Building Better Access

Policy Strategies to Improve Refugees' and Asylum Seekers' Access to Mental Health Services and Outcomes in the United Kingdom

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About the Author

Tahmina Sayfi is a third-year medical student at Leicester Medical School (LMS) and a Young Fabians Policy Research Fellow, with a longstanding interest in health equity and health policy. She serves as a co-chair of the MedRACE and Inclusion Oversight Committees, which lead work on inclusion, diversity and equity in medical education at LMS. She completed a one-month internship at Chongqing Medical University in Chongqing, China, gaining insight into medical education within a contrasting healthcare system. Tahmina has extensive experience volunteering with asylum seekers, including teaching conversational English, and co-founded Afghans Beyond Borders in 2021.

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Executive Summary

Struggle is seemingly central to what it means to be a refugee, as defined by the UNHCR 1951 Refugee Convention to be someone who flees to another country 'owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion'[1]. This is in clear distinction with economic migrants, with mental disorders twice as likely in refugees as in economic migrants, as per a meta-analysis on the subject[2]. Displaced persons' circumstances could be said to predispose these individuals to poorer mental health, out of the sheer fact that they are likely to have been subject to harsher situations and experiences. Not only their reason for fleeing providing a valid source of fear but also the variety of regular or irregular routes they are forced to take when seeking a safe place of sanctuary. Findings from the World Health Organisation support this, stating that the prevalence of depression and anxiety among populations affected by humanitarian crises is almost doubled, with those affected by conflict in their home countries, or war, within the past 10 years exhibiting a one in five rate of depression, anxiety, post-traumatic stress disorder (PTSD), or severe mental health disorder. There is also a slight gendered nature to some mental health concerns, with more women likely to be affected by depression in conflict-affected settings, compared to men[3].

In European host countries however, refugees are seen to underutilise mental health services in comparison with the higher burden of psychological needs and trauma in this group[4]. According to the Refugee Council UK, 54% of those seeking asylum who have declared experiencing mental health challenges, have faced barriers to accessing health services. This can stem from several causes, starting as early as having trouble registering with a GP, through to language barriers preventing them from booking or utilising appointments in primary care[5]. This unfortunately leads to more severe escalations of their conditions due to delayed recognition and intervention. In those with a background of displacement, complications of untreated mental illness can be even more sinister, such as neurological challenges, substance abuse, acute malnutrition, as well as death or suicide[6,7].

There is some evidence to suggest an increase in mental health service utilisation with more time spent in a host country. However, as per early-integration monitoring for the Vulnerable Persons' Resettlement Scheme, which records health outcomes at 6- and 12-months post-arrival, it is apparent that many new arrivals are still limited in their ability to access services, due to challenges such as a lack of proficiency in English, which may contribute to their elevated risk in mental health[7].

Introduction

The cause of such a high incidence of mental illness in asylum seekers and refugees is multifactorial. This inevitably includes a proportion who may suffer from difficulties in their mental health, independent of their environmental circumstances. Others may suffer from existing mental health problems which have always required intervention but would significantly benefit from the optimisation and continuity of their care upon reaching their host country. Overlapping with these categories is a significant proportion of refugees for whom external stressors associated with uprooting their lives, both during and post-migration, can tip them over the threshold between distress and established mental illness.

Broadly, causes of poor mental health in displaced individuals can be organised into two categories: pre-migration conditions and post-migration stressors. Although the British government does play a role in the former through its engagement in international affairs and foreign policy decisions, it has the most control over post-migration stressors, through its policies which directly affect refugees and asylum seekers in the United Kingdom. Therefore, the government's bearing over post-migration conditions will be the focus of this report. To be able to better understand the barriers for refugees to using mental health services, access warrants definition so that the effect of barriers can be better understood and solutions can be proposed with a view towards these.

This report synthesises the available literature, guidance and current practice in regard to mental health support across disciplines, in order to dissect the barriers to refugees and how these can be addressed. The insights of refugees and asylum seekers are invaluable to this discussion. In order to safeguard the identities and traumatic experiences of individuals, my enquiry as to asylum seekers' and refugees' lived experiences has been made through experts who work with them on a day-to-day basis, in hopes of lifting the most pertinent and recurring themes, as many of these experts carry years' worth of rapport and conversations.

