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BARRIERS ASSOCIATED WITH INACCESSIBLE MENTAL HEALTH SERVICES FOR YOUTH REFUGEES AND ASYLUM SEEKERS: AN INTEGRATIVE REVIEW

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Résumé de l'article

Youth refugees and asylum seekers are vulnerable to mental health conditions. Although their mental health needs are well documented, evidence reveals that they are underutilizing mental health services. This integrative literature review aims to examine the evidence on barriers to mental health access experienced by youth refugees and asylum seekers, determine the literature gaps, and identify the future direction of research in the field. Academic databases, such as CINAHL, OVID MEDLINE (R), PsycINFO, EMBASE, and Web of Science, as well as grey literature, were used to identify eligible articles. A total of 29 articles were included in this review. Our findings revealed 5 major themes: (a) approachability and ability to perceive; (b) acceptability and ability to seek; (c) availability, accommodation, and ability to reach; (d) affordability and ability to pay; and (e) appropriateness and ability to engage. These findings can assist multiple stakeholders in improving mental health access, quality, and provision.

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Abstract: Youth refugees and asylum seekers are vulnerable to mental health conditions. Although their mental health needs are well documented, evidence reveals that they are underutilizing mental health services. This integrative literature review aims to examine the evidence on barriers to mental health access experienced by youth refugees and asylum seekers, determine the literature gaps, and identify the future direction of research in the field. Academic databases, such as CINAHL, OVID MEDLINE (R), PsycINFO, EMBASE, and Web of Science, as well as grey literature, were used to identify eligible articles. A total of 29 articles were included in this review. Our findings revealed 5 major themes: (a) approachability and ability to perceive; (b) acceptability and ability to seek; (c) availability, accommodation, and ability to reach; (d) affordability and ability to pay; and (e) appropriateness and ability to engage. These findings can assist multiple stakeholders in improving mental health access, quality, and provision.

Keywords: youth, refugees, asylum seekers, mental health care, barriers to access

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Conflicts, violence, human rights violations, and environmental issues are continually occurring around the world. In 2021, over 84 million people were forced to leave their homes and communities to seek refuge in other regions or countries; in the first months of 2022 this number surpassed 100 million; and in 2023, according to early estimates, it had risen to 117.2 million people (United Nations High Commissioner for Refugees [UNHCR], 2021, 2023a, 2023b). Such migration journeys greatly impact the health and well-being of refugees and asylum seekers; the mental health of youth refugees and asylum seekers (YRAS) is particularly affected (Kadir et al., 2019). Hence, the purpose of this review is to assess the barriers YRAS experience while accessing mental health services.

Children and YRAS account for 40% of those forcibly displaced in 2020, despite representing only 30% of the world's population (UNHCR, 2021). An asylum seeker is a person who leaves the borders of their country of origin or citizenship to seek protection from another country (UNHCR, 2010, p. 3). Once their request has been approved by the host country, their immigration status then becomes that of refugee (UNHCR, 2010). Throughout their migration journey, children and YRAS have a high risk of communicable and non-communicable disease, sanitation insecurity, physical injury, nutritional deficiencies, and, especially, mental health difficulties (Kadir et al., 2019). Numerous stressors that they encounter before, during, and after migration may heighten their susceptibility to mental illnesses such as post-traumatic stress disorder, depression, anxiety, and behavioural problems (Eruyar et al., 2018; Kadir et al., 2019; Mohamed & Thomas, 2017; Papadopoulos & Shea, 2018).

Refugees and asylum seekers often encounter traumatic events prior to migration, which are generally related to the cause of their departure (Eruyar et al., 2018). Some children and youth have even been coerced into becoming soldiers, leading to greater chances of exposure to rape, torture, violence, and death (Mohamed & Thomas, 2017). Those who do manage to escape and seek refuge risk being separated from their families and forced to reside in refugee camps or detention centres (Mohamed & Thomas, 2017). Post-migration, their difficulties often continue: legal and language barriers as well as financial constraints can make it difficult for them to access mental health care when it is needed (Hodes et al., 2018).

Compared to younger children, YRAS have been found to be more vulnerable to mental health issues (Baak et al., 2020). In addition to having greater prevalence of post-traumatic stress disorder, depressive disorder, and suicidal behaviours (Colucci et al., 2015, 2017; Copolov & Knowles, 2021), YRAS are in the life stage when the occurrence of mental health difficulties drastically rises (Malla et al., 2018). Most adults with mental health problems experienced their first onset prior to the age of 25 (Malla et al., 2018).

Although the mental health needs of YRAS are well documented, studies show that they underutilize mental health services (Colucci et al., 2014; Marshall et al., 2016). Cultural and

language barriers, discrimination, stigma, financial costs, and difficulty navigating the health care system are some of the factors that impede YRAS from accessing appropriate mental health support (Betancourt et al., 2015; Marshall et al., 2016; Sullivan & Simonson, 2016).

Recently, there has been a gradual increase in literature regarding barriers to mental health access experienced by YRAS; however, we were unable to locate any recent reviews on this topic. Hence, this review will aim to examine the evidence regarding barriers to mental health access experienced by YRAS, determine the gaps in the literature, and propose future directions for research in the field.

Theoretical Framework

We used Levesque and colleagues' (2013) conceptual framework regarding access to health care as the theoretical underpinning for this review. They defined access as "the opportunity to identify healthcare needs, to seek healthcare services, to reach, to obtain or use health care services, and to actually have a need for services fulfilled" (p. 1). Levesque et al. pointed out that variations in access and barriers to access can be exposed by observing patients' experiences as they transition through the stages of their health care trajectory: identification of care needs, perception of needs and desire for care, health care seeking, health care reaching, health care utilization, and health care consequences. They also proposed five dimensions of accessibility of services: approachability, acceptability, availability and accommodation, affordability, and appropriateness, along with five corresponding abilities of potential service users to obtain access: ability to perceive, ability to seek, ability to reach, ability to pay, and ability to engage.

The term "approachability" is used by Levesque et al. (2013) to represent how services become known to service users and how they can be deemed accessible or usable. They stated that this dimension is related to the ability of individuals to perceive their own need for care, which is generally affected by their health literacy, health beliefs, and knowledge about health and illness. They used "acceptability" to refer to the cultural and social factors that influence whether health interventions are accepted by individuals seeking or about to seek care. Correspondingly, an individual's "ability to seek health care relates to the concepts of personal autonomy and capacity to choose to seek care, [and] knowledge about health care options and individual rights that would determine expressing the intention to obtain health care" (Levesque et al., 2013, p. 5). For Levesque and colleagues, "availability and accommodation" denotes the physical existence of the health service as well as its capacity to deliver care in a timely manner; hence, this dimension refers to the existence and accessibility of health facilities, equipment, and system processes, as well as the ability of individuals to physically reach the health services and providers, which is affected by their personal mobility, the availability of transportation, and whether they can obtain leave from work to access health care. "Affordability" represents the financial capacity of individuals to allocate their money and time to obtain health care; this dimension necessarily involves individuals' ability to pay (Levesque et al., 2013). Lastly, "appropriateness" corresponds to the suitability of the service as it relates to the individual's health needs; this reflects the

timeliness of the service; the quality of care provided by clinicians and staff; the adequacy of the assessment, diagnosis, and treatment received; and the effectiveness of the intervention (Levesque et al., 2013). An individual's ability to engage is crucial for this dimension, which entails the participation and involvement of service users in decision-making throughout the health encounter (Levesque et al., 2013). Service users must, therefore, be able to fully communicate their needs and values to the health care providers (Levesque et al., 2013).

