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# Solace studies in therapeutic work with refugees and asylum-seekers

No. 6

## Refugees and Asylum Seekers' Experience Accessing Mental Health Care in Leeds

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**Editor's note:** This is the latest in a series of working papers reflecting on aspects of therapeutic work with refugees and asylum seekers undertaken by therapists and others working for SOLACE, a regional organisation based in Leeds (www.solace-uk.org.uk), and others associated with it. The views expressed here are those of the author. Esme Wishart was a student from Leeds University working on a structured placement, jointly supervised by the University and by a Solace Trustee.

Anyone working in this area is welcome to submit drafts of short papers (3000-5000 words) to the series editor at Gary.Craig@galtres8.co.uk

# 1. Introduction

Solace provides free therapeutic services for asylum seekers and refugees throughout the Yorkshire and Humber region. Solace's clients have predominantly fled violence and persecution and require support for the wide-ranging difficulties they have experienced. Solace adopts a multifaceted approach to support the complex needs of this marginalised and highly vulnerable community: for example, one-to-one counselling, advocacy, family therapy, and complementary therapy, such as sacro-cranial massage (Solace 2020). Solace is regarded as an expert in this field of provision (Burghgraef 2020). The service is fundamental to the mental health provision for asylum seekers and refugees, and no other organisation has the capacity and scope of Solace to support the specific needs of this community in the region (Blossom 2020).

This research was undertaken by Esme Wishart, an undergraduate student from the University of Leeds on behalf of Solace. This research specifically focused on Leeds, which in 2019 had 830 asylum seekers, 55 unaccompanied asylum-seeking children and 46 resettled Syrian refugees (Migration Yorkshire 2019). Notably, these figures do not represent everyone in the process of claiming asylum or with refugee status in Leeds. The intention of this research was to contribute to a deeper understanding of asylum seekers' and refugees' experiences accessing care in this area.

**Aims:**

1. Identify and evaluate the systemic reasons that have produced barriers for asylum seekers' and refugees' access to mental health services.
2. Discuss individual perceptions of mental health and services available.
3. Focus on steps forward to strengthen area where a weakness has been identified.

The aims were thus set to address the lack of in-depth, focused research on the barriers asylum seekers and refugees face specifically accessing mental health services, therefore it is hoped the findings will make a contribution to this growing body of research.

Crucially, this study will highlight the lack of funding available and promote the need for Clinical Commissioning Groups to invest in this area of provision. This study has identified a number of significant barriers to accessing mental health care in Leeds, some of which correspond with the findings of previous research, for example long wait times. Interestingly, participants suggested that mental health difficulties were one barrier to accessing care; the researcher found no evidence of this being reported in the literature.

## Literature Review

The World Health Organisation [WHO] defines health as: “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (2011:1). Importantly, this definition recognises that “mental health is more than just the absence of mental disorders or disabilities” (WHO 2020). This report suggests mental health support includes one-to-one counselling; psychoeducation; psychosocial groups; GP services; and crisis care.

Experiences of pre-migration traumas, transit experiences, and post-migration stressors render asylum-seekers and refugees highly vulnerable to physical and mental health problems (McCallin and Jareg 1996; Lewis et al., 2008). Burnett and Peel (2001) reported 2/3 of refugees in the UK as experiencing anxiety or depression. Nonetheless, experiencing traumatic events and psychological distress does not necessarily mean an individual develops psychological problems (Burnett and Peel 2001; Hek 2005; Keating 2012). Whilst some support is available, a growing body of literature highlights the inadequacy of mental healthcare support systems in the UK for refugees and asylum-seekers (Silove et al. 2000; Phillimore et al. 2012; Kang et al. 2019). Consequently, numerous barriers challenge refugees’ and asylum-seekers’ ability to access care (Equality and Human Rights Commission [EHCR], 2019; Patel, 2009).

The three different legal statuses: refugee, asylum seeker, and ‘failed’ (or refused) asylum-seeker, define the specific healthcare entitlements of individuals (Aspinall and Watters 2010). A refugee is a person who has “a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinion” (United Nations 1951). An asylum-seeker is an individual who claims to be a refugee and is waiting for their application to be approved by the country in which they are residing (United Nations High Commissioner for Refugees 2009).

