Best practice for working with refugees and asylum seekers with mental health difficulties: Development of a service evaluation tool for Bradford District Care Trust Community Mental Health Team

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Introduction

In this Service Evaluation Project (SEP) I aimed to develop best practice guidelines for working with refugees and asylum seekers (RAS) in a community mental health team (CMHT) in Bradford. Here I will outline the background to and context of the report including the original aims for the project, along with what was completed. Please see

Appendices

Appendix A for a Glossary of definitions that may be helpful when reading this report.

Mental health of refugees and asylum seekers

In the year ending June 2021, over 31,000 people made asylum applications in the UK (Home Office, 2021b) and it has been estimated that between a third and a half of asylum seekers experience some form of mental distress (Hoare et al., 2017). A recent systematic review and meta-analysis found rates of Post-Traumatic Stress Disorder (PTSD) diagnosis to be around 31% in RAS populations (Blackmore et al., 2020); hugely higher than the estimated 3.7-5.1% in the general UK population (NHS Digital, 2021).

Although mental health difficulties in RAS are often attributed to traumatic past experiences in their country of origin, which may range from violence, torture, war conflict, violations of their human rights, and loss of loved ones, many other factors also contribute including both events experienced during the journey to the UK, and after arrival (Porter & Haslam, 2005; Tonsing & Vungkhanching, 2020). A flowchart illustrating the steps involved in the asylum-seeking process can be found in Appendix B. A study of 21 RAS in London found that all participants reported some

kind of mental health problem, with over half attributing trauma in their country of origin as a key reason for the difficulties (Palmer & Ward, 2007). However, all referred to the contribution of difficulties on arrival to the UK with one participant stating; “Here they think things will be easier but then you can’t find job or money or housing, study, national insurance number and there are all these problems that they didn’t know about. You lose hope and this causes depression” (Palmer & Ward, 2007; p.204).

If an individual’s asylum claim is accepted and they are granted refugee status, they have 28 days to find alternative accommodation and work before they lose their asylum benefits and provided accommodation. People are at high risk of becoming homeless or destitute at this time as they try and get paperwork in order, or risk further exploitation (Dwyer & Brown, 2005). Evidently, RAS face a multitude of social and financial issues that are likely to increase risk of experiencing mental health difficulties (Allen et al., 2014; Mckenzie et al., 2014).

Miller and Rasmussen (2017) propose an ecological model of migrant distress, whereby mental health difficulties in refugees stem not only from prior war/conflict exposure, but ongoing 'displacement-related stressors', which suggests that to effectively treat their mental health difficulties, other needs and stressors must be addressed first. This model was developed from their previous research which found that daily stressors in refugees lives partially mediate the relationship between prior war exposure and mental health difficulties (Miller & Rasmussen, 2010). Although not all asylum claims are made due to war conflict, this study provides evidence that suggests that poor quality of life in the host country may be the catalyst to development of mental health difficulties as a stressor in a diathesis-stress model. Consistent with this, Summerfield (1999) reported that when refugees are asked what

would help their situation, most will point to social and economic factors rather than psychological help. This is also consistent with Maslow's hierarchy of needs, which argues that before psychological needs such as esteem and belonging can be met, basic needs for food, shelter, and safety must be met first (Maslow, 1943).

Are the mental health needs of refugees and asylum seekers being met?

The Department of Health report on delivering race equality in mental health care recognised that RAS face barriers to accessing and using mental health services. Accordingly, they committed to an action plan which included aiming to develop more appropriate and responsive services for this population (Department of Health, 2005). There is scant research on RAS utilisation of mental health services, however, one systematic review found the rate of uptake to be much lower than the general population, despite having greater mental health needs (Satinsky et al., 2019). Reasons proposed for this mismatch in level of need versus help seeking include services not meeting the specific needs of RAS, cultural differences in attitudes towards mental health and stigma, language barriers, and difficulties accessing transport to get to appointments (Byrow et al., 2020; Vostanis, 2014). For example, it has been reported that refugees are more likely to describe mental distress using physical symptoms or observable behaviours, and to attribute it to religious or supernatural causes (Byrow et al., 2020), and therefore may not perceive Westernised mental health services as being able to help.

Bradford, City of Sanctuary

Bradford has been a home for asylum seekers and refugees dispersed by the Home Office since 1999 (City of Bradford Metropolitan District Council, n.d.), and is recognised as a City of Sanctuary by the national movement (City of Sanctuary UK, n.d.). Broadly, this recognises a city for working towards inclusion and equality for

refugees and people seeking sanctuary, gathering support from groups and organisations, engaging with the local authority, and sharing good practice. Yorkshire and the Humber accept a high number of asylum seekers, with Bradford taking a large proportion of those (Home Office, 2021a). As of the 30th of June 2021, Bradford local authority were supporting 1050 asylum seeking individuals in addition to a high number of resettled refugees, and likely others not known to the authorities (Home Office, 2021a).

Bradford is the fifth most income deprived local authority in England, with 30% of children under the age of 16 living in absolute poverty (City of Bradford Metropolitan District Council, 2020b), and 10% of households are overcrowded (City of Bradford Metropolitan District Council, 2020a). There is "considerable overlap" between areas recognised as deprived and those used to house dispersed asylum seekers in National Asylum Support Service (NASS) housing (Carter & El-Hassan, 2003; p.14). This means that already vulnerable individuals are likely to be placed in areas with socioeconomic issues where housing is run down and undesirable, they do not know anyone, and do not speak the language.

Commissioning

This Service Evaluation Project (SEP) was commissioned by Dr. Emma Van der Gucht, Consultant Clinical Psychologist within Bradford District Care NHS Foundation Trust (BDCT). BDCT are committed to reducing health inequalities and barriers to mental health care provision for Bradford's RAS population.

Aims

This SEP originally aimed to:

1. Identify best practice in the delivery of mental health services for refugees and asylum seekers
2. Create a service evaluation tool in accordance with identified best practice
3. Implement the tool in Bradford City CMHT, and use data to provide feedback on areas of good practice, and identify areas for development within the service

Due to difficulties with data collection, we were unable to pilot the service evaluation tools as despite distribution to care co-ordinators within the team and service users identified as appropriate participants, no responses were received within the available time frame. Consequently, the write up of this SEP will focus on the first two aims which will be presented as two parts.

Part One: Identifying best practice for working with RAS with mental health difficulties.

Part Two: Creating a service evaluation tool.

Part One

Method

Scoping review

Scoping reviews are one method of reviewing existing literature on a topic area, intended to achieve breadth and depth of findings rather than answering a highly specific research question (Arksey & O'Malley, 2005), therefore a scoping review was thought to be the most appropriate format of literature review for this SEP. Using this methodology allowed review of any literature or documentation deemed to be relevant regardless of study design, and did not require quality-checking of included

studies which was appropriate for the time frame of the SEP. (Arksey & O'Malley, 2005).

Figure 1 below summarises the steps involved in a scoping review, which are described in detail in Arksey and O'Malley (2005). These steps were broadly followed, please see Appendix C for a detailed explanation of steps followed. Any sources found to contain relevant information are charted in Appendix D following guidance from the Joanna Briggs Institute (Peters et al., 2020).

Figure 1. Summary of a scoping review, taken from Arksey and O'Malley (2005).

Interviews

Key stakeholders were selected for interview by contacting NHS services, charities, and social enterprises in West Yorkshire that work with RAS and enquiring as to whether their staff would be willing to be interviewed about their work with refugees and asylum seekers, and mental health services for RAS more broadly. All staff willing to participate were interviewed. Interviews lasted approximately 60 minutes and were carried out over Zoom. Interviews were not recorded; however detailed notes were taken with some direct quotes. All participants gave consent for the information they shared to be included in this SEP report, and for anonymised direct quotes to be used. An informal approach was taken, as it seemed most appropriate to engage the stakeholders in conversation and allow them to speak more freely about the topic area. Accordingly, interviews were semi-structured, with four key questions asked to each interviewee with relevant follow-up questions and discussion based on their answers.

The key questions were:

- How does [insert service] work with RAS?
- Can you tell me about your role within [insert service]?
- From your work with RAS, what do you think mental health care/services should look like with this population?
- What do you think are the barriers to accessing mental health services for RAS?

Four interviews were successfully conducted with a GP at a local specialist practice; a Clinical Director of a charity, a safeguarding lead of a service, and a Psychological Therapist, all of whom had direct experience working with RAS. I also contacted a local community space, a specialist NHS outreach team, and two other local charities, however I was unsuccessful in arranging a meeting with them.

Ethical approval

Ethical approval for this SEP was granted by the School of Medicine Ethics Committee at the University of Leeds on 02/08/2021 (Ethics number: DClinREC 20-015).

Results

Here, the information gathered from the scoping review will be presented as a narrative review, integrated with the information gathered from the interviews, and summarised according to themes.

Therapy provision

The Refugee Council reported that in March 2021 there were over 50,000 individuals who had been waiting over 6 months to receive a decision regarding their

asylum claim, and over 33,000 had waited for more than a year (Hewett, 2021). The GP interviewee discussed the impact this can have on the acceptance of referrals of RAS for CMHTs, stating that referrals are often rejected due to unstable living circumstances. Despite this, there is evidence that therapy with asylum seekers is beneficial and can result in good outcomes (Lambert & Alhassoon, 2015; Slobodin & De Jong, 2015; Ter Heide et al., 2016). Other interviewees had differing opinions about the appropriateness of therapy for asylum seekers due to the potential of deportation mid-way through therapy, which could cause further harm from an uncontained ending. However, all agreed that safety and stabilisation work can and should be offered regardless of an individual's asylum status. Clinicians should enquire as to whether there is an ongoing asylum claim to determine the appropriateness of offering other therapies.

The Clinical Director (CD) and Psychological Therapist (PT) emphasised the importance of offering RAS choice in the gender of their therapist, particularly in cases where an individual has experienced sexual violence. The literature does not support the notion that having choice over therapist gender influences therapy outcomes (Blow et al., 2008), however it is possible that service users who are unable to have a request for a certain gender facilitated do not engage in therapy at all, particularly in cases where the individual has previously experienced sexual violence.

