Barriers and Opportunities: Improving access to mental health support for refugees and people seeking asylum

VCSE health & wellbeing alliance

British Red Cross

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VCSE Health and Wellbeing Alliance

This research has been conducted through the Voluntary Community and Social Enterprise (VCSE) Health and Wellbeing Alliance (HW Alliance). The HW Alliance is a partnership between voluntary sector representatives and the health and care system. Its purpose is to:

- Provide a coordinated route for health and care organisations to reach a wide range of VCSE organisations.
- Support collaboration between VCSE organisations and provide a collective voice for issues related to VCSE partnerships in health and care.
- Enable health and care organisations and VCSE organisations to jointly improve ways of delivering services which are accessible to everyone. Making it easier for all communities to access services will reduce health inequalities.
- Ensure health and care decision-makers hear the views of communities which experience the greatest health inequalities.
- Bring the expertise of the VCSE sector and communities they work with into national policymaking.

Contents

Executive Summary

This research seeks to explore the barriers faced by adult refugees and people seeking asylum when trying to access support for their mental health. By working closely with 16 individuals with lived experience of seeking asylum in England (VOICES Ambassadors), the research draws on some of the benefits of co-production. Ambassadors were involved at the design, analysis, and solution-development stages of the project – helping to shape the research in accordance with themes that they stressed as most important. The fieldwork consisted of two focus groups with 16 professionals working within organisations such as the NHS and charities such as Solace, Doctors of the World and the British Red Cross who provide mental health services and/or related support to refugees and people seeking asylum. This includes specialist refugee trauma services within the NHS, the support provided through accommodation providers, and support provided through the Home Office.

Identifying themes

Ambassadors agreed that mental health exists on a spectrum, is not static and can change over time. A distinction was made between 'less severe mental ill-health' (which could include anxiety or sustained low mood) and 'severe mental ill-health' (which could include very severe periods of depression, psychotic episodes, or suicidal ideation).

Ambassadors identified numerous access barriers which they wanted the research to explore. These were categorised into themes reflecting an individual's journey through the process of accessing support for mental health. In addition to exploring access barriers, Ambassadors felt it was important for the research to explore potential contributing factors to mental ill-health for refugees and people seeking asylum. The five themes were:

- potential contributing factors to mental ill-health
- awareness of services and support available
- accessing support, including referrals and appointments
- quality and delivery of care
- capacity to feedback and complain.

Focus group findings

Taking the themes and topics identified by the Ambassadors as a starting point for discussion, focus group participants identified several additional barriers to accessing mental health support and factors which can contribute to poor mental health for refugees and people seeking asylum. These were:

Social isolation and the asylum application process

Ambassadors raised that some of the less-severe mental health problems experienced by refugees and people seeking asylum were preventable, often caused or exacerbated by the process of applying for asylum in the UK. The focus group participants strongly agreed with this and suggested that by addressing these contributing factors, some of the mental health problems that refugees and people seeking asylum experience could be alleviated.

Lack of awareness of available mental health support

Participants acknowledged that the wide range of different services and roles within the mental health support system can be bewildering. This can make it hard for refugees and people seeking asylum, as well as those supporting them, to know what form of support is appropriate, or available to them.

The stigma around mental ill-health

Participants perceived stigma around mental ill-health to be a barrier preventing some refugees and people seeking asylum from accessing mental health support. Some focus group participants suggested that the stigmatisation of mental ill-health contributes to a reluctance among some in this group to accept clinical mental health treatment (as opposed to non-clinical treatments such as exercise groups).

Digital exclusion and financial hardship

Participants agreed that accessing appointments, either face-to-face or remotely, was often problematic for people seeking asylum and refugees due to the cost of public transport and problems with accessing online appointments.

Language barriers and problems with interpretation services

Focus group participants agreed that for refugees and people seeking asylum who do not have a confident command of English, problems with the quality and availability of interpreters can impact their ability to access timely and effective mental health support.

Lack of trauma-informed working

Participants highlighted the absence of a trauma-informed approach[1] among many healthcare professionals working with refugees and people seeking asylum. It was felt that a lack of trauma-informed working could unintentionally result in distressing situations.

Poor communication between services

Participants reported a lack of coordination between agencies working with refugees and people seeking asylum, which could lead to disrupted treatment. Often, fears associated with the possibility of breaching confidentiality meant that they felt unable to pass on information.

Dispersal, continuity of care and information sharing

Several participants spoke about how people seeking asylum often struggle to access suitable support for their mental health in their new location after being dispersed to another part of the country and highlighted how this can cause disruptions to treatment.

Lack of feedback mechanisms

Participants felt it was important for refugees and people seeking asylum to have the opportunity to feedback on their experiences of the healthcare system in a meaningful way, to ensure any challenges in accessing support were identified and addressed.

Opportunities for improvement

Ambassadors made several suggestions for addressing the problems raised throughout the research. The opportunities they identified apply not only to healthcare services but also to the asylum system and other public services systems. Their suggestions were:

- ensure a person-centred, trauma-informed approach
- improve communication with refugees and people seeking asylum
- improve communication between services
- provide access to peer support
- improve continuity of care
- ensure effective feedback mechanisms.

[1] The Social Research Association defines trauma-informed practices as “that which recognise that individual's responses are a way of adapting and coping with symptoms of trauma”. It requires understanding of the effects of trauma and recognising triggers and trauma responses, to reduce the risk of re-traumatisation and ensure participant wellbeing

1. Background

1.1. Access to healthcare

Access to free healthcare in the UK can be restricted based on a person's immigration status. Primary healthcare – including GP and nurse consultations – is free of charge to all, irrespective of immigration status. Anyone can register with a GP surgery and should not need proof of address, identity documents or an NHS number to do so. Testing, treatment and care for some conditions is also exempt from charging. This includes some communicable diseases, such as Covid-19, and services for treating physical or mental conditions caused by torture, female genital mutilation, domestic violence and sexual violence.[2]

While people with insecure immigration status can be charged for secondary healthcare, people seeking asylum and people who have been granted refugee status are entitled to access free healthcare in England[3], including secondary care services.[4] However, a review by the Equality and Human Rights Commission and Doctors of the World into access to healthcare for both people seeking and refused asylum[5], evidenced that these groups are often put off accessing healthcare because of concerns about healthcare charging and worries that medical information could be used for immigration enforcement. The review highlighted that the complex changes to healthcare entitlements in the Immigration Act 2014 and NHS charging regulations introduced in 2015 and 2018 have resulted in 'confusion and inconsistency' about who has to pay for care among both healthcare staff and patients. This has resulted in healthcare sometimes being wrongly withheld or refused[6] and concerns that accessing healthcare will affect a person's asylum application.

