SUPPORT FOR MIGRANT COMMUNITIES

PATHWAYS

Geneva Challenge 2025

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About the Team

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Jane Loyola Pereira is a healthcare professional from India, currently pursuing an MSc in Global Health Policy at the University of Edinburgh. With a background in Radiotherapy Technology, she completed a year-long internship at a cancer hospital, where she developed a strong interest in improving cancer care access for underserved populations. Her experience in clinical settings sparked a passion for health equity and system strengthening in low- and middle-income countries. Jane is committed to advancing policies that make cancer care more accessible, affordable, and equitable.

Yesha Viren Dharamshi is an aspiring psychologist studying her master's in psychology of Mental Health at the University of Edinburgh. Over the years, she has contributed to both individual projects and large-scale campaigns, collaborating with organisations focused on youth development, education, and psychological well-being. Yesha's interests lie at the intersection of mental health, community impact, and research, with a growing focus on promoting systems for underrepresented groups. She is committed to using her skills to create meaningful change and promote inclusive, empathetic practices in all areas of her work.

Zannatul Ferdush Amin is a doctor from Bangladesh, currently pursuing an MSc in Global Health Policy at the University of Edinburgh. She brings nearly four years of experience in clinical trials and public health initiatives in Bangladesh. Before joining the University of Edinburgh, she worked as a Research Investigator for the World Health Organization's ACTION-III trial, a multi-country study focused on antenatal corticosteroids in late preterm births to reduce neonatal morbidity and mortality. Zannatul is deeply committed to advancing research in maternal and child health, vaccine trials, and improving health systems for underserved communities.

Abstract

International students in the United Kingdom, especially those from diverse cultural backgrounds, face significant mental health challenges, worsened by language barriers and the difficulties of adjusting to new environments. Despite existing support systems at universities and the NHS, many international students report dissatisfaction with the mental health services available. This research project – PATHWAYS, showcases the importance of culturally sensitive and language-inclusive mental health interventions, focusing on creating a helpline tailored to the specific needs of international students. The project looks at the psychological stressors they encounter, such as increased anxiety, depression, loneliness, and cultural stigma around mental health. It stresses the role of language in emotional processing and its effect on mental health experiences. The project proposes a volunteer-led helpline with multilingual support and cultural sensitivity training, aimed at providing immediate emotional aid and guiding students to appropriate resources. It calls for a comprehensive, community-based approach to improve mental health service delivery, emphasizing the need for policy changes that include culturally competent care in university systems. Volunteers from universities will be trained in mental health first aid and cultural sensitivity to ensure effective crisis intervention and ongoing support. The goal of this model is to enhance engagement with mental health services among international students, reduce the stigma of mental health issues, and promote a more inclusive and supportive university environment.

Problem Statement

Introduction

The UK has consistently been one of the leading destinations for international students, after the USA and Australia (Bolton, Lewis & Gower, 2024). According to QS rankings, in the UK, London tops the charts as the best student city, and Edinburgh in the second place with it and being placed at 16th globally (QS World University Ranking, 2025). Edinburgh being a major academic hub, has the largest international student population in Scotland (HESA, 2025). The University of Edinburgh hosting over 18,000 international students representing 36% of its student body (University of Edinburgh, 2025), Edinburgh Napier University with 28% international students (UCAS, 2025) and Heriot-Watt University having 39% international students (UCAS, 2025). While these numbers show the UK's global appeal, they also highlight the growing need for targeted mental health (MH) support within the international student population.

Through our engagement with the student body and service providers, we found that one of the main challenges preventing international students from accessing prompt and efficient support through the current mental health hotlines was the language barrier. When seeking assistance especially in times of crisis, many people experience feelings of loneliness and misunderstanding. Our concern over these deficiencies led to the creation of this document, which serves as a guide for creating a mental health support system that is culturally accessible. In this document we propose our project – PATHWAYS to address this challenge,

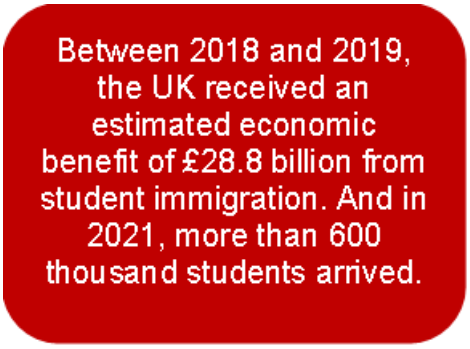
Source: BMC Public Health (2023)

We will also discuss systemic barriers, map relevant stakeholders, and lay the groundwork for an inclusive trauma crisis response among the immigrant international student population in Edinburgh and then eventually scale up to the entire United Kingdom (UK).

Challenges Faced by Student Immigrants

In 2021, the number of international students in the UK surpassed 0.6 million. This significant influx contributes substantially to the UK's economy, with an estimated net economic benefit of £28.8 billion generated from the 2018/19 intake alone (Brennan, 2022). However, while international students form a substantial portion of the UK's population, their mental health needs are distinct and often differ from those of their domestic counterparts (Zhou, 2023). As a result, international student faces a unique set of emotional challenges, many from countries affected by war, instability, or economic hardship, carrying unaddressed trauma into their new lives.

For students, this is could be compounded by academic pressure, language differences, financial stress, and social isolation. The stages of international study: preparation, cultural adjustment, maintaining social networks, and eventually return, can each generate psychological conflict, overload, and distress (Cardiff University, 2018). The “language gap” further exacerbates isolation, creating emotional strain and impeding social integration (Li, 2023). As noted by Hick et al. (2009), mental health is shaped by biological, psychological, and social systems, highlighting the need for an inclusive, trauma-informed approach that addresses these diverse stressors.



Source: Brennan (2022)

Despite the substantial presence and economic contribution of international students in the UK, mental health support for this group remains a significant challenge. One of the primary obstacles they face is adapting to the UK's healthcare system, which can differ greatly from what they are used to. While international students gain access to healthcare through the National Health Service (NHS), they must first pay the Immigration Health Surcharge (University of Edinburgh, 2025). Even with this provision, navigating the healthcare system, particularly in terms of mental health services, continues to be a daunting task for many students.

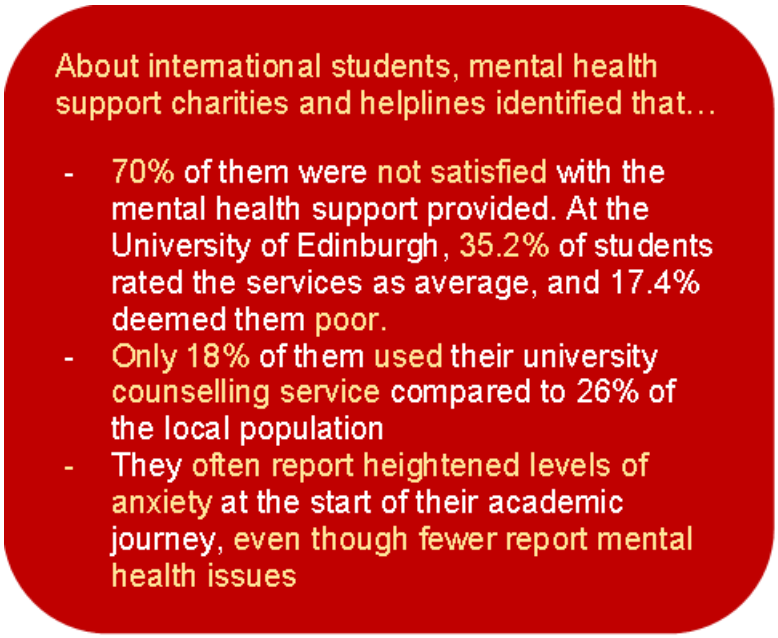
Helplines

However, despite these challenges, universities in the UK, including Edinburgh, have implemented various support systems. These services aim to address the mental health needs of students, though they often fall short in fully meeting the diverse requirements of international students. Among the services offered are:

- Wellbeing services that deliver low-intensity support and refer students to non-medical services.
- Counselling services for students experiencing moderate mental distress.
- Disability services for students who receive disabled students' allowances and have a diagnosed mental illness.