This conceptual framework emphasizes that the health care individuals receive is directly influenced by their demographic, social, and economic characteristics as well as the attributes of the health systems and environment where they reside (Levesque et al., 2013). By placing these factors at the centre of the framework while focusing on individuals' experiences as they attempt to fulfil their health care needs, a more comprehensive list of barriers to access — one attentive to patient-centred care — can be identified (Levesque et al., 2013).

Methodology

This review followed an integrative literature approach as outlined by Coughlan et al. (2013), Toronto and Remington (2020), and Whittemore and Knafl (2005). Compared to systematic reviews, which have a narrower scope and stricter inclusion criteria, integrative reviews examine a broader phenomenon of interest through consideration of diverse sources of literature, including theoretical and methodological articles (Toronto & Remington, 2020). To start, key concepts were identified from the review question, and an initial search of CINAHL and OVID MEDLINE (R) was conducted to determine the appropriate search terms. These key concepts are "youth"; "refugees OR asylum seekers"; "mental health conditions"; and "access OR utilization of healthcare OR health services". Titles, abstracts, and index terms of potentially relevant articles were reviewed, and a preliminary search strategy was developed (see Appendix A). This preliminary search strategy informed a comprehensive search strategy specific to each chosen database (i.e., CINAHL, OVID MEDLINE (R), PsycINFO, EMBASE, and Web of Science). Next, the health sciences librarian of the University of Saskatchewan was consulted to assist in refining the search strategy. The appropriate modifications were applied, and the final search strategy, seen in Appendix B, was piloted. On March 22, 2022, the complete run of the search strategy was performed. Relevant websites and organizational platforms were also searched for gray literature. These websites included Canadian Council for Refugees, Canadian Mental Health Association, Doctors Without Borders, Mental Health Europe, Mental Health America, the Multicultural Mental Health Resource Centre, ProQuest Dissertations and Theses Global, UNHCR, and the World Health Organization.

Once the search for published and unpublished articles was completed, all duplicates were manually removed and the remainder of the citations were imported to Rayyan, a web-based tool developed to facilitate the initial screening of the titles and abstracts of potentially eligible articles (Ouzzani et al., 2016). The titles and abstracts of the articles were screened following the inclusion criteria.

Inclusion Criteria

Characteristics of Participants

Documents focusing on YRAS were considered for inclusion. Though the most common age range that identifies youth is 15 to 24, there is currently "no universally agreed international definition of youth" (Bersaglio et al., 2015; United Nations, n.d., para. 1). Some definitions include the start of the teenage years and some extend to age 35 (Bersaglio et al., 2015). In many countries, however, the legal definition of an adult is age 18 and above, and youth generally fall below this range (United Nations, n.d.). Due to this uncertainty surrounding the term "youth", this review applied a flexible definition by considering articles that identified their participants as youth or young people, irrespective of their age. Nevertheless, articles were excluded if they focused primarily on infants, toddlers, preschoolers, prepubescent age groups, or adults (i.e., age 18 and above).

Articles about immigrants or internally displaced individuals were also excluded. An immigrant, also known as a voluntary migrant, is a person who has moved from their birth country into a new country for short-term or long-term settlement (Migration Observatory, 2019). Unlike refugees and asylum seekers, who leave due to fear of persecution, immigrants usually move for financial and economic gains (Becker & Ferrara, 2019). In comparison, internally displaced persons are similar to refugees and asylum seekers in that they are considered to have been forcibly displaced; however, because they have not crossed an internationally recognized border they are not eligible for asylum (Office of the High Commissioner for Human Rights, n.d.).

Phenomenon of Interest and Context

The phenomenon of interest in this review is the presence of barriers to mental health service access for YRAS. Access to health services represents "the possibility to identify healthcare needs, to seek healthcare services, to reach the healthcare resources, to obtain or use healthcare services, and to actually be offered services appropriate to the needs of care" (Levesque et al., 2013, p. 4). Only articles that specifically discussed factors that impede or delay access to mental health services for this population were considered. Mental health services generally include prevention, screening, evaluation, treatment, and monitoring (Deber, 2018). They are mostly delivered in hospitals, clinics, physicians' offices, community centres, clients' homes, schools, and supportive housing units by interdisciplinary teams, such as doctors, psychologists, nurses, social workers, counsellors, and other providers (Canadian Institute for Health Information, 2019; Deber, 2018). This review did not exclude articles based on their context and setting, except for those that focused on mental health services offered in refugee camps or home countries of YRAS.

Types of Studies

Empirical, secondary, and anecdotal sources of information were considered for inclusion as well as theoretical and grey literature. Moreover, no date limitations were specified. However, only articles published in English or French were considered for inclusion.

After the initial screening, full texts of the selected articles were retrieved and assessed for eligibility. Reasons for exclusion were noted and included in the results. Once all eligible articles were identified, ancestry and offspring searches were performed to ensure that no relevant articles were missed. Data extraction was then initiated: information about the article type, location, participant characteristics, and barriers to access was gathered, whenever possible. This data was then analyzed using thematic analysis and presented in a tabular form with descriptive and interpretive synthesis as described by Braun and Clarke (2006). The coding process began with the authors reading and rereading the extracted data multiple times to ensure that they were fully immersed in the data. This phase was followed by the identification of initial codes through a deductive approach, which was chosen to specifically address the main purpose of this review — examining the barriers to mental health access experienced by YRAS — while respecting Levesque et al.'s (2013) conceptual framework. All segments or paragraphs of data extracts were manually coded, uncoded, recoded, and collated, as required. Once all codes were established, related codes were categorized together, and broader themes and subthemes were identified in line with the conceptual framework and the review's aim. We used the five dimensions of the framework and their corresponding abilities to guide the creation of themes and subthemes while at the same time we ensured their link to the review's aim.

Results

A total of 29 articles were included in this review. Details regarding the set of articles identified and screened are given in Appendix C: PRISMA 2020 Flow Diagram, including the reasons for exclusion. Out of 29 articles, 18 (62%) represent original research studies, while seven (24%) are reviews, two (7%) are reports, one (3.5%) is a thesis manuscript, and one (3.5%) is a position report. The studies' and authors' locations varied significantly: 10 (35%) were from Australia, 8 (28%) from the United Kingdom, 4 (14%) from the United States, and 3 (10%) from Canada. The remainder were articles published from Belgium, Germany, the Netherlands, and Sweden, each with one article.