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Anyone seeking asylum in the UK has the right to access all kinds of healthcare, namely primary, secondary, community, and emergency care (EHRC 2019). Nonetheless, insecure legal status and the asylum process itself are major factors making persons seeking asylum in the UK so extremely vulnerable (Ager 2014; Nellums et al. 2018a). ‘Failed’ asylum-seekers are not entitled to free secondary care, for example mental healthcare, unless in special circumstances (Aspinall and Watters 2010; Nellums et al. 2018b). Nonetheless, a local Mental Health Trust is still able to charge for these services (Patel 2009). The Voluntary and Community Sector [VCS] also provides mental health support services; however, they are limited, and its capacity is not enough to address the number of people seeking help (Aspinall and Watters 2010; Lewis et al. 2008). It has been argued that that the right of access to healthcare should be delinked from immigration status (Craig 2015).

Asylum-seekers and refugees trying to access mental healthcare face a plethora of challenges relating to their insecure economic position and charging regulations (Ager 2014; Nellums et al. 2018; Kang et al. 2019). In addition, ethnic health inequalities emanate from social and structural factors, such as racist victimisation (Patel and Fatimilehin 1999; Karlsen and Nazroo, 2002; Craig et al. 2012; Karlsen et al. 2012; Keating, 2012). Health services find it difficult to respond to demand and are not prepared in general to deal with the multifaceted nature of refugees’ and asylum-seekers’ problems that require culturally appropriate care (Lewis et al. 2008; Phillimore et al. 2012). Acknowledging and assessing this and the different ways racism is manifested within the mental health system is crucial to address the access difficulties currently faced (Patel and Fatimilehin 1999; Patel 2009; Keating 2012).

A number of studies have revealed that personal factors present greater challenges for asylum- seekers and refugees trying to access mental healthcare services, namely gender, sexuality and age (Hek 2005; Keating, 2012; White et al. 2019). Keating (2012: 218) asserts “refugee and asylum-seeker women require specific attention” as services available are not suitable for women who have experienced sexual violence (Phillimore et al. 2012).

The following barriers concern the relationship of service users and mental healthcare providers. Poor English language skills prevent refugees’ and asylum-seekers’ accessing mental healthcare (Karpuk et al. 2012). Interpreters are often vital for mental health appointments, but they are not always available (Nellums et al. 2018b)[1]. Authors have attributed asylum-seekers and refugees not engaging with services to the lack of adequate information available (Karpuk et al. 2012; Nellums et al., 2018b). General inefficiencies, such no clear guidance about support, restricted access (Karpuk et al. 2012). The long waiting times and reliance on postal services containing appointment times and information resulted in refugees and asylum seekers finding it difficult to access mental health support (Patel 2009; Karpuk et al. 2012). Moreover, organisations that were established specifically for this community were more welcoming and understood them better, therefore refugees and asylum seekers had better relationships with these organisations (Karpuk et al. 2012; Nellums et al. 2018b).

This review has revealed a number of themes that may be applicable to asylum-seekers and refugees accessing mental health care in Leeds. Whilst a number of key authors have been identified, the academic research concerning this topic is limited, therefore necessitating further research.

# Methodology

Qualitative research methods were used in order to gain insights into the barriers asylum-seekers and refugees face accessing mental health care. Semi-structured interviews were chosen because they “provide data on people’s behaviour and experiences” (Hay 2005: 103). Content focused questions were asked (See Appendix A) but they allowed flexibility for the interviewee to lead the conversation (Hay 2005). Communication difficulties occurred whilst conducting the interviews. With all participants speaking English as a second language, questions were not always understood. It was necessary to use an interpreter for two interviews.

Whilst this was essential, there are serious methodological issues associated with this approach. For example, Aranguri et al. (2006) suggest the interpreter could change the meaning of the response if it is not translated in its entirety. Nonetheless, Edwards (1998) contends interpreters strengthen research with sensitive participants.

