limited specialist expertise, restricted capacity to deliver recommended therapies and uncertainty regarding available treatment pathways. Service eligibility criteria were documented for 19 children (8.4%) and included age restrictions, diagnostic or severity thresholds, and children’s needs falling outside the remit of particular services or teams.

Figure 2.3

Example of a Child's Referral Pattern and Repeated CAMHS Contact



Note. Blue panels represent documented CAMHS referral episodes; entries outside these panels represent relevant clinical documentation occurring between referrals or at the last recorded contact. Clinical-record extracts have been condensed for presentation.

Table 2.3

Assessment Completion, Treatment Receipt and Treatment Modalities (N = 226)

	n	**%**
Assessment completed	180	79.6
Treatment received	**116**	**51.3**
Direct psychological treatment (child)	46	20.4
Psychological intervention delivered to parent	11	4.9
Parent-mediated psychological intervention	11	4.9
Family therapy	2	0.9
Psychotropic medication	24	10.6
Other medication	16	7.1
Psychoeducation	27	11.9
Professional consultation and liaison	78	34.5
Other clinical support	43	19
Social prescribing	17	7.5
Referral to another service/team	66	29.2
No documented treatment received	**109**	**48.2**
Awaiting assessment or treatment	22	20.2
Did not engage or attend	10	9.2
Declined treatment	10	9.2
Treatment ‘not indicated’	52	47.7
Service limitations	5	4.6
Accessibility or practical barriers	2	1.8
Signposting	47	43.1
Service eligibility criteria	6	5.5
Transfer of care or relocation	10	9.2
Missing information/unclear	5	4.6
Missing	1	0.4

Note. Treatment categories are not mutually exclusive. Reasons for no documented treatment are calculated among children with no documented treatment (*n* = 109).

Table 2.4

Factors Documented at Any Point in the CAMHS Pathway as Reasons for Treatment Not Being Received (N = 226)

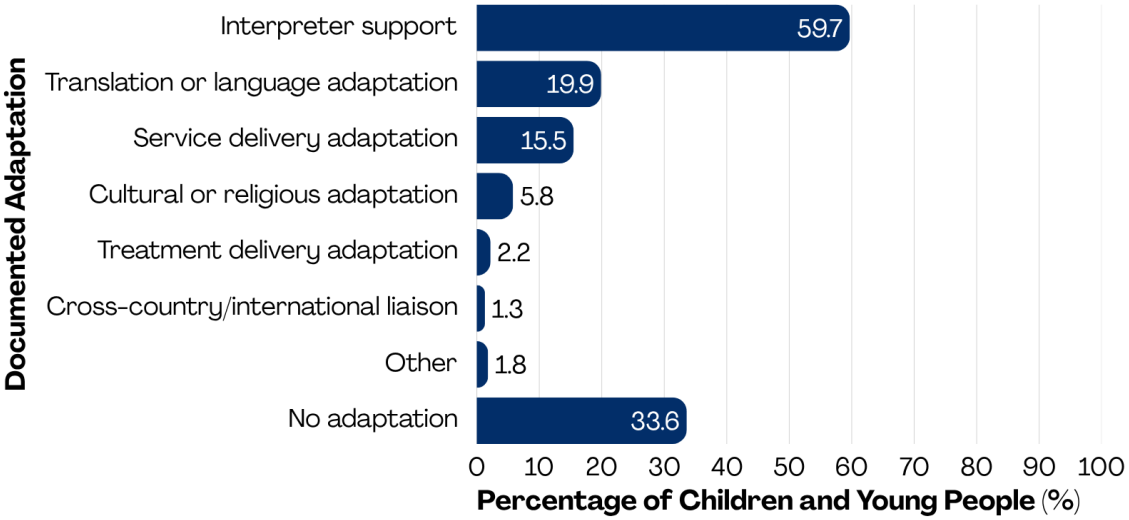
Documented reason for treatment not being received	***n***	**%**
Treatment ‘not indicated’	80	35.4
Declined treatment	40	17.7
Did not engage or attend	30	13.3
Transfer of care or relocation	26	11.5
Does not want to relive memories	22	9.7
Service eligibility criteria	19	8.4
Treatment deferred due to instability	17	7.5
Service limitations	14	6.2
Accessibility or practical barriers	10	4.4

Adaptations to Assessment and Care Delivery

Adaptations to care were common, with a median of one documented adaptation per child across their CAMHS record (range = 0–6). CAMHS arranged interpreters for 135 children and/or their parents or carers (59.7%), making it the most frequently documented adaptation (Figure 2.4). Adaptations extended beyond interpreter provision and included translation of clinical correspondence, assessment materials and psychoeducational resources; modification of appointment format or location (e.g., school- or home-based appointments and video consultations); adaptations to therapeutic delivery (e.g., prioritising rapport building before trauma-focused work and modifying session frequency); culturally responsive care, including language- or gender-concordant clinicians and consideration of religious and cultural preferences; and cross-country liaison with overseas clinicians to clarify previous diagnoses, treatments and ongoing management.

Figure 2.4

Documented Adaptations to Assessment and Care Delivery



Treatment Outcomes

Across the cohort (N = 226), documented treatment outcomes could be determined for 25 children (11.1%; Table 2.5). Positive treatment effects were documented for 16 children (7.1% of the total sample), mixed effects for one (0.4%), six (2.7%) had no documented effect, and negative effects were documented for two (0.9%). Outcomes could not be determined for the remaining 201 children (88.9%). The most common reasons an outcome could not be determined were that no evaluable treatment had been provided or treatment was considered to be ‘not indicated’ (31.3%), the child was awaiting assessment or treatment (18.4%), care had transferred to another service or the CAMHS episode had ended (14.9%), or documentation was insufficient (12.9%).

Table 2.5

Documented Treatment Outcomes Across the Cohort (N = 226)

Outcome	***n* (%)**
Positive effect	16 (7.1)
Mixed effect	1 (0.4)
No effect	6 (2.7)
Negative effect	2 (0.9)
Outcome could not be determined	201 (88.9)

Differences in Treatment According to Patient Characteristics

Following Bonferroni correction for 32 comparisons (α = .0016), no differences in treatment receipt, treatment modality or reasons treatment was not received met the threshold for statistical significance across age, gender, immigration status or accompaniment status. However, sample sizes were pragmatically determined, rather than being based on providing power to detect clinically meaningful differences, and several patterns were observed. Children aged ≤11 years appeared to have lower observed odds of receiving direct psychological treatment (OR = 0.53, 95% CI [0.25–1.12]) and declining treatment (OR = 0.43, 95% CI [0.19–1.00]) than adolescents. Asylum-seeking children also appeared to have lower observed odds of receiving psychotropic medication than children with refugee status (OR = 0.42, 95% CI [0.17–1.07]). However, confidence intervals were wide, indicating considerable uncertainty around the magnitude of these differences (Appendix Table F1).

2.4 Discussion

This study provides a detailed description of the mental health presentations, referral pathways and patterns of care for refugee children within routine CAMHS in three areas in England using electronic health records. Children entered CAMHS with complex mental health presentations, including high rates of anxiety, depression, trauma-related symptoms and self-harm, yet relatively few received direct psychological intervention. Instead, care commonly comprised consultation, liaison, signposting and multi-agency working. Clinical records frequently described children's mental health difficulties as understandable responses to war, forced migration, family separation and ongoing resettlement. Together, these findings highlight a central tension: highly vulnerable children with complex mental health presentations reached specialist services, yet direct psychological intervention was often not considered indicated within the context of their ongoing circumstances.

Presenting Problems

Anxiety, depression, self-harm and trauma-related symptoms were prominent in this CAMHS cohort. The high frequency of anxiety, depression and trauma-related symptoms is consistent with previous systematic reviews based largely on community and epidemiological samples of refugee

children (Blackmore et al., 2020; Kien et al., 2019). These difficulties are also common in routine CAMHS populations, where self-harm or suicidality accounts for almost 40% of referrals and emotional and behavioural difficulties for around one-third (Evans & Huws-Thomas, 2020; Smith et al., 2018). Bereavement and persistent worry about and distress related to missing family members overseas were also frequently documented, reflecting the continuing influence of displacement on children's presentations.

Alongside these mental health difficulties, neurodevelopmental concerns were common and introduced additional complexity into assessment and ongoing care. Trauma, attachment, and neurodevelopmental presentations can share emotional, behavioural and interpersonal features (e.g., Davidson et al., 2022; Rutter et al., 1999; Sadiq et al., 2012), creating challenges for differential assessment and formulation and increasing the risk of diagnostic overshadowing or misdiagnosis (e.g., Sarr et al., 2025). Importantly, attachment disorders, trauma-related difficulties and neurodevelopmental conditions are distinct and may also co-occur, making careful developmental and contextual assessment particularly important (e.g., Minnis, 2013). For refugee children, this assessment may be further complicated by disrupted developmental and educational histories, unavailable previous clinical records, and assessment across languages. In the present study, these challenges were documented both when assessing new neurodevelopmental concerns and when attempting to verify diagnoses made before arrival in the UK. For some children with established diagnoses, requirements for verification or reassessment delayed ongoing management and prescribing, including continuity of medication. Forced migration may therefore complicate not only the assessment of neurodevelopmental difficulties, but continuity of established care across healthcare systems.

Clinical Response and Treatment

A key issue raised by the findings concerns how specialist services respond to psychological distress that is closely intertwined with continuing adversity. Clinicians frequently understood children's difficulties in the context of war, displacement and ongoing resettlement, and among children who did not receive treatment, almost half (47.7%) had treatment documented as 'not

indicated', with wider social or community support often recommended instead. Such contextual formulation is consistent with ecological approaches to refugee mental health, which emphasise the contribution of post-migration stressors to psychological distress (e.g., Miller & Rasmussen, 2010). The potential influence of refugee context on clinical interpretation has been raised previously in UK specialist services; Howard and Hodes (2000), for example, questioned whether knowledge of children's exposure to extreme adversity might influence how otherwise similar symptoms are diagnostically conceptualised. At the same time, anxiety, depression and trauma-related symptoms were prominent in this cohort, for which evidence-based psychological interventions are available (Cowling & Anderson, 2023; Lawton & Spencer, 2021; Molendijk et al., 2024). Understanding the context in which distress has developed is therefore distinct from determining how it should be addressed: distress may be an understandable response to adversity and still warrant psychological intervention (e.g., Schreyer et al., 2026).

The question of whether children needed to achieve greater stability before psychological intervention illustrates this complexity. For 17 children (7.5% of the total cohort), a lack of stability was explicitly documented as a reason for not providing psychological intervention at a particular stage of care. These cases included records referring to the need for a "safe and stable environment" or "asylum stability before trauma work". The emphasis on safety is consistent with phased approaches to complex trauma (Herman, 1992), however, evidence in adults with complex PTSD suggests that phase-based approaches are not consistently superior to trauma-focused treatment delivered without a preceding stabilisation phase (Lee et al., 2026). For refugee children specifically, trauma-focused interventions have been associated with reductions in post-traumatic stress symptoms despite continuing uncertainty around residence status (Nahlén Bose & Diaz, 2025; Unterhitzenberger et al., 2019). More broadly, psychological interventions have also been successfully delivered to children and families living with continuing adversity (Alzaghoul et al., 2022). For example, a family-based intervention delivered to Palestinian families in Gaza demonstrated improvements in adolescent and family outcomes despite ongoing exposure to political violence (Miller-Graff & Cummings, 2022). For refugee children, psychological and contextual needs may therefore be addressed concurrently rather than assuming that social adversity must first be resolved before psychological

treatment can begin, consistent with layered and multi-tier approaches that combine community, psychosocial and specialist mental health support according to need (Ellis et al., 2013; IASC, 2007).

This emphasis on children's wider circumstances was also evident in the care documented within CAMHS. Signposting and referrals frequently directed families towards social care pathways, including MASH and Team Around the Family (TAF), alongside recommendations for school and voluntary sector support (e.g., "sufficient concern to warrant CAMHS assessment… but social care should explore first"). This is consistent with ecological approaches recognising that children's mental health cannot be separated from their family and social environments (Bronfenbrenner, 1979). Yet the records also indicated that these forms of support were not always readily accessible to families. For instance, quotes from within the clinical records illustrated how language barriers restricted participation in some parenting programmes (e.g., "mum would like to go to the parent group again as she only understood about 50%"), while some quotes illustrated how families declined support from social services for fear of their children "being taken away" and repeated referrals documented continuing concerns after wider support had been recommended. Thus, while addressing children's wider social circumstances may be an appropriate component of care, its effectiveness depends on whether families can access, engage with, and benefit from the services to which they are directed.

Against this context, direct one-to-one psychological intervention was documented for only 20.4% of children, while even fewer received parent-mediated or parent-focused psychological interventions. Psychological provision was heterogenous, ranging from stabilisation and supportive approaches to structured trauma-focused interventions. Without a non-refugee CAMHS comparison group, it is not possible to determine whether this level of provision differed from that experienced by other children with similar presentations. Earlier UK clinical evidence provides some historical context. Howard and Hodes (2000) found no significant differences between refugee, non-refugee immigrant and White British children in receipt of individual psychological or family-based treatment within a single specialist London child psychiatry service. However, comparisons with the present study are limited by the small sample, different service context and treatment classifications, and substantial changes in CAMHS and refugee populations since that study was conducted. Evidence from routine CAMHS also provides some context; in STADIA, approximately 40% of children and

young people referred with emotional difficulties were offered an intervention within 12 months (Sayal et al., 2025), although receipt of direct psychological intervention was not reported separately.

Importantly, the records suggest that the range of interventions available was not determined by clinical presentation alone. Service limitations (6.2%) and eligibility criteria (8.4%) documented constraints relating to capacity, specialist expertise, age and service remit, while some records explicitly linked treatment options to clinicians' training in particular approaches. Variation between services in the allocation and outcomes of care has also been identified across child mental health services more broadly (e.g., Edbrooke-Childs et al., 2017) and may be especially relevant for refugee children, given geographical variation in refugee- and UASC-specific provision in England, from dedicated specialist pathways to reliance on looked-after-child, local-authority or third-sector provision (Armitage et al., 2022; Yim et al., 2025). These findings suggest a need for clearer evidence and guidance to support consistent treatment selection and equitable access to appropriate psychological intervention within routine CAMHS.

Alongside questions of treatment availability, the findings highlight challenges around engagement with psychological interventions once refugee children reach specialist services. Across the cohort, treatment was declined by children and/or their parents in 17.7% of cases, while non-attendance was documented for 13.3%. One specifically documented concern was reluctance to revisit traumatic experiences, recorded for 9.7% of the total cohort. This proportion should be interpreted in the context of the full cohort, which included children for whom trauma-focused intervention was not under consideration. Trauma-related avoidance is well recognised among trauma-exposed children and may create additional barriers to disclosure and engagement with trauma-focused intervention (Cervin et al., 2021; Danese et al., 2020). These engagement challenges are not unique to refugee children. Indeed, earlier UK clinical research found no greater premature treatment dropout among refugee children than matched non-refugee immigrant or White British CAMHS patients, albeit in a single specialist clinic (Howard & Hodes, 2000), suggesting caution in interpreting disengagement as a refugee-specific phenomenon. Similar difficulties are reported among other vulnerable groups, including children in care, where treatment may end prematurely in the context of placement instability or disengagement (Phillips et al., 2023). For refugee children, engagement also occurs

within the wider context of forced migration and, for those seeking asylum, immigration procedures in which difficult or traumatic experiences are likely to have already been recounted (van Os et al., 2020). Evidence of mistrust towards services and authorities among some refugee families also suggests that engagement may be shaped by how safe and trustworthy support is perceived to be (e.g., Colucci et al., 2015; Essex et al., 2022). Continuity, careful pacing and avoiding unnecessary repetition may therefore be important not only in reducing the burden of repeated disclosure, but in establishing the trust required for psychological work.

Language also shaped how routine CAMHS care had to be delivered. Interpreter support was the most frequently documented adaptation and provided for almost 60% of the cohort, alongside translated materials and other language adaptations. The inclusion of interpreters is consistent with wider evidence that linguistic discordance can complicate assessment, therapeutic relationships and engagement in refugee mental healthcare (Gadeberg et al., 2017; Hanft-Robert et al., 2023), suggesting that interpreter-mediated practice is not peripheral but a core component of care for this population.

Finally, evaluating the effectiveness of CAMHS care for refugee children was challenging. Formal mental health diagnoses were documented for only 15.9% of children, and treatment outcomes could only be evaluated for 11.1%. Although clinicians clearly recognised and formulated children's distress, formal diagnoses were infrequently documented and routine records seldom included repeated disorder-specific outcome measures. This limits the extent to which clinical change can be evaluated using electronic health records. The extent to which this picture is specific to refugee children remains unclear, as challenges in obtaining longitudinal outcome data are longstanding within routine CAMHS. A case-note audit across three English CAMHS services found baseline and follow-up outcome measurement in fewer than one fifth of cases (Batty et al., 2013), while a more recent prospective audit found paired routine outcome measures for 46–60% of cases closed to the service (Gibbons et al., 2021). Although the present study took a broader approach to determining treatment outcomes than relying on standardised measures alone, this illustrates the wider difficulty of evaluating clinical change from routinely collected CAMHS data. Particular difficulties evaluating mental healthcare from routine records have also been highlighted for other particularly vulnerable or

'complex' groups, such as children in care (Phillips et al., 2023; Sayal & Hiller, 2025). These wider service limitations may be particularly consequential when evaluating refugee children's care, which frequently comprised indirect and contextual interventions without readily measurable individual outcomes. More consistent diagnostic assessment and routine outcome measurement would therefore help clarify children's needs and strengthen evaluation of CAMHS care.

Implications for CAMHS

Refugee-responsive CAMHS care requires psychological and contextual needs to be considered together. Children's difficulties were frequently understood within the context of displacement and continuing adversity, but contextual formulation should inform rather than determine decisions about mental health interventions. Where wider support is recommended, greater attention is needed to whether families can realistically access and engage with it. Schools, social care, voluntary organisations and refugee-specific services may play important roles alongside CAMHS, but the present findings highlighted that language barriers and fear of services could limit families' engagement with these forms of support. Signposting or referral should therefore be accompanied, where needed, by practical support to facilitate access and coordination between services alongside, rather than as a substitute for, indicated psychological intervention.

The findings also support the need for clearer and more consistent pathways to evidence-based psychological care for refugee children. Anxiety, depression, trauma-related symptoms and behavioural difficulties were prominent in this cohort, and effective psychological interventions including child, parent and family focused approaches are available for these presentations (Cowling & Anderson, 2023; NICE, 2018, 2019). Importantly, as discussed above, continuing adversity does not necessarily preclude their use (e.g., Alzaghoul et al., 2022; Nahlén Bose & Diaz, 2025). Psychotropic medication was documented for 10.6% of the cohort. Although symptom documentation does not establish an indication for medication, pharmacological treatment forms part of evidence-based management for several presentations observed in the cohort (e.g., NICE, 2013, 2018, 2019). The records also highlighted potential complexities in continuing medication initiated overseas,

including requirements to verify previous diagnoses and treatment before prescribing could continue within UK services.

For psychological intervention specifically, the findings highlight a need to reduce the extent to which access to evidence-based care depends on local service configuration or individual clinicians' expertise. Clearer guidance is needed to support treatment selection for refugee children within routine CAMHS, alongside access to appropriate training, supervision and specialist consultation where required. Given geographical variation in specialist provision, this may be particularly important in services without dedicated refugee or UASC pathways. Guidance should also address how evidence-based interventions can be delivered within the complex and continuing social circumstances experienced by some refugee children.

Finally, refugee-responsive care requires attention to how treatment is delivered. Interpreter-mediated assessment and therapy should be supported by appropriately trained interpreters, sufficient clinical time, translated and accessible resources, and clinician skills in working across languages and cultures. Greater continuity across services and minimising unnecessary repetition of traumatic histories may also support engagement. Together, these findings suggest that improving care requires not a single refugee-specific intervention, but service pathways capable of combining appropriate psychological treatment with accessible contextual support and adapting delivery to the circumstances of refugee children and their families.

Strengths and Limitations

A major strength of this study is the use of routinely collected electronic health records from three NHS mental health trusts, providing one of the largest and most detailed descriptions of refugee children's care within CAMHS in England. Analysis of free-text clinical documentation captured information rarely available in structured datasets, including presenting problems, sources of concern, treatment adaptations, reasons treatment was not provided and barriers to engagement. The multicentre design increased cohort diversity, while the structured annotation and coding framework enabled consistent examination of multiple stages of care.

Several limitations should be considered. Findings depended on the completeness, accuracy and consistency of routine clinical documentation, and absence of documented symptoms, concerns, treatments, adaptations or outcomes should not be interpreted as evidence that they did not occur. Annotation was supported by structured coding frameworks, training and adjudication, so in line with the planned procedures, formal inter-rater reliability was not assessed. While conducting the study it became clear that treatment and outcome coding required greater interpretation than presenting symptoms, so this was manually re-reviewed against each child's clinical record. Finally, although bereavement and worry about or missing family members overseas were coded, other migration and refugee-specific experiences, such as asylum uncertainty, were not systematically captured. The findings therefore do not provide a comprehensive account of migration-related concerns documented within CAMHS.

This study specifically aimed to provide a detailed description of refugee children's interactions with CAMHS. However, the absence of a non-refugee CAMHS comparison group means that the study cannot determine whether observed patterns of presentation, treatment or service use differed from children attending CAMHS more broadly. Subgroup analyses were also exploratory and likely underpowered to detect clinically meaningful differences, particularly for less common treatments and smaller subgroups. Generalisability is further limited by pragmatic site selection and variation in local service configuration, specialist trauma provision, interpreter availability and clinical pathways. The Hampshire and Isle of Wight cohort was reduced following information-governance exclusions, while incomplete ethnicity recording precluded meaningful analyses by ethnic group. As OHFT contributed 183 of 226 participants, the overall findings may be weighted towards care documented in this trust. Treatment effectiveness could be evaluated for only a small proportion of the cohort, limiting conclusions regarding comparative effectiveness.

Methodological Challenges and Opportunities of Routine Clinical Records

Routine clinical records also created methodological challenges that could not be fully addressed within the study design. First, the cohort represents refugee children whose referrals progressed to CAMHS assessment and therefore cannot characterise unmet need among children who

were never referred or whose referrals did not reach this stage. Second, refugee and asylum-seeking status was not systematically recorded within CAMHS. Case identification therefore depended on clinicians documenting relevant terminology, meaning children whose status was not recorded could not be identified. Eligibility required evidence that the child had themselves experienced forced migration; being born in the UK to refugee parents or referral to refugee-specific support without documented refugee or migration history was insufficient for inclusion. This may have disproportionately identified children whose migration or displacement experiences were considered clinically relevant, while missing refugee children for whom these experiences were less prominent in the clinical record. Consequently, the cohort may not be representative of either the wider population of refugee children requiring mental health support or all refugee children accessing the participating CAMHS services.

The amount of documented information also differed between children. Those with longer or more intensive CAMHS contact generated more clinical documentation and consequently had greater opportunity for symptoms, barriers, adaptations and interventions to be recorded. Conversely, children with brief contact or early disengagement may have fewer documented needs or components of care simply because there was less opportunity to observe them. Referral count could not adequately account for this variation because referrals differed substantially in duration and intensity. The study therefore describes what was documented across each child's available clinical record rather than equivalent observation periods, and symptom frequencies should not be interpreted as standardised prevalence estimates.

The long study period introduced further complexity. Service configuration, clinical guidance, documentation practices, and the populations of refugees arriving in England changed over time, while data coverage also differed between trusts. These temporal and site effects could not be fully disentangled within the available data. Similarly, synthesising care at the child level enabled complex pathways to be described across multiple records but necessarily reduced temporal information; the sequencing, duration and recurrence of referrals, interventions and outcomes could not be examined systematically.

These limitations illustrate the trade-off inherent in using routine free-text records. They provide unusually rich insight into real-world clinical reasoning and care across large samples, but the data are generated for clinical rather than research purposes and therefore cannot fully control who becomes observable, what is recorded, or for how long. Manual record review, structured coding and multicentre sampling reduced some sources of uncertainty, but could not eliminate these underlying features of retrospective EHR research.

Future Research

Clinical records included in this study indicate that it is likely that refugee children may face particular challenges in accessing targeted treatments within CAMHS, for example, based on reference to lack of availability of clinicians with the required expertise to work with this group of children. However, future research should directly compare refugee and non-refugee children within CAMHS to establish whether differences in clinical presentation, treatment pathways and outcomes persist after accounting for age, clinical need and service context.

Prospective longitudinal research is also needed to understand how care pathways develop over time. Following children across referrals and episodes of care would help establish how changes in post-migration circumstances, and clinical presentation relate to treatment decisions, engagement and outcomes, and identify when opportunities for intervention arise or are missed.

Further research is needed to guide the selection and timing of psychological interventions for refugee children experiencing continuing adversity. Although evidence-based interventions already exist for many of the anxiety, depressive, trauma-related and behavioural difficulties observed in this cohort, and emerging evidence suggests that trauma-focused treatment can be effective despite ongoing adversity (e.g., Nahlén Bose & Diaz, 2025), important questions remain regarding which approaches are most appropriate for which children, how interventions should be adapted or combined with contextual support, and whether or when greater stability is required before treatment begins.

Finally, methodological research should also improve the identification of refugee and asylum-seeking children within electronic health records and develop more robust approaches to

extracting treatment and outcome data. More consistent diagnostic assessment and routine outcome measurement would further strengthen service evaluation and comparisons of treatment effectiveness across CAMHS.

2.5 Conclusion

This study provides a detailed description of refugee and asylum-seeking children's mental health presentations and care within routine CAMHS in England. Children presented with complex mental health presentations, yet psychological interventions, including child- and parent-focused approaches, were relatively infrequently documented, with care commonly involving consultation, liaison and wider multi-agency support. These findings highlight the need for stronger evidence to guide the selection and delivery of psychological interventions for refugee children experiencing continuing post-migration adversity within routine CAMHS.

The findings also point to parents as central to children's pathways through care. Parents were the most commonly documented source of concern, and were involved in care through parent-mediated and parent-focused interventions, as well as in accessing wider community, social and parenting support. However, electronic health records provide a predominantly clinician-documented account of these processes. While they can identify patterns of parental involvement and documented barriers to care, they cannot explain how parents themselves understood their children's difficulties, what shaped their responses and help-seeking, or how they experienced and navigated available support. Addressing these questions therefore requires qualitative methods capable of examining parents' perspectives and the processes underlying the patterns observed in Study 1.

Parents' perspectives may be particularly important for understanding how mental health needs are recognised and addressed among preadolescent children. Although parents remain important sources of recognition and support throughout childhood and adolescence (Radez et al., 2021; White et al., 2024), younger children are particularly reliant on parents and other adults to recognise and interpret their difficulties, support them to understand and articulate their experiences, and facilitate help-seeking (Maddox et al., 2025). Study 2 therefore narrows the developmental focus while shifting the methodological approach, using qualitative interviews to examine how parents of

refugee and asylum-seeking children aged 3–11 years understand and respond to their children's mental health needs following resettlement.

Chapter 3: Refugee Parents' Experiences of Supporting Their Children's Mental Health Following Resettlement

3.1 Background

As outlined in Chapter 1.4, childhood represents a period of heightened vulnerability in the context of forced displacement, as cumulative exposure to adversity increases the risk of psychological difficulties and may disrupt developmental processes central to emotional regulation and adaptation (Bronstein & Montgomery, 2011; Shonkoff et al., 2012). While research on the prevalence of psychiatric disorders in refugee children remains limited, the small evidence base suggests substantial mental health difficulties, with some reports indicating problems affecting up to 80% of refugee children aged 8 years and under, including symptoms of anxiety, depression, post-traumatic stress, and behavioural difficulties (Frounfelker et al., 2020; Murray, 2019). These vulnerabilities may extend beyond mental health symptoms: a systematic review of forcibly displaced children aged 0–6 years identified difficulties across social-emotional and cognitive domains, including family and peer relationships, play, learning and language development, shaped by factors including repeated adversity, parental separation, parental distress and resettlement conditions (Bernhardt et al., 2024). More broadly, childhood mental health difficulties are associated with adverse health, social and educational outcomes over the life course (e.g., Schlack et al., 2021). Supporting early mental health needs in children affected by conflict and displacement is therefore a key global health priority (Dominguez et al., 2026; Yildirim et al., 2026).