In addition to university-provided services, organizations and helplines such as Student Minds, Globally MindEd, The NHS 24/7 Mental Health Crisis Helpline, Nightline, Samaritans, and the National Suicide Prevention Helpline UK offer valuable mental health resources nationwide (Office for Students, 2023; Student Minds, 2023). Many of these helplines provide freephone numbers, while services like Mind and Nightline offer email or web chat support. Some also provide online resources, including live chat options, to help students access additional assistance (Mind, 2023; Nightline, 2023).

However, questions remain about the accessibility, inclusivity, and overall effectiveness of these services in truly meeting the unique mental health needs of international students. A specific challenge around support provision and international students relates to the NHS-often perplexed by prescription charges when told 'everything is free' or going to A&E before attempting to see a GP or call 111 (Student Minds, 2025). Failing to provide students with the information they need to access the appropriate services leads to frustration for the NHS, as students inadvertently become a disruption, and for students themselves, who feel like they are being bounced around without receiving the timely support they need. This issue was previously identified in Scotland, where enhancing referral pathways and connections between Higher Education Institutions and the NHS became a priority due to the confusion among international students, experience regarding the relationship between university and NHS services (Maguire and Cameron, 2021). On the other hand, 48% of international students in Portsmouth city were unregistered with a GP, and many were unaware of how to access mental health services through the NHS (Portsmouth City Council, 2018).



Source: Schifano (2023)

In the 2022/23 Mental Health Survey, conducted with Campaign Against Living Miserably (CALM), a suicide prevention charity, it was found that 70% of students who sought mental health support from the university were not satisfied with the help they received (Schifano, 2023). A report from St ternational students utilized university counselling

services, compared to 26% of their UK counterparts. This engagement gap may suggest that cultural factors, such as the way mental health is discussed and conceptualized, play a significant role in shaping international students' willingness to seek help (Brennan, 2022). Additionally, international students often report heightened levels of anxiety at the start of their academic journey, even though fewer report mental health issues compared to UK students. These findings reflect broader trends across the UK, where international students face distinct mental health challenges (Student Minds, 2025), and Edinburgh, with its diverse student body of 15,000 international students from over 130 countries (Best Student Halls, 2025; Universitas 21, 2025), offers a case in point to further examine the adequacy of support systems in addressing these needs.

Building on this, a survey conducted at the University of Edinburgh on student well-being highlighted significant dissatisfaction with mental health services, with 35.2% of students rating the services as average and 17.4% deeming them poor (Schifano, 2023). Furthermore, while international students in Edinburgh report lower self-reported instances of mental health issues compared to their UK-domiciled peers, they often feel a stronger sense of anxiety at the beginning of the academic year. This highlights a crucial difference in their mental health needs, which may not be adequately addressed by the current support structures in place (Student Minds, 2025). The gap in mental health service engagement calls for a revaluation of the existing models, particularly focusing on the language and cultural nuances that shape how mental health is perceived and accessed by international students.

Barriers

Despite the clear need, many immigrants and international students do not access mental health services in the UK. One major reason is a lack of awareness—many are unaware that such services exist

or do not understand how to access them (Cardiff University, 2018). This invisibility of services delays early intervention and worsens long-term outcomes.

This issue is further compounded by a language barrier. For those whose first language is not English, concerns about being misunderstood can deter them from seeking help. Wenxuan Li (2023) highlights that the psychological strain caused by language difficulties is profound, often leading to withdrawal and increased stress. Even when services are available, they are not always culturally competent. Research by Sakız & Jencius (2015) and Zunker (2016) stresses that an inclusive mental health model must respect cultural diversity and adapt care to the client's cultural framework.

Key challenges for international students to access mental health services in the UK

- Lack of **awareness of the availability** of the service
- **Language barriers** for non-native English speakers
- **Stigma** and **fear of academic repercussions** or other consequences of reporting mental health problems
- **Systematic barriers**, as long waiting times in the health care services, its quality, etc.
- The **quality of the service** does not reflect **cultural sensitivity** to the migration diversity in the UK

Source: Cardiff University (2018); Wenxuan Li (2023); Nam et al. (2023)

Stigma is another barrier; mental health remains a taboo topic in many cultures. Students may fear academic repercussions or even immigration-related concerns if they disclose mental distress (Nam et al., 2023). Systemic barriers also exist: NHS mental health services are overwhelmed, often with long waiting lists, which can discourage or delay access for vulnerable populations (Cambridge Global Mental Health, 2024).

As a result, these challenges contribute to heightened mental health issues among international students. They face elevated rates of anxiety (2.4–43%), depression (3.6–38.3%), psychological distress (31.6–54%), loneliness (60–65%), financial strain (15.4–95%), and discrimination (9–50%) (Maharaj et

al., 2024). These challenges are particularly pronounced among Asian students, who often value familial support, emphasize emotional self-control, and may stigmatize psychological distress, making them less likely to seek professional help (Kim, Li, & Ng, 2005; Li & Lin, 2014; Zhang, 2012).

Moreover, female students report higher rates of self-harm and suicide attempts than their domestic peers, while males show increased perceived stress, low self-esteem, and reduced locus of control (Forbes-Mewett & Sawyer, 2016). Repeated exposure to stress may alter their self-perceptions and increase psychological vulnerability, often leading to anxiety, depression, and suicidal ideation (Smith & Khawaja, 2011; Liu, 2009). In some cultures, the stigma around suicide is also lessened, potentially contributing to underreporting and delayed intervention (Wasserman et al., 2005).

Culture and Language

Under the settled scenario, culture becomes a critical component in any mental health intervention. Even when its formal definitions stablish culture as “the values, beliefs, language, rituals, traditions, and other behaviours that are passed from one generation to another within any social group cultural groups could include groups based on shared identities” (APA, 2023); authors as Spencer-Oatey (2012), adds reflexions where culture works as “basic assumptions” shared by groups of people that not only to regulate social behaviours but also emphasizing on the interpretations of “meanings” of others and the world. This raises the awareness about culture shaping more than social constructs, but inner worlds of the individual through its components, with the emphasize in the role of language.