Purposive sampling was used to recruit the target population of asylum-seekers and refugees in Leeds. Twelve key workers from organisations in Leeds were contacted; six responded. Subsequently, due to time constraints and organisations' willingness to take part, all participants were recruited from Positive Action For Refugees and Asylum Seekers [PAFRAS] and Leeds Refugee Forum. This study aimed to interview 8 asylum seekers and 8 refugees with a gender balanced sample. Initially, criterion sampling was used (Patton 1990), limiting potential subjects to refugees and asylum seekers who had tried to access mental health services. Participant 3 and 4 were recruited on this basis. The rest of the participants were obtained using convenience sampling "selecting participants on the basis of access" at the PAFRAS well-being drop-in (Hay 2005: 72) (see Table 1). Due to the well-being drop-in being very busy and the sensitive nature of this topic, the researcher was unable to ascertain whether individuals had accessed mental health services before interviewing them. Six of seven interviews were recruited from PAFRAS whose service users are predominantly asylum seekers and Participant 5's experiences reflect the time period he was an asylum seeker. Therefore, this study is more representative of the experiences of asylum-seekers, and thus hereafter will refer to asylum seekers. Three interviews arranged via Refugee Council had to be cancelled due to the emergence of the COVID-19 crisis Attempts to re-arrange digitally were unviable due to the socio-economic position of individuals and the impact of COVID-19 on well-being. Due to these unforeseen circumstances the resultant small sample size may threaten the validity and generalisability of the study (Hay 2005). Nevertheless, there are some important insights gained from the study, despite its unexpectedly early suspension.

Table 1 - table of participants

| Participant | Recruited from | Characteristics | | | | | | | | | Use of Inter-preter | Date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Gender | Age (years) | Legal Status | Lived in UK (years) | Country of Origin | Ethnicity | Religion | Commit-ments & Activities | Dependents | | |
| 1 | PAFRAS | Female | 20-30 | Asylum seeker | <5 | Iran | Kurdish | n/a | College | No | Yes | 19.02.2020 |
| 2 | PAFRAS | Male | 30-40 | Asylum seeker | <1 | Iran | Kurdish | Christian | Nothing | No | Yes | 19.02.2020 |
| 3 | PAFRAS | Male | 60+ | 'Failed' asylum seeker | 5+ | Sri Lanka | Sinhalese | Christian | Interpreter course Volunteer | 1 son living in Sri Lanka | No | 26.02.2020 |
| 4 | Leeds Refugee Forum | Female | 60+ | 'Failed' Asylum Seeker | 15+ | Iraq | Kurdish | Muslim | Exercise | 1 daughter & 1 son living in the UK | No | 6.03.2020 |
| 5 | PAFRAS | Male | 30-40 | Refugee | 5+ | Iran | Kurdish | Christian | Volunteer College Exercise | No | No | 6.03.2020 |
| 6 | PAFRAS | Male | 30-40 | Asylum seeker | <5 | Egypt | - | Muslim | Used to go to College Exercise | - | No | 11.03.2020 |
| 7 | PAFRAS | Male | 30-40 | Asylum seeker | <5 | Syria | - | Muslim | - | 1 son in UK | No | 11.03.2020 |