What Does Access Mean in Practical Terms?

In a policy context, access is defined as 'the match between societal commitment and institutional capacity to deliver rights and services and people's capacity to benefit from those rights and services', as per De Jong and Rizvi[8]. This reflects the need for clinical, community-based and other social services to work interdisciplinarily to optimise access to mental health services. Much like in the realm of safeguarding - it is everyone's responsibility to contribute to the improvement of mental health and access to support[9].

Penchansky and Thomas' Frameworks, as well as those additionally proposed by Satinsky et Al, more specifically define access through key parameters, which enable us to quantify and understand which aspects of it, when optimised, might result in the

most improvement overall, in the context of health services and health policy research.

The Principles of Penchansky and Thomas' Framework[10]:

- Availability
- Accessibility
- Accommodation
- Affordability
- Acceptability

Those Proposed in Addition by Satinsky et Al[5]:

- Language
- Help-Seeking Behaviours
- Awareness.
- Stigma
- Negative Attitudes towards and by Providers

Barriers For Refugees:

An umbrella review in the British Medical Journal highlighted the key barriers to refugees and asylum seekers in accessing mental health care, both in clinical and community-based settings. Importantly, this study encompasses undocumented migrants, unaccompanied children, migrants and displaced people within its scope, due to the notable overlap in practical terms between these categories, despite their distinct definitions in law[11]. These barriers have been categorised thematically for evaluation. This report will reinforce and evaluate the current research and guidance available with the collective lived experiences of asylum seekers and refugees via non-profit organisations such as Freedom From Torture, Conversation Over Borders and Mental Health Foundation UK, to safeguard the identities of vulnerable individuals. This report argues that co-creation is a necessity in any domain where the aim is to reduce barriers or improve accessibility.

Structural Barriers to Mental Health Access

From a service perspective, limitations in language provision and terminology create challenges for refugees accessing mental healthcare. Within primary care, barriers such as registering with a GP practice can prevent asylum seekers from continuity of care under a GP, despite this being very important to refugees. Difficulty navigating the healthcare system is only exacerbated by a lack of services in the preferred languages of these displaced patients, as well as healthcare information and resource pamphlets. For many refugees, there is a lack of awareness particularly as to the mental health support available to them and the fact that concerns such as anxiety are treatable and the appropriate pathways through which to access treatment[5]. Homogenisation of diverse patients and clients who share a background of displacement, causes a greater resistance for those who do come forward with concerns as they are not always understood.

Government guidance demonstrates a preference towards the use of professional interpreters when communicating the needs of refugees in the healthcare settings. This is because reliance on family members and intimate relatives can diminish confidentiality and have the potential to reduce a patient's sense of openness in so far as the information they share with their clinician. The patient's history is central to their diagnosis and management, with unintended discrepancies caused by a reliance on inexperienced interpretation posing clinical risk. Within the NHS, a combination of interpreters and Language Lines are used, however, the variety of language interpreters varies depending on availability through the service and is inconsistent. Despite guidance and the preference of General Practitioners in primary care towards professional interpreters, a study entitled PROMO, reviewing mental healthcare services for marginalised groups, found that only 53% of the services across 14 European capital cities had interpreters available[5]. It can only be inferred the additional barriers that would be experienced by those who are Deaf or hard of hearing[5].

Linguistic challenges also arise from the variety of ways in which languages conceptualise mental health, such as inconsistent use of terminology. Some languages differ in their description of conditions such as postpartum depression (PPD), with other cultures lacking a distinct word for it. This makes it difficult to establish a common understanding of a patient's state, in order for this to be managed or supported. This is only exacerbated by the previously mentioned reliance on family members and relatives who are inexperienced in translation and to whom this burden often defaults. Some patients, such as women, may use different language for expressing emotional distress compared to that which is physical, and particularly in communicating mental health challenges, nuances in language are exceptionally important.

To address these challenges, professional interpreters should be proactively offered at first contact with healthcare or asylum support services. Former asylum seekers can

make excellent interpreters, upon training, due to a more trauma-informed perspective. Refugees in the UK reported a preference for diversity in staff in psychiatric and other services due to a greater sense of trust and cultural humility. Kurdish refugees, for example, reported increased levels of comfort around Turkish-speaking clinicians[5]. This openness and comfort among those that are more similar to oneself aligns with the concept of Affinity Bias, which likely reflects a trauma-responsive preference for familiarity and perceived safety, so should be considered to provide more peer-supportive means of communication[12].