Social sciences theorized models about this influence of language and culture in the construction of reality, and a critical contribution to the mental health sphere is the “languages of distress” definition. Here, in a critique to reductionist and westernized diagnostic models in psychiatry that might not be

accurate with the diverse realities, suffer and even local labels of emotional experiences of the different societies and cultures; “languages of distress” understood that standard biomedical terminology and cannot be captured through literal translation alone, and globalizing the experience of distress would not be accurate at intervention or even understanding the psyche of people (Brinkmann, 2014). So, when it comes to intervention in mental health, assuming that global models are the only pathway to generate “evidence-based” interventions can generate more inequities, increasing the accessibility gap of the public health system, and even reproduce epistemic injustice, which is a term used to describe people´s experience of being unfairly wronged in their capacity as knowers by structural issues or prejudice in the systems (Stenhouse et al., 2024).

Recent research highlights the overrepresentation of WEIRD (Western, Educated, Industrialized, Rich, and Democratic) populations in psychological studies, limiting the generalizability of findings. Mostafa Salari Rad et al. (2018) found that most research in Psychological Science relies on Western samples, while Newson et al. (2020) reported 92% of studies in leading psychology journals came from European and English-speaking nations. This bias extends to learning analytics, with Baek & Doleck (2024) noting at least 58% of studies focused on WEIRD samples. The dominance of Western perspectives in mental health practices has led to calls for more culturally indigenous approaches (Xu, 2016). To address this issue, researchers suggest diversifying sample populations, increasing ecological validity, and developing novel methodologies (Newson et al., 2020). These efforts aim to create a more representative psychological science that better reflects the human condition across diverse cultures and contexts.

Moreover, and beyond the social importance of culture and language in mental health, neuroscience evidenced that “language helps constitute emotion by representing conceptual knowledge

that is necessary to make meaning of otherwise ambiguous affective states" as Brooks et al., (2017) mentions, but moreover emotional perception relies on neurocognitive access to culturally rooted emotion concepts, not merely on universal facial expression decoding as traditional models used to state (Leshin et al., 2024). So, it can be identified the critical component of culture at feeling but also expressing emotions and behaviours in People.

Using a **foreign language** in distressful moments is seen as **less emotional** and more cognitively demanding **or logical** for bilingual speakers. Still, it **fails at regulating the bodily experience**, rather than when labelling in the native language.

Source: Lluís-Vives et al. (2021)

This gains even more relevance when distressful moments come. Lluís-Vives et al. (2021) noted that even when a foreign language is seen as less emotional and more cognitively demanding or logic for bilingual speakers, it fails at regulating the amygdala activation, the primal emotional response centre in the brain, and even generates higher activation than when labelling in the native language. This reflects the fact that the language in which people name their emotions has important consequences in how they experience them. Considering mental health intervention, it would be completely erratic in design interventions that do not acknowledge the importance of these cultural-linguistic links, especially in stressful events.

Additionally, global changes and mass migration challenge the traditional idea of some psychological theories and research, but also the local governance and policies that assume cultural homogeneity and stability in their nations (Cooper & Denner, 1998). This gains even more relevance for places like the UK where cultural diversity and immigration is a determinant in the demography as shown in the previous subheadings. Minutillo et al., (2020) shows the impact of these assumptions of homogeneity for international students in their acculturation, which is the process of adaption to a host

culture, as in parallel to academic demands, they have to deal with stressors of living in an unfamiliar cultural and linguistic environment.

Here, even when the economic and cultural benefits of international cohorts are recognized, universities often fail to provide services tailored to their mental-health vulnerabilities, rendering this population especially prone to overwhelming isolation. In the UK, most universities offer induction-week orientation, peer-mentoring schemes, and general wellbeing workshops; however, these initiatives frequently emphasize academic and logistical integration over culturally and linguistically sensitive emotional support. This raises awareness of what type of inclusion and wellbeing support can be offered in a space that demands leaving a part of their self-identification since the beginning to access it, even when this is ineffective at generating regulation as it was mentioned previously.

At approaching intervention in such a diverse environment, it is important to highlight that **evidence-based practices frequently rely on limited evidence**, which is **commonly bias by cultural assumptions.**

Source: Kirmayer (2012)

There exists a divide between evidence-based practice (EBP) and cultural competence (CC) in mental health services. Kirmayer (2012) argues that EBP often relies on limited evidence biased by cultural assumptions, particularly for minority populations. Good and Hannah (2015) emphasize the need for nuanced approaches to culture in clinical settings, considering local contexts and individual experiences. Whaley & Davis (2007) propose that EBP and CC are complementary, especially in developing culturally adapted interventions. Culturally informed MH practices are imperative since international students experience unique challenges related to language and sociocultural barriers. (Mori, 2000).

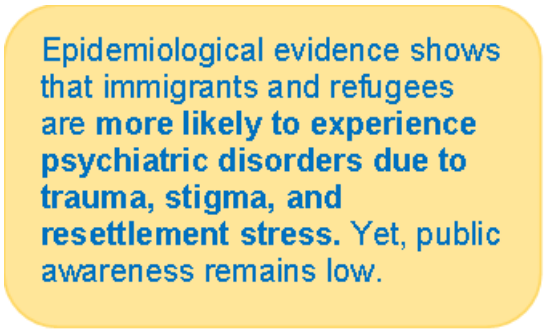
Studies have shown that, during the cross-cultural transition, many international students experience acculturation stress due to conflicting cultural norms, values, and expectations (Smith & Khawaja, 2011). Prolonged exposure to acculturation stress may lead to mental health challenges (Berry, 2005; Berry, Kim, Minde, & Mok, 1987; Zhang & Goodson, 2011).

While there is a strong preference for culturally and linguistically concordant care, professional interpreters are not always preferred due to issues of cost, availability, and the potential for miscommunication or bias (Krystallidou et al., 2023). Interpreters may influence clinical outcomes unless properly trained for psychological contexts (Paone & Malott, 2008; Bradford & Muñoz, 1993).

Developing bilingual clinical capacity, providing translated materials, and using culturally sensitive gestures, such as speaking a patient's native language or displaying culturally meaningful artifacts which can foster trust and disclosure. These efforts are particularly critical for international students and newcomers (Giacco et al., 2014).

Innovative models such as the Multi-Phase Model of Psychotherapy offer structured approaches to bridging cultural and linguistic gaps in mental healthcare (Soares et al., 2024). Additionally, technology-based interventions and collaborative frameworks have shown promise in improving engagement with mental health services among immigrant populations. There is a consistent association between limited language proficiency and underutilization of psychiatric services across diverse contexts. However, most existing research is cross-sectional, and prospective studies on the impact of language interventions remain scarce. Notably, studies by Snowden et al. (2011), McClellan et al. (2012), and Snowden & McClellan (2013) were excluded from systematic reviews due to the lack of rigorous language proficiency assessments.

This research gap persists despite clear epidemiological evidence showing that immigrants and refugees are more likely to experience psychiatric disorders due to trauma, stigma, and resettlement stress (de Jong et al., 2001; Ladin & Reinhold, 2013). Yet, public awareness remains low, likely because those fluent in the dominant language are not directly affected (International Migration, 2009).



Source: de Jong et al. (2001); Ladin & Reinhold (2013); International Migration (2009)

Importantly, inconsistencies in findings regarding ethnic background and mental health access suggest that language proficiency may be a more decisive factor in psychiatric care access than ethnicity itself. Addressing linguistic barriers through systemic, culturally informed interventions is therefore crucial to ensuring equitable mental health support for diverse populations.