Alongside the impact of charging for healthcare and data-sharing for immigration enforcement purposes, evidence suggests that people seeking asylum and refugees can struggle to access healthcare for a range of reasons, including language barriers, lack of information and understanding about healthcare processes, and administrative and legal barriers.[7]

Doctors of the World identified language as the third most prevalent barrier for migrant patients in accessing healthcare, alongside administrative and legal barriers and lack of knowledge or understanding about the healthcare system.[8] Problems communicating can make it harder for people seeking asylum and refugees to understand and access healthcare services. Additionally, the report found that language barriers may also make it more difficult to achieve a diagnosis and increase the likelihood of misdiagnosis.

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[2] GOV.UK (2021) *NHS Entitlements: Migrant Health Guide*, accessed 6 April 2022, gov.uk/guidance/nhs-entitlements-migrant-health-guide.

[3] Entitlements are different in England, Scotland, Wales and Northern Ireland. This research focuses on England.

[4] GOV.UK (2021) *NHS Entitlements: Migrant Health Guide*, accessed 6 April 2022, gov.uk/guidance/nhs-entitlements-migrant-health-guide.

[5] Equality and Human Rights Commission (2018) *Access to Healthcare for People Refused and Seeking Asylum in Great Britain: a review of evidence,* equalityhumanrights.com/sites/default/files/research-report-121-people-seeking-asylum-access-to-healthcare-evidence-review.pdf.

[6] Women's Health & Equality Consortium, Maternity Action (2017) *The Impact on health inequalities of charging migrant women for NHS maternity care: a scoping study, https://www.maternityaction.org.uk/wp-content/uploads/ChargingReportMarch2017FINALcompressed.pdf*

[7] Doctors of the World UK (2015) Access to Healthcare in the UK, doctorsoftheworld.org.uk/wp-content/uploads/import-from-old-site/files/DOTW_Access_to_healthcare_final.pdf, 3.

[8] Ibid.

Asylum support, including accommodation, is closely connected to people's health and access to healthcare.[9] People seeking asylum are not allowed to work or access public funds. If facing destitution, they can apply for housing and financial support from the Home Office while they await the outcome of their claim or appeal. Accommodation is provided on a no-choice basis, and people are 'dispersed' to different locations around the UK.[10] At the time of writing, people receiving cash support are provided with £40.85 per week. Much asylum support accommodation is located on the outskirts of cities and towns which can make it unaffordable to travel to medical appointments.[11] In addition to the cost of travelling, many people seeking asylum are unable to purchase phones and credit for calls and internet data[12], which made the increased use of telemedicine during the Covid-19 pandemic difficult for many.

The 28-day 'move on' period means that these problems do not end with a positive decision on an asylum application. Once refugee status has been granted, new refugees have 28 days to make all the necessary arrangements to move on before any asylum support they have been receiving, including payments and accommodation, comes to an end. This usually includes opening a bank account, finding a job and/or applying for mainstream benefits (and receiving the first wages or benefit payment), and finding and moving into new accommodation.[13] Research carried out by the British Red Cross found that the move-on period can expose new refugees to an unacceptably high risk of extreme poverty and negatively impacts mental health and the risk of suicide.[14]

1.2. Experiences of mental ill-health and mental health support

People seeking asylum and refugees are more likely to experience mental ill-health, including higher rates of depression and Post-Traumatic Stress Disorder than the wider UK population.[15] Research has found that increased vulnerability to mental ill-health is connected both to people's experiences before seeking asylum, such as trauma connected to experiences of war and violence, and experiences after seeking asylum such as separation from family, and poor housing and support.[16]

The mental health charity Mind found that the principal causes of mental ill-health among the refugees they supported included: the process of waiting for an outcome on an asylum application; isolation and dislocation; relationship with home; destitution; family relationships, and perceptions of mental health in refugee communities.[17] Similarly, recent research by the

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[9] British Red Cross (2021) *Far from a home: why asylum accommodation needs reform,* redcross.org.uk/-/media/documents/about-us/what-we-do/far-from-a-home.pdf

[10] Ben Politowski and Terry McGuinness, "Policy on the Dispersal of People seeking asylum," House of Commons Library, January 6, 2022, .

[11] Refugee Council (2021) *A note on barriers experienced by refugees and people seeking asyum when accessing health services,* media.refugeecouncil.org.uk/wp-content/uploads/2021/10/29174557/A-note-on-barriers-experienced-by-refugees-and-people-seeking-asylum-when-accessing-health-services_March_2021.pdf

[12] Ibid.

[13] British Red Cross (2018) *Still an ordeal: The move-on period for new refugees*, *https://www.redcross.org.uk/-/media/documents/about-us/research-publications/refugee-support/still-an-ordeal-move-on-period-report.pdf*

[14] British Red Cross (2020) *The costs of destitution: a cost-benefit analysis of extending the move-on period for new refugees*, https://www.redcross.org.uk/-/media/documents/about-us/research-publications/refugee-support/the-costs-of-destitution.pdf

[15] Mental Health Foundation (2016), Mental Health Statistics: Refugees and Asylum Seekers, mentalhealth.org.uk/statistics/ mental-health-statistics-refugees-and-asylum-seekers

[16] Porter and Haslam (2005), Pre-displacement and post-displacement factors associated with mental health of refugees and internally displaced persons: A meta-analysis. JAMA, 294, 602–612 jamanetwork.com/journals/jama/articleabstract/20133

[17] Mind (2009) *Improving mental health support for refugee communities – an advocacy approach,* https://www.mind.org.uk/media-a/4396/refugee_report_1.pdf

British Red Cross found that poor housing and support provided to people seeking asylum has a serious impact on their mental health[18], as can separation from family[19] and risk of destitution.[20]

Dispersal occurs when the Home Office moves destitute asylum seekers to specified local authorities across the UK.[21] This can present additional challenges to people seeking asylum accessing mental health care.[22] The 'Healthcare Needs and Dispersal Policy' published by UK Visas and Immigration provides guidance to Home Office staff on accommodation provisions for people seeking asylum who have healthcare needs. It sets out considerations to prevent the dispersal process from adversely affecting people receiving treatment and care for their mental health.[23] There is limited information available about how this policy is implemented in practice. From an NHS Talking Therapies (Improving Access to Psychological Therapies (IAPT) programme perspective, however, there is clear guidance that dispersal should not impact access to talking therapy services and treatment should continue regardless of the location of their GP.

