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CAMBRIDGE



Mental health in a migration crisis

Designing front-line services for refugees, asylum seekers and local populations at-risk in the United Kingdom

Insights from an academic - policy knowledge exchange workshop

UK Research and Innovation (UKRI)

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and Innovation

Report authors

Coutts A. P, Deakin S, Pochard D, Kienzler H, Chen A, Vernon P, Alnarjes H, Rayes D, Hamada N, Oliveau Morel S, Charles L, Miller F, Burghgraef A, Abbara A, Weise M, Chaddad V, Bashmi L, Fouad F. M, Sullivan R.

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Organisation committee, report authors and reviewers

[Professor Richard Sullivan](#), [Centre for Conflict and Health, King’s College London.](#)

[Professor Hanna Kienzler](#), King’s College London, Co-Director, ESRC Centre for Society and Mental Health.

[Professor Simon Deakin](#),

[Dr Adam P Coutts](#), Department of Psychiatry and Centre for Business Research, [University of Cambridge](#). Dr Coutts is supported by the National Institute for Health and Care Research (NIHR) Applied Research Collaboration, East of England (NIHR ARC EoE). The views expressed are those of the author and not those of the NIHR.

[Dr Fouad M. Fouad](#), [Faculty of Health Sciences, American University of Beirut](#) and Co founder of the [Syria public health network](#).

[Lorraine Charles](#), CEO [Na’amal](#).

[Diane Pochard](#), CSAP fellow, [Centre for Science and Policy](#), University of Cambridge.

[Sophie Oliveau Morel](#), Project consultant.

[Edith Champagne](#), Filmmaker.

[Madita Weise](#), Policy advisor.

[Dr Aula Abbara](#), [Imperial College London](#). Co founder of the [Syria public health network](#).

[Fran Miller](#), Senior Psychotherapist, Complex PTSD Pathway, [South London and Maudsley NHS Foundation Trust](#).

[Poppy Vernon](#), Refugee and Sexual Health Specialist.

[Anne Burghgraef](#), [Clinical director, Solace](#).

[Dr Vlad Chaddad](#), [International Rescue Committee](#), Lebanon.

[Dr Alexandra Chen](#), Trauma Psychologist & United Nations Advisor.

[Diana Rayes](#), Department of International Health, Johns Hopkins Bloomberg School of Public Health and Chair of the [Syria Public Health Network](#).

Luma Bashmi: PhD candidate, Department of Psychiatry, University of Cambridge. Co-Founder & Director, Elaa Beirut

Thank you to Raymond Harb, Mental Health and Psychosocial Support Manager International Rescue

Workshop facilitator: [Khaoula Trigui](#).

Participants from the following institutions attended the workshop:

Academics: Centre for Business Research - University of Cambridge, Conflict and Health Research Group - King's College London, [Refugees Health Program at the Global Health Institute](#) - American University of Beirut.

Frontline public services and civil society in the UK: NHS, [Doctors of the World UK](#), [Médecins sans Frontières UK](#), [Helen Bamber Foundation](#), [Solace](#), [UCLH Respond](#), [Freedom from Torture](#), [Action West London](#), [British Medical Association](#).

Civil society and Humanitarian agencies from MENA: [United Nations High Commissioner for Refugees](#), [Medair](#), Doctors of the World ([Medicine du Monde](#)), [International Medical Corps](#), [International Rescue Committee](#), [Middle East](#).

Details of the Research for Health in Conflict (R4HC) project can be found [here](#) along with [interviews with our research leads](#).

- 1) [What were the challenges in R4HC-MENA research?](#)
- 2) [What are the key research findings of R4HC-MENA?](#)
- 3) [Why is research important for academia and policy?](#)
- 4) [What were the key lessons from the research and project?](#)

Foreword

With public and political attention fixated on numbers of refugees arriving from Europe, giving proper thought and weight to their experiences as individual human beings is long overdue. There are many voices calling for this, but few have had an effect so far on policy-making by governments.

Britain has a mixed record: the genuine compassion for refugees shown in much of society is set against the chilling “hostile environment” policy put in place by the government. Subsequent hardening of the policy, in the face of its failure to achieve its deterrent purpose, has compounded its harmful effects on human lives. The harm inflicted on individuals goes on to damage the social cohesion of communities and families, for lifetimes.

The work done by the participants in this workshop springs from both a humanitarian approach to refugee needs, and clear-headed understanding that the psychological harm being inflicted by current policies is creating a greater problem for Britain as a society, with serious consequences long into the future.

This report explains how these unintended and highly undesirable consequences of policy choices can be mitigated, and if possible reversed, without creating pressure on public services that is not more than offset by long-lasting and beneficial outcomes.

The report is centred on mental health services. These will never be sufficient to meet the needs of the population if, elsewhere in the picture, government policies are not helping to enhance the existing capacity of frontline services for both local populations at risk and newly arrived refugees. Coping with trauma and mental health issues, as the great majority of refugees arriving in Britain are, requires a supportive environment of trust, hope and recognition. Not its exact opposite.

I hope all those involved in wrestling with the difficult questions of refugee and asylum policy will take time to read and think about the important conclusions reached in this report. And act in the way proposed.

James Watt is a former British Ambassador to Lebanon, Jordan and Egypt and Chairman, International Advisory Board, Research for Health in Conflict in the Middle East and North Africa, Conflict and Research Group, King’s College London.

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Abbreviations and acronyms

DWP: Department for Work and Pensions

DHSC: Department of Health and Social Care

FCDO: Foreign, Commonwealth and Development Office

HO: Home Office

IMC: International Medical corps

IOM: International Office of Migration

MH: Mental Health

MdM: Médecins du Monde

MENA: Middle East and North Africa

MHPSS: Mental health and Psychosocial Support

R4HC: Research for Health in Conflict

RAS: Refugees and Asylum Seekers

UK: United Kingdom

UNHCR: United Nations High Commissioner for Refugees

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Policy brief: Options and recommendations

The current asylum and refugee crisis response being played out in Portland off the Dorset coast is damaging brand Global Britain. It threatens to relegate us from the Premiership of nations. In the media and political hubbub, the personal stories, mental health and wellbeing of migrants, refugees and asylum seekers is absent.

Survival migration¹ and population displacement are challenges that will worsen in coming years due to climate change, conflict, and economic crises. The United Nations state that one in eight of all people across the world are on the move – an estimated 1 billion people. Of this population, one in 10 (100 million people by end of May 2022) have been displaced due to armed conflict and climate change.² Practical policy ideas based on evidence, and which treat people humanely are now needed to tackle these systemic challenges.

Current situation

The arrival of refugees via the Home Office resettlement programme and smuggling routes across the English Channel has become a highly politicised issue creating anger and fear among the UK population. The latest immigration estimates suggest that in June 2022, around 16% of immigration was accounted for by asylum seekers and refugees. This included 75,000 people who sought asylum through the UK's in-country process, 12,000 relocated Afghans, and 89,000 Ukrainians.⁴ In an international league table the UK sits at the bottom in terms of registration of new asylum seekers. European countries have resettled more refugees relative to their populations, as well as more asylum seekers.³

¹ Betts, Alexander (2013) *Survival migration: failed governance and the crisis of displacement*. Cornell University Press. Available at: <https://library.oapen.org/bitstream/handle/20.500.12657/30779/642723.pdf?sequence=1>

² WHO-UNHCR (2023) *Concept Note for the Third Global Consultation on the Health of Refugees and Migrants 13-15 June 2023*. Rabat, Kingdom of Morocco. Available at: https://cdn.who.int/media/docs/default-source/country-profiles/refugee-and-migrant-health/concept-note-for-3rd-global-consultation-on-the-health-of-refugees-and-migrants_final.pdf?sfvrsn=3b11930d_6

³ Kienzler H, Mitwalli S, Cicek M (2022) 'The experience of people with psychosocial disabilities of living independently and being included in the community in war-affected settings: A review of the literature', *International journal of law and psychiatry*. 81, 101764.

‘Global Britain’⁴ is perceived as a stable and welcoming country adhering to the rule of law; one in which people are safe and can *get on* and better their lives and that of their families. Unfortunately, the policy landscape, media and domestic environments in which they arrive are similar to the ones they left in the Middle East. They are confronted by coarse statements from governing politicians who tell them to ‘*F*** off back to France*’⁵, portrayed as ungrateful and dependent on the State, an ‘*unwanted influx who are taking our jobs*’ and threatening ‘*our ways of life*’, including the social cohesion of local communities.⁶ These vulnerable groups have become ‘stuck in legal limbo’, politicised by the Illegal Immigration Act and the policy mantra of ‘stop the boats’;⁷ political rhetoric wheeled out in hope of placating disgruntled constituents in marginal seats in England.⁸ Indeed, a June 2023 poll by Nesta shows ‘managing the numbers of both legal and illegal migration to the UK’ as a key public concern in these battleground Westminster constituencies.⁹

The economic case: a win-win

Recent research shows that employing refugees and asylum seekers seems to be an *economic no-brainer*. The Migration Observatory at Oxford University found that allowing people seeking asylum the right-to-work would increase tax revenue by £1.3 billion, reduce Government expenditure by £6.7 billion, increase GDP by £1.6 billion, and improve the mental

⁴ HM Government (2021) *Global Britain in a competitive age The Integrated Review of Security, Defence, Development and Foreign Policy*. March. Available at:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/975077/Global_Britain_in_a_Competitive_Age_-_the_Integrated_Review_of_Security__Defence__Development_and_Foreign_Policy.pdf

⁵ The Independent Newspaper (2023) Lee Anderson’s ‘*f*** off back to France*’ remark risks making Tories ‘even nastier party’. August 9th. Available at: <https://www.independent.co.uk/news/uk/politics/lee-anderson-asylum-seekers-gb-news-b2389815.html>

⁶ Commission on the integration of refugees (2022) *A broken system: Asylum reform initiatives 1997-2022*. Produced by the Good Faith Partnership for The Commission on the Integration of Refugees, November. Available at: https://refugeeintegrationuk.com/wp-content/uploads/2022/12/CIR_Asylum_Reform_Report.pdf

⁷ United Kingdom Parliament (2023) *Illegal Migration Act. Government Bill*. Available at: <https://bills.parliament.uk/bills/3429>

⁸ Institute for Government (2022) *Stop the boats, get the votes? Inside briefing podcast*. Available at: <https://www.instituteforgovernment.org.uk/podcast/inside-briefing/stop-boats-get-votes>

⁹ Nesta (2023) What does the public expect the government to be able to solve by 2040? Available at: <https://options2040.co.uk/what-public-expect-government-to-solve-by-2040/>

health and wellbeing of those individuals'.¹⁰ Current political arguments that asylum seekers cost six million pounds per day in terms of accommodation needs could easily be offset by allowing the right-to-work.¹¹ There are currently over a million job vacancies in the UK with industries such as hotel and catering struggling to find staff.¹² The NHS is facing critical staff resource shortages which displaced medics and nurses could help alleviate.¹³ *Asylum seekers and refugees could pay for themselves: they have a good rate of return and are value for money!*

The security and cohesion case

In addition, emerging research shows that social discrimination suffered by refugees in host countries may negatively impact their mental health. This developing body of research suggests these mental health issues may also increase their susceptibility to extremism and radicalisation.^{14 15 16} Existing research shows that frontline mental health professionals have a role to play in the treatment and understanding of radical engagement particularly among

¹⁰ National Institute of Economic and Social Research (2023) *The Economic and Social Impacts of Lifting Work Restrictions on People Seeking Asylum*. June. Available at: <https://www.niesr.ac.uk/publications/economic-social-lifting-restrictions-people-seeking-asylum?type=discussion-papers>