The BPS recommend that clinicians consider the configuration of the therapy/assessment room, for example ensuring that the service user can face a window in a small room, or away from the window if it has bars on (Douglas et al., 2018). Several interviewees acknowledged that NHS therapy rooms are furnished in a very basic manner and that it can be difficult to change the layout of rooms in

accordance with this guidance, however all agreed on the importance of exploring whether the service user feels safe to be seen in the building.

Barriers to access

A large systematic review found that the key barriers to help-seeking in refugees included mental health stigma and differing knowledge/beliefs, finance and language, and a lack of trust in authority figures (Byrow et al., 2020). All interviewees discussed the financial difficulties faced by RAS. The BPS guidelines recommend that Psychologists working with RAS check whether they qualify for reimbursements of travel costs (Douglas et al., 2018). All agreed that reimbursement for travel costs is crucial to widen access and suggested an alternative option of offering appointments at locations within walking distance for the service user if possible. A further barrier not mentioned within the literature is a lack of childcare. The PT shared that RAS families without a support network that cannot afford paid childcare are forced to bring children to appointments, which is inappropriate for therapy and may mean they feel unable to speak freely about their concerns.

Importance of a holistic approach

Mind (2009) reported a lack of co-ordination between primary care trusts and local health boards regarding meeting the needs of RAS, which results in a greater burden on the volunteer sector. Consistent with this, the GP stated that RAS need a "proper orientation" to services where they are advised what is and is not available within the NHS. The GP also stated that care co-ordinators have a crucial role in liaising between services to ensure that service users do not "fall in the gaps", and to build trust with regards to confidentiality, respect, and trust, which is often

lacking in this group due to previous negative experiences with authority (Byrow et al., 2020).

Tonsing and Vungkhanching (2020) found that the number of post-migration living difficulties (PMLDs; which include access to healthcare, difficulty adapting to the host country, and financial issues amongst others) significantly predicted psychological distress. The safeguarding lead (SL) stated "therapeutic work is not effective if a family is struggling financially", highlighting the difficulty in addressing psychological trauma if an individual's basic needs are not being met.

Strijk et al. (2011) surveyed RAS in the Netherlands and found a high prevalence of unmet needs and psychological distress. The most common unmet needs were company (73.3%), purposeful activities (56.7%), and travel (46.7%) (Strijk et al., 2011). Lack of social support and the loss of close interpersonal relationships has been identified in other research as being a key factor in leading to poor psychological wellbeing in RAS in the UK (Taylor et al., 2020).

The BPS guidelines aforementioned emphasise the importance of a holistic approach to care, where if a service cannot provide biopsychosocial care they should signpost to and liaise with other services (e.g. a GP, food bank, or community group) (Douglas et al., 2018). Priebe et al. (2016) reviewed evidence on mental health care for RAS in Europe and recommended that mental health services should facilitate RAS access to other services.

Unique needs

RAS have specific physical health needs; they are more likely to have suffered female genital mutilation (FGM; Novak-irons, 2015), to have had a head injury (McPherson, 2019), and to experience chronic pain (Hodes et al., 2001). The PT

shared that most of her RAS therapy clients experience chronic pain. Psychological services should screen for these issues during assessment with RAS and offer cognitive assessment when appropriate, and/or signpost to specialist services.

Asylum seekers also have ongoing legal needs whilst awaiting a decision on their asylum claim. Rhodes (2016) recommended that clinicians enquire whether the individual is currently seeking asylum, what stage of the process they are in, and whether they are receiving any other support, which the PT also recommended. BPS guidance recommends that clinicians offer to write a letter in support of an individual's legal claim (Douglas et al., 2018)

Language and communication

The GP stated that around a third of their patients require an interpreter, and emphasised the need to consider dialect, as dialects within the same language can be mutually unintelligible. However, interpretation services and knowledge of how to work appropriately with interpreters are limited (Mind, 2009). The BPS state that interpreters should always be used when needed (Douglas et al., 2018), and have produced specific guidance for Psychologists working with them (The British Psychological Society, 2017b). They recommend that family members are not used as interpreters due to issues with confidentiality, and the possibility that non-professional interpreters may subtly change meaning (Searight & Armock, 2013). They also advise allowing at least 10 minutes at both the start and end of the appointment to brief and debrief the interpreter. This is crucial to allow discussion of any cultural issues ahead of the appointment, and to offer appropriate support if traumatic material is discussed (The British Psychological Society, 2017b).

The PT commented that RAS are often excluded from opportunities to feed back about their experience of care because outcome and evaluation measures are not usually translated into their preferred language. The PT also identified that crisis and contingency care plans should be made available in the individual's own language, which the BPS recommends (Douglas et al., 2018), but in her experience does not usually occur.

Fennig and Denov (2021) synthesised research on interpreters working with refugees in mental health settings, which supported what was shared in interviews. Some RAS express concerns about confidentiality and stigma when working with interpreters, and worry they will talk to others in the community about their difficulties (Palmer & Ward, 2007). Despite these concerns, interpreters are essential to provide effective services; in Bradford alone there are over 120 different languages spoken (Office for National Statistics, 2011).

Cultural awareness

Research has suggested that culture can influence how individuals express psychological distress, as well as the meaning and perception of trauma (Suhaiban et al., 2019). Mind (2009) report that there is a lack of cultural awareness, poor understanding of refugee issues, and limited provision of culturally sensitive mental health services.

Rhodes (2016) recommend that staff new to working with RAS should research the service users' religion, country of origin, and common abuses of human rights there. However, the CD disagreed and stated that although cultural awareness is important, clinicians must be mindful to not assume experiences and to always treat the person as an individual. The CD also added that clinicians should regularly check

mutual understanding throughout appointments as the clinician may have a differing opinion on what the 'problem' is (Byrow et al., 2020). Priebe et al. (2016) identified barriers to mental health care and recommendations for good practice in this population group, and reported that RAS may have difficulties trusting public organisations based on experiences of persecution in their host country, and recommended that professionals should have training in cultural awareness when working with migrant groups.

Protective factors

Posselt et al. (2019) carried out a systematic review of psychological wellbeing in RAS, and found eight factors to be supportive of this; social support; faith, religion and spirituality; cognitive strategies; education and training opportunities; employment and economic activities; behavioural strategies; political advocacy; and environmental conditions. The CD recommended that clinicians enquire about presence of social support and meaningful activity, as these protective factors are often lacking in this population group.

Taylor and colleagues (2020) found that in a study of 12 RAS in the UK, connecting to God and religious or spiritual beliefs were perceived as being helpful coping strategies. Evidently, it is a potential protective factor that should be explored within a mental health service.

'Post-traumatic growth' (PTG) was frequently mentioned in the literature but not by interviewees, referring to positive psychological change following traumatic life circumstances (Tedeschi et al., 1998). Chan, Young, and Sharif (2016) reviewed factors that facilitate PTG in refugees. Social support was found to enable PTG,

however findings regarding religiosity were mixed and may depend on whether the individual uses positive or negative religious coping.

In summary, the key themes identified were:

1. Therapy provision: the importance of offering this whilst considering the psychological safety of RAS
2. Barriers to access: identifying them, and how to reduce/remove them
3. The importance of a holistic approach to care provision: the need for services to liaise, signpost, and work together to provide biopsychosocial care
4. Language and communication: the need for interpreting and translation services, and concerns regarding these
5. Unique needs: RAS are more likely to have suffered FGM or a head injury, experience chronic pain, and have ongoing legal needs
6. Cultural awareness: there is often a lack of this within mental health services
7. Protective factors: these may help to offset psychological distress, particularly social support, and access to meaningful activity

These themes were key to the development of the service evaluation tool, which will be explained in Part Two.

Part two

Method

Development of the tool

Principles from thematic analysis were used to inform the creation of the service evaluation tool with the data gained from the scoping review and interviews. However, due to the nature of the evaluation, not all of these were followed up. Figure 2 below illustrates the steps usually involved in thematic analysis, which are described in detail in Braun and Clarke (2006). I did not formally generate codes due to the nature of the data; interviews were not transcribed and there were insufficient direct quotes to create codes. Instead, I proceeded from familiarising myself with the data to searching for relevant themes and patterns.

Figure 2. A summary of the steps involved in thematic analysis (Braun & Clarke, 2006).

The identified themes and data gathered from the scoping review and interviews map directly onto the questions in the service evaluation tool which is illustrated in Appendix E.

Credibility check and researchers' perspective

Credibility was achieved by sharing the themes and findings with one of the interviewees and incorporating their suggestions into the final narrative review and results. In disseminating the tools widely, other clinicians have also had the chance to comment and offer feedback. A draft of the tool was reviewed with the PT. A Psychiatrist working for a relevant charity was also able to offer some feedback

however unfortunately this received after the questionnaires had been finalised and distributed. This feedback can be found in Appendix F.

During clinical placements as part of the DClinPsy I have had opportunities to work with RAS, and I am passionate about social justice and improving equity of provision of mental health services. I reflected upon my position and possible biases in completing the narrative review and service evaluation tool during discussions with the commissioner and my academic tutor. I have heard first-hand descriptions of the difficulties RAS have faced both in accessing services in a timely way, and the cultural insensitivity of services when they are provided. It is likely that this will have influenced my perspective in favour of the need for services to develop and change in response to this.

Results

Two service evaluation tools for use with RAS service users and their clinicians were developed, and can be seen in Appendix G and H. Each tool is formatted as a questionnaire with two sections. Section 1 contains 24 questions which are answered by ticking to indicate 'yes', 'no', or 'not applicable', for example "Was an interpreter provided if English isn't your first language?". The questionnaires also include a question about the impact of Covid-19, as early research has found this to have disproportionately impacted RAS (Kluge et al., 2020).

Section 2 comprises of a table with tick-boxes to indicate whether key areas of additional need were enquired about, and whether signposting was provided to where further support could be accessed.

Piloting the tool

A Support Worker used SystmOne records to identify which CMHT service users were RAS. Eight service users were identified under four care co-ordinators. The questionnaires, easy read information sheet, and consent form (see Appendices G-K) were translated into Arabic, Iraqi Arabic, Malawi, Polish, Urdu, and Slovakian for distribution. Service users were provided with pre-paid envelopes to return the questionnaires anonymously without financial burden. Unfortunately, no questionnaires were returned within the time frame of the SEP.