Systemic Disempowerment Creates Psychological Stressors

Disempowerment and retraumatisation is entrenched in the experiences of refugees, with dispersal policies, financial control and problems with accommodation undermining their mental health. Many refugees experience physical barriers to accessing mental health services, such as a lack of autonomy over where they live, often putting them at considerable distance from their nearest support services. This frequently causes them to incur transportation costs which are significant relative to the financial support they receive weekly, in light of the inability to work until refugee status is confirmed.

Whilst asylum seekers commence their asylum process in 'initial accommodation' such as hotels, the government's dispersal policy, introduced by the Immigration and Asylum Act in 1999, means that they are scattered across the UK, both at great distance from other refugees as well as the town they initially will have arrived in, on a 'no choice' basis[13]. This approach, shifting in 2022 to 'Full Dispersal', only propagates the level of uncertainty experienced by refugees and disruption to their continuity of care, despite its intention to spread housing costs across different councils and local authorities.

Although 'Full Dispersal' provides some economic benefit due to how it seeks to avoid straining particular councils financially and limiting the formation of more cultural or ethnic enclaves, it ought to be complemented by a more integrated, trauma-responsive offering in terms of mental health and social services. In conversation with Aaliyah Burns, Digital Campaigns and Engagement Manager from Freedom From Torture, it was shared that a key barrier for refugees is that they 'aren't housed inside communities' but instead in 'isolated places' where it is 'hard to access resources or rebuild a life'. This sense of isolation is compounded by media commentary portraying initial accommodation as luxurious or 'all-inclusive', despite many independent reports to the contrary[14]. Slicker digital communication across hubs in different parts of the country could promote a greater sense of continuity of care and mitigate bureaucratic barriers and administration costs to refugees uprooting their care every time they are relocated to a different part of the UK.

Throughout the period of awaiting an asylum decision, refugees' financial support is set at a weekly rate of merely £49.18 per person when living in self-catered housing or £9.95 per person for those in catered accommodation, like the initial accommodation 'hotels'[15]. There is also the possibility of being refused a payment card if refusing the accommodation choice proposed to them. Although the nature of the NHS is that all care is free at the point of use, including for refugees, there is profound disempowerment associated with unemployment and a loss of control over weekly funding. For example, the risk of being questioned by the Home Office if an individual doesn't use all of their weekly allowance over consecutive weeks, or restrictions as to the number of nights they are able to spend outside of their accommodation within a six-month period. These measures limit the ability to save

money, maintain social relationships or enjoy basic independence, reinforcing a sense of loss of control, which exacerbates many mental health difficulties.

An analysis of initial accommodation hotels by Conversation over Borders (CoB) has found asylum seekers reporting pooling together their weekly financial support to cover the cost of cleaning supplies, as many of their facilities are unsanitary or they are provided spoiled food, thus limiting their ability to cover travel costs to appointments with this allowance[16]. Additionally, asylum seekers with lived experience report that staff can be 'dismissive or actively discriminatory regarding mental health conditions, including suicidal ideation'[17], as documented by Colette Batten-Turner, Founder of CoB in a report on the mental health of LGBTQIA+ asylum seekers within the UK[18]. One asylum seeker who spoke in a focus group with CoB felt that 'some people are protesting because they have been given false information about [asylum seekers]' and that resentment from other communities makes them feel 'unwelcome and unsafe… like the community doesn't want [them] here'. This sense of fear and isolation was widely shared in discussions with experts from numerous NGOs which informed this report.

Unfortunately, psychological distress and retraumatisation also seems to be embedded within many routine practices in the British asylum system. For example, the manner through which vulnerability assessments are undertaken, through to application of medico-legal evidence. The risk of re-traumatisation needs to be taken into greater account by the government when considering support measures. For instance, the age assessment system, which has been critiqued by the Royal College of Paediatrics and Child Health, can have an error margin of up to five years[19]. A lack of refinement to the age assessment system therefore places minors at risk of being placed in inappropriate adult accommodation, with significant implications to their safeguarding as well as exacerbating existing isolation and retraumatisation, particularly for those that have experienced physical and sexual abuse.