¹¹ Sarah Dines, a Home Office minister, told Sky News earlier on Monday August 7th that the barge formed part of a plan to increase the number of sites the government could use to house migrants after the bill for hotels rose to 6 million pounds (\$7.7m) a day. See also The Independent Newspaper (2022) 'Government spending £6.8m a day housing asylum seekers in hotels', Government spending £6.8m a day housing asylum seekers in hotels'. October 26th. Available at: <https://www.independent.co.uk/news/uk/diana-johnson-channel-government-french-mps-b2210968.html>

¹² Office of National Statistics (2023) *Vacancies and jobs in the UK: May 2023: Estimates of the number of vacancies and jobs for the UK*. Available at: <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/bulletins/jobsandvacanciesintheuk/may2023>

¹³ House of Lords Library (2022) *Staff shortages in the NHS and social care sectors*. December 9th. Available at: <https://lordslibrary.parliament.uk/staff-shortages-in-the-nhs-and-social-care-sectors/>

¹⁴ Brooks S K, Greenberg N (2021) *Mental health, complex needs and vulnerability to radicalisation*. National Institute of Health Research Health Protection Research Unit in Emergency Preparedness and Response. Report for the Department of Health and Social Care. Available at: <http://epr.hpru.nihr.ac.uk/sites/default/files/DHSC%20Radicalisation%20Report%20-%20pdf.pdf>

¹⁵ Viazminsky A, Borho A, Morawa E, Martin Schmitt G, Erim Y (2022) 'Perceived discrimination among Syrian refugees in Germany and its associations with mental health', *Global Public Health*, 17:11, 2854-2867,

¹⁶ European Union, Home Affairs (2019) *Extremism, radicalisation and mental health handbook for practitioners*. Available at: https://home-affairs.ec.europa.eu/system/files/2019-11/ran_h-sc_handbook-for-practitioners_extremism-radicalisation-mental-health_112019_en.pdf

young people.¹⁷ An NIHR (2021) report prepared for the DHSC, on the links between mental health and radicalisation proposes that it is important to establish the evidence base for the relationship between mental health and radicalisation, in order to ensure that the support being provided by Prevent and other programmes is appropriate' (Page 4).¹⁸

Displacement from the Middle East: impacts on mental health

Displaced people from the Middle East are heavily represented within the cohort of asylum seekers.¹⁹ In 2021, 42% of asylum applicants were nationals of Middle Eastern countries (three of the top five countries being Iraq, Iran and Syria).²⁰ Home Office data shows that of all refugees resettled in the UK from January 2010 to December 2021, around 70% were Syrian citizens. From January 2010 to December 2021, '31,101 refugees were resettled in the UK under its six different resettlement schemes. Around three-quarters (76%) were citizens of Middle Eastern countries, and 17% were citizens of sub-Saharan African countries. Most were nationals of Syria: 68%.'²¹

This is unsurprising given the Eastern Mediterranean Region has experienced severe humanitarian emergencies as a direct result of conflict, economic and political instability over the past ten years. In 2020, nine countries out of 22 countries in the region were affected by protracted and ongoing conflicts, which has left a population the size of the UK - more than 62 million people living in daily chaos and in dire need of access to basic quality health care.²² The 2011 conflict in Syria alone led to the largest displacement of people since World War Two. Alongside this in-country support and funding from the Foreign and Commonwealth

¹⁷ Campelo N, Oppetit A, Neau F, Cohen D, Bronsard G (2018) 'Who are the European youths willing to engage in radicalisation? A multidisciplinary review of their psychological and social profiles', *European Psychiatry*, 52, 1-14.

¹⁸ Brooks S K, Greenberg N (2021) *Mental health, complex needs and vulnerability to radicalisation*. NIHR Health Protection Research Unit in Emergency Preparedness and Response. Report for the Department of Health and Social Care. Available at: <http://epr.hpru.nihr.ac.uk/sites/default/files/DHSC%20Radicalisation%20Report%20-%20pdf.pdf>

¹⁹ House of Commons Library (2023) *Asylum statistics, Research Briefing*, Published Wednesday, March 1st. Available at: <https://commonslibrary.parliament.uk/research-briefings/sn01403/>

²⁰ Ibid.

²¹ The Migration Observatory (2022) *Asylum and refugee resettlement in the UK*. COMPASS. University of Oxford. Page 15. Available at: <https://migrationobservatory.ox.ac.uk/wp-content/uploads/2022/08/MigObs-Briefing-Asylum-and-refugee-resettlement-in-the-UK.pdf>

²² Fouad F M, Soares L, Diab J L, Abouzeid A (2022) 'The political economy of health in conflict: Lessons learned from three states in the Eastern Mediterranean Region during COVID-19', *Journal of Global Health*. Feb 12.

Development Office has dwindled over recent years thereby hampering development and early recovery policies which may have helped to stabilise neighbouring frontline countries and offset migration and displacement out of these humanitarian crises.²³

The majority of refugees and asylum seekers arriving in the UK are highly vulnerable and traumatised compared to the general population after having experienced conflict and armed violence in their home countries.²⁴ A small body of research exists which shows that many arrive with severe pre-existing conditions (e.g. schizophrenia, bipolar etc) about which we know hardly anything in conflict affected settings and among refugee populations.²⁵ On top of this they face considerable challenges along the migration and smuggling routes through Africa, the MENA and Europe. Upon arrival in Europe and the UK they must deal with the complicated and protracted administrative processes of asylum applications.²⁶

Various commentators have suggested that some European countries and the UK have a 'double standard' in their approach to Afghan, Syrian and Iraqi refugees versus those recently originating from the Ukraine.²⁷ In March 2022 the UK Home Office confirmed that 25,500 visas had been issued to Ukrainians since the war began, while the UK resettled only 20 000 Syrian refugees over the last six-years.²⁸

²³ The Foreign, Commonwealth & Development Office (FCDO) (2023) *Annual report and accounts for financial year 2022 to 2023*. Available at: <https://www.gov.uk/government/publications/fcdo-annual-report-and-accounts-2022-to-2023>

²⁴ See Fazel M and others (2005) '[Prevalence of serious mental disorder in 7,000 refugees resettled in Western countries: A systematic review](#)', *The Lancet*, 365, 1309-1314; Tempany M (2009) '[What research tells us about the mental health and psychosocial wellbeing of Sudanese refugees: A literature review](#)', *Transcultural Psychiatry*, 46, 300-315; Pollard T, Howard N. (2021) '[Mental healthcare for asylum-seekers and refugees residing in the United Kingdom: a scoping review of policies, barriers, and enablers](#)', *International Journal of Mental Health Systems*. 2021;15(1):60.

²⁵ Kienzler H, Mitwalli S, Cicek M (2022) 'The experience of people with psychosocial disabilities of living independently and being included in the community in war-affected settings: A review of the literature. *International Journal of Law and Psychiatry*', 81, 101764.

²⁶ Pollard T, Howard N (2021) '[Mental healthcare for asylum-seekers and refugees residing in the United Kingdom: a scoping review of policies, barriers, and enablers](#)', *International Journal of Mental Health Systems*. 2021;15(1):60.

²⁷ Chatham House (2022) *Ukraine exposes Europe's double standards for refugees*. Available at: <https://www.chathamhouse.org/2022/03/ukraine-exposes-europes-double-standards-refugees>

²⁸ Ibid.

How we treat the most vulnerable, both those newly arrived and locals, is understood beyond the UK to reveal a great deal about the level of care and importance to which policy and politicians pay to those who most need our help. Perceptions of how debased policy and the media narrative have become in modern Britain are now commonplace abroad, limiting the scope for meaningful cooperation with our international partners.

Workshop overview: Designing mental health services for refugees, asylum seekers and local populations at risk

The purpose of the workshop was to bring together policy and frontline staff from across the UK and frontline humanitarian countries in the Middle East who work in or have experience of mental health (MH) provision for refugees and asylum-seekers. The aim: *to critically examine how mental health services for refugees and asylum seekers could be improved and how policy discourses in the UK may be framed to become more humanitarian and sensitive to the MH needs of refugees and asylum seekers.*

The Global Challenges Research Funded -Research for Health in Conflict (R4HC) project has generated a [vast amount of knowledge and evidence on the health](#) of refugees and health system design across a number of Middle Eastern countries such as Turkey, Jordan, Lebanon and Gaza. The workshop aimed not only to share this knowledge with UK counterparts but also to ensure the first-hand experience of refugees were present. Challenges faced and ideas for improvement were workshopped to bring together a set of key policy and research recommendations.

36 participants took part in the full-day workshop, ranging from healthcare professionals, researchers, students and policy advisors. Facilitators used a human-centred design approach with six stages: plan, discover/empathise, define, ideate, prototype and test, embed.

Participants first mapped the MH service landscape for refugees in the UK. MH services are under increasing strain with over 1.4 million people waiting for treatment.²⁹ It is well documented that Refugees and Asylum Seekers (RAS) have complex and diverse needs, due to the profound impact of migration and trauma, the stress of acculturation and social discrimination, as well as additional barriers when accessing MH services. Participants noted that current MH provision is fractured, confusing and often ill-equipped to manage this complex population.

When asked to explore challenges in more detail, workshop participants examined micro- and macro-level factors. A hostile UK policy environment, unsuitable living arrangements, lack of support and information-sharing, drawn-out claims, as well as language barriers currently intensify RAS' MH difficulties.³⁰ Healthcare providers and refugees with first-hand experience reported how the lack of early intervention can lead to long-term MH conditions and increased fiscal burden on the NHS. Knowledge and data on the health status of refugees and asylum seekers in the UK is limited, as is experience and specialisation in supporting healing. The recent Department for Health and Social Care (DHSC) discussion paper 'Mental health and wellbeing plan' discussion paper noted that 'there is a gap in the literature regarding UK-wide assessment of access and delivery of mental healthcare for asylum seekers and refugees in the UK'.³¹

For the third part of the workshop, participants were asked to examine the root causes of the issues. Public opinion towards those claiming asylum in the UK is complex and often exploited

²⁹ Royal College of Psychiatrists (2022) Record 4.3 million referrals to specialist mental health services in 2021. Available at: <https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2022/03/15/record-4.3-million-referrals-to-specialist-mental-health-services-in-2021>

³⁰ Asif Z, Kienzler H (2022) 'Structural barriers to refugee, asylum seeker and undocumented migrant healthcare access. Perceptions of Doctors of the World caseworkers in the UK', *Social Science and Medicine-Mental Health*, 2, 100088.

³¹ Department of Health and Social Care (2022) *Mental health and wellbeing plan: discussion paper*. Available at: <https://www.gov.uk/government/consultations/mental-health-and-wellbeing-plan-discussion-paper-and-call-for-evidence/mental-health-and-wellbeing-plan-discussion-paper>; See original paper: Pollard T, Howard N (2021) 'Mental healthcare for asylum-seekers and refugees residing in the United Kingdom: a scoping review of policies, barriers, and enablers' *International journal of mental health systems*. 2021;15(1):60.

by political agendas. The strain on health provision leads to competition for care which can cause a detrimental effect on social cohesion and increased animosity towards refugees. Furthermore, government policy currently appears to focus on deterring migration, rather than supporting those who have claimed asylum here to successfully navigate their new life and employment in the UK.

The importance of social integration was discussed in-depth, in order to improve long-term outcomes for refugees and continued migration. Two workshop participants from Lebanon described how creative hobbies during their displacement helped them mitigate the continuous stress they faced. In terms of policy, several participants advocated strongly for the participation of asylum-seekers in the labour force, particularly displaced medics and commissioning research to demonstrate the economic value of providing the right-to-work for refugees and asylum seekers in the UK.

The final section of the workshop brought together key policy options and recommendations to improve mental health services, provision and policy. These are detailed in section five of the report and summarised below in options for high level policy, humanitarian operations and future research needs.