Indigenous communities, immigrants, refugees, and racialized groups experience mental health disparities influenced by cultural and societal factors. Culture significantly shapes mental health experiences and outcomes, necessitating culturally sensitive services. Policy advancements are required in areas such as cultural competence training, language interpreter standards, cultural mediators, and the integration of cultural elements into service design and practice. Both immigrants and refugees and healthcare providers face challenges due to language barriers when accessing or delivering mental health services (Lawrence et al., 2019). There is a preference for mental health services that are linguistically and culturally aligned, yet professional interpreters are not always the preferred or flawless solution. Language barriers impede access to mental health services, highlighting the need for enhanced language support and cultural competency (Krystallidou et al., 2023). Collaborative efforts and technology-driven

interventions can improve access and engagement with mental healthcare services for immigrant populations (Giacco et al., 2014).

The Multi-Phase Model of Psychotherapy offers a promising approach to addressing cultural and linguistic obstacles (Soares et al., 2024). These articles consistently demonstrate a strong link between limited language proficiency and the underutilization of psychiatric services, irrespective of the research location. However, the field is dominated by cross-sectional studies, and there is a lack of prospective data on improving access to care through linguistic interventions. To our knowledge, only three prospective studies have examined the impact of language programs on access to mental health services; however, these studies did not meet our inclusion criteria because they did not systematically assess participants' language proficiency (Snowden et al., 2011; McClellan et al., 2012; Snowden & McClellan, 2013). Thus, the literature search clearly highlights the scarcity of data related to the connection between language proficiency and access to mental health services, particularly data on interventions to address this widespread issue, which is likely to delay appropriate treatment for those in dire need of help. Unfortunately, the lack of data on this topic seems to attract little public attention, suggesting that those fluent in the official language (a societal majority) may not be aware of the problem. However, this issue is expected to become a significant public concern as global migration increases (International Migration, 2009). Epidemiological data have clearly shown that immigrants and refugees are more likely than the general population to experience psychiatric disorders (de Jong et al., 2001; Ladin and Reinhold, 2013), partly due to the stressful, potentially stigmatizing, and traumatic situations they face in their home countries and in the countries where they have relocated. Language is a significant barrier in seeking and providing appropriate treatment among immigrants and refugees; language proficiency is particularly crucial in psychiatric care because determining psychiatric

diagnoses heavily rely on verbal communication between patients and professionals. The fact that the associations between access to psychiatric care and ethnic background were not always consistent in the literature may suggest that language proficiency plays a more significant role in access than ethnic background does.

Why does only having interpreters not solve the problem?

- Logistical problem due to its cost and immediate availability
- If they do not have a psychological training, their presence might influence in the therapeutic space

Source: Bradford & Muñoz, (1993); Farooq, (2003); Miller, (2005); Paone & Malott, (2008)

Addressing language barriers often involves the use of interpreters; however, the cost and immediate availability of certified interpreters present logistical challenges. Furthermore, interpreters, by controlling the information exchanged between the student and clinician, may exert influence over the clinical interview's outcome (Bradford & Muñoz, 1993; Farooq, 2003; Miller, 2005; Paone & Malott, 2008), unless they are specifically trained as psychological, professional translators (Paone & Malott, 2008). An alternative strategy for managing language barriers is the development of bilingual proficiency among clinicians, particularly in ethnic-specific community mental health services for groups such as Hispanics, Chinese, or specific refugee populations. A third, and potentially most practical, approach to enhancing communication between clinicians and international students is the utilization of translated written materials. Through over a decade of collaboration with international students and their families, we have observed that when clinicians engage in culturally sensitive gestures (e.g., greeting students in their native languages or incorporating cross-cultural artifacts as office decorations), students appear more comfortable and more inclined to share their concerns. These observations suggest that incorporating culturally sensitive models and practices, as well as language use in mental health crisis helplines, may yield beneficial outcomes.