Discussion

Here I will discuss strengths and limitations of the scoping review, interviews, and the audit tool. I will end with some consideration of the clinical implications of the developed tool, and finally propose recommendations for the service.

Strengths

This SEP has several strengths. It has developed a novel service evaluation tool to assess the standard of care provision for RAS in a CMHT setting. This could highlight areas of good practice for clinicians working with this population group, but also bring attention to areas where improvement is needed both within BDCT and other services nation-wide, which could assist in requests for service funding. It was created using expertise from both published and grey literature, and experts currently working with this population group thus allowing for academic input in addition to 'on the ground' sources.

The SEP has also drawn from critical and community psychology approaches that look to consider social and economic inequalities and how this can impact well-being, rather than an individual model of distress that pathologizes the individual

(Miller & Rasmussen, 2017; Parker, 2007). Although some individual approaches to treatment have been discussed, e.g., offering of therapy, this SEP has largely aimed toward promoting a holistic model of care for refugees and asylum seekers, where services are able to work collaboratively. Ideally, biopsychosocial care would be provided by a specialist service, but where this is not possible liaison between services is essential to ensure physical and mental health needs are met.

Limitations

The original plan for this SEP placed more focus on reporting on what the service is currently doing well and where there may be room for improvement based on the data collected. Accordingly with no data there was less focus on the scoping review and interviews. With hindsight, knowing that these would form a larger part of the project and write up, I would have recorded and transcribed the interviews. This would have resulted in more direct quotes from interviewees to be coded and used for a methodologically sound thematic analysis rather than the more informal approach taken. Secondly, it would have been preferable to interview RAS as experts by experience to give them a voice, but unfortunately this was not possible due to the additional cost of an interpreter.

Scoping reviews do not include critical appraisal of the included studies (Arksey & O'Malley, 2005), making it harder to draw conclusions about the reliability of information being reported. There were no other formal exclusion criteria for the literature search than non-English articles, which may also have impacted on the quality of evidence gathered. Due to the breadth of information collected from a scoping review, decisions are made about what information was most relevant to include and therefore another researcher or clinician may come to different conclusions about what is most important.

Refugees and asylum seekers were grouped in this project. Although they share some characteristics and previous experiences, they are not a homogenous group and have different entitlements and protection. A research study found that refugees with temporary protection visas had significant more psychiatric symptoms than refugees with permanent visas, despite experiencing similar levels of past trauma and persecution (Momartin et al., 2006). In future separate service evaluation tools could be developed based on specific guidance for working with refugees or asylum seekers, however, most existing research considers them a homogenous group. This SEP also did not specifically include or make reference to failed asylum seekers who again, have different entitlements to RAS (British Medical Association, 2020) but face similar threats.

Clinical implications

In this SEP, recommendations for involving vulnerable migrants in research were followed where possible (Van Den Muijsenbergh et al., 2016), including provision of a pre-paid return envelope and providing materials in an easy-read and translated format. Despite these efforts, no questionnaires were returned, which could illustrate the difficulty of implementing the tool into services in future.

To professionally translate three documents required for the tool into six languages cost approximately £1000. One of the good practice recommendations identified from the interviews was ensuring that letters and care documents are translated into the service user's preferred language. In Bradford alone there are an estimated 120+ languages spoken (Office for National Statistics, 2011), making interpretation and translation services essential. The process of arranging these translations illustrated the prohibitive cost of doing so in NHS services, and the need

for a gate-kept part of the budget for interpretation and translation services within mental health departments.

Conclusion and recommendations

In conclusion, this SEP achieved its aims of reviewing standards of best practice for working with RAS in a CMHT and developing a service evaluation tool to assess adherence to these standards. The following recommendations were identified:

- For a future SEP to pilot the tool and collect data
- Further amendments should be made to the tools based on additional feedback, and with further research
- For BDCT to collect data on whether service users are RAS to facilitate providing the best possible standard of care that meets their specific needs

5 Dissemination

This SEP was presented at the University of Leeds DClinPsychol SEP Conference 2021. The developed tools and recommendations have been shared with senior staff and Equality and Diversity leads within the team and wider trust. The SEP will feed into a new project under the Act as One partnership (Bradford and Craven) for improving joint working between services for RAS. The SEP is due to be presented at the Trust's Cultural Curiosity Training in February. A summary of the findings will be shared with the services who contributed to development of the tool and provided feedback, Avon and Wiltshire Refugee Service, and the Traumatic Stress Wales RAS pathway.

References

Allen, J., Balfour, R., Bell, R., & Marmot, M. (2014). Social determinants of mental health. *International Review of Psychiatry*, *26*(4), 392–407. https://doi.org/10.3109/09540261.2014.928270

Arksey, H., & O'Malley, L. (2005). Scoping studies: Towards a methodological framework. *International Journal of Social Research Methodology: Theory and Practice*, *8*(1), 19–32. https://doi.org/10.1080/1364557032000119616

Blackmore, R., Boyle, J. A., Fazel, M., Ranasinha, S., Gray, K. M., Fitzgerald, G., Misso, M., & Gibson-Helm, M. (2020). The prevalence of mental illness in refugees and asylum seekers: A systematic review and meta-analysis. *PLoS Medicine*, *17*(9), 1–24. https://doi.org/10.1371/journal.pmed.1003337

Blow, A. J., Timm, T. M., & Cox, R. (2008). The role of the therapist in therapeutic change: Does therapist gender matter? *Journal of Feminist Family Therapy*, *20*(1), 66–86. https://doi.org/10.1080/0895280801907150

British Medical Association. (2020). *Refugees' and asylum seekers' entitlement to NHS care*. Refugee and Asylum Seeker Patient Health Toolkit.

Byrow, Y., Pajak, R., Specker, P., & Nickerson, A. (2020). Perceptions of mental health and perceived barriers to mental health help-seeking amongst refugees: A systematic review. *Clinical Psychology Review*, *75*(July 2018), 101812. https://doi.org/10.1016/j.cpr.2019.101812

Carter, M., & El-Hassan, A. A. (2003). *Between NASS and a hard place: Refugee housing and community development in Yorkshire and Humbersire: a feasibility study*.

Chan, K. J., Young, M. Y., & Sharif, N. (2016). Well-being after trauma: A review of posttraumatic growth among refugees. *Canadian Psychology*, *57*(4), 291–299. https://doi.org/10.1037/cap0000065

City of Bradford Metropolitan District Council. (n.d.). *What is a City of Sanctuary?* City of Sanctuary. Retrieved April 12, 2021, from https://www.bradford.gov.uk/your-community/asylum-seekers-and-refugees/city-of-sanctuary/

City of Bradford Metropolitan District Council. (2020a). *A Place to Call Home, a Place to Thrive: Housing Strategy for Bradford District 2020-2030*.

City of Bradford Metropolitan District Council. (2020b). Poverty and deprivation. In *Understanding Bradford District*. https://doi.org/10.1201/9781315379845-7

City of Sanctuary UK. (n.d.). *Welcome to Bradford City of Sanctuary*. Bradford City of Sanctuary.

Department of Health. (2005). *Delivering race equality in mental health care: An action plan for reform inside and outside services and the Government's response to the Independent inquiry into the death of David Bennett*. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4100773

Doherty, S. M., Craig, R., Gardani, M., & McMillan, T. M. (2016). Head injury in asylum seekers and refugees referred with psychological trauma. *Global Mental Health*, *3*(28), 1–5. https://doi.org/10.1017/gmh.2016.23

Douglas, A., Farsimadan, F., Hughes, J. H., Hawker, D., Hulusi, H., Patel, N., Papadopoulos, R., Robjant, K., Searle, R., Tribe, R., Yule, W., & Zlotowitz, S.

(2018). *Guidelines for psychologists working with refugees and asylum seekers in the UK: Extended version* (Issue February).

Dwyer, P., & Brown, D. (2005). Meeting Basic Needs? Forced Migrants and Welfare. *Social Policy and Society*, *4*(4), 369–380. https://doi.org/10.1017/s1474746405002538

Fennig, M., & Denov, M. (2021). Interpreters working in mental health settings with refugees: An interdisciplinary scoping review. *American Journal of Orthopsychiatry*, *91*(1), 50–65. https://doi.org/10.1037/ort0000518

Gov.uk. (n.d.). *About Us*. Retrieved April 6, 2021, from https://www.gov.uk/government/organisations/home-office/about

Hewett, A. (2021). *Living in Limbo: A decade of delays in the UK asylum system* (Issue July).

Hoare, T., Vidgen, A., & Roberts, N. (2017). In their own words: a synthesis of the qualitative research on the experiences of adults seeking asylum. A systematic review of qualitative findings in forced migration. *Medicine, Conflict and Survival*, *33*(4), 273–298. https://doi.org/10.1080/13623699.2017.1419902

Hodes, M., Macdonald, B. K., Mummery, C. J., & Heaney, D. (2001). Health needs of asylum seekers and refugees. *British Medical Journal*, *323*(7306), 229. https://doi.org/10.1136/bmj.323.7306.229/a

Home Office. (2021a). *Section 95 support by local authority*. Asylum and Resettlement Datasets.

Home Office. (2021b). *Summary of latest statistics: How many people do we grant asylum or protection to?* Immigration Statistics, Year Ending June 2021.

https://www.gov.uk/government/statistics/immigration-statistics-year-ending-june-2021/summary-of-latest-statistics#how-many-people-do-we-grant-asylum-or-protection-to

Kluge, H. H. P., Jakab, Z., Bartovic, J., D'Anna, V., & Severoni, S. (2020). Refugee and migrant health in the COVID-19 response. *The Lancet*, *395*(10232), 1237–1239. https://doi.org/10.1016/S0140-6736(20)30791-1

Lambert, J. E., & Alhassoon, O. M. (2015). Trauma-focused therapy for refugees: Meta-analytic findings. *Journal of Counseling Psychology*, *62*(1), 28–37. https://doi.org/10.1037/cou0000048

Maslow, A. H. (1943). A Theory of Human Motivation. *Psychological Review*, *50*, 370–396.