Headline policy and operational options

- 1. Ensure equitable service access and delivery for RAS and local populations at risk.**
- 2. Develop a cross-departmental government approach to supporting refugees and asylum seekers.**
- 3. Support and fund holistic models of care at local, regional and national levels.**
- 4. Creation of Refugee and Asylum Seeker Mental Health Guardians.**
- 5. NHS England to increase 'trauma sensitive' training of frontline staff.**
- 6. Trialling of healthcare record passport.**

-
7. **Include interventions and programmes sensitive to refugee and asylum seeker needs in the Levelling Up agenda.**
 8. **Changing public perceptions and the media narrative.**
 9. **Quality Rights assessments of any institution or frontline service delivering MH support.**
 10. **Increase funding support to successful employment interventions for refugees and asylum seekers.**
 11. **Enhance and speed up process to employ medical professionals who are stuck in the asylum system.**

Research and community of practice recommendations

1. **Establish an assessment (updated each month) of available MH service provision across the UK.**
2. **Develop the economic case for employing refugees and asylum seekers.**
3. **Establish research to examine links between refugee mental health and susceptibility to extremism and radicalisation.**
4. **Develop advocacy strategy and engagement plan.**
5. **The inclusion of policy professionals in all network activities.**
6. **Organise resources and formalise research, policy and community of practice network.**
7. **Impact evaluation of public and media campaigns to assess effects on social cohesion and general public attitudes and views.**
8. **Address the evidence gap on interventions targeting the MH of RAS and refugees in the UK.**

Policy options and recommendations

- 1) **Ensure equitable service access and delivery:** Any future policy developments concerning health service and mental health support for refugees and asylum seekers needs to also incorporate the ongoing needs of host communities and local populations at risk. The equivalent capacity building among service providers for local populations at risk is required. This will help to increase equity of access and avoid increasing local tensions between service users - *a them and us scenario in service*

delivery. It will prevent different health systems and treatment paths from developing which are inefficient, cumbersome and have fiscal implications. Currently this is a major issue in humanitarian contexts with dual health systems being present such as UNRWA services in Lebanon and Jordan which operate alongside the public and private systems.

- 2) **Develop a cross-departmental government approach:** Establish a Humanitarian and Domestic Health Hub for refugees and asylum seekers, that includes key third-sector stakeholders, to improve data-sharing and budgetary planning for MH service with designated focal points per department responsible for coordination. This would function across DHSC, Home Office, DWP and FCDO.
- 3) **Support and fund holistic models of care at regional and national level:** bringing employment, health and welfare services together in the asylum process. This requires adopting and promoting a social determinants of health approach to service design and delivery.³² This means better interoperability and cooperation must be developed between the Home Office, DWP, JCP, NHS and local MH frontline services.
- 4) **Refugee and Asylum Seeker Mental Health Guardians:** Strengthen clinically effective prevention, early intervention, community-based and peer support approaches. The approach currently advocated by the NGO Solace to develop a network of Refugee and Asylum Seeker Mental Health Guardians³³ should be further supported by local and central governments.
- 5) **NHS England to organise training of frontline staff:** by experts in refugee mental health to increase staff awareness for treating refugees and asylum seekers in a respectful, inclusive and patient-centred manner, and to better understand cultural and experience-influenced cues and barriers. Services need to be nuanced in their

³² World Health Organization. *The social determinants of health*. Available at: <https://www.who.int/health-topics/social-determinants-of-health>

³³ Solace (2023) *The champions model*. Available at: <https://www.solace-uk.org.uk/new-free-e-learning>

sensitivity to the diverse background experiences and non-homogeneous needs of refugees and asylum seekers. Within this a pragmatic and quick win is to increase funding for training of translators and interpreters in trauma-sensitivity and Psychological First Aid and pipeline them to staff all actors in this sector. They are often the main focal point for refugees and a source of psychosocial support. This is the German model and has been effective.

- 6) **Trialling of a healthcare record passport:** Explore the feasibility of a 'health information passport' which contains key individual health information that a refugee can carry with them on a mobile application. This could be updated in each country they pass through. To facilitate this and provide the infrastructure a feasibility study should be established which explores the possibilities and challenges of linking and harmonising the humanitarian and asylum data ecosystem (especially health information) between INGOs and multilaterals in frontline countries such as Lebanon and Turkey to frontline domestic MH services and the Home Office in the UK.³⁴ *Interoperability between these organisations is absent and hinders health service planning and budgeting. Joining up the data ecosystem will help frontline UK services to prepare in terms of MH demands and needs among refugee populations departing frontline countries.*

Include and support interventions and programmes sensitive to refugees and asylum seeker needs in the [levelling up agenda](#): to enhance social participation of refugees and asylum-seekers in local communities. Various examples exist which use community [social infrastructure](#) to increase social connection and social capital between groups. One is the Sanctuary Kitchen / [CitySeed in New Haven, United](#)

³⁴ There are serious ethical and data protection issues with this proposal. Considering that many refugees move through a number of countries before settling in the UK, these health records might be out-of-date. Also, to what extent might this be dangerous when regimes are involved (including their health services) that do not have the best interest of people fleeing in mind?

[States](#).³⁵ ³⁶ This is a culinary training and development programme for refugees and asylum seekers which uses food from the countries of refugees to break down cultural barriers and educate local people about the challenges of being a refugee. In the UK there are various example initiatives of community led approaches that enable locals to interact with refugees.³⁷ The intended aim of these community projects is to overcome many of the stereotypes local people have of resettled refugees. In setting up local community initiatives it is advisable that they seek guidance from UNHCR. The agency has a toolkit and resource to support this.³⁸ These small scale and local initiatives are vital. They encourage public opinion to push for a more empathetic asylum-process. It is the case that most people in England do not know, interact or ‘rub along’ with refugees or asylum seekers and therefore do not have an accurate idea of the issues they face.

- 7) **Quality Rights assessments of any institution or frontline service delivering in-patient or out-patient mental health care:** These are needed to ensure adherence to human rights and ethical practices. This can help advocate for a better quality of care. Considering the vulnerability of RAS, instances of human right violations or unethical practices may take place.

- 8) **Changing public perceptions and the media narrative:** Academics, NGOs and the media must coordinate to shape narratives to be more welcoming and positive about refugees and asylum seekers to counter the growing social discrimination. Mass media

³⁵ ‘Sanctuary Kitchen provides professional development and employment at an above-market wage for immigrants, refugees, and asylum seekers in the Greater New Haven area. Currently, 100% of Sanctuary Kitchen chefs are women. Sanctuary Kitchen chefs have reported reduced social isolation, increased financial stability, improved English language skills, professional culinary skills, and new relationships and networks that provide sustained holistic support. Since its establishment, they have also hosted more than 700 refugee/immigrant-led culinary events, which have reached thousands of community members in New Haven, and across the world’. See: <https://www.sanctuarykitchen.org/>

³⁶ Ermansons G, Kienzler H, Asif Z, Schofield P (2023) ‘Refugee mental health and the role of place in the Global North countries: A scoping review’, *Health and Place*, 79, 102964. UK: <https://www.sciencedirect.com/science/article/pii/S1353829223000011>

³⁷ Sona Circle (2023) *Five Great Initiatives Supporting Refugee Integration in the UK*. Available at: <https://sonacircle.com/5-great-initiatives-supporting-refugee-integration-in-the-uk/>

³⁸ UNHCR (2023) *Promoting integration through social connections. Integration handbook*. Available at: <https://www.unhcr.org/handbooks/ih/social-connections/promoting-integration-through-social-connections>

and awareness campaigns using positive case-studies is one method to raise awareness and understanding of challenges refugees and asylum seekers face. These are important mediums by which to begin to dispel and challenge misconceptions surrounding refugee behaviours and attitudes.

However, there is a need to avoid ‘preaching to the choir’ in terms of raising awareness and changing public attitudes. Information and media campaigns should challenge misinformation and ‘bad’ statistics where they exist. Reporting should be balanced to take account of local residents' views, government representatives, frontline staff, refugee and asylum seekers. *We are producing two advocacy films to document the humanitarian and policy challenges in supporting refugees and issues with the asylum process in the UK.*

- 9) **Increase funding support to successful employment interventions:** such as the integration of refugee medics such as the [Lincolnshire Refugee Doctors Project](#) (LDRP).³⁹ More widely this involves supporting initiatives such as the [Medical Support Worker](#) scheme which was established during COVID-19 to allow refugee doctors and International Medical Graduates in the UK to work for the NHS (with some restrictions to practise) while undertaking registration with the General Medical Council.⁴⁰ In 2023, though the scheme is to continue with central funding, as of June 2023, the release of funds from the treasury is awaited, leaving many refugee doctors, particularly from Sudan and Ukraine in limbo. The Syrian British Medical Society and the Syria Public Health Network, continue to advocate for the continuation of this scheme.

³⁹ See University of Cambridge (2020) *Syrian refugee health workers can help Europe cope with COVID-19*. Available at: <https://www.cam.ac.uk/research/news/syrian-refugee-health-workers-can-help-europe-cope-with-covid-19>

⁴⁰ National Health Service (2023) *Medical support worker role helps hundreds of refugees to become NHS doctors*. Available at: <https://www.england.nhs.uk/2022/06/medical-support-worker-role-helps-hundreds-of-refugees-to-become-nhs-doctors/>

Research recommendations

- 10) **Establish an assessment (updated each month) of available MH service provision across the UK** (County by county), creating an online and realtime platform for healthcare professionals to triage patients and map service availability and providing translation in key languages where possible. *Frontline service staff who attended the workshop said this would be a valuable resource for domestic and refugee groups. It currently does not exist. An example from London is the Mental Health and Psychosocial Support Directory for Refugees and Migrants: <https://www.kcl.ac.uk/research/mhpss-directory>.*⁴¹
- 11) **Develop the economic case for employing refugees and asylum seekers:** From case study interventions and programmes such as the refugee employment initiative Na’amal and the LRDP, it is possible to develop an economic case for participation of professional groups of refugees and asylum seekers in host communities in the Middle East and the UK labour markets. The evidence for employing asylum seekers is developing. A recent report by the National Institute of Economic and Social Research found that ‘allowing people seeking asylum the right to work would increase tax revenue by £1.3 billion, reduce Government expenditure by £6.7 billion, increase GDP by £1.6 billion, and improve the mental health and wellbeing of those individuals’.⁴² Therefore we propose that research should be commissioned through organisations such as [Elrha](#) and the new *The International Science Partnerships Fund (ISPF)* of the [UKRI](#). Research should explore (a) the appetite of UK employers to employ remote talent from the refugee community and (b) how much of refugee and asylum seeking is now economically driven as much as it is war and displacement driven, the latter which can be led in partnership with frontline actors working with the refugee community. This will generate evidence on 1) the cost-effectiveness especially Return on Investment (ROI) and Value for Money (Vfm) of interventions to support refugees

⁴¹ See the directory at: <https://www.kcl.ac.uk/csmh/assets/csmh-mhpss-refugee-migrant-directory-v2-june22.pdf>

⁴² National Institute of Economic and Social Research (2023) *The Economic and Social Impacts of Lifting Work Restrictions on People Seeking Asylum*. June. Available at: <https://www.niesr.ac.uk/publications/economic-social-lifting-restrictions-people-seeking-asylum?type=discussion-papers>

particularly the provision of MH services to asylum seekers in frontline humanitarian countries and in domestic settings such as the UK. 2) research is needed on the fiscal contribution of employing displaced professional groups such as medics and nurses in the NHS and for the UK economy.

12) Address the evidence gap on interventions targeting the MH of RAS and refugees in the UK. Currently there is little evidence from a UK context about interventions to support the MH of refugees and RAS. This evidence gap was highlighted by the recent DHSC *Mental health and wellbeing plan*.⁴³ Example interventions from humanitarian contexts in which may field experiments have taken place may be replicated and transferred to the UK context.