Five major themes were identified. These were based on the five dimensions of accessibility of services and five corresponding abilities of service users (Levesque et al., 2013). The themes are: (1) approachability and ability to perceive; (2) acceptability and ability to seek; (3) availability, accommodation, and ability to reach; (4) affordability and ability to pay; and (5) appropriateness and ability to engage. Specific information about the included articles and their designated themes is given in Appendix D. Although key concepts were categorized into themes, we should remember that these factors influence one another, compounding the barriers to mental health access experienced by YRAS.

Theme 1: Approachability and Ability to Perceive — Unfamiliar Services and Differing Conceptualizations of Mental Health and Treatment

Numerous young people with refugee backgrounds are unaware of the existence of mental health services within the host countries (Centre for Multicultural Youth, 2011; de Anstiss & Ziaian, 2010; Valibhoy et al., 2017; van Es et al., 2021). In the words of unaccompanied refugee youths from Afghanistan, Eritrea, and Syria, "Most refugee came here because of war, and they have no experience about psychologist, counsellor and other things", and "They don't know what is the psychiatrist, what is the counsellor, what is the social worker" (Valibhoy et al., 2017, p. 72). In addition to their lack of knowledge about mental health services and specialists, YRAS' conceptualization of mental health and treatment differs significantly from what is offered in host countries.

Conceptualizations of Mental Health and Mental Illness

For many YRAS, the terms "mental health" and "mental health illness" or "mental illness" are viewed as interchangeable (Majumder, 2019). Instead of seeing mental health as a continuum, many YRAS came from communities that perceive it as a dichotomous state: a person either has mental illness or does not (Ellis et al., 2011; Jacobs, 2014). Additionally, some YRAS believe that all types of mental illnesses are the same (de Anstiss & Ziaian, 2010; Jacobs, 2014). According to some YRAS participants from Afghanistan, Bosnia, Iraq, Liberia, Sudan, Somalia, and Eritrea, mental illness has been regarded as similar to terms such as "retarded", "weird", "sick", "crazy", "abnormal", "psych", "mental", or "mad" (de Anstiss & Ziaian, 2010; Majumder, 2019). In other languages, equivalents to English terms for psychological problems may not exist, leading to mental health problems being described in terms of associated physical symptoms, such as headaches, red eyes, and sleeping disturbances (Copolov & Knowles, 2021; Ellis et al., 2011; Majumder, 2019). Nevertheless, mental health and mental illness often seem to be associated with negative connotations and behaviours. Numerous YRAS in the United Kingdom who participated in Majumder's (2019) study associated "a mentally ill person with someone who has lost all sense of basic upkeep, hygiene, dressing, and hair; is locked up in a hospital or prison; sleeps on the streets and drinks alcohol; and is being beaten up or stoned" (p. 278). Besides stemming from their experience and observations in their home countries, YRAS' conceptualizations of mental health and mental illness are also based on their communities' beliefs and their religious or spiritual backgrounds.

Many participants reported their communities' beliefs about mental illness, which varied greatly. Certain communities were said to believe that certain groups of individuals are immune to mental illness. For instance, some participants thought that Somalians do not experience mental illness; the same was said of children and adolescents, as "they had less to worry about than adults" (de Anstiss & Ziaian, 2010, p. 35; Jacobs, 2014). Mental illness was viewed as serious, chronic, and contagious by some (de Anstiss & Ziaian, 2010; Jacobs, 2014). Some argued that they could always tell when a person has mental illness from their behaviour or their speech; generally, it was believed that when you are talking to someone with mental illness, you are unable to have a

coherent conversation (de Anstiss & Ziaian, 2010; Saberi et al., 2021). For certain communities, mental illness was considered to be caused by spiritual or religious factors. In some African groups, witch doctors or devils are believed to be able to induce mental health problems (de Anstiss & Ziaian, 2010). In the Somali community, "many Somali individuals would view mental illness … as a sign of evil not a medical disorder … if you have it you may be possessed" (Jacobs, 2014, p. 44). In sum, YRAS' conceptualizations of mental health and illness were predominantly negative, which potentially led many to deny that they are having such difficulties and to delay seeking professional assistance (Majumder, 2019).

Conceptualizations of Mental Health Treatment

Although host countries generally emphasize a modern, Western biomedical understanding of health and illness, YRAS have multiple diverging beliefs about mental health treatment (Buccitelli & Denov, 2019). Certain YRAS saw it as normal to feel some mental health symptoms and thus simply ignored such problems (Buccitelli & Denov, 2019; Jacobs, 2014). Others divulged that the treatment of individuals with mental illnesses in their home country is typically unfavourable. YRAS from Afghanistan, Eritrea, Iran, Iraq, and Somalia reported that such individuals are mocked, locked up in hospitals or prisons, stoned, or beaten (Majumder, 2019; Majumder et al., 2015). In certain African groups, mental illness is treated by medicine men who prescribe physical and spiritual traditional remedies or by witch doctors who perform spell reversals (de Anstiss & Ziaian, 2010). Traditional remedies or medicines are widely used worldwide and, for some, they represent the primary mode of health care (World Health Organization, 2013). According to the World Health Organization (2013), these remedies are regarded as accessible, affordable, culturally acceptable, and trusted by the majority of the world's population. Hence, some YRAS may seek the help of church elders who can conduct group prayers or exorcisms to get rid of an "evil spirit" (de Anstiss & Ziaian, 2010). Mental health issues are also viewed in certain cultures as uncontrollable and not able to be changed or improved by the individual (Saberi et al., 2021). Instead, only religion can affect them: "The mind has been set like, there is no cure except religious ones, don't believe in the doctors, because they are not God" (Saberi et al., 2021, p. 453). For members of the Somali community, religious treatments must be performed to cure mental illness through reading the holy Quran with family and friends (Jacobs, 2014).

Relying on the support of families, relatives, friends, or religious or spiritual advisors was also commonly cited by participants as the right and natural way to address mental illness (Buccitelli & Denov, 2019; de Anstiss & Ziaian, 2010; Ellis et al., 2010; Hodes & Vostanis, 2019; Valibhoy et al., 2017). YRAS' social networks can be an important source of informal mental health support. In some cases, members of the network may even lead YRAS to seek formal assistance (Colucci et al., 2014; de Anstiss & Ziaian, 2010; Ellis et al., 2010); however, YRAS' families, friends, and communities may also present a barrier to accessing mental health services. The unfamiliarity of YRAS with mental health services, as well as their differing conceptualizations and perceptions of mental health, illness, and treatment, inherently result in them viewing the current system as unapproachable, and so contributing to its inaccessibility.

Theme 2: Acceptability and Ability to Seek — Stigma and Cultural Factors

Two important factors that impact the acceptability of mental health services to YRAS and their ability to seek care are stigma and cultural factors.

Stigma

Stigma has been identified as a major barrier to mental health support access for YRAS as it hinders the acceptability of services and YRAS' ability to seek assistance (Baak et al., 2020; Colucci et al., 2015; Ellis et al., 2011; Majumder, 2019). There are three major types of stigma: social, institutional, and self (Fazel et al., 2016).