Mckenzie, S. K., Gunasekara, F. I., Richardson, K., & Carter, K. (2014). Do changes in socioeconomic factors lead to changes in mental health? Findings from three waves of a population based panel study. *Journal of Epidemiology and Community Health*, *68*(3), 253–260. https://doi.org/10.1136/jech-2013-203013

McPherson, J. I. (2019). Traumatic brain injury among refugees and asylum seekers. *Disability and Rehabilitation*, *41*(10), 1238–1242. https://doi.org/10.1080/09638288.2017.1422038

Miller, K. E., & Rasmussen, A. (2010). War exposure, daily stressors, and mental health in conflict and post-conflict settings: Bridging the divide between trauma-focused and psychosocial frameworks. *Social Science and Medicine*, *70*(1), 7–16. https://doi.org/10.1016/j.socscimed.2009.09.029

Miller, K. E., & Rasmussen, A. (2017). The mental health of civilians displaced by

armed conflict: An ecological model of refugee distress. *Epidemiology and Psychiatric Sciences*, *26*(2), 129–138. https://doi.org/10.1017/S2045796016000172

Mind. (2009). *A civilised society: mental health provision for refugees and asylum-seekers in England and Wales*. http://www.scie-socialcareonline.org.uk/a-civilised-society-mental-health-provision-for-refugees-and-asylum-seekers-in-england-and-wales/r/a11G00000017w9uIAA

Momartin, S., Steel, Z., Coello, M., Aroche, J., Silove, D. M., Brooks, R., & Journal, M. (2006). A comparison of the mental health of refugees with temporary versus permanent protection visas. *Medical Journal of Australia*, *185*(7), 357–361.

NHS Digital. (2021). *Adult Psychiatric Morbidity Surveys*. Mental Health and Wellbeing Surveys Directions 2021.

Novak-irons, F. (2015). Female genital mutilation: a case for asylum in Europe. *Forced Migration Review*, *49*, 77.

Office for National Statistics. (2011). *2011 Census aggregate data*. https://doi.org/http://dx.doi.org/10.5257/census/aggregate-2011-1

Palmer, D., & Ward, K. (2007). “Lost”: listening to the voices and mental health needs of forced migrants in London. *Medicine, Conflict, and Survival*, *23*(3), 198–212. https://doi.org/10.1080/13623690701417345

Parker, I. (2007). *Critical Psychology: What It Is and What It Is Not*. https://doi.org/10.1111/j.1751-9004.2007.00008.x

Peters, M., Godfrey, C., McInerney, P., Munn, Z., Trico, A., & Khalil, H. (2020). Chapter 11: Scoping Reviews. In *JBI Manual for Evidence Synthesis*. JBI.

https://doi.org/10.46658/JBIMES-20-12

Phelen, M., Slade, M., Thornicroft, G., Dunn, G., Holloway, F., Wykes, T., Strathdee, G., Loftus, L., McCrone, P., & Hayward, P. (2018). The Camberwell Assessment of Need: the validity and reliability of an instrument to assess the needs of people with severe mental illness. *The British Journal of Psychiatry*, *167*(5), 589–595.

Porter, M., & Haslam, N. (2005). Predisplacement and Postdisplacement Factors Associated with Mental Health of Refugees and Internally Displaced Persons. *The Journal of the American Medical Association*, *294*(5), 610–612. http://jama.jamanetwork.com/article.aspx?articleid=201335

Posselt, M., Eaton, H., Ferguson, M., Keegan, D., & Procter, N. (2019). Enablers of psychological well-being for refugees and asylum seekers living in transitional countries: A systematic review. *Health and Social Care in the Community*, *27*(4), 808–823. https://doi.org/10.1111/hsc.12680

Priebe, S., Giacco, D., & El-Nagib, R. (2016). Public Health Aspects of Mental Health Among Migrants and Refugees: A Review of the Evidence on Mental Health Care for Refugees, Asylum Seekers and Irregular Migrants in the WHO European Region. In *Health Evidence Network Synthesis Report 47*.

Rhodes, E. (2016). *Exploring the unique needs of asylum-seekers and refugees*. The Psychologist. https://thepsychologist.bps.org.uk/volume-29/november-2016/exploring-unique-needs-asylum-seekers-and-refugees

Satinsky, E., Fuhr, D. C., Woodward, A., Sondorp, E., & Roberts, B. (2019). Mental health care utilisation and access among refugees and asylum seekers in Europe: A systematic review. *Health Policy*, *123*(9), 851–863.

https://doi.org/10.1016/j.healthpol.2019.02.007

Searight, H. R., & Armock, J. A. (2013). Foreign language interpreters in mental health: A literature review and research agenda. *North American Journal of Psychology*, *15*(1), 17–38.

Slobodin, O., & De Jong, J. T. V. M. (2015). Mental health interventions for traumatized asylum seekers and refugees: What do we know about their efficacy? *International Journal of Social Psychiatry*, *61*(1), 17–26. https://doi.org/10.1177/0020764014535752

Strijk, P. J. M., Van Meijel, B., & Gamel, C. J. (2011). Health and Social Needs of Traumatized Refugees and Asylum Seekers: An Exploratory Study. *Perspectives in Psychiatric Care*, *47*(1), 48–55. https://doi.org/10.1111/j.1744-6163.2010.00270.x

Suhaiban, H. A., Grasser, L. R., & Javanbakht, A. (2019). Mental health of refugees and torture survivors: A critical review of prevalence, predictors, and integrated care. *International Journal of Environmental Research and Public Health*, *16*(13). https://doi.org/10.3390/ijerph16132309

Summerfield, D. (1999). A critique of seven assumptions behind psychological trauma programmes in war-affected areas. *Social Science and Medicine*, *48*(10), 1449–1462. https://doi.org/10.1016/S0277-9536(98)00450-X

Taylor, S., Charura, D., Williams, G., Shaw, M., Allan, J., Cohen, E., Meth, F., & O'Dwyer, L. (2020). Loss, Grief, and Growth: An Interpretative Phenomenological Analysis of Experiences of Trauma in Asylum Seekers and Refugees. *Traumatology*, *February*, 1–33. https://doi.org/10.1037/trm0000250

Tedeschi, R. G., Park, C. L., & Calhoun, L. G. (1998). *Posttraumatic growth: Positive changes in the aftermath of crisis* (1st ed.). Routledge.

Ter Heide, F. J. J., Mooren, T. M., Van De Schoot, R., De Jongh, A., & Kleber, R. J. (2016). Eye movement desensitisation and reprocessing therapy v. stabilisation as usual for refugees: Randomised controlled trial. *British Journal of Psychiatry*, *209*(4), 311–318. https://doi.org/10.1192/bjp.bp.115.167775

The British Psychological Society. (2017a). *Position Statement: The need for psychosocial care and support for refugees and asylum seekers*.

The British Psychological Society. (2017b). Working with interpreters: Guidelines for psychologists. *British Psychological Society*, *November*, 1–33. https://www.bps.org.uk/news-and-policy/working-interpreters-guidelines-psychologists

Tonsing, K. N., & Vungkhanching, M. (2020). The relationship between postmigration living difficulties, social support, and psychological distress of burmese refugees in the United States. *Asian American Journal of Psychology*, *11*(3), 179–186. https://doi.org/10.1037/aap0000200

UK Government. (n.d.). *Claim asylum in the UK*. Retrieved April 12, 2021, from https://www.gov.uk/claim-asylum/eligibility

Van Den Muijsenbergh, M., Teunissen, E., Van Weel-Baumgarten, E., & Van Weel, C. (2016). Giving voice to the voiceless: How to involve vulnerable migrants in healthcare research. *British Journal of General Practice*, *66*(647), 284–285. https://doi.org/10.3399/bjgp16X685321

Vostanis, P. (2014). Meeting the mental health needs of refugees and asylum seekers.

British Journal of Psychiatry, *204*(3), 176–177.

https://doi.org/10.1192/bjp.bp.113.134742

Appendices

Appendix A

Glossary and definitions

Appeal rights exhausted (ARE) – Used to describe people who have exhausted their opportunities to challenge a negative decision on their asylum claim.

Asylum seeker = People seeking international protection abroad, but who are not yet recognised as a refugee". They will have applied on the basis of the UN Refugee Convention or Article 3 of the European Convention on Human Rights (Convention Relating to the Status of Refugees, 1951). They have asked to be recognised as a refugee and are awaiting a decision from the Home Office. To claim asylum in the UK, an individual must be able to prove they are unable to live safely in any part of their country of origin due to fear of persecution, which could be due to race, religion, nationality, political opinion, or anything else that could put someone at risk due to the countries sociocultural, religious, or political situation (UK Government, n.d.). Asylum seekers are known to the authorities and part of an ongoing legal process.

Dispersal – Where asylum seekers requesting accommodation support are sent to different areas around the UK on a no-choice basis.

Healthcare entitlements – Refugees are entitled to receive all NHS services free of charge. Asylum seekers can receive primary and secondary care for free, so long as they have an active application or appeal ongoing. Refused or ARE asylum seekers can receive primary care for free but can only receive secondary care free of charge under specific circumstances; if the care is immediately urgent or necessary, or for conditions caused by torture or domestic or sexual violence (British Medical Association, 2021).

Home Office – the lead government department for immigration and passports, drugs policy, crime, fire, counter-terrorism, and police (Gov.uk, n.d.).

Indefinite Leave to Remain (ILR) – Also known as 'settled status'. This grants permission to stay in the UK permanently without immigration or travel restrictions. The current fee for application is currently £2389, which also requires the individual to prove their English language proficiency and pass the 'Life in the UK' test. This is not the same as British Citizenship – people with this permission still cannot get a British passport or vote in general elections.

Limited/discretionary leave to remain – Also known as 'refugee status'. This grants temporary permission to stay in the UK for up to five years, after which the individual is eligible to apply for indefinite leave to remain.

National Asylum Support Service (NASS) – NASS administer the Section 4 or Section 95 support provided to eligible asylum seekers who would otherwise be destitute, in addition to providing accommodation on a no choice basis. This accommodation covers initial accommodation for 3-4 weeks, before an individual is moved on to dispersal accommodation for the longer-term whilst awaiting a result on their asylum claim. It is provided by private companies under contract with NASS.