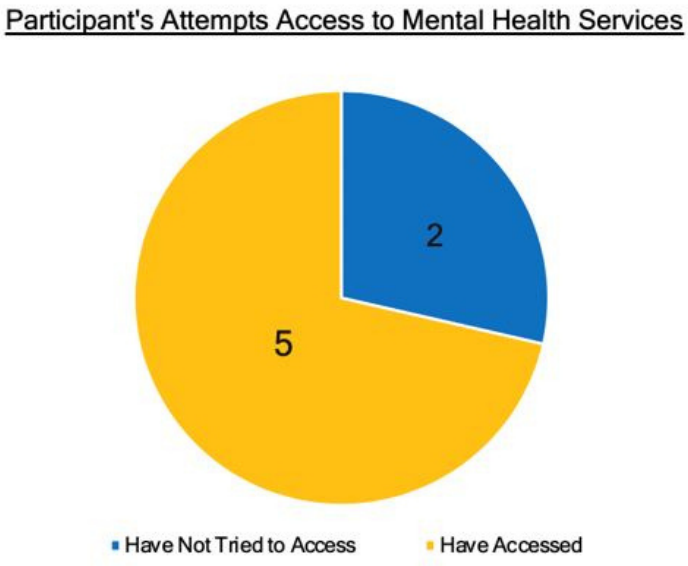
Asylum-seekers are an extremely marginalized and vulnerable community; therefore, interviews posed a number of ethical issues. A risk assessment was completed prior to data collection ensuring the safety of the participants and researcher. The participant was given an information sheet and consent form before the interview outlining the details of the study, the confidentiality of their information, and stating their right to withdraw (See Appendices B & C). Discussing one's mental health is often a sensitive and private topic. In many cultures within and outside the UK, mental health is heavily stigmatized (Patel and Fatimilehin 1999). To prevent psycho-social harm, if the participant became distressed, predominantly when discussing attempts to take their own life, the participant was asked if they wished to continue and reminded of their right to withdraw. Further, there was potential for the researcher to find the participant's accounts distressing. Whilst the researcher did not ask about previous experiences, the nature of the asylum process means asylum-seekers and refugees could be forthcoming about this (Browne 2020). The researcher was aware of their right to terminate the interview and had counselling support from the Senior Therapist at Solace in case traumatic events emerged during the interviews.

Asylum-seekers migrate involuntarily, escaping perilous and intolerable political environments to seek asylum in other countries, often escaping torture, ethnic cleansing or violence (Lewis et al. 2008). On a number of occasions participants became emotionally distressed whilst describing their situation. As a student researcher with no experience of the asylum process or destitution, I am situated within a different social structure to the participants and cannot easily relate to their lived experiences (England 1994). This power relation cannot be removed from the research "since it exists in all social relations" (Hay 2005: 23). Nonetheless, in order to reduce this, I practiced critical reflexivity to scrutinise my position and the impact this could have on my interpretation of the data. During the interview I would make use of silence and empathy to allow the participant to be heard and making no judgements or suggestions. In this case, Participant 4 stated "when I talk to you little bit relaxing" at the end of the interview, suggesting she felt comfortable, thus conveying reliable experiences.

A reflective journal was kept throughout this fieldwork to record challenges and ideas. The data recordings were transcribed and deleted within 48 hours. The transcripts were stored on a password-protected University OneDrive and were destroyed at the end of this study. Coding techniques were used to sort the data into relevant themes. These themes were analysed and sorted into categories, thus enabling interpretation (Crang and Cook 1995).

# Results and Discussion

Asylum seekers are vulnerable to psychological distress (Phillimore et al. 2012). The majority of participants described that they had experienced mental health problems and that these were induced from post-migration stressors, “my depression started after experiences in the [Birmingham] hostel” (Participant 5). Consequently, participants were asked whether they had tried to access mental health support in Leeds (Figure 1).




## Figure 1 – Pie Chart showing the Participants who have tried to access mental health services

Figure 1 indicates the majority of participants accessed mental health care. Notably, Participant 1 said her mental health problems were “not too serious”, therefore had not tried to access mental health services. Literature has indicated that asylum-seekers are separate and heterogenous, therefore the universality of experiences of mental health issues should not be assumed (Fernando 2003; Hek 2005; Keating 2012; Ager, 2014). When experiences of migration are viewed through a psychiatric lens it is often suggested that all asylum-seekers have mental health problems because of expected experiences of trauma; however, this discredits this community’s adaptive capacities (Ager 2014).

Adaptive capacity refers to asylum-seekers' ability to respond to new environments and social contexts to improve their livelihood, health and well-being, for example individuals' motivations to make use of the opportunities in Leeds, such as volunteering or attending college. Thus, whilst mental health problems are commonly experienced by asylum-seekers, the occurrence and severity of these issues should not be presumed.

