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Solace studies in therapeutic work with refugees and asylum-seekers

No. 7

How has Covid-19 impacted therapeutic services for refugee & asylum seekers

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surviving exile and persecution

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

Author Acknowledgements: I would like to thank my project supervisor, Gary Craig, for his guidance and support throughout this project. Also, thank you to all the Solace therapists who contributed their time towards this research study.

1. Introduction

This project was conducted in partnership with Solace, a Leeds-based charity with a mission to alleviate the distress and suffering of Refugees and Asylum Seekers(RAS) in the Yorkshire and Humber region. Solace provides therapeutic services, counselling, and advocacy to support those who have survived exile and prosecution and have been traumatised by torture, rape, war, death or disappearance of loved ones, and other atrocities (Solace2021).

Following UK Covid-19 national lockdowns in March 2020, where the government announced people were only allowed to leave their homes for shopping, exercise, medical need, and essential work, there was a sudden change in ways of life and working, including that of therapeutic services for refugees and asylum seekers (Johnson2020). Therapeutic services which were typically delivered on a face-to-face basis at Solace moved to other modes of delivery, such as telephone or videoconferencing (typically Zoom) methods. Solace therapists formed a focus group for this study, participating in a questionnaire and a 40-minutesemi-structured interview, for the researcher to gain insights into how the Covid-19 pandemic has impacted their ways-of-working. This study found that for all Solace therapists interviewed, there may be a permanent change to the therapeutic service delivery model with therapists incorporating remote-working into their ‘normal’ ways-of-working following the pandemic; this would not have been considered before the pandemic.

The project’s aims and objectives were as follows:

1. Investigate the advantages and disadvantages of alternative methods of therapeutic delivery.
2. Explore if there is a standard model which might fit all circumstances.
3. What lessons might be learnt for service delivery if and when the pandemic comes to an end.

Literature Review

Due to the specific nature of this research study, there are no published studies exploring the particular impact of Covid-19 on therapeutic services for RAS. However, the academic literature on videoconferencing is highly relevant to this research project in its aim to explore how alternative ways-of-working have performed. Psychological treatments have traditionally followed a face-to-face delivery model with both therapist and client in the same room (Simpson et al. 2005; Bee et al. 2008). However, in recent years, the advancement of technology and the growing awareness that all clients may not respond equally well to the same therapy delivery has resulted in the development of alternative forms of therapy delivery, such as videoconferencing (Durham et al. 2000).

A range of videoconferencing/video-therapy advantages emerged; the most consistent was the improved accessibility of therapy and the subsequent time, cost and travel savings for both therapist and client (Pesämaa et al. 2004; Simpson et al. 2005; García-Lizana and Muñoz-Mayorga 2010; Norwood et al. 2018;). This is particularly important for clients who struggled to travel for therapy sessions, whether this was due to health or transport issues (Pesämaa et al. 2004; Simpson et al., 2005; Harvey & Gumport, 2015; Norwood et al. 2018). Knott et al. (2020) identified that in some circumstances, video-therapy improved engagement. Some therapists who are resistant to video-therapy emphasise the lack of non-verbal communication as a limitation; it reduces the availability and readability of eye contact, physical expression, and body language(Wootton et al. 2003; Norwood et al. 2018; Knottet al. 2020); poor internet connection is believed only to exacerbate this (Norwood et al. 2018). This is suggested as contributing to reduced interpersonal connection, displays of empathy, and rapport building (Wooton et al. 2003; Knott et al. 2020). However, both psychiatric and psychological studies have found that it is the personality of both client and therapist that most strongly influence the therapeutic alliance as opposed to the use of videoconferencing (Simpson et al. 2005).

Videoconferencing may be particularly suitable to those who are tentative about face- to-face therapy, as explored by Simpson et al. (2005). Videoconferencing may lead to a greater sense of personal space and control for the client as both parties have their own space compared to face-to-face therapy which may occur within the therapists ‘territory’ (Ibid.).

Therefore, videoconferencing can result in the equalising of the power-balance within the therapeutic relationship. However, those who find it difficult to trustothers and lack social confidence may be more anxious about videoconferencing (Simpson et al. 2005).