Next steps for the community of practice will be to:

- 1) **Advocacy strategy and engagement plan:** Organise a series of follow up meetings to propose an advocacy strategy and engagement plan. There is an opportunity to strengthen these networks and knowledge exchange between researchers and practitioners, particularly in supporting a group initiated during the workshop.
- 2) **The inclusion of policy professionals:** Future workshops must ensure participation of policy decision makers and those on-the-ground. For such a complex challenge as mental health service design and delivery, it is proposed that further and more focussed workshops are organised to address service issues such as system interoperability and data sharing agreements across the spectrum of contexts (IOM, UNHCR, UK Home Office).

⁴³ Department of Health and Social Care (2022) *Mental health and wellbeing plan: discussion paper*. Available at: <https://www.gov.uk/government/consultations/mental-health-and-wellbeing-plan-discussion-paper-and-call-for-evidence/mental-health-and-wellbeing-plan-discussion-paper>

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- 3) **Organise resources and formalise network:** Create a central repository of resources, a virtual group (ie. LinkedIn group) and a directory of individuals and organisations working in the field.
 - 4) **Further funding:** Prepare a grant application to conduct an audit of MH service provision and access across England.
 - 5) **Impact evaluation:** Conduct a pre / post evaluation of the local UK sentiment towards Refugees and Asylum Seekers to measure whether public and media campaigns have been successful in improving social cohesion and general public attitudes and views.

1. Introduction, workshop aims and objectives

The objective of the workshop was to bring together a community of practice stakeholders - academics, frontline workers, policy decision makers and those with lived experience to examine the challenges of designing mental health services for vulnerable groups in the United Kingdom. This includes local at-risk populations in 'left behind' areas of the UK, and refugees and asylum seekers originating from conflict and humanitarian crises in the Middle East and North Africa (MENA) region.

The brief of the workshop was to explore two key objectives:

- 1) *'How asylum, refugee, health, development and humanitarian policies can be brought together in order to provide a more holistic, equitable, cost effective and humane approach to stabilising people's lives?' and*
- 2) *'Are there commonalities and lessons of what works and what does not work from the spectrum of contexts in which refugees, asylum seekers and vulnerable host communities access MH services?'*

The 2022 WHO World Report on the Health of Refugees and Migrants⁴⁴ stated that migrants' and refugees' health needs should be a global health priority. The strengthening and sustaining of health systems is paramount to guarantee the specific health needs of refugees and vulnerable communities are supported. Recently the *Third Global Consultation on the Health of Refugees and Migrants* noted that '...the health of refugees and migrants has never been so important, as one in eight of all people across the world are on the move – an estimated 1 billion people. Of this population, one in 10 (an estimated 100 million people by end of May 2022) were forcibly displaced from their homes and communities due to conflict, violence, human rights violations, natural and human-generated disasters and, increasingly, from the consequences of climate change'.⁴⁵

⁴⁴ WHO (2022) *World report on the health of refugees and migrants*. Geneva. Available at: <https://apps.who.int/iris/handle/10665/360404>

⁴⁵ WHO-UNHCR (2023) *Concept Note for the Third Global Consultation on the Health of Refugees and Migrants 13-15 June 2023*. Rabat, Kingdom of Morocco. Available at: <https://cdn.who.int/media/docs/default->

Frontline mental health workers from across contexts – London, Leeds to Beirut and Damascus attended the workshop. They are well placed to understand the challenges that refugees, asylum seekers and vulnerable local populations face in their daily lives particularly mental health issues. At first glance these are diverse social, economic, and political settings, yet there are commonalities that can be identified in terms of policies and social issues across countries. For example, ‘hostile policy environments’ and the politicisation of refugees and asylum seekers especially how they are viewed and treated by local domestic populations and the media is common to all contexts. Unfortunately, in all settings refugees and asylum seekers have become politicised and used and framed to suit the interests of governments in each country.

In addition, both settings also experience challenges in terms of being able to provide and finance MH services. Private sector MH provision is dominant in all settings and requires large out-of-pocket payments or insurance to access good quality MH services. The treatment gap is much worse in Lebanon and Syria. However, the UK could not be said to be a ‘shining example’ of mental health service provision given the current state of NHS services, long referral and waiting times required for support and difficulties in retention and recruitment of the mental health workforce.⁴⁶ Mental health services in the UK have been chronically underfunded. The COVID-19 pandemic added further strain to the existing system, depleting services for local populations at risk and new arrivals of refugees and asylum seekers.⁴⁷

The workshop provided a *space for open discussion*, to share examples of best practice and policy innovations. Such a diverse group consisting of frontline workers, academics and populations at risk rarely meet therefore the workshop was a unique opportunity to collaboratively and closely explore the issues. The majority of academic evidence and studies on refugee and asylum seekers mental health have focused on the more clinical and medical

source/country-profiles/refugee-and-migrant-health/concept-note-for-3rd-global-consultation-on-the-health-of-refugees-and-migrants_final.pdf?sfvrsn=3b11930d_6

⁴⁶ Long J, Ohlsen S, Senek M, Booth A, Weich S, Wood E (2023) ‘Realist synthesis of factors affecting retention of staff in UK adult mental health services’, *BMJ Open*. 13(5):e070953.

⁴⁷ Department of Health and Social Care (2022) *Mental health and wellbeing plan: discussion paper*. Available at: <https://www.gov.uk/government/consultations/mental-health-and-wellbeing-plan-discussion-paper-and-call-for-evidence/mental-health-and-wellbeing-plan-discussion-paper>

aspects such as the state of their health and wellbeing. See for example a recent special issue of the *British Journal of Psychology*.⁴⁸

As an NGO representative commented, '*...We know that being a refugee or asylum seeker is not good for your health...There is now a wealth of evidence to show that they have poorer MH than local populations. We do not need more research on this...I don't see why funding councils repeatedly give millions to document misery.*'

Several participants commented that what is much less known concerns the types of interventions and services that may be effective for supporting and protecting mental health. For instance, what are the current challenges these services face in terms of funding and staffing capacity?

Therefore, a key objective of the workshop focused on the more operational and *live policy service issues* in terms of access to and quality of care in humanitarian and domestic policy contexts. Workshop participants examined who and which organisations assume responsibility for the health of these groups in the UK and the MENA; how policy interests and fiscal constraints shape decisions on health service design and delivery both in domestic and development policies.

1.1 Research for Health in Conflict

The workshop forms part of the policy dissemination process from the [Research for Health in Conflict \(R4HC\) project](#), which was funded by the [Global Challenges Research Fund](#), UK Research and Innovation.⁴⁹ The findings of the five-year Research for Health in Conflict (R4HC

⁴⁸ *British Journal of Psychology*. Open Refugee and Asylum Mental Health Themed Series. Available at: <https://www.cambridge.org/core/journals/bjpsych-open/bjpsych-open-refugee-and-asylum-mental-health-themed-series>

⁴⁹ Details of the project and outputs can be found at: <https://r4hc-mena.org/>
End of project conference: <https://www.youtube.com/watch?v=CDmT-3helfE>
Interviews with R4HC project leads: <https://vimeo.com/user/16039450/folder/9604023> /-
<https://vimeo.com/user/16039450/folder/9432965>

- <https://r4hc-mena.org/>) project which has developed research and policy capacity in conflict affected and humanitarian settings were shared with participants to provide background context for the workshop. This helped participants to better understand how politics and the policy process in various countries influences the provision and quality of public services especially health and mental health services.

The R4HC project created partnerships between universities in the UK and in the Middle East. Several publications were produced: five reports on the political economy of health in Lebanon, Gaza, Jordan and Turkey), as well as articles, films, workshops and major international conferences.⁵⁰ The R4HC has generated a vast amount of knowledge and evidence on the health of refugees and health system design in the MENA. A policy and academic network have been developed which provides a solid foundation for future research focusing on the role of conflict and humanitarian situation on population health and health services.

2. Situation and policy context: demand and access to mental health care in the Middle East region and the United Kingdom

2.1 Mental health services in the Middle East

The Eastern Mediterranean Region continues to experience severe humanitarian emergencies as a direct result of conflict and political instability. In 2020, nine countries out of 22 countries in the region were affected by protracted and ongoing conflicts, which left more than 62 million people in dire need of access to quality health care. COVID-19 exacerbated humanitarian needs leading to further pressure on already overstretched health care systems in the region.⁵¹ Health-related policies are often underdeveloped or inadequate in the region;

⁵⁰ See <https://r4hc-mena.org/publications/>

⁵¹ F M Fouad, L Soares, J L Diab, A Abouzeid (2022) 'The political economy of health in conflict: Lessons learned from three states in the Eastern Mediterranean Region during COVID-19', *Journal of Global Health*.

many health systems are under-resourced and poorly managed; and humanitarian emergencies are impacting the region on an unprecedented scale.^{52 53}

Conflict-affected populations have been shown to have a higher prevalence of both common and severe mental disorders compared to the general population.⁵⁴ Treatment gaps are considerable especially in conflict affected areas of the region due to inadequate infrastructure and depleted human resources in the health sector.⁵⁵

In terms of spending on MH as a proportion of total health spending the region devotes minimal funds: Palestine: 2.5%; Lebanon: 5%; Syria: 2% of total health spending. Services are severely constrained. There are minimal inpatient, day care or residential facilities and a lack of trained staff and little to no formal mental health care regulations or laws.^{56 57} In 2017, Lebanon spent 3.4 USD per capita on mental health compared to 21 USD in Europe. The private sector governs the supply of mental health services from Damascus to Beirut requiring large out of pocket payments - a private consultation with a psychiatrist in Beirut, Lebanon for example could reach 100 USD in 2023.⁵⁸

⁵² World Health Organization. *Strategy for the Eastern Mediterranean Region, 2020–2023*. Available: <https://applications.emro.who.int/docs/EMRPUB-RDO-014-2019-EN.pdf>

⁵³ Ismail S, Coutts A P, Fouad M F (2022) *Lebanon on life support: how corruption and politics made a nation sick*. Available at: <https://r4hc-mena.org/wp1/wp-content/uploads/2022/01/The-political-economy-of-health-in-Lebanon.pdf>

Accompanying documentary film: *Lebanon: How politics made a nation sick*: https://www.youtube.com/watch?v=Uak_WI0zpRY

⁵⁴ Charlson F, van Ommeren M, Flaxman A, Cornett J, Whiteford H, Saxena S (2019) 'WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis', *Lancet*. July 20;394(10194):240-248

⁵⁵ Washington Post (2021) *Lebanon was famed for its medical care. Now, doctors and nurses are fleeing in droves*. Available at: https://www.washingtonpost.com/world/middle_east/lebanon-crisis-healthcare-doctors-nurses/2021/11/12/6bf79674-3e33-11ec-bd6f-da376f47304e_story.html

⁵⁶ See <https://r4hc-mena.org/our-work/mental-health-in-conflict/>

⁵⁷ WHO Mental health atlas (2011). Available at: https://apps.who.int/iris/bitstream/handle/10665/119996/emropub_2013_1578.pdf

⁵⁸ Community mental healthcare in Lebanon 2020. Available at: <https://consortium-psy.com/jour/article/view/34>

Before the crisis in Syria, there used to be 65 psychiatrists and 40 MH trained doctors in 2008. In the whole of Syria there were a total of seven hospitals with psychiatric wards.⁵⁹ Currently there are only two psychiatrists for four million people and only two facilities capable of treating mental health conditions.⁶⁰ Similarly, in 2020, the mental health treatment gap in Lebanon, where there is a significant refugee population, was staggering with only 11% of patients with serious MH issues being supported. In Lebanon, stigma against people living with a mental health condition remains high in society, even among family members and healthcare providers.⁶¹

In contrast, Step-by-Step an electronic self-help intervention has showed through several randomized controlled trials premise for being accessible, cost-effective, and effective in the Lebanese context.^{62 63 64} In parallel, the Lebanese national lifeline for suicide prevention and psychological support has played a major in allowing access for psychological support. The lifeline was able to effectively reduce distress among callers highlighting the need for and importance of such services.⁶⁵

These national services were complementary to the Lebanese Ministry of Public Health's effort to integrate mental health services into primary healthcare centres⁶⁶. Lebanon is currently in the phase of piloting mental health packages as part of the long-term primary

⁵⁹ Mental health in the Syrian Arab Republic. Available at:- <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6734838/>

⁶⁰ Two psychiatrists for more than three million people <https://www.who.int/news-room/feature-stories/detail/2-psychiatrists-for-almost-4-million-people>

⁶¹ Abi Hana R, Arnous M, Heim E, Aeschlimann A, Koschorke M, Hamadeh RS, Thornicroft G, Kohrt B A, Sijbrandij M, Cuijpers P, El-Chammay R (2022) 'Mental health stigma at primary health care centres in Lebanon: qualitative study', *International Journal of Mental Health Systems*, 2022 May 7;16(1):23

⁶² Harper Shehadeh M J, Abi Ramia, J, Cuijpers P, El Chammay R, Heim E, Kheir W, Carswell K (2020) 'Step-by-Step, an e-mental health intervention for depression: a mixed methods pilot study from Lebanon', *Frontiers in psychiatry*, 10, 986.