Social stigma. Social stigma can arise from the fear of being ostracized, mocked, or otherwise discriminated against by people who have negative views towards individuals with a certain illness or disorder (Fazel et al., 2016). YRAS were particularly concerned about the opinions and behaviours of their parents, friends, and community members. Some participants divulged that their parents may simply laugh at them if they express their mental health concerns (Jacobs, 2014; Valibhoy et al., 2017). Parents were also believed to not fully understand mental health difficulties, even if YRAS expressed their problems to them:

> Participants noted that Hazara parents expected their children to not complain because they had a far better life. Parents don't realise mental situation of kids because they come from backgrounds where things have not [been] easy, they had a really, really hard life. For them good clothing, good house and eating three meals is a lot, more than what we can ask for. (Saberi et al., 2021, p. 453)

In other cases, YRAS participants feared that they would be punished by their parents for speaking about their mental health difficulties (Saberi et al., 2021). The relationship between parents and youth in some cultures was described as less intimate and more hierarchical than in Western culture (de Anstiss & Ziaian, 2010). Youth are generally not encouraged to talk about their personal problems (de Anstiss & Ziaian, 2010); hence, youth predominantly conceal their psychological difficulties from their parents (Valibhoy et al., 2017).

In addition to fearing their parents' reactions, YRAS were afraid that if they shared their mental health problems with their friends, the friends might abandon or reject them, or gossip and talk about them behind their backs, which can be very devastating for YRAS who already have a limited social network within the host countries (Majumder, 2019; Valibhoy et al., 2017).

Their communities' perceptions of mental illness also affects YRAS' help-seeking behaviours (Copolov & Knowles, 2021; Jacobs, 2014). YRAS were afraid that seeking mental health support could impact their future chances of having a partner and family (de Anstiss & Ziaian, 2010). Thus, their worries about the consequences of sharing their mental health problems with their families, friends, and community members impedes YRAS from seeking mental health support (Ellis et al., 2011; Valibhoy et al., 2017).

Institutional stigma. In addition to social stigma, YRAS may avoid seeking mental health support due to institutional stigma. Institutional stigma, also known as structural stigma, constitutes societal norms, policies, and conditions that hinder those who are stigmatized from accessing opportunities and flourishing (Hatzenbuehler, 2016). Due to such stigma, YRAS had a tendency to distrust healthcare services, fearing that being under their care could be disadvantageous when making asylum applications or pursuing educational and employment opportunities (Fazel et al., 2016; Posselt et al., 2017). YRAS worried that disclosing personal information or being diagnosed with a mental health illness could result in rejection of their migration applications, return to a detention centre, or deportation (Copolov & Knowles, 2021; Posselt et al., 2017). As illustrated in Colucci et al. (2015), "People of refugee backgrounds may have had negative experiences with authority during their migration path, resulting in lack of trust in institutions and professionals, including hospitals and people in uniform" (p. 774). YRAS generally come from countries where authorities and government officials have subjected them to injustice and violence (Marshall et al., 2016). Hence, government-run establishments, such as healthcare systems in certain host countries, have the potential to elicit similar fear and mistrust (Centre for Multicultural Youth, 2011; Colucci et al., 2015). As such, confidentiality is crucial for YRAS, especially when interpreters and same-culture health care providers (HCPs) are involved (Colucci et al., 2015; de Anstiss & Ziaian, 2010).

Self-stigma. Another type of stigma that was highlighted by YRAS is self-stigma. Self-stigma, or internalised stigma, represents the negative view YRAS have about themselves when they are experiencing mental health difficulties (Fazel et al., 2016). YRAS with mental health concerns may devalue and isolate themselves from others because they anticipate that their families, friends, community members, and the public will perceive them negatively, exacerbating their mental illness and impeding their desire to seek assistance (Fazel et al., 2016; Marshall et al., 2016).

Cultural Factors

Cultural differences were also reported by YRAS to be a barrier to mental health service access. YRAS participants in the articles included in this review originated from a range of countries[1] that are generally considered representative of Eastern culture, while the host countries mostly follow a Western culture. As a result, differences in culture predominate during YRAS' resettlement within the host countries. Participants feel that they can never be fully understood by people outside their culture, as emphasized in the following statement: "They really don't understand us, about our journey, about the life we had" (Colucci et al., 2017, p. 191). A participant in Buccitelli and Denov (2019) added:

> How many people do you find in social work that are a minority? Maybe there are one or two. But how can you understand someone's culture if you have just studied

[1] YRAS' countries of origin included Afghanistan, Albania, Bhutan, Bosnia, Burundi, Colombia, Côte d'Ivoire, Democratic Republic of Congo, Eritrea, Ethiopia, Iran, Iraq, Liberia, Nepal, Pakistan, Rwanda, Serbia, Sierra Leone, Somalia, Sri Lanka, Sudan, Syria, Tanzania, Togo, Vietnam, and Zimbabwe.

> it from your own perspective? … Social workers here, one of the greatest biases they have is that they don't see it from the client's own view. They see it from their own theories. (p. 6)

This lack of understanding led to YRAS encountering numerous types of misconception and prejudice. They emphasized that there is a common misconception that all individuals from refugee backgrounds are "traumatized" and "psychologically harmed" and therefore need assistance from health care professionals, which might not necessarily be the case (Buccitelli & Denov, 2019).

Attitudes of racism and xenophobia were also viewed by YRAS as barriers to accessing mental health support (Buccitelli & Denov, 2019; Majumder, 2019). YRAS have reported being subjected to racial oppression and discriminatory remarks in schools, healthcare institutions, and public spaces, which makes them distrustful of formal mental health services, and thus reluctant to use them (Buccitelli & Denov, 2019; Hodes & Vostanis, 2019; Serneels et al., 2017; Valibhoy et al., 2017). According to one participant:

> People don't trust the system. Maybe I don't trust it. I know a lot of people don't trust it. People don't even like to go to the hospital because they know. They don't have to tell them, "We don't want you here." Psychologically, the way they treat you, you feel it. (Buccitelli & Denov, 2019, p. 11)

Host countries' refugee policies and practices were also viewed as avenues of discrimination (de Anstiss & Ziaian, 2010). As stated by one participant:

> If you are born in Australia, you get more respect, they care more about you because you are part of them, one of them. Rather than coming from overseas, you get treated … [trails off]. I think they care more about you if you are citizen and you are born in Australia. (Posselt et al., 2017, p. 8)

Theme 3: Availability, Accommodation, and Ability to Reach — Organizational Barriers

This theme refers to the existence of mental health interventions and the potential for YRAS to reach or obtain them in a timely manner. Many YRAS spoke of the diverse organizational barriers in host countries' healthcare systems that hinder or delay them from accessing mental health care. These consist of strict inclusion criteria, rules surrounding missed appointments or late arrivals, long waiting lists, the locations where care is delivered, and complex referral processes (Baak et al., 2020; Copolov & Knowles, 2021; Posselt et al., 2017; Valibhoy et al., 2017). Some organizations restrict their services for youth to individuals aged 17 or less (Colucci et al., 2015). Additionally, services are often solely offered for limited hours (e.g., from 9 a.m. to 5 p.m.) that may coincide with the times YRAS are attending school; as a result, youth can find it difficult to schedule appointments, or follow through on their appointments even if they have waited for months to obtain them (Baak et al., 2020; Colucci et al., 2015; de Anstiss & Ziaian, 2010).