Refugee = The 1951 Convention Relating to the Status of Refugees, defines a refugee as: "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. Someone who is outside the country of his/her nationality and is unable or, owing to such fear, is unwilling to avail himself/herself of the protection of that country; or who, not having a nationality and being outside the country of his/her former habitual residence is unable, or owing to such fear, is unwilling to return to it." (Convention Relating to the Status of Refugees, 1951).

Refused asylum seeker = Someone who has had their claim for asylum refused because the Home Office has decided that they do not need protection in the UK. This is also referred to as a 'failed' asylum claim.

Section 4 Support – The Home Office can provide housing and financial support to someone who has been refused asylum if they can prove one of the following: taking all reasonable steps to leave the UK, unable to leave UK due to physical impediment, no safe route of return, granted leave to appeal, requiring support to avoid a breach of their human rights. This is known as Section 4 support. Financial support of £39.63 per week is given per each person in household on a special debit card called an ASPEN– only to be used for food, clothing, and toiletries, plus accommodation on a no-choice basis in dispersal areas around the UK.

Section 95 Support – Home Office support provided to individuals who have submitted an asylum claim if they meet the 'destitution test'. People are classed as destitute if they do not have adequate accommodation, or enough money to meet living expenses for themselves or dependants. The financial support and accommodation provided is the same as Section 4 support.

Trafficking – process of moving a person from one country to another to exploit them. This could mean forced labour, prostitution, or other practices similar to slavery.

Undocumented migrant = someone in the UK who does not have permission from the Home Office to be in the UK and has not made an asylum claim.

Appendix B

Flow chart to illustrate the process of claiming asylum in the UK

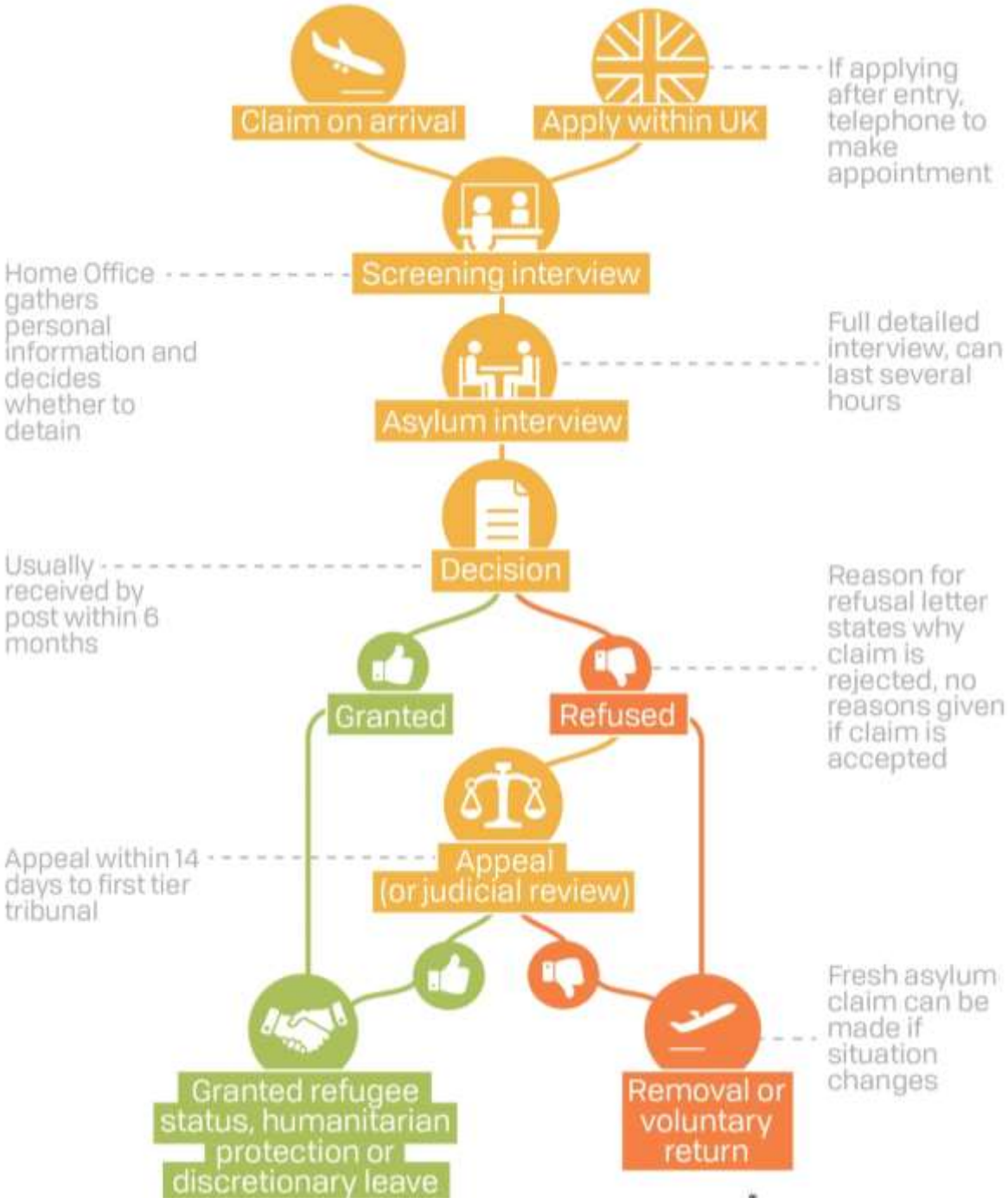

Figure 3. Flow chart produced by Free Movement to illustrate the process and steps of a UK asylum application (Gbikpi 2018) https://www.freemovement.org.uk/how-to-claim-asylum-in-the-uk/

Appendix C

Scoping review process

As described in the methods section, Arksey and O'Malley's (2005) framework was used for the scoping review.

Stage 1: Identifying the research question	The research question used for the scoping review was "What is known about good practice for mental health assessment and treatment for refugees and asylum seekers from the existing literature?". 'Good practice' is admittedly ambiguous, however we wanted to get information on all aspects of mental health treatment, rather than just efficacy of different therapies, for example. Other parameters needed to be defined, such as which types of mental health treatment were to be considered relevant. A broad approach was taken, and literature relating to NHS community and inpatient services in both the UK and internationally was reviewed due to the aim to achieve broad coverage of existing literature and resources. All types of mental health symptoms were considered relevant.
Stage 2: Identifying relevant studies	Relevant studies were identified by searching for evidence across different sources including electronic databases such as Psycinfo, and Google Scholar. Grey literature such as British Psychological Society (BPS) guidelines, government reports, conference presentations, and information on the web pages of relevant third sector organisations were also included. Any papers published in languages other than English were not reviewed or included due to the time and financial constraint of translation. There were no other formal inclusion or exclusion criteria.
Stage 3: Study selection	Any study deemed to be relevant from the abstract was reviewed, and further research was conducted on the specific topics of interest that arose. For key texts, I searched the reference lists and used Google Scholar's 'cited by' feature. This process was continued until I reached saturation. Data was not collected on the number of articles and sources initially selected and reviewed, but 20 sources were selected for inclusion in the review.
Stage 4: Charting the data	Data 'charting' is where key issues and themes from the literature are synthesised and interpreted. I have presented a short summary of literature included in the scoping review with key information in the main text, and included a full table of all sources used in Appendix I.
Stage 5: Collating, Summarizing, and Reporting the results	The results are presented in a narrative review style, structured according to themes identified from both the scoping review and interviews.
Stage 6 (optional): Consultation	Credibility was achieved by sharing the themes and key findings of the scoping review with the PT interviewee and incorporating their suggestions into the final narrative review and results.

Appendix D

Table 1.

Scoping review sources on good practice for working with RAS

Author(s) and year of publication	Type of source	Location	Aims	Important results/findings
Douglas et al. (2018)	BPS Extended Guidelines	n/a	Providing basic information and resources for psychologists beginning to work with RAS	Guidelines are presented for Psychologists working with RAS adults, children and young people, nurseries, schools, and colleges, families, communities, workplaces, and for working with intersectionality.
The British Psychological Society (2017)	BPS Position Statement	n/a	The BPS calling upon various Government and Health and Social Care groups and professionals to provide routes to assessment and service delivery for RAS.	n/a
MIND (2009)	Literature review and case studies	n/a	To explore the contributing factors to RAS difficulties in accessing appropriate mental health services, and provide examples and suggestions of how they can be overcome.	Key findings are summarised on the language barrier, cultural differences, healthcare entitlements, gaps in service provision, statutory healthcare sector, GP practices, secondary mental healthcare, detention centres, voluntary sector mental health services, with recommendations made.
Strijk et al. (2011)	Research article	Specialist inpatient hospital; Netherlands	To enable traumatised refugees to tell their own stories, so that their experiences and needs could be more adequately be	• Loneliness and grief were found to be key themes. • Refugees are in severe psychological distress

			addressed in the nursing process	• Refugees encounter a great deal of practical problems that negatively influence their quality of life
Rhodes (2016)	Conference report	BPS Conference; London	The conference aimed to inform and educate Psychologists working with refugees	• Insufficient attention is being paid to the effects of cultural and language barriers on refugees and healthcare professionals • It is important to bear in mind the effects of illness or migration on a person in addition to sociocultural and economic context • Advice for Psychologists working with interpreters
Posselt et al. (2019)	Systematic review	Nepal, India, Lebanon, Israel, Nigeria, Thailand, Australia, South Africa, Uganda, Rwanda, and Kenya.	To synthesise existing peer reviewed quantitative and qualitative evidence regarding enables of psychological wellbeing among RAS living in transitional countries.	Eight enablers of psychological wellbeing were identified: social support, faith, religion and spirituality, cognitive strategies, education and training opportunities, employment and economic activities, behavioural strategies, political advocacy, and environmental conditions.
Hodes et al. (2001)	Review article	n/a	Summarises the health needs of RAS	• Asylum seekers are not a homogenous group of people and have differing experiences and expectations of health care • Particular difficulties which face women are often not acknowledged • Symptoms of psychological distress are common, but do not necessarily signify mental illness
Priebe et al. (2016)	Review article	Europe	Reviewing evidence for mental health care for RAS and irregular migrants in Europe	• RAS are exposed to risk factors for mental health difficulties before, during, and after migration • Prevalence of PTSD in RAS is much higher than host populations • Discusses good practice for mental health care in RAS