⁶³ Heim E, Abi Ramia J, Abi Hana R, Burchert S, Carswell K, Cornelisz I, Van't Hof E (2021) 'Step-by-step: feasibility randomised controlled trial of a mobile-based intervention for depression among populations affected by adversity in Lebanon', *Internet interventions*, 24, 100380.

⁶⁴ Cuijpers P, Heim E, Abi Ramia J, Burchert S, Carswell K, Cornelisz I, El Chammay R (2022) 'Guided digital health intervention for depression in Lebanon: randomised trial' *BMJ Ment Health*, 25(e1), e34-e40.

⁶⁵ Zeinoun P A, Yehia F E, Khederlarian L Z, Yordi S F, Atoui M M, El Chammay R Nahas Z H (2021) 'Evaluation of Lebanon's National Helpline for emotional support and suicide prevention: reduction of emotional distress among callers', *Intervention*, 19(2), 197.

⁶⁶ Hijazi Z, Weissbecker I, Chammay R (2011) 'The integration of mental health into primary health care in Lebanon', *Intervention*,9(3), 265-78.

healthcare subsidization protocol (LPSP). Such initiative has allowed thousands to access free-of-charge quality specialized mental health services nationwide.

2.2 Mental health services in the United Kingdom

The arrival of refugees via the Home Office resettlement programme and informal channel routes have become a highly politicised policy issue. The latest immigration estimates suggest that in June 2022, around 16% of immigration was accounted for by asylum seekers and refugees. This included 75,000 people who sought asylum through the UK’s in-country process, 12,000 relocated Afghans, and 89,000 Ukrainians.⁴ In an international league table the UK comes bottom in terms of registration of new asylum seekers (Figure 1). European countries have resettled more refugees relative to their populations, as well as more asylum seekers.

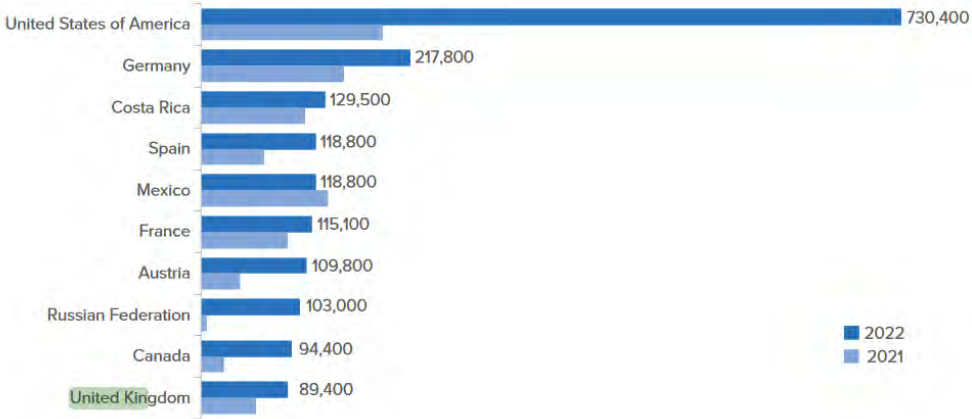


Figure 1: Major countries for individual registration of new asylum-seekers | 2021 and 2022⁶⁷

UK asylum statistics for 2022 show that people from MENA are heavily represented within the cohort of asylum seekers. In 2021, 42% of asylum applicants were nationals of MENA countries (3 of the top five countries being Iraq, Iran and Syria).⁶⁸ Many are highly vulnerable and

⁶⁷ UNHCR (2023) *Global trends: forced displacement in 2022*. Available at: <https://www.unhcr.org/sites/default/files/2023-06/global-trends-report-2022.pdf>

⁶⁸ House of Commons Library (2023) *Asylum statistics, Research Briefing*, Published Wednesday, 01 March. Available at: <https://commonslibrary.parliament.uk/research-briefings/sn01403/>

traumatised after having experienced conflict in their home countries, followed by the complex refugee and asylum process in addition to the perilous journey they experience travelling across Europe. A small body of research exists which shows that many arrive with severe pre-existing conditions (e.g. schizophrenia, bipolar etc) about which we know hardly anything in conflict affected settings and among refugee populations.⁶⁹

Various commentators have suggested that some European countries and the UK have a 'double standard' in their approach to Afghan, Syrian and Iraqi refugees versus those originating from the Ukraine.⁷⁰ In March 2022 the UK Home Office confirmed that 25,500 visas had been issued to Ukrainians since the war began, while the UK resettled 20 000 Syrian refugees over a six-year period.⁷¹ Home Office data shows that of all refugees resettled in the UK from January 2010 to December 2021, around 70% were Syrian citizens. From January 2010 to December 2021, '31, 101 refugees were resettled in the UK under its six different resettlement schemes. Around three-quarters (76%) were citizens of Middle Eastern countries, and 17% were citizens of sub-Saharan African countries. Most were nationals of Syria: 68%.⁷²

As a result of years of underfunding of mental health services in the UK, mental health bed occupancy has frequently been above safe levels across England putting people at greater risk.⁷³ At the same time, demand for services and support is increasing resulting in long waits often over six months for treatment across all vulnerable groups. Latest estimates put the waiting list at 1.4 million people.⁷⁴

⁶⁹ Kienzler H, Mitwalli S, Cicek M (2022) 'The experience of people with psychosocial disabilities of living independently and being included in the community in war-affected settings: A review of the literature. *International Journal of Law and Psychiatry*. 81, 101764.

⁷⁰ Chatham House (2022) *Ukraine exposes Europe's double standards for refugees*. Available at: <https://www.chathamhouse.org/2022/03/ukraine-exposes-europes-double-standards-refugees>

⁷¹ Ibid.

⁷² The Migration Observatory (2022) *Asylum and refugee resettlement in the UK*. COMPASS. University of Oxford. Page 15. Available at: <https://migrationobservatory.ox.ac.uk/wp-content/uploads/2022/08/MigObs-Briefing-Asylum-and-refugee-resettlement-in-the-UK.pdf>

⁷³ Mental Health Foundation (2022) *Research costs: statistics*. Available at: <https://www.mentalhealth.org.uk/explore-mental-health/mental-health-statistics/research-costs-statistics>

⁷⁴ [NHS England and NHS Improvement Board meetings held in common. Update on Mental Health Services. Public session 5 \(2022\). Available at: https://www.england.nhs.uk/wp-content/uploads/2021/11/board-item-5-251121-update-on-mental-health-services.pdf](https://www.england.nhs.uk/wp-content/uploads/2021/11/board-item-5-251121-update-on-mental-health-services.pdf)

Refugees and asylum seekers face more barriers to accessing mental health services in the UK. Research shows these groups have diverse and additional healthcare needs when compared to host populations. Multiple sources suggest they face difficulty accessing appropriate health care in host countries. A recent literature review highlighted difficulties with communication, poor doctor–patient relationships, and culturally inappropriate primary care settings in the UK.⁷⁵ A recent investigation by Human Rights Watch found that services for asylum seekers with disabilities in the UK are grossly inadequate and may be contravening the [UN Convention on the Rights of Persons with Disabilities](#), which the UK ratified in 2009.⁷⁶

Home Office data from 2021 shows that 71.4% of asylum seekers in the UK required medical care and had a mental health diagnosis. Other research has found that the main barriers experienced by refugees and asylum seekers in seeking MH support were a lack of knowledge about the host healthcare system, language differences, and administrative barriers.⁷⁷ Moreover, local vulnerable communities in the UK along with newly arrived asylum seekers and refugees are accessing the same services leading to competition of service use. This may have a detrimental effect on social cohesion and increased animosity toward refugees and asylum seekers. A recent report from the Council of Europe stated that the UK has significantly regressed in terms of policies and support for the rights of refugees and asylum seekers.⁷⁸

⁷⁵ 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 Practitioners*. August;69(685):e537-e545.

⁷⁶ Human Rights Watch (2023) UK Turns its Back on Asylum Seekers with Disabilities Authorities Should Ensure Access to Services and Support. July 23rd. Available at: <https://www.hrw.org/news/2023/07/03/uk-turns-its-back-asylum-seekers-disabilities>

⁷⁷ Doctors of the World (2022) *Asylum seekers, health, and access to healthcare in initial and contingency accommodation*. Available at: <https://www.doctorsoftheworld.org.uk/wp-content/uploads/2022/04/DOTW-Access-to-healthcare-in-initial-and-contingency-accommodation-report-April-2022.pdf>

⁷⁸ Council of Europe (2022) *Commissioner for human rights: Council of Europe, Dunja Mijatovic report following her visit to the United Kingdom from June 27th to July 1st*. Available at: <https://www.ein.org.uk/news/council-europe-human-rights-commissioner-finds-significant-regression-uks-protection-rights>

Although IOM and public opinion data from 2022 reports that 70% of the British public support the protection of refugees and asylum seekers.^{79 80}

⁷⁹ British Futures (2022) *Where is public opinion on refugee protection?* Available at: <https://www.britishfuture.org/where-is-public-opinion-on-refugee-protection/#:~:text=Public%20support%20for%20refugee%20protection,escape%20from%20war%20or%20persecution>

⁸⁰ International Office of Migration IOM (2022) *As UK public attitudes toward migration are increasingly positive, it's time for more balanced and evidence-based narratives.* Available at: <https://weblog.iom.int/uk-public-attitudes-toward-migration-are-increasingly-positive-its-time-more-balanced-and-evidence-based-narratives>

3. Workshop methodology

Human centred design (HCD) was selected as a method for the workshop, following its use in our previous policy work on the design of MH services in the East of England. It is a collaborative approach to solving complex, 'wicked' problems such as public service design, unemployment and MH.

There are six stages to the HCD methodology: plan, discover/empathise, define, ideate, prototype and test, embed.



Figure 2: Extracted from the report 'Human centred design workshop. Exploring HCD methods to improve the digital transformation of frontline mental health services in the East of England. Illustration from PA Consulting & Think Lab Cambridge University.

Plan: Participants were first asked to map the MH system to generate a common group view. They were then requested to envision the future of the system and suggest first actionable steps.

Discover/Define: Building upon insights gained in the morning session, the group was prompted to empathise further with users, experiences and identify the challenges faced throughout their journey. Participants clustered the different barriers into themes and selected the ones to focus on in the next stages. '[PESTEL](#)', the macro-environmental factors framework, was used for this exercise. It aims at collaboratively exploring political, environmental, social, technological, legal barriers from refugees' perspective. For this exercise, participants were split into two teams.

Ideate: Participants were asked to challenge their own thinking and assumptions to generate insights on root causes of the issues. Given the complexity of the issue, the [Iceberg model](#) was selected. This system thinking model steers audiences towards exploring the underlying issues of the problem, the values and beliefs that maintain the system in place (which is the invisible 90% of the iceberg).

Prototype/Test: the final part of the process consisted of modelling in 3D the transformed system. The perspectives in each team were visible in their final model.