At the same time, many refugees are apprehensive that not engaging with what can often be invasive or humiliating tests may prejudice their asylum case, with there being a widespread sense of mistrust and impression that the asylum system is out to get them[20]. Regardless of these age-related concerns, accommodation for refugees is frequently described as unfit for purpose. Conditions are unsuitable and 'detention-like'[21] facilities and environments re-traumatise refugees, many of whom are fleeing persecution, torture or incarceration[22].

Greater accountability as to facilities and safeguarding in these accommodation would allow asylum seekers to make more effective use of their financial support from the government and hold providers to account for the services they claim to offer. This would directly address excessive financial and psychological strain on asylum seekers because of unsanitary conditions and inconsistent services. Unannounced inspections of initial accommodation facilities could provide a clearer assessment of the state of living conditions and the treatment of refugees, as many vulnerable individuals report discrepancies in services between times at which Home Office inspections are taking place and otherwise. Having more responsible and accurate coverage of this in the media may to some extent counter some of the hostility towards asylum seekers,

whose motivations and circumstances are often sensationalised and misrepresented in public discourse.

Engagement, Retraumatisation and Service Mismatch

Those who do succeed in accessing mental health services, nonetheless, demonstrate poorer adherence to medical management plans, with uncertainty shaping many of their life circumstances. Financial insecurity, employment restrictions, a loss of control over housing arrangements, risk of separation from family members and uncertainty around their legal status frequently take precedence over sustained engagement with treatment, particularly when changes are sudden or difficult to foresee.

Differences in engagement with care have been noted across age and accompaniment status. Worst affected are child and adolescent refugees, with a UK-based study finding unaccompanied minors to be more likely than those who were accompanied to have been through traumatic experiences prior to their resettlement and exhibiting a higher rate of PTSD. Despite greater clinical need, they were also found to demonstrate poorer adherence to and engagement with their care, reflected by higher rates of missed treatment sessions as well as appointments[5].

The value of interdisciplinary collaboration when approaching mental health services can be seen in the fact that UK-based studies showed that school-based services were better utilised by children with experiences of displacement. However, many experience difficulties finding appointments to access this support within the school day, without the need to miss academic teaching and classes. This places young people in a position to have to make decisions between and evaluate their mental wellbeing and education regularly. Over time, this adds to the already increased cognitive load of traumatic past experiences, reinforcing and widening the performance gap seen in outcomes and attainment across ethnicity, socioeconomic status and migration background, later in life[23].

Service inflexibility in opening hours similarly affects adult refugees, many of whom are parents; with only 30% of refugee and asylum seeker-specific services open outside of normal office hours or 13% on weekends, per a study of six European capital cities. This, alongside challenges in childcare, affects the ability for adults to access necessary support[5]. The rigidity of administrative processes can hinder refugees' engagement.

Awareness and Help-Seeking Behaviours

Reduced help-seeking among refugees reflects systemic ambiguity and a culture of fear. Across services currently accessible to migrants and refugees, there are many barriers to accommodating refugees' backgrounds and needs. One key example is the perceived coupling between the National Health Service (NHS), which runs the health service in the United Kingdom and the Home Office, which is in charge of the British asylum system. Although there is formally a clear separation, in practice the perceived overlap between these systems renders many asylum seekers fearful of making the most of available support, in case this might harm their asylum claim.

Although asylum seekers are entitled to free NHS care at the point of use, changes to asylum status, such as refusal, can cause a loss of access to secondary care services or imposition of financial charges, affirming the belief that the asylum system has a legal bearing over healthcare, even if this sentiment is not desired or enforced by clinicians as individuals[24]. Uncertainty surrounding confidentiality further blurs the boundaries between healthcare and the asylum system, leaving services to feel fragmented.

Barriers to accessing support are also driven by confusion surrounding the British healthcare system. Refugees may present to secondary care or emergency services with mental health complaints as opposed to utilising primary care and the referral pathways available to escalate their needs to specialists. This may stem from the fact that many other healthcare systems globally take a more interventional approach. The lack of uniform mental health pathways for refugees means that uncertainty is only echoed by clinical and community-based services, where clinicians may miss atypical presentations of trauma and can struggle to build trust with patients. Asylum seekers could significantly benefit from multilingual resources with a peer-led focus, taking the expertise of those with lived experience into account, with service providers remunerating them appropriately. This could highlight confidentiality to patients as well as support with skills navigating the healthcare system, such as digital literacy, as well as differentiating between services such as GPs and primary care, from emergency numbers and emergency departments[17,18].