Across childhood, the family environment represents a primary context through which children's mental health is shaped and supported (Bush et al., 2020; Chrisman & Dougherty, 2014; Cox & Paley, 2003). Parental support and involvement play a crucial role in moderating children's responses to adversity, helping children make sense of their experiences and re-establish feelings of safety and belonging (Murphy et al., 2017; Tol et al., 2013). However, parents' capacity to provide such support may itself be constrained by post-migration conditions, including financial and language difficulties, cultural dislocation, unfamiliarity with host systems, loss of social support, prolonged uncertainty and their own experiences of loss (Bryant et al., 2018; Drummond Johansen et al., 2025),

which can undermine parental confidence and limit engagement with available support services. At the same time, refugee parents may themselves experience significant psychological distress (Giallo et al., 2017), within a wider context of elevated rates of PTSD and depression among adult refugees and asylum seekers compared with general populations (Blackmore et al., 2020). This creates a dual burden, as parents must manage their own emotional experiences while supporting their children's adjustment to resettlement, and the strong association between parental and child mental health further highlights the importance of understanding these processes within the family context (Kelstrup & Carlsson, 2022; Sangalang & Vang, 2017).

Despite this, relatively little is known about how parents of refugee children understand and respond to their children's mental health needs in resettlement contexts. Existing parent-focused research has tended to examine parenting experiences within specific refugee populations or particular aspects of parenting and resettlement (e.g., Huntley et al., 2021; Kimathi, 2025; Omata & Habash, 2025), rather than how parents recognise, understand and respond to their children's mental health needs across heterogeneous refugee populations. Less attention has been given to parents' lived experiences of recognising, interpreting, and responding to early mental health difficulties in everyday contexts. Understanding these processes is essential for identifying barriers to support, informing the development of culturally responsive interventions, and ensuring alignment between family needs and service provision. This study therefore explores how parents of refugee and asylum-seeking children understand and respond to their children's mental health needs following resettlement in the UK.

3.2 Methods

Study Design

I used semi-structured qualitative interviews as part of the ENRICH study to capture parents' understanding of their children's mental health needs as well as their experiences of managing those needs. I conducted interviews between July 2023 and February 2024.

Participant Recruitment and Sample Characteristics

Parents of refugee and asylum-seeking children (aged 3-11 years) were recruited through refugee charities, local communities and local authorities. Participants were initially recruited using

convenience sampling followed by purposive and maximum variation sampling methods to increase heterogeneity across characteristics including country of origin, language, immigration status, length of resettlement, parental education and geographical location within the UK. The resulting sample also included parents from diverse cultural, religious and ethnic backgrounds. Inclusion criteria for the study were i) refugee or seeking asylum in the UK (based on persecution or fear of persecution due to race, religion, nationality, political opinion, or membership in a particular social group); ii) parent/carer to at least one child aged 3-11 years; iii) 18 years or over; and iv) currently living in the UK and arrived within the last 3 years. The sample size was determined based on the principle of information power [the more information relevant to the study aim that a sample holds, the fewer participants are needed (Malterud et al., 2016)], balancing inclusion of variation in parental and child mental health, country of origin, urban vs rural location in the UK, visa status, parental education, child age with practical constraints (e.g., study capacity and time constraints).

In total, 23 parents participated in the study. Most were mothers (n = 18) and were living in the South of England (n = 22), with one participant living in the West of England. Parents were aged 22–50 years and had arrived in the UK between 2 and 27 months before interview. They originated from Sri Lanka, Qatar, Afghanistan, Kurdistan, Syria, Sudan, Kuwait and Ukraine, and varied in immigration status, educational background and mental health status (Table 3.1). Four parents had travelled directly to the UK, while 19 had travelled via another country. No participants were members of the same wider family.

Parents discussed 41 children aged 3–11 years (M_{age} = 7.06, SD_{age} = 2.55) who had resettled in the UK. Participating families included 58 children in total, with parents having an average of 2.52 children, ranging in age from 7 months to 22 years.

Table 3.1

Demographic Characteristics of Refugee and Asylum-Seeking Parents and Their Child(ren).

Participant	Gender	Mental Health (parent)	Mental Health (child/ren)	Visa Status (child/ren)
P1	Female	Struggling	Fair	A/S
P2	Female	Neutral	Neutral	TPS
P3	Female	Struggling	Neutral	TPS
P4	Female	Struggling	Good	TPS
P5	AR	Positive	Excellent	ILR
P6	Female	Neutral	Good; Neutral	TPS
P7	Male	Neutral	Good	TPS
P8	Female	Positive	Good; Poor	TPS
P9	Male	Positive	Good	TPS
P10	Female	Positive	Good	TPS
P11	Female	Neutral	Fair	A/S
P12	Female	Struggling	Good	TPS
P13	Female	Struggling	Good	TPS
P14	AR	Neutral	Good; Poor	ILR
P15	AR	Positive	Excellent	ILR
P16	Female	Positive	Good	A/S
P17	Female	Struggling	Fair	A/S
P18	Female	Positive	Fair	A/S
P19	Female	Not sure	Good	A/S
P20	Female	Positive	Excellent	A/S
P21	Female	Positive	Good	A/S
P22	Female	Struggling	Fair	A/S
P23	AR	Positive	Excellent	ILR

Note. A/S = Asylum-seeker; TPS = Temporary Protected Status; ILR = Indefinite Leave to Remain; AR = Anonymised for Reporting; Gender information withheld to maintain anonymity. See Appendix H for more detail on Emotional Wellbeing Scale.

Measures

A screening questionnaire was used to assess parent (e.g., age, gender and education) and child demographics (e.g., age, gender and refugee status) and emotional wellbeing. Mental health was framed as emotional wellbeing to provide more accessible language, with minor refinements made to response categories during data collection, including replacing "fair" with "neutral". Participant information sheets were translated to Persian, Arabic and Ukrainian to reflect the languages commonly spoken by recently arrived refugees in the UK. Interpreters speaking Ukrainian, Kurdish, Arabic, Farsi/Dari, and Pashto dialects were recruited from charitable organisations or were University of Oxford students. All interpreters signed confidentiality agreements. A flexible topic guide prompted discussions throughout the interview (see Appendix G). Topics included relevant contextual information such as parenting experiences in their home country, during migration and resettlement, child and parent mental health problems, and the impact and management of these problems.

Procedure

Flyers were distributed through social media (e.g., Twitter/X) and voluntary organisations, with paper advertisements used where applicable. To address barriers relating to fear of authority systems and interviews, participants could choose to have a charity volunteer present and/or bring an interpreter of their choice. Individual in-depth interviews were conducted in person (N = 11), via telephone (N = 10), or through Microsoft Teams (N = 2; one with video, one without). Eleven of the interviews were conducted individually and 12 with an interpreter present. Interviews were held in mutually agreed locations, including private university and community settings. Participants received a small financial reimbursement for their time. Interviews lasted approximately two hours (ranging from 45 to 130 minutes, M = 87.2 minutes) and were digitally recorded and transcribed.

Analysis

Data were stored and managed using NVivo (Mac version *14*) and analysed using Reflexive Thematic Analysis (RTA) following Braun and Clarke's six-phase approach to generate patterns of shared meaning in the dataset (Braun & Clarke, 2021; Jackson & Bazeley, 2019). This inductive, data-driven approach involved familiarisation with the data, generating initial codes, searching for

themes, reviewing themes, defining and naming themes, and producing the final report. RTA emphasises the role of researchers' subjectivity during the analytic process and encourages reflection and recognition of one's own assumptions and biases (e.g., Braun & Clarke, 2021). This reflexivity is particularly important in studies that aim to amplify the voices of socially marginalised groups, as it allows researchers to engage critically with power dynamics and their own positioning in relation to the data.

I led the data analysis but regularly met with the research team during the initial coding phase to facilitate data interpretation and reflect on how my prior experiences may have influenced shaping of the data. The team brought complementary perspectives, including clinical mental health experience (CC) and expertise in qualitative methods and psychological interventions (CC, SLH, LB) and community-based work with refugees (LR). These perspectives informed engagement with the data, and the team maintained detailed analytic notes and held reflexive discussions to support transparency and integrate multiple viewpoints. The thematic structure was developed iteratively over several meetings, including two in-depth coding meetings with CC, SLH and LB. This collaborative process encouraged the exploration of alternative interpretations of the data and a thorough examination of data extracts, ensuring a credible final interpretation.

Study Quality, Rigour & Reflexivity Statement

The four principles of qualitative research quality guidelines (sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance) guided this work (Yardley, 2000). Sensitivity to context was shown by focusing on the vulnerable status of refugees during recruitment, interviews, analysis, and dissemination. Due to the sensitive nature of the interviews, member checking was not performed, and participants were given the choice of their words not being quoted in this paper (which three participants chose). Commitment and rigour were ensured by recruiting a heterogeneous sample reflecting various refugee experiences (e.g., culture, faith, visa status, emotional wellbeing) and maintaining an audit trail to enhance rigour and transparency (Braun & Clarke, 2023). The aim was to use the identified needs and experiences of

parents to inform meaningful work including culturally sensitive interventions and supportive policies for refugee families promoting good mental health during resettlement.

Ethics

Ethical approval for the study was granted by the Oxford Central University Research Ethics Committee (Oxford CUREC; Reference: R86792/RE001). Given the vulnerable status of refugees, it was made clear that inclusion in the research study was entirely voluntary and would not affect their immigration status or their access to services provided by the referring organisation (if relevant). A risk of harm protocol was developed for this study. If participants appeared distressed during the interview, participants were provided the option to pause the interview, reschedule, or potentially stop completely. The interviewer could consult a clinical psychologist within the research group if there was a need to guide an interviewee to further healthcare after the interview, but no need for such assistance arose.

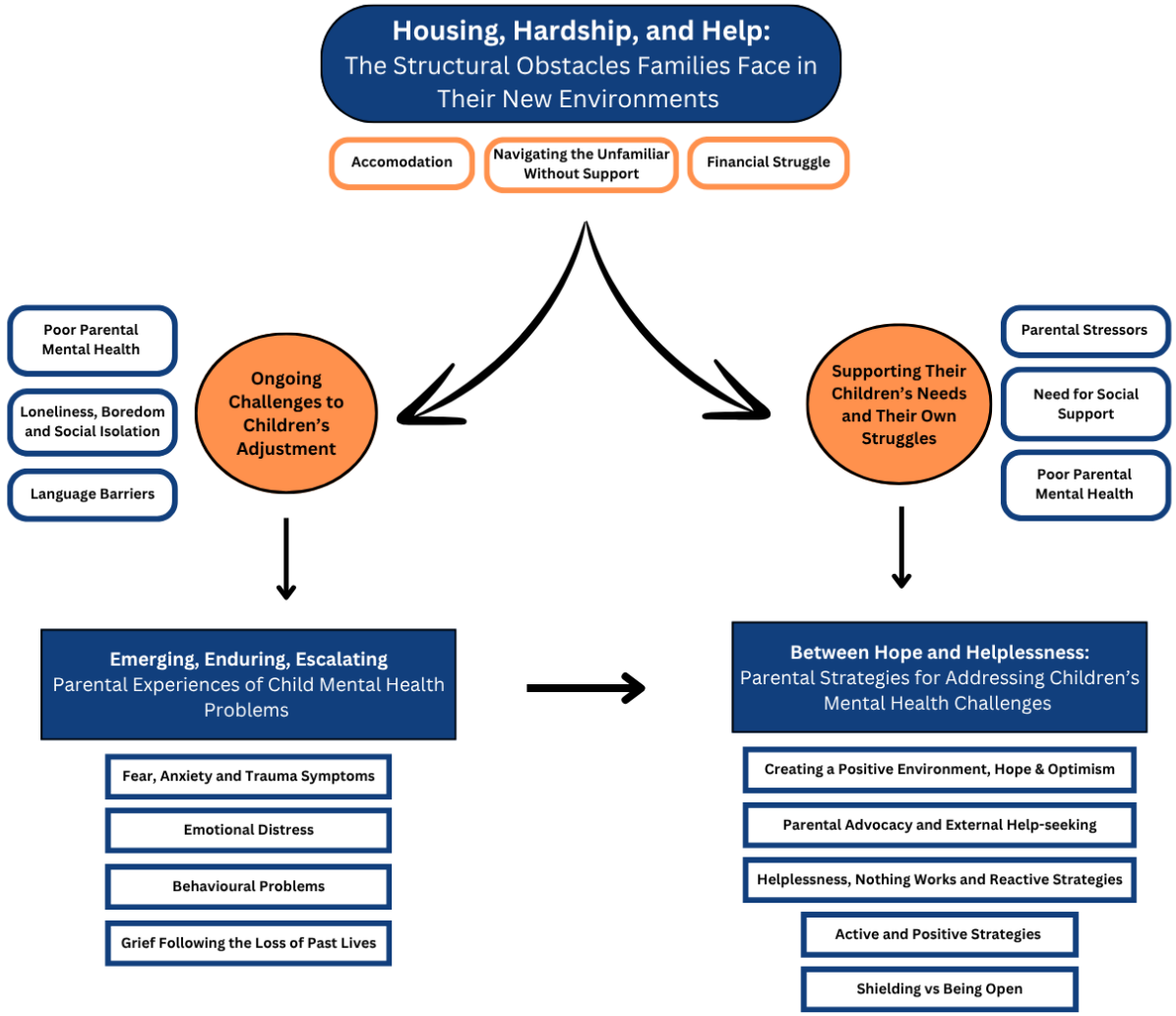
3.3 Results

Five themes were generated through RTA (Figure 3.1). Before presenting the themes, I first outline patterns in how parents described their children's mental health across the interviews. Parents' accounts revealed a notable distinction between initial, global ratings of children's mental health and the more detailed descriptions that emerged during interviews.

While many parents initially characterised their children's mental health in broadly positive terms (e.g., "good" or "excellent"), more nuanced accounts later revealed a range of emotional, behavioural, and trauma-related difficulties. As interviews progressed and rapport developed, parents often disclosed concerns such as anxiety, sleep disturbances, behavioural challenges, and, in some cases, more severe difficulties (e.g., stress-related alopecia, suicidal ideation). This pattern varied across families. Some parents maintained positive descriptions of their children's mental health throughout, suggesting relatively adaptive functioning. Others described increasing concern over time, with difficulties becoming more visible as trust developed, while a smaller group reported persistent or more severe challenges. Together, these accounts reflect both resilience and emerging expressions of distress across families.

Figure 3.1

Thematic Map of Parents' Experiences of Supporting Their Children's Mental Health Following Resettlement



Theme 1. Children's Mental Health: Patterns of Distress and Adaptation

Parents' accounts reflected a spectrum of adjustment following resettlement. Some children were described as adapting relatively well, particularly when they were able to access school and form friendships. Others showed mixed patterns of adjustment, with resilience in some areas alongside emotional or behavioural difficulties, while a smaller group were described as experiencing more persistent or severe challenges.

Narratives of Resilience

A subset of parents described their children as coping relatively well overall, particularly when key protective factors were present. Access to education, opportunities for social interaction, and the development of peer relationships were frequently associated with improvements in children's wellbeing. As one parent described, "[their mental health] also improved because they started going to school, they made friends, and they've learned about 20% English" (P19).

In some cases, children were described as demonstrating adaptability and emotional strength despite the challenges associated with displacement. One parent reflected, "it was easy... not easy, but my son smiled; he understood it all" (P7). Parents also highlighted the importance of family cohesion and emotional support, with expressions of love and stability within the family contributing to children's adjustment.

However, even among children described as generally coping well, some parents noted fluctuations in emotional or behavioural responses, suggesting that positive adaptation to their new environment did not necessarily preclude the presence of underlying difficulties.

Emerging Narratives of Distress

Alongside accounts of positive adaptation, many parents described a range of emotional, behavioural, and trauma-related difficulties affecting their children. These difficulties were described as emerging in some cases following migration "it was started when he left my country" (P1), or intensifying during resettlement in others "when we came here it was worse than usual" (P3). Across accounts, these experiences were often interconnected and shaped children's broader emotional and social adjustment.

Subtheme 1.1: Fear, Anxiety and Trauma Symptoms

Parents described various challenges their children faced due to past traumatic experiences, commonly reporting that their children experienced sleep difficulties, bed-wetting, flashbacks, nightmares, and phobias *"she was just having nightmares in the beginning. She was screaming the night some nights and awake up with the screaming. She also was suffering"* (P11). Some asylum-seeking parents, who preferred not to be quoted verbatim, noted that their children developed phobias

of water and trees, linked to, for example, traumatic Channel crossings. Children also showed fear of strangers and separation from parents, due to having been separated from other immediate and extended family members during migration and during resettlement "*When we separate from them, he cries loudly"* (P1). For some asylum-seeking families, separation difficulties emerged after prolonged periods in which children remained almost continuously with their parents while awaiting school places, making the subsequent transition into school and separation from parents particularly challenging.

These difficulties affected children's wider adjustment, often resulting in social and emotional withdrawal. One parent shared, *"if there is some kind of issue or problem… she doesn't open up… she comes home asking if she can wash her hands and then says can I just go into the room and be there by myself sometime"* (P12). School-related anxiety was also common, with one parent noting, *"he didn't understand anything and he was so anxious that every interaction he thought that it's some danger"* (P3), leading some children to refuse school altogether: *"he didn't want to go to classroom and he was hugging me and crying"* (P3). Fear of further change compounded their distress, leading to resistance to new transitions, as another parent observed: *"my children were scared about the change of the flat"* (P6).

Subtheme 1.2: Emotional Distress

Parents described observing signs of emotional distress in their children during resettlement. Many children appeared highly reactive, with minor frustrations or changes in routine often triggering intense outbursts. As one parent shared, *"when he starts something and doesn't get the result, he immediately gets frustrated…throws books or toys"* (P8). Other parents reported signs of depression, describing their children as frequently sad or tearful. One parent noted, *"he cries a lot…especially before bed" (P8),* while another stated, *"I think he got depressed"* (P1).

Subtheme 1.3: Behavioural Problems

Some parents reported significant behavioural problems including aggressive actions like hitting or biting other children at nursery. One parent noted, "*When she started kindergarten, she bit children—it was terrible"* (P2). Some parents also observed difficulties with social behaviours, such

as resistance to sharing toys or following instructions. As one parent described, *"He says, 'I don't want,' and that's all"* (P8).

Subtheme 1.4: Grief Following the Loss of Past Lives

Parents described how their children faced deep grief and a sense of emptiness upon arriving in the UK, struggling with the loss of their previous lives and connections. Separation from siblings, fathers, friends, and extended family created an emotional void; where one parent describes their child as seeking sibling-like bonds *"He tries to become friends with the girls. That means like his sister and brother. He calls them sister and brother. He needs them"* (P1). Many children frequently reminisced about their old lives, comparing them to their new reality. "*The older one has more memories…and he compares every time what he had and what he has*", a parent shared (P8). This sense of loss was often intensified by a feeling of not belonging, with children expressing a desire to return to their home country. One parent recounted *"[child says] I will not sleep here I want to go home"* (P4).

Theme 2: Ongoing Challenges to Children's Adjustment

This theme describes several factors that parents identified as shaping their children's mental health and adjustment, including language barriers; loneliness, boredom and social isolation; and poor parental mental health. These factors were also influenced by structural obstacles (theme 5) and contributed to a variation in children's experiences.

Greater exposure to social isolation, language barriers, and parental distress was often associated with poorer mental health outcomes. However, parents also described how improvements in these areas – such as access to school, opportunities for social interaction and increased stability, were associated with positive changes in children's mental health and adaptation. As such, these factors functioned not only as challenges, but also potential points of recovery and support.

Subtheme 2.1: Loneliness, Boredom and Social Isolation

While waiting for school enrolment, during school holidays and on weekends, many parents described that limited access to recreational activities left children spending much of their time at home, often in cramped spaces, which intensified feelings of boredom and loneliness. One parent noted, *"there are no hobbies for them to do in their free times"* (P20). Some attributed behavioural

issues to boredom; as one parent explained, *"when he can't find a game or something to do he starts to go to my daughter and he is doing something that she doesn't like, to take his toys or he can do something we don't like … he is doing because he don't know he doesn't know what to do "* (P4). Others expressed concern over excessive screen time, describing tablets as their children's *"only hobby, it's a big problem for me "* (P3). This lack of activity contributed to social isolation, making it difficult for children to connect with peers. One parent shared, *"she's lonely, a bit different than the rest"* (P11). Incidents of bullying further discouraged social interaction, as a parent recalled, *"he had some problems with another children, someone tried to bully him maybe two or three times"* (P9). This led some children to withdraw, with one child reportedly *"sitting in the toilets for long periods of time in school"* to avoid others (P14).

However, parents also described improvements in children's mood and behaviour when opportunities for social interaction increased, particularly through school attendance or engagement in activities. As one parent noted, *"They really like it [school]…they wake up in the morning themselves to go to school"* (P22). In these contexts, children were better able to form peer relationships and develop a sense of belonging. Access to structured activities also appeared beneficial; as one parent described, *"they have access to swimming pool classes… I think they have some sort of kids parties, churches that they go to. The school takes them on field trips to London. So that all contributed to their wellbeing"* (P19).

Subtheme 2.2: Language Barriers

Parents reported that their children's inability to communicate with others in social settings and at school affected their children's adjustment, limiting their ability to make friends and causing frustration. As one parent explained *"the language problem, they don't have any friends right now"* (P21). Children often felt alienated in class, unable to participate fully or understand instructions, which led to feelings of frustration: "*she doesn't know what they wanted from her and…she doesn't understand what she needs to do*" (P2). Conversely, as children's language skills developed, parents often observed improvements in confidence, peer relationships, and classroom engagement. As one

parent reflected, *"after she met her friends… now she is better, absolutely, because now she understood English and she can speak with everybody… that's why for her it's easier now"* (P10).

Subtheme 2.3: Poor Parental Mental Health

Refugee parents described how their own traumatic experiences stemming from war and displacement had affected their own mental health, which, in turn, had affected the children. One parent observed "*yeah sometimes this pressure also make our relationship worse because when I have some anxiety about something I put it in our family"* (P2). Stress and anxiety often reduced their ability to engage with their children, as another parent shared "*I was so stressed…I couldn't play. I was always with some thoughts, read news. I tried to decide what to do. ..and I couldn't pay attention to him. I think it was the worst period for him"* (P3). Children were sensitive to their parent's emotional states, with one parent noting *"If mama happy, my daughter happy"* (P10) despite a parents' efforts to conceal *"as much as you try to cover, but they feel it. They're not a robot"* (P11). As a result, parents describe their children changing or adjusting their behaviour or even attempting to comfort their parents. One child, distressed by a parent's tears, "*I can realise my son sometimes hitting me. Because I'm crying every time. He don't like me to cry all the time"* (P1).

Theme 3: Between Hope and Helplessness: Parental Strategies for addressing Children's Mental Health Problems

This theme describes parents employing a variety of strategies to manage their children's mental health problems during the resettlement process, drawing on a combination of approaches including creating a positive environment, hope and optimism, active and positive approaches, external resources and parental advocacy, as well as helplessness, reactive strategies and attempting to shield their children.

Subtheme 3.1: Creating a Positive Environment, Hope And Optimism

Many parents focused on fostering hope and optimism, emphasising the potential for a better future through education "*it's about how to create a better future for them, focus on their education and study"* (P15). Other parents highlighted the importance of a loving, accepting home: *"Just*

enjoying that there's a receiver at home who just accepts them …that's family and warmth and love" (P15).

Subtheme 3.2: Active and Positive Strategies

One prominent approach described by parents involved the use of active and positive strategies to address challenges. For instance, becoming their child's friend when they felt isolated *"when we arrived from Ukraine because he don't have friends here ... we try to be these friends"* (P9), or facilitating contact with family members and old friends. Some parents highlight the importance of providing a sense of normalcy and routine despite the barriers they faced *"And I try to make him timetable, you know, not to be boring and not to remember this [missing Ukraine]. So not to think a lot about it. So I try to make them busy"* (P8). Faith was also a source of strength, with one parent sharing, *"I try to fill that gap with faith…to make them stronger"* (P11). Parents described communication as a key tool available to them to help their children express emotions constructively: *"you must not control your emotion, but you must change your process how you show your emotion* " (P9). Some parents used incentives and reminders to keep children engaged and motivated with school *"we have two days [left of this week]. And then we have weekends, and we have holidays. And like this"* (P6).

Subtheme 3.3: Parental Advocacy and External Help-seeking

Some parents took an active role in seeking out resources and advocating for their children's needs, especially for those with additional needs, despite limited institutional support. One parent explained *"[mum] would go to the school to …explain to them that in order for her daughter to understand you need to be face-to-face with her and close to her to speak"* (P14). Where parents felt that their children's needs may require expertise beyond what they could provide, some sought external mental health support *"we request from doctor to introduce my kids for this kind of like treatments … like for socially to emotionally treatment"* (P20). However, parents faced delays *"it takes time I think about two years for them to receive an appointment"* (P14). Some felt discouraged by unfulfilled promises and ineffective support, particularly for children with additional needs as one parent shared, *"there have been promises of getting him checked…, but nothing has been done so far"*

(P5). Concerns about re-traumatizing their children *"I don't want to bring back these memories for my child that has already passed"* (P11) or stigmatisation from a mental health diagnosis also hindered help-seeking efforts.

Subtheme 3.4: Helplessness, Nothing Works and Reactive Strategies

Despite these efforts, many parents felt helpless when strategies to help their children fell short. One parent shared, *"any type of method they would try to like distract her …wouldn't work"* (P14). Parents described having no other options than just communicating with their child "*it's very hard but I think you must just communicate and try to speak again and again ... because we don't have another way"* (P9) or simply taking them outside to play. Others felt overwhelmed by their child's distress, sometimes crying alongside them *"it's very hard, sister. Sometimes I cry with him"* (P1). Parents described questioning themselves *"I don't know what should I do at that moment how he can release his feelings and emotions. I tried him to explain you can push the pillow or you can beat the sofa or something soft but he don't do it he doesn't do it so I don't know what is the reason"* (P4) when active strategies fail to yield results, while some resort to reactive measures, like punishment, when they felt unable to manage their children's emotional outbursts: *"I often punish him and…shout at him"* (P8).

Subtheme 3.5: Shielding vs Being Open

Parents grappled with whether to shield their children from parents' own struggles or to be open with them. Many chose to protect their children by not sharing stressful details "*I did not let her know all the problems happened with us because this is only between me and my husband. I don't want them to know these details. It's not good for them"* (P11). However, the impact of withholding information from their child was described by one parent "*Now my daughter asking you lie me. You cheat me. There's no any answer from me for my daughter's question"* (P1). To further shield them, parents also hid their own emotions, with one parent noting,*" because all the time I'm trying not to show them that it's difficult and I know that if I would show them they will feel the same"* (P14).

Theme 4: Supporting Their Children's Needs and Their Own Struggles

This theme incorporates various factors that parents described as influencing their ability to manage their children's mental health, with notable differences across immigration groups. Asylum-seeking parents faced significant challenges due to a lack of support, which intensified stress and hindered their ability to address their children's needs. Refugees, while still experiencing hardships, often had access to case workers who provided guidance. Ukrainian parents generally benefited from strong support from host families who assisted with resettlement and practical tasks. However, many Ukrainian mothers were resettled without their partners, placing additional emotional and logistical strain on mothers.

Subtheme 4.1: Parental Stressors

Parents described significant stressors that impacted their mental health as well as their capacity to support their children's mental health. Uncertainty about the future, worries for family left behind, and the constant demands of resettlement created ongoing strain as one parent described experiencing *"uncertainty in all my life* " (P3). The continuous need to adapt to a new culture and navigate complex systems left many parents exhausted *"every task seemed like a mountain to climb"* (P12), with less energy for their children " *he wants to have fun with me and I cannot do it. Because I'm always tense*" (P3). This constant state of vigilance and problem-solving could leave parents emotionally and physically exhausted, and parents reported reducing their interactions with their children in order to focus on other tasks or having to sacrifice their rest and sleep instead. Stress also strained marital relationships, which further affected the children causing insecurity and anxiety; one parent explained, " *[when] argued with my wife, my son hear all this and say, Daddy, you don't left us* " (P7).