Embed: Finally, direct actions were identified in both teams for the long, mid and short term.

One team was composed of two medical doctors and researchers, a clinical psychologist, two nurses (including one who is a refugee in the UK), and a policy adviser. The second team was composed of three clinical psychologists, a medical doctor, a researcher and a student (who is also a refugee in the UK).

4. Workshop insights⁸¹

Opening speakers gave an overview of the situation of refugees and asylum seekers in the UK. They detailed current government policy approaches to supporting people escaping from humanitarian and conflict zones. Speakers advocated that policy makers should make fair and respectful decisions to reduce inequalities and provide better care to populations at risk, particularly those suffering from mental health issues. They stressed the importance of raising awareness for reducing mental health-related stigma, breaking down the barriers to mental

⁸¹ The agenda of the workshop can be found in Annex 1.

health care and empowering, dignifying and humanising people living with mental health conditions.

4.1 Experiences of frontline workers from Syria and Lebanon: Challenges in accessing mental health care, inspiring stories and policy opportunities

Representatives from UNHCR provided insights into the current health and policy situation in the region, particularly the different barriers to accessing mental health services. They highlighted the widespread stigma and lack of awareness of mental health problems. They discussed the most reported mental health conditions in the region - depression, anxiety, PTSD, as well as alarming reports of increase of suicide attempts, the lack of mental health professionals and difficulty to access specialized mental health services.

INGOs - IMC, MDM and Medair shared experiences of supporting Syrian refugees and vulnerable Lebanese. They described the importance given to community support, offering locally based safe spaces to people who can therefore take ownership of their own health and access their traditional ways of coping. Community-based approaches are founded on using existing networks and skills of refugees. All agreed that embedding mental health services within primary health care settings in humanitarian contexts such as Lebanon can also help reduce the stigmatisation of seeking MH support. Above all it enables easier access to care.

Box 1: International Rescue Committee (IRC) experience in system strengthening can support replicating, implementing, and/ or adapting MHPSS interventions in the Middle East and UK

Interventions supported by IRC including Step-by-Step, the national lifeline, mental health gap action program (mhGAP), problem management plus (PM+), self-help plus (SH+), and others were deemed successful in responding to the mental health demands of the host and RAS communities without resorting to a high number of MH specialists in Lebanon. They build upon available resources and can be delivered by trained non-specialists as they are of low intensity. It is important to note that these services are not delivered in silos away from their specialized counterparts, meaning that they complement one another and provide a comprehensive package of MHPSS services to RAS.

Although the need for specialised services is increasing, it only constitutes around 4% of the total MHPSS needs in an emergency setting. In contrast, delivering focused non-specialized services constitute 20% of the RAS population and are thus in higher demand.⁸² Capacity-building is a first step in that direction; however, supervision and follow-up are mandatory to ensure quality intervention. Capacity-building can focus on four main areas: safe detection and referral of mental health conditions, psychological first aid, emotional crisis management, basic psychosocial skills and self-care. Such training modules must target all frontliners working with RAS and complemented with clear care and referral pathways.

National public sensitisation campaigns are needed to promote access to MHPSS services through the 4Ws platform, impede stigma, and lead to desirable changes in knowledge, attitudes, and practices, which in its turn can lead to more cohesion among the different populations within a given community.

In addition, Quality Rights assessments of any institution delivering in-patient or out-patient mental health care are needed to ensure adherence by human rights and ethical practice and push for a better quality of care. Considering the vulnerability of RAS, instances of human right violations or unethical practices may take place.

Due to the collapse of the financial systems in Lebanon and Syria, salaries of medical doctors in the public sector decreased by 98%. This had a direct effect in reducing the availability of services for the most vulnerable population as most of the specialised healthcare was provided through the private sector. The collapse has also driven healthcare providers to emigrate leaving the health system under a much more increased stress. In Lebanon, where Lebanese mainly go to the private sector for health services, they have switched to accessing public primary healthcare leading to a shift in the age profile of patients that the PHCCs are servicing in various Lebanese communities. The pharmaceutical sector has also been hit hard by the financial collapse leading to the *dollarization* of pharmaceuticals, leaving a vast number of people across Lebanon and Syria without access to medicine, especially NCD treatment. This has led to the deterioration of people's health status.

INGO speakers stressed the importance of raising awareness and recognising mental health needs, as an integral part of any humanitarian response plan. This must be done from when people are displaced, along migration routes to the final stage of the asylum process experienced in the UK. Currently this *spectrum of need* is not fully recognised or understood

⁸² World Health Organization (2012) *Assessing mental health and psychosocial needs and resources: Toolkit for humanitarian settings*. World Health Organization.

by humanitarian donors nor is there much academic evidence examining how this migration journey affects health and wellbeing. For example, UN agencies and INGOs do not share data with the Home Office or other government departments regarding the health status and needs of those who have used their services in frontline host communities such as Jordan and Lebanon. In sum we do not really know what the health needs of people are arriving in the UK. This makes service budgeting and planning challenging. There is also little data interoperability between agencies and host governments. The focus for donors and humanitarian agencies is on MH issues experienced in neighbouring frontline host countries like Lebanon or Turkey rather than how the migration journey and asylum process affect MH.

The importance of a coordinated multi sectoral approach was highlighted as urgently needed when supporting vulnerable people suffering from mental health conditions in humanitarian and asylum contexts. For example, the representative from the NGO Na'amal led a discussion on how basic needs must be met and employment opportunities created, even informally, to support the development and protection of individual mental health. It is essential that refugees have the right-to-work, so that they do not have to rely permanently on cash assistance. This assistance should be seen as an emergency and temporary option. Medium to long term policy options are required that link the policies of livelihoods, development and health in humanitarian and asylum contexts.

4.2 Experiences of frontline workers in the United Kingdom: Challenges accessing mental health care and good practices

Panel speakers provided an overview of the process migrants go through after they reach the UK - See Box 1, 2 for example. The arrival accommodation in which refugees find themselves should provide safety and security but according to workshop participants are often a source of additional trauma and stress.⁸³ They highlighted the challenges to accessing health care in general, and mental health services, for migrants but also for the host population. All

⁸³ BBC News (2023) *Asylum seekers camped on street outside hotel*. Available at: <https://www.bbc.co.uk/news/articles/cd1xvvnj1p8o>

participants acknowledged that the health system in the UK is fragmented, overwhelmed, and extremely difficult to navigate, even for service providers themselves. *“It is very difficult to know the appropriate services for refugees”* as one frontline service staff member noted. A notable challenge as several participants highlighted was the absence of any clear mapping of local MH services. People often are not aware of what locally exists and what they are entitled to. In addition, when information exists on local services it comes in the forms of long lists with no indication of what type of MH services are offered or the quality of these services. A MHPSS directory has been set up for refugees and migrants but only for London and Greater London.⁸⁴

⁸⁴ Kings College London. Mental Health and Psychosocial Support (MHPSS) *Directory for Refugees and Migrants in London*. Available at: <https://www.kcl.ac.uk/research/mhpss-directory#:~:text=The%20MHPSS%20Directory%20is%20a,in%20London%20and%20Greater%20London.>

Box 1: Refugee and asylum seeker mental health: insights from Solace (Home Office Initial Accommodation Asylum Seeker Mental Health Support. Reflections by Anne Burghraef, Solace Clinical Director May 2023)

“There are many approaches to considering asylum seeker mental health, but what is recognized is that it is multifactorial, thus no single

intervention will suffice to support the mental health and wellbeing of asylum seekers. The first thing that unites all asylum seekers is the reality of having been uprooted from their homes with all the broken connections and multiple losses which that implies - loss of family, community, resources, livelihood, and status.

The second thing is extremely high levels of stress. If overwhelming stress is a shared threat to asylum seeker mental health, then to alleviate or mitigate this threat, two responses may help. Either the factors causing/perpetuating the stress are reduced or increasing the individual’s resilience and ability to cope with stress, or a combination of both. This latter approach is one which has been utilised very successfully by Solace Surviving Exile and Persecution in Yorkshire to alleviate the distress and improve the mental health of thousands of refugees and asylum seekers in the 17+ years of its existence.

The recent [Report by Migrant Voice \(April 2023\), No rest, no security. Report into the experiences of asylum seekers in hotels \(migrantvoice.org\)](#), details the problems of asylum seekers in hotel accommodation. This is based on consultation with 50+ residents and our experience at Solace. Many asylum seekers living in hotels for more than a short period find it stressful, especially combined with the uncertainties and bureaucratic complexities of dealing with the asylum decision making process. The temporary and unpredictable nature of the accommodation also inhibits integration into the community and forming new and sustaining relationships. Thus the request by the migrant mental health subgroup is for interventions that do not address many of the sources of the stress/pressure, but are intended to mitigate the risks to mental health and protect those with specific wellbeing needs and challenges”.

In terms of care pathways, asylum seekers are often moved from one region to another, with little notice as to where they are being placed. In such cases mental health care treatment is interrupted, and no systematic referrals are set in place. Access to secondary care for people with complex mental health issues is extremely difficult, with a two to three year waiting time according to workshop policy stakeholders. Those working on the frontline such as detailed in Box 2 feel overwhelmed and frustrated as they often cannot find services to refer patients in need.

A policy participant commented on the “erosion of human rights and the potential criminalisation for people seeking asylum and safety”. It was felt that refugees are being “politicised”, in an increasingly hostile policy context in the UK. Participants discussed the Home Office's use of former Ministry of Defence sites as accommodation for asylum seekers. NGO participants noted that they had recorded numerous cases of residents having limited or no access to independent legal advice and medical care.

Box 2: A view from the frontline of mental health services provision in the UK: Working with asylum-seekers living in temporary accommodation, in London (Poppy Vernon, Respond Service, UCLH, London)

As a specialist nurse for the Respond service, I have worked with nearly 500 individuals and recognise a pattern of experience that people face while claiming asylum in the UK. The people I meet have faced persecution, immeasurable trauma, and unmet basic needs. Arriving in the UK, they now face uncertainty, lack of autonomy, understanding and a voice. They are provided with virtually no support to access healthcare, do not understand the language, and lack confidence and trust when using the GP system. There is no standardisation of care among this group and outcomes depend on chance, goodwill of others and how much English a person can understand. Similarly, health care providers I link with are frustrated by patients missing appointments, over-running appointment-times, and the populations complex health and social needs.

Working within the accommodation sites across North London, I witness first-hand how social and housing issues undermine physical and mental health outcomes. People live in cramped, dark rooms, often with as many as nine other people. Scabies outbreaks are common and difficult to control (not least because of the challenges of getting up to five different people a GP appointment). One patient described how he was unable to sleep in his shared dormitory at night as he had been raped by another male in his home-country and did not feel safe around strangers who did not speak his language. While I was able to set-up counselling for this gentleman as he spoke English it is likely he will be moved to another area and this care will be interrupted.

In my experience, the people I meet nearly all suffer from some level of poor mental health. This ranges drastically from feeling hopeless and having low energy, to suffering from debilitating flashbacks, anxiety and paranoia. It has taken me months to understand the different pathways suitable for patients depending on their area, age, gender, home-country, level of English and complexity of needs. When you do successfully refer somebody, they may lack the confidence to attend an appointment or not have money to use public transport. Furthermore, patients have described discrimination by health professionals, cancelled appointments or been moved to a different area of the country, with a couple of days' notice.

Some of these issues cannot be resolved without significant policy change, improved housing and sustainable funding however, some can. The feedback I received from patients was that our appointment was sometimes the first time they felt listened to and were treated like a human being. Just a one-hour appointment with appropriate follow-up. Additionally, peer-support casework could provide an important opportunity to refugees who have received their status to provide invaluable assistance to those still going through the asylum process. The sharing of common experience, language and the understanding of the UK system could help give people hope and provide essential guidance, alleviating primary care workers of this unsuitable responsibility.