Hewett (2021)	Refugee Council Report	n/a	Summarising data on the increasing rise of people waiting for long periods for a decision on their asylum claim	• In March 2021, ¾ of the people awaiting a decision had been waiting for more than 6 months, of which 70% had been waiting for more than a year, and 5% waiting more than 3 years • Recommendations made to the Home Office
Palmer & Ward (2007)	Qualitative research article	London	To gain a service user perspective of the difficulties faced by forced migrants in London	• Psychological distress results from social circumstances after arrival in the UK in addition to migration and prior challenging experiences • Health providers need to provide a holistic response to the needs of forced migrants • Approaches which empower communities should be used
Porter & Haslam (2005)	Meta-analysis	Global	To establish the extent of mental health difficulties in RAS using a worldwide sample, examining potential moderators	• Post displacement conditions moderate mental health outcomes • Poorer outcomes are observed for refugees living in institutional accommodation, with restricted economic opportunity, who are internally displaced, repatriated to a country they previously fled, and for female, older, and more educated individuals
Summerfield (1999)	Opinion article	n/a	A critique of assumptions behind psychological trauma programmes in war-affected areas	The author argues that there is no evidence that war-affected populations are seeking Westernised approaches to dealing with trauma. They criticise Western agencies and "experts" who try to define an understandable suffering of war as a technical problem that only they have the cure for.
Searight & Armock (2013)	Literature review	U.S.	To review empirical literature on interpreters in mental health settings	• Despite widespread use of interpreters in mental health, there is limited research on their impact on outcomes

				• Many studies suggest that training can improve interpreter accuracy and helpfulness to the clinician, however there are not any widely agreed standards for interpreter training in mental health
Fennig & Denov (2021)	Scoping review	Canada, United States, France, Switzerland, Sweden, The Netherlands, Australia, New Zealand, Germany, Spain, Greece, United Kingdom, Italy, and Denmark	To provide a synthesis of research on interpreters working in mental health settings with refugees	Six thematic areas were identified. Overall, the results indicate that despite some challenges and issues, interpreters have a positive impact on RAS quality of care and clinical outcomes
Lambert & Alhassoon (2015)	Meta-analysis	Uganda, US, Western Europe	To compare the results of RCTs of therapeutic interventions for RAS with PTSD	• Generally, large overall effect sizes were found when comparing to participants in control conditions • Number of sessions (maximum of 12) predicted magnitude of effect size • No significant difference in outcome when using an interpreter • No significant difference based on the measure used to assess PTSD symptoms
Suhaiban et al. (2019)	Review article	Global	To review literature on demographics, predictors, mental health outcomes of torture, and integrated care for the mental health needs of refugees	• PTSD prevalence was documented as high as 88.3% among torture survivors across 3 continents • Depression prevalence was documented up to 94.7% among African torture survivors, and anxiety as high as 91% • Torture severity, post-migration difficulties, and wait time to receive clinical services were significantly associated with higher rate of mental health symptoms

				• Integrated care models are lacking, but would greatly benefit this community to prevent progression to worsened mental health symptoms
Tonsing & Vungkhanching (2020)	Research article	Burmese refugees in the US	To examine the relationship between post-migration living difficulties (PMLD), social support, and mental health of Chin-Burmese refugees that are resettled in the US	• Across the sample, 34,3% reported symptoms of psychological distress • More than 1/3 of participants reported experiencing difficulties in accessing health care and social services • The most common PMLD were communication, accessing health care, and worrying about family back home • Number of PMLD significantly predicted psychological distress
Taylor et al. (2020)	Interpretative Phenomenological Analysis	UK	To examine the nature of the trauma of the participants, including the possibility of resilience and posttraumatic growth (PTG)	• Experiences of trauma were characterised by symptoms of suicidal ideation, sleeping problems, flashbacks, and high levels of anxiety • Characteristics relating to resilience and PTG were reported, including increased gratitude and a desire to be of service • Religion was supported as a significant source of psychological support/coping
Byrow et al. (2020)	Systematic review	Global	To synthesise literature examining perceptions of mental health, and barriers to help seeking in individuals from a refugee background	Barriers to help seeking were largely related to cultural barriers; structural barriers; and barriers specific to the refugee experience.
Doherty et al. (2016)	Research article	Scotland	To investigate the prevalence of head injury in RAS referred to a complex psychological trauma service	• Overall prevalence of head injury was 51% • 38% of individuals with a head injury had a moderate-severe head injury that could cause persisting disability

- In 53% of head injuries, the cause was torture, human trafficking, or domestic violence
- The head injury was not known to clinicians prior to screening in 64% of cases

Appendix E

Service evaluation questions organised thematically complete with references

In this context, 'worker' or 'health care professional' refers to the individual primarily working with the service user, or who has the most direct contact with them. This may be a care co-ordinator, mental health nurse, or therapist. 'Service user' refers to refugee and asylum seeker service users in the context of this project.

1. Language and communication

- An interpreter should be offered if English is not the preferred/primary spoken language.[2] *Friends, family, or children do not count as an appropriate interpreter. This question refers to a professional service. dialect should be considered in addition to language. E.g. Sudanese Arabic vs. Iraqi (Mesopotamian) Arabic. Interpreters should be adequately briefed and debriefed prior to and after the service users appointment.*
- Information, letters, and guidance should be provided in a language the service user understands[2]
- If outcome measures are used, they should be given in a language the service user understands[3]
- The service user should be given a copy of their care plan and crisis and contingency plan in a language they understood[4]

2. Cultural awareness

- Key workers should research the service users country of origin prior to meeting with them to *gain a broader cultural understanding. Assumptions should not be made about the experiences of individuals.* [1]
- Service users should be offered a choice of male or female worker, particularly if the individual has experienced sexual violence [19]
- When assessing for mental health difficulties, the person administering the assessment should explore whether the service user has a religious or spiritual understanding of their mental health difficulties[18]
- During assessment, the health professional should ask what impact covid is having/had on the service user[8]

3. Barriers to access

- To prevent financial barriers to attending appointments, service users should be seen within walking distance of their home[11.] Alternatively, if physical difficulties present an additional barrier or this is not possible, service users should be offered financial reimbursement for the cost of transport or phone calls[11]

4. Therapy provision, unique needs,

- The service user should be offered a chance to learn strategies to cope with intrusive and distressing thoughts, feelings, and experiences (E.g. breathing work, mindfulness, etc)[12]
- Therapy should be offered[10]
- If previous head injury is suspected, a cognitive assessment should be offered [9]
- The worker should ask about their experience of the immigration process[14], including where they are in the process currently [16], and how they are coping with the impact of the asylum process[13]

- The worker should explore whether the service user has any other personal or professional support they are currently accessing [5]
- The worker should ask if the service user has access to any meaningful activities. This could include access to religious services, books, television, or games [5]
- The worker should explore whether the service user felt safe to been seen in the building/location of the initial appointment?[17]

The worker or health care professional should enquire as to whether the service user had any additional needs in the following areas, and if so, should be signposted to relevant external services:

Childcare [15]
Spiritual/religious needs[5]
Physical health (excluding pain management.)[6]
Pain management[6]
Housing[7]
Legal aid/assistance[17]

5. Therapy provision (only relevant if therapy is offered and accepted)

- Service users should be given the opportunity to learn strategies to self-soothe or ground themselves, e.g. guided relaxation or breathing exercises[5]

6. Unique needs (legal - only complete if the service user is currently undergoing an asylum claim)

- The worker should enquire whether they have access to a solicitor [17]
- If the individual is currently undergoing an asylum claim, and if it is deemed relevant, the worker should offer to write a letter regarding their mental health in support of their asylum claim[17]

References

1	Douglas, A., Farsimadan, F., Hughes, J., Hawker, D., Hulusi, H., Patel, N., Papadopoulos, R., Robjant, K., Searle, R., Tribe, R., Yule, W. and Zlotowitz, S., 2018. *Guidelines for psychologists working with refugees and asylum seekers in the UK: Extended version*. [online] The British Psychological Society. Available at: <https://www.bps.org.uk/news-and-policy/guidelines-psychologists-working-refugees-and-asylum-seekers-uk> [Accessed 19 April 2021].
2	Tribe, R., & Lane, P. (2009). Working with interpreters across language and culture in mental health. *Journal Of Mental Health*, *18*(3), 233-241. https://doi.org/10.1080/09638230701879102
3	Department of Health, Department for Communities and Local Government, Local Government Association, NHS England. (2015). *How to... understand and measure impact*. The Better Care Fund. Retrieved from https://www.england.nhs.uk/wp-content/uploads/2015/06/bcf-user-guide-04.pdf.pdf
4	Ashman, M., Halliday, V., & Cunnane, J. (2017). Qualitative Investigation of the Wellness Recovery Action Plan in a UK NHS Crisis Care Setting. *Issues In Mental Health Nursing*, *38*(7), 570-577. https://doi.org/10.1080/01612840.2017.1300840
5	Posselt, M., Eaton, H., Ferguson, M., Keegan, D., & Proctor, N. (2019). Enablers of psychological well-being for refugees and asylum seekers living in transitional countries: A systematic review. *Health And Social Care In The Community*, *27*(4), 808-823. https://doi.org/10.1111/hsc.12680