Subtheme 4.2: Need for Social Support

All parents were separated from extended family and friends, while most were also separated from immediate family members including partners and other children. Most Ukrainian mothers described becoming a single parent overnight *"I don't like to feel like single parent and I'm not a single parent, but I had this role ... I didn't choose this role"* (P2). Many mothers, particularly those

parenting alone, struggled with the dual responsibility of managing their own emotional challenges while caring for their children. One parent expressed, *"It's hard ... at home in Ukraine, we had support from my mother, but here we don't have any"* (P9). This lack of support also led to increased stress and frustration, as parents found themselves unable to manage their children's behaviour as effectively: *"yeah can be like some bad behaviour from her side and I couldn't contain it because I have some on my own anxiety… when I had some problems with her … I can always leave and ask my husband to spend some time but here I don't have this possibility"* (P2). Temporary reunification with partners in Ukraine provided some respite *"I rested physically and psychologically"* (P3). Some parents also delegated tasks to older children for respite, while expectations of their children increased for others as one parent describes "*but I want him to be like my partner to discuss, to talk, uh, to make decisions"* (P8). Ukrainian parents appreciated the support from host families who became *"like relatives"* (P13).

Subtheme 4.3: Poor Parental Mental Health

Parents faced significant emotional challenges, which in turn affected their ability to address their children's emotional needs. Anxiety, panic attacks, social withdrawal and exhaustion were common, with one parent sharing, *"I don't want to wake up sometimes because it's hard"* (P7). Another described a partner's suicide attempt due to stress: "*He was hospitalised…he was trying to do suicide because he can't manage these situations*" (P1). Minor frustrations often triggered intense emotional reactions: *"Even small events…make me feel very angry and very sad"* (P3). This emotional strain left parents feeling distracted and unable to engage fully with their children, as one explained, "*I'm really free. But my mind is not good to do everything for him to make him happy. Because I was stressed"* (P1). Emotional strain also limited their ability to calmly support their children's needs, as one parent noted, *"I can't give her as much support in a calmer way"* (P2).

Theme 5. Housing, Hardship, and Help: The Structural Obstacles Families Face in Their New Environments

This theme describes several structural obstacles that negatively impact factors which influence child mental health as well as factors which influence a parent's ability to manage their

child's mental health problems. The theme consists of three subthemes including accommodation, financial struggle, and navigating unfamiliar processes. Living in hotels (specifically for asylum-seekers), delayed school enrolment, frequent relocations, parents not getting access to language classes, financial barriers, and a lack of support settling in (particularly for asylum-seekers) were described as particularly harmful.

Subtheme 5.1: Accommodation

Asylum-seeking parents described the cramped and restrictive living conditions in hotels, which strained families' physical and mental health. As one parent describes *"right now we have one double bed for me and my wife and the three kids have three separated beds at the same room*" (P21). Issues such as limited space, families co-sleeping in a single room, and restricted freedom of movement and autonomy were common, while lack of basic amenities (e.g., access to kitchen) and pest problems added further stress, as one parent reported, *"bugs are eating my daughter's skin"* (P19). These conditions were often described as exacerbating children's mental health issues. Co-sleeping led to separation anxiety, as one parent described *"here [mum]and [child] share one room.., so they are inseparable from evenings when they are nose to nose … when [mum] went to the Western Ukraine to visit her husband ..[child] would get upset, because [mum] would dedicate a bit more time to other people, and [child] would read it as some kind of betrayal, asking her to go back to the UK, where she has her mother completely to herself"* (P12). Asylum-seeking parents also struggled with children refusing to eat unfamiliar hotel food, due to not having a kitchen to prepare meals, which sometimes resulted in weight loss and food refusal. Additionally, the constant togetherness created relationship fatigue, with one parent sharing, *"she told me… I'm really tired of you, and I was also tired of her"* (P2).

Subtheme 5.2: Navigating the Unfamiliar Without Support

Unfamiliar processes, such as school enrolment and long waiting periods before school admission, often lasting several months, were significant stressors impacting children's mental health, contributing to boredom and loneliness. Parents had to depend on hotel or charity staff to handle school referrals, as one noted: *"The others have to do it for us, but we have to be patient until your*

time coming" (P11). The waiting period heightened parental anxiety, with one stating, *"we [parents] can say, we have a very high anxiety in that time because we don't know. Most important for the children is the school... I was thinking about school, school, school"* (P11). Additionally, asylum-seeking parents faced limitations, such as being ineligible for language courses until six months after arrival. This language barrier hindered their ability to support their children, particularly with schoolwork or communication with services, as one shared: *"[Mum] cannot help them because she does not understand any English, she cannot help their homework, and she cannot help with their meetings"* (P18). While all parents struggled with these challenges, resettled refugees often benefited from caseworker support, and many Ukrainian parents received assistance from host families with applications and other settling-in tasks: *"but my host family is really kind people and they help me very much... with documents, with bank, with all this together"* (P3).

Subtheme 5.3: Financial Struggles

Asylum-seeking parents described severe hardships, living on less than £9 per person per week, which increased parental stress and limited their ability to meet basic needs. One parent recalled, *"during ..very hard time we faced, we didn't have any single pence to buy milk for my son"* (P1). Although refugees were permitted to work, they faced significant challenges with limited job opportunities and benefit caps. Ukrainian parents similarly worried about employment, with one saying, "*I ask everyone, where do you work? Maybe I can work there also. So, yeah ... a big problem"* (P8). For some Ukrainian parents, initial rent coverage reduced stress. Financial difficulties impacted mobility and social opportunities; one parent noted, *"our village is very far from (town). The bus ticket I speak about this £6"* (P23). These challenges also limited access to activities for children as shared by an interpreter on behalf of a parent: *"[child] would love to have some dancing class to go to, unfortunately here in [town], this opportunity has not arisen. There was some offers, outside of [town], pay transportation, [mum] doesn't drive here"* (P12). Children comparing their lives to their peers added further emotional strain: *"they say oh mum we don't have these things... these sort of things sometimes make me sad"* (P21).

3.4 Discussion

This qualitative study explored parents' experiences of their asylum-seeking and refugee children's mental health problems as well as how parents manage such problems, synthesising perspectives from parents with various cultural, religious and immigration backgrounds. Refugee parents reported a variety of mental health problems experienced by their children (including anxiety, conduct problems, and sleeping difficulties). These problems were compounded and influenced by both psychosocial factors such as language barriers, social isolation and boredom (due to delay in school registrations and financial barriers) as well as structural obstacles including accommodation related issues and financial and logistical barriers. The themes also provide insight into how parents manage their children's mental health needs, revealing that while many parents employ a variety of strategies, ranging from active to reactive and help-seeking, their ability to do so is often constrained by environmental factors such as a lack of social support and structural obstacles. The resultant themes captured a broad range of parents' experiences, allowing us to identify implications for developing supportive policies and resources to facilitate parental capacity and ability to manage their children's mental health problems during early resettlement.

A key finding emerging from this study was the discrepancy between parents' initial ratings of their children's mental health and the more detailed difficulties described during interviews. While many parents initially characterised their children's mental health positively, subsequent accounts revealed a range of emotional, behavioural, and trauma-related challenges. Previous research has highlighted potential discrepancies in parent and child reporting of mental health difficulties among refugee children, as well as variation in how psychological distress is recognised and conceptualised (e.g., Maddox et al., 2025; Rousseau & Drapeau, 1998). The present findings suggest that children's distress may not be fully captured through brief or surface-level assessments and highlights the importance of considering how factors such as stigma, protective responding, and evolving trust may influence parental reporting.

Consistent with previous research (e.g., Kien et al., 2019; Scharpf et al., 2021), children were described as showing varied patterns of adjustment, with some demonstrating resilience despite the

disruptions associated with forced displacement. However, many also faced mental health problems stemming from experiences both pre-migration (e.g., rumination and sleep-related difficulties) and during migration (e.g., phobias linked to their journeys). These difficulties were often intensified, and new problems developed, due to current living conditions. In particular, living conditions varied considerably for different immigration groups who had differences in associated rights (e.g., asylum-seekers, those on refugee resettlement schemes, and families hosted by the Homes for Ukraine scheme). Asylum seekers were often placed in inadequate, cramped accommodation, with little autonomy, financial constraints and frequent relocations (e.g., Spira et al., 2025). These conditions were described to be particularly harmful for the mental health of asylum-seeking children, for example many parents reported that their children had developed separation anxiety, which impacted their adjustment to school and socialisation. Additionally, long delays in school enrolment left children isolated and bored, further intensifying mental health problems. Thus, the findings highlight the importance of considering children's wider circumstances in order to address mental health needs.

The findings also highlight the significant challenges parents face in managing their children's mental health, which are often exacerbated by limited social support, their own mental health problems, and difficulties accessing essential services such as healthcare and schools; all of which are particularly pronounced for parents of children with additional needs. This aligns with previous research showing an associations between poor post-migration stressors and poor health and wellbeing following resettlement (e.g., Sengoelge et al., 2022). Parents emphasised the crucial role of social support in alleviating these challenges, with Ukrainian families noting how host families often provided vital assistance and created a sense of community for both parents and children. Case workers offered guidance and support for refugees (variable by refugee scheme) and in some cases, charities provided support for asylum seekers. However, parents frequently lacked necessary resources unless they actively sought such support, which could be difficult without awareness and knowledge about how to navigate complex systems (e.g., Baker et al., 2019; Merry et al., 2017). Thus, the findings highlight a crucial gap in accessibility to mental health and community support underscoring the urgent need for more proactive support services.

Despite these challenges, parents described a range of intentional and adaptive strategies to support their children's mental health, from fostering hope to creating structure and routine. These efforts - often in the absence of formal support - reflect the commitment and resourcefulness of parents striving to protect their children's mental health in exceptionally challenging circumstances. This highlights an important opportunity for services to recognise and build on existing parental strengths in future service provision.

Strengths and Limitations

The use of in-depth interviews allowed for rich and meaningful insights into the experiences of parents of refugee children that have recently resettled in the UK. The use of a purposive sampling approach also enabled me to capture a diverse range of experiences, including mothers and fathers from different cultural, religious, and ethnic backgrounds, as well as different language groups, levels of education, and lengths of resettlement and immigration status in the UK. I collaborated closely with my team to ensure interviews and coding adhered to best practice guidelines (Braun & Clarke, 2023) while also bringing a mix of professional and personal experiences with migration and parenting to the analysis. This background offered nuanced perspectives on the data but also required ongoing reflexivity to minimise potential biases.

The study also has several limitations. I did not conduct diagnostic interviews to establish current or past mental health problems, instead relying on parents' reports of their children's mental health, which may be influenced by their own emotional state. Notably, during screening questionnaires, parents often described their children's mental health favourably (good or excellent). However, several discrepancies emerged between these initial accounts and the more detailed descriptions that surfaced later in the interviews. As parents became more comfortable, they sometimes disclosed more serious concerns, such as stress-related alopecia, or suicidal thoughts, suggesting that initial underreporting may have occurred. This discrepancy also highlights both the limitations of relying on brief screening-stage reports to characterise children's mental health and the potential for parental accounts to vary with context, trust and perceived consequences of disclosure. The sample was also predominantly drawn from the South of England, limiting the generalisability of

the findings to all refugees in the UK. Unique political and cultural contexts may apply to different UK regions. Additionally, the use of interpreters to support discussions may have introduced some bias, such as misinterpretations or a lack of nuanced translation, especially during telephone interviews.

Implications

The findings of the present study highlight significant opportunities to strengthen support for refugee parents in promoting their children's mental health and psychosocial adjustment. Providing proactive guidance and fostering support networks, such as community groups, peer-led initiatives, or culturally informed parenting programmes, can help alleviate parental stress, promote constructive parenting strategies, and offer advocacy and respite for families navigating complex resettlement challenges. Schools in particular were described by parents as critical to children's wellbeing, not only for learning and routine but also for building friendships and self-confidence. Bridging the gap between registering for and starting school with interim activities, community camps, or language-focused programmes could help reduce distress and anxiety during this transition. In addition, these findings suggest that relying solely on brief parent-report assessments may overlook important aspects of children's distress, highlighting the need for more context-sensitive and relational approaches to assessment in resettlement settings.

However, family-, community- and school-based support cannot be considered separately from the wider conditions in which families are resettling. The findings highlight ongoing practical and structural barriers - including inadequate housing, financial stress, delays in school registration, and limited early language support - that continue to impact both parental capacity and children's mental health. While broad structural change may be slow, targeted interventions at key touchpoints - such as fostering inclusive school environments or integrating mental health guidance into school and family interactions - offer realistic, meaningful steps. Improving access to local services can also support parents to engage more fully in their roles, form connections, and better manage both their own and their children's mental health.

3.5 Conclusion

This study explored refugee parents' experiences of managing their children's mental health during resettlement. The findings highlight that children's mental health difficulties, and parents' capacity to respond to them, are closely shaped by broader contextual factors, including housing instability, language barriers, and legal and systemic constraints. These difficulties are best understood as reflecting dynamic and context-dependent patterns of adjustment, rather than discrete or isolated problems.

These findings underscore the need for more proactive and contextually responsive support systems that address both psychosocial and structural barriers, and that strengthen parents' capacity to support their children's mental health during early resettlement. At the same time, parents' ability to recognise and respond to their children's needs is shaped not only by their own resources and experiences, but also by the accessibility and responsiveness of the wider systems in which they are embedded. Understanding how children's mental health needs are identified and acted upon therefore requires consideration of how frontline practitioners across sectors interpret and respond to these needs. The following chapter extends this analysis by examining how stakeholders understand and respond to the mental health needs of refugee children in the UK.

Chapter 4: Exploring Professional and Stakeholder Perspectives on Identification and Responses to Refugee and Asylum-seeking Children's Mental Health

4.1 Background

Building on the previous chapter, which examined how parents understand and respond to their children's mental health needs during resettlement, this chapter shifts focus to the wider systems within which these processes are situated. While parents play a central role in recognising and managing children's distress, their ability to act can be shaped by interactions with professionals and services across multiple sectors. Understanding how children's mental health needs are identified and acted upon therefore requires examination of both family-level and system-level processes.

Within resettlement contexts, children's psychological distress is addressed through interactions between families and the professionals who surround them. Refugee parents are often the first to notice changes in their children's behaviour; however, unfamiliarity with host-country systems, language barriers, stigma, and parents' own experiences of trauma and displacement can limit their ability to act on concerns (Byrow et al., 2020; Rousou et al., 2025). These barriers contribute to persistently low rates of formal mental health service use among refugee communities despite elevated levels of need (Barbo & Petrucka, 2024; Colucci et al., 2014; Satinsky et al., 2019).

Frontline practitioners across sectors - including education, healthcare, social care, and community-based organisations occupy important positions within the systems surrounding refugee children and families. Evidence from the World Health Organization (WHO) European Region highlights the importance of coordination between mental health services, schools, social workers and community organisations in identifying needs and facilitating pathways to appropriate support (Dumke et al., 2026). Refugee-sector organisations may additionally act as important connectors between newly arrived families and wider statutory and community networks (e.g., Käkelä et al., 2023). Through their contact with children and families, professionals across these sectors may therefore be well placed to recognise emerging difficulties, build trusting relationships and facilitate pathways to support. However, despite this central role, there remains limited understanding of how

different professional groups interpret and respond to children's mental health needs in practice, and how organisational and contextual pressures shape these responses (Dumke et al., 2026).

This study addresses this gap by examining how frontline stakeholders understand and respond to the mental health needs of asylum-seeking and refugee children during the early resettlement period. Adopting an inclusive, cross-sector approach, the study draws on perspectives from local authorities, third-sector organisations, health services, and both child and adult education, spanning roles from volunteers to chief executives. Bringing together these varied perspectives enables analysis of both the practical realities of frontline work and the organisational and policy-level factors that shape how children's needs are recognised and acted upon across systems. By foregrounding these perspectives, the study aims to identify both the opportunities and constraints practitioners encounter and to inform more inclusive, accessible, and contextually responsive models of support for refugee and asylum-seeking children and their families.

4.2 Methods

Study Design

I used semi-structured qualitative interviews as part of the ESTEEM study to explore professionals' and community stakeholders' perspectives on refugee children's mental health and service responses. The interviews were conducted between March and August 2024.

Participant Recruitment and Sample Characteristics

Participants were recruited using convenience sampling followed by purposive and maximum variation sampling for stakeholder roles, professional experience, location of families they support (urban vs rural / north vs south), and organisational context (e.g., charity vs governmental organisation). Sampling also aimed to capture experience across a broad range of migration contexts and immigration groups (e.g., resettled refugees, asylum-seeking populations, and families from recent humanitarian schemes). Inclusion criteria for the study required stakeholders to (1) have experience of providing support to school-aged children and/or their parents in a professional capacity, where the child is an asylum-seeker or refugee in the UK; (2) be 18 years old or over; and (3) be currently living and working in the UK. The focus on school-aged children reflects evidence

that childhood and early adolescence are key periods for the emergence of mental-health difficulties and for early identification and support (e.g., Solmi et al., 2022). The sample size was determined based on the principle of information power (Malterud et al., 2016). While focused studies with highly specific samples may require fewer participants, the heterogeneity of stakeholder groups in this study warranted a larger sample to capture a breadth of perspectives reflecting the diverse experiences of support provided to asylum-seeking, and refugee populations.

Data Collection

Participants were sent an information sheet prior to providing consent. A flexible topic guide was used to prompt discussion during the interviews (see Appendix I). Topics included stakeholders' roles in supporting refugee families, their perspectives on children's mental health problems and how parents manage these, as well as the support they are both able to provide and are constrained from providing.

Participants were recruited via flyers distributed through social media (e.g., Twitter/X), voluntary organisations and local authorities. Individual in-depth interviews were conducted via Microsoft Teams (N = 30). Participants received a small financial reimbursement for their time. Interviews lasted approximately one hour (ranging from 35 to 90 minutes, M = 54.1 minutes) and were digitally recorded and transcribed.

Analysis

Data were stored and managed using NVivo (Mac version 14) and analysed using RTA, following Braun and Clarke's six-phase approach to identify and interpret patterns of shared meaning across the dataset (Braun & Clarke, 2021; Jackson & Bazeley, 2019). This inductive, data-driven method involved familiarisation with the data, generating initial codes, searching for and reviewing themes, defining and naming the themes, and producing the final report.

I led the analysis while engaging in ongoing reflexive practice, including regular meetings with the wider research team whose disciplinary and experiential perspectives are described in Chapter 3. These discussions provided opportunities to consider alternative interpretations and reflect on how researchers' perspectives shaped engagement with the data. The thematic structure was

developed iteratively through three in-depth coding discussions with CC and LB, followed by review and feedback from SLH (see Table 4.1 for illustrative quotes). These collaborative exchanges facilitated critical interrogation of the data, consideration of alternative interpretations, and refinement of themes, contributing to a credible and analytically robust final analysis.

Table 4.1

Themes, Sub-themes and Illustrative Quotes.

Theme:	**Systemic Barriers to Mental Health Visibility and Support**	
Subtheme(s)	*Legal Status*	"I think there is a big grey area when someone is waiting for the asylum decision. It's a big problem because they're almost kind of invisible to services" [S18]
	Overstretched and Under-Resourced Services	"Access to healthcare is a quagmire of quicksand" [S22]
	Fragmented Support Networks	"There is help out there, but everything is so disconnected" [S10]
Theme:	**Understanding and Misunderstanding of Child Mental Health**	
Subtheme(s)	*Navigating Cultural Uncertainty: Between Sensitivity and Safeguarding*	"There's a level of anxiety around cultural inappropriateness or that whole language thing that is a huge barrier" [S5]
	Recognition Gaps: Overreliance on Visibility and Disclosure	*"*The first sign of somebody wanting and needing support is that they come through our doors during the drop-in hours and they ask for help or they call up and send a message" [S28]
	Feeling Unequipped: Training Gaps in Refugee Child Mental Health	"The main obstacle it's probably I don't know too much about mental health myself" [S4]
Theme:	**Variability in Stakeholder Support**	
Subtheme(s)	*Hands-on Help: Direct Mental Health Support Within Everyday Roles*	*"*We set up workshops for asylum seekers and the children, and we incorporate all these things which we discuss about mental health issues" [S21]
	Contextual Lottery of Informal Support	*"*What I'm currently working on is a befriending project, and one of the things that has sort of somewhat organically sprouted out from it is a parent's support group, because that's what parents want. They want to know other parents" [PS28]

	Aware but Powerless: Limits to Acting on Concerns	"As I said, I can feel they need help, but nothing in my hand" [S19]
Theme:	**Family Factors Shaping Engagement: Barriers and Enablers**	
Subtheme(s)	*From Caution to Confidence: The Slow development of Trust*	"We build a trust as well so they can really share their concerns" [S3]
	Silence Shaped by Fear and Stigma	"There's also quite a lot of fearfulness you know, what does this actually mean - I don't think it's you know the same sort of fear as you see with British families around you know social services get involved does that mean my child's being taken away" [S5]
	Language as a Structural and Emotional Barrier	"But when they haven't got the language, you've got to start right back from the beginning. Because it's really hard, even if the interpreter is there, it's really hard understanding" [S27]
	Parental Engagement: Readiness, Knowledge, and Capacity	"So sometimes we set a recommendation. We tell them this is our recommendation. You want us to help you. This is what you have to do. It's up to you to say yes or no." [S2]

Ethics

Ethical approval for the study was granted by the Oxford Central University Research Ethics Committee (Oxford CUREC; Reference: R86792/RE002).

4.3 Results

In total, 30 stakeholders provided informed consent and participated in the study (for demographics, see Table 4.2). Stakeholders were mostly female (N = 25), based in the Southeast (N = 14), Southwest (N = 2), Northwest (N = 3), Yorkshire and Humber (N = 7), and the Northeast (N = 4) of England. Stakeholders held a range of paid and voluntary roles across education, healthcare, local authorities, and voluntary and community sectors, including housing officers; community and outreach workers; trustees and chief executives of third-sector organisations; child and family therapists; integration managers; community inclusion coordinators; English for Speakers of Other Languages (ESOL) and school teachers; safeguarding and policy practitioners; family support and early help workers; and befriending volunteers. Stakeholders had an average of 7 years of professional experience working with refugee populations (ranging between 1 and 26 years). Table 4.2 describes stakeholder characteristics including sector of employment, length of professional experience, and role category, while illustrative job titles and employment groupings are detailed in Appendix J.

Table 4.2

Demographic Characteristics of Stakeholders.

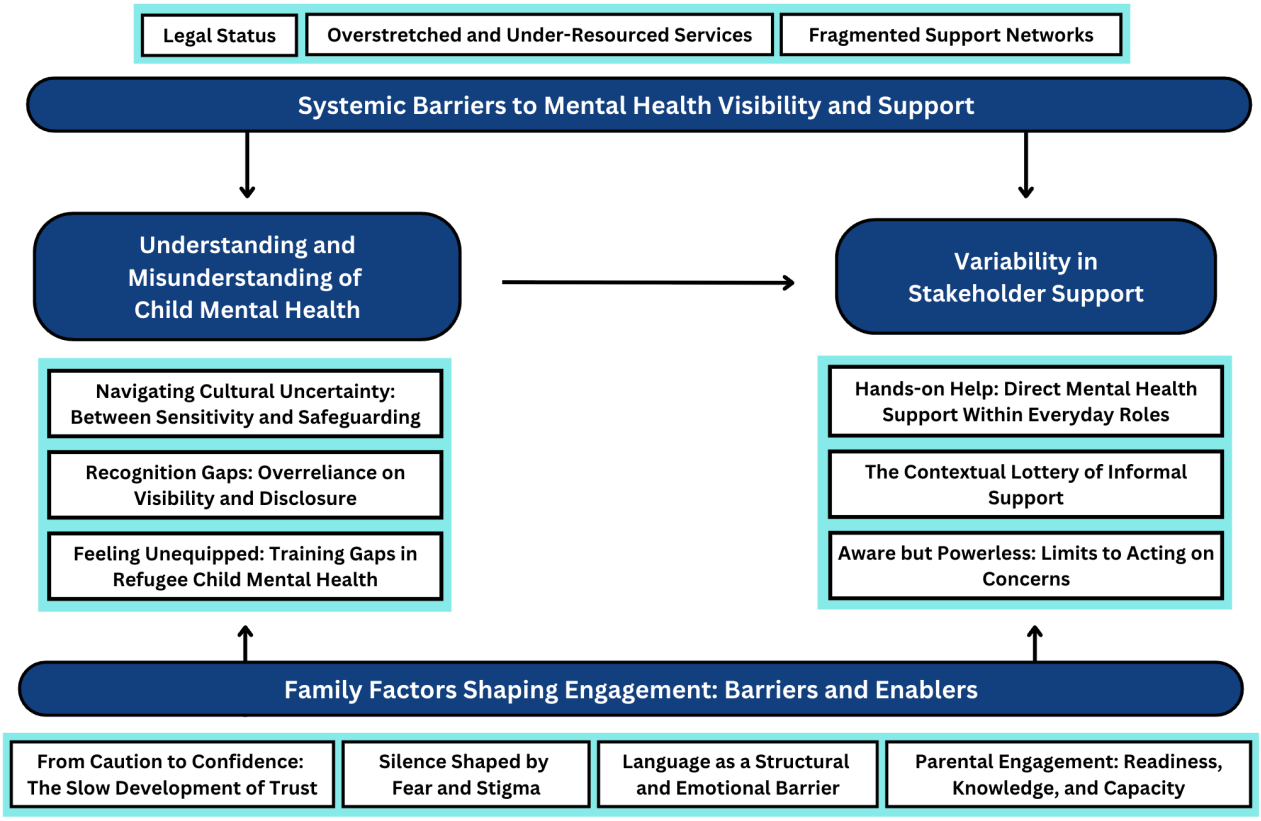
Participant	Sector of Employment	Experience (years)	Role Category
S1	Local Authority	5-10	Resettlement & Housing Support
S2	Third sector	<5	Resettlement & Housing Support
S3	Local Authority	5-10	Resettlement & Housing Support
S4	Local Authority	<5	Resettlement & Housing Support
S5	Third Sector	<5	Community Engagement & Outreach
S6	Third Sector	<5	Community Engagement & Outreach
S7	Third Sector	5-10	Volunteering & Civil Society Roles
S8	Third Sector	5-10	Volunteering & Civil Society Roles
S9	Third Sector	<5	Community Engagement & Outreach
S10	Third Sector	<5	Education, ESOL & Early Years
S11	Local Authority	<5	Community Engagement & Outreach
S12	Third Sector	>10	Leadership, Strategy & Policy
S13	Third Sector	<5	Community Engagement & Outreach
S14	Third Sector	<5	Leadership, Strategy & Policy
S15	Third Sector	>10	Community Engagement & Outreach
S16	Across Sector	<5	Education, ESOL & Early Years
S17	Across Sector	5-10	Community Engagement & Outreach
S18	Local Authority	<5	Resettlement & Housing Support
S19	Local Authority	5-10	Resettlement & Housing Support
S20	Third Sector	<5	Health, Wellbeing & Therapeutic Support
S21	Third Sector	>10	Education, ESOL & Early Years
S22	Across Sector	<5	Health, Wellbeing & Therapeutic Support
S23	Third Sector	>10	Resettlement & Housing Support
S24	Third Sector	5-10	Leadership, Strategy & Policy
S25	Third Sector	<5	Education, ESOL & Early Years
S26	Third Sector	>10	Leadership, Strategy & Policy
S27	Third Sector	<5	Health, Wellbeing & Therapeutic Support
S28	Third Sector	5-10	Community Engagement & Outreach
S29	Third Sector	5-10	Leadership, Strategy & Policy
S30	Local Authority	<5	Health, Wellbeing & Therapeutic Support

Note [1] Third Sector = non-governmental, non-profit organisation. [2]

A thematic map of the results is shown in Figure 4.1. Four overarching themes captured how identification and support were shaped by professional role, cultural interpretation, system structures and family-level dynamics.