However, a recent scoping review of policies, barriers and enablers to accessing mental healthcare for people seeking asylum and refugees in the UK[24] noted that many other mental health policies and plans generally lack explicit guidance on refugees and people seeking asylum.[25] In England, despite commitments to address health inequalities, various policies and initiatives including the NHS Long Term Plan[26]; the NHS Mental Health Implementation Plan 2019/20 – 2023/24[27]; the 2011 government strategy 'No Health Without Mental Health: A cross-government mental health outcomes strategy for people of all ages'[28], and the revision of the Mental Health Act 1983 in 2017[29], do not highlight refugees and people seeking asylum, or any other migrant groups.[30]

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[18] British Red Cross (2021) *Far from a home: why asylum accommodation needs reform,* redcross.org.uk/-/media/documents/about-us/what-we-do/far-from-a-home.pdf

[19] British Red Cross (2022) *Together at last: Supporting refugee families who reunite in the UK, redcross.org.uk/-/media/documents/about-us/together-at-last---supporting-refugee-families-who-reunite-in-the-uk.pdf*

[20] British Red Cross (2021) How will we survive? Steps to preventing destitution in the asylum system, redcross.org.uk/-/media/documents/about-us/how-will-we-survive-preventing-destitution-in-the-asylum-system.pdf

[21] Migration Scotland (2019), *Asylum Dispersal, migrationscotland.org.uk/our-priorities/current-work/asylum-dispersal*

[22] Equality and Human Rights Commission (2018) The lived experiences of access to healthcare for people seeking and refused asylum, equalityhumanrights.com/sites/default/files/research-report-122-people-seeking-asylum-access-to-healthcare-lived-experiences.pdf

[23] UK Visas and Immigration, "Healthcare Needs and Pregnancy Dispersal Policy - Gov.uk", January 28, 2016, assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/496911/new_Healthcare_Needs_and_Pregnancy_Dispersal_Policy_EXTERNAL_v3_0.pdf

[24] Pollard, T. and Howard, N, (2021) *Mental healthcare for asylum-seekers and refugees residing in the United Kingdom: a scoping review of policies, barriers and enablers*, International Journal of Mental Health Systems, vol. 15, issue 60, p.1, doi.org/10.1186/s13033-021-00473-z.

[25] Ibid.

[26] NHS England and NHS Improvement (2019*) The NHS Long Term Plan,* longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

[27] NHS England and NHS Improvement (2020) *NHS Mental Health Implementation Plan 2019/20 – 2023/23*, longtermplan.nhs.uk/wp-content/uploads/2019/07/nhs-mental-health-implementation-plan-2019-20-2023-24.pdf

[28] HM Government (2011) *No health without mental health: Delivering better mental health outcomes for people of all ages,* assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/215811/dh_124057.pdf

[29] Parliament. House of Commons (2022). *Mental health policy in England*, 30 March 2022 CBP07547 commonslibrary.parliament.uk/research-briefings/cbp-7547/.

In recognition of the social determinants of health, the impact of Covid-19 and the need for a consistent approach to reducing mental health inequalities, NHS England launched the Advancing Mental Health Equalities Strategy in October 2020.[31] The Strategy outlines the short and longer-term actions NHS England is taking to reduce inequalities in access, experience, and outcomes within mental health services including a commitment to developing the Patient and Carer Race Equality Framework (PCREF) for ethnic minority communities. There is recognition that the experiences of refugees and those seeking asylum are also unique, so a core part of the PCREF will seek to imbed intersectional approaches to care.

Furthermore, the NHS Talking Therapies (IAPT) programme, which has been operating since 2008, has provided some guidance on refugees and asylum seekers in the context of improving access, experiences and outcomes for this group in talking therapy services. The IAPT Manual[32], written for commissioners, managers and clinicians, highlights people seeking asylum and refugees as under-represented groups in IAPT services and notes that additional consideration should be given to the potential for the complex nature of presentation. The IAPT Black Asian Minority Ethnic Positive Practice Guide in particular provides practical guidance on service-level changes to increase representation from this group as well as ways to adapt therapy to support better outcomes.[33]

Beyond IAPT, the Office for Health Improvement and Disparities has published advice and guidance on the health needs of migrant patients for healthcare practitioners which highlights the effects of stress and post-traumatic stress disorder on people who have been forcibly displaced, and signposts to VCSE providers of mental health support.[34] Additionally, Mind, Pathway, and NHS England have published guidance to support the commissioning of mental health services for vulnerable adult migrants.[35]

This co-produced research aims to contribute to the existing literature by exploring refugees and people seeking asylum's access to, and experience of, mental healthcare in England.

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[31] NHS England and NHS Improvement (2020) *Advancing mental health equalities strategy*, https://www.england.nhs.uk/publication/advancing-mental-health-equalities-strategy/.

[32] [32] The National Collaborating Centre for Mental Health (2021), *The Improving Access to Psychological Therapies Manual,* https://www.england.nhs.uk/wp-content/uploads/2018/06/the-iapt-manual-v5.pdf, pp. 58 and 109

[33] British Association for Behavioural and Cognitive Psychotherapy, Improving Access to Psychological Therapies (IAPT) *Black, Asian and Minority Ethnic Service User Positive Practice Guide, https://babcp.com/Portals/0/Files/About/BAME/IAPT-BAME-PPG-2019.pdf?ver=2020-06-16-004459-320*

[34] Office for Health Improvements and Disparities (2021) *Mental health: migrant health guide*, https://www.gov.uk/guidance/mental-health-migrant-health-guide

[35] Yohannes Fassil, Angela Burnett (2015) *Commissioning Mental Health Services for Vulnerable Adult Migrants: Guidance for commissioners* https://www.mind.org.uk/media-a/4398/vulnerable-migrants_2015_mindweb.pdf

2. Aims and methodology

This is an exploratory piece of research that aims to investigate some of the barriers faced by refugees and people seeking asylum when trying to access support for their mental health. The research also seeks to explore potential areas for improvement – in addressing some of the problems raised throughout the research. The research adopted a co-production approach by collaborating with people with lived experience of the asylum system to develop the research questions for the focus groups, analyse the findings and produce suggestions for improvement.

The research utilised focus groups to provide insights from individuals with professional experience working within organisations providing mental health and related support to refugees and people seeking asylum. The focus group participants were asked to discuss topics developed in the co-production workshops and to identify how mental health support can be better improved to meet the needs of refugees and people seeking asylum.

2.1. Research aims

- To collaborate with people with lived experience of seeking asylum in England to design research which explores the barriers faced by refugees and people seeking asylum when trying to access support for their mental health.
- To explore what professionals working within organisations providing mental health and related support to refugees and people seeking asylum, including within the NHS, identify as barriers to accessing mental health support among this group.
- To enable people with lived experience of seeking asylum to identify opportunities for improving the access to, and provision of, mental health support for refugees and people seeking asylum in England.

2.2. Methods

As Figure 1 below shows, the project included three co-production workshops with people with lived experience of seeking asylum and two focus groups with professionals working within organisations providing mental health and related support to refugees and people seeking asylum.