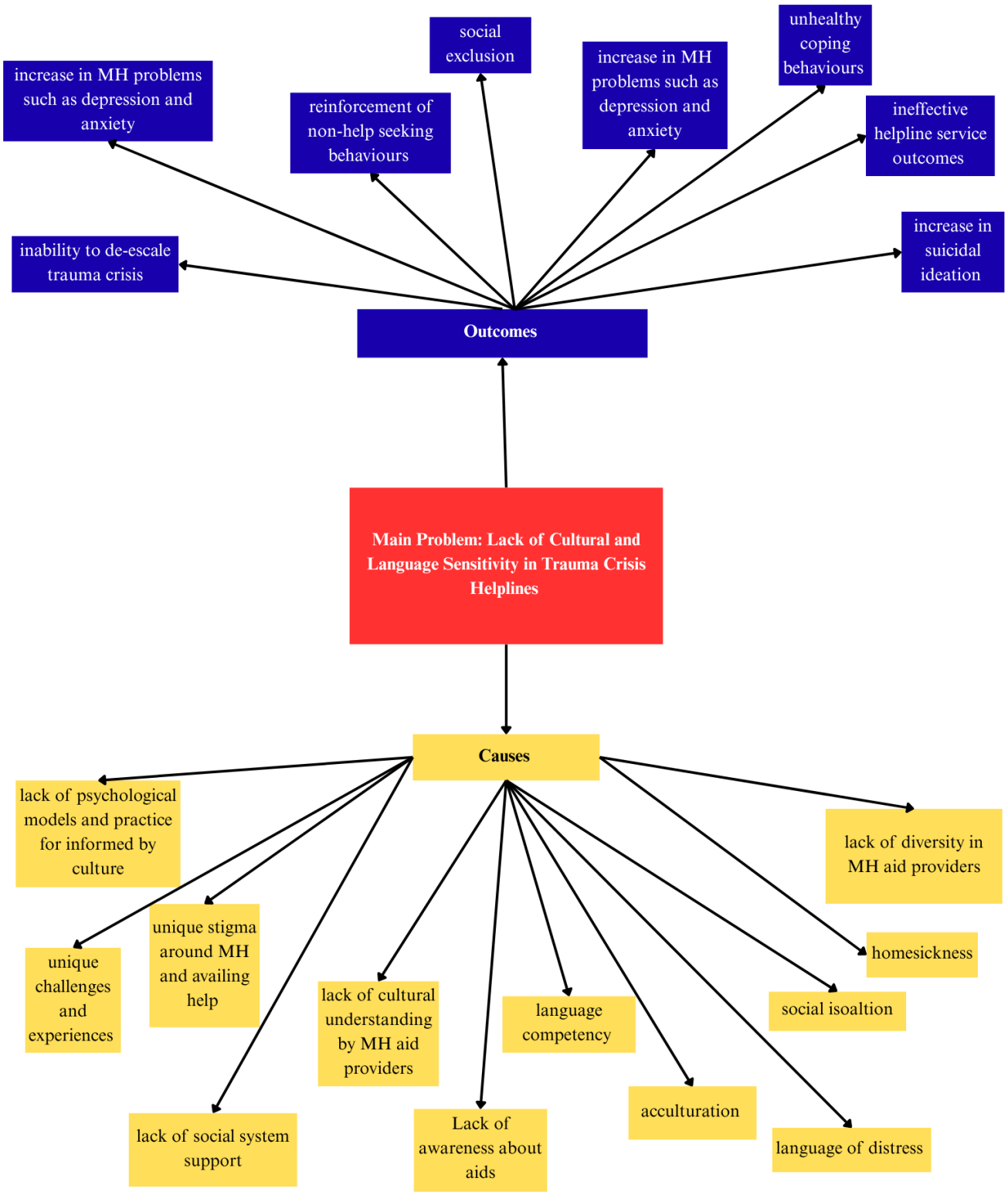


Figure 1. Tree of Problems

Methodology

Our approach to support cultural inclusive mental health services for the immigrant student population in the UK involves providing comprehensive access to an adapted first response channel, in form of helpline, for distressful moments or emotional crises outbreaks for the population, as seen in the Figure x. The resources and intervention protocols would be adapted by local experts of the different regions that the project will partner with and would provide a safer and more familiar response in these critical moments, reducing the disparities at accessing the service, but also increasing the quality of the attention. As it will be explained in the further headings, the intervention proposed goes beyond translation of mental health services but address a rotted problem in the treatment gap for mental health services, the warmth of culturally sensitive support to the population during the distressful moment. The basis will be mentioned in the current heading and developed later in the following headings.

Figure 2. Visual representation of the solution

As mentioned, the project has a strong foundation in strategic alliances and partnerships. This is because the UK, as established previously, offers a wide range of mental health support for its inhabitants. The main problem with those is how fitted they fit in the roots of the large and diverse immigrant population. Hence, to make use of the already existent services, the current proposal offers to solve the complex challenge of those systems in a culturally responsible and aware way. Moreover, the intervention has a critical human-centred design. This means that the solution proposed ahead focuses on prioritizing needs, values, and lived experiences in distress.

5 pillars of the intervention

- Strategic alliances and partnerships
- Interdisciplinary teams
- Research and co-creation of knowledge and interventions.
- Community awareness and education
- Peer-support

Engaging with local grounded interventions is a complex challenge, and interdisciplinary approaches are needed. Hence, this proposal has its foundations in clinical and transcultural psychology, public health, and sociolinguistics. However, its implementations will require more than the technical mental health experts, but broader teams from information technology partners to support the logistics of the helpline, to legal advisors to provide insights about regulations in different scenarios. In addition to that, the proposal is deeply rooted in knowledge co-creation and research, as partnership with local experts and user voices in both problem diagnosis and solution co-design is a key component to the change. This will be done through participatory methods, as the following phases use tools such as focus groups, technical round tables with local experts (Delphi method), storytelling, and others. However, the purpose of the participatory approach is not only based on the use of tools, but also to merge with its human rights and collaborative framework in each stage of the current project.

Another of the axes of the proposal is grounded in peer support training and community awareness. As expected, the service adaptations are run by volunteers. As much of their own perspectives would feed back on the different phases, also, evidence-based training will be provided according to the local adaptations that the international partners would provide. At the same time, community awareness will not only be useful for the users to access the service, but also for the partners who deliver further interventions. The goal of this project at generate accessibility involves improving the quality of experience for the users but also addressing structural factors in the healthcare system. Hence, the research and information produced will be socialized with the allies and the broader systems to offer information about alternative routes for approaching to immigrant population and their mental health.

I. Pre-Intervention

Phase 1

The pre-intervention phase is required to implement a culturally aware mental health crisis response system for immigrant populations in the UK. The pre-intervention phase guarantees that all project phases to be followed are morally sound, culturally sensitive, and evidence-based procedures. We are going to do this by integrating aspects of international cooperation, stakeholder mapping, and strategic and logistical planning. This helps establish the framework for an effective and responsive intervention.

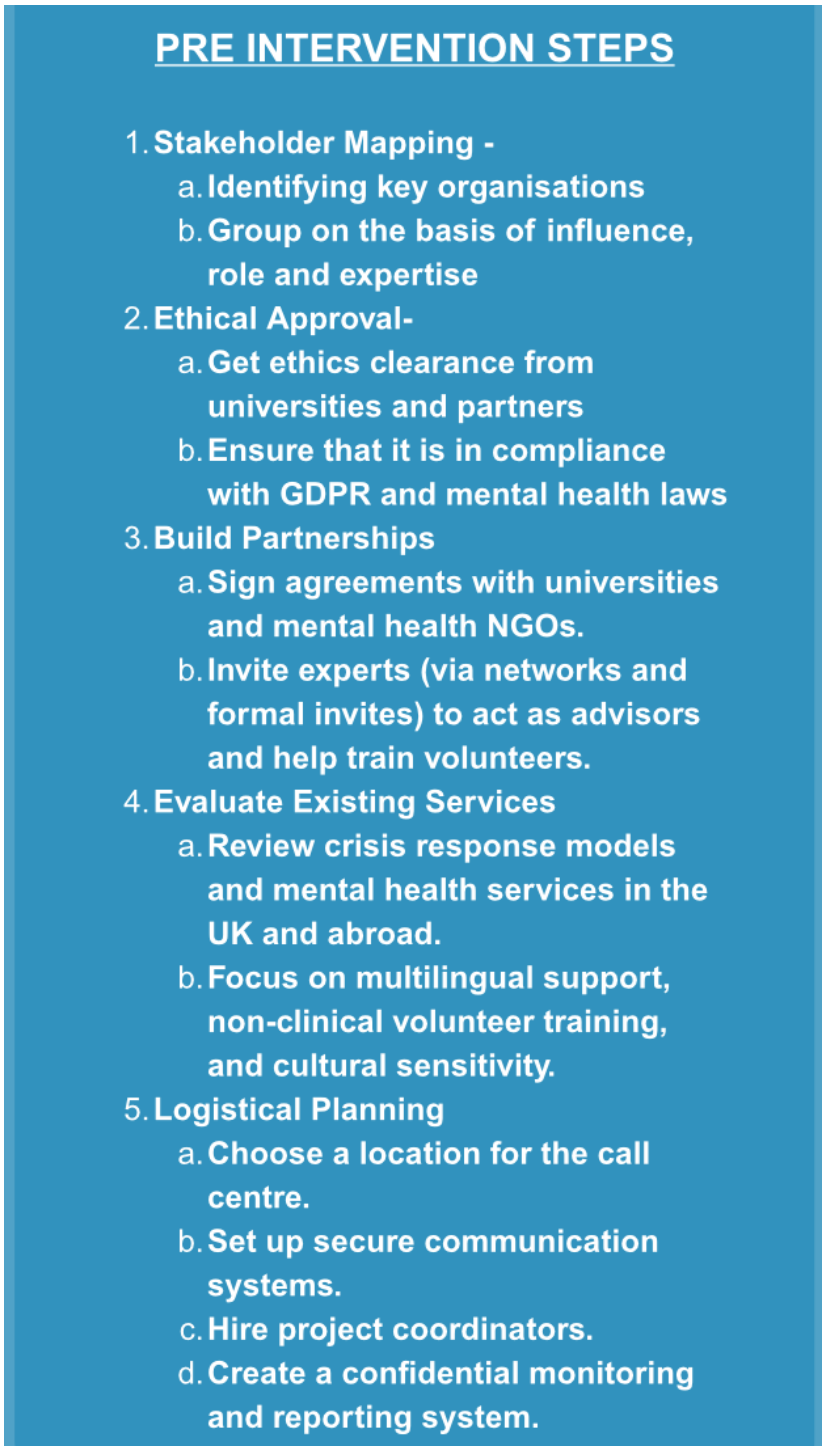


Figure 3. Steps involved in the pre-intervention phase

The planning and mapping sub-phase focuses on developing cooperative collaborations, creating operational and ethical principles, and comprehending the systemic environment of immigrant student mental health support in the UK. The following elements are essential:

- Identification and Mapping of Stakeholders- Finding key players in the academic and mental health service sectors and analysing them. These are National and local Counselling and wellness services at universities and hotlines (such as Shout and Samaritans), student-led organizations, particularly those that consist of international students, organizations that advocate for migrants and refugees, public health organizations, university departments, and international groups that focus and specialize in trauma, migration or transcultural psychology. The stakeholders will be grouped according to the contribution to the project, level of influence, and level of knowledge.