The location of services has also been considered a barrier, particularly since the required travel times are often too lengthy for youth (Baak et al., 2020; Copolov & Knowles, 2021; Valibhoy et al., 2017). In addition to the barriers experienced by youth, service providers also encounter difficulty in referring youth to mental health services. As asserted by one participant in Colucci et al. (2015), "Mental health services are so strict with their boundaries, they don't take people … You can't get mental health services for kids unless you have an acute diagnosed, often psychotic illness" (p. 774). Frustrations about the fragmented mental health system and lack of continuity of care were also expressed by YRAS and service providers in multiple articles (Colucci et al., 2015, 2017; de Anstiss & Ziaian, 2010; Hodes & Vostanis, 2019; Posselt et al., 2017). Consequently, YRAS believe that the healthcare systems in host countries are simply not ready to fulfil their needs (Buccitelli & Denov, 2019).

Theme 4: Affordability and Ability to Pay — Financial Constraints

For some YRAS, mental health difficulties are not the priority. Numerous resettlement stressors, such as employment, housing, and food security are generally given high priority by their parents and by the youths themselves (Baak et al., 2020; Ellis et al., 2011; Hodes & Vostanis, 2019). According to Ellis et al. (2010), YRAS usually avoid sharing their mental health needs with their parents in order to keep from adding to the burden the latter are already experiencing from the resettlement. This is especially the case when mental health support may add a financial burden to the family or youth (de Anstiss & Ziaian, 2010; van Es et al., 2021) or when youth are unable to access the needed services (Valibhoy et al., 2017). Mental health services should, therefore, not only focus on the mental health symptoms experienced by youth but also consider a holistic approach to care (Posselt et al., 2017). Such an approach considers not just those symptoms but also environmental and social factors impacting the lives of YRAS. By addressing these broader aspects, mental health services can provide more effective and contextually appropriate supports, helping to alleviate the overall burden faced by these young individuals during their resettlement journey.

Theme 5: Appropriateness and Ability to Engage — Culturally Insensitive Services and Language Barriers

YRAS' perceptions and experiences of the host countries' mental health treatment services were generally negative: the treatments are described as too focused on preconceived ideas and theories, culturally inappropriate, and making YRAS feel worse than before they sought support (Buccitelli & Denov, 2019; Copolov & Knowles, 2021; Majumder et al., 2019). Host countries' health care systems typically assume that the therapies offered to the general population may also be appropriate for YRAS, such as talking therapies and mindfulness techniques (Copolov & Knowles, 2021; Ellis et al., 2010; Jacobs, 2014; Majumder et al., 2019). However, these therapies were mostly seen as difficult to understand and unhelpful (Copolov & Knowles, 2021; Jacobs, 2014). The reasons for undergoing talking therapies seemed difficult for the youth to comprehend or trust, particularly since no immediate improvement in their mental health was usually apparent (de Anstiss & Ziaian, 2010; Majumder et al., 2019). Additionally, the way such therapies are

conducted ("sitting face-to-face, making eye contact, and speaking one's mind freely") was seen as unconventional for certain cultures (Valibhoy et al., 2017, p. 74).

Furthermore, talking therapies remind some YRAS of their past traumatic experiences:

> The intervention reawakened memories of their experiences in their country of origin and relocation to their host country that they thought had led to the current mental health concerns. This was mostly perceived by the young people as regressing rather than making progress. (Majumder et al., 2019, p. 376)

As many desire to forget about their past experiences to avoid feeling depressed, talking therapies that concentrate on those experiences were upsetting for many participants (Majumder et al., 2019). Most participants would rather discuss the "here and now" and their preferred futures.

In addition to YRAS' perceptions and experiences of therapies, the style and approach of mental health providers were reported to be an important factor in the YRAS' help-seeking behaviours. The way HCPs treated YRAS during their appointments greatly influenced the youth's desire to seek help and engage with the healthcare system. HCPs who were caring and had a sense of humour were seen as valuable and positive (Colucci et al., 2015; Majumder et al., 2019). Moreover, when HCPs did not involve YRAS directly in their own care, such as by adequately communicating the process of referral or how the appointment system works, YRAS often did not understand the importance of keeping their appointments (Colucci et al., 2015, 2017). Conversely, if providers were overly confident with their diagnoses, asking questions in an insistent fashion and forcefully pushing YRAS to share their past experiences, YRAS were likely to disengage from the healthcare system (Colucci et al., 2015). YRAS highly discouraged HCPs from using "firing questions", an approach widely implemented in the immigration and legal systems that can cause further trauma to YRAS (Colucci et al., 2015). The HCPs' style and approach often appeared to not coincide with YRAS' expectations; this may be due to the lack of training and education received by HCPs concerning YRAS' backgrounds and mental health needs.

Some studies highlight the fact that HCPs often have insufficient knowledge of, and are unfamiliar with, the specific mental health problems experienced by YRAS (Canadian Council for Refugees, 2016). Service providers who participated in Posselt et al.'s (2017) study addressing barriers to mental health care for YRAS in Australia emphasized the need for specialized training in working with people who have a refugee background. Only 25% of the managers surveyed, Posselt et al. (2017) reported, had received such training: universities and vocational training establishments generally did not offer such courses. Consequently, few (15%) of them felt competent in providing care to YRAS (Posselt et al., 2017). Often, providers must rely on their preconceived assumptions about the client's cultural background, religion, and traditional practices, rather than basing their care on evidence (Posselt et al., 2017). Given that YRAS encounter such negative perceptions and experiences from HCPs, it seems logical that they tend

to underutilize mental health services and may even discourage other members of their community from seeking formal support (Copolov & Knowles, 2021).

Language barriers can also prevent YRAS from adequately engaging with HCPs. When YRAS were not familiar with the host countries' primary language, they were generally more reluctant to seek mental health support (Baak et al., 2020; Berg et al., 2021; Chiumento et al., 2011; Ellis et al., 2011; Majumder et al., 2019; van Es et al., 2021). At times, interpreters were unavailable to assist YRAS during their appointments, resulting in the need to use family members or friends to translate, and thereby blurring the lines of privacy and confidentiality (Copolov & Knowles, 2021; Majumder et al., 2019). Even when interpreters were available, YRAS and service providers still experienced other issues, such as unprofessionalism and mistranslation (Colucci et al., 2015). Overcoming language barriers is certainly crucial to increasing access to mental health support for YRAS.

In sum, the inappropriateness of the mental health services offered to YRAS, the approaches used by HCPs, and language barriers for YRAS who are not familiar with the host countries' primary language all contribute to the inaccessibility of services by hindering the ability of YRAS to fully engage with their care.

Discussion and Conclusion

This review identified five major themes of barriers to mental health access of YRAS: (1) approachability and ability to perceive; (2) acceptability and ability to seek; (3) availability, accommodation, and ability to reach; (4) affordability and ability to pay; and (5) appropriateness and ability to engage. Through applying an integrative approach to literature review, a wide breadth of information was retrieved, resulting in rich and thick description of the findings. These findings can assist YRAS, service providers, managers, policymakers, and scholars in improving mental health care access, quality, and provision in a number of ways.