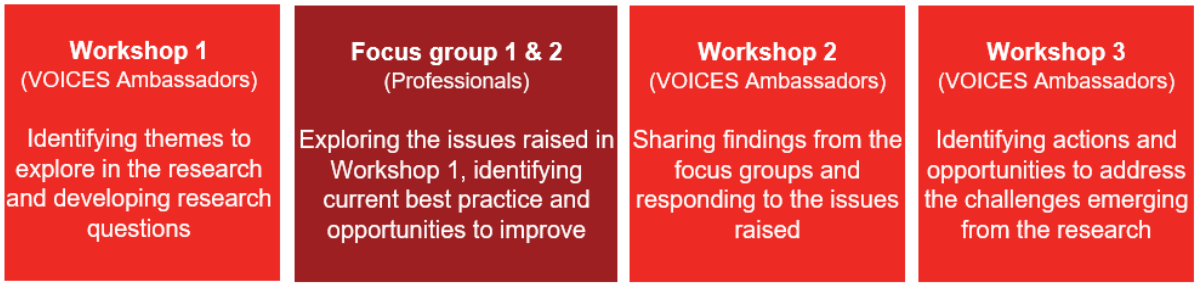

Figure 1: Research design

2.2.1. Coproduction workshops

For this project, 16 VOICES Ambassadors – individuals with lived experience of seeking asylum in England – helped to co-produce the research. All were members of the VOICES Network, which is a nationwide programme supported by the British Red Cross which provides

people with refugee backgrounds with a platform to share the challenges they face and raise those issues with decision-makers. The research used a participatory appraisal approach, a form of co-production which entailed a collaboration with the VOICES Ambassadors to identify key research questions, themes, and opportunities for improvement that were salient to them.

Three successive co-production workshops were attended by the same group of Ambassadors, one during the design phase, and two after the research fieldwork had taken place. The aims of each session were shaped by the preceding sessions:

- In Workshop 1, Ambassadors' understanding of mental health was discussed and themes to explore in the research were identified.
- In Workshop 2, key findings from the focus groups were shared with the Ambassadors for them to discuss and respond to.
- In Workshop 3, opportunities for improving access to, and provision of, mental health services for refugees and people seeking asylum in England were identified.

The research was designed to be trauma-informed.[36] Due to the sensitivity of the subject and the potential for re-traumatisation, it was decided that those with lived experience of seeking asylum should be involved in the project as co-producers and not as research participants. As such, the VOICES Ambassadors who collaborated on this project were not expected or asked to disclose any personal experiences of mental health. Their expertise or personal experience with mental health support was also not a factor in the participant selection process or a topic of the workshops.

2.2.2. Focus groups

The focus groups were designed to explore the key challenges faced by refugees and people seeking asylum when attempting to access mental health support, exploring the themes and topics raised by the VOICES Ambassadors in Workshop 1. The objectives were to:

- discuss the issues relating to mental health identified by the Ambassadors,
- explore the barriers faced by refugees and people seeking asylum when accessing support for their mental health,
- explore realistic ways in which this group could be better supported in accessing support for their mental health.

A total of 16 professionals from statutory, voluntary and community sector organisations participated in an online focus group (nine in the first, seven in the second). Participants were based across England, spread across regions including the south-west, London, Yorkshire and the north-east. Each session lasted two hours, was facilitated by an independent researcher, and was attended by a British Red Cross representative. This group included:

- four clinical psychologists, a psychiatrist, a psychotherapist and a general practitioner
- two service managers, a caseworker, a policy officer, and a chief executive working in various charities which support refugees and people seeking asylum
- a peer support lead working within a hospital
- a policy advisor from the Home Office
- two safeguarding leads, one from the Home Office and one working within contingency accommodation.

[36] The Social Research Association defines trauma-informed practices as "that which recognise that individual's responses are a way of adapting and coping with symptoms of trauma". It requires understanding of the effects of trauma and recognising triggers and trauma responses, to reduce the risk of re-traumatisation and ensure participant wellbeing.

2.3. Limitations

This is a small-scale piece of exploratory research. The intention was to investigate an under-researched subject area and to develop a better understanding of the barriers experienced by refugees and people seeking asylum to act as a starting point for further research.

The broad focus of the research means that the findings encompass various treatment pathways. As such, there is no direct applicability to specific mental health services.

The research prioritised the benefits of a co-production approach. The opportunities for improvement were developed by a small group of people with lived experience of seeking asylum. As a result, the research has not resulted in formal policy recommendations. However, Ambassadors' suggestions for addressing the problems raised throughout the research provide useful insight for those working in healthcare services, the asylum system and other public services. Where possible, we have identified which system or body is most relevant to an opportunity.

Due to its exploratory, qualitative nature, the research had a small sample. This means that it is not possible to generalise the findings to the wider population. In general, the focus group participants were more familiar with the provision of clinical support available to people seeking asylum and refugees than non-clinical support. Whilst many participants came from clinical support backgrounds, none specialised in suicide prevention.

The approach enlisted the help of people with lived experience of seeking asylum in England to co-produce elements of the project, but crucially, not as research participants. This meant that it was not possible to draw out intersectional issues within this diverse group. Future work should consider greater intersectionality, for example, the specific barriers faced by LGBTQ+ refugees and people seeking asylum.

While there was a breadth of experience among focus group participants, it was not possible to include professionals from every relevant care pathway within mental health, including IAPT. We hope policy leads working within different treatment pathways and clinical specialities will consider how the barriers identified apply in their own speciality.

3. Identifying themes (Workshop 1)

In Workshop 1, Ambassadors focused on building collective definitions of mental health and mental ill-health. Following this, they were supported to identify key themes which they wanted the research to explore. These included factors which could impact the mental ill-health of refugees and people seeking asylum, and barriers to accessing support for mental health.

3.1. Ambassadors' understanding of mental health

The VOICES Ambassadors spent time exploring how they defined and interpreted 'good mental health'. Figure 2 below highlights some of their responses. Key themes included:

- having control over your day-to-day life
- having a sense of belonging
- being healthy and sleeping well
- being hopeful and having positive thoughts.

Figure 2: Ambassadors' perceptions of 'good mental health' (Miro board from Workshop 1)

Ambassadors reflected on cultural differences in perceptions of mental health and discussed the stigmatisation of mental ill-health. They agreed that mental health exists on a spectrum, is not static and can change over time. A distinction was made between 'less severe mental ill-health' (which could include anxiety or sustained low mood) and 'severe mental ill-health' (which could include very severe periods of depression, psychotic episodes, or suicidal ideation).

Most of the Ambassadors felt it was important for the research to explore the social determinants[37] of mental ill-health for refugees and people seeking asylum, which they felt

[37] The World Health Organisation (WHO) (2022) *Social determinants of health*. who.int/health-topics/social-determinants-of-health#tab=tab_1 Accessed 02 Feb 2022.
The WHO defines social determinants of health as the non-medical factors that influence health outcomes such as the conditions in which people are born, work and live.

that – if properly addressed – could help to keep people mentally well. Several Ambassadors suggested that when social determinants of mental ill-health accumulated and were sustained over a long period without progress or resolution, it was more likely that severe mental ill-health could result. Many Ambassadors suggested that lots of these contributing factors could be addressed preventatively, rather than waiting for more severe mental health problems to emerge.