Late presentation could be further explained by the difference in clinical presentation in some displaced populations. Psychological distress often manifests through somatic complaints and illness, making mental ill-health more difficult to diagnose and manage through specialist care due to clinicians' lack of familiarity with these. These presentations can include fatigue, sleep problems, loss of appetite or gastrointestinal upset and medically unexplained physical symptoms or non-specific pain; as well as the more frequently thought of emotional and cognitive changes. Behavioural issues such as hyper-arousal, emotional numbing through substance misuse, as well as aggression or excessive anger can mask PTSD or Generalised Anxiety Disorder (GAD) and depression[25]. These are often poorly distinguished by clinicians from malingering, which creates a mistrusting environment for refugees to disclose their concerns. Guidance has been issued by the government on recognising somatic

presentations, however, this awareness as well as teaching on cultural humility should start from the medical school curriculum and be integrated throughout postgraduate training to make these signs and symptoms more difficult to miss[26]. An awareness of this is also beneficial to prevent overmedication of problems which are otherwise associated with physical illness, as well as inappropriate referral.

In 2017, the Office for Health Improvement and Disparities issued guidance on caring for 'Vulnerable Migrants', encompassing refugees, asylum seekers, migrant workers, sex workers, victims of trafficking, unaccompanied minors and those who are homeless[25]. This raised awareness of the way in which social and legal circumstances may inform physical and mental health needs in these groups and signposted non-governmental and charitable organisations. Additional resources exist for assessing new patients arriving in the United Kingdom from overseas, though these only place a secondary focus on stressors applicable to refugees on migration and trauma-informed practice. This guidance, due to its advisory nature, is difficult to evaluate in terms of practical implementation, making progress difficult to measure. For this reason, a clear standard of care would be beneficial, against which clinical services could be audited for a higher level of transparency.

Stigma and Negative Perception

In the United Kingdom, stigma towards refugees has become quite an unfortunate and increasingly visible aspect of the socio-political landscape. On a personal and social level, stigma surrounding mental health exists across different cultures, creating barriers to access at the help-seeking stage[25]. Physical and mental health are not always seen as related to one another and there can be a tendency to suppress previous traumas, with individuals avoiding discussion or support.

The elevated risk of destitution among asylum seekers and refugees predisposes these groups to both poverty-related stigma and a sense of social exclusion, reinforced by mistreatment from members of their host communities. There is a clear relationship seen between financial insecurity and poor mental wellbeing, as demonstrated by Mental Health Foundation UK[27]. This is exacerbated by resentment and racism from many host communities, manifesting in forms from demonstration and protest to riots and violence at the doorsteps of initial accommodation hotels. This stems from misconceptions surrounding initial accommodation, which has been portrayed as a luxury by some media outlets, stoking resentment and taking a serious toll on the relational health of already disempowered refugees, who often feel worthless, a poorer sense of connectedness and most importantly threatened in their safety[14].

The relationship between self-empowerment and health outcomes is seen more widely in social epidemiology. A prominent example of this is Marmot's Social Determinants of Health, a culmination of factors determining socioeconomic status on a gradient, which shape daily living conditions and ultimately health outcomes such as life expectancy[28]. The landmark research projects - The Whitehall Studies I and II - additionally demonstrate a social gradient seen across groups of civil servants when considering their social status, with control over their living and circumstances inversely associated with health outcomes[29]. This parallels the experiences of refugees, who face a lack of autonomy which can negatively affect their mental health outcomes.

Children suffer from a third layer of stigma beyond the poverty that is out of their control, with fears among those who are school-aged that they will face social repercussions from peers if their mental health needs become apparent when accessing support, as much of this takes place within school hours and requires them to experience some academic disruption[5,30].