First, by being aware of the barriers they may encounter, YRAS may become more knowledgeable about the interrelated factors that influence their access to mental health support, thus enhancing their mental health literacy, which has been identified as the primary solution to addressing stigma (Centre for Multicultural Youth, 2011; Marshall & Begoray, 2019; Posselt et al., 2017; Saberi et al., 2021). A potential avenue to ensuring YRAS receive this information is disseminating the findings of this review to schools and community-based organizations working with YRAS in host countries. It is important to note, however, that due to the presence of high levels of stigma related to mental health conditions, mental health literacy education sessions must not solely focus on mental health conditions. Unduly emphasizing mental health concerns might deter individuals from participating. It is therefore essential to approach these sessions with a broader perspective: framing them as opportunities to enhance overall well-being and wellness will potentially be more inclusive and appealing. Instead of resorting to use of the label "mental health", which might be off-putting for some, such an approach broadens the scope to encompass

a more holistic view of health. Involving YRAS and community members of refugee background throughout the development of educational programs and health services is also critical in addressing barriers to accessing mental health care; without this, culturally inappropriate practices will persist, and YRAS' mental health needs will too often go without adequate treatment.

Second, equipped with this information about barriers to access, service providers (e.g., nurses, physicians, social workers, and counsellors) may be willing to make changes in their practice to mitigate the effects of those barriers they have control over (e.g., communication style and approach). Certainly, training is urgently required for health care providers to become fully proficient in tackling the barriers to mental health care access; however, there are some strategies that can be integrated into their practice immediately. Engaging in self-reflexivity and cultural humility is a viable, simple first step. Self-reflexivity entails critically examining one's practice and being self-aware of one's values, attitudes, and behaviours and how they impact others (Hankivsky, 2014). Self-reflexivity can help HCPs understand both the distribution of power and privilege within a health encounter with YRAS, and thus the need for modifications in their communication style and approach. When self- reflexivity is augmented with cultural humility, the concepts of openness, equity, diversity, and respect are promoted, fostering supportive interactions between HCPs and YRAS (Foronda, 2020). Cultural humility requires HCP to commit to a humble stance, in which they view YRAS as experts regarding their own lives and experiences who should therefore be treated as active partners in their care (Foronda, 2020).

Third, managers and policymakers can utilize the findings of this review to inform future programs and policies that may be beneficial to YRAS and the general public. Levesque and colleagues' (2013) conceptual framework of access to health care, and the themes of this review that are derived from it, easily lend themselves to assisting managers and policymakers to identify key target areas that require immediate attention. Examining each barrier more systematically and in greater depth with the assistance of scholars can provide insight into the appropriate interventions or programs to overcome these barriers and finally resolve this long-standing issue of mental health service inaccessibility.

In addition to determining the barriers YRAS face in accessing mental health services, this review also discovered some gaps in the literature. For instance, all articles included in this review originated from high-income countries, even though 83% of the world's refugees are hosted in low- and middle-income countries (UNHCR, 2022). More studies are needed to investigate the barriers that impede YRAS access to mental health services within low- and middle-income countries, where sociocultural, legal, and systemic factors may significantly differ from those in high-income countries and priorities and interventions will therefore need to be different.

Another identified literature gap is the restricted reporting of included articles about the cultural background of participants. Apart from providing an overview of the participants' country of origin, the majority of the included articles do not characterize the cultural background of the participants when presenting their results or direct quotations. By this omission distinct cultural

and contextual factors may be lost, making it difficult to identify specific cultural or subcultural differences between participants. It is imperative to recognize that YRAS represent a heterogeneous group, from diverse cultural and ethnic backgrounds. Reporting this information to readers not only enriches the findings of the studies but also informs them about the vast diversity and uniqueness of YRAS' cultures.

These research and practice recommendations are crucial, but they could not be initiated, developed, and implemented without adequate funding. Along with health advocacy groups, we therefore call for the passing of the Mental Health Parity Act. This Act demands the recognition by all that mental health is as important as physical health, and patients with such disorders therefore deserve equal access to health services (Canadian Mental Health Association, 2018; Kwok & Watson, 2021; Schibli, 2019). The passing of this Act would oblige the government to guarantee the same level of health service access for mental health patients as for those with physical illnesses through mandating that "annual or lifetime dollar limits on mental health and substance use benefits be no lower than any such dollar limits for medical or surgical benefits" (Canadian Alliance on Mental Illness and Mental Health, 2021, p. 10). Passage of the Act would result in more consistent funding and resources being allocated to mental health care; this, in turn, could support programs and interventions to address barriers to access encountered by YRAS (Schibli, 2019). To conclude, YRAS face numerous barriers to accessing mental health support. These barriers are complex, interrelated, and compounding. It is only through a comprehensive, in-depth examination of each of these barriers that specifically tailored solutions may be identified, and YRAS' mental health needs can be fully met.

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Appendix A: Preliminary Search Strategy

	Key concepts	Search terms
1	Youth	young people OR young adult OR teen* OR pubescen* OR adolescen* OR youth* OR young
2	Refugees/asylum seekers	refugee* OR asylum seeker* OR asylum-seeker* OR forced migration OR forced displacement OR refugee identity
3	Mental health conditions	mental health disorder* OR mental health condition* OR mental health illness* OR anxiety disorder* OR mood disorder* OR post*traumatic stress disorder* OR schizophrenia
4	Access/utilization of healthcare/health services	access to healthcare OR access to health care OR healthcare access OR health care access OR access* OR service access OR accessibility OR service utili*ation OR utili*ation of health service* OR health service* OR health support*