6	Hodes, M., Macdonald, B. K., Mummery, C. J., & Heaney, D. (2001, July 28). Health needs of asylum seekers and refugees. *BMJ*. https://doi.org/10.1136/bmj.323.7306.229/a
7	Strijk, P. J. M., Van Meijel, B., & Gamel, C. J. (2011). Health and Social Needs of Traumatized Refugees and Asylum Seekers: An Exploratory Study. *Perspectives in Psychiatric Care*, *47*(1), 48–55. https://doi.org/10.1111/j.1744-6163.2010.00270.x
8	Kluge, H., Jakab, Z., Bartovic, J., D'Anna, V., & Severoni, S. (2020). Refugee and migrant health in the COVID-19 response. *The Lancet*, *395*(10232), 1237-1239. https://doi.org/10.1016/s0140-6736(20)30791-1
9	McPherson, J. (2017). Traumatic brain injury among refugees and asylum seekers. *Disability And Rehabilitation*, *41*(10), 1238-1242. https://doi.org/10.1080/09638288.2017.1422038
10	Kronick, R. (2017). Mental Health of Refugees and Asylum Seekers: Assessment and Intervention. *The Canadian Journal Of Psychiatry*, *63*(5), 290-296. https://doi.org/10.1177/0706743717746665
11	Kang, C., Tomkow, L., & Farrington, R. (2019). Access to primary health care for asylum seekers and refugees: a qualitative study of service user experiences in the UK. *British Journal Of General Practice*, *69*(685), e537-e545. https://doi.org/10.3399/bjgp19x701309
12	ter Heide, F., Mooren, T., van de Schoot, R., de Jongh, A., & Kleber, R. (2016). Eye movement desensitisation and reprocessing therapy v. stabilisation as usual for refugees: randomised controlled trial. *British Journal Of Psychiatry*, *209*(4), 311-318. https://doi.org/10.1192/bjp.bp.115.167775
13	Schock, K., Rosner, R., & Knaevelsrud, C. (2015). Impact of asylum interviews on the mental health of traumatized asylum seekers. *European Journal Of Psychotraumatology*, *6*(1), 26286. https://doi.org/10.3402/ejpt.v6.26286
14	Liebling, H., Burke, S., Goodman, S., & Zasada, D. (2014). Understanding the experiences of asylum seekers. *International Journal Of Migration, Health And Social Care*, *10*(4), 207-219. https://doi.org/10.1108/ijmhsc-06-2013-0016
15	Childcare. There is no formally conducted research on childcare creating barriers to accessing services in refugee and asylum seeking service users, however anecdotal evidence from service leads and professionals working with asylum seekers cite this as a barrier to care. They report that often women do not have family or friends they can leave children with whilst they attend a mental or physical healthcare appointment, meaning they have to bring them. This can be inappropriate, and prevent women from feeling able to discuss particularly sensitive issues with healthcare professionals.
16	Hoare, T., Vidgen, A., & Roberts, N. (2017). In their own words: a synthesis of the qualitative research on the experiences of adults seeking asylum. A systematic review of qualitative findings in forced migration. *Medicine, Conflict And Survival*, *33*(4), 273-298. https://doi.org/10.1080/13623699.2017.1419902
17	Patel, N., Tribe, R., & Yule, W. (2018). *Guidelines for psychologists working with refugees and asylum seekers in the UK: Extended version*. The British Psychological Society.
18	Menezes, A., & Moreira-Almeida, A. (2010). Religion, Spirituality, and Psychosis. *Current Psychiatry Reports*, *12*(3), 174-179. https://doi.org/10.1007/s11920-010-0117-7
19	Choice of male or female therapist There is no formal evidence to suggest that gender of therapist influences outcome. However, the experience and expertise shared by NHS and third sector service leads was that many refugee service users (particularly South Asian women, and those who have suffered sexual trauma) prefer a female therapist. Being unable to facilitate this

could result in a complete barrier to access/refusal to engage, or a poorer therapeutic alliance.
Evidence regarding the importance of the therapeutic alliance: Horvath, A., & Luborsky, L. (1993). The role of the therapeutic alliance in psychotherapy. *Journal Of Consulting And Clinical Psychology*, *61*(4), 561-573. https://doi.org/10.1037/0022-006x.61.4.561

Appendix F

Additional feedback received from a psychiatrist at a relevant third sector organisation

I am not sure that offering to write an unsolicited letter is a good thing, unless the clinician has training in the style of writing needed (I've seen really kindly meant letters pleading for the person to be believed etc). Maybe suggesting the person shows a copy of their (impartially written) clinic letter to their solicitor would be better?

Maybe a key thing to add might be has the practitioner made use of some kind of reflective space to discuss their work, e.g. clinical (not management) supervision?

In our book chapter on treatment, there will be a table on things to be attended to even when there is only one contact. This would give the following additional points

- For someone who is ARE, have NHS charges been considered?
- Is the person known to be registered with a GP?
- Has a letter been written to the GP? And the person offered a copy?
- Did the person go away with written information so they definitely know what service they've been to – as a minimum the clinician's name and details of the service they work for
- For someone in the asylum system, does the safety/risk management plan attend to any fears they have about reporting and detention?
- Has the clinician ensured that the person has opportunity for support from a refugee community organisation? If they are not already in touch with one, has support been offered to help them get in touch, not just signposting? (I think this is a really important point as people have so many practical issues, and often also are very isolated)

If a solicitor has requested information, has this been provided?

Appendix G

Service evaluation tool for service users

Translations of the document below were available in Arabic, Iraqi Arabic, Malawi, Polish, Slovakian, and Urdu.

Version number: 3 Ethics approval number: QClin REC 20-015

Thank you for agreeing to take part in my project. Please complete both sections of the questionnaire below.

When completing the questionnaire, we are interested to hear about the FIRST appointment you had with Bradford Community Mental Health Team (CMHT). This may have been face to face, over the phone, or by a video consultation.

Throughout this questionnaire, 'worker' refers to the person who met with you during your first appointment with Bradford CMHT.

Section 1.

	Please read the questions below, and answer yes or no by ticking the box. Please tick n/a if the question does not apply to you	***Yes*** ✓	***No*** ✓	***N/A*** ✓
1	Was an interpreter provided if English isn't your first language? Friends, family, or children do not count.			
2	Did you receive information, letters, and guidance in a language that you understood?			
3	Were you asked to complete feedback forms in a language that you understood?			
4	Were you given a copy of your care plan and information on what you should do in a crisis, in a language that you understood?			
5	Were you offered a choice of a male or female worker?			
6	Did your worker explore your religious and spiritual understanding of the difficulties you are currently experiencing?			
7	Did your worker ask about the impact Covid-19 is having on you?			
8	Were you offered money to cover the cost of transport to appointments, or the cost of making phone or video calls to your worker? *If you answered 'No' to this question, please go to question 8.1. If you answered 'Yes' to this question, please go to question 9.*			
8.1	Was your appointment with Bradford CMHT within walking distance of your home?			
9	Were you offered the chance to learn strategies to deal with any upsetting thoughts, if you had them?			
10	Were you offered therapy? *If you answered 'No' to this question, please go to question 11. If you answered 'Yes' to this question, please go to question 10.1.*			

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10.1	If you were offered therapy, did you receive therapy? *If you answered 'No' to this question, please go to question 11. If you answered 'Yes' to this question, please go to question 10.2.*			
10.2	If you received therapy, did your therapist teach you ways to calm or soothe yourself, such as guided relaxation and breathing exercises?			
11	Were you offered a cognitive assessment? *These are tests that help us to understand how your brain is working and whether it may have been injured. If you aren't sure whether you had one, you can ask your worker.*			
12	Did you feel that your worker understood what your main concerns were?			

13	Did your worker ask you about your experience of the journey to the UK?			
14	Did your worker ask you what stage of the asylum process you are at?			
15	Did your worker ask you how you are coping with the impact of the asylum process?			
16	Did your worker ask you if you have any other people supporting you?			
17	Did your worker ask you if you have things to do to occupy your time?			
18	If your appointment was face to face, did your worker ask if you felt safe at the location of your appointment?			
19	If your appointment was face to face, did you feel welcomed by the staff you met while you attended your appointment? (This may include reception staff, cleaners and any other staff member you saw)			
20	Did your worker ask if you have a solicitor?			
21	If you are currently claiming asylum, did your worker offer to write a letter about your mental health difficulties to support your claim?			

Section 2.

For this part, we would like to know if your CMHT worker asked you if you needed help or support with different areas of your life.

We would also like to know whether they told you where you could get this help or support if you needed it.

Please turn over the page to continue completing the questionnaire.

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	Please **tick** the box if your worker asked whether you needed additional help or support in this area of your life	Did your worker tell you where you could get this help/support? Please **tick yes or no.**	
	✓	Yes ✓	No ✓
Childcare			
Spiritual/religious needs			
Physical health (excluding pain)			
Pain management			
Housing			
Other (please specify):			

Thank you for taking the time to take part in this project.

Please return the completed questionnaire along with the consent form to Bradford Community Mental Health Team using the pre-paid envelope provided.

If you have any questions, please contact Charley Blackwell by email on umcab@leeds.ac.uk

Appendix H

Service evaluation tool for clinicians

Version number: 3 Ethics approval number: DClin REC 20-015

Thank you for agreeing to take part in this project. Please complete the questionnaire below in relation to your service user who has been identified as a refugee or asylum seeker.

N.B. Please note, for questions enquiring about language, dialect should also be considered where relevant. E.g. Sudanese Arabic vs. Iraqi (Mesopotamian) Arabic.

Section 1.

Please answer the following questions in relation to the FIRST appointment meeting with the service user, regardless of whether it was face to face, or a phone or video consultation

	Please read the question and TICK to answer yes or no. Tick n/a if the question does not apply.	***Yes*** ✓	***No*** ✓	***N/A*** ✓
1	Was an interpreter offered if English is not the preferred/primary spoken language? *Friends, family, or children do not count as an appropriate interpreter. This question refers to a professional service.*			
2	If an interpreter was used, were they briefed and debrief before and after the service user's appointment(s)?			
3	Did you give/send information, letters, and guidance to the service user in a language they understood?			
4	Were outcome measures used in a language they understood?			
5	Was the service user given a copy of their care plan and crisis and contingency plan in a language they understood?			

6	Do you feel you gained an understanding of the service users main concerns?			
7	Were they offered therapy?			
7.1	If yes, was therapy received?			
7.2	If they received therapy, were they offered a chance to learn strategies to cope with intrusive and distressing thoughts, feelings, and experiences? (E.g., breathing work, mindfulness, etc)			
8	Was a cognitive assessment offered?			

9	Were they offered financial reimbursement for the cost of transport or phone calls? *If you answered 'yes' to this question, please proceed to question 11. If you answered 'no' to this question, pleased proceed to question 10.*			
10	Were they seen at a location within walking distance of their home?			