Figure 4.1

Thematic Map of Factors Influencing Stakeholders' Identification of and Responses to Refugee Children's Mental Health



Theme 1. Understanding and Misunderstanding of Child Mental Health

Stakeholders encountered various mental health presentations among refugee children, although they also described many children they had worked with as "*flourishing*" or "*resilient*" (S5). Behavioural and relational problems were most frequently noted, particularly within school settings, including misbehaviour, conflict with peers and children "*not settling in*" or problems with attendance "*almost zero*" (S1, S10). Separation-related anxiety was common, especially among younger children, with some "*not wanting to be left at school*" or becoming distressed when parents moved out of sight (S6). Many stakeholders also described special educational needs (SEN), most often autism or

learning difficulties, observing "*a lot of children… appear to be on the spectrum*" (S24). Trauma-related responses were also described, ranging from emotional withdrawal to distress misinterpreted as being "*very naughty*" (S14). These presentations formed the context against which stakeholders attempted to identify and act on children's mental-health needs.

1.1 Navigating Cultural Uncertainty: Between Sensitivity and Safeguarding

Cultural differences created uncertainty about whether behaviours reflected distress, cultural norms or safeguarding concerns. Practitioners described feeling anxious and under-equipped, noting that an already "*massively under stress*" system faced "*another layer of complication around cultural issues*" (S5). Many feared being perceived as "*racist if you challenge a safeguarding issue where they think something's rooted in culture*" (S26) and this occasionally led to tensions, such as host families (families temporarily hosting Ukrainian refugees) disagreeing with how the mother "*was bringing up her son"* (S11).

Differences in communication styles also complicated discussions; for example, "*Ukrainians are used to very direct communication, in the way that we're not*" (S1). Practitioners often avoided explicit mental-health language or adopted broader terms like "*wellbeing*" (S23), partly because uncertainty about the role of culture made them unsure how such discussions would be received. Others tended "*not to ask too many questions*" (S10) or "*leave it to them… it is not an easy discussion to have*" (S18). Support from colleagues familiar with specific communities was highly valued, helping distinguish "*what is cultural and what should be a cause for concern*" (S7). Cultural uncertainty therefore shaped both recognition and response.

1.2 Recognition Gaps: Overreliance on Visibility and Disclosure

Stakeholders highlighted significant gaps in recognising children's mental-health difficulties, with identification often dependent on visible or overt signs such as families *"looking haggard"* (S11), noticing when a child who *"was doing well… now… misbehaving"* (S21), or when volunteers observed children becoming *"clingy… not letting go of mum's hand"* at school transitions (P6). Concerns were typically recognised only when *"the parents tell us"* (S2) or when schools raised *"safeguarding"* (S11) issues. Practitioners also used contact frequency as a proxy for need *"the*

number of calls… you feel like they are struggling" (S3), with coping inferred when *"they don't contact us as much"* (S4). Reliance on overt cues, disclosure and crisis referrals meant internalised problems frequently "*slipped through the net*" (S16), limiting opportunities for early identification and support.

Stakeholders emphasised that recognition gaps were shaped not only by reliance on overt cues but by practitioners' roles and the nature of their contact with families. Those conducting home visits noted that sustained interaction helped them notice subtle changes *"when I go out and visit the family… I could then notice any kind of behaviours and any kind of mental health issues"* (S29). In contrast, staff in drop-ins or activity-based settings described contact as brief *"they might help someone once"* (S23), which limited their ability to detect problems. Others worked in roles with little direct engagement with families *"my role is very housing focused… I'm not actually sat with these people on a regular basis"* (S1). Together, these differences in contact created uneven opportunities to recognise mental-health problems.

1.3 Feeling Unequipped: Training Gaps in Refugee Child Mental Health

Many stakeholders reported feeling unequipped to identify and respond to refugee children's mental-health difficulties. One admitted, *"the main obstacle… I don't know too much about mental health myself"* (S4), while another reflected that mental health *"wasn't a thing I was looking for… it was all about practicalities"* (S8). Several also highlighted gaps in understanding of the asylum experience itself, noting a lack of *"knowledge from the providers about what they have been going through"* (S17). Practitioners described *"learning as we go along"* (S7) as new groups arrived, with limited formal guidance or training. This lack of preparedness extended to schools, where insufficient training meant teachers were not always *"aware of you know things like their behaviour, their language, [and] how to help the children navigate systems"* (S16). Although some teams had received trauma-informed training, broader services lacked the resources to invest consistently in staff skills and development (S17), leaving many practitioners uncertain about which signs warranted concern, how to interpret them, and when to escalate.

Theme 2. Systemic Barriers to Mental Health Visibility and Support

This theme highlights how immigration status, limited resources, and fragmented services constrained stakeholders' abilities to identify and support children's mental-health needs.

2.1 Legal Status

Legal status fundamentally shaped what support families received and how visible they were to services. Stakeholders explained that Ukrainian families accessed a different package of support compared with other resettled refugees, while asylum-seeking families received far less and, in many cases, very limited support (S23). Resettled refugee families benefited from structured early help *"we meet the family in the first two weeks… we hold their hands"* (S17), whereas asylum-seeking families were described as existing in *"a big grey area… almost invisible to services"* (S18). Practitioners often felt unsure about what asylum-seeking families were entitled to *"I can't support clients that are on asylum… or can I?"* (S17) and several noted that services frequently *"won't support asylum-seeking children"* (S14).

Accommodation instability further reduced contact, and stakeholders linked much of this instability directly to families' immigration status. Asylum-seeking families were frequently placed in temporary hotel accommodation with restricted access, meaning practitioners could not enter buildings and families "*had to come out to meet us*" (S10). High turnover within these settings *"they've gone… even the hotel staff don't know where"* (S12) was described as routine, making sustained engagement difficult. These moves disrupted schooling and relationships, *"potentially… leading to more anxiety disorders"* (S6) and leaving families *"cut off again from the connections that were being made"* (S12). In this way, immigration status not only shaped entitlement to support but also the stability required for children to remain visible to services, further limiting opportunities for early identification.

2.2 Overstretched and Under-Resourced Services

Stakeholders described child mental-health support as extremely limited. Services were difficult to access "*for the locals, let alone for clients coming through a forced migrant background"*, leaving families navigating "*a quagmire of quicksand*" (S22). CAMHS waits of "*two years… and*

even worse in [deprived town]" (S29) and a lack of specialist provision ("*no available resources"* P29), left many areas unable to take referrals "*we're full… we can't take any*" (S12).

Voluntary organisations also operated beyond capacity and were often treated as substitutes for statutory care: "*we get people referred to us as an end destination… but we're not an end destination of treatment*" (S24), with programmes collapsing when funding ended (S17). Refugee resettlement workers managed large caseloads "*15 or 20 families… then 50*" (S3). Under these pressures, support was often reactive, reaching families only "*when it got to worst-case scenario*" (S16), while workforce strain left some staff feeling "*overwhelmed*" or *"less tolerant"* (S13), limiting their capacity to intervene early.

2.3 Fragmented Support Networks

Stakeholders described a landscape characterised by poor coordination and inconsistent communication. Although *"people are doing fantastic things"* services often worked *"in isolation"* making navigation difficult (S22). Practitioners reported that *"everything is so disconnected"* (S10), and even experienced workers continued to encounter services they *"had been unaware of"* (S22). Access often depended on finding *"the one person… who can unlock all the help and support"* (S7), rather than on clear pathways. Where multi-agency collaboration occurred, outcomes were better, for example, when *"the right people around the table"* facilitated a coordinated relocation and school support plan (S26). Overall, fragmentation led to inconsistency and missed opportunities for timely response.

Theme 3. Variability in Stakeholder Support

Stakeholders described a wide range of responses to children's mental-health needs. Their actions reflected both creativity and constraint, shaped by role boundaries, service availability and wider systemic pressures.

3.1 Hands-on Help: Direct Mental Health Support Within Everyday Roles

Some practitioners, particularly across education, family support and community roles described providing direct, low-level mental-health support embedded in everyday work. This included emotional check-ins *"are you okay?… talk to me if you are struggling"* (S19), embedding

psychoeducation into adult ESOL classes (S25), and teaching grounding or breathing techniques to help children regulate emotions (S20). Those with more sustained child contact, such as school-based staff or therapeutic workers, delivered structured support, including *"six-week interventions"* targeting trauma-related needs (S27). Stakeholders described children benefiting from these efforts, such as parents reporting that their child became *"happy in the classroom"* (S21) or children engaging positively with counselling (S23). Several also described adapting their roles creatively when formal mental-health services were inaccessible or slow; such as completing *"a diploma in counselling"* (S21).

Alongside direct support, stakeholders guided families through a fragmented system, encouraging GP visits for CAMHS referrals (S29), liaising with schools, making specialist referrals (S3), facilitating *"soft introductions"* (S9) and advocating when referrals were rejected "*... I said no, we need more support now"* (S3). Together, these examples show how practitioners adapted their roles to provide early support and system navigation in contexts where formal mental-health pathways were inconsistent or delayed.

3.2 Contextual Lottery of Informal Support

The availability of support varied widely across locations, organisational capacity and funding, creating a genuine "contextual lottery" in what families could access. In some localities, stakeholders described well-established initiatives, such as parent- and sibling-support groups (S27), strong school partnerships where staff had *"great connections with the nurseries"* (S24), and emerging mental-health projects (S29). In contrast, many families depended on far more informal provision, including parent groups, football clubs, ESOL classes, drop-ins and ad hoc practical help, with some organisations doing *"anything our clients may find beneficial"* (S24). This ranged from drafting emails to schools (S22) to arranging emergency assistance (S5). Such variation meant that children's access to emotional, social and practical support depended heavily on where they lived and which community organisations happened to be active locally, rather than on the level or urgency of need.

3.3 Aware but Powerless: Limits to Acting on Concerns

Despite recognising children's distress, many stakeholders described feeling unable to act on their concerns because the system offered no viable pathways forward. Specialist services were described as *"extremely difficult"* to access (S23), with referrals repeatedly rejected when instability or parental conflict rendered children *"not suitable"* for therapy (S29). Practitioners expressed deep frustration when children in unsafe or distressing environments were denied support *"we cannot delay the support… even if they go back to a room full of insects"* (S29).

This sense of powerlessness was intensified by professional boundaries and limited remit. Some workers were acutely aware they were being asked to manage needs that exceeded their training *"I am not a psychologist… this will affect me and stop me doing my job"* (S19). Long waits, consent constraints (S18) and rigid thresholds meant that many could offer only listening or reassurance: *"sometimes you cannot make things better… you can only listen"* (S24). Across accounts, practitioners described the discomfort of knowing a child needed help while operating in an overstretched system that prevented them from providing it.

Theme 4. Family Factors Shaping Engagement: Barriers and Enablers

This theme highlights how fear, stigma, language, knowledge and trust shaped families' willingness and ability to engage with mental-health support.

4.1 From Caution to Confidence: The Slow Development of Trust

Stakeholders emphasised that trust was essential before families felt able to discuss mental-health concerns. As practitioners described, *"building up a rapport… is very, very important"* (S18), and families tended to share worries only *"once they are comfortable with you"* (S9). Stakeholders noted that trust developed slowly and could *"be undone very quickly"* when expectations were unmet (P18).

Practitioners explained that they built trust through honest communication *"if we can't do something, don't promise it"* (P6) and by offering consistent reassurance that they were there to help (S10). Regular contact, such as weekly visits, helped families recognise *"who they could trust"* (S15), while approachability enabled parents to initiate private conversations when they were reluctant to

speak in groups (S9). Stakeholders also observed that cultural and linguistic familiarity supported openness, with families sharing more *"the more they felt safe with me"* (S25). From practitioners' perspectives, trust was therefore a slow but crucial foundation for disclosure and engagement.

4.2 Silence Shaped by Fear and Stigma

Stakeholders reported that stigma surrounding mental health often prevented families from sharing concerns. Practitioners described some families viewing mental health as *"that taboo of mental health… there is no such thing"* (S30), particularly in relation to SEN, where they observed parents not wanting to *"talk about things like that"* (S16), or being reluctant for a child to be *"tagged"* with a mental-health label (S29).

Stakeholders also described fear as a major barrier to disclosure. They recounted families worrying that raising mental-health concerns would trigger social services involvement *"don't talk about anything… social services will be involved"* (S19), or immigration consequences, including fears of deportation (S12). Practitioners noted that some parents only engaged when prompted by safeguarding concerns, accepting support *"just because they have a MASH issue… not because they feel they need it"* (S2). Across accounts, stakeholders highlighted how these fears restricted open communication and reduced opportunities for early identification.

4.3 Language as a Structural and Emotional Barrier

Practitioners perceived that limited English proficiency made it difficult for parents to express concerns *"they don't have enough language skills to express their feelings"* (S21) and contributed to children being *"missed because they don't have an articulate parent"* (S9). Stakeholders also described challenges with interpreting. They noted that some families were reluctant to disclose sensitive information through unfamiliar interpreters *"the family doesn't want to share to every different interpreter"* (S3) and reported that telephone interpreting sometimes *"translated something completely different"* or failed to convey technical mental-health language accurately (S17). These barriers, as practitioners described, hindered engagement with schools and services, contributing to safeguarding misunderstandings when families *"didn't understand what the teacher said"* (S2). Several stakeholders also observed that families who *"can't read or write"* were unable to follow

written signposting (S4). Practitioners perceived these barriers as limiting families' ability to communicate needs and access support, increasing reliance on stakeholders to advocate and coordinate care on their behalf.

4.4 Parental Engagement: Readiness, Knowledge, and Capacity

Stakeholders reported wide variation in parents' readiness to engage, which they felt was shaped by limited knowledge, emotional capacity and competing pressures. Practitioners described parents as often lacking understanding of *"how mental health works here"* (S4) or not *"recognising"* concerns as mental-health related (S15). Several also perceived gaps in parents' awareness of available services (S17) or noted that acknowledging difficulties could be *"so worrying"* (S20) for some families. Resettlement demands further reduced capacity; stakeholders described families as *"at different stages… some will engage, some won't"* (S27), with many overwhelmed by tasks such *as "reading Home Office letters, getting ready for interviews"* (S14). Some groups appeared reluctant to seek help, with practitioners noting that Hong Kong families *"have not come back to me"* even when support was offered (S30), and that funded counselling for Ukrainians saw *"only one person step forward"* (S5).

From stakeholders' perspectives, engagement ultimately depended on parental capacity and willingness *"you want us to help you… it's up to you to say yes or no"* (S2) and unable to progress concerns when families did not engage: *"I can refer you… but if the clients are not helping me, I can't do"* (S19). Stakeholders described immediate survival needs often creating "*too many other pressing concerns"* (S14) for parents to prioritise mental health, limiting opportunities for early intervention even when support was available.

4.4 Discussion

This study highlights how stakeholders perceived refugee children's access to mental-health care to be shaped less by the severity of their difficulties, and more by how those difficulties are made visible, interpreted, and taken up within fragmented service systems. Drawing on perspectives across statutory, community and voluntary sectors, the findings point to a convergence of pressures. These include a highly variable understanding of child mental health among practitioners, culturally specific

barriers to help-seeking within families, and overstretched, unevenly resourced services. Together these factors interact to constrain support for already vulnerable families. As a result, access to support was often described as inconsistent, shaped by service contact, continuity of relationships, and whether children's mental health needs aligned with system thresholds and capacities.

Stakeholders described substantial challenges in identifying mental-health difficulties across services. Practitioners commonly relied on overt behavioural indicators or explicit disclosure, raising concern that internalised or masked difficulties could be overlooked. This is consistent with wider concerns that the emotional and psychological needs of displaced children may go unrecognised or unmet (Joshi & Fayyad, 2015), and is particularly important when considered alongside Chapter 3, where parents' initial accounts of their children's mental health were sometimes more favourable than the concerns disclosed later in interviews as rapport developed. Although the interview context cannot be equated with clinical help-seeking, the findings from Chapters 3 and 4 point to a potential tension in systems that rely on parents to communicate concerns: disclosure may itself depend on trust, familiarity and repeated opportunities for discussion. Cultural uncertainty further complicated interpretation, with workers hesitant to intervene for fear of misjudging culturally shaped behaviours, reflecting wider concerns that 'getting it wrong' can inhibit proactive safeguarding (Munro, 2011). Limited training in child mental health, trauma and refugee experiences compounded this hesitancy, leaving practitioners unsure which early indicators warranted concern or escalation (Baak et al., 2023; Robinson et al., 2025; Vostanis et al., 2024).

Beyond individual interpretation, structural visibility played a key role in whether children's needs were recognised. Practitioners described how children who moved frequently, lived in hotels, or whose parents feared services were often invisible to services, noting that support tended to reach those already connected to schools or community settings rather than those who are most marginalised (Kienzler, 2024; Stevens & Sivasathiaseelan, 2022; Yim et al., 2025). In their accounts, identification relied heavily on relational continuity; on having the time and opportunity to see families regularly. Participants described current service structures as often limiting opportunities for such continuity, particularly when families were repeatedly relocated. As a result, these dynamics reproduced inequities: stakeholders perceived children in more stable placements or with consistent

practitioner contact as more likely to have their needs recognised. Stakeholders described how this contributed to a wider 'crisis logic', whereby difficulties were often only recognised once they escalated into safeguarding concerns or overt disruption (e.g., Munro, 2011).

Even when needs were identified, responses to children's mental-health needs were highly inconsistent, with practitioners' actions heavily shaped by system constraints. Staff offered emotional support, regulation strategies and informal psychoeducation, but the extent of what they could provide varied widely due to fragmented pathways, unclear role boundaries and inconsistent local resources. Many practitioners relied on personal contacts to 'unlock' support when formal routes were difficult to navigate. This reliance on informal networks reflects adaptive practice within fragmented systems, but also highlights the lack of reliable, equitable pathways, reflecting wider evidence of poorly coordinated provision for displaced families (Colucci et al., 2014; Dumke et al., 2026). Legal status was described as amplifying these disparities: resettled refugees typically received structured support, while asylum-seeking families were frequently excluded from comparable provision (e.g., Hodes & Vostanis, 2019), leaving access determined more by geography, capacity and immigration route than by children's needs.

Within this context, frontline practitioners were often required to extend their roles beyond formal remits, taking on therapeutic, advocacy, and navigational responsibilities. Many reported feeling overwhelmed when they recognised a child's needs but lacked tools or pathways to respond, consistent with wider evidence of frontline workers often compensating for systemic gaps without adequate supervision (Guhan & Liebling-Kalifani, 2011). Third-sector organisations played a critical buffering role, offering relational and flexible support. This complements the patterns observed in Chapter 2, where CAMHS frequently directed families towards community and voluntary-sector provision, and parents' accounts in Chapter 3 of the importance of informal and community support. However, dependence on third-sector provision may itself create vulnerabilities, given geographical variation in specialist provision and the precarious funding experienced by refugee-sector organisations (Mayblin & James, 2019; Yim et al., 2025).

Finally, stakeholders described frequent refusal or delay of psychological therapy when housing instability, family conflict or immigration uncertainty rendered children 'unsuitable' for

treatment. This closely mirrors the clinical-record findings in Chapter 2, where instability was explicitly documented as a reason for delaying or not providing psychological intervention for some children. Together these findings suggest a potential ‘catch-22’ situation, whereby displaced children are deemed unsuitable for therapy until their circumstances stabilise, even though instability itself exacerbates distress and increases risk (e.g., Rana et al., 2025). Such criteria may also contribute to structural exclusion and widen inequalities, as withholding timely intervention may increase the risk of persistent post-traumatic difficulties (Berkowitz et al., 2011; Dumke et al., 2026). Addressing this requires shifting away from stability-dependent thresholds toward approaches that treat instability as a core feature of the refugee experience, and therefore a clinical reason for timely support rather than a barrier to it.

Implications

These findings have several implications for policy and practice. First, strengthening identification requires reliable communication support and workforce development in child mental health and culturally responsive practice. Improved access to trained interpreters and translated materials is essential for all practitioners working with displaced families. This need was evident across the preceding studies: Chapter 2 identified language barriers affecting access to some forms of support, while parents in Chapter 3 described language as shaping their ability to navigate services and support their children.

Second, stakeholders also highlighted the need for role-specific training: staff providing direct emotional or educational support may require ongoing supervision and reflective space, while resettlement, housing and community workers often need clearer guidance on mental-health indicators and referral pathways. Together, these forms of support can reduce misidentification, build practitioner confidence and help prevent burnout in an already stretched workforce.

Third, structural barriers to the visibility of struggling children must be addressed. Identification depends on system structures that allow sustained contact; therefore, services should prioritise outreach, continuity across housing placements and routine engagement with children living in temporary or hard-to-reach accommodation.

Finally, improving access to mental-health support requires clear and coordinated pathways. Fragmented networks and inconsistent information highlight the need for integrated referral guidance and stronger multi-agency collaboration. The current reliance on third-sector organisations also signals the need for sustainable funding and strategic partnerships, ensuring that community provision supplements, rather than substitutes, statutory responsibility.

Strengths and Limitations

A key strength of this study is its inclusion of a diverse range of stakeholders across statutory, voluntary and community sectors, enabling a multi-level understanding of the structural, organisational and interpersonal factors shaping children's access to mental-health support. The use of RTA allowed for rich, nuanced insights into how practitioners interpret and act on children's needs. The study also contributes to a limited UK evidence base examining frontline perception of refugee child mental health.

However, several limitations should be noted. The absence of general practitioners, frequently described as the gateway to mental-health services, limits insight into primary-care decision-making and referral thresholds. The breadth of stakeholder roles strengthened the multi-sector perspective but also meant that participants varied in the nature and extent of their contact with refugee families. Stakeholders who chose to participate may additionally have had greater interest or experience in refugee mental health than practitioners more broadly. Importantly, the findings represent stakeholders' accounts and interpretations of service provision rather than direct observation of practice and therefore cannot establish how frequently the barriers or practices described occurred. Stakeholders' nationality was not collected, limiting assessment of its potential influence on perspectives. Finally, the findings are also context-specific and may not fully translate to political or cultural settings outside the UK.

4.5 Conclusion

This study demonstrates that the identification and support of refugee and asylum-seeking children's mental-health needs are shaped by intersecting structural, cultural and relational factors that may limit visibility and delay access to care. Fragmented pathways, high thresholds and legal status

requirements may mean that children's access to support is at times contingent not on level of need, but on when, where and by whom they are recognised within the system. While practitioners frequently respond with flexibility and commitment to bridge these gaps, such efforts are uneven and unsustainable within current structures. Addressing these challenges requires strengthened early identification, coordinated cross-sector pathways, needs-based access irrespective of legal status and stability, and sustained investment in both statutory services and the third sector. Without such reforms, there is a risk that support will remain reactive, inconsistent and dependent on individual advocacy rather than children's needs.

Chapter 5: Integrating Parent and Stakeholder Perspectives to Identify Key Support Needs and Conditions

5.1 Background

Taken together, the preceding studies suggest that recognition of refugee and asylum-seeking children's mental health needs does not necessarily translate into timely and appropriate support. Parents and stakeholders frequently recognised children's difficulties but described structural and service-level conditions that could constrain how these needs were addressed. As highlighted in Chapter 4, service thresholds, legal status, fragmented pathways and the availability of advocacy were perceived to influence access to support. While these findings point to the need for wider structural and service-level change, they also highlight a gap between the recognition of need and its translation into appropriate support.

Within this context, parents occupy a pivotal - yet often under-supported role. As demonstrated in Chapter 3, parents described observing changes in their children's behaviour, interpreting their significance, and navigating decisions about help-seeking. However, parents' capacity to fulfil this role was constrained by the same structural barriers that limit service responsiveness, including limited access to information, cultural and linguistic barriers, and fragmented care pathways identified by stakeholders in Chapter 4. Parents may therefore be expected to play a substantial role in recognising and responding to their children's needs without always having the information, resources or support required to do so.

Focusing on parent's risks shifting responsibility for addressing systemic shortcomings onto families. However, supporting parents need not imply transferring responsibility from services to families; rather, it recognises the substantial role parents already play and asks how services can better support them in that role. Strengthening parents' capacity to understand and respond to their children's mental health needs may support earlier recognition, day-to-day management and engagement with appropriate services, while complementing rather than replacing wider structural and service-level change. Parents therefore represent a key and potentially modifiable point of intervention through which services may extend the reach and impact of available support.

This study builds on this rationale by examining how refugee parents can best be supported to promote their children's mental health during resettlement. By integrating both parent and stakeholder perspectives, it seeks to identify not only what forms of support are needed, but how these can be delivered in ways that are accessible, culturally responsive, and feasible within real-world service contexts.

5.2 Methods

Study Design

This study draws on qualitative data from the parent and stakeholder studies described in Chapters 3 and 4. The combined dataset comprised 53 participants: 23 refugee and asylum-seeking parents of children aged 3–11 years and 30 professionals and community stakeholders with experience supporting refugee families. The datasets were integrated for the present analysis to examine, across both perspectives, how refugee parents can be supported to promote their children's mental health following resettlement. Full details of eligibility criteria, sampling, recruitment and participant characteristics are provided in Chapters 3 and 4.

Integrating and re-analysing data from both studies to address novel research questions enabled a comprehensive understanding of refugee parents' experiences and needs, together with insights from those responsible for designing and delivering services to support parents, and children's mental health.

Measures

Full interview materials and data collection procedures are described in Chapters 3 and 4. Relevant interview topics for the present study explored how refugee parents could be better supported with their children's mental health, including perceived support needs, barriers to accessing services, gaps in existing provision, and how support could best be delivered. These issues were explored with both parents and stakeholders, with stakeholder interviews additionally considering them from a professional and service perspective.

Procedure

No additional data were collected for this study. The parent and stakeholder interview data collected in Chapters 3 and 4 were combined for the present analysis. Full recruitment, interview and transcription procedures are reported in the respective chapters.

Analysis

Data were managed in NVivo (Mac version 14) and analysed using template analysis, following the six-phase process outlined by King (2012) and further developed by Brooks et al. (2015). This approach provides a structured yet flexible framework for identifying patterned meaning within complex datasets, making it well-suited to integrating parent and stakeholder perspectives on refugee family support.

The analytic process involved iterative familiarisation, preliminary coding, and the development of an initial template of broad themes. This template was progressively refined through repeated engagement with the data and discussion within the research team. Template analysis was chosen because it accommodates both *a priori* categories, informed by existing literature and findings from the preceding studies, and inductive insights arising from participants' accounts. This was particularly appropriate to the present study, which sought to build on existing knowledge while remaining responsive to support needs and priorities identified within the data.

Initial coding captured broad domains such as structural challenges, organisational roles, and mental-health awareness. Through iterative review, these were refined into more specific, actionable dimensions - culminating in the final template, which included both anticipated categories (e.g., Basic Living Needs, Specialist Psychological Support) and new cross-cutting themes (e.g., Responsiveness and Parent-Professional Communication). The final thematic structure is presented in Table 5.1, with an example of the template's evolution from early to final iterations.

I led the analysis, with regular analytic discussions involving CC, LB and SLH, whose disciplinary and experiential perspectives are described in Chapter 3. Reflexivity was maintained throughout, including consideration of how prior literature, findings from the preceding analyses and researchers' perspectives shaped engagement with and interpretation of the data. The developing

template was reviewed collaboratively, with discussions used to challenge interpretations, examine the fit of categories across both parent and stakeholder accounts, and refine the structure as coding progressed. Six iterations of the template were developed before the final template was systematically applied across all transcripts.