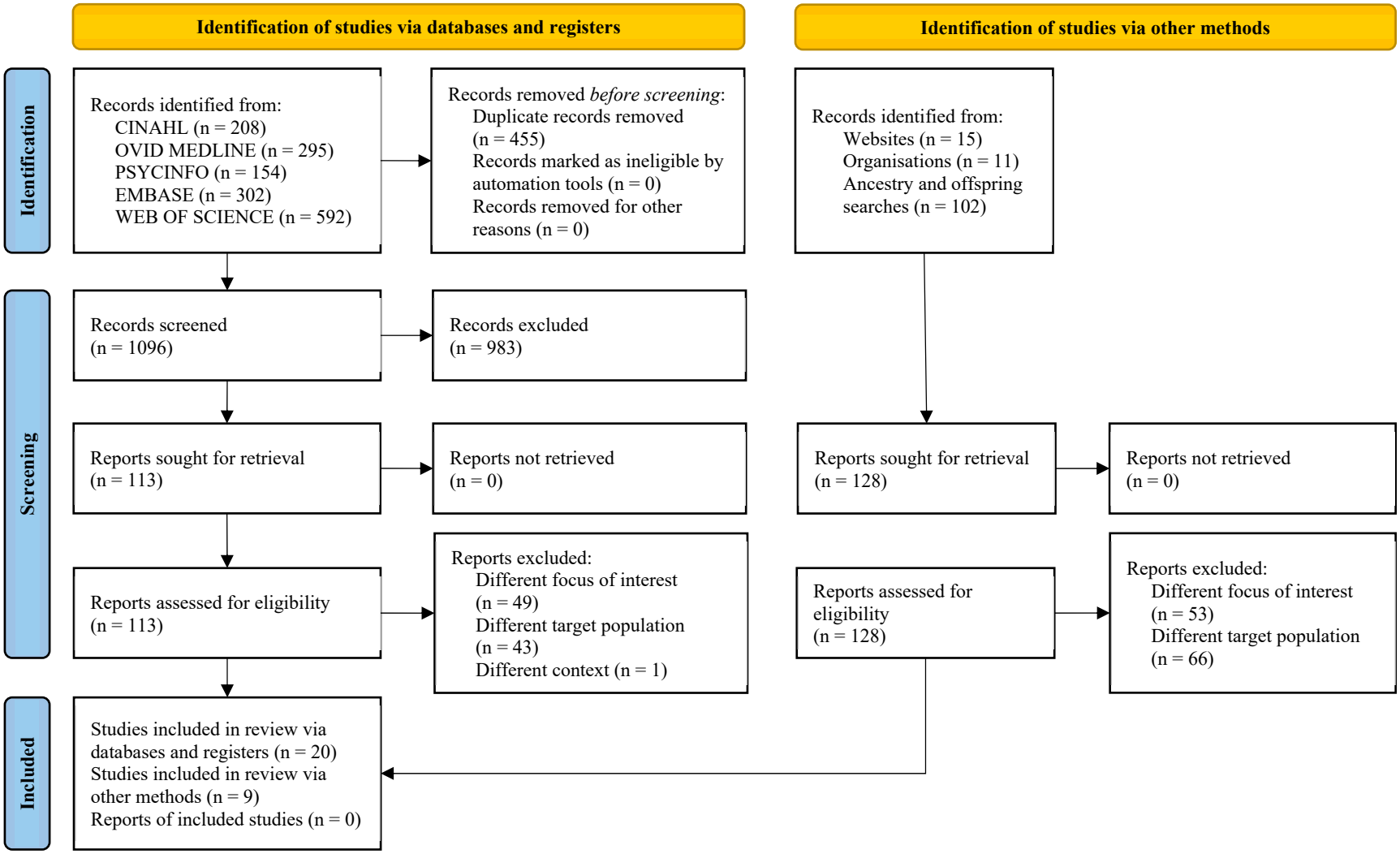
Note. Search terms 5 = 1 AND 2 AND 3 AND 4; search terms 6 = Filter: English and French.

Appendix B: Final Search Strategy

CINAHL CINAHL Plus with Full Text	**OVID MEDLINE (R)** 1946 to March Week 2 2022	**PSYCINFO** APA PsycInfo 1967 to March Week 2 2022	**EMBASE** 1974 to 2022 March 21	**WEB OF SCIENCE** Clarivate Analytics (Firm) issuing body
1. MH Adolescence+ 2. MM Young Adult 3. young people 4. young adult 5. teen* 6. pubescen* 7. adolescen* 8. youth* 9. young	1. *Adolescent/ 2. *Young Adult/ 3. young people 4. young adult 5. teen* 6. pubescen* 7. adolescen* 8. youth* 9. young	1. exp Adolescent Development/ 2. exp Young Adult/ 3. young people 4. young adult 5. teen* 6. pubescen* 7. adolescen* 8. youth* 9. young	1. exp adolescent/ 2. exp young adult/ 3. young people 4. young adult 5. teen* 6. pubescen* 7. adolescen* 8. youth* 9. young	1. young people 2. young adult 3. teen* 4. pubescen* 5. adolescen* 6. youth* 7. young
10. 1 or 2 or … through 9	10. 1 or 2 or … through 9	10. 1 or 2 or … through 9	10. 1 or 2 or … through 9	8. 1 or 2 or … through 7
11. MH Refugees+ 12. refugee* 13. asylum seeker* 14. asylum-seeker* 15. forced migration 16. forced displacement 17. refugee identity	11. *Refugees/ 12. refugee* 13. asylum seeker* 14. asylum-seeker* 15. forced migration 16. forced displacement 17. refugee identity	11. exp Refugees/ 12. exp Asylum seeking/ 13. refugee* 14. asylum seeker* 15. asylum-seeker* 16. forced migration 17. forced displacement 18. refugee identity	11. exp refugee/ 12. refugee* 13. asylum seeker* 14. asylum-seeker* 15. forced migration 16. forced displacement 17. refugee identity	9. refugee* 10. asylum seeker* 11. asylum-seeker* 12. forced migration 13. forced displacement 14. refugee identity
18. 11 or 12 or … through 17	18. 11 or 12 or … through 17	19. 11 or 12 or … through 18	18. 11 or 12 or … through 17	15. 9 or 10 or … through 14
19. MH Mental Disorders+ 20. mental health disorder* 21. mental health condition* 22. mental health illness* 23. anxiety disorder* 24. mood disorder* 25. post*traumatic stress disorder* 26. schizophrenia	19. exp Mental Disorders/ 20. mental health disorder* 21. mental health condition* 22. mental health illness* 23. anxiety disorder* 24. mood disorder* 25. post*traumatic stress disorder* 26. schizophrenia	20. exp Mental Disorders/ 21. mental health disorder* 22. mental health condition* 23. mental health illness* 24. anxiety disorder* 25. mood disorder* 26. post*traumatic stress disorder* 27. schizophrenia	19. exp mental disease/ 20. mental health disorder* 21. mental health condition* 22. mental health illness* 23. anxiety disorder* 24. mood disorder* 25. post*traumatic stress disorder* 26. schizophrenia	16. mental health disorder* 17. mental health condition* 18. mental health illness* 19. anxiety disorder* 20. mood disorder* 21. post*traumatic stress disorder* 22. schizophrenia
27. 19 or 20 or … through 26	27. 19 or 20 or … through 26	28. 20 or 21 or … through 27	27. 19 or 20 or … through 26	23. 16 or 17 or … through 22