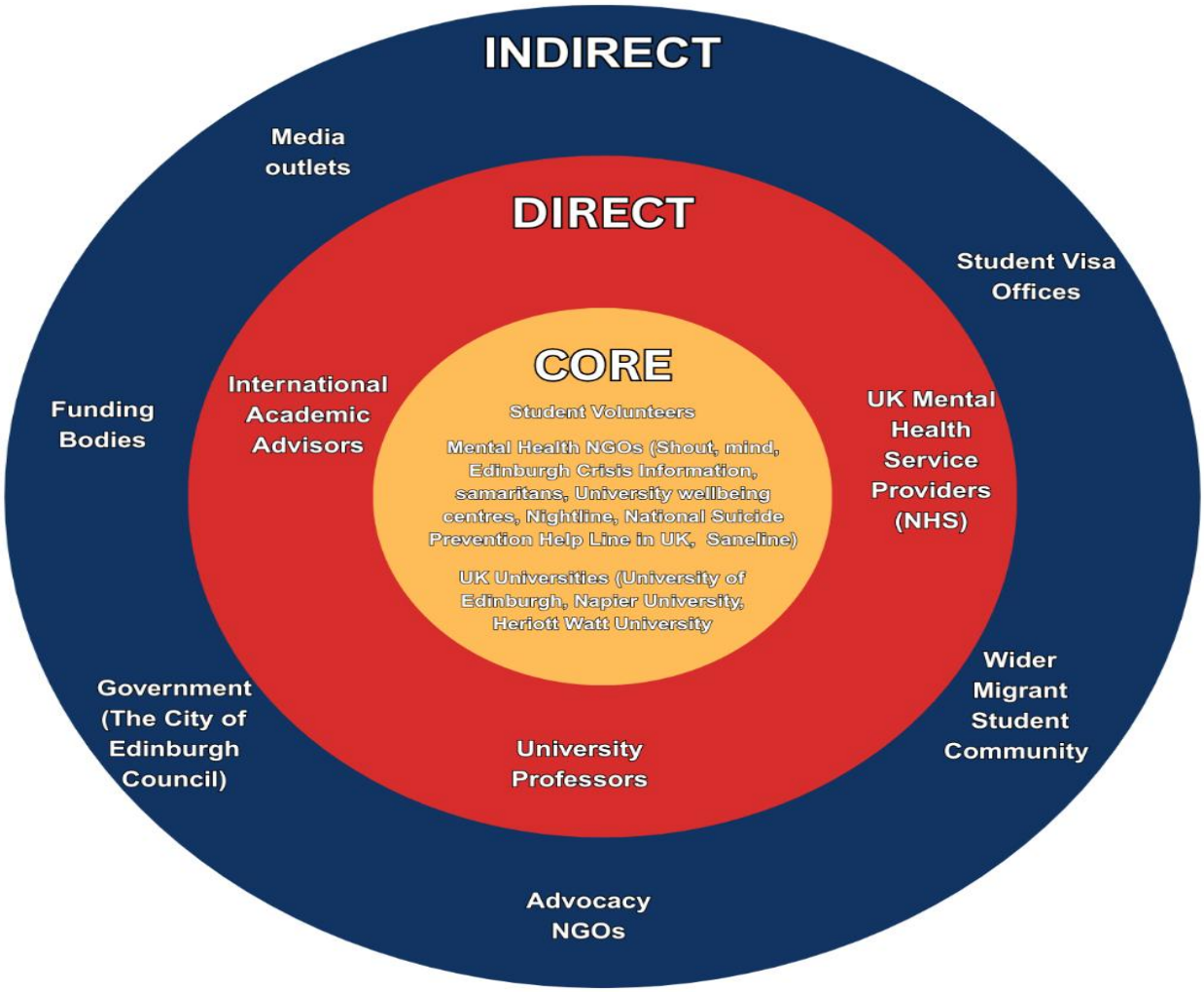


Figure 4. Visual representation of stakeholder mapping

- Ethical Clearance- This phase involves getting ethical approval from the university review boards and/or institutional partners due to the sensitive nature of the intervention, especially when it comes to working with traumatized or distressed students. This would involve data protection policies, safeguarding procedures, guidelines for volunteers, and informed consent protocols that follow GDPR and mental health laws. We will also carry out a risk assessment in

addition to university-specific ethics approvals to find potential risks to the volunteers, especially psychological overload, cultural misunderstandings, or violation of confidentiality.

- Formalization of Collaborations- Formal Memorandums of Understanding (MOUs) will be signed with important partners, such as academic departments at the UK universities (University of Edinburgh, Heriot Watt University and Napier University), mental health NGOs (Shout,Mind, Edinburgh Crisis information, Night line, National Suicide, Saneline) and service providers, internation al academic advisors to foster shared accountability and institutional support. We will approach the international experts through formal invitations. We will also reach out to university professors and experts through our university networks and recommendations from partners. Our main goal is to invite them into an advisory role and work together to create a culturally informed guideline. They will also assist in training and recruiting student volunteers more effectively.
- Methodical Evaluation- We will analyse crisis response plans and migrant-specific mental health services. This would include reviewing
    - Helpline services for multilingual populations
    - Training protocols for non-clinical volunteers
    - Transcultural psychology frameworks
    - Ethical crisis response that involves students and youth

  We will also compile procedures that are followed by the current mental health support lines in the UK and compare them with models of other international helplines that have effectively dealt with linguistic or cultural diversity

- Other logistical preparation- to guarantee a seamless pilot phase, it is crucial to establish logistical groundwork. This includes:
    - setting a location for the call handling centre (ideally near or within our partner universities)
    - setting up a secure phone call system and/or digital platform to facilitate the calls and record the basic data
    - recruiting project coordinators responsible for volunteer management, scheduling and troubleshooting
    - creating a monitoring and reporting framework that protects confidentiality

Phase 2

The second phase of the pre-intervention phase addresses the co-development of culturally grounded, ethically sound, and practically implementable protocols for the helpline. This is led by representatives from multiple academic disciples and cultural backgrounds.