In terms of a policy response, speakers stressed the importance of showing kindness and empathy. The adoption of a more “trauma-informed” posture in the asylum process when “making life and death decisions based on what they believe plausible” (in appeal or court hearings). Decision-makers should keep in mind how these hearings may be extremely distressing and how trauma may impact memory and narrative.

When discussing efficiency in health service delivery, participants described a number of clinically effective early intervention programmes to prevent cascading mental health conditions and associated costs. All speakers and participants stressed the long-term effect of not treating mental health conditions for individuals, such as disability, substance abuse, chronic physical conditions, suicide, excessive litigation and incarceration. This has severe impacts on the individuals themselves and their families, but also places an added fiscal burden on local NHS services.

Our NGO partner - Solace described how they aim to develop a network of Refugee & Asylum Seeker Mental health Champions. Mental Health services for refugees and asylum seekers are very uneven across the UK. There are very few specialist services aside from organisations like Solace in Yorkshire, Helen Bamber, Freedom from Torture, Baobab or Nafsiyat Intercultural Therapy Centre in London. Some NHS mental health services have set up some specialist services such as the Hope service for refugees and asylum seekers with the Avon and Wiltshire

Partnership Foundation Trust. It was noted by NHS representatives that a comprehensive survey and mapping of accessible mental health services for refugees and asylum seekers would be very useful for designing treatment pathways. The representative from Solace commented that:

“Physical health, mental wellbeing, and safeguarding concerns should be reviewed as part of a holistic need assessment, ideally in an outreach capacity, taking services to the people who need it, treating their issues in a patient-centred manner. Holistic models of care should be sustainably funded at regional and national level, to reduce inequality of access across different locations”.

In the absence of specialist services, Solace recommended a network of *champions* by identifying people in existing mental health services who have an interest and passion for refugees and developing the scope of the work roles. In this role, they would have responsibility for championing the needs of asylum seekers and refugees to make them more accessible and engaging. So not only would they be the specialist ‘go to’ person in the mental health team but they would be a resource and support other members of their team to provide an effective therapeutic service. As all local authorities are obligated to accept asylum seekers, many are now being accommodated in ‘non-dispersal’ areas as all local authorities have to accept asylum seekers. It is recommended there are appropriate mental health services wherever people are dispersed. This will help to fulfil the NHS mandate to address health inequalities for groups with specific needs and local populations at risk.

To become a ‘champion’ people would need to learn about the asylum process/system, local resources and undertake training in understanding the mental health needs of asylum seekers and refugees, effective therapeutic practice. This can be done by accessing Solace’ two free E-Learning courses on <https://www.solace-uk.org.uk/new-free-e-learning>.

4.3 The experiences of Alnarjes and Hanan: What does it mean to be a refugee in the UK today?

Participants heard from Alnarjes (Box 3) and Hanan and the long journey they undertook took from Syria, to Lebanon, finally ending up in the UK. They described the difficulties they had

faced and how it affected their mental health. Both detailed how they developed resilience along this journey. Participants reflected on the overlapping trauma that migrants forced to flee suffer from: the trauma of living in a war zone, fleeing their country, being exposed to discrimination, and struggling to have a right to live and work with dignity. As Alnarjes stated:

“I realised that my life in Syria, my life in Lebanon, in Turkey and in the UK were different kinds of war, they were difficult journeys that I passed through”.

Box 3: The experience of Alnarjes: a refugee from Syria. The journey from Lebanon to the UK

Alnarjes shared her experience of being forced from Syria to Lebanon and then seeking asylum in the UK.

“It is not easy to know or describe what you feel in an environment where all people think their reactions, anxiety, stress and anger are normal and do not count as mental health disorders. In some cases, I did not realise how I was dealing with stressful events, the death of loved ones and the way we moved from one place to another as refugees. Living as a refugee in Lebanon made me unaware of my successes and achievements. I felt I was running for miles but I was still in my place, a place that I did not choose, did not belong to and could not leave. However, I could feel my successes particularly after reading and listening to poems. Creative writing, poetry, photography, design and video editing were some hobbies that I enjoyed during tough times. Few years later, I knew that I used those creative methods as coping strategies to mitigate the impact of war and displacement on my mental health.

Recently, I realised that storytelling is significant to encourage people to read and learn more about mental health and to find their own coping strategies. Displaced people share the same suffering but in different forms. However, they do not share a common language to translate their suffering into words due to the stigma around mental health and the traditional way of talking. It is crucial to introduce people to more creative methods and invite them to share their experiences in different ways to remove that stigma. This does not mean that all people will adopt these strategies but at least they will be aware of them. As some parts of our stories are horrible and cannot be told, not all people are expected to talk about their experience. However, I could highly touch how storytellers have an impact on others when a friend commented on my story saying “oh! I have the same experience actually!”. She felt as if someone was telling her about herself for the first time and she was surprised as if she was saying “how did you know that about me!” although I was talking about myself. This is a significant part of storytelling, raising awareness.”

4.4 Afternoon sessions – Group work

The afternoon session aimed at creating a space where all stakeholders were able to discuss the state of mental health services and delivery in the UK, drawing on its limitations and strengths. The aim was to propose a series of actionable steps to improve the current situation facing local populations, asylum seekers and refugees.

4.4.1 Observed outcomes and insights

The UK's illegal migration bill⁸⁵ provided the background policy context for the workshop. Under this Bill, people who illegally arrive in the UK are subject to being deported back to their country of origin or a third-party host country. The Bill proposes that people who arrive in the UK irregularly with the intention of claiming asylum will be barred from the asylum system and then deported back to their country of origin or a third-party host country.

4.4.2 'Double standards' in supporting refugees and asylum seekers

The difference in treatment pathways offered to refugees in the UK from the MENA region and attitudes towards them, as opposed to those originating from Ukraine, was cited multiple times. According to a [YouGov poll conducted in 2022](#),⁸⁶ more than 70% of the UK population were likely to support Ukrainian refugees versus 40% to 48% for Afghan or Syrian refugees. Racism and the colonial past of the UK were highlighted as the beliefs and underlying values that maintain a societal divide that persistently produces damaging perceptions towards refugees from the MENA region.

Doctors, nurses, developers, designers, fleeing their countries have valuable skills. As Al Narjes' testimony reminded us, and as highlighted over brainstorming sessions: people are fleeing a country because they have to – it is survival migration. Their main motivation is to build a better life for themselves and their children. People are eager to learn and to become part of local UK communities if they are given a chance. It was proposed that a scalable nation-wide survey and comparative analysis on attitudes, perceptions and schemes would help examine this assumption further.

⁸⁵ HM Government policy paper on the UK Illegal migration bill, April 2023: <https://www.gov.uk/government/publications/illegal-migration-bill-factsheets/illegal-migration-bill-overarching-factsheet>

⁸⁶ Yougov study on perception of refugees from Ukraine, Syria and Somalia, May 2022: <https://yougov.co.uk/topics/politics/survey-results/daily/2022/05/04/db479/3>

4.4.3 Economic case for the participation of refugees and asylum seekers in the UK labour market

'Immigrants are stealing the work of the British' was highlighted by each team as a dominant narrative among certain sections of the UK media, public and certain sections of the UK political landscape. Indeed, these anti refugee and asylum seeker sentiments are commonplace across the MENA. However, [asylum seekers in the UK do not have the right to work⁸⁷](#) in the UK. They can be granted refugee status and permission to stay and work in the UK, but it takes months or years. A proposal from participants was that initial efforts could be made to provide work visas to displaced professional groups such as medics. This is a 'win-win' opportunity for the NHS considering the shortage of medical staff the UK is experiencing. Dr Aula Abbara, a consultant in infectious diseases at Imperial College NHS Healthcare Trust who also co-chairs the Syria Public Health Network has been advocating for streamlining the registration of displaced medics through the General Medical Council. See Box 4.

⁸⁷ House of Commons Library (2022) *Research policy paper on asylum seekers' permission to work in the UK*. December. Available at: <https://commonslibrary.parliament.uk/research-briefings/sn01908/>

Box 4: Support for doctors who are refugees towards General Medical Council registration

The pathway to registration for doctors who are refugees can be arduous with many hurdles, over and above those which are faced by other IMGs (international medical graduates.) The process of GMC registration for IMGs (including refugee doctors) includes 1. Proving their Primary Medical Qualification 2. Proof of Clinical Knowledge and Skills (PLAB 1 and 2) 3. Evidence of Internship or Equivalent Experience 4. English language proficiency 5. Certificate of Good Standing 6. Activities for the last 5 years 7. Identity Check in the UK.

Though in principle, this process appears straightforward, for refugee doctors who may not have all the required evidence, have had breaks in their clinical careers due to conflict or persecution, they may face multiple challenges. The GMC recognises this and both the GMC⁸⁸ and BMA⁸⁹ provide information for doctors who are refugees, identifying where support can be found. Such support includes pastoral or logistical support from certain organisations such as Building Bridges⁹⁰ or the Lincoln Refugee Doctors Project⁹¹ and the waiving of application and examination fees for those with refugee status.

In recognition of the challenges which doctors who are refugees face, the GMC may make allowances in their approach to refugee doctors; for example, some may not have access to their original documents and would be unable to obtain replacements e.g. if they are political refugees. For Syrian doctors who are refugees, the Syrian British Medical Society has been able to provide support.

However, despite support and allowances, primary qualitative research conducted at Imperial College, London (in press) by Wihba *et al* describes the numerous challenges which doctors who are refugees may face. Many voice their frustration at the prolonged nature of the registration process and a feeling that they are ‘living a life in stagnation’ while being unable to work; this can lead to a crisis in identity given how closely aligned this is to their vocation as a doctor.

During the COVID-19 pandemic, NHSE and HEE (the latter now merged with NHSE) established a role called the Medical Support Worker.⁹² This allowed doctors who are in the UK, predominantly refugees, to work with restrictions e.g. prescribing restrictions while they are in the process of their GMC registration. The criteria is that they had passed their language examination and had completed their internship year in their country of origin. Doctors found this very useful as it allowed them to practise their clinical skills and better understand the culture of the NHS. It also helped with their medical language and PLAB examinations. For this role, they received a band 6 NHS salary while working. Funding for this scheme ended in March 2023 however, though an extension of funding has been agreed in principle, it is awaiting the release of funds centrally. As such, despite the potential to support doctors who are refugees as they transition to the NHS, funding has not materialised leaving many in limbo. Current refugees who may benefit from this scheme include those from Ukraine and Sudan.

The cost to sponsor a refugee's medical licence is estimated to be £25,000, versus 10 times more (up to £250,000) to train a new doctor. The case of displaced as an invaluable pool of talent for Europe has been highlighted by research as a key policy area to consider.^{93 94} Providing work visas for displaced medics may also be a more publicly palatable policy option given the present social and media climate and attitudes concerning refugees and asylum seekers.

Box 5: Lincolnshire Refugee Doctors Project

LRDP was formed in 2016 and since the end of 2018 we have recruited refugee medics with the aim to create the best possible scheme across Lincolnshire, Northeast Lincolnshire and North Lincolnshire by supporting refugees who are medically qualified in their home Country to achieve GMC registration, which will enable them to continue their careers in the UK and support the local NHS workforce. As well as providing support with preparing for the GMC registration requirements through a structured learning programme, LRDP will also help our programme members to settle well in the local community by providing support with: Help with finding suitable local accommodation for members and their families. Help with securing part-time employment and/or clinical placements with local NHS Trusts to enable positive learning experiences. Offering both clinical and social support through our volunteer mentors.

Further details can be found at: <https://lincsrefugeedoctors.co.uk/>

⁸⁸ General Medical Council (2023) *Help for refugee doctors*. Available at: <https://www.gmc-uk.org/registration-and-licensing/join-the-register/before-you-apply/help-for-refugee-doctors>

⁸⁹ Ibid.