CINAHL CINAHL Plus with Full Text	**OVID MEDLINE (R)** 1946 to March Week 2 2022	**PSYCINFO** APA PsycInfo 1967 to March Week 2 2022	**EMBASE** 1974 to 2022 March 21	**WEB OF SCIENCE** Clarivate Analytics (Firm) issuing body
28. MH Mental Health Services+ 29. MM Hospitals, Psychiatric 30. access N3 healthcare 31. access N3 health care 32. healthcare access 33. health care access 34. access* 35. service access 36. accessibility 37. service utili*ation 38. utili*ation N3 health service* 39. health service* 40. health support*	28. exp Mental Health Services/ 29. *Hospitals, Psychiatric/ 30. exp Preventive Health Services/ 31. exp Health Services Accessibility/ 32. access adj3 healthcare 33. access adj3 health care 34. healthcare access 35. health care access 36. access* 37. service access 38. accessibility 39. service utili*ation 40. utili*ation adj3 health service* 41. health service* 42. health support*	29. exp Mental Health Services/ 30. exp Psychiatric Hospitals 31. exp Preventive Health Services/ 32. exp Health Care Access/ 33. exp Health Care Utilization/ 34. access adj3 healthcare 35. access adj3 health care 36. healthcare access 37. health care access 38. access* 39. service access 40. accessibility 41. service utili*ation 42. utili*ation adj3 health service* 43. health service* 44. health support*	28. exp mental health service/ 29. exp preventive health service/ 30. exp health care access/ 31. exp health care utilization/ 32. access adj3 healthcare 33. access adj3 health care 34. healthcare access 35. health care access 36. access* 37. service access 38. accessibility 39. service utili*ation 40. utili*ation adj3 health service* 41. health service* 42. health support*	24. access to healthcare 25. access to health care 26. healthcare access 27. health care access 28. access* 29. service access 30. accessibility 31. service utili*ation 32. utili*ation of health service* 33. health service* 34. health support*
41. 28 or 29 or … through 40	43. 28 or 29 or … through 42	45. 29 or 30 or … through 44	43. 28 or 29 or … through 42	35. 24 or 25 or … through 34
42. 10 and 18 and 27 and 41	44. 10 and 18 and 27 and 43	46. 10 and 19 and 28 and 45	44. 10 and 18 and 27 and 43	36. 8 and 15 and 23 and 35
43. Filter: English and French	45. Filter: English and French	47. Filter: English and French	45. Filter: English and French	37. Filter: English and French

Appendix C: PRISMA 2020 Flow Diagram



Note. From Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., et al. (2021). The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. *BMJ,372*, Article 71. doi:10.1136/bmj.n71

Appendix D: Summarized Findings

Article	Type	Country	Participant characteristics (sample size)	Participant country of origin	Approachability and ability to perceive	Acceptability and ability to seek	Availability, accommodation, and ability to reach	Affordability and ability to pay	Appropriateness and ability to engage
Baak et al. (2020)	Research	Australia	Staff and service providers working with young people from refugee backgrounds between the age of 15-21 years	Not specified		•	•	•	•
Berg et al. (2021)	Research	Sweden	11-18 years old, includes foreign-born refugee children; Swedish-born refugee parents; Swedish-born with one Swedish-born and one refugee parent; Swedish-born with 2 Swedish-born parents (n= 93537)	Afghanistan, Eritrea, Iran, Iraq, Somalia, Syria, and Vietnam			•		•
Böge et al. (2020)	Research	Germany	14-21 years old and 18-65 years old	Not specified					•
Buccitelli and Denov(2019)	Research	Canada	15-30 years old (n=22)	Colombia, Democratic Republic of Congo, Nepal, Rwanda, Sierra Leone, Sri Lanka, Togo, and Zimbabwe	•	•			•
Canadian Council for Refugees (2016)	Position paper	Canada	Not applicable	Not specified					•
Centre for Multicultural Youth (2011)	Report	Australia	Young people from refugee backgrounds (n=6) and professionals from government, academic and service provider backgrounds (n=12)	Ethiopia, Iran, Iraq, Somalia, and Sudan	•	•	•		
Chiumento et al. (2011)	Research	UK	Teachers of refugee children and youth	Not specified			•		•
Colucci et al. (2014)	Review	Australia	Not applicable	Not specified		•	•	•	

Article	Type	Country	Participant characteristics (sample size)	Participant country of origin	Approachability and ability to perceive	Acceptability and ability to seek	Availability, accommodation, and ability to reach	Affordability and ability to pay	Appropriateness and ability to engage
Colucci et al. (2015)	Research	Australia	Service providers of refugee young people (n=115)	Not specified		•	•	•	•
Colucci et al. (2017)	Research	UK	Service providers with direct experience in youth and refugee mental health (n=115) 18-25 year old refugee status and had received services from a mental health professional (n=131)	Not specified		•	•		•
Copolov and Knowles (2021)	Research	Australia	Hazara refugees 18 to 30 years old (n=18)	Afghanistan and Pakistan	•	•	•	•	•
de Anstiss et al. (2009)	Review	Australia	Not applicable	Not specified					
de Anstiss and Ziaian (2010)	Research	Australia	Adolescent refugees aged 13-17 years (n=85)	Afghanistan, Bosnia, Iran, Iraq, Liberia, Serbia, and Sudan	•	•	•	•	•
Ellis et al. (2010)	Research	US	11 to 20 years old (n=144 for surveys; n=14 for interview; and n=16 for focus groups)	Somali	•				•
Ellis et al. (2011)	Review	US	Not applicable	Not specified	•	•		•	•
Eruyar et al. (2018)	Review	UK	Not applicable	Not specified	•		•		
Fazel et al. (2016)	Research	UK	15-24 years old refugees (n=40)	Afghanistan, Albania, Iran, Iraq, Somalia, and Sudan,		•	•		•
Hodes and Vostanis (2019)	Review	US	Not applicable	Not specified	•	•	•	•	
Jacobs (2014)	Thesis	US	Service providers with experience working with Somali youth (n=8)	Not specified	•	•			•

Article	Type	Country	Participant characteristics (sample size)	Participant country of origin	Approachability and ability to perceive	Acceptability and ability to seek	Availability, accommodation, and ability to reach	Affordability and ability to pay	Appropriateness and ability to engage
Majumder (2019)	Research	UK	15-18 years old unaccompanied refugees and asylum seekers and their carers (n=15)	Afghanistan, Eritrea, Iran, Iraq, and Somalia	•	•			
Majumder et al. (2015)	Research	UK	15-18 years old unaccompanied refugees and asylum seekers and their carers (n=15)	Afghanistan, Eritrea, Iran, Iraq, and Somalia	•	•			
Majumder et al. (2019)	Research	UK	15-18 years old unaccompanied refugees and asylum seekers and their carers (n=15)	Afghanistan, Eritrea, Iran, Iraq, and Somalia					•
Marshall et al. (2016)	Report	Canada	Not specified	Not specified		•			
Marshall and Begoray (2019)	Review	UK	Not applicable	Not specified			•		
Posselt et al. (2017)	Research	Australia	12-25 years old refugees (n=15) and service providers (n=30)	Afghanistan, Bhutan, Burundian, Congo, and Liberia		•	•		•
Saberi et al. (2021)	Research	Australia	18-30 years old Hazaras students (n=15)	Afghanistan and Pakistan	•	•	•		•
Serneels et al. (2017)	Review	Belgium	Not applicable	Not specified		•			
Valibhoy et al. (2017)	Research	Australia	18-25 years old refugees who attended a mental health service (n=16)	Afghanistan, Côte d'Ivoire, DR Congo, Ethiopia Iran, Iraq, Pakistan, Sudan, and Tanzania	•	•	•	•	•
van Es et al. (2021)	Research	Netherlands	12-19 years old unaccompanied refugees (n=41)	Afghanistan, Eritrea, and Syria	•		•	•	•

Note. UK = United Kingdom; US = United States.