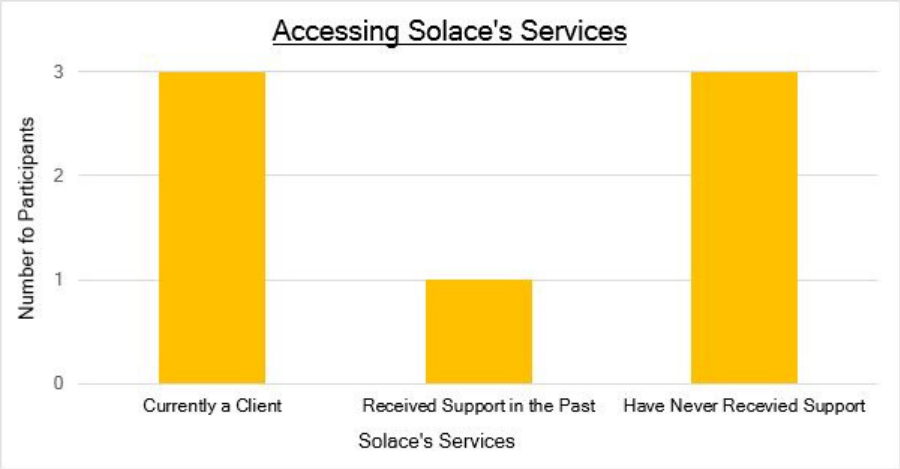



Figure 2 – Bar Chart showing 7 Participants' Access to Solace's Services, the predominant service provider for mental health support in Leeds. This data is relevant throughout the discussion.

***Barriers Impacting Access to Mental Health Care***

The following factors were identified as barriers for asylum-seekers accessing mental health care: contextual factors, legal status and socio-economic status; individual mental health struggle; and experiences with the service-provider.

One 'failed' asylum-seeker emphasised significant despair and frustration with the immigration system, with no access to public services and reliance on night shelters for accommodation; he disclosed "it is not a life". 'Failed' asylum-seekers in particular are situated precariously by UK legislation that restricts access to secondary mental health care, this exacerbates problems accessing care thus making individuals often dependent on VCS provision(Phillimore 2018; EHRC 2019).

The findings support this claim, although two ‘failed’ asylum-seekers in this study still continue received medication to help reduce anxiety and improve sleep via their General Practitioner [GP]. Previous studies also support this study’s findings that socio-economic status prevented asylum-seekers from attending appointments because participants said they “did not have the money to pay [for the] bus pass” (Karpuk et al. 2012).

An individual’s own mental health struggle as a barrier to accessing care was a recurrent theme in the interviews. Six out of the seven participants described problems with their mental well-being. Whilst this report does not attempt to comment on the prevalence of challenges to access mental health services beyond the original sample, the number of participants who reported mental health issues is noteworthy. In particular, the finding that four of the participants had either attempted to commit suicide more than once or described the intentions they had to take their own life should not be understated. For example, Participant 2, who is living on the streets said:

"when everything is make you tired and you don’t have any joy in your life… you just wanna see this life to be finished … you don’t wanna see any organisation or access to health because you cannot, you cannot decide your life or future."

The suggestion that participants’ individual mental health struggle prevents them from accessing care is therefore a major concern. Very little was found in the literature illustrating one’s mental health acting as a barrier to access care. This finding has important implications to guide how organisations try to find new ways to engage with asylum-seekers who may not previously have tried to seek help. Nonetheless, this is a complex challenge because these individuals represent an extremely marginalised community.

Analysing participants’ experiences with the service provider reveals a number of barriers to accessing care. Long wait times were mentioned as a common occurrence when accessing mental health care. Participants who needed to access specialist mental health care explained that their GP or PAFRAS would refer them to Solace. However, they would have to wait over a year to access one-to-one counselling. The existing literature reveals that lack of trust and a poor relationship between service user and provider is a barrier to accessing care (Karpuk et al. 2012), although this was not particularly prominent in the interview data. Most participants explained that they felt “connected”, “understood” and had a positive experience with friendly staff in a variety of mental healthcare settings.

Nonetheless, one participant suggested the receptionists at Solace need to be prepared to "talk very politely, very calmly" when discussing not being available for an appointment, explaining this was an important first impression for the client who is stressed.