Despite certain limitations of existing research, including the lack of studies and long- term follow-up, small sample sizes,and absence of face-to-face controlgroups, studies suggest that videoconferencing is a feasible and effective alternative to face-to-face therapy (Hilty et al. 2004; Pesämaa et al. 2004; García-Lizana and Muñoz-Mayorga 2010).

Methodology

In December 2020, a questionnaire produced by Solace and the researcher using the ‘Survey Monkey’ platform was distributed to a focus group of 21 therapists associated with Solace through email. The questionnaire consisted of 10 questions (Appendix 1) and had an average completion time of around14 minutes. The aim of the questionnaire was to provide an initial insight into the experiences of therapists, which would then inform the structure of the subsequent semi-structured interview. The survey received15 responses which were analysed to identify key themes. The next stage of the research project was for the researcher to conduct interviews with Solace therapists who had completed the survey; these interviews took place over February and March 2021. Ten Solace therapists participated in a 40-minute semi-structured interview, which acted as a deeper-dive into therapist’s experiences with Covid-19 ways-of-working (Appendix 2).Interviews were recorded and transcribed, then key themes were identified and reported. All responses and interviews were only seen by the researcher; they were stored as the report was finalized and have since been deleted after the release of this report. Furthermore, responses were completely anonymised.

Critical reflection of Methodology

First, whilst therapists provided insight into the RAS experiences, the fact that the researcher was unable to speak to clients (RAS) directly (which would not have been possible due to confidentiality and ethical reasons)may act as a limitationin understanding the full extent of how Covid-19 has impacted their experience of therapy. Seven females and three males were interviewed, and whilst this initially appears to be a gender imbalance, the ratio reflects that of psychotherapy as an occupation where 74% of UK Council for Psychotherapy members are female (BACP 2017). Both the questionnaire survey and interviews produced the desired outcomes, and because the questionnaire and survey took place 2-3 months apart, and changes and adaptations to Covid-19 ways-of-working were identifiable.

Results

This section will provide an objective summary of the findings and themes that emerged from the questionnaire survey and interviews.

Questionnaire findings

Reported advantages and disadvantages of Covid-19 ways-of-working	
Advantages	**Disadvantages**
• Improved accessibility of therapeutic services. • Time-savings from reduced travelling: therapists had more time to dedicate to clients, and other activities such as improving in their practice and training other professionals. • Increased geographical reach, engaging clients who may previously have struggled to access sessions due to distance or health. • Several therapists expressed the sentiment that'in many cases it works nearly as well as 'face-to-face'. • Technology provision of phones and data for clients - enabled access to therapy sessions and broader connectivity during the pandemic. • Improved confidence with technology for both client and therapist, which was empowering. • Covid-19 saw the creation of stress- management groups, which may continue in thefuture.	• Therapists felt 'deskilled': unable to observe client's body language. • Therapists unable to use their physical presence to show empathetic responses. • Clients no longer had a physical space where they felt accepted and cared for in a multi-sensory way. • Living situations for some clients added complexity; some were unable to find a safe space for therapy, particularly clients in asylum accommodation and those living with family. • Initially, not all clients had access to the necessary technology for remote sessions, this needed to be facilitated through sourcing equipment and data. • Both client and therapist faced technology and/or internet failures. • Therapists were unable to utilise creative therapies; this made it difficult to work with clients who wanted to express themselves non-verbally, particularly with children. • Hands-on therapists were unable to work with clients in their normal ways-of-working.

Of the therapists surveyed,73% stated that they would incorporate remote ways-of- working to some degree if and when the pandemic comes to an end.

Interview Findings

Benefits of videoconferencing as a method

Therapists have found some clients, particularly teenagers, suggested it was easier to engage with videoconferencing. Therapists noted that ‘the biggest challenge was my own ambivalence about it’ and clients ‘have adapted very well, and they have found it as good as face-to-face therapies in many ways’. Furthermore, one therapist noted that the experience of remote working was more dependent on the personality of both client and therapist, as opposed to the absence or presence of technology, a finding which supports previous research (Simpson et al. 2005). Secondly, several therapists mentioned that videoconferencing has enabled them to engage family members they may have struggled to engage previously; there were occasions where therapists would be on a video-call with one family member and then others would join in.