3.2. Themes identified by Ambassadors

During Workshop 1, the Ambassadors identified a range of issues and barriers which they wanted to be explored within the research. These were grouped by the research team into nine different topics for discussion. The topics were then categorised into themes reflecting an individual's journey through the process of accessing support for their mental health. In addition to exploring barriers, Ambassadors felt it was important for the research to explore potential contributing factors to mental ill-health for refugees and people seeking asylum.

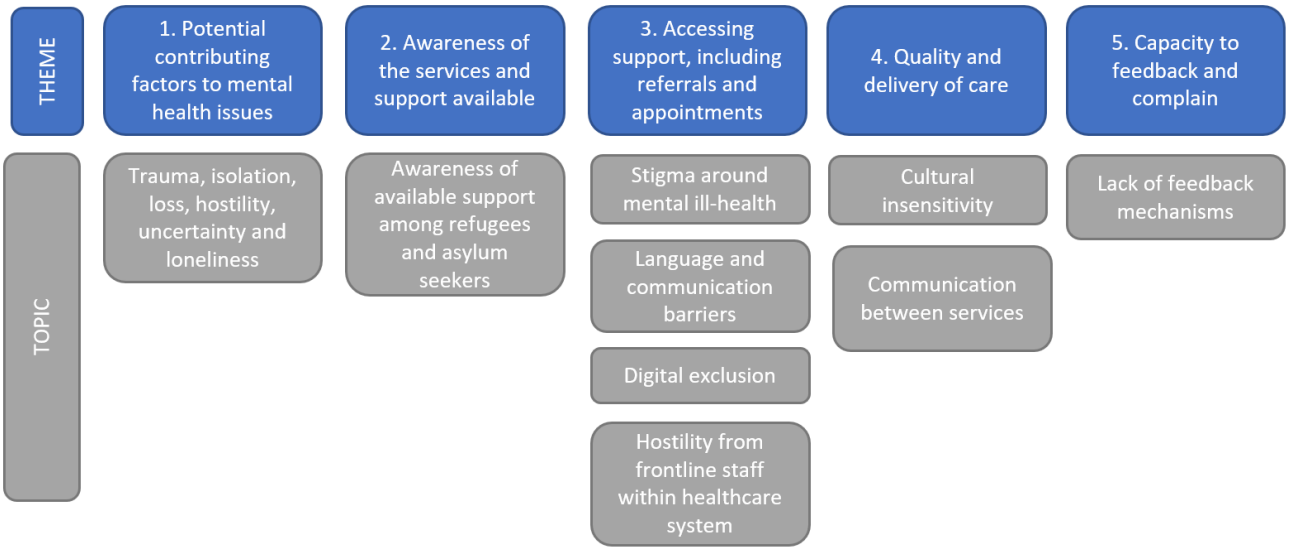

Figure 3: Themes and topics identified by Ambassadors in Workshop 1

The five themes identified were:

1. **Potential contributing factors to mental health issues.** Social isolation, loneliness, loss of community and experiences of hostility were all identified as factors which can negatively impact the mental health of refugees and people seeking asylum. The impacts of dispersal and uncertainty around the asylum application process were also cited as factors which can cause and exacerbate mental ill-health. Ambassadors suggested by addressing these contributing factors, some of the mental ill-health experienced by refugees and people seeking asylum could be prevented.

2. **Awareness of the services and support available.** Some Ambassadors felt that many refugees and people seeking asylum do not know what support is available to them, what kind of support would be appropriate for their needs, or how to access it. Ambassadors wanted the focus group participants to explore ways in which this awareness could be improved.

3. **Accessing support, including referrals and appointments.** Several barriers to accessing support for mental health were identified. These included: the impact of language and communication barriers; difficulties in navigating often complex

healthcare systems; a lack of signposting to different forms of support, such as that provided by charities, hostility from frontline staff within the healthcare system and experiences of digital exclusion.

4. **Quality and delivery of care.** Several Ambassadors suggested that the services which refugees and people seeking asylum are in touch with are often poorly connected, which can result in some individuals not receiving sufficient support for their mental health. Additionally, some Ambassadors perceived hostility and cultural insensitivity from frontline staff within the healthcare system and suggested this topic could be explored in the focus groups.

5. **Capacity to influence, feedback and complain.** Ambassadors highlighted the importance of being able to take on roles where they felt they could influence and shape the experience of others like them. However, they perceived a lack of effective feedback mechanisms within health services and highlighted the importance of being able to feedback or make complaints to help improve these.

This framework formed the basis of the discussion guide for the focus groups with professionals working within organisations providing mental health and related support to refugees and people seeking asylum professionals (see Figure 3 above).

4. Focus group findings

Taking the themes and topics identified by the Ambassadors in Workshop 1 (Figure 3) as a starting point for discussion, participants discussed barriers to accessing mental health support amongst the refugees and people seeking asylum they had worked with or supported.

The focus groups were semi-structured, meaning that participants were able to lead the discussion and to pick up on topics which resonated with them, from their experience of working within organisations providing mental health and related support to refugees and people seeking asylum. Figure 4, below, shows the contributing factors and barriers which were identified.

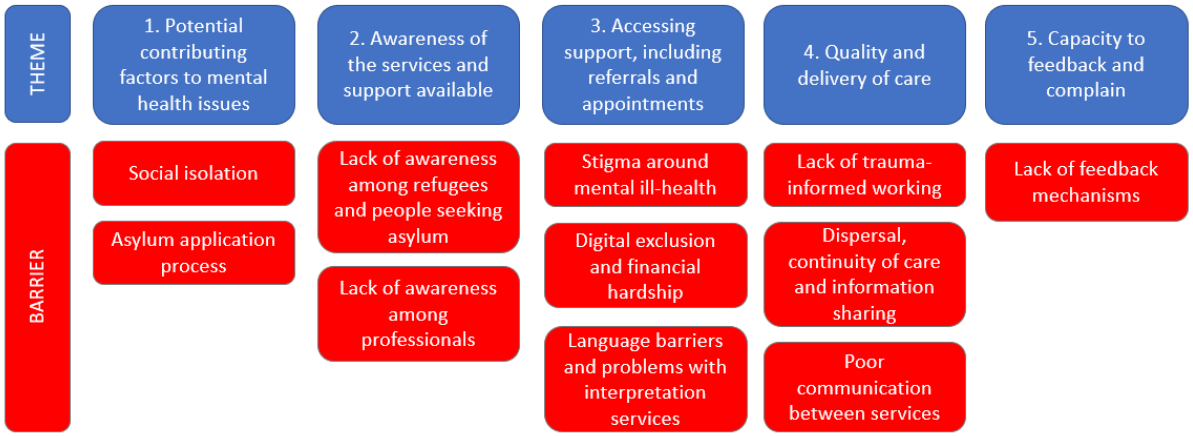

Figure 4: Focus group findings: barriers and contributing factors identified by the focus group participants.