In reality, asylum-seekers struggle with a number of these problems concurrently as they are inter-related and combine to magnify these complex barriers to accessing care (Brandenberger et al. 2019; Kang et al. 2019). Participants often referenced organisations providing services specific to asylum-seekers and refugees when describing mental health support that was particularly effective. This finding supports other studies linking these variables, therefore validating the participants' suggestions (Nellums et al. 2018b).

***Perceptions of Mental Health and Support Services Available.***

Participants were asked about their understanding of what mental health meant. There were only two occasions where participants responded to this question, although the responses described the psychological distress they experienced, rather than engaging with the question in more detail. Arguably, the limited English language skills of participants prevented a more detailed discussion of mental health; the use of interpreters in a further study could produce more data.

The following mental health services were identified by participants: GP, PAFRAS, Solace, Touchstone IAPT [Improving Access to Psychological Therapy] and Leeds and Yorkshire Primary Foundation Trust [LYPFT] crisis assessment unit. Crucially, most participants revealed they did not know where to go until somebody in the community told them about PAFRAS. Thereafter, participants reported dissatisfaction with the treatment options they were given by the GP, "when you are go to [the] GP, they just give you tablets and then sleep. They are not listening to you". All participants who had accessed Solace's services reported extremely positive experiences and were resoundingly grateful for the support they received. The participants were aware this project was on behalf of Solace; therefore, this could have possibly led to biased accounts of the service in order to gain favour from the organisation. However, the fact participants offered suggestions to improve Solace invalidates potential for bias. Suicidal participants had used the LYPFT crisis service, however one participant indicated they did not want to call the service and in the past a neighbour had called because of the noise and concern for them. Crucially, this conversation about suicide revealed asylum-seekers have extremely limited access to follow-up mental healthcare after being hospitalised for attempted suicide.

In general, therefore, it seems participants had experiences with a range of healthcare providers that were beneficial for their mental well-being. Nonetheless, the many challenges they faced whilst accessing these services are mentioned above.

| | Recommendations | Suggested by |
|---|---|---|
| | **Health Promotion** | |
| 1 | Participants advocate the importance and benefit of seeking help | Asylum-Seeker |
| 2 | Promote and develop the activities available for asylum seekers in the community e.g. physical activity | Researcher |
| 3 | Increase the opportunity to volunteer and feel part of a group/organisation | Researcher |
| | **Awareness of Services** | |
| 4 | Increase awareness of the benefits of learning English | Asylum-Seeker |
| 5 | Central point of information distribution to make it easier to find out information | Researcher |
| | **Mental Health Service Specification** | |
| 6 | Education for staff to ensure their language and tone is appropriate for dealing with individuals struggling with mental health issues | Asylum-Seeker |

The aim of this study was to uncover experiences accessing services in Leeds and suggest steps forward to ensure current difficulties do not persist. Table 2 illustrates recommendations that could respond to the requirements of asylum-seekers in Leeds. Notably, addressing post-migration challenges asylum-seekers face could improve mental well-being for asylum-seekers, thus reduce the demand for mental health services. Recommendation 2 and 3 respond to a number of participants' suggestion that increased physical activity, involvement in education and social groups improved their well-being. In addition, promoting asylum-seekers' health, independence and agency are critical factors because "mental health is a state of well-being in which an individual realises his or her own ability ... and is able to make a contribution to his or her community" (WHO 2020).

# Conclusions

Everyone has a basic human right to access healthcare and everyone should be able to exercise this (Hall 2006; Nellums et al. 2018b). Therefore, the challenges refugees and asylum-seekers face must be addressed. This report has identified several key barriers for asylum-seekers accessing care, including contextual factors - legal status, personal factors - the state of one's mental well-being, and the relationship between service provider and service user. A number of recommendations were made in Table 2 advocating ways to reduce the barriers asylum-seekers face accessing mental health services. In addition, asylum-seekers' perception of mental health were discussed. However, due to a language barrier between the researcher and participant this aim was not fully realised.

Further studies could: recruit refugees to capture information to understand experiences of this group, COVID-19 needs to be acknowledged as thus brought this study to a premature end; use a research sample of both asylum-seekers, refugees and service providers to improve validity of the recommendations; and explore specific prevalent barriers. Notably, one's poor mental health acting as a barrier to care is not thoroughly studied in existing academic debate.