Table 5.1

Example of Iterative Development of the Coding Template

Theme	**Sub-theme**
Template 1	
Structural Challenges	*Basic Living Needs* *Language*
Role of Organisations	*Community, Faith and Peer Support* *Third Sector Support* *School Support*
Supporting Parents	*Parenting Strategies* *Culture & Lived Experience* *Specialist Child Mental Health Support* *Child Clubs and Activities* *Addressing Parental Mental Health*
Mental Health Education & Awareness	*Staff Training* *Help-Seeking support*
Template 6	
Foundations for Wellbeing: Meeting Basic Needs and Accessing Support	*Safe and Stable Homes* *Economic Stability and Access to Services*
Rebuilding Belonging through Community, Language, and Play	*Belonging and Connection through Community and Play* *Language and Learning as Pathways Integration*
Understanding and Trust: Mental Health Literacy and Peer Support	*Understanding and Navigating Mental Health Support* *Trust through Peer and Culturally Informed Support*
Specialist Psychological Support	*Gap in Specialist Refugee Support* *Strengthening Parental Capacity for Children's Mental Health* *Family-Centred and Therapeutic Approaches*
Coordination, Communication and Competence	*Parent–Professional Communication* *Collaborative Working and Pooled resources* *A Trained Workforce and Quality Provision*
Responsiveness	*Reactive Systems and the Need for Early Help* *Thresholds and Delays in Support*
Right Setting	*Integrated vs. Outreach Services* *Accessibility*

Ethics

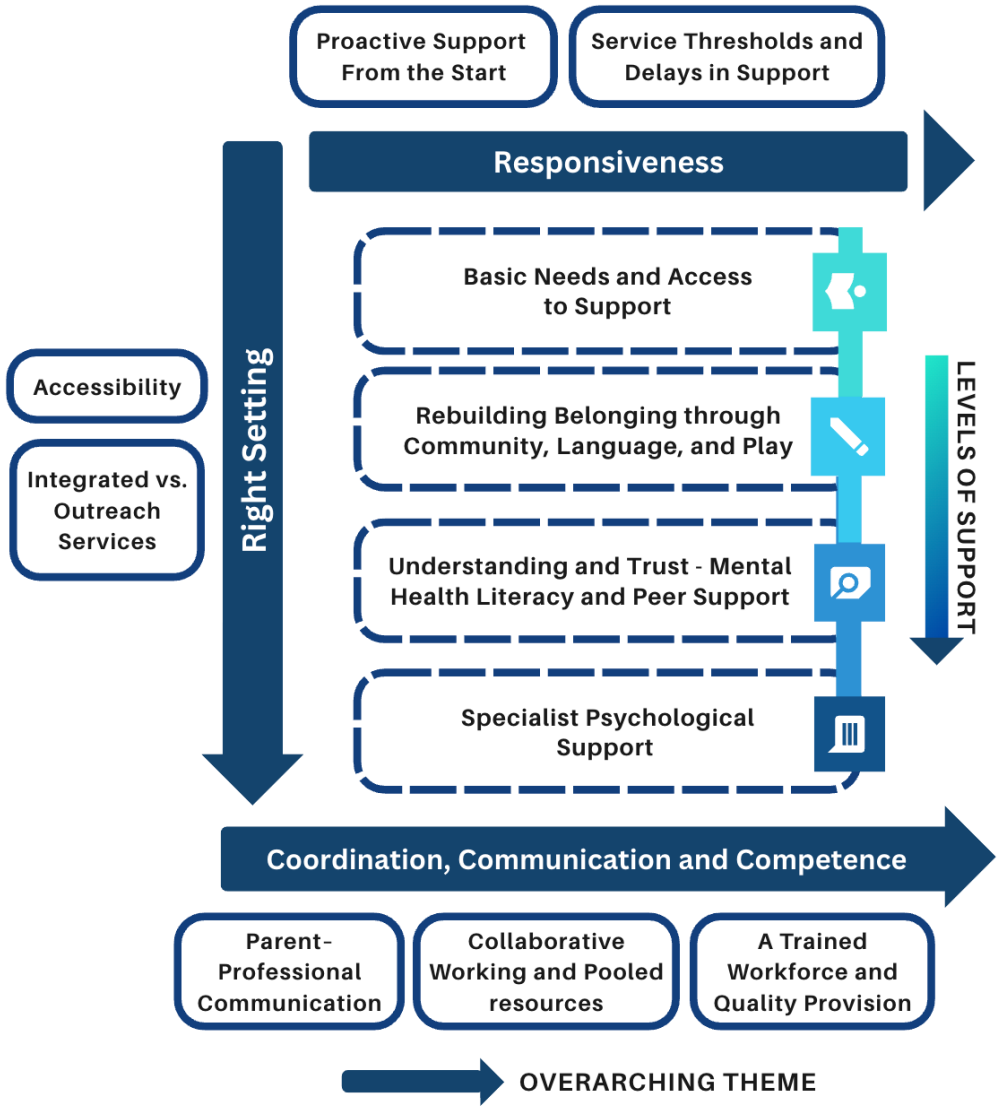
Ethical approval (Oxford CUREC; Ref. R86792/RE002) and associated ethical procedures are described in Chapters 3 and 4.

5.3 Results

Figure 5.1 presents four levels of support that parents and stakeholders viewed as essential for enabling refugee parents to support their children's mental health: basic needs and access to support, rebuilding belonging through community, language and play, developing understanding and trust, and accessing specialist psychological support. Three overarching themes; 1) responsiveness, 2) right setting, and 3) coordination, communication and competence, cut across all levels, highlighting the need for timely, accessible and well-coordinated provision.

Figure 5.1

Thematic Structure Illustrating Four Levels of Support and Three Overarching Themes Identified by Parents and Stakeholders as Necessary to Help Refugee Parents Support Their Children's Mental Health



Conditions for Caregiving vs. Conditions for Services

Parents and stakeholders held complementary but distinct views on how to support refugee parents with their children's mental health. Parents prioritised basic stability such as safe housing and income, explaining that *"before anything we need our own home… then I can see what she is thinking"* [P17]. They viewed support in practical, everyday terms and felt that once core needs were met, children often needed little formal help. Stakeholders, in contrast, emphasised system-level conditions including culturally informed practice, proactive early help, coordinated pathways and trained professionals. Parents focused on concrete barriers such as transport, language and cultural mismatch, while stakeholders highlighted fragmented systems and limited interpreter competence. Both groups stressed the need for specialist provision, identifying major gaps, and described practical guidance and family-centred therapeutic approaches as important.

Theme 1: Basic Needs and Access to Support

Parents and stakeholders described stable living conditions as *"the first important thing for any family that arrives… feeling safe, this is my room, this is my home"* [P15] and as the foundation for children's mental health, helping *"lift pressure from parents… [so children are] happier, more relaxed"* [S29]. Overcrowded or temporary accommodation left children unsettled: *"all I can think about is if I have a home… my children would not be upset or bored"* [P16].

Practical and material support eased adjustment. One Ukrainian mother described her host family helping *"with documents, with bank… you understood that you are not alone… day by day, it was more easy"* [P10]. Parents valued community and faith groups that provided essentials *"we came only with two little backpacks… they really helped"* [P2] - while poverty restricted children's play and learning: *"you visit a family and barely see any kind of toy or game… even a notebook"* [S29]. Stakeholders also emphasised the need for help navigating universal services such as *"GPs, health visitors, midwives, education and legal aid,"* with legal aid often *"next to impossible"* to access [S29]. Meeting these basic conditions enabled parents to focus on their children's mental health and reduced reliance on formal services.

Theme 2: Rebuilding Belonging through Community, Language, and Play

Community and faith spaces were described as lifelines that rebuilt belonging after displacement, *"a place where we can go and ask about help"* [P4]. Parents valued culturally familiar groups where children could *"communicate with other Ukrainians"* [P4], and these settings gave adults brief respite to *"be in their mind… think about future"* [P9].

For children, play and peer contact also provided *"something like a normal life… he can find stability and can change all emotional problems"* [P9]. These supports were especially important while children waited for school placements, which often left them isolated. Stakeholders felt *"not enough is done to help children transition"* [S16], with many *"put in at the deep end and then let… survive"* [S5]. They called for interim learning and *"safe spaces"* to prepare children for school [S16], giving children the ability *"express their feelings"* [S5].

Opportunities for parents to learn local language also supported belonging and communication. Stakeholders described English classes as essential for parents because *"talk[ing] to other people in the community is important"* [S7], while parents attended not only *"to study English but to be together, speak their own language… almost like a therapy"* [P12].

Theme 3: Understanding and Trust - Mental Health Literacy and Peer Support

Parents and stakeholders emphasised that trust was the bridge between having information and being able to act on it when seeking support for children's mental health. Many parents felt unprepared to navigate unfamiliar systems, describing a lack of basic guidance: *"If they could do a course… how to sign up with a GP, get a bus ticket… these things need to be taught"* [P17]. Without such guidance, some relied on home-country care: *"I don't understand this medicine system… it's easier for me to go to Ukraine"* [P3]. Parents described the need for information about *"the system, where to go, and what it gives children"* [P3].

Trust was further undermined by fear and stigma. Some parents associated services with risk *"they think their children are going to be taken"* [S17], while others feared the consequences of diagnosis: *"in Ukraine… diagnosis is like a label… no parent wants this for their child"* [P3]. In this context, peer and community initiatives played a critical role in rebuilding trust. Parents described

how shared spaces allowed families to *"gather… share information, help each other"* [P8], while stakeholders noted the value of hearing from others with similar experiences: *"speaking to people who actually had that support to say… this did work for me"* [S27]. Stakeholders also felt that trust was strengthened when support was delivered by staff with lived refugee experience, which *"helps them connect and build trust"* [S25].

Theme 4: Specialist Psychological Support

Parents and stakeholders identified substantial gaps in specialist psychological provision, describing services as overstretched and rarely tailored for refugees: *"a big gap is whether we've actually got services to direct the children and parents to"* [S16]. Parents felt strongly that *"when emotionally they are damaged, someone should be here to help"* [P21].

Specialist support was viewed as needing to strengthen caregivers' capacity as well as children's mental health. Participants emphasised supporting *"parents feeling that they are okay,"* as this enables them to *"know how to talk to their children when they're not so good, and… strategies to cope"* [S13]. Parents wanted practical guidance: *"I'd appreciate some ABC of how you can be a better mom"* [P12] and valued advice they could apply at home: "*when the psychologist talks to me, I therefore use it in my parenting"* [P12]. Such strategies offered emotional relief: "*tips… help me and him… I'm a little calmer… because I have somebody to ask"* [P3]. One stakeholder described offering a native-language parenting course that parents *"loved… so much"* [S3].

Family-centred approaches were also valued. Parents appreciated opportunities to *"sit together and learn from each other"* [P20], suggesting joint activities *"where children and parents… could play or do something with a specialist"* [P4], or *"a session with specialized books"* [P10]. Stakeholders echoed the need for practical, hands-on support, emphasising modelling strategies with parents to *"create an environment where the child can embed those thought processes"* [S26], including *"tangible activities… painting… paddling in the sea"* to strengthen communication [S26], rather than offering abstract advice such as *"this might be a nice thing to do with your kid"* [S28]. Holistic approaches offering shared development and respite were similarly valued: *"parents were*

able to do what they needed to do and the children were entertained and developing and playing… mental health support for both mother, father, carer, baby, child" [S14].

Theme 5: Coordination, Communication and Competence

This overarching theme highlighted systemic issues that shaped families' abilities to engage with support.

5.1: Parent- Professional Communication

Communication barriers with professionals limited parents' abilities to act on concerns. Information was often routed through hosts, even though *"it's the parent that needs this information"* [P16], and confusion between schools and parents *"can then impact the child"* [S3]. Parents described struggling to raise issues because of the *"language barrier"* [S14], leaving some unable to explain when *"a child has been bullied… the child can be left out with no support"* [S3] or when misunderstandings led to safeguarding concerns: *"they didn't understand what the teacher said… and the teacher raised a safeguarding issue"* [S2]. Parents wanted more chances for *"open conversation with a headmaster or teachers"* to share *"a little bit more what they have been going through"* [P2]. Parents often relied on Google Translate, which was *"pretty impossible"* for meaningful communication [S5], with some discussions reduced to a *"thumbs up"* [S13]. Interpreter access *"hasn't been easy"* and often required parents *"to pursue it"* [S13], highlighting the need for clear, translated communication delivered by culturally aware staff.

5.2: Collaborative Working and Pooled Resources

Stakeholders described poor coordination across statutory, voluntary and community organisations, with services often duplicating work or leaving gaps in provision. As one explained, *"everyone's individually figuring it out… a lot of time wasted"* and *"we don't know officially what resources are available… especially with mental health"* [S9].

Participants called for shared systems, clearer referral routes and liaison roles *"to go out and find the services available… so charities can call and know who to refer to and how"* [S22]. Stakeholders described how coordination could work in practice, including a colleague who had mapped local activities, knowledge they felt *"could be really valuable"* [S22]. Cross-organisation

shadowing was also seen to *"break down the barriers"* between services and strengthen joint working [S14]. Schools were viewed as key linking organisations, with family link workers acting as *"first contact"* for parents and helping them become *"aware"* of their child's needs [S3].

Many emphasised the importance of co-designed approaches, where councils and communities shape provision together: *"things come from the grassroots up… it's about what people feel would be helpful"* [S5]. Others felt improvement depended not on creating new services but on strengthening collaboration and competence within existing ones, as *"there's lots of people that want to help… but everyone's doing their own thing, so it's not connected"* [S9].

5.3: A Trained Workforce and Quality Provision

Staff were often compassionate but lacked understanding of refugee experiences, with one stakeholder describing *"a massive lack of understanding… even the basics around what it means to be an asylum seeker or a refugee"* [S14]. Limited time and funding further restricted professional learning: *"schools plan out their CPD [Continuing Professional Development] for a year… if we just paused and did an hour on how to support new arrivals, it would be a lot more helpful"* [S16]. Supporting refugee families was seen to require refugee-specific knowledge "*it takes a really informed therapist"* [S29], and competence in working with interpreters was considered *"really key"* [S20]. Quality was viewed as uneven and dependent on individual goodwill, meaning that effective support relied on the motivation and experience of particular staff, affecting trust in provision: *"It's one thing to have activities for children… it's another thing to trust that they'll work well with our clients"* [S28].

Theme 6: Responsiveness

This overarching theme highlights timing as a key challenge, with support which "does not start early enough," and when it does, it responds "too slowly".

6.1: Proactive Support from the Start

Participants described an absence of early checks or conversations about children's mental health. Support was *"reactive rather than proactive… nothing felt cohesive or strategic in terms of how to support the children"* [S16] and should *"be there from the beginning… part of the agenda of*

conversations" [S13]. Participants requested *"workshops… as soon as people come"* [S21]; and stressed that early support must reflect refugee-specific needs, including *"grief... that could have been helped earlier"* [S8]. Early school-based supports, such as *"teaching assistants… homework clubs"* [S3], helped children settle before problems escalated. Early help plans were also seen as more effective when developed by professionals who *"already know the family,"* as this had *"more impact than a new person coming in"* [S26]. Many emphasised the need for *"a named person"* to guide families into school and community life [S22].

6.2: Service Thresholds and Delays in Support

Eligibility rules and long waiting lists left families without timely care. "Waiting lists are a massive issue for this transient community… people are often moved just as they're at the front" [S14], and specialist referrals were "very, very long", despite having "a contract with a charity, so you can imagine the NHS" [S2]. Refugee-specific services had delays of "three to four months, if not longer" [S29], with parents relying on stakeholders to navigate delays.

Theme 7: Right Setting

Participants highlighted *where* and *how* mental health support is delivered determines whether families access it. Support was most effective when delivered in familiar, culturally safe, and flexible settings that reduced practical and emotional barriers.

7.1: Accessibility

Accessibility was shaped by language, culture, cost, geography, and delivery mode. Participants described needing practitioners *"who spoke their language"* [S4] and emphasised the importance of translated materials, explaining that *"if it's serious, I need it in my language"* [P11]. Families struggled when services lacked culturally or religiously matched staff, such as *"Muslim counsellors… someone who understands the culture"* [S25], or when activities did not align with cultural needs. Some stakeholders acknowledged that limited cultural understanding resulted in difficulties engaging "*older mums and African-heritage mums*" [S6]. Travel costs were described as *"a big chunk of income"* [S24], and rural placements intensified isolation, with one parent noting, *"it is very difficult… I not have car… in rural place"* [P23]. Online support was often ineffective, as

"they start… then drop out quickly; it's too easy not to log in" [S23], and phone contact could lose connection entirely [S23]. Flexible provision, such *as "sessions in school or at home"* [S20], helped reduce these barriers.

7.2: Integrated vs Outreach Provision

Schools were viewed as effective, non-stigmatising settings because children were not *"segregated or singled out"* [S5] and staff *"see it the most and pick up"* on mental health needs [S7]. However, schools required *"more support"* to sustain this role [S7]. Outreach was equally important for families outside mainstream systems. Parents in hotels described having no support *"I expected… a psychologist in the hotel… but no one is here"* [P16], despite "*people staying in the hotels for a long time"* [P20]. Community organisations filled gaps when families were ineligible for English for Speakers of Other Languages (ESOL), with *"the only organisation supporting us… offering ESOL and workshops"* [P11]. Stakeholders also viewed ESOL as a space to integrate early mental health education, with tutors able to *"run workshops"* alongside language learning [S21].

5.4 Discussion

This study built on Chapters 3 and 4 by bringing parent and stakeholder perspectives together to examine how refugee parents can best be supported to respond to their children's mental health needs. Whereas the preceding studies examined parents' experiences and stakeholders' perspectives separately, the present analysis enabled areas of convergence and complementarity between these perspectives to be identified and integrated into a set of support priorities. Four levels of support were identified, ranging from basic stability to specialist psychological support. These levels align with wider social determinants perspectives, which emphasise the importance of material and social conditions in shaping mental health and wellbeing (Marmot, 2010; Patel et al., 2018; WHO, 2015). The present study extends this wider literature in two important ways. First, it identifies three system conditions (coordination, communication and competence; responsiveness; and the right setting) that determine whether families can engage with support at any level of need. Second, it clarifies the specific forms of specialist, family-centred support that parents and practitioners view as meaningful.

Crucially, the findings show that effective support depends not only on the content of services but on the system conditions that determine whether families can *access*, *understand* and *use* them.

System Conditions as Determinants of Access and Engagement

The four identified levels of need reflect models such as the Mental Health and Psychosocial Support framework, in which mental health is supported through layered and interdependent resources (IASC, 2007). Yet the findings show that these layers only function as intended when system conditions enable families to reach, understand and benefit from them. Coordination, communication and competence shaped parents' initial contact with services, influencing whether information was clear, culturally attuned and supported by interpreters. Poor coordination, unclear roles, and inconsistent information left parents navigating services alone, often through host families or voluntary organisations. Responsiveness was equally crucial: long waits and high thresholds undermined confidence, whereas early, relationship-based engagement, whether via outreach, orientation on arrival or proactive school contact, helped prevent escalation. The right setting was equally important; families felt safer accessing support in familiar, non-stigmatising spaces such as schools, community hubs or faith settings, while those living in hotels or temporary accommodation required proactive outreach. These mechanisms were highlighted by concrete examples. Schools were trusted settings but struggled to act on concerns without training in refugee-responsive practice, interpreter support, or clear referral pathways, leaving staff carrying complex needs without sufficient capacity. Specialist psychological care was similarly affected by systemic gaps: limited provision, repeated relocations, poor cross-sector communication and long waits often resulted in families losing access before support began. These findings underscore that refugee mental-health support cannot be understood as a series of discrete services but as an interconnected system whose organisation fundamentally shapes parents' ability to act on children's needs.

What Specialist Psychological Support Should Look Like

Parents and practitioners converged on the need for specialist support that was practical, relational, and culturally attuned. Parents consistently requested clear, actionable guidance for responding to children's emotional and behavioural difficulties, describing uncertainty about how to

support their children day-to-day and valuing strategies that felt achievable at home. Both groups emphasised the value of joint parent–child activities and therapeutic spaces that foster relational safety and address issues common in refugee families, such as grief and the emotional impacts of displacement. Practitioners further highlighted the necessity of supporting parents' own mental health and confidence, recognising that caregivers' emotional capacity shaped children's mental health.

Although the importance of family processes and parental wellbeing for refugee children's mental health is well established (e.g., Bryant et al., 2018; Nielsen et al., 2019), the integrated findings add specificity to broad recommendations for family-centred and trauma-informed care by identifying the forms of support parents and practitioners considered useful in everyday practice. These findings therefore extend existing calls for "trauma-informed care" by illustrating what culturally responsive, family-centred and trauma-aware practice should look like in everyday support for refugee parents.

Implications for Policy and Practice

The findings suggest that improving support for refugee parents requires system conditions that make support accessible and effective. Stability is foundational: rapid access to secure housing, predictable income, and early legal clarity create the conditions in which parents can support their children.

The three overarching system conditions offer a practical framework for strengthening provision. Coordination, communication and competence require connected systems with clear referral routes, reliable interpreter support and staff confident in working cross-culturally. This may include establishing liaison roles to map local services, community assets and families as well as to ensure routine information exchange between statutory and voluntary agencies. Responsiveness depends on early, flexible engagement. For example, arrival-stage orientation, school-based mental health check-ins, and pastoral staff with protected time to support newly arrived families. The right setting involves delivering support in trusted environments such as schools, community hubs and faith spaces, alongside proactive outreach to families in hotels or temporary accommodation. This is particularly important given plans in the UK to relocate asylum seekers to Ministry of Defence sites,

which are often remote and risk further restricting access to services and community networks (Rankl & Gower, 2025). These principles can guide commissioners, and service leads in assessing gaps and improving provision across all levels of need.

To support translation of these findings into practice, Table 5.2 draws on the three system conditions to provide a set of reflective questions that services can use to consider how accessible and responsive their provision is to refugee families. Rather than prescribing a single model of care, the questions are intended to support reflection on how local pathways, communication, responsiveness and delivery settings may facilitate or constrain families' engagement with support.

Table 5.2

Practice-informed Reflective Questions to Guide Services Supporting Refugee Families' Mental Health.

Domain	**Focus of reflection**	**Reflective questions**
Coordination, Communication and Competence	*How service systems, professional practices and communication processes enable or constrain refugee parents' ability to understand concerns, raise issues, and engage with support*	- Do professionals across health, education, community and voluntary sectors understand each other's roles and referral pathways? - Are clear, coordinated referral routes in place so families are not "bounced" between services or lost during relocation? - Are information-sharing processes in place so parents do not need to repeatedly retell their stories? - Is information provided directly to parents, in their own language, rather than via hosts or intermediaries? - Are interpreter needs routinely identified and met with trained interpreters and translated materials? - Do staff receive training in refugee experiences, trauma, and culturally shaped parenting norms? - Do practitioners feel confident working with interpreters and assessing behaviour through a refugee-informed lens? - Are families actively involved in discussions and decisions about their child's mental health? - Is there a named contact or liaison role to help families navigate services?
Responsiveness	*How the timing, thresholds and continuity of support shape families' access to early, proactive and sustained mental healthcare*	- Are early conversations, orientation and guidance offered soon after arrival? - Do services proactively identify early signs of stress rather than waiting for crisis or safeguarding thresholds? - Are early-help plans developed by professionals who already know the family? - Are waiting times manageable, and is support maintained when families move or are relocated?

Domain	Focus of reflection	Reflective questions
		- Do families know where and how to seek help without fear of negative consequences (e.g., child removal, immigration implications)? - Can staff respond flexibly when children struggle with transitions such as school changes or relocation? - Is follow-up timely and consistent, avoiding long periods of silence? - Is family feedback used to improve timeliness, continuity and relevance of support?
Right Setting	*How the location, accessibility and relational qualities of services influence trust, engagement and sustained participation*	- Are supports delivered in settings families recognise and trust (e.g., schools, ESOL classes, community hubs, faith spaces)? - Do parents feel safe, welcomed and able to speak openly in these settings? - Are outreach supports offered in hotels or temporary accommodation rather than relying on self-referral? - Is contact maintained with families after relocation, including to rural or remote placements? - Are services physically, financially and practically accessible (transport, childcare, timing)? - Are interpreter-supported sessions available within these settings? - Do spaces feel culturally safe and inclusive rather than formal or intimidating? - Are low-barrier engagement opportunities (e.g., playgroups, informal gatherings) used to build trust and belonging? - Are community partnerships used to strengthen engagement and continuity?

Alongside these system-level considerations, the findings also have implications for the content of support available to families. Specialist psychological support should reflect the forms of help parents identified as most useful, including practical guidance, family-centred and joint parent-child approaches and culturally responsive therapy. Global evidence synthesised by WHO, UNICEF and the Special Representative of the Secretary-General on Violence Against Children identifies evidence-based parenting support as a scalable and cost-effective approach to improving child and caregiver wellbeing and preventing childhood adversity (WHO, 2024; WHO et al., 2021). Investing in a trained workforce with expertise in trauma, displacement, and interpreter-mediated practice is therefore essential to ensure timely, continuous, and effective care.

Strengths and Limitations

A key strength of this study is the integration of refugee parent and cross-sector stakeholder perspectives, enabling support needs to be examined across family, service and system levels. Template analysis provided a structured approach for bringing these perspectives together around a focused applied question, while allowing both anticipated and data-driven dimensions of support to be identified. However, the use of *a priori* categories informed by existing literature and the preceding studies may have shaped which aspects of the data were foregrounded, although iterative refinement of the template allowed participants' accounts to modify and extend the initial analytic structure. Strengths and limitations relating to the original samples, recruitment, interpreter use and data collection are detailed in Chapters 3 and 4 and also apply to the present analysis. The broader methodological implications of re-analysing the same interview datasets across studies, including potential conceptual overlap between analyses, are considered in the General Discussion.

Future Directions

Future research should examine how services can operationalise and evaluate the three system conditions identified here. Co-produced work with refugee communities could support the development of tools to assess coordination, responsiveness, and contextual fit within real service pathways. Studies should also explore how family-centred and preventative therapeutic approaches can be embedded within schools, early-help provision and community programmes, including parent-led models that build caregivers' confidence and skills. Longitudinal and implementation research will be essential for understanding how support needs evolve across resettlement and for evaluating sustainable models of delivery.

5.5 Conclusion

Integrating parent and stakeholder perspectives identified a shared view of support as extending across four interconnected levels, from basic stability and community support to parent-focused and specialist psychological care. Importantly, the analysis identified three cross-cutting system conditions, coordination, communication and competence; responsiveness; and the right setting, that shaped whether support across these levels was perceived as accessible and useful to

families. Together, these findings provide a more specific account of both the support refugee parents may need and the service conditions required for them to engage with it.

Within these support conditions, parents and practitioners placed particular value on practical, family-centred and relational forms of psychological support that could strengthen parents' capacity to help their children. This raises the question of whether evidence-based psychological strategies could be delivered through parents in ways that are both scalable and professionally supported. Therapist-guided parent-led interventions offer one potential approach, but their feasibility within refugee contexts cannot be assumed given the structural, relational and practical conditions identified in this study.

The following study therefore examines the perceived acceptability and feasibility of therapist-guided parent-led child mental health interventions, using an implementation science framework to identify the conditions required for their delivery within refugee-serving systems.

Chapter 6: Perceived Feasibility of Implementing Therapist-Guided Parent-led Interventions for Refugee Children's Mental Health

6.1 Background

As outlined in Chapter 2, effective psychological treatments for childhood anxiety and trauma are well established. Chapters 1 and 2 highlight how refugee children in high-income host countries continue to experience a substantial gap between mental health need and engagement with specialist services. Chapters 3–5 describe how barriers to seeking, accessing and receiving support operate at multiple levels. At the family level, these studies identified how parents' engagement with formal healthcare systems could be constrained by language barriers, limited familiarity with service pathways, and mistrust or fear of authorities. These findings are consistent with wider evidence demonstrating how linguistic, cultural and trust-related barriers can shape refugee families' engagement with mental health services (e.g., Ellis et al., 2011; Silove et al., 2017). At the service and system levels, the studies identified fragmented provision across statutory, voluntary and community sectors and difficulties navigating pathways between services. These challenges occur within a wider context of rising demand and workforce pressures within CAMHS, which contribute to prolonged waiting times and difficulties accessing specialist support (Children's Commissioner for England, 2021).