- International Academic Consultation - we start a consultation process with academic representatives from each of the main migrant student sending regions in recognition of the variety of the immigrant student community in the UK (Higher Education Statistics Agency (HESA), 2025). These are
    - South Asia (Bangladesh, Pakistan and India)
    - East Asia (China and Malaysia)
    - Sub-Saharan Africa (Ghana and Nigeria)
    - Latin America (Colombia and Brazil)
    - North Africa and the Middle East

Each representative would offer insights into linguistic considerations, local perceptions of trauma and mental health, and cultural communication patterns. The content of the follow-up processes, crisis script language, and volunteer training design are all influenced by this input. The project follows transcultural psychology which highlights the significance of examining mental health symptoms and manifestations via a cultural lens, providing insight into the endeavour. One major worry is that culturally particular manifestations of pain may be misinterpreted by western frameworks. This can be prevented by making a hotline to provide non-diagnostic, non-clinical, and empathic support, directing callers to the right resources when needed.

- Volunteer Guidelines - volunteers will not be required to diagnose or offer therapeutic services. Rather they will be trained to:
    - Recognize crisis or severe distress symptoms
    - Respond in a soothing culturally aware manner
    - Keep a record of basic (non-identifying) data and provide links to community and university resources.
    - To gauge wellbeing, conduct two planned follow-ups check-ins.

We will back up the model by conducting volunteer peer support sessions with written manuals that are adapted to various linguistic and cultural situations.

Participatory Tool Design

We are working with partners throughout the world to create tools like the "Tree of problems" concept that may be used in crisis response situations. This technique, which doesn't require extensive psychological training, graphically depicts the social, cultural, and emotional

elements causing a caller's suffering. It can help volunteers prioritise support responses and identify referral needs.

Lastly, a Theory of Change framework serves as the foundation of the project. It details how inputs (such as trained volunteers and stakeholder partnerships) are anticipated to result in outputs (such as convenient helpline support), outcomes (such as a rise in help-seeking behaviour), and impact (such as better mental health outcomes among immigrant students).

II. Recruitment

We will recruit volunteers to support our project. The recruitment process for this project focuses on engaging university students who are passionate about mental health, multilingual, and culturally aware. We will reach out to our partner institute professors and encourage them to invite members within their networks to join the team. The eligibility criteria will be:

- *Language Proficiency:* Volunteers with multilingual capabilities, particularly those fluent in languages relevant to the student demographic (e.g., Southeast Asian, East Asian, Latin American, etc), will be preferred.
- *Academic Background:* Volunteers should be students studying mental health, psychology, counselling, or social work.
- *Skills:* Strong communication, empathy, and active listening skills are essential for this role.
- *Personal Experience:* Preference will be given to volunteers who have lived experiences of migration or are familiar with the challenges faced by international students.
- *Commitment:* Volunteers must be able to commit to at least 10-12 hours per week for six months.

- *Safeguarding Check*: All volunteers will undergo a background check (e.g., DBS check) to ensure the safety and security of the helpline users.

The application process will involve submitting an online form followed by an interview to assess cultural awareness, communication abilities, and motivation.

III. Training

Volunteer Training Program

Once selected, volunteers will receive comprehensive training, which includes Mental Health First Aid and cultural sensitivity training. This will ensure they are equipped to offer initial support to students in distress while respecting the diverse cultural backgrounds of international students. The training will also involve role-playing scenarios to prepare volunteers for real-life situations. Volunteers will learn crisis intervention techniques, de-escalation strategies, and when to refer cases to professionals. All training will be conducted by experts from the partner organization.

Mental Health First Aid training provides individuals with the necessary skills to support those experiencing worsening mental health challenges (Kitchener and Jorm, 2002). Unlike traditional first aid, it does not focus on diagnosing or treating mental health or substance use disorders (Kitchener, Jorm, and Kelly, 2025). Instead, it teaches how to provide immediate support until professional help is available, or the crisis is resolved.

For language support, volunteers with multilingual capabilities will be trained in providing language assistance, including the use of basic phrases to support students in distress.

Support & Supervision

- *Ongoing Mentorship:* Volunteers will be paired with a supervisor (e.g., NHS doctor or professional) to ensure they have the necessary tools and support to handle sensitive situations effectively and are emotionally supported in their role.
- *Supervision & Feedback:* Monthly group supervision meetings will be held, where volunteers can discuss their challenges, share experiences, and receive feedback from peers and professionals.
- *Refresher Training:* Volunteers will attend periodic refresher courses on mental health first aid, cultural sensitivity, and trauma-informed practices to ensure ongoing learning.

In addition, A WhatsApp group will facilitate continuous interaction and serve as a platform for sharing resources and information among volunteers, ensuring they stay connected and well-supported throughout the project.

IV. Socialisation and Sensitisation of the Initiative

As was mentioned in the methodology, one of the main foundations of the current proposal is established in partnership and generating community awareness. This means that even when the main goal of socialization is to increase the reach of the project and get more users involved to spread the impact, it also targets addressing structural problems in the public sector. Even culturally sensitive approaches still face a challenge in approaching realities. Hence, the socialization and sensitization part will be done in 2 areas:

Table 1. Areas of socialisation and sensitisation

Area	Description
Users´ community awareness	Workshops and events with partner wellbeing or crisis centres target not only recruiting volunteers for the initiative, but also spreading the use of the service, benefits, and possibilities for the population. Would work with the academic schedules of the Universities as their data would show peak times for distressful events for students, but also it will be available at least once a month to position the project. As stigma is one of the main challenges to overcome in generating accessibility, the event will be deeply rooted in participatory strategies to engage with pathways to approach the problem.
Public Health and institutional engagement	As it is intended to learn the knowledge and experiences that the services have to understand and approach the realities, the proposal aims to engage in sharing good practices within the system to establish a reference for more accurate cultural awareness approaches to the immigrant population. Even though the population is students, the approach would be flexible to adaptations for a bigger impact, according to the engagement of the different institutional actors.

V. Impact Study

To sustain a reflexive path that not only measures effectiveness and accessibility of the service but also ensures accountability, cultural integrity, and iterative learning, a process of monitoring will be established. For that, the impact of the intervention will be assessed through continuous feedback rooted in participatory evaluation with the different stakeholders and actors involved. For that, some of the key objectives identified are related to evaluating whether the helpline improves access to immediate emotional support for student migrants in Edinburgh in a culturally and linguistically inclusive way.

To achieve this monitoring process, mixed methods will be used, balancing structured indicators with qualitative tools that allow for narrative, emotional, and contextual depth. For example, some

components are deployed in the Box x. However, as this is a reflexive process, the monitoring tools and indicators might change.

Table 2. Tools for monitoring and impact study

Quantitative Components	Qualitative and Participatory Tools
Brief pre/post user surveys: To identify perceived distress, cultural comfort, and likelihood to access services again.	Storytelling: Done through anonymous interviews with volunteers and users to reflect on their experience with the helpline. Participants may choose oral, written, or creative formats (drawing, audio, etc.).
Trends and tracking data: To identify the patterns of use in the service as the number and timing of calls, user demographics (anonymous), language used, topics presented, and referral rates.	
Volunteer baseline and follow-up surveys: To assess perceived preparedness, confidence in handling crises, emotional burden, and other emerging challenges or resources needed to provide the service.	Feedback workshops and/or meetings: As it is intended to have a local base approach, all the results in the monitoring will be shared with the international experts of each region to ensure accuracy in interpreting the information collectively and to validate conclusions.