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# Appendices

# Appendix A: Interview Guide

SECTION 1: Introduction

Thank you. Introduce self. Explain study.

The interview should take roughly 30 minutes, is strictly confidential, and you can still withdraw at any time without giving a reason.

Would you like to introduce yourself?

What do you understand psychological well-being to mean?

Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community. (WHO)

SECTION 2: Personal Context

First, I have some (further) questions about your background. Remember that the information you give me is confidential.

| | |
|---|---|
| Age | |
| Length of time living:<br>UK<br>Leeds | |
| Nationality | |
| Ethnicity | |
| What stage of the immigration process are you at? | |
| Family | |
| Religion | |
| What do you do with your time while you are waiting to get on with your life? | - Volunteering<br>- Education/English lessons<br>- Work (refugees)<br>- Other (specify) |

SECTION 2: Access to (health) services

I am going to ask some questions about your experience needing/using services in Leeds...

-What services have you made use of whilst living in Leeds?

- o Housing, Education
- o Healthcare (specify)
- o Other

-What do you think about the services you received?

- o Excellent
- o Good
- o Neither/nor
- o Poor
- o Very poor

-Have you had any health-related issues whilst being in the UK?
-Tell me about your experience of NHS services?
-What was the quality of help that you had?
-What do you think about the services you received?
-Are you registered with a GP?

SECTION 3a: Access to mental healthcare

Now I am going to ask some questions about access to mental health/psychological services specifically. I would like to remind you that you do not have to respond to any of these questions.

EXPERIENCE OF SERVICE

Do you have personal experience of emotional or psychological distress?

Do you know what types of psychological services are available?
·Counselling, Therapy, Physical treatment e.g. massage

Have you ever accessed or wanted to access psychological or emotional support services?
-Yes or No

If Yes:
Could you tell me about your experiences using these services?

-How was your health assessed and by whom?
- Counsellor, psychologist, therapist
- GP referral/NHS or voluntary organisation referral

-Can you describe what your experience of [type of service] was like?

-What do you think about the services you received?
- Excellent
- Good
- Neither/nor
- Poor
- Very poor

-What was the outcome of the appointment?
- Medicine, Treatment, Hospitalised

-Did it sufficiently deal with the problem?
-Frequency of use

EXPERIENCE TRYING TO ACCESS SERVICE

-How did you find out about these services?
- Who did you ask?
- Where did you find the information?

-What was your overall experience trying to access the service?
- Can you tell me about anything that prevented you from getting the care you needed or made it harder?
- Can you tell me about anything that made it easier to get the care you needed?
- Did you find it easy to connect with the service?

o Did you feel like you were understood/supported?
o Was the service effective in addressing the issue?
o Was it easy for you to find your way around in this service?
o How long did you have to wait to access care?

-Can you tell me about any ways in which your legal status in the UK has impacted on whether you seek care, when and where you seek care?

-Do you know whether you are entitled to free healthcare services?

-Why did you try and access these services?

-Where else have you lived in the UK?

OTHER

-What do you think the outcomes might be if you don't get the care you might need?

-Have you tried to receive support from your community?

-Do you think it is important to seek help?

If No:
-Are you aware of any medical and support services that provide psychological support?
-Do you know how to access these mental health services?
o Who would you ask?
o Where would you find the information?

-Do you know of anyone that has tried to access psychological services?

-What were their experiences of it?

**SECTION 3b: Access to psychological healthcare through organisations**

-Are you aware of any other services that support psychological issues?

-What type of support did you receive?
- Counselling/Therapy
- Referral
- Massage/physical therapy
- Self-help
- Information resources

-How did you find out about these organisations?

-Did you approach, or were you approach by a member of the organisation for help with this issue?

SECTION 4: Perceptions of psychological wellbeing
Revisited from introduction. Possibly refer to WHO definition again.

-What do you understand psychological health to be?

-How do you feel discussing these issues with:
o Family, Friends, Community, Healthcare staff?