Limitations of videoconferencing as a method

The majority of therapists highlighted they were unable to observe body language, the subtleties of interaction between a couple or family, and non-verbal communication, with one therapist stating, ‘if I can’t see that tapping foot then we can’t talk about it’. Those who conducted sessions via telephone struggled further as they couldn’t see facial expressions. However, one therapist noted the subtleties in breathing were more pronounced via telephone. The ability to access a safe space for therapy varied between clients, some took great effort to find space, whether that was outdoors or in their bathroom. Several therapists noted that clients are resourceful and willing to overcome this problem, but clients are limited by their living circumstances which may be extremely cramped given their general situation. Furthermore, therapists are unable to offer the clients containment, and explained that they were tentative for clients to begin therapeutic work in their bedrooms, which they may then associated with painful memories and flashbacks. Therapists who utilised creative therapies noted they could not use their normal toolkit of activities, such as interactive games, sand tray boxes, and other materials. This impacted children in particular as they would often have communicated their unconscious states of mind through play. Finally, a few therapists highlighted that relationships and rapport took longer to establish.

For hands-on therapists (e.g. massage),they were unable to conduct their therapies and were unable to ease some of the pain and suffering faced by clients.

Accessibility and convenience

There was a general consensus that increased accessibility of therapy was an advantage, especially for those who have been previously harder to engage due to distance or health issues. Therapists described occasions where they worked with clients outside of their normal geographical reach, which they wouldn't have considered possible before Covid-19. For some clients, it was easier to find time for video-calls because of the increased accessibility and flexibility; this has been particularly useful for clients with children. From the therapists' perspective, the significant reduction of travelling was an advantage. Previously, therapists could pend upwards of two hours driving on a round trip to a client's house, school, or to meetings; contributing to additional exhaustion. Therefore, the time-savings enabled therapists to offer more and longer appointment slots for clients, prepare and conduct training, liaise with other professionals, and improve in their practice. Therapists also acknowledged that remote-working was better environmentally and economically (petrol costs).

Technology

Technology was a significant theme which emerged from the interviews, however both client and therapists had varying experiences with it. What differed in responses as between the questionnaire and the interview, was that the RAS difficulties in accessing technology identified during the questionnaire were no longer significant problems by the time interviews were conducted. However, therapists noted that some clients had a lack of knowledge and/or ability to use technology, which was further exacerbated with many clients' levels of literacy. This particularly applied to women, where in some cases they couldn't use the technology at all, unless they had a husband or son to help them. For the clients who engaged with technology, therapists believed it was a positive experience through the new skills gained, increased connectivity to society, and subsequent empowerment. Therapists also mentioned that Covid-19 forced them to expand their skill set and acknowledged that their technological abilities had improved since the pandemic.

Relationship-building

Almost half of therapists mentioned that the pandemic helped equalise the power-dynamic between therapist and client, which they hypothesised was because Covid-19 had impacted society as a whole and refugees had not been singled out (RAS often feel targeted with abuse and hate crime, or regarded as objects of particular concern).Furthermore, one therapist mentioned how therapists had shown their vulnerability through technology glitches and their reactions to the pandemic e.g., illness, bereavement, which humanised the therapist and again helped to equalise the power balance. A few therapists reflected that the pandemic may have further deepened the therapeutic relationship as the client has clearly witnessed that the therapist cares about them through check-ins, messages, and ‘fighting their corner’ in Covid-19 related issues. This was further reinforced through the therapists’ creation of wellbeing and stress management groups, which provided additional support to clients during the pandemic. On the other hand, some therapists highlighted that relationships took longer to build online as opposed to face-to-face sessions.

Impact of Covid-19 ways-of-working on therapists

A key theme that came out from the interviews was that working from home meant therapists struggled to reflectand process from their own homes, recharge the batteries, and distance themselves from work. Therapists noted that they missed the small interactions, conversations, and informal support that they previously had with colleagues.

After Covid-19

The most significant finding is that all therapists stated they would incorporate remote ways-of-working, to some extent, if and when the Covid-19pandemic comes to an end.