Traditional therapist-led, child-facing interventions that are typically delivered to children through regular individual or group sessions (e.g., Creswell et al., 2020) can require substantial therapist time and continuity of service contact. Notably in the present thesis, Chapter 2 found that delivery of child-facing psychological intervention was relatively uncommon for refugee children and young people in routine CAMHS and that treatment pathways could be affected by service capacity, eligibility and relocation, while Chapters 3-5 highlighted practical and structural barriers that could make sustained engagement with services difficult for some families. Approaches requiring prolonged, regular, in-person attendance with the same service may therefore be challenging where families face relocation, transport or financial constraints, or fragmented care pathways. Thus, the

challenge lies not only in identifying effective interventions, but in delivering them in ways that are accessible, acceptable, and sustainable within resource-limited refugee-serving contexts.

The preceding studies also pointed towards the potential value of working through parents rather than focusing solely on child-facing provision. Parents described already undertaking substantial day-to-day work to support their children, while parents and stakeholders identified a need for practical guidance, strategies that could be used at home, and family-centred support (Chapters 3–5). This aligns with wider evidence on the central role of caregivers in children's recovery from adversity, and the growing development and adaptation of parenting and family-based interventions for refugee populations (e.g., Gillespie et al., 2022). Parenting practices, caregiver-child relationships, and parental self-efficacy are established protective factors in the context of trauma and chronic stress (Masten & Palmer, 2019). Accordingly, parent-focused programmes targeting parenting skills, psychoeducation, and trauma-informed support have demonstrated improvements in family functioning and child internalising and externalising symptoms, with emerging evidence of acceptability in refugee populations (Bunn et al., 2022; Fazel & Betancourt, 2018; Gillespie et al., 2022; Kazdin et al., 2018). Examples include culturally adapted interventions such as SPARE (Strengthening Parenting Among Refugees in Europe), which integrates Parent Management Training-Oregon Model (PMTO) principles with refugee-specific content (Sigmarsdóttir et al., 2025). However, many existing parenting interventions require substantial and sustained therapist involvement, which may constrain their scalability within capacity-pressured specialist services. Furthermore, while these interventions have demonstrated benefits for parenting practices, family functioning, and child adjustment, they have generally been developed as parenting and family support programmes aimed at promoting wellbeing or preventing difficulties, rather than as treatments for children presenting with clinically significant mental health disorders. Consequently, they differ in both their therapeutic targets and mechanisms of change from therapist-guided parent-led psychological interventions, which are designed to treat specific child mental health problems.

In these approaches, caregivers are supported to implement structured, evidence-based strategies in their child's daily life, with time-limited and targeted professional guidance. In non-refugee populations, guided parent-led interventions have demonstrated clinical and cost-effectiveness

for childhood anxiety and trauma-related difficulties, substantially reducing therapist time compared to traditional child-directed approaches (e.g.,. By redistributing elements of psychological intervention to the home while retaining professional oversight and support, such models may offer a pragmatic pathway to extending intervention delivery beyond conventional service settings. However, little is known about whether and how guided parent-led approaches can be effectively implemented within refugee-serving systems, or how they may need to be adapted to account for cultural diversity, trauma histories, family roles, literacy levels, and ongoing contextual stressors.

Addressing these questions requires moving beyond considerations of intervention efficacy to examining the contextual, organisational, and individual determinants that shape adoption, delivery, and sustainment in real-world settings. This qualitative study therefore investigates refugee parents' and cross-sector stakeholders' perspectives on therapist-led and guided parent-led approaches to child mental health support. Drawing on an implementation science perspective, it explores perceived barriers, facilitators, and adaptation needs across intervention, organisational, and system levels, with the aim of informing the development of culturally responsive and scalable guided parent-led interventions for refugee children.

6.2 Methods

Study Design

This qualitative study draws on semi-structured interviews conducted within two complementary projects: ENRICH, involving refugee and asylum-seeking parents (July 2023-February 2024), and ESTEEM, involving professionals and community stakeholders supporting refugee and asylum-seeking families across health, education, and voluntary sectors (March-August 2024). The present study reports a secondary, theory-informed analysis examining perceptions and implementation influences related to therapist-led and guided parent-led child mental health interventions. Including both refugee parents and cross-sector stakeholders enabled exploration of determinants operating across individual, organisational, and system levels. Detailed recruitment and data collection procedures are reported in Studies 2 and 3 (Chapters 3 and 4).

Adopting an implementation science perspective, the analysis addressed the following questions: a) how do refugee parents and cross-sector stakeholders understand and evaluate therapist-led and guided parent-led approaches to child mental health support?; b) what multilevel barriers and facilitators shape the acceptability, feasibility, and adoption of guided parent-led interventions within refugee-serving systems?; and c) what contextual adaptations and implementation strategies are required to support their delivery and sustainability?

Participants

This study drew on the parent and stakeholder datasets described in Studies 2 and 3 (Chapters 3 and 4). The combined dataset comprised 53 participants: 23 refugee and asylum-seeking parents of children aged 3–11 years and 30 professionals and community stakeholders with experience supporting refugee families. Full eligibility criteria, recruitment procedures, sampling strategy and participant characteristics are reported in Chapters 3 and 4, respectively.

Procedure and Measures

Full details of the measures, interview procedures, translated materials and interpreter arrangements used for the parent and stakeholder studies are provided in Studies 2 and 3 (Chapters 3 and 4). For the present study, interviews included questions specifically exploring perceptions of therapist-led and guided parent-led therapy, illustrated using examples from cognitive behavioural therapy (CBT) for supporting refugee children's mental health. Both sets of participants were provided with a brief, plain-language explanation of therapist-led and parent-led approaches, using CBT as an example (see Appendix G and I). Both sets of interview questions focused on perceived acceptability, concerns, and potential barriers and facilitators to parent-led approaches, as well as preferences regarding mode of delivery (e.g., online vs in-person; group vs individual). In the parent interview guide questions were framed around parents' own experiences, whereas stakeholders were asked to reflect on the refugee families they supported.

Data Analysis

Data were managed in NVivo (Mac version 14) and analysed using template analysis, following the six-phase process outlined by Brooks et al. (2015) building on the approach described

by King (2012). Template analysis was selected for its capacity to integrate theory-informed analytic structure with inductive, interpretive analysis, making it well suited to examining multilevel influences on the implementation of child mental health interventions within complex refugee-serving systems.

The Consolidated Framework for Implementation Research 2.0 (CFIR 2.0; hereafter CFIR) was used as an analytic scaffold to inform the development of the initial coding template. *A priori* domains corresponding to CFIR's five core domains; innovation, outer setting, inner setting, individuals, and implementation process - were included in the initial template to sensitise analysis to established determinants of implementation. These domains were not treated as fixed or exhaustive; rather, they provided an organising structure within which participants' accounts could be examined and interpreted.

The analytic process involved iterative familiarisation with the data, preliminary coding, and the progressive refinement of the template. Within each CFIR domain, inductive sub-themes were developed to capture context-specific meanings, experiences, and adaptations described by participants. Where data did not align clearly with existing CFIR constructs, new codes were generated, and the template was adapted accordingly. This ensured that the analysis remained grounded in participants' perspectives while allowing findings to extend, nuance, or challenge existing implementation theory.

I led the analysis, with regular analytical discussions involving CC, LB and SLH, whose disciplinary and experiential perspectives are described in Chapter 3. Reflexivity was maintained throughout, with particular attention to how researchers' perspectives and the use of CFIR shaped engagement with and interpretation of the data. Collaborative discussions were used to challenge interpretations, review coding decisions and examine the fit between themes and CFIR domains. The template was refined through these discussions before being systematically applied to all transcripts. Findings are presented according to CFIR domains to facilitate transparent examination of implementation barriers, facilitators, and adaptation needs across system levels.

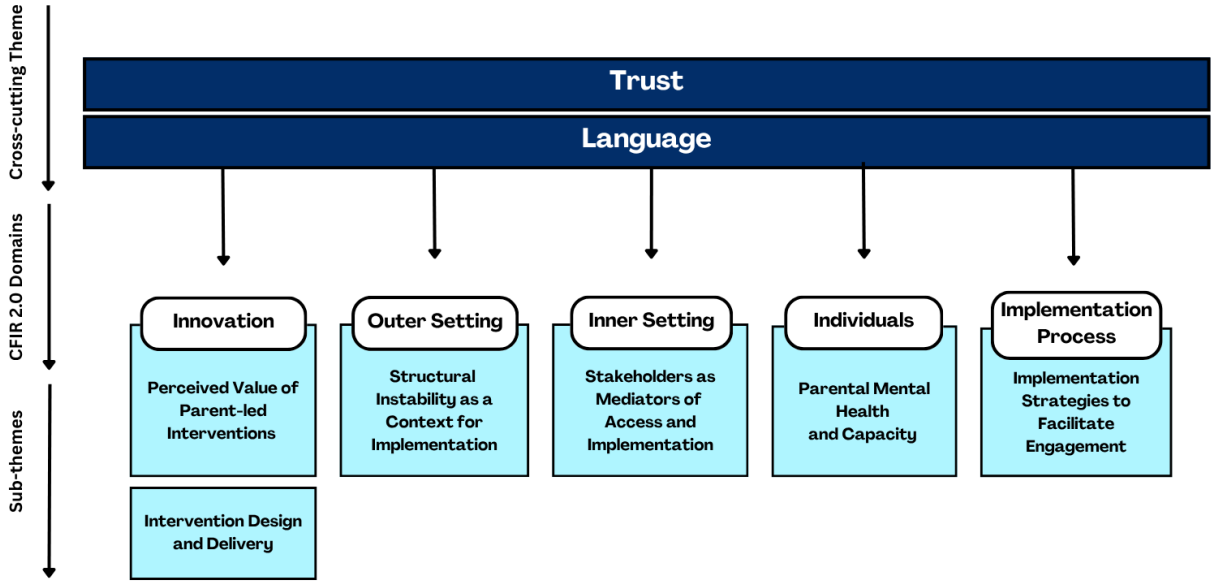
6.3 Results

A conceptual model of the findings is presented in Figure 6.1. Through the analysis, I identified a set of interrelated factors shaping the perceived feasibility of implementing parent-led child mental health interventions with refugee families across intervention, individual, organisational, and system levels. Although parent-led interventions were widely perceived as acceptable and, in many cases, preferable, participants consistently described successful implementation as contingent on conditions that differ from those assumed by standard parent-led models, including language concordance, service familiarity, relational continuity, and parental capacity. Rather than simply identifying additional barriers, the findings illustrate how experiences of forced migration and resettlement reshape the conditions under which guided parent-led interventions are perceived to be feasible.

Language and trust emerged as cross-cutting determinants operating across all domains of the conceptual model. Together, the remaining themes describe how intervention, organisational, individual, and contextual factors interact to shape the perceived feasibility of implementing parent-led interventions with refugee families and identify where adaptation may be required.

Figure 6.1

Conceptual Model Illustrating Cross-Cutting and Multi-Level Determinants of Feasibility and Engagement with Parent-Led Child Mental Health Support in Refugee Contexts.



Cross-cutting Determinant 1: Language

Language was perceived to operate as a cross-cutting determinant shaping the perceived feasibility of implementing parent-led interventions across intervention, individual, organisational, and system levels. Participants described language as influencing parents' abilities to communicate their experiences, with one parent explaining the difficulty of trying to “explain to someone how you're feeling” (P6), as well as their understanding of intervention strategies, particularly where more complex content required “an adequate interpreter” to ensure understanding (S17). Participants further described inconsistent access to interpreters (“can't find an interpreter” (S6)) and concerns that interpreted communication could compromise both understanding and trust (S19).

While interpreters were perceived to facilitate communication, some participants described a preference for practitioners “who spoke their language” (S4) and “who understands the culture” (S25), because shared language and cultural understanding were perceived to facilitate understanding, trust, and engagement with intervention strategies.

Cross-cutting Determinant 2: Trust

Participants described trust as a perceived precondition for engagement with parent-led interventions. Within refugee contexts, concerns regarding immigration status, confidentiality, and the potential consequences of disclosure meant that interventions were evaluated through perceptions of safety and credibility. Participants perceived trust to depend on linguistic and cultural alignment, continuity of relationships (e.g., “face change, change, change… I don’t trust this man” (P7)), and confidence that personal information would be handled appropriately. Across the findings, trust was perceived to shape the feasibility of implementing parent-led interventions by influencing whether families felt able to access, engage with, and sustain participation.

Theme 1: Innovation: Intervention Characteristics Shaping Feasibility

Participants described views that successful implementation of parent-led interventions will be dependent on how well parent-led interventions align with the realities of refugee families’ lives. This shaped both their perceived value and how participants considered they should be designed and delivered.

Subtheme 1a. Perceived Value of Parent-led Interventions

Participants perceived parent-led interventions as being potentially valuable because they were considered likely to reduce exposure to risks to children and families associated with formal services while enabling parents to retain responsibility for supporting their child's mental health. Parents expressed reluctance to entrust their children to unfamiliar professionals, with one parent explaining, “I will not let my child to be one-to-one to other adults… it’s scary for me. Because I don’t know him” (P3). For some participants, concerns regarding asylum status, social services involvement, and the potential consequences of recorded information appeared to reinforce preferences for interventions that remained within the parent-child relationship. As one participant explained, “if I feel 0.1% that this will happen, I will stop immediately… I will prefer to deal my daughter with my own way rather than take my daughter from me” (P11), illustrating how perceived institutional risks influenced preferences for intervention delivery.

Participants also perceived continuity as a key advantage of parent-led interventions. As one stakeholder noted, “the parent is a constant… whereas a professional… comes and goes” (S15), highlighting the importance of maintaining support within the family in contexts characterised by instability and disrupted service contact.

Beyond reducing perceived risks, parent-led interventions were also viewed as empowering and practically advantageous in the context of displacement. As one stakeholder reflected, “when you come through… forced migration… everything [has] been taken from you… to give back… something that they [parents] will be able to do themselves… that’s quite powerful” (S17), while another described how “everything that makes them [parents] feel involved… could be very, very valuable” (S18). Together, these findings suggest that the perceived value of parent-led interventions derives not only from their therapeutic approach but also from the way they align with refugee families' preferences for continuity, parental control, and reduced reliance on formal services.

Subtheme 1b. Intervention Design and Delivery

Participants considered how parent-led interventions were designed and delivered to be important for successful implementation. Their accounts highlighted the need to balance accessibility

and engagement with families' preferences, circumstances and practical constraints. Different delivery formats involved trade-offs between accessibility, relational engagement, and privacy. Face-to-face delivery was perceived to facilitate engagement and communication, allowing participants to "give full attention" (P5), but was not always feasible because of financial and travel constraints: "sometimes we have to take a bus… [and] sometimes we don't have money" (P1).

Remote delivery offered greater accessibility but introduced different challenges. Participants noted that "calling is way better… I don't have to grab a bus" (P11) and described the use of informal platforms such as WhatsApp to support flexible communication (S28). However, remote approaches were also perceived to introduce trade-offs, particularly where language barriers and the absence of face-to-face interaction made communication more difficult, with one stakeholder noting "we've discovered over the phone stuff doesn't work terribly effectively" (S6). Concerns regarding privacy and surveillance further reduced the acceptability of remote delivery for some participants, with one explaining, "your mobile is under the trace… when you talk about each thing there is a trace" (P20).

Group delivery involved similar trade-offs. While stakeholders valued opportunities to share experiences with others who were "in the same boat" (S15), participants described concerns regarding privacy, disclosure, and social visibility within close-knit refugee communities, where "everybody knows everybody's business" (S23). Parents expressed reluctance for others to know about their child's difficulties ("I don't want other Ukrainians to know my child's problems" (P3)) and described feelings of "shame" (P10). Consequently, some participants perceived more individualised approaches to be preferable, noting that "some people cannot open in the group" (P9).

Intervention content and materials also needed to be accessible. Theory-heavy or instructional approaches were viewed as difficult to implement, with one stakeholder commenting, "I don't think giving them a piece of paper would work at all… even if you translated this information…" (S30). Instead, participants suggested more experiential approaches such as "modelling and mirroring", noting that "I don't know if we always learn behaviours by words" (S28), particularly for some "families where they're illiterate" (S23).

Theme 2: Outer Setting: Structural Instability as a Context for Implementation

Participants described engagement with parent-led interventions as contingent on broader life conditions, rather than parents' motivation alone. In refugee contexts, housing instability, financial constraints, and competing responsibilities shaped whether engagement was possible at all, with one stakeholder noting that children could remain out of school for “three months… at home all day every day” (S4) while waiting for a school or nursery place, highlighting the extent to which disruption and unmet needs structured daily life.

Engagement was often secondary to immediate priorities, with one stakeholder emphasising that “if you don’t have those basics… the parents would struggle” (S10). Structural instability was not only described as a barrier to initiating intervention but also to sustaining it, as families “might get started… and then suddenly they’re plucked up and sent somewhere else… we get started with things and then it breaks down” (S12).

Theme 3: Inner setting: Stakeholders as Mediators of Access and Implementation

Participants described stakeholders as playing a central role in implementing parent-led interventions by introducing, explaining, and legitimising interventions through existing relationships within community, voluntary sector, and educational settings. Rather than expecting families to engage independently with specialist mental health services, participants described implementation as being facilitated through trusted organisational relationships.

Schools were identified as a particularly important organisational setting because they represented one of the few familiar and consistent points of contact within otherwise fragmented service pathways. As one stakeholder explained, “the child’s already in school… that’s really good… easily accessible for the family” (S27), while another suggested that schools could “identify children who’d benefit… and where parents would engage” (S16), positioning them as stable organisational entry points for implementation.

Stakeholders also described introducing and explaining parent-led interventions as a core implementation activity because many families were unfamiliar with specialist mental health services and “not familiar with how specialists work… what that intervention would mean” (S30). Similarly,

participants explained that “they find it easiest if we take solutions to them rather than them having to come” (S7), highlighting that implementation relied on stakeholders actively connecting families with interventions rather than expecting independent help-seeking.

Theme 4: Individuals: Parental Mental Health and Capacity to Implement Intervention Strategies

While parent-led interventions were widely valued (1a), participants questioned whether parents would always have the emotional capacity to implement intervention strategies, particularly given their own mental health needs. Parents described being overwhelmed by their own experiences, with one reflecting, “I am suffering myself… how can I console my son?”, illustrating how emotional distress could limit their ability to support their child. Others similarly emphasised that “sometimes if the parents are emotional, they can’t do that work well effectively” (P1), while stakeholders noted that some parents were “so engrossed in their own issues… they might struggle” (S6).

These accounts suggest that parents and stakeholders assume that parent-led approaches require a level of emotional capacity that may not always be present in refugee contexts. Implementation may therefore need to account for parents' own mental health needs, recognising that parents may require support to effectively deliver intervention strategies.

Theme 5: Process: Implementation Strategies to Facilitate Engagement

Participants described implementation as requiring proactive approaches to engagement rather than relying on standard referral pathways. Delivering interventions through familiar, “welcoming” (S27), and accessible settings (“such as schools and charities” (S9)), alongside outreach and regular communication, was perceived to facilitate engagement.

Participants also emphasised the importance of establishing relationships before expecting parents to engage with interventions. Addressing immediate practical needs and providing tangible supports, such as “food is a great incentive” (S27) or “a £10 shopping voucher… a little sweetener… because it works” (S24), were described as helping establish relationships and support engagement.

6.4 Discussion

Existing evidence demonstrates that parenting and family-based interventions can be acceptable and beneficial for refugee families (e.g., Bunn et al., 2022; Gillespie et al., 2022) but may be prohibitively resource intensive. In parallel, therapist-guided parent-led psychological interventions have demonstrated clinical and effectiveness to treat common mental health problems in general populations (e.g., Creswell et al., 2017), with potential to markedly reduce therapist time without compromising acceptability or child outcomes (Creswell et al., 2024). This study brings these literatures together by examining the implementation conditions perceived to be required to support guided parent-led interventions in refugee-serving contexts. The findings suggest that forced migration and resettlement shape many of the conditions on which guided parent-led intervention models rely. The resulting conceptual model (Figure 6.1) therefore extends existing implementation knowledge by identifying how intervention, organisational, individual, and contextual factors interact to shape the perceived feasibility of implementing guided parent-led interventions with refugee families

Participants perceived guided parent-led interventions to offer a distinctive advantage over traditional therapy formats, in refugee contexts because they reduced perceived exposure to risks associated with formal services while allowing therapeutic support to remain within the parent-child relationship. Trust was central to this perception. Although trust has long been recognised as facilitating refugees' engagement with mental health services (e.g., Majumder et al., 2015), participants described trust as extending beyond confidence in individual clinicians to encompass wider perceptions of institutional safety, confidentiality, and the potential consequences of disclosure. Trust was therefore closely linked to perceptions of safety, reflected in preferences for face-to-face, one-to-one delivery and continuity of relationships. Within this context, guided parent-led interventions were perceived to offer greater parental control over disclosure while limiting a child's interaction with unfamiliar professionals and formal services. Thus, the findings suggest that trust shapes not only engagement with services but also the perceived acceptability of guided parent-led interventions.

Establishing trust was perceived to depend not only on the intervention itself but also on the organisational pathways through which families encountered it. Whereas therapist-guided parent-led interventions in general populations are typically delivered through established healthcare pathways, participants described implementation in refugee contexts as relying on trusted organisations and stakeholders to identify families, introduce interventions, and facilitate engagement. This extends existing evidence on the role of cultural brokers in post-conflict mental healthcare (e.g., Arambewela-Colley, 2021) by suggesting that trusted organisational relationships may facilitate not only access to care, but also the implementation of guided parent-led interventions. Participants consistently identified schools and community organisations as stable and familiar points of contact through which interventions could be introduced despite otherwise fragmented service pathways. Structural instability and competing resettlement demands further reinforced the need for flexible implementation pathways, with outreach, practical support, and repeated opportunities for engagement supporting implementation over time. Stakeholders also described tangible practical support, including food or vouchers, as potentially facilitating initial engagement. Although financial incentives can increase uptake and engagement with health interventions (e.g., Khazanov et al., 2022; Michaud et al., 2022), their use may warrant particular caution where financial insecurity could influence families' decisions to participate. Thus, rather than assuming participation will happen as long as services are available, implementation should be understood as being actively constructed through organisational relationships and ongoing system-level support.

Access to guided parent-led interventions was perceived as only one component of implementation. Participants also questioned whether parents would consistently have the emotional capacity to undertake the therapeutic role these interventions require. Previous research has demonstrated that parental mental health influences parenting and child outcomes among refugee and conflict-affected families (e.g., Bryant et al., 2018; Sim et al., 2018), while parenting interventions with refugee families may also improve aspects of parental wellbeing (e.g., Miller et al., 2023). The present findings extend this literature by suggesting that, within guided parent-led psychological interventions, parental mental health may also shape the perceived feasibility of implementation because parents become responsible for delivering therapeutic strategies with their children. Rather

than assuming that all parents are equally positioned to undertake this therapeutic role, implementation may benefit from considering parental mental health when determining whether additional family support should be provided alongside the intervention. This raises important considerations for equitable implementation, particularly in avoiding the transfer of therapeutic responsibility onto already burdened caregivers without adequate support.

Implications

The findings suggest that guided parent-led interventions with refugee families are likely to require adaptation at both the intervention and implementation levels. At the intervention level, findings concerning language and intervention design highlighted the need for linguistically accessible communication, appropriate interpreter provision and demonstration-based rather than predominantly written or theory-heavy materials. Participants' accounts of trade-offs between face-to-face, remote and group delivery further indicated that flexible delivery formats may be needed to accommodate differing preferences around accessibility, privacy and parental control. Findings concerning parental mental health and capacity also raised questions about the support parents may require to undertake therapeutic strategies alongside existing responsibilities and in the context of wider challenges. Rather than treating parental distress as necessarily precluding parent-led intervention, implementation may consider what additional support or adaptation may enable parents to undertake this role, including where appropriate support for parents' own mental health alongside their child's treatment.

Adaptation of the intervention itself may be insufficient without implementation approaches that enable families to access and engage with it. Findings across the Outer Setting, Inner Setting and Process domains highlighted the potential importance of trusted organisations and stakeholders in introducing and legitimising guided parent-led interventions, alongside proactive outreach, practical support, and repeated opportunities for engagement as families' circumstances changed. This builds on Chapter 4, where stakeholders similarly occupied an important intermediary position between families and mental-health services, but varied in their confidence, knowledge and perceived responsibility for responding to children's mental-health needs. The present findings suggest that this

intermediary role may also be relevant to intervention implementation, while highlighting that involvement would need to reflect stakeholders' existing remit and capabilities. In England, Mental Health Support Teams (MHSTs), and the Education Mental Health Practitioners working within them, may provide one potential pathway for delivery, given their established role in providing early mental health interventions within schools (Ellins et al., 2024). Their position within schools also aligns with participants' emphasis on trusted settings and familiar relationships as facilitators of engagement. Future research should examine the feasibility and acceptability of delivering guided parent-led interventions through MHSTs and other school- or community-based mental health services. Collectively, these findings indicate that implementation requires adaptation of both the intervention to meet families' needs and of service approaches to ensure they are capable of establishing and sustaining engagement over time.

Strengths and Limitations

As in the preceding qualitative studies, a strength was the inclusion of refugee parents from varied cultural, national and migration backgrounds alongside stakeholders working across statutory, voluntary and community sectors. For the present study, combining these perspectives was particularly valuable because implementation determinants could be examined across family, organisational and system levels. The use of CFIR-informed template analysis also provided a more explicitly theory-informed analytic lens than the approaches used in the preceding qualitative studies. Whereas RTA in Chapters 3 and 4 explored patterns of meaning within participants' experiences, and template analysis in Chapter 5 integrated parent and stakeholder perspectives around support needs, the CFIR-informed analysis enabled these accounts to be examined specifically in relation to established implementation determinants and the conditions required for intervention delivery. CFIR provided an initial structure for the analysis, while the flexibility of template analysis allowed the template to be refined in response to participants' accounts rather than restricting the findings to predetermined CFIR constructs.

Several limitations should be considered. Limitations relating to the parent and stakeholder samples and interview procedures are discussed in detail in Chapters 3–5; here, I focus on those with

particular implications for the present implementation analysis. The parent sample was predominantly mothers, limiting understanding of fathers' perspectives and of how responsibility for delivering parent-led interventions might be negotiated within families. This is particularly relevant because parent-led models could inadvertently reinforce unequal caregiving responsibilities if implementation assumes that mothers will undertake the therapeutic role. Similarly, although recruitment of families within three years of arrival was deliberate, the focus on early resettlement has particular implications for the present study because the feasibility of parent-led interventions may change as families become more established and practical demands, familiarity with services and support networks evolve. The study examined perceived rather than observed implementation: participants considered a proposed intervention rather than delivering it within routine services, so perceived barriers and facilitators may differ from those encountered in practice. Prospective piloting is therefore needed to test the model's acceptability and feasibility and to examine its implementation across different stages of resettlement and refugee-serving contexts.

6.5 Conclusion

Therapist-guided parent-led interventions represent a potentially promising approach to improving access to evidence-based child mental health treatment for refugee families. This study extends existing evidence by identifying the implementation conditions perceived to be required to support these interventions in refugee-serving contexts. The findings demonstrate how forced migration and resettlement shape the conditions on which guided parent-led interventions rely, requiring adaptation to both the intervention and the systems through which it is delivered. The conceptual implementation model developed in this study provides a framework to inform future adaptation, piloting and implementation of guided parent-led interventions that are both scalable and responsive to refugee families' needs.

More broadly, these findings reinforce a pattern that emerged across the programme: the support refugee children and families receive cannot be understood independently of the conditions in which that support is recognised, accessed and delivered. The General Discussion therefore brings

together findings across all five studies to examine these conditions across family, community and specialist mental health contexts, and their implications for refugee children's mental healthcare.