It is important to mention that during the partnership with key allies and wellbeing institutions located in the city, a baseline will be estimated in order to contrast the implications and impact of the

approach. Moreover, in the broader proposal, the tools to conceptualize the actions and KPI´s will be further developed through the Theory of Change model, and Logic frameworks to detail each strategy to follow and resources. The pilot's impact study is not only a means of validation but an act of advocacy, bringing forward the voices of the users, volunteers, and stakeholders to inform institutional practices and redefine what culturally responsive crisis support looks like within UK higher education systems.

VI. Accountability

We will adhere to the accountability framework by Candler and Dumont (2010) that aims to inform and give account of inputs including financial resources, volunteer resources, and reputational capital and outputs like good and services, social capital and policy impact, as well as procural elements like law, formal mission, ethics, and legitimacy to the stakeholders (i.e., members, service seekers, funder, government, general public, media, staff, volunteers and collaborators).

VII. Advocacy Campaign

Objective

The advocacy campaign aims to highlight the mental health challenges faced by international students, particularly focusing on issues of cultural and language barriers. It seeks to build support for a helpline that provides culturally and linguistically sensitive assistance, while also engaging stakeholders to ensure the initiative's long-term viability.

Target Audience

- Government and Policymakers: Advocate for the inclusion of culturally sensitive mental health services and language support in university frameworks, alongside securing funding for the helpline.

- University Administration: Ensure institutional banking and financial resources for the helpline's implementation and sustainability.
- International Students: Raise awareness regarding available mental health resources tailored to their unique needs.
- Mental Health Professionals and Volunteers: Focus on collaboration with NHS mental health professionals to serve as mentors, ensuring volunteers are equipped with the essential skills and training to offer effective support.

Key Strategies

1. Community Engagement
    - Host informational workshops and webinars targeted at international students, explaining the mental health challenges they face and introducing the helpline. Work closely with international student groups and associations to spread the word about the initiative.
    - Peer mentorship programs: Enlist students from diverse cultural backgrounds to serve as ambassadors for the helpline, promoting mental health awareness and encouraging peers to seek help when needed.
2. Media and Social Media Campaign
    - Utilize social media platforms to raise awareness, including posting testimonials, success stories, and information about mental health challenges faced by international students.
    - Collaborate with university media to feature articles and interviews with mental health professionals, international students, and advocates.
3. Policy Advocacy

- Advocate for policy change within universities to integrate culturally sensitive mental health services. Engage university leaders in discussions on the importance of culturally competent care for international students.
- Work with government bodies to create frameworks that support the mental health needs of international students, including funding for helplines and awareness campaigns.

4. Collaborations and Partnerships
    - Form strategic partnerships with mental health organizations, educational institutions, and NGOs to build a network of support for international students.
    - Work with community organizations that serve immigrant populations to ensure the helpline reaches as many international students as possible, particularly those from underserved communities.

VIII. Campaign Phases

Phase 1 – Awareness and Outreach*:*

- Initial focus on raising awareness of the mental health challenges international students face.
- Launch informational sessions and social media campaigns.
- Begin recruitment for volunteers and mental health professionals.

Phase 2 – Training and Program Implementation*:*

- Provide mental health first aid training and cultural sensitivity training for volunteers and staff.
- Officially launch the helpline, ensuring that international students have access to support through phone or digital channels.

***Phase 3 – Monitoring and Advocacy**:*

- Monitor the effectiveness of the helpline and gather feedback from international students.
- Continue to advocate for the integration of culturally competent mental health services in university systems and influence policy changes at the university and governmental levels.

IX. Scaling

Once our helpline services have achieved success and made good progress at the City of Edinburgh with our service model, we shall identify and aim to expand the services to other university-dense cities in Scotland and eventually towards other university-dense cities in the UK. This process will also include establishing ties and collaborating with respective local governments and helpline organisations. The evaluation of this service model will be consistently done while scaling up, including improving it with user feedback.

We hope that as our model grows and the number of volunteers increases, eventually increasing our network and reach, our services will diversify even further, catering to the needs of more people.

While scaling up, we shall also host stakeholder and funder events to show them the impact of our work. This will help us solidify our reach and uphold goodwill while we scale up.

X. Evaluation

Evaluation is an imperative part of informing the model of services and scaling up to understand its efficacy. For the process of evaluation, several data-driven key performance indicators (KPIs) shall be monitored, keeping in mind the goals, outcomes, and outputs as listed below:

Goal - to increase the efficiency of crisis helplines through the inclusion of cultural and language diversity.

Outcome - the callers receive trauma crisis help through a cultural and language lens.

Output - Callers are de-escalated from crises, feel heard and understood, and are effectively connected to long-term resources or solutions.

KPIs

- Response Time: Average time taken to respond to a crisis call.
- Resolution Rate: Percentage of calls that end with a satisfactory resolution or referral.
- Language Coverage: Number of languages available and used in service provision.
- Volunteer Engagement: Retention, training completion, and language proficiency of volunteers.
- User Satisfaction: Ratings and feedback collected post-interaction.

Impact analysis - We will conduct periodic impact assessments using mixed-methods research through surveys and case studies.

Sustainability - this ensures that the service model can function long-term with stable funding, volunteer engagement, and stakeholder support. This step shall include assessing optional costs, funding streams, volunteer turnout, and demand over time.

Relevance - To ensure services remain aligned with the evolving needs of the international student population and other vulnerable groups, we will conduct periodic needs assessments and stakeholder consultations.

Effectiveness - To evaluate how well the helpline achieves its intended outcomes, we shall track outcomes such as caller relief, follow-up compliance, and reduction in repeat crisis calls.

Efficiency - To ensure optimal use of resources to deliver timely and high-quality support, we will conduct a cost-benefit analysis, volunteer-hours vs. outreach served, and technological performance monitoring.

We will establish a quarterly review system, where findings from evaluations are shared internally and with stakeholders. These annual impact reports shall be shared with stakeholders to maintain transparency.

Conclusion

This project aims to create a culturally aware, morally sound mental health crisis hotline specifically for overseas students who study in the UK. Through a two-phase pre-intervention process, it lays the foundation by securing ethical approval, developing culturally informed volunteer training, while simultaneously building a strong partnership with universities, mental health providers, and migrant organisations. More than offering translated support, the helpline allows for a conversation that feels safer and more respectful, and personal.

Alongside the service itself, an advocacy campaign will involve stakeholders, increase awareness, and push for policy reforms that embed culturally competent mental health support into the university systems. The project pushes for long-term systemic change, a staged rollout that includes outreach, training, implementation, and monitoring, and guarantees immediate support. The program commits to engaging stakeholders, using resources with responsibility, and being transparent using Candler and Dumont's accountability framework. As the project expands beyond the city of Edinburgh into other university cities across the UK, the model will adjust according to local contexts while staying true to its goal. This will ensure that students feel seen and supported no matter what their background. The hotline will continuously improve and will be fuelled by a review that integrates both quantitative and qualitative data, guaranteeing that the service is effective. Frequent evaluations will encourage cooperation and openness among volunteers.

At its core, this hotline addresses gaps in mental health support for international students. It partners up with universities and migrant organizations. By sharing lessons learned and lived experiences, the project encourages more inclusive and culturally sensitive mental health care throughout UK universities by elevating the voices of users and volunteers and disseminating insights widely. Many students struggle in silence. Our goal is to change that.

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