The majority of therapists would still encourage face-to-face therapy where possible as they felt it has a better quality, offers containment, and therapists could observe body language. However, remote-therapy could ‘fill gaps’ in the future for clients who may struggle physically to access therapeutic services due to distance or health, during holidays, keeping in touch during a period where they aren’t doing face-to-face work, or involving family members who wouldn’t normally be engaged. One therapist noted that there is an opportunity to capitalise on the use of technology, creating online resources that could further support the wellbeing of clients such as YouTube videos, podcasts, and documents. Finally, a few therapists mentioned it may be difficult to go back to ‘normal’ ways-of-working and how it may be a ‘shock’ to begin face-to-face work, having adapted to remote-working.

Discussion

This sectioncritically evaluates the findings in relation to the projectaims, demonstrates how the study fits into the context of previous research, and assess the significance and limitations of the project.

Aim 1: Investigate the advantages and disadvantages of alternative methods of therapeutic delivery

A clear advantage of remote-working was the improved accessibility of therapy sessions, which increased the geographical reach of Solace and produced time and cost-savings for the therapist and organisation, which could then be invested into clients or for training other professionals. This is consistent with existing literature (Pesämaa et al. 2004; Simpson et al. 2005; García-Lizana and Muñoz-Mayorga 2010;Norwood et al. 2018). Interestingly, therapists highlighted that Covid-19 equalised the power-balance in the therapeutic relationship whilst previous research states that this occurred through the use of technology. Perhaps, it was a combination of both these factors.

Disadvantages included the loss of body language, the inability to offer containment, and difficulty in conducting creative-therapies (which particularly impacted children). Whilst body language is a frequently acknowledged limitation of remote-therapy (Wootton et al. 2003; Norwood et al. 2018; Knott et al., 2020), the lack of containment and inability to conduct creative therapies had not been highlighted in existing literature; perhaps because research had not studied video-therapy with children, those in unstable accommodations, or clients with significant trauma.

There were significant variations in experiences of remote ways-of-working. Whilst some believed it to be ‘just as good’ as face-to-face sessions, others described occasions where both therapist and client longed to be back to ‘normal’ face-to-face sessions. The use of technology was thought to be positive as it enabled general connectivity for clients, as well as broadening the client and therapist’s skill set. This is a unique finding as previous studies have not focused on groups which may not have previously had access to technology. However, the opposite was also said; some therapists and clients struggled to utilise the technology due to a lack of training or knowledge.

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As this study focuses on the experiences of therapists working with RAS, who are already marginalised within society, disadvantages possibly extended further thanother client groups explored in previous studies; for example, the varying literacy knowledge levels impact their technology use, and accommodation may be more of an inhibiting factor in finding a safe space for therapy.

Aim 2: Explore if there is a standard model which might fit all circumstances

The varying experiences of clients and therapists found in this study in regard to engagement and technology-ability coincides with previous research which states that suitability for remote ways-of-working is largely dependent on the personality of both client and therapist (Simpson et al. 2005). Therefore, in line with study findings and existing literature, the researcher concurs that there is no standard model which would fit all circumstances; sessions need to be tailored to suit individual client needs, supporting the growing awareness that all clients may not respond equally well to the same therapy delivery (Durham et al. 2000; Schmidt2003).

Aim 3: What lessons might be learnt for service delivery if and when the pandemic comes to an end.

Remote ways-of-working can be a beneficial tool to be utilised in the future, whether that be for team meetings, therapeutic services, or even on a smaller scale such as ‘top-ups’ or ‘check-ins’ with clients. Additionally, the fact that Covid-19 has taken away the fear of technology for some therapists and clients should be seen as a positive outcome. There is an opportunity to capitalise on the Covid-19 pandemic and the increasingly technological world it has left in its wake; with increased clients with phone and internet access, Solace and other organisations could provide online resources, such as videos, podcasts, or documents which can help reduce stress and improve wellbeing. Perhaps there is even opportunity to provide support to RAS outside the UK. The improved accessibility and subsequent time-savings appear to be a significant benefit of remote ways-of-working, which should be considered more in the future.