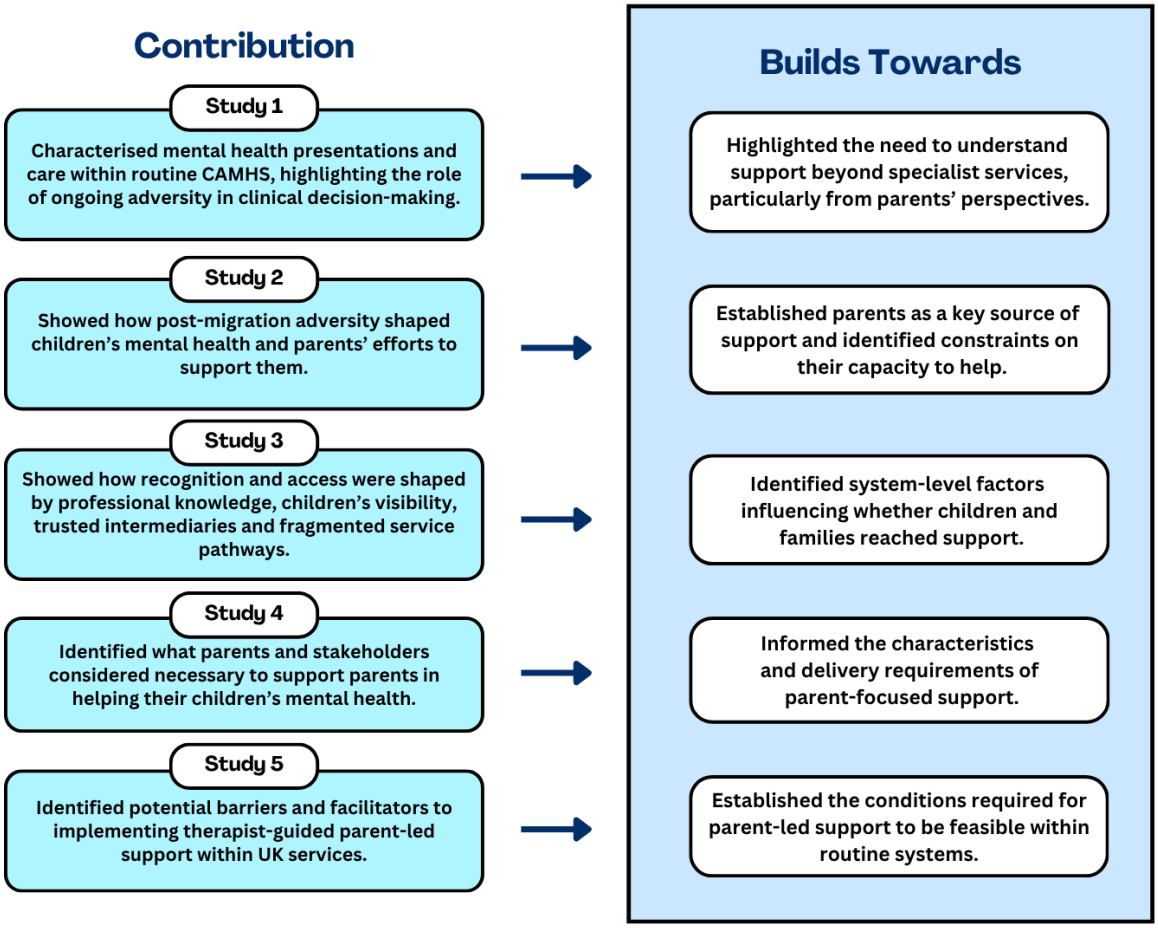
Chapter 7: General Discussion

7.1 Overview of the Programme of Research

Taken together, the five studies provide a multi-level understanding of refugee children's mental health needs, the support they require and receive, and how these needs are recognised and addressed across family, community and specialist mental health contexts (Figure 7.1).

Figure 7.1

Contributions of the Five Studies and Their Progression Across the Programme of Research



Three consistent findings emerged. First, children's mental health was closely intertwined with continuing post-migration adversity, which also shaped parents' capacity to support them. Second, access to support depended not only on service availability, but on how children's needs were recognised and responded to across fragmented systems, with language barriers, variable provision and difficulties engaging with services limiting access to care. Third, although parents were central to

supporting children's mental health, their capacity to do so, including through parent-led interventions specifically, depended on wider conditions including trust, practical and emotional capacity, language accessibility, coordinated services and organisational flexibility. Collectively, the thesis demonstrates that improving refugee children's mental health requires attention not only to what support is provided, but to the conditions that enable children and families to access, engage with and benefit from it.

7.2 Post-Migration Adversity Shapes Both Mental Health and Mental Health Support

The influence of post-migration adversity on refugee children's mental health is well established, with insecure immigration status, housing instability, language barriers, poverty and family separation associated with poorer psychological outcomes (Scharpf et al., 2021; Sengoelge et al., 2022). These conditions can also create barriers to accessing appropriate mental health support (Barbo & Petrucka, 2024; Colucci et al., 2014; Dumke et al., 2026). This thesis extends this literature by suggesting that post-migration adversity may operate not only as a determinant of mental health need, but also as determinant of the opportunity to respond to that need. Across the five studies, the same conditions that contributed to children's distress also shaped parents' capacity to support them, professionals' opportunities to recognise need, access to services, clinical decision-making and families' engagement with care.

Importantly, these influences operated at different levels of the support system, consistent with ecological accounts emphasising interactions between individual experiences and wider family, community, and structural conditions (Miller & Rasmussen, 2010, 2024). From the family perspective, parents described trying to support children while managing housing instability, language barriers, financial pressures and their own resettlement demands (Chapter 3). Stakeholder accounts complemented this picture by showing how the same conditions could affect the systems around the families: repeated relocation, legal uncertainty and fragmented provision were perceived to disrupt opportunities for recognition and continuity of support (Chapter 4). Within CAMHS, children's difficulties were frequently understood in relation to displacement and continuing adversity, which shaped decisions about whether direct psychological intervention was appropriate and the extent to

which wider social and community support was prioritised (Chapter 2). The implementation study extended this pattern further, indicating that practical and emotional pressures associated with resettlement could also shape parents' perceived capacity to engage with and deliver parent-led psychological interventions (Chapter 6). Taken together, post-migration adversity appeared to operate in two interconnected ways: it contributed to children's mental health difficulties while simultaneously constraining the capacity of families and services to respond to them.

7.3 Current Models of Care Depend on Systems that are Often Inaccessible to Refugee Families

Reflecting the multiple determinants of refugee children's mental health, existing literature has advocated multimodal and multilevel approaches that combine individual interventions with family, school, community and wider psychosocial support (Springhetti et al., 2026). This is reflected in refugee mental health frameworks that propose layered or multisectoral models of care, combining practical and community-based support with focused and specialist mental healthcare according to need (IASC, 2007), alongside more recent WHO recommendations emphasising coordinated action across individual, family, community and health-system levels (WHO, 2023). Findings across the programme supported the rationale for these approaches but also exposed difficulties in delivering them.

One tension concerned how children become visible to support systems in the first place. In Chapter 4, stakeholders described identification as often relying on parents communicating concerns to professionals. Yet Chapter 3 suggested that parents may be reticent to share concerns about their child's mental health and that parents may only develop the confidence to disclose this as trusted relationships develop, as suggested by the fact that brief initial ratings of children's mental health were often more favourable than the difficulties subsequently described during longer interviews. Although a research interview cannot be equated to clinical help-seeking, the juxtaposition is important. Systems that depend on parents readily identifying and disclosing concerns may be less effective where trust, familiarity with mental-health concepts or perceived consequences of disclosure shape what parents feel able to communicate. This interpretation is consistent with evidence that refugee families' disclosure and help-seeking may be influenced by mental-health literacy, stigma,

trust in services, and concerns about disclosure (Byrow et al., 2020; Colucci et al., 2014), but extends this literature by suggesting that these factors may shape not only whether families seek help, but how children's needs become visible to professionals. Recognition may therefore be better understood as a relational process requiring trust, continuity and repeated opportunities for discussion, rather than a discrete event occurring at initial contact.

A second tension concerned the relationship between adversity and access to psychological intervention. In Chapter 2, treatment was documented as 'not indicated' for almost half (47.7%) of the children who received no documented treatment, often where difficulties were contextualised within displacement and ongoing resettlement. More specifically, instability was explicitly documented as a reason for not providing psychological intervention for 7.5% of the full cohort. Stakeholders in Chapter 4 independently described a similar dilemma, where children could be considered unsuitable for therapy until housing, family, or immigration circumstances became more stable. This convergence across routine clinical records and professional interviews is notable in the context of wider debate about whether stabilisation should precede trauma-focused interventions. Although safety and stabilisation have historically been emphasised within phased approaches to complex trauma (Herman, 1992), evidence increasingly questions whether a preceding stabilisation phase is routinely necessary, including evidence that trauma-focused interventions can be effective in contexts of continuing adversity (e.g., Nahlén Bose & Diaz, 2025; Yim & Polymerou, 2026). Together, the findings add a service-level dimension to this debate: instability appeared not only as a source of distress, but as a factor informing decisions about whether psychological intervention could proceed. Continuing adversity may therefore occupy a paradoxical position within care pathways, simultaneously increasing need for support while reducing opportunities to receive it.

This paradox has wider implications for layered models of care, in which psychological and contextual support are intended to operate alongside one another. Chapter 2 showed that CAMHS frequently directed families towards schools, social care, community and voluntary-sector provision, while Chapters 3 and 4 indicated that these forms of support were valued but not consistently accessible. Parents described language and navigational barriers, while stakeholders described fragmented pathways, uneven local provision and limited capacity within schools and community

organisations. These findings mirror wider evidence of fragmented services, unclear referral pathways and limited cross-sector coordination in mental healthcare for forcibly displaced children (Byrow et al., 2020; Dumke et al., 2026). The issue is therefore not simply whether each layer of support exists, but whether families can move between them and receive the support to which they are directed. Layered care depends on functioning connections between its components; where these are weak, signposting or referral risks redistributing responsibility without resolving need.

A challenge identified across the thesis was therefore not simply insufficient provision at any single level, but the accessibility and coordination of the system as a whole. Wider psychosocial support cannot substitute for indicated psychological treatment, just as specialist treatment alone cannot resolve the structural conditions contributing to distress. Direct psychological intervention was relatively uncommon in the Chapter 2 CAMHS cohort, while stakeholders in Chapter 4 described difficulties accessing specialist provision. Although the thesis cannot determine whether the level of psychological intervention observed in Chapter 2 was specific to refugee children, this pattern sits within international evidence of lower outpatient specialist mental-health service use and lower receipt of guideline-concordant treatment among refugee and asylum-seeking children than non-refugee peers (Abou Seif et al., 2026; Sengun Filiz et al., 2026). At the same time, implementation research across child mental-health services more broadly indicates that delivery of evidence-based interventions depends on organisational capacity, workforce expertise, and available resources (Peters-Corbett et al., 2024). Effective multilevel care therefore requires contextual and psychological support to operate as complementary components of an accessible pathway, rather than as disconnected or sequential alternatives between which families must navigate.

7.4 Supporting parents requires supporting the context in which parents are raising children

Parents are widely recognised as central to children's mental health, with growing evidence supporting guided parent-led interventions (e.g., Creswell et al., 2025). Across the thesis, this centrality was evident from different perspectives: parents were the most commonly documented source of concern within CAMHS (Chapter 2), parents themselves described undertaking substantial day-to-day work to manage children's difficulties and wanting greater support to do so (Chapter 3),

and stakeholders described parents as playing an important role in communicating children's needs and facilitating engagement with and access to support (Chapter 4). Yet the findings also showed that parental centrality did not necessarily imply parental capacity. Parents were supporting children while themselves navigating language barriers, limited social support, practical pressures, and unfamiliar service systems. This aligns with wider refugee parenting literature showing that parenting and parental wellbeing are shaped by post-migration and structural conditions rather than parenting practices alone (Khraisha et al., 2024; Scharpf et al., 2021). The contribution of this thesis is therefore not simply to reinforce the importance of parents, but to show that strengthening parental support requires attention to the conditions that enable parents to provide it.

Therapist-guided parent-led interventions offer one potential way of strengthening parents' existing role by providing evidence-based strategies alongside professional guidance. This builds on evidence that guided parent-led approaches can provide effective, lower-intensity treatment for childhood mental health difficulties (e.g., Creswell et al., 2020; Jewell et al., 2022), while parenting and family interventions have also demonstrated benefits for refugee families (e.g., Bunn et al., 2022; Gillespie et al., 2022). Bringing these two literatures together, the findings suggest that guided parent-led interventions with refugee families cannot be considered independently of the conditions in which parents are raising their children, with their perceived feasibility shaped by trust, language accessibility, parental capacity, relational support and service organisation. Parent-led approaches should therefore be understood as offering one potential route of extending professionally supported psychological care, rather than substituting for it or shifting responsibility for treatment onto families already managing substantial resettlement demands.

7.5 Implications for Policy, Practice and Service Delivery

7.5.1 Mental Health Should be Embedded Within Wider Resettlement Systems

Because post-migration conditions shape both children's mental health and families' capacity to engage with support, improving mental health cannot be the responsibility of specialist services alone. The need for coordinated, multi-agency responses is similarly recognised for other children with complex needs, particularly children in care, for whom integrated approaches spanning mental

health, social care and the wider professional network have long been advocated (Kelly et al., 2003; NICE, 2021). More broadly, interagency collaboration in children's mental health can improve access and coordination, although its effectiveness depends on communication, shared understanding, adequate resources and organisational support (Cooper et al., 2016). Housing, education, immigration, primary care and community provision should be recognised as integral to the mental health response, with policies that reduce post-migration adversity forming an important component of the wider mental health response. This requires coordinated pathways across CAMHS, schools, primary care, local authorities and voluntary organisations, rather than relying on families to navigate fragmented systems independently.

7.5.2 Parents Should Be Recognised as Partners in Children's Mental Healthcare

Parents should be recognised as partners in children's mental healthcare rather than solely as recipients or providers of parenting interventions. Services should strengthen parents' capacity to support their children through practical assistance, language support, advocacy, social connection and support for their own mental health. This aligns with wider refugee parenting literature showing that parenting and parental mental health are shaped by the broader conditions of displacement, and that strengthening parenting therefore requires attention to these wider circumstances rather than parenting practices alone (Khraisha et al., 2024). Parent-led psychological interventions may represent one component of such support, but their feasibility and effectiveness for refugee families require further evaluation. Where appropriate, they should be considered within wider systems of support that recognise the resettlement conditions shaping parents' capacity to engage with and deliver therapeutic strategies.

7.5.3 Services Should Become Refugee-Responsive

A substantial literature advocates culturally responsive and trauma-informed mental healthcare for refugees, including culturally and linguistically appropriate communication, interpreter support and adaptation of interventions (Krystallidou et al., 2024; Lau & Rodgers, 2021; Mattar & Gellatly, 2022). However, refugee-service literature emphasises that responsiveness also requires attention to structural and organisational conditions, including service accessibility, continuity,

coordination and connections with community support (e.g., Dumke et al., 2026; Pollard & Howard, 2021). Refugee-responsive care can therefore be understood as broader than cultural adaptation or trauma-informed practice alone, encompassing how services are organised and delivered within the realities of forced migration and resettlement.

The findings across this programme support this broader conceptualisation. Language accessibility, trust, continuity, organisational flexibility and coordination shaped families' ability to access and engage with support. This requires not only reliable interpreter provision and accessible communication, but pathways that build trust through continuity and trusted relationships, accommodate continuing adversity, and coordinate psychological and practical support. Care should minimise unnecessary repetition of assessments and traumatic histories where possible. Importantly, however, service adaptation cannot compensate for structural conditions that continue to generate distress. Refugee-responsive mental healthcare therefore requires both services capable of responding to the circumstances of displaced families and wider policy action on the social conditions affecting children and families.

The findings also have implications for workforce development beyond specialist mental-health services. Stakeholders in regular contact with refugee families may be well placed to recognise concerns and facilitate access to support, yet Chapter 4 identified variation in mental-health knowledge and confidence in recognising and responding to concerns. Role-appropriate training in recognising child mental health concerns, the effects of displacement and resettlement, refugee-responsive communication, and local referral pathways may therefore strengthen early recognition across refugee-serving systems. However, strengthening recognition should not entail transferring responsibility for assessment or intervention to stakeholders without appropriate expertise, capacity or remit.

7.6 Future Research

Based on the overall findings of this thesis, three priorities for future research are proposed. First, a stronger evidence base is needed to establish which psychological interventions are effective for refugee children, for whom, and under what circumstances. This should include consideration of

trauma-focused, parent-led and school-based approaches, with particular attention to whether and how interventions can be delivered effectively while post-migration adversity remains ongoing rather than assuming that stability must precede treatment.

Second, longitudinal research should examine how children's mental health, parental capacity to provide support and service use evolve throughout resettlement, and how changing presentations, repeated referrals and transitions between services relate to longer-term outcomes. This would clarify how continuing post-migration adversity shapes engagement, recovery and pathways through care over time.

Finally, prospective implementation research should examine how effective interventions can be implemented within routine services in ways that address wider contextual considerations. Priorities include developing and evaluating interpreter-mediated assessment and therapy, workforce development, and implementation strategies that address trust, accessibility, organisational flexibility and coordination across services. Research should also establish feasible approaches to evaluating the reach, engagement and outcomes of refugee-responsive care in routine practice, with refugee children meaningfully involved alongside parents and professionals.

7.7 Strengths and Limitations

This thesis combines multiple methods and perspectives to examine refugee children's mental health support across family, community and specialist service contexts. Integrating routinely collected electronic health records, with independently collected parent and stakeholder datasets, enabled triangulation across routine clinical practice, family experience and professional perspectives. The sequential design allowed findings from each study to inform subsequent stages of the programme, progressing from understanding current service provision and families' experiences to identifying parent support needs and examining the perceived feasibility and implementation of a therapist-guided parent-led intervention.

A further methodological consideration is the reuse of the parent and stakeholder interview datasets across multiple studies. This was a deliberate feature of the research design: the interviews generated rich data relevant to distinct but related research questions, allowing the same accounts to

be examined through different analytic lenses. Analytic approaches were selected according to the questions being addressed, with separate reflexive thematic analyses used to explore parent and stakeholder experiences, template analysis to integrate perspectives on support needs, and a theory-informed analysis to examine implementation. This enabled different dimensions of the same accounts to be examined while retaining continuity across the programme. However, reuse of the datasets inevitably introduced some conceptual and thematic overlap between studies. Recurring findings across these analyses should therefore be understood as analytic convergence within shared data rather than independent corroboration. Although the distinct research questions and analytic approaches generated different insights, the analyses were not independent of one another.

Study-specific methodological limitations are considered within the relevant chapters; several broader limitations of the programme should also be acknowledged. Refugee and asylum-seeking children are a highly heterogeneous population, with substantial variation in migration experiences, legal status, family circumstances and resettlement contexts. Common patterns identified across the programme should therefore not be interpreted as representing a uniform refugee experience. The studies were conducted in England, and findings may not transfer directly to different healthcare, immigration and resettlement systems. Furthermore, recruitment across the programme necessarily identified children, parents, and professionals who were visible to services, community organisations, and or willing and able to participate in research. Families experiencing the greatest barriers to both services and research participation may therefore be underrepresented. Parent perspectives were also predominantly those of mothers, limiting understanding of fathers' roles in supporting children and their perspectives on parent-led approaches. Accordingly, the thesis characterises experiences, support needs and service responses within the populations studied rather than estimating the prevalence or distribution of mental health need across the wider refugee population.

The thesis also provides a predominantly cross-sectional account of children's mental health support. Although the electronic health records captured care over time, differences in observation periods and the retrospective nature of the data limited examination of how needs, family circumstances and service responses changed throughout resettlement. The qualitative studies similarly captured participants' perspectives at particular stages of resettlement. Longitudinal research

is therefore needed to examine how children's needs, parents' capacity to provide support and families' engagement with services and the feasibility of different forms of interventions change as resettlement circumstances evolve.

Finally, children's perspectives were not directly explored. This reflected the programme's specific focus on the systems surrounding children, particularly how parents and professionals recognised and responded to children's needs and how parents might be better supported to provide mental health support. Nevertheless, parents' and professionals' accounts cannot substitute for children's own experiences. Existing research with refugee young people has highlighted issues including trust, belonging, accessibility and concerns about mental health services, broadly aligning with themes identified across this thesis (e.g., Fazel et al., 2016; Majumder et al., 2015); however, much of this literature has focused on adolescents. Future research should therefore meaningfully involve refugee children to examine how they understand their own mental health, the support they receive and what they consider helpful.

7.8 Conclusion

This thesis demonstrates that improving refugee children's mental health requires more than increasing access to psychological support. Existing ecological and tiered models recognise the need for support across families, communities and specialist services, but this thesis shows that their delivery depends on whether refugee families can access, trust and engage with the systems through which that support is provided. Across the programme, access and engagement depended on relational, linguistic, organisational and structural conditions surrounding families and services, particularly trust, continuity and coordination, with trusted intermediaries often helping to connect families with otherwise unfamiliar systems of support. Therapist-guided parent-led interventions appear to offer one potential route to increasing the reach of psychological support, but their perceived feasibility was similarly dependent on these wider conditions. These factors should therefore be understood not simply as barriers to care, but as conditions that enable refugee-responsive mental healthcare. Future efforts must strengthen both the evidence base for refugee

children's mental healthcare and the systems needed to deliver effective support while adversity remains ongoing.

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Appendices

Appendix A HIOWH Governance Review (Chapter 2)

Following the initial data extraction from the Hampshire and Isle of Wight Healthcare NHS Foundation Trust (HIOWH) CRIS database, routine information governance review identified that patient progress notes contained unmasked third-party information. While this did not directly affect the aims of the study, a cautious approach was adopted to ensure compliance with information governance and confidentiality standards. Consequently, the affected patients were opted out of the dataset used for analysis. This reduced the number of eligible patients available from HIOWH. Re-including these patients would have required a new data extraction process; however, due to project timelines, it was agreed that the analysis would proceed using the existing extract and reduced cohort. No further exclusions were applied at the remaining participating NHS trusts.

Appendix B Coding Frameworks (Chapter 2)

Coding frameworks were developed iteratively following familiarisation with the clinical records. Categories were defined *a* priori where appropriate and refined during annotation to capture concepts identified within the records. Unless otherwise specified, categories were not mutually exclusive and multiple categories could be coded for each child across their available CAMHS records.

Table B1

Operational Definitions for Sources of Concern

Category	Definition	Examples
Parent/carer	A parent was documented as raising concerns about the child's mental health, behaviour or functioning.	Mother; father; parent(s).
Extended family	A family member other than a parent was documented as raising concerns.	Siblings; grandparents; aunts; uncles; spouses/partners; other relatives.
Foster carers and alternative caregivers	A non-parental caregiver responsible for the child's day-to-day care was documented as raising concerns.	Foster carers; residential staff; care-home staff; other alternative caregivers.
Education staff	A professional working within an education setting was documented as raising concerns.	Teachers; headteachers; SENCOs; learning mentors; school counsellors; school nurses; safeguarding leads.
Health professionals	A healthcare professional or service was documented as raising concerns.	GPs; paediatricians; psychologists; psychiatrists; CAMHS clinicians; emergency department staff; specialist nurses; dietitians; other healthcare professionals.
Social care	A statutory social-care professional or service was documented as raising concerns.	Social workers; safeguarding teams; looked-after children services; UASC services; other statutory social-care services.
Third sector and refugee organisations	A voluntary, charitable, community or refugee-support organisation was documented as raising concerns.	Refugee Council; Refugee Forum; Asylum Welcome; Migrant Help; charities; voluntary organisations; community groups; other refugee-support services.
Family support and key workers	A non-clinical professional providing ongoing practical, family or resettlement support was documented as raising concerns.	Family support workers; key workers; case workers; resettlement workers; similar support roles.
Other	A documented source of concern that could not be classified within the categories above.	Host families; other individuals or organisations not otherwise classified.

Table B2

Operational Definitions for Treatment and Care

Category	Definition	Examples
Assessment completed	A CAMHS assessment was documented as completed, regardless of whether subsequent treatment was provided.	Initial CAMHS assessment; psychiatric assessment; psychology assessment; neurodevelopmental assessment.
Direct psychological treatment (child/young person)	One-to-one therapeutic intervention delivered directly to the child or young person with the aim of improving their mental health or psychological functioning.	Stabilisation; emotion regulation; coping skills; behavioural activation; play therapy; art psychotherapy; EMDR; NET; CBT; psychotherapy; MBT.
Psychological intervention delivered to parent	Psychological, therapeutic or structured supportive intervention delivered directly to a parent or carer. The parent/carer was the direct recipient of the intervention, rather than being supported to deliver an intervention to the child.	Parent support groups; parent-focused psychoeducation; post-diagnostic parent groups; trauma-related parent support; individual parent support.
Parent-mediated psychological intervention	Therapeutic strategies delivered through a parent or carer with the primary aim of addressing the child's mental health, behaviour or functioning.	Parent-mediated intervention; parent coaching; behavioural strategies; support implementing coping, grounding, sleep, eating or emotional-regulation strategies with the child.
Family therapy	Therapeutic intervention involving the child and one or more family members, with an explicit therapeutic focus on the child and/or family relationships or functioning.	Family therapy
Psychotropic medication	Medication prescribed, continued or monitored for the treatment of a mental health or neurodevelopmental condition.	Antidepressants (e.g., sertraline); antipsychotics (e.g., risperidone); ADHD medication (e.g., methylphenidate).
Other medication	Medication prescribed or continued to address symptoms relevant to the child's mental health care but not classified as psychotropic medication within the coding framework.	Melatonin for sleep difficulties; promethazine.
Psychoeducation	Information or education provided by CAMHS about mental health, symptoms, diagnoses or strategies for understanding or managing difficulties.	Psychoeducation about anxiety, sleep, trauma responses, emotional regulation or neurodevelopmental conditions.
Professional consultation and liaison	Consultation, liaison or collaborative intervention provided by CAMHS to professionals supporting the child, with the aim of improving the child's mental health, behaviour, emotional functioning or participation. Administrative communication alone was not coded.	Consultation with schools, social workers, GPs or paediatricians; multidisciplinary/network meetings; advice to professionals about supporting the child.
Other clinical support	Clinical care or support provided that did not meet criteria for psychological treatment, medication or another specified treatment category.	Safety planning; crisis telephone/ team support; risk management; in-patient care, home visits.
Social prescribing	CAMHS-directed access to community-based or non-clinical activities/support intended to improve wellbeing or address relevant social needs.	Sports activities; refugee community groups; social activities and housing-related support.
Referral to another service/team	CAMHS initiated or facilitated a formal referral or transfer to another service or team to address an identified need.	Internal CAMHS teams; neurodevelopmental services; social care; specialist trauma services; eating-disorder services; voluntary-sector mental health services.
Signposting	CAMHS provided information about or recommended another source of support without initiating a formal referral.	Refugee organisations; voluntary-sector services; school-based support.

Table B3

Operational Definitions for Factors Affecting Treatment Provision

Category	Definition	Examples
Awaiting assessment or treatment	Assessment or treatment had been planned or indicated but had not commenced by the end of the available clinical records.	Waiting for psychology; psychiatry; CAMHS assessment; specialist assessment or intervention.
Did not engage or attend	Assessment or treatment could not proceed or was discontinued because of non-attendance, loss of contact or disengagement.	Repeated missed appointments; family stopped responding; unable to establish contact; disengagement after treatment commenced.
Declined treatment	The child/young person or parent/carer explicitly declined an offered assessment, treatment or other CAMHS intervention.	Declined psychological therapy; declined trauma-focused work; declined medication.
Treatment 'not indicated'	CAMHS explicitly documented that an intervention or treatment was not considered indicated at that stage of care.	No identified need for CAMHS; presentation considered better addressed through school/social care; watchful waiting recommended; intervention considered inappropriate at that time.
Stability required before treatment	A lack of stability in the child's circumstances was explicitly documented as a reason for not providing or delaying psychological intervention at a particular stage of care.	Need for a "safe and stable environment"; asylum/residence stability before trauma-focused work; unstable placement or living circumstances; anticipated relocation affecting treatment.
Service limitations	An intervention or form of support could not be provided because of limitations in available service provision, capacity or specialist expertise.	No appropriately trained clinician; limited capacity; intervention unavailable locally; insufficient specialist expertise; pathway/ service unavailable.
Accessibility/ practical barriers	Practical or logistical circumstances prevented or substantially impeded access to assessment or treatment.	Transport difficulties/ inability to travel to appointments; appointment timing/logistics.
Signposting	The child/family was directed towards another source of support without a formal referral from CAMHS.	Refugee organisations; voluntary-sector support; parenting services; school support; Early Help; community resources.
Service eligibility criteria	Assessment or treatment could not proceed because the child did not meet the eligibility, threshold or remit criteria of a particular service or pathway.	Below service threshold; outside age criteria; presentation outside service remit; diagnostic/severity criteria not met; out-of-area criteria.
Transfer of care or relocation	Assessment or treatment within the current CAMHS pathway ended or could not proceed because responsibility for care transferred or the child's circumstances changed.	Transfer to another CAMHS trust/team; relocation; moved school where provision was school-based; aged out/transitioned to adult services.
Missing information/unclear	Available records did not contain sufficient information to determine why treatment was not initiated, continued or received.	