4.1. Potential contributing factors to mental health issues

Focus group participants agreed with Ambassadors about the importance of addressing the social determinants of mental ill-health. They agreed that some of the mental health problems experienced by refugees and people seeking asylum were preventable and could be alleviated through addressing contributing factors such as social isolation and problems with the asylum application process.

4.1.1. Social isolation

Overall, it was felt that it was important that refugees and people seeking asylum had good social connections, which they could draw on to share their experiences and receive informal support.

> *"It's vital that people are able to have open and supportive conversations about what's going on for them, not just about mental health, but about everything they experience."*
> *Professional, focus group 2*

There were many examples given of good work being done to support refugees and people seeking asylum to engage with their communities and engage in activities which might help them to make friends and feel a sense of value and purpose. Some professionals described how they had signposted refugees and people seeking asylum to community groups. For example, one participant had forged a link with a local football club, which they felt was a good source of support for individuals who were resistant to engaging with clinical mental health support.

All the focus group participants felt that more could be done to ensure that refugees and people seeking asylum were supported and enabled to build support networks and join activities – they saw this as an important part of helping people to recover from mental ill-health. Some focus group participants were aware of local authority or community-led befriending or networking schemes, which were designed to build connections between refugees and people seeking asylum and people in the local community[38], but many suggested that it was hard for them to know what was available locally.

4.1.2. Asylum application process

There was consensus among participants that problems with the asylum application process could both cause and exacerbate mental ill health and should be addressed as an important part of supporting people with their mental health. At the same time, they emphasised that addressing these issues was hard for those working in clinical roles specifically, as they often felt that they had limited influence to make changes in areas outside of healthcare. The asylum support dispersal process, for example, was noted as a significant cause of stress and ill-health for people seeking asylum (this issue is explored in Section 4.4.2).

4.2. Awareness of the services and support available

Focus group participants agreed that more work needed to be done to support refugees and people seeking asylum to better understand what support is available to them, what kind of support would be appropriate for their needs, or how to access it. They also highlighted how

[38] For example, Norfolk County Council was running befriending services as part of a range of support for refugees and people seeking asylum within its New Routes programme.

professionals working with refugees and people seeking asylum could also lack awareness about what services were available to this group, and what their entitlements are.

4.2.1. Lack of awareness among refugees and people seeking asylum

Focus group participants acknowledged that the wide range of different services and roles within the mental health support system can be bewildering, making it challenging for refugees and people seeking asylum to know what form of support is appropriate, or available, for their needs.

Participants felt that in order to be informed about services and support, individuals need to be proactive in seeking advice and information. However, it was felt that some refugees and people seeking asylum are unable to advocate for themselves, as such, they may 'get lost in the system'.

> *"If you put yourself in their shoes, they are really disempowered and have no real agency which makes pressing their needs much harder"*
> *Professional, focus group 2*

4.2.2. Lack of awareness among professionals

Participants felt that confusion about the availability of appropriate mental health support was also an issue for those working with refugees and people seeking asylum, many of whom are unaware of what is available locally for this group. Given that people seeking asylum often rely on signposting to ensure they access the right support, the lack of knowledge about what support was available from the people who were in day-to-day contact with refugees and people seeking asylum was felt to be a significant problem.

Focus group participants reflected on how, unless a professional worked within a specialist service for refugees and people seeking asylum, they were unlikely to also be informed about the eligibility and entitlements of those going through the immigration process. This was perceived as a barrier to accessing primary care.

> *"Lots of people do not know what the entitlements are and who's entitled and who's not. So that can lead to huge confusions around who is going to be charged and those that are not"*
> *Professional, focus group 2*

One participant gave an example of GP surgeries requiring people seeking asylum to provide identification documents when registering, which is against NHS policy[39] and the National Health Service (Charges to Overseas Visitors) Regulations 2015.[40]

4.3. Accessing support, including referrals and appointments

Focus group participants agreed that the issue of accessing appointments, either face-to-face or remotely, was problematic for refugees and people seeking asylum. Issues raised

[39] NHS England and NHS Improvement (2021), 'Policy Book for Primary Medical Services', B0134-primary-medical-care-policy-and-guidance-manual-v3.pdf (england.nhs.uk).

[40] The National Health Service (Charges to Overseas Visitors) Regulations 2015 (SI 2015/238). Available at: https://www.legislation.gov.uk/uksi/2015/238 (Accessed: 28 April 2022).

concerning accessing support included the stigmatisation of mental-ill health; digital exclusion and financial hardship; and language barriers.

4.3.1. The stigma around mental ill-health

The stigma around mental ill-health was highlighted by participants as a barrier to accessing services, preventing many refugees and people seeking asylum from reaching out for support.

> *"There's definitely still that stigma attached… a lot of it goes unreported and [so] they don't ask for help"*
> *Professional, focus group 2*

Many of the focus group participants recounted experiences of refugees and people seeking asylum being reluctant to accept mental health support. They reported that, sometimes, refugees and people seeking asylum did not understand what was being offered or how it could benefit them. They described how additional time was often needed to build trust and explain what was involved in the treatment process, but this was often not possible.

> *"I think the main challenges are in understanding the process of assessment and the shame of disclosing their presentation of mental health"*
> *Professional, focus group 2*

Professionals highlighted that some individuals may express a preference for non-clinical support, such as attending a sport or exercise group, as opposed to clinical mental health services, which tended to be more stigmatised.

Some focus group participants had previously facilitated co-production activities around mental health service provision, including delivering mental health education and workshops alongside people with lived experience of seeking asylum. They felt that these approaches could help to improve understanding of mental health and therefore reduce stigma.

4.3.2. Digital exclusion and financial hardship

Participants agreed that the cost of public transport acts as a barrier for those experiencing financial hardship to access in-person appointments. It was also suggested that, while the transition to online services due to the Covid-19 pandemic has helped to overcome this, the issue of digital exclusion has become more pronounced. Participants reported how accessing healthcare appointments remotely (for example, by video call) can be difficult for those refugees and people seeking asylum who do not have access to a personal device and/or cannot afford mobile phone data.

> *"People feel that they have to beg a charity or elsewhere to get a tablet or a phone or data for them to join anything that it's happening online, et cetera"*
> *Professional, focus group 2*

Participants described some work that had been done to overcome these issues, including making digital devices available and providing funding for mobile phone credit. They also mentioned some voluntary and community sector organisations that had been issuing laptops to enable refugees and people seeking asylum to maintain access to services during the Covid-19 pandemic. However, it was felt that more needed to address the financial hardship and digital exclusion experienced by this group.