The scale of the asylum backlog crisis also suggests that an increased number of refugees are stuck in a 'limbo' phase, where the outcome of their asylum claim is uncertain and their ability to rebuild their lives through integrating into their community and work is scuppered by the multi-year wait for a decision[31]. A Freedom of Information Request made by the Refugee Council reports a fourfold increase in the number of individuals awaiting an initial decision on their asylum claims, as of 2022. In the same year, 725 people, including 155 children were seen to be waiting on a decision for over 5 years[32]. Freedom From Torture has highlighted concerns about proposals to limit people's access to the asylum system, with citizenship being seen as

‘really important’ to being able to rebuild their lives. Many asylum seekers resort to masking mental health symptoms for fear of discrimination or retaliation and affecting their outcomes within the asylum process[33]. Insights from experts who make regular contact with refugees say there seems to be a sense that their asylum claims hinge on a conditionality that they would be a model citizen, with physical and mental health difficulties something they worry might be seen as shortcomings. A lack of clarity on the interactions of these services with one another and the principles of confidentiality within medicine, coupled with a fear of racial discrimination, creates a mistrusting relationship between patients and busy healthcare professionals.

Across the available data on this subject, there could be a more specific focus on inequalities within sub-groups found within refugees, who are made up of a very heterogeneous mix of individuals and so interventions or needs which apply to some may not be applicable to the whole group. A gap in government insight in this area could be filled by more specific gathering of lived experience data by subgroups of refugees with heightened vulnerability to psychological challenges, such as gender, age and cultural groups. Whilst some information is available regarding the experiences of Unaccompanied Asylum-Seeking Minors, a more specific analysis of this issue could be undertaken to provide focussed recommendations in policy for this group.

Co-Designing a Clearer Standard of Care

Whilst guidance surrounding refugees' mental health is available for clinicians, on analysis, this is often loosely-worded and difficult to implement, or ascertain adherence to. It is worthwhile mandating a specific standard of Trauma-Informed Care which the government could commission the National Institute for Health and Care Excellence (NICE) to develop official guidelines for. This should also aid the creation of more uniform clinical pathways, with both asylum seekers and clinicians experiencing a lack of clarity in this area[34]. These standards and pathways would greatly benefit from co-creation with these two groups, as they will encounter these standards and pathways the most. Accountability is also needed within the staffing of the NHS. Appointment of a specific Trauma-Informed Care Lead could provide a structure for the advancement of Trauma-Informed Practice as well as a point of contact for transparency.

For many patients seeking asylum from countries with contrasting healthcare systems to the UK, they may be familiar with a more paternalistic approach towards healthcare, which can make shared-decision making an initially unfamiliar or dissonant experience. As well as this, repeated uprooting of individuals from initial accommodation to other places to live creates a lack of efficiency as to the way that information is shared between services, with administrative cost implications that provide no added benefit. For these reasons, any services introduced or made more widely available in the UK should be integrated in nature, with expert-led partnership at their core.

Independent UK charity, Freedom From Torture (FFT), provide an excellent model for the integration of services and provision of trauma-informed care. Aaliyah Burns, their Digital Campaigns and Engagement Manager describes their services as 'alongside therapy [using] translators as part of that therapy and... also [having] a legal and welfare service called the Legal and Welfare (LAWS) team... so that people receiving therapy can also get help with their housing or accessing benefits or accessing legal support which as all very vital as... different parts of healing'. This service supports torture survivors as well as asylum seekers and ought to be made available more widely. Freedom From Torture takes limited government funding, particularly not taking funding from the Home Office, in aims to distance from the Home Office to reduce the perception of coupling between support services and the often retraumatising asylum system. However, its reliance on individual donations and fundraising means that, although the impact of its campaigns is far-reaching, on a therapeutic level their benefit to service users is more localised[35]. This speaks to a wider issue of non-governmental and charitable organisations facing increasing pressure to plug fundamental gaps in funding and providing support services that the government ought to adopt in a wider and more uniform fashion nationwide.

Government-mandated Interdisciplinary Trauma Response Hubs should be pursued to mitigate the fragmented nature of support services. These hubs should coordinate assistance for high-risk individuals to receive mental health support, assistance with housing and accommodation as well as legal support as an inextricable link has been

established between financial and social insecurity with mental health outcomes. The government should seek to fund such hubs to mitigate pressure on non-governmental organisation and redirect administrative costs saved by integrating services towards improving them.