Table B4

Operational Definitions for Treatment Outcomes and Outcome Evaluability

Category	Definition	Examples
Treatment outcome		
Positive effect	Any documented beneficial response to treatment, including symptom improvement, improved functioning, improved emotional regulation, enhanced coping strategies, or improved management of symptoms. Minor or transient improvements were not sufficient; complete symptom resolution was not required.	Reduced anxiety or trauma-related symptoms; improved emotional regulation or coping; improved functioning; improved management of symptoms.
Mixed effect	Documented improvement in one or more symptoms or areas of functioning alongside persistence or worsening of others.	Improvement in anxiety but continued sleep difficulties; improved functioning with persistent symptoms.
No effect	Explicit documentation that treatment resulted in little or no improvement in the difficulties being addressed.	Symptoms unchanged; no reported improvement following intervention.
Negative effect	Explicit documentation of deterioration, adverse effects or worsening associated with treatment.	Worsening symptoms; deterioration in functioning; adverse treatment effects.
Outcome not evaluable	Available clinical records did not contain sufficient information to evaluate treatment response. The reason for non-evaluability was coded separately.	See reasons below.
Reason outcome not evaluable		
Treatment ongoing	Treatment had commenced and remained ongoing at the end of the available clinical records, preventing evaluation of a completed treatment episode.	Psychological therapy ongoing; medication treatment ongoing; ongoing therapeutic work.
Awaiting assessment or treatment	Assessment or treatment had not commenced by the end of the available clinical records.	Waiting list; awaiting psychology, psychiatry or specialist assessment or treatment.
Treatment not commenced	Treatment had been offered or planned but did not begin.	Treatment declined before commencement; failure to engage before first treatment session.
Treatment discontinued	Treatment commenced but ended before an outcome could be established.	Disengagement during treatment; repeated non-attendance.
No evaluable treatment provided / treatment not indicated	No intervention from which a treatment outcome could meaningfully be evaluated was provided, including where treatment was explicitly considered ‘not indicated’.	Assessment only; consultation/signposting without evaluable treatment; treatment considered ‘not indicated’.
Transfer of care or episode ended	CAMHS involvement ended before a treatment outcome could be evaluated.	Transfer to another CAMHS team/trust; relocation; transition to another service; aged out of service.
Insufficient documentation	Treatment may have occurred, but available documentation was insufficient to determine its effect.	Outcome not recorded; insufficient follow-up information.
Other	Reason an outcome could not be evaluated that was not captured by another category.	

Table B5

Operational Definitions for Adaptations to Assessment and Treatment

Category	Definition	Examples
No adaptation recorded	No implemented modification to usual assessment, treatment or care was documented.	
Interpreter support	Use of spoken-language interpretation to facilitate assessment, treatment or other clinical contact.	Face-to-face, telephone or video interpreter; Language Line
Translation or language adaptation	Modification of written or other communication to accommodate the child's or family's language needs.	Translated letters, reports, forms, psychoeducational materials, worksheets or appointment messages; bilingual communication aids; translation software used.
Cultural or religious adaptation	Modification of care to accommodate documented cultural or religious needs, preferences or practices.	Consideration of Ramadan; prayer arrangements; Imam involvement; culturally matched clinician; accommodation of gender preferences for cultural or religious reasons.
Service-delivery adaptation	Modification to how, where or when care was delivered to improve accessibility, engagement or continuity.	Home or school-based appointments; face-to-face rather than remote contact (or vice versa); flexible appointment times; communication through schools or accommodation settings; continuity with the same clinician.
Treatment-delivery adaptation	Modification to the content, format or delivery of a psychological intervention in response to the child's needs or circumstances.	Shorter or more frequent sessions; drawing or play rather than verbal discussion; additional grounding or stabilisation work.
Cross-country/international liaison	Communication or collaboration with professionals or services outside the UK to support assessment, treatment or continuity of care.	Liaison with overseas psychiatrists or psychologists; obtaining overseas clinical records; communication with healthcare providers in another country.
Other	An implemented adaptation that did not meet criteria for another category.	

Presenting Symptoms and Difficulties

Presenting symptoms and difficulties were initially coded using the 30 symptom/problem categories from the Current View tool (Jones et al., 2013). Three additional categories relating to autism, neurodevelopmental and learning difficulties were adapted from the complexity component of Current View and included within the symptom framework. Additional transdiagnostic and refugee-specific indicators identified during record review were coded separately, as detailed below.

Table B6

Additional and Adapted Categories Used to Code Presenting Symptoms and Difficulties

Category	Definition
Additional neurodevelopmental categories	
Autism symptoms	Social communication difficulties; restricted/repetitive behaviours; sensory differences.
Neurodevelopmental symptoms	Speech/language delay; communication difficulties; processing and executive-functioning difficulties; developmental coordination difficulties; motor delay.
Learning-difficulty symptoms	Literacy/numeracy difficulties; educational delay; academic difficulties; suspected learning disability.
Additional refugee-specific / contextual indicators	
Missing and worry about family overseas	Persistent worry, distress or preoccupation concerning family members remaining overseas or separated from the child.
Bereavement	Documented bereavement or death of a significant family member/person.
Additional transdiagnostic indicators	
Sleep disturbance	Difficulties initiating or maintaining sleep; disrupted sleep; poor sleep.
Nightmares	Documented nightmares/distressing dreams.
Appetite-related difficulties	Reduced/increased appetite or other appetite changes not captured by a specific eating-disorder presentation.
Emotional dysregulation	Difficulty regulating or managing emotional responses.
Anger	Increased or problematic anger.
Increased crying/tearfulness	Increased crying, tearfulness or frequent episodes of crying.
Withdrawal	Social or emotional withdrawal; reduced interaction or engagement.
Hypervigilance	Heightened vigilance, alertness or monitoring for threat.
Stress	Explicit documentation of stress not otherwise captured by a more specific symptom category.
Self-esteem difficulties	Low self-esteem, negative self-evaluation or reduced confidence.
Overthinking	Repetitive excessive thinking described as “overthinking” where not more specifically coded elsewhere.
Memory difficulties	Reported or observed memory difficulties.
Noise sensitivity	Heightened sensitivity or distress in response to noise.
Other transdiagnostic indicators	Less frequently documented indicators not captured above, including irritability, developmental regression, rumination and other isolated transdiagnostic symptoms.

Appendix C Country and Regions of Origin (Chapter 2)

Table C1

Countries and Regions of Origin of Refugee and Asylum-Seeking Children and Young People

Country/region of origin	*n*	%
Afghanistan	42	18.6
Syria	38	16.8
Ukraine	37	16.4
Iran	15	6.6
Unknown	15	6.6
Sudan	12	5.3
Iraq	10	4.4
Albania	7	3.1
Ethiopia	5	2.2
Kurdistan	4	1.8
Eritrea	3	1.3
Kuwait	3	1.3
Libya	3	1.3
Nigeria	3	1.3
Somalia	3	1.3
Vietnam	3	1.3
Bangladesh	2	0.9
China	2	0.9
Pakistan	2	0.9
Trinidad	2	0.9
Africa	1	0.4
Algeria	1	0.4
Antigua	1	0.4
Botswana	1	0.4
Brazil	1	0.4
Gaza	1	0.4
Grenada	1	0.4
Hong Kong	1	0.4
India	1	0.4
Morocco	1	0.4
Saudi Arabia	1	0.4
Sierra Leone	1	0.4
Sri Lanka	1	0.4
Turkey	1	0.4
Yemen	1	0.4

Appendix D Mental Health Symptoms and Difficulties (Chapter 2)

Table D1

Documented presenting mental health symptoms and Difficulties

Presenting symptom or difficulty	***n***	**%**
Anxious away from caregivers (separation anxiety)	23	10.2
Anxious in social situations (social anxiety/phobia)	25	11.1
Anxious generally (generalised anxiety)	121	53.5
Compelled to do or think things (OCD)	12	5.3
Panics (panic disorder)	17	7.5
Avoids going out (agoraphobia)	2	0.9
Avoids specific things (specific phobia)	8	3.5
Repetitive problematic behaviours (habit problems)	3	1.3
Depression/low mood (depression)	119	52.7
Self-harm (self-injury or self-harm)	90	39.8
Extremes of mood (bipolar disorder)	13	5.8
Delusional beliefs and hallucinations (psychosis)	24	10.6
Drug and alcohol difficulties (substance abuse)	12	5.3
Difficulties sitting still or concentrating (ADHD/hyperactivity)	62	27.4
Behavioural difficulties (CD or ODD)	75	33.2
Poses risk to others	55	24.3
Carer management of CYP behaviour	22	9.7
Doesn’t get to toilet in time (elimination problems)	18	8.0
Disturbed by traumatic event (PTSD)	84	37.2
Eating issues (anorexia/bulimia)	14	6.2
Family relationship difficulties	7	3.1
Problems in attachment to parent/carer (attachment problems)	5	2.2
Peer relationship difficulties	37	16.4
Persistent difficulties managing relationships with others	8	3.5
Does not speak (selective mutism)	6	2.7

Gender discomfort issues	1	0.4
Unexplained physical symptoms	42	18.6
Unexplained developmental difficulties	3	1.3
Self-care issues	16	7.1
Adjustment to health issues	2	0.9
Autism symptoms	41	18.1
Neurodevelopmental symptoms	36	15.9
Learning difficulties	16	7.1
Bereavement	39	17.3
Missing/worry about family overseas	61	27.0
Sleep disturbance	118	52.2
Nightmares	65	28.8
Withdrawal	37	16.4
Emotional regulation difficulties	57	25.2
Appetite-related difficulties	63	27.9
Anger	50	22.1
Memory difficulties	15	6.6
Self-esteem difficulties	19	8.4
Noise sensitivity	12	5.3
Overthinking	18	8.0
Hypervigilance	31	13.7
Increased crying/tearfulness	47	20.8
Stress	21	9.3
Other transdiagnostic symptoms/indicators	22	9.7

Note. ADHD = attention-deficit/hyperactivity disorder; CD = conduct disorder; CYP = child or young person; OCD = obsessive-compulsive disorder; ODD = oppositional defiant disorder; PTSD = post-traumatic stress disorder.

Appendix E Documented Mental Health and Neurodevelopmental Diagnoses (Chapter 2)

Table E1

Documented Mental Health and Neurodevelopmental Diagnoses

Diagnosis (ICD-10 code)	***n***	**%**
Autism spectrum disorder (F84)	15	6.6
Attention-deficit/hyperactivity disorder (F90)	15	6.6
Psychosis (F29)	3	1.3
Depression (F33)	2	0.9
Post-traumatic stress disorder (F43.1)	2	0.9
Obsessive-compulsive disorder (F42)	2	0.9
Non-organic enuresis (F98.0)	2	0.9
Generalised anxiety disorder (F41.1)	1	0.4
Acute stress (F43)	1	0.4
Complex PTSD (F43)	1	0.4
Specific learning disorder/dyslexia (F81)	1	0.4
Developmental disorder of scholastic skills (F81.9)	1	0.4
Mild intellectual disability (F70)	1	0.4
Conduct disorder (F91)	1	0.4
Oppositional defiant disorder (F91.3)	1	0.4
Selective mutism (F94.0)	1	0.4
Anorexia nervosa (F50.0)	1	0.4
Dissociative identity disorder (F44.8)	1	0.4

Note. Complex PTSD was retained as a separate descriptive category because ICD-10 does not include a distinct diagnostic code for complex PTSD; it was therefore coded within the broader F43 category. Diagnoses were not mutually exclusive.

Appendix F Subgroup Analyses of Treatment (Chapter 2)

Table F1

Treatment and Factors Affecting Treatment Provision According to Patient Characteristics

Treatment / reason	Age group				Gender				Immigration status				Accompaniment			
	Child n (%)	**ADO n (%)**	***p***	**OR (95% CI)**	**M n (%)**	**F n (%)**	***p***	**OR (95% CI)**	**REF n (%)**	**A/S n (%)**	***p***	**OR (95% CI)**	**AC n (%)**	**UASC n (%)**	***p***	**OR (95% CI)**
Any treatment received	39 (51.3)	77 (53.5)	.761	0.92 [0.53–1.60]	81 (50.9)	35 (53.0)	.776	1.09 [0.61–1.93]	51 (56.0)	56 (46.7)	.177	0.69 [0.40–1.19]	77 (50.3)	36 (52.9)	.720	0.90 [0.51–1.60]
Direct psychological treatment	11 (14.5)	35 (24.1)	.093	0.53 [0.25–1.12]	31 (19.4)	15 (22.7)	.569	1.22 [0.61–2.46]	18 (19.8)	23 (19.0)	.888	0.95 [0.48–1.89]	29 (19.0)	15 (21.7)	.630	0.84 [0.42–1.70]
Parent- or family focused intervention	9 (11.8)	11 (7.6)	.295	1.64 [0.65–4.14]	13 (8.1)	7 (10.6)	.550	1.34 [0.51–3.53]	10 (11.0)	7 (5.8)	.167	0.50 [0.18–1.36]	17 (11.1)	2 (2.9)	.043	4.19 [0.94–18.66]
Psychotropic medication	7 (9.2)	17 (11.7)	.568	0.76 [0.30–1.93]	17 (10.6)	7 (10.6)	.997	1.00 [0.39–2.53]	13 (14.3)	8 (6.6)	.064	0.42 [0.17–1.07]	20 (13.1)	4 (5.8)	.106	2.44 [0.80–7.44]
Professional consultation and or liaison	27 (35.5)	51 (35.2)	.958	1.02 [0.57–1.81]	53 (33.1)	25 (37.9)	.494	1.23 [0.68–2.24]	29 (31.9)	43 (35.5)	.577	1.18 [0.66–2.10]	49 (32.0)	27 (39.1)	.302	0.73 [0.41–1.32]
Treatment ‘not indicated’	31 (40.8)	49 (33.8)	.304	1.35 [0.76–2.39]	54 (33.8)	26 (39.4)	.420	1.28 [0.71–2.31]	34 (37.4)	43 (35.5)	.784	0.92 [0.53–1.63]	54 (35.3)	26 (37.7)	.732	0.90 [0.50–1.63]
Declined treatment	8 (10.5)	31 (21.4)	.044	0.43 [0.19–1.00]	25 (15.6)	15 (22.7)	.203	1.59 [0.78–3.25]	19 (20.9)	18 (14.9)	.254	0.66 [0.33–1.35]	29 (19.0)	11 (15.9)	.589	1.23 [0.58–2.64]
Did not engage or attend	11 (14.5)	18 (12.4)	.667	1.19 [0.53–2.68]	19 (11.9)	11 (16.7)	.334	1.48 [0.66–3.32]	10 (11.0)	17 (14.0)	.508	1.32 [0.58–3.05]	22 (14.4)	8 (11.6)	.574	1.28 [0.54–3.04]

Note. ADO = adolescent (>11 years); M = male; F = female; REF = refugee; A/S = asylum-seeker; AC = accompanied child; UASC = unaccompanied asylum-seeking child; OR = odds ratio; CI = confidence interval. Unknown values were excluded from relevant subgroup analyses. Parent-delivered psychological intervention, parent-mediated intervention and family therapy were combined into a single parent- or family-focused category. *p*-values are from Pearson’s chi-square tests. Bonferroni correction was applied across 32 comparisons (α = .0016). OR contrasts: child (≤11 years) vs adolescent (>11 years); female vs male; asylum seeker vs refugee; accompanied child vs UASC.

Appendix G Parent Topic Guide (Chapter 3)

Interview questions	Areas explored
To start with, can you tell me about yourself and your family? - How many people are in your family? - What would you like me to call them? - Have you got any family members still living in your homeland? - Do you have any family members or friends living in England? In our interview, we will focus on your experience of parenting your child/ren. **How would you describe your child/ren?** - What is his/her character? - How is his/her school life? - What are his/her interests or hobbies? **How would you describe the relationship between you and your child/ren?** - Do you and (other caregiver) have different styles of parenting? How would you describe the differences?	Family context, relationships and sources of support.
We want to understand the circumstances you were in before you came to England. **Can you tell me what it was like being a parent/caregiver before coming to the UK?** - What was a typical day like? - What did you enjoy/ find difficult? - What was important for you to do [role/responsibilities] as a parent/caregiver? **Can you tell me what (name of child) was like before the war?** - What was a typical day like for (name of child)? - What did (name of child) enjoy? - How would you describe (name of child)'s emotional wellbeing? **If poor** - How did this affect your child's day to day? - How did you try to resolve this? - What are the challenging parts for you? - What things did you find helpful? **If good** - What things did you found contributed to the child's wellbeing?	Parenting and child mental health prior to migration.
We would like to discuss when you left your homeland and the journey you undertook to come to the UK. **What was it like when you had to decide to leave?** - Did you discuss why you had to leave with the children? If so, what did you say? If not, why not? **Can you tell me what it was like during your migration journey?** - Can you tell me what it was like being a parent/ what changed or stayed the same / what was important for you to do as a parent? **Can you tell me what it was like for (name of child) during the migration period?** **What services did your child have access to (e.g., school/healthcare)?**	Parenting and child mental health during migration, including access to support.

How would you describe (name of child)'s emotional wellbeing? **If poor** - How did this affect your child's day to day? - How did you try to resolve this? - Can you describe any problems that you have with parenting when child is feeling XXX? - What were the challenging parts for you? - What things did you find helpful? **If good** - What things did you found contributed to the child's wellbeing?	
I will ask you some questions about your experiences when arriving in the UK. **Can you tell me about your initial experiences when you first arrived?** - What was helpful/ supported you during this time? - What has been the most difficult for you since you arrived? **Can you give me an overview of your emotional wellbeing?** - How do your emotions affect your life? **If poor - Is your mental health difficulty managed? E.g., are you on medication or receiving therapy?** **If yes... do you notice a difference in your parenting when you are feeling XXX?** - Do you think your emotions affect how your child feels? What difference do you think it makes, if at all? **How did your child(ren) respond the resettlement in the UK?** - What about now? **What support have you provided to your child?** **What if any services were offered to you when you arrived?** - Have they helped, if at all? - What things were not helpful? **In what ways has school and education helped your child since coming to the UK, if at all?**	Parent and child adjustment following resettlement, parenting challenges and experiences of support.
Emotional problems are common among refugee children. They often come and go and may be a response to stressful events or new environments. **Is your child experiencing difficulties with any emotional difficulties?** **If No:** - What things did you find contributed to the child's wellbeing? **If Yes:** **Can you describe the difficulties your child has experienced?** - When did this start? Is it happening now, or has it finished? - What do you think has caused this? - Are there moments/situations when you find your child's (difficulty) is better or worse? **Can you tell me one or two stories (specific examples) about that?** - In that example, what did your child do/say? What did you think your child is [xx] about? Did your child share about what s/he is [xx] about? What did you do/say? - In that situation, what are the most challenges for you? How have you tried to resolve this? What things did you find helpful? **What is your understanding of the available mental health services here in England?**	Recognition and management of children's emotional difficulties, help-seeking and access to mental health services.

- Do you have any personal experience with the type of mental health services you described for your child? - Have you ever tried to get help but were discouraged for some reason? If yes - what was that reason? - If not, can you imagine yourself seeking out the type of services you described? - What do you feel are some of the greatest barriers for parents of refugee children when it comes to accessing mental health services in England?	
Every family has unique challenges and needs. We would like to hear from you about how we can find a better way to meet the needs of families who might share similar views and experiences with you. **What do you think would be most helpful to support parents of refugee children with their emotional wellbeing?** - Why do you think that would be good? - What do you think would be difficult or problematic about that? - How should this support be delivered? **Is there anything that is unhelpful?** Previous research has shown that helping children using a set of strategies that changes the way we think and behave (can use CBT as an example), can get really good outcomes for children with emotional and trauma-related problems. There are different levels of parental involvement for this type of support. Therapist-led: Therapists work individually with children to help them overcome their mental health problems. Parent-led: Therapists work with parents to help them put strategies in place in their child's day-to-day life to help them overcome their mental health problems. **What do you think about these approaches?** **What do you think about the idea of supporting parents to help their children overcome emotional problems in refugee families?** - What would be the main concerns for you about this kind of treatment? Do you think there is any reason that it would be difficult for you to benefit from this kind of treatment? If so, what would that be? - How should a parent-led intervention be delivered? Do you think there are any possible advantages or disadvantages of providing support for you online rather than in person? Do you think there are any possible advantages or disadvantages of providing this support in a group of parents rather than on a one-to-one basis? - Where/by whom do you think support like this should be delivered, if at all? I think that's basically everything I had to ask you to talk about, have you got anything else you'd like to say or any kind of final thoughts or any things you'd like to follow-up that I haven't asked you? Are there any worries or concerns from the interview that you have that you want to share?	Parents' support needs and perspectives on parent-led psychological support, including perceived benefits, barriers and delivery preferences.

Appendix H Emotional Wellbeing Scales Parent Interviews (Chapter 3)

Table H1

Emotional Wellbeing Scales (Parent)

Which statement best describes how you have been feeling since coming to UK?	
Positive	I am feeling hopeful about my new life in the UK. I have been able to make some connections and feel supported by the community
Neutral	I have good days and bad days. While I am happy to be here, I am also feeling a bit overwhelmed and unsure of what the future holds
Struggling	I am experiencing significant emotional and mental distress since arriving in the UK. I feel isolated and disconnected from others, and may be struggling with symptoms of depression, anxiety, or trauma
Not sure	I am not sure how I am feeling right now. It's been a difficult transition and I'm still trying to adjust to my new life
Prefer not to say	

Table H2

Final Emotional Wellbeing Scales (Child)

Which statement best describes your child's emotional and mental wellbeing in the last month?	
Very Poor	My child has ongoing emotional or behavioural difficulties that significantly impact their daily life. They require ongoing support and intervention.
Poor	My child has occasional emotional or behavioural difficulties. They may need some additional support.
Neutral	My child's emotional and mental wellbeing falls between poor and good, displaying a moderate level of stability with occasional challenges.
Good	My child is generally happy and well-adjusted but may experience some ups and downs.
Excellent	My child is happy, confident, and resilient
Prefer not to say	

Appendix I Stakeholder Topic Guide (Chapter 4)

Interview questions	Areas explored
Could you give me a brief overview of the work you do? - How does your team work together? - In what capacity do you work with refugees/asylum seeking families? - During what stage of the resettlement process? **Can you give me a general overview of the refugee and asylum-seeking families that you have worked with?** *(Background/visa status/ages of children etc.).* In our interview, we will focus on parents with children who are roughly between 3 and 11 years old. **What are the signs for you that a family needs support or is coping well?** **Have you observed any mental health symptoms or problems among asylum-seeking and refugee children or have any symptoms or problems been relayed to you by parents?** - Could you provide specific examples or cases that highlight the mental health problems children in this population may face? - What do you feel caused this difficulty/problem? - What do you feel would have been the best way to address this difficulty/problem? - How did the parents try to resolve this? If – brings up parent-child relationship: - How have their parent-child relationships/parenting styles been in general? If – brings up parental mental health: - Do you feel the parent's mental health has been a relevant consideration? If so in what way? **What if anything have you been able to do to support a parent who has a child that experiences mental health problems/difficulties?** - Can you provide an example of any instances where you were able to provide support? - Can you describe the mental health problems they had? - In your role what interventions or support strategies have you found effective in addressing the mental health needs of these children? **If signpost only:** - What resources/techniques/strategies/approaches have you used? - Have families found them helpful? If yes, can you give an example? If no – why do you feel that is?	Stakeholders' roles and experiences supporting refugee families; understanding and recognition of children's mental health needs; responses to identified difficulties
Are there any obstacles you feel that parents (of refugee/asylum seeking children) may encounter generally? **Are there any obstacles you feel that parents (of refugee/asylum seeking children) may encounter when attempting to support the mental health of their children?** - Can you provide an example of an instance where children needed emotional support but were unable to receive any help? - What do you feel would be helpful in these instances?	Barriers experienced by families and stakeholders in supporting children's mental health

What obstacles or challenges have you encountered when attempting to support the mental health of children in asylum seeker and refugee families? - What is the challenging part for you? How have you tried to resolve this?	
From your perspective, what if any gaps exist in the current mental health provision for children in asylum seeker and refugee families? **Are there specific areas where additional resources or support services are needed to address these gaps?**	Gaps in mental health provision and perceived support needs
Every family has unique challenges and needs. We would like to hear from you about how we can find a better way to meet the needs of refugee and asylum-seeking families in relation to supporting children's mental health. **What do you think would be most helpful to support parents of refugee children with their mental health? Is there anything that is unhelpful?** - Why do you think that would be good? - What do you think would be difficult or problematic about that? - How should this support be delivered? Previous research has shown that helping children using a set of strategies that changes the way we think and behave (can use CBT as an example), can get really good outcomes for children with emotional and trauma-related problems. There are different levels of parental involvement for this type of support. Therapist-led: Therapists work individually with children to help them overcome their mental health problems. Parent-led: Therapists work with parents to help them put strategies in place in their child's day-to-day life to help them overcome their mental health problems. **What do you think about these approaches?** **What do you think about the idea of supporting parents to help their children overcome mental health problems in refugee families?** - What would be the main concerns for you about this kind of treatment? Do you think there is any reason that it would be difficult for parents to benefit from this kind of treatment? If so, what would that be? Do you think there would be any potential benefits for this kind of treatment? If so, what do you think these are? - How should a parent-led intervention be delivered? Do you think there are any possible advantages or disadvantages of providing support for you online rather than in person? Do you think there are any possible advantages or disadvantages of providing this support in a group of parents rather than on a one-to-one basis? - Where/by whom do you think support like this should be delivered, if at all? I think that's basically everything I had to ask you to talk about, have you got anything else you'd like to say or any kind of final thoughts or any things you'd like to follow-up that I haven't asked you? Are there any worries or concerns from the interview that you have that you want to share?	Parent support needs and perspectives on therapist-led and parent-led interventions, including perceived benefits, barriers and delivery preferences

Appendix J Stakeholder Employment Roles (Chapter 5)

Table J1.

Overview of Participant Employment Groups and Generalised Role Titles

Employment Group	Job roles
Resettlement & Housing Support	- Resettlement programme officer - Resettlement and integration coordinator - Housing support officer (refugee resettlement) - Project coordinator, resettlement programme - Migration and Resettlement Support workers - Resettlement team manager
Community Engagement & Outreach	- Community outreach worker - Community liaison officer (refugee support) - Community inclusion coordinator - Community visits and training coordinator - Volunteer coordination and mentoring - Volunteer/ peer support role - Befriending project coordinator
Education, ESOL & Early Years	- Volunteer language and activities tutor - ESOL tutor and engagement officer - Early years practitioner - Drop-in service practitioner (ESOL/education)
Health, Wellbeing & Therapeutic Support	- Child and family therapist - Health and wellbeing practitioner - Community family support worker
Volunteering & Civil Society Roles	- Volunteer and trustee role - Trustee and coordinator - Community group coordinator (voluntary roles)
Leadership, Strategy & Policy	- Chief executive (voluntary sector) - Integration and programme manager - Safeguarding policy and practice manager - Early help programme coordinator