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11	Did you research their country of origin prior to meeting with them? *This is to gain a broader cultural understanding. Assumptions should not be made about the experiences of individuals.*			
12	Did you explore whether they have a religious or spiritual understanding of their mental health difficulties?			
13	Did you ask what impact covid is having/had on them?			
14	Were they offered a choice of male or female worker?			
15	Did you ask about their experience of the immigration process?			
16	Did you ask where in the immigration process they are currently?			
17	If they are currently undergoing an asylum claim, did you ask if they have a solicitor?			
18	If they are currently undergoing an asylum claim, did you offer to write a supporting letter in relation to their mental health difficulties?			
19	Did you ask about how they are coping with impact of the asylum process?			
20	Did you ask if there is anyone else currently supporting the individual?			
21	Did you ask if they have access to any meaningful activities?			
22	Did you ask if they felt safe to been seen in the building/location of the appointment? (Only applicable if the service user was seen face to face)			

Section 2.

For this part, we would like to know if you asked the service user whether they needed help or support with different areas of their life, and if so, whether you signposted them to where they could find this help or support.

	Please **tick** if you **enquired** about support needs in this area	Did you **signpost** the service user to where they could get this help/support? Please **tick yes or no.**	
	✓	Yes ✓	No ✓
Childcare			
Spiritual/religious needs			
Physical health (excluding pain)			
Pain management			
Housing			

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Other (please specify):			

Thank you for taking the time to take participate in this project.

Please return the completed questionnaire and consent form to Usman Ali at Bradford CMHT.

If you have any questions, please contact:

Charley Blackwell
Email: umcab@leeds.ac.uk

Appendix I

Information sheets for distributing the service evaluation tool

Care co-ordinator information sheet

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Version number: 4 Ethics approval number: DClin REC 20-015

Participant Information Sheet

What are the biopsychosocial needs of refugees and asylum seekers with severe mental health needs, and does Bradford City Community Mental Health Team (CMHT) meet their needs?

You are being invited to take part in a service evaluation of the care provision for refugees and asylum seekers in Bradford CMHT. Before you decide whether to participate, it is important for you to understand what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. You can keep this information sheet. Please contact Charley Blackwell if you would like more information, contact details given on the final page.

What is the purpose of the project?

This project has compiled evidence-based guidelines for the psychological treatment of refugees and asylum seekers with severe mental health difficulties in community settings. These have been created through a review of existing literature, and conversations with experts and clinicians who work with this population.

For the second part of this project, we would like to investigate to what extent Bradford City CMHT are providing care consistent with these guidelines. Please note, this is not an audit or formal assessment of the team, but an exploratory project that may provide evidence for additional funding or service provision.

Ethical approval has been given by the Doctorate in Clinical Psychology Research Ethics Committee at the University of Leeds (DClinREC 20-015)

Why have I been chosen?

We are inviting refugees and asylum seekers who are currently receiving treatment within Bradford City CMHT and their care coordinators to participate. We are aiming to recruit at least 10 service users and 10 care coordinators.

You have been identified as a care coordinator for a refugee or asylum seeker. Your identified service user will also be invited to take part and will receive an alternative easy read participant information sheet.

Do I have to take part?

It is up to you to decide whether to take part. If you do not decide to take part, you do not have to give a reason. If you do decide to take part after reading this information sheet, you will indicate your informed consent on the form at the end of this sheet.

After participation, withdrawal will not be possible as all data is anonymous and therefore it will not be possible for the research team to identify your data to withdraw it.

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Version number: 4 Ethics approval number: DClin REC 20-015

What do I have to do?

This project requires completing a short questionnaire in relation to the treatment that your refugee or asylum seeker service has received (or not received) within the CMHT. This will take no more than 5-10 minutes and requires ticking a box to answer brief questions. For example, questions include items such as "Was an interpreter arranged if needed? Yes / No / Not applicable"

Questionnaires should be returned to Usman Ali (Operational Manager at Bradford City CMHT), FAO Charley Blackwell.

Any data collected is anonymous, and the research team will not be able to trace responses back to any individual.

What are the possible disadvantages and risks of taking part?

There are no identified disadvantages to taking part.

What are the possible benefits of taking part?

Whilst there are no immediate benefits for those participating in the project, it is hoped that this work will help to inform future care provision for refugees and asylum seekers with severe mental health problems in Bradford.

Use, dissemination, and storage of data

There are not currently any plans to re-use the data. As per University of Leeds policy, the data will be stored within encrypted files on the University of Leeds M: Drive until the researcher completes the DClinPsychol programme, at which point it will be transferred to the secure S: Drive via encrypted USB. The S: Drive area is administered by the DClinPsychol research coordinator, who will delete the files approximately 3 years after project completion.

The project findings will be disseminated in a report which will be submitted to the University of Leeds as part of a Doctorate in Clinical Psychology qualification, and with the service who commissioned the project. The report will also be presented at a University Conference verbally and in poster format. No participants will be identifiable in any part of the written or presented work.

A summary of the results will be made available to anyone who is interested in hearing more about the findings, please contact Charley Blackwell if you wish to receive this.

What will happen to my personal information?

No personal data will be collected, and all responses will be completely anonymous. It will not be possible to link your identity with your questionnaire responses.

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Who is organising the audit?

This audit has been commissioned by Bradford City Community Mental Health Team and is being undertaken by a Psychologist in Clinical Training at the University of Leeds as part of the DClinPsychol.

Thank you for taking the time to read this information sheet and for considering participating in this project. Please do not hesitate to contact the team if you have any questions.

Charley Blackwell, Psychologist in Clinical Training - Lead Researcher – umcab@leeds.ac.uk

Gary Latchford, Consultant Clinical Psychologist – Supervisor – g.latchford@leeds.ac.uk

Dr. Emma Van der Gucht, Consultant Clinical Psychologist - Commissioner - EmmaVanDerGucht@bdct.nhs.uk

If you wish to participate in this project, please complete the consent forms attached separately.

Service user easy read information sheet

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Information about the project

This project is about refugees and asylum seekers, and the care they receive in Bradford Community Mental Health Team (CMHT).

Would you like to take part in this project?

Before you decide it is important that you understand why I am doing this project.

It is important that you understand what taking part might involve for you.

Please read this information carefully. You can talk to other people about it if you would like to.

Please ask someone if there is anything you don't understand.

After you have finished reading this booklet, you can decide if you want to take part.

Thank you for thinking about taking part in my project!

1

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What is the project about?

I want to find out what type of care refugees and asylum seekers are receiving from Bradford CMHT.

They might have different needs to other people being treated there.

For example, they might also need:

An interpreter

Information on where to find other things

Information and documents translated

I am doing this project because I am a student at the University of Leeds. Bradford CMHT have asked me to help them with this project as part of my course.

2

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I want to find out if refugees and asylum seekers are receiving the best and most suitable care for their needs.

I think that it is important that refugees and asylum seekers receive the best care possible.

I hope this project will show what Bradford CMHT could do better for refugees and asylum seekers. I also hope it will show what it is doing well.

Why do you want me to take part?

I am trying to find out what care refugees and asylum seekers are receiving in Bradford CMHT.

I need to speak to refugees and asylum seekers. I also need to their care co-ordinators.

Do I have to take part?

No, it is up to you. If you change your mind you can stop at any time. You don't have to tell me why. This will not affect your care in the CMHT.

3

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What do I do if I take part?

You will complete a short questionnaire. It will ask you about your experience of care in Bradford CMHT. We will give you the questionnaire in the language you understand best.

You will answer 'yes' or 'no' to different questions. This will help me understand the type of care you have had.

If you complete the questionnaire, you will post it back to us. We will give you an envelope and stamp for this.

Will taking part be good or bad for me?

Taking part will take up some of your time, and I can't pay you for it. I will tell the service what I have found out. This may help services provide better treatment to refugees and asylum seekers in future.
Ethical approval has been given by the Doctorate in Clinical Psychology Research Ethics Committee at the University of Leeds (DClinREC 20-015).

Will you tell people what I say?

If you choose to take part, you do not have to put your name on your questionnaire. All of your answers will be confidential. This means that nobody else will know what

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you have written. When I write about what we find, there is no way for anyone to know what you wrote.

What will you do with what you find out?

I will do three things with what I find out:

1) I will write a report for the university. They will look at this and give me a grade for my work.

2) I will write a summary of what I find out and send it to Bradford CMHT. Your care co-ordinator will ask you if you would like to read this.

3). I will try and let other people who might be interested know what I find out.

Thank you for thinking about taking part in my project! If you have any questions, you can email me on umcab@leeds.ac.uk.

You can also contact my supervisor Gary Latchford, Consultant Clinical Psychologist g.latchford@leeds.ac.uk / 0113 206 5897 if you have any concerns or questions.

If you would like to take part, please read and sign the statements on the consent forms. You don't have to decide right now, you can think about it and decide later.

5

Appendix K

Consent forms for completing the service evaluation tool

Care co-ordinator consent form

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Version number: 1 Ethics approval number: DClin REC 20-015

Participant consent form

I have read and understood these information sheets	☐
I understand what I will be asked to do if I participate in this project.	☐
I understand that any information I give is confidential and will not be linked to my name or identity.	☐
I understand that I do not have to take part in this project. If I choose not to take part, I will not be asked	☐
I understand that if I do participate in this project, withdrawal will not be possible after I return the questionnaire due to the anonymity of the data.	☐

Keep one copy of this consent form and the information sheet for your own information.

Please return this consent form along with your completed questionnaire in an envelope to Usman Ali, Bradford City CMHT Manager. Alternatively, they can be posted back to the following address:

FAO Charley Blackwell

Usman Ali
Level 3
Horton Park Centre
Horton Park Avenue
Bradford
BD7 3EG

Service user consent fo

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Version number: 1 Ethics approval number: DClinREC 20-015

Participant consent form

Please read the statements, and sign your initials in the boxes

I have read and understood the information sheets	☐
I understand what I will be asked to do if I take part in this project.	☐
I understand that any information I give is confidential and will not be linked to my name or identity.	☐
I understand that I don't have to take part in this project. If I choose not to take part, I will not be asked to explain this decision	☐
I understand that after I post my questionnaire back, I cannot withdraw from the study	☐

If you would like to take part, please return this page to your care co-ordinator now. Keep the first page and the information sheets for your own information.

Your care co-ordinator will arrange for you to receive the questionnaire written in the language that you understand best.

1