Significance of findings, limitations, and future research

The fact that all therapists interviewed considered incorporating remote ways-of- working after the pandemic suggest there may be a permanent change to the service delivery model at Solace, which is a significant finding. Covid-19 has ‘opened doors’ for alternative therapeutic service delivery, with one therapist stating ‘it would now be a shame to not offer online-therapy’. As mentioned earlier, some reported advantages and disadvantages such as technology empowerment/struggles, lack of safe space for therapy, and inability to conduct creative therapies may be specific to both the Covid- 19 context and of the RAS client group. Therefore, it is important to think critically regarding the distinction between remote working and Covid-19 induced ways-of-working e.g. therapists’ difficulties in recharging the batteries may be because of national lockdowns as opposed to remote-working. Whilst fairly consistent with previous research, this study’s small sample size and lack of insight into the client’s
experience of remote-therapy presents a limitation to findings. Therefore, research which gains insight into the client’s experience and whether there are certain personalities or client groups who are more likely to engage more with remote-working would be beneficial. Furthermore, in line with concerns expressed by therapists, future research should focus on the transition back to pre-Covid-19 ways-of-working and explore potential implications of a ‘hybrid model’.

Conclusion and Recommendations

The Covid-19 pandemic caused an immediate, involuntary, and significant change in Solace therapists' ways-of-working, however the adaptability of therapists and clients has been remarkable. Covid-19 appears to have opened doors for therapeutic service delivery at Solace, with therapists looking to incorporate remote ways-of-working in the future. This project successfully addresses the three outlined aims, and supports findings from previous research, such as the online-therapy advantages of improved accessibility, time-savings from travel reduction, increased engagement from some client groups, and disadvantages such as the loss of body language. However, other findings, particularly the advantage of technology in increasing connectivity for RAS and the equalising power-dynamic because of the Covid-19pandemic, and disadvantages such as the lack of access to a safe space and loss of creative- therapies, are possibly factors unique to the RAS and Covid-19 context. As a result of this study, recommendations for action include initiating conversations with clients regarding their preferred ways-of-working in the future; consider presenting the option for online or face-to-face organisational or external meetings; create or compile online resources to further improve client well-being; gain insight into the client's perspective on remote ways-of-working; and conduct research into the implications of a hybrid model.

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Appendices

Appendix 1 : Survey Questions

1. Please provide your name, email address and professional title

2. What style or type(s)of therapy do you offer?

3. How many clients do you have currently (approximately)?

4. Please describe how you were working with clients pre-Covid (i.e. individual sessions, weekly/daily etc, fixed venue -specify type [home, Solace office, public building etc],)

5. Please describe how you are working now with clients, emphasising the changes in relation to the previous answer and outlining the rationale for these changes

6. To what extent was client feedback/engagement used to inform changes to sessions? (please tick one)

7. Please explain briefly how they affected the changes and in what areas.

8. Please answer the following two questions:
a)What has been positive about the impact of these changes, if anything?
b)What has been negative about the impact of these changes?

9. If Covid-19 ended tomorrow, would you revert to your former way of working? (Yes or No) Please explain your response

10. Any other comments?

Appendix 2 – Semi-structured interview questions

For context setting:
Please could you explain the type of therapy that you do?
How would you usually have worked with clients before Covid-19?
-How often? Where?

Current context:
How has this changed since covid-19? How are you now working with clients? Did clients have much say in these changes to sessions?
-If yes, could you explain briefly how they affected these changes?

Impact:
How have the clients been impacted by these changes? What have been the positives about these changes?
-For both the client,
-and yourself
What have been the negatives about these changes?
-For both the client,
-and yourself
What have been the biggest challenges for the client?
What have been the biggest challenges for yourself as the therapist?

Have you received any feedback from clients? What feedback have you received?

Key themes questions
[If applicable to therapist responses]

Technology:
Have clients been able to access technology needed?
Have clients found the use of telephone/ video therapy presents specific problems for them?
How have you found the use of technology? Have there been positives/ negatives?

Access to a safe space:
Have your clients been able to find a safe space for the therapy sessions?
-Has this impacted therapy sessions?
-What happens if a client can't find a safe space to talk?

Loss of physical contact/body language
Has the loss of physical/face-to-face contact impacted your therapy sessions?

Are there other issues which this new way of working has thrown up?

After Covid:
A lot of the therapists, [including yourself] would say that they would offer a hybrid mix of both f2f and virtual sessions once the pandemic is over.
-[if applicable]
o Please could you explain a bit further why you would continue to offer both / go back to your usual ways of working

Are there any other ways of working that you would like to continue once this pandemic is over?

Working virtually, do you have any best practice or anything that worked particularly well that you would like to share with other therapists?

Do you have any final thoughts or comments that we haven’t talked about yet?

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.