4.3.3. Language barriers and problems with interpretation services

Focus group participants agreed that, for refugees and people seeking asylum who do not have a confident command of English, communication difficulties can impact all stages of the journey to accessing timely and effective mental health support. This included the practicalities of booking appointments, describing symptoms, and understanding advice.

When delivering psychological support, it was considered vital to enable the individual receiving support to communicate complex or nuanced personal issues in their first language. A lack of well-trained interpreters was highlighted as a barrier to delivering successful mental health interventions.

Focus group participants felt that interpreters could be time-consuming to access and were expensive, meaning that they were not always available.

> *"Interpreters [are booked] in advance, so it does not allow for a very quick response…it is done for appointments. But it is not something that is done at the reception"*
> *Professional, focus group 1*

The focus group participants described numerous instances where they had worked with interpreters who lacked the skills to provide high-quality interpreting. For example, they might be able to speak the right language but not the right dialect. Other participants felt that interpreters might omit information that they felt uncomfortable with or that, in their opinion, should not be discussed. Some had had issues with breaches in confidentiality when using local interpreters who they believed had shared private information with other people in the community. These issues were all felt to undermine trust in mental health support and prevent people from coming forward for help.

> *"Sometimes you struggle with the quality of interpreters or there is a mismatch in dialect, or they are just not available. But we are trying to encourage frontline staff like receptionists to use those telephone services, particularly when they're triaging for appointments"*
> *Professional, focus group 2*

Focus group participants felt that there needed to be better awareness across healthcare services about the obligation to provide interpreters, and how to access them.

> *"There is an interpreting phone line that GP receptionists can use when they have people with language barriers, but they don't use it or aren't aware of it."*
> *Professional, focus group 2*

Participants described how pressures on frontline workers can mean they are unable to take the additional time needed to provide a good quality service to those experiencing language barriers.

4.4. Quality and delivery of care

Focus group participants suggested several features which they felt could impact the quality and delivery of mental healthcare and support for refugees and people seeking asylum. These included: a lack of trauma-informed working, the impact of dispersal and information sharing, and poor communication between services.

4.4.1. Lack of trauma-informed working

Participants highlighted the absence of a trauma-informed approach among many healthcare professionals when working with refugees and people seeking asylum, often because of limited training being delivered in this area. Without a trauma-informed approach, it was felt that healthcare professionals could unintentionally create distressing situations for refugees or people seeking asylum.

> *"You have to have someone who understands trauma within the context of where they are… [specialists] need to be at least supervising the care workers because if there are misunderstandings, they [can be] very serious"*
> *Professional, focus group 2*

Focus group participants highlighted that this was a known issue, and the Home Office is piloting some training around trauma-informed working, particularly for people working directly with refugees and people seeking asylum.

4.4.2. Dispersal, continuity of care and information sharing

Several focus group participants who worked as clinical psychologists spoke about the impact of dispersal on continuity of care. Two participants spoke about how a patient could begin a course of therapy, only for them to be dispersed without much warning. These participants felt concerned about the impacts of a patient being unable to finish a course of treatment, which could render the treatment less effective or even harmful.

Participants described how, when someone seeking asylum is dispersed to another part of the country, this can disrupt their continuity of care, as they may struggle to access suitable support for their mental health in their new location. The participants raised that when people are moved to different parts of the country, they effectively must re-join waiting lists in the new area, lengthening delays in accessing support.

> *"They [refugees and people seeking asylum] are moved around as part of their asylum support, and it means they have to register with a new GP and their referrals then fall through… I have had one client who was been assessed last week, he has been in London for five years and waiting for help, and he only had his initial [mental health] assessment last week"*
> *Professional, focus group 1*

This raised the question of whether it was ethical to start mental health interventions without guarantees about the continuity of treatment.

> *"I also have patients in deep therapy, trauma therapy, and they were just displaced, or they were sent back but without regard in that they may need only six months or three months therapy"*
> *Professional, focus group 2*

> *"If someone is kind of facing deportation, then that might not be the time to kind of open up some of these issues"*
> *Professional, focus group 2*

Some participants felt that even if they raised concerns about continuity of treatment, or about the vulnerability of an individual, it was hard to identify the relevant people responsible for decisions around dispersal. Even if they were identified, it could be difficult to know that they were listening. A few focus group participants described experiences in which they had tried to communicate the importance of continuity of treatment for an individual to the Home Office,

in writing and by telephone, but that it had made no difference to the outcome and the patient was dispersed regardless.

4.4.3. Poor communication between services

Focus group participants raised the issue of data sharing agreements and the Data Protection Act 2018 as barriers to providing joined-up care for individuals. Often, fears associated with the possibility of a breach of confidentiality meant that they felt they could not pass on information. In many cases, this was compounded by not knowing who the right people would be to pass the information onto, and a lack of confidence that the information would be acted on appropriately. One focus group participant described how they felt that some of these barriers to data sharing could be overcome through informed consent. For example, exploring with the individual receiving treatment why data sharing might be helpful to them and what the risks might be, and seeking their explicit consent to share that information.

> *"If you ask permission to the patient and tell them that it will support their care… they have no issue. They normally agree to it"*
> *Professional, focus group 2*

Other participants felt concerned that even with consent, there could be no guarantee as to how the information would and would not be used.

4.5. Capacity to feedback and complain

4.5.1. Lack of feedback mechanisms

Focus group participants felt it was important for refugees and people seeking asylum to have the opportunity to feedback on their experiences of the healthcare system in a meaningful way. They believed this would ensure any challenges in accessing support were identified and addressed. It was highlighted that, sometimes, information about how to complain or give feedback was not included in the translated versions of patient information forms.

> *"When we send letters, we tend to translate the key bits of the letters that are about treatment and care. And we tend to forget the framing of the letter, which includes ways to feedback and other more general information"*
> *Professional, focus group 1*

One focus group participant felt that the power imbalance that exists between service users and service providers can undermine their confidence to complain. There was also a perception by participants that refugees and people seeking asylum may fear that complaining will negatively impact their asylum applications.

> *"I think there is something in perhaps them feeling that whatever they get and should be grateful for. And the idea that they should then go and complain about the care that they have received is kind of against my fear"*
> *Professional, focus group 1*

One participant reflected that the opportunities to join 'patient panels' or 'lived experience groups' may exclude people seeking asylum because they were paid roles that were inaccessible to those without the right to work.

Some focus group participants raised that the Patient Advice and Liaison Service (PALS) teams in some hospitals were doing particularly good work in engaging with refugees and people seeking asylum, by taking a particularly proactive approach in terms of seeking feedback from these audiences.