SECTION 5: Final

Moving onto the final part of the interview. I have a few more questions and then we are finished.

-If you could change one thing about the psychological health care services you have received, what would that be?

-Is there anything about you that you think makes it easier or more difficult to get the right care when you need it?

-What guidance would you give other people like you for accessing healthcare in the UK?

-Can you tell me about any other things you worry about relating to your:
- Health?
- Legal status?

SECTION 6: Summary/General Reflections

Is there anything you would like to add or review at this point?

Thank you for your time.

Reminder that this information is strictly confidential. The data is being using for a report and presentation.

My contact details are on the information sheet so feel free to contact me, or any of my supervisors.

# Appendix B: Information Sheet

INFORMATION SHEET

Research Study About Refugees' and Asylum-Seekers' Access to Mental Health Services

You are being invited to take part in a research project. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

The aim of the research is:

1. Identify and evaluate the systemic reasons that have produced barriers for refugees and asylum seekers access to mental health services.
2. Discuss individual perceptions of mental illness and services available.
3. Focus on solutions or steps forward to strengthen area where a weakness/problem has been identified.

You have been chosen to participate as you are a refugee or asylum-seeker who has had difficulty accessing mental health services. Your participation in the research is entirely voluntary. It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep and asked to sign a consent form. You can still withdraw at any time without it affecting you in any way, you do not have to give a reason. If you agree to take part, you will participate in an interview that will last approximately 30 - 45 minutes. The interview will be conducted [Organisation office], or another suitable agreed location. The questions you will be asked will be primarily open-ended, to allow you to explain your thoughts.

Some of the topics we discuss may be upsetting to you. You are free to decline to answer any/all questions and to stop the interview at any point. Should you wish to speak with someone after the interview you can contact Gary Craig who can direct you to resources that can be of help. While there are no direct benefits to participants from participating in the project, it is hoped that your responses will enrich understanding of this topic.

All information that we collect about you during the course of the research will be kept strictly confidential. You will not be able to be identified in any reports or publications. Information that I will collect about you will include:

- Your name, gender, ethnicity, country of origin, languages
- Which services you have accessed in the UK e.g. housing, education, healthcare
- Awareness and Experiences of using these services, e.g. difficulty navigating the services, or accessing a specific service
- Perceptions of mental health and services provided to support this

The information gathered will be used for a presentation to SOLACE's Trustees and a report for the university.

Interviews will be recorded using a recording app on my iPhone/laptop. These recordings will only be used for analysis purposes. No other use will be made of them without your written permission, and no one outside of the project will be allowed access to the original recordings. All data will be stored securely on a password protected drive for three months and then destroyed, in accordance with Solace's ethics and data storage protocols.

The research is being undertaken on behalf of Solace, by Esme Wishart as part of a placement collaboration, which is overseen by the School of Geography University of Leeds. Please contact the researcher or Gary Craig if you have any questions or concerns about the research. Please contact Deirdre Conlon for questions about the work placement module.

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# Appendix C: Consent Form

Consent to take part in Research Study About Refugees' and Asylum-Seekers' Access to Mental Health Services

| | Add your initials next to the statements you agree with |
|---|---|
| I confirm that I have read and understand the information sheet dated [insert date] explaining the above research project and I have had the opportunity to ask questions about the project. | |
| I agree for the data collected from me to be stored and used in relevant future research in an anonymised form. I agree for the data I provide to be archived on a password protected drive for 6 months, and then destroyed. | |
| I understand that relevant sections of the data collected during the study, may be looked at by individuals from the University of Leeds or from regulatory authorities where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records. | |
| I agree to take part in the above research project and will inform the lead researcher should my contact details change. | |

| | |
|---|---|
| Name of participant | |
| Participant's signature | |
| Date | |
| Name of lead researcher [or person taking consent] | |
| Signature | |
| Date* | |

*To be signed and dated in the presence of the participant.

Once this has been signed by all parties the participant should receive a copy of the signed and dated participant consent form, the letter/ pre-written script/ information sheet and any other written information provided to the participants. A copy of the signed and dated consent form should be kept with the project's main documents which must be kept in a secure location.