⁹⁰ <https://www.refugeecouncil.org.uk/get-support/services/refugee-health-professionals-building-bridges-programme/>

⁹¹ Lincolnshire Refugee Doctors Programme: See <https://lincsrefugeedoctors.co.uk/>

⁹² NHS England (2022) *Medical support worker role helps hundreds of refugees to become NHS doctors*. <https://www.england.nhs.uk/2022/06/medical-support-worker-role-helps-hundreds-of-refugees-to-become-nhs-doctors/>

⁹³ Syrian refugee health workers can help Europe cope with COVID-19 (2020) Research paper on Syrian refugee Health workers, September. Available at: <https://www.cam.ac.uk/research/news/syrian-refugee-health-workers-can-help-europe-cope-with-covid-19>

⁹⁴ Ismail S, Coutts A, Fouad F (2020) *Syrian health workers in Lebanon: supporting an informal workforce in crisis*. IIED, London. Available at: <https://www.iied.org/17452iied>

4.5 Right-to-work: employment is good for mental health and the economy

Granting permission to asylum seekers to work means they would be proactively taking part in the host country's economy, which could help in changing perceptions, especially if their contributions save money for the NHS, [still a very precious British institution](#).⁹⁵ It is likely to increase a sense of purpose and pride, civic duty, and increased social capital in local areas. This has benefits for both host communities and refugees themselves. As the evidence shows, being in decent work helps to protect [mental health and well-being](#).^{96 97}

⁹⁵ A poll conducted by Engage Britain in September 2021 showed that 77% of British people felt that the NHS made them proud to be British: <https://www.hospitaltimes.co.uk/nhs-still-a-source-of-pride-for-brits-despite-many-facing-fight-for-treatment/>

⁹⁶ Coutts A P (2009) *Active Labour Market Programmes (ALMPs) and health: an evidence-base*. University College London. Marmot Review (2010). Available at: <https://www.instituteofhealthequity.org/file-manager/economic-active-labour-market-full-report.pdf>

⁹⁷ Health Foundation (2022) *The relationship between employment and health*. Available at: <https://www.health.org.uk/evidence-hub/work/employment-and-underemployment/relationship-between-employment-and-health>

Box 6: Na’amal: Digital employment for refugees

Livelihoods and mental health are closely linked, as employment and income can have a significant impact on psychological well-being. In a recent article in [Forced Migration Review](#), Alexander Betts comments that “refugees’ psycho-social well-being as well as a range of quality of life indicators are improved by access to meaningful work.”

Refugee resilience is commonly presented as a goal of UNHCR and various humanitarian agencies. Yet, what is more important is to give refugees agency. This is what [Na’amal](#) aims to do. Na’amal believes that talent is everywhere but opportunity is not. Na’amal supports refugees and other underrepresented communities, particularly from countries affected by conflict and humanitarian crises, in securing dignified remote employment. It does so by providing them with human or soft skills training coupled with technical digital skills training, provided by partner organisations, mentorship and support in finding, applying for, and interviewing for remote jobs. By preparing refugees to work remotely, refugees can access decent and dignified work wherever they are.

Na’amal is an active participant in the efforts to reshape narratives surrounding what it is and how it is to be a refugee. We do this by providing platforms for refugees to properly represent themselves and their experiences through mediums such as our ‘[Voices of Resilience](#)’ Podcast and with the [Migration Summit](#), which Na’amal co-hosted with Massachusetts Institute of Technology Refugee Action Hub ([MIT ReACT](#)) at the and [Karam Foundation](#).

Anne Burghraef, Solace Clinical Director commented that:

“I see many refugees who are underused in their work potential and not able to access employment which is commensurate with their education, training and experience. The provision of clear routes to validate previous work experience and educational qualifications are sadly lacking. It is only in the medical field where there are such pathways. Currently a colleague from City of Sanctuary is attempting to develop such a pathway in dentistry...English language classes can be excellent but may not be pitched at the right level, for example for very basic beginners or it may not be sufficiently comprehensive – typically just three one hour sessions per week. There is also a lack of occupational English to go with routes to professional and vocational validation”.

Testimonies from refugees and mapping of the asylum journey, starting from a country of origin to the host country made it very clear that the UK health system, particularly mental health services are highly fragmented and difficult to navigate where services do exist. This is the case for both local domestic populations at risk and those newly arrived as refugees and asylum seekers.

The refugee participants and representatives from international agencies described the refugee and asylum process. People flee a conflict zone, some will land in a refugee camp: known to be unsafe, traumatising and potentially a place where they will [reside for years](#).⁹⁸ At that stage, international organisations such as UNHCR, IOM, Doctors without Borders handle the situation in terms of addressing health needs and movement to a third country in Europe. Once someone is lucky enough to make it to the host country, refugees are placed, according to workshop participants, in shared, squalid, unsafe accommodations, where rat infestations and sexual abuse are common. Living in these conditions does not help those suffering from trauma and mental health issues.

Anne Burghgraef from the NGO Solace further stated that by March 2023, there were over 51,000 in hotels with over 100,000 in total asylum accommodation.⁹⁹ There are about 380 *contingency hotels* in the UK. Unfortunately there are many difficulties associated with this accommodation which pose threats to asylum seekers' mental health. The report by Refugee Action explains that people 'are detained indefinitely, segregated from communities, do not have access to legal or welfare services and have limited contact with the outside world due to restrictions and the cost of transport and communications. They live in an environment of fear of attacks by racist groups stoked by dangerous, inflammatory, racist language of

⁹⁸ World Bank (2009) *Update: How long do refugees stay in exile? To find out, beware of averages*. Available at: <https://blogs.worldbank.org/dev4peace/2019-update-how-long-do-refugees-stay-exile-find-out-beware-averages>

⁹⁹ BBC News (2023) *Private firms profiting from UK asylum hotels*. Available at: <https://www.bbc.co.uk/news/uk-64991234>

politicians and sections of the media. In this system, people who came to the UK seeking safety are forced to live in conditions so bad that they present a clear threat to their lives".¹⁰⁰

Box 7: Insights on accommodation challenges (Anne Burghraef, Solace)

“When I consulted with City of Sanctuary colleagues of the recently established national health & wellbeing stream of Sanctuary about supporting asylum seekers in hotels, the coordinator of the 120+ local groups throughout the UK (see <https://data.cityofsanctuary.org/groups/list>) advised me that the first thing that should be done, would be to allow these groups who want to provide support through ESOL, activity classes, access to resources etc to asylum seekers is to facilitate access to the hotels, which has been difficult in many places. Some have wellbeing managers who are very helpful while others are obstructive. Also, hotels vary in their facilities, with some having communal spaces and others none. Thus, enabling asylum seekers to access community resources would be a positive first step as part of the stress of living in hotels is the enforced passivity and boredom due to the prohibition to work and limited financial resources (less than £10 per week). Those who do access support through the voluntary sector usually have their bus fares paid for as transport costs can take up a large proportion of their weekly stipend, and be a barrier to accessing the needed services”.

It was highlighted by one participant that the main housing provider for asylum seekers (Clearsprings) boosted their incomes from [4 to £28 billion pounds](#). Questions were raised by participants as to whose responsibility it is to support refugees and asylum seekers in the UK -the Home Office, Department of Health and Social Care, Foreign Commonwealth and Development office? Currently the policy response is made up of locally based NGOs providing immediate support with oversight from the Home Office. There is little coordination and interoperability between the HO, DHSC, DWP and the FCDO to tackle the issues which face

¹⁰⁰ EIN (2023) Refugee Action says thousands of asylum seekers housed in accommodation centres and hotels face de facto immigration detention. Available at: <https://www.ein.org.uk/news/refugee-action-says-thousands-asylum-seekers-hotels-and-accommodation-centres-face-de-facto>

refugees and asylum seekers. Further there is little to no cooperation or data sharing between HO and the UN agencies and IOM who supervise the legal movement of people from humanitarian contexts to third countries. It was noted by government and UN participants that far greater work and cooperation could be carried by which to form 'realtime' links between UN agencies and IOM in the field and UK government agencies such as HO and DHSC particularly with regard to data sharing on the health needs of refugees entering the UK via formal channels.

5. Recommendations for future research and policy actions.

We have divided recommendations into those for UK policy decision makers and those in humanitarian field operations. A series of research needs are proposed that will help policy decision makers in terms of evidence and operational insights.

5.1 Policy and operational recommendations

- 1) **Equitable service access and delivery:** Ensure that any future policy developments concerning health service and mental health support for refugees and asylum seekers is sensitive to the ongoing needs of host communities and local populations at risk. The equivalent capacity building among service providers for local populations at risk is required. This will help to increase equity of access and avoid increasing local tensions between service users - *a them and us scenario in service delivery*. It will prevent different health systems and treatment paths from developing which are inefficient, cumbersome and have fiscal implications. Currently this is a major issue in humanitarian contexts with dual health systems being present such as UNRWA in Lebanon and Jordan.
- 2) **Develop a cross-departmental government approach:** Establish a Humanitarian and Domestic Health Hub for refugees and asylum seekers, that includes key third-sector stakeholders, to improve data-sharing and budgetary planning for MH service with designated focal points per department responsible for coordination. This would function across DHSC, HO, DWP and FCDO.

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- 3) **Support and fund holistic models of care at regional and national level:** bringing employment, health and welfare services together in the asylum process. This requires adopting and promoting a social determinants of health approach to service design and delivery.¹⁰¹ This means better interoperability and cooperation must be developed between the Home Office, DWP, JCP, NHS and local MH frontline services.

 - 4) **Refugee and Asylum Seeker Mental Health Guardians:** Strengthen clinically effective prevention, early intervention, community- based and peer support approaches. The approach currently advocated by the NGO Solace to develop a network of Refugee and Asylum Seeker Mental Health Guardians¹⁰² should be further supported by local and central governments.

 - 5) **NHS England to organise training of frontline staff:** by experts in refugee mental health to increase staff awareness for treating refugees and asylum seekers in a respectful, inclusive and patient-centred manner, and to better understand cultural and experience-influenced cues and barriers. Services need to be nuanced in their sensitivity to the diverse background experiences and non-homogeneous needs of refugees and asylum seekers. Within this a pragmatic and quick win is to increase funding for training of translators and interpreters in trauma-sensitivity and Psychological First Aid and pipeline them to staff all actors in this sector. They are often the main focal point for refugees and a source of psychosocial support. This is the German model and has been effective.

 - 6) **Healthcare record passport:** Explore through pilot studies the feasibility of a ‘health information passport’ which contains key individual health information that a refugee can carry with them on a mobile application. This could be updated in each country they pass through. To facilitate this and provide the infrastructure a feasibility study

¹⁰¹ World Health Organization. The social determinants of health. Available at: <https://www.who.int/health-topics/social-determinants-of-health>

¹⁰² Solace (2023) The champions model. Available at: <https://www.solace-uk.org.uk/new-free-e-learning>

should be established which explores the possibilities and challenges of linking and harmonising the humanitarian and asylum data ecosystem - (especially health information) between INGOs and multilaterals in frontline countries such as Lebanon and Turkey to frontline domestic MH services and the Home Office in the UK.¹⁰³ *Interoperability between these organisations is absent and hinders health service planning and budgeting. Joining up the data ecosystem will help frontline UK services to prepare in terms of MH demands and needs among refugee populations departing frontline countries.*

- 7) **Include interventions and programmes in the [levelling up agenda](#):** to enhance social participation of refugees and asylum-seekers in local communities. Various examples exist which use community [social infrastructure](#) to increase social connection and social capital between groups. One is the Sanctuary Kitchen / [CitySeed in New Haven, United States](#).¹⁰⁴ ¹⁰⁵ This is a culinary training and development programme for refugees and asylum seekers which uses food from the countries of refugees to break down cultural barriers and educate local people about the challenges of being a refugee. In the UK there are various example initiatives of community led approaches that enable locals to interact with refugees.¹⁰⁶ The intended aim of these community projects