5. Opportunities for improvement (Workshops 2 and 3)

In Workshops 2 and 3, the findings from the focus groups were shared with the VOICES Ambassadors in the form of questions which were designed to help them to identify priorities for change. The goal of these sessions was to provide the Ambassadors with a chance to respond to the focus group findings and to identify opportunities for improvement in the access to and provision of mental health support for refugees and people seeking asylum.

Ambassadors made several suggestions for addressing the problems raised throughout the research.[41] The opportunities they identified apply not only to health care services but also to the asylum system and other public services systems.

5.1. A person-centred, trauma-informed approach

The suggestions in this section are of particular relevance to health care providers and non-clinical providers of mental health support.

Ambassadors felt it was important to ensure that time was taken to understand the specific needs of the individual and that the most appropriate form of mental health support for that individual is identified and offered (whether clinical or non-clinical). This should include preventative measures as well as treatments to manage symptoms. One Ambassador suggested social prescribing as a good way to bridge the gap between medical and social needs.

Ambassadors stressed the role that non-clinical professionals (such as housing officers and caseworkers from the voluntary and community sector) could play in encouraging refugees and people seeking asylum to access community-based social and emotional support to help combat social isolation and build social connections. This could include providing 'maps' of the services and support available in the local area, such as local community groups they could attend.

Some mentioned the importance of not feeling compelled to explain traumatic life histories repeatedly to different professionals. This process of going over past events was perceived to bring unnecessary stress which could harm the individual's mental health. Although Ambassadors did not refer to the concept of 'trauma-informed' approaches themselves, this reflects the need for trauma-informed care.

Several Ambassadors suggested that services which specialise in supporting refugees and people seeking asylum, such as specialist GP clinics and mental health clinics, can provide care which is more trauma-informed and tailored to their needs.

5.2. Improving communication with refugees and people seeking asylum

The suggestions in this section are of particular relevance to commissioners and clinicians working within primary care and mental health services.

Many of the Ambassadors stated a preference for face-to-face GP consultations and in-person mental health support. However, travel costs were recognised as an issue, and some felt that this was a barrier which needed to be addressed.

The findings have demonstrated how language issues can be compounded by a lack of time during appointments, leading to individuals feeling rushed and unable to explain themselves

[41] Where possible, the system or system or body most relevant to an opportunity has been identified, however it is important to note that the suggestions were made by the Ambassadors and are not formal British Red Cross recommendations.

properly. Ambassadors felt that longer appointments could help to overcome these communication challenges. They felt it was important that whoever provided the support could allocate the appropriate time to sit and listen, to ensure they understood the needs of the person seeking help.

Ambassadors suggested that verbal instructions could be difficult to remember and recommended that many refugees and people seeking asylum would value receiving written communication. In particular, information from mental health clinicians about diagnoses, treatment plans and next steps.

Ambassadors suggested that all information from NHS England and the Home Office should be translated into the first language of the refugee or person seeking asylum and that they should have access to professionally trained interpreters who speak both their language and dialect, where needed.

To improve the quality of interpretation, some felt it was important to consider how trust is established between the person seeking support, the interpreter, and the healthcare professional. They suggested that this could include a structured conversation about how the interpreting relationship will work and what the professional boundaries and rules of the interaction will be (e.g., privacy, transparency), as standard practice when beginning to work together.

5.3. Improving communication between services

The suggestion in this section is of relevance to everyone working with and providing services for people seeking asylum and refugees

The need for services to better coordinate and communicate with each other was identified by both Ambassadors and focus group participants. Ambassadors also raised concerns around the sharing of patient health data, particularly with the Home Office. Some were worried about their health data being used in a way that could negatively impact their asylum application.

Ambassadors felt a solution to this could be for healthcare professionals to ask permission from refugees and people seeking asylum to share data, so they could be in control of what was shared and with whom where possible. They stressed the need for safeguards to be in place, to ensure that personal data is protected and was not used in inappropriate ways. Where an individual's safety and health could be at risk, healthcare professionals have a duty to care to share information, in these circumstances, it may not always be possible to seek permission.

5.4. Access to peer support

This suggestion is of particular relevance to commissioners and workforce planning teams.

Ambassadors felt peer support would be a valuable way to help refugees and people seeking asylum improve their mental health, particularly by providing emotional support and practical advice on how to navigate the healthcare and immigration system.

5.5. Improving continuity of care

The suggestions in this section are of particular relevance to commissioners and clinicians working within primary care and the Home Office.

Ensuring continuity of care – being able to have ongoing access to the healthcare professionals once a relationship has been established – was felt to be important, particularly for people seeking asylum who are dispersed mid-way through a course of therapy. Where

not possible, Ambassadors felt that more could be done to support people re-register with a new GP after being dispersed and to ensure that notes are transferred promptly to make the transition smoother and reduce delays.

5.6. Effective feedback mechanisms

The suggestions in this section are likely to be of particular interest to primary care and mental healthcare providers, caseworkers from the voluntary and community sector and professionals working within the asylum system.

Ambassadors felt that, in order to improve the experiences of accessing mental health services by refugees and people seeking asylum, it is essential to build in mechanisms to ensure that their needs and experiences are heard. Ambassadors suggested that service providers should routinely invite feedback and explain the purpose of this feedback and how it would be used. Ambassadors suggested that to make feedback processes more accessible, forms should be translated or read out by an interpreter, and language should be clear and easy to understand.

Alongside better feedback mechanisms, the Ambassadors advocated for more co-production with refugees and people seeking asylum to ensure services are better designed to meet their needs from the outset.

6. Conclusion

Refugees and people seeking asylum are more likely to experience poor mental health than the wider UK population but can struggle to access the mental healthcare and support they need. This research was designed alongside people with lived experience of seeking asylum in England to explore the barriers refugees and people seeking asylum face when attempting to access support for their mental health and identify opportunities for improvement.

The research has highlighted multiple barriers experienced by refugees and people seeking asylum when attempting to access support for their mental health. These included: a lack of awareness of available support (among both refugees and people seeking asylum and professionals); problems with accessing support (including stigma, language barriers, digital exclusion and financial hardship); issues with quality and delivery of care (a lack of trauma-informed working, communication issues and problems associate with the dispersal process) and inadequate feedback mechanisms. Participants also agreed on the importance of addressing social determinants of mental health, particularly concerning social isolation.

Ambassadors identified several opportunities to address the barriers encountered when attempting to access mental health support and to address the factors which contribute to poor mental health. They identified a need for person-centred, trauma-informed ways of working across all public services interacting with refugees and people seeking asylum and suggested ways to improve communication continuity of care feedback mechanisms.

By co-producing this research with individuals from the VOICES Network, the research has drawn on the expertise of those with lived experience of seeking asylum. In this way, it represents a valuable contribution to the existing literature on the topic. The research has contributed to improving understanding of how access to, and experiences of, mental health support in England can be improved to better meet the mental health needs of refugees and people seeking asylum.