Trauma-Informed Practice

What is Trauma Informed Practice?

Trauma-Informed Practice is a holistic approach to physical and mental healthcare which takes into account the impact of exposures and traumatic experiences on a patient's physical health, mental health and social development, following a biopsychosocial model for healthcare. Whilst not a treatment for traumatic experiences, it is a lens through which the experiences of patients with traumatic backgrounds could be considered, with the aim of reducing barriers to access of services. It is framed around the needs of the individual rather than their perceived shortcomings[36].

Trauma-Informed Practice is embodied through 6 tenets:

- Safety
- Trust
- Choice
- Collaboration
- Empowerment
- Cultural Consideration

Whilst these principles are embodied in the positive, it is also important to avoid re-traumatisation of patients, which can occur both actively and passively through situations where the circumstances, feelings or thoughts of a traumatic event in someone's past may be re-experienced even if the events themselves have not reoccurred. Investigation and analysis of current practices within the British asylum system, as well as accommodation, is needed to build a more realistic picture as to the support asylum seekers are receiving, as well as identify specific areas where the asylum system is doing more harm than good. This could be done through unannounced inspections and mandatory mental health and safeguarding training for all staff who come into contact with vulnerable individuals.

It is important to note that Trauma-Informed Practice should consider the experiences of clinicians and support staff too, as many of them can be vulnerable to Vicarious Trauma. Vicarious Trauma is a 'process of change resulting from empathetic engagement with trauma survivors', as defined by the British Medical Association[37]. Appointing specific Trauma-Informed Care Leads across NHS trusts would also serve as a point of contact from a wellbeing perspective for clinicians who are experiencing repeated signs of Vicarious Trauma.

Recommendations

1. Implement a specific Mental Health risk questionnaire to Pre-Entry Health Assessments for asylum seekers and refugees, with provision of fast-track referrals on mental health pathways to specialist services before or soon upon arrival in the UK to provide better continuity of care to those with existing mental health or chronic conditions[38]. Supplement this with a more thorough initial screening process, including provision of a Mandatory Health Screening for refugees, with a specific section covering mental health needs. Access to professional interpreters should be mandated for all refugees at this point.

2. Mandate Trauma-Informed Care of asylum seekers and refugees by tasking NICE to develop official guidelines and a set of auditable standards to monitor adherence to this. Incorporating these standards into medical training, as well as training on recognising atypical mental health presentations at an undergraduate level and beyond.

3. Create Interdisciplinary Trauma Response Hubs to mitigate the fragmented nature of support services. These should coordinate assistance for high-risk individuals to receive mental health support, assistance with housing and accommodation as well as legal support as an inextricable link has been established between financial and social insecurity with mental health outcomes. The government should seek to fund such hubs and mitigate pressure on non-governmental organisations to plug this gap.

4. Ensure all NHS Trusts have Trauma-Informed Care Leads embedded within them, who are responsible for maintaining trusts' transparency on adherence to government guidance, as well as promoting the wellbeing of clinicians who are often vulnerable to Vicarious Trauma. This could be modelled after the EDI leadership put in place further to the NHS England Improvement Plan.

5. Mitigate 'No Recourse to Public Funds' by streamlining the asylum process for those arriving in the UK, with clear standards set by the Home Office for the time it should take to process their cases or reconsidering their rights to work. Key areas of opportunity for refugee empowerment may include training pathways for employment in translation and interpreting.

6. Improve opportunities for refugees' participation in policymaking outside of charitable organisations and NGOs, such as co-designing patient pathways with individuals and community groups who have lived experience navigating the UK's healthcare and asylum system.

7. The Home Office should carry out unannounced inspection of accommodation and asylum services, acting more efficiently on the testimonies provided by vulnerable individuals. Emergency action must be taken where standards are

inadequate and anyone who makes professional contact with refugees must be adequately trained in safeguarding, including initial accommodation staff.

8. The Office for National Statistics should gather lived experience data from subgroups of refugees who have heightened vulnerability to psychological and mental health challenges. It should also commission longitudinal policy analysis, which is wider in scope temporally, to analyse health trajectories further down the line after resettlement to observe patterns in chronic illness and long-term mental health illness. This would enable clinical and community-based services to better target existing mental health needs which are only resolved to some extent by health assessments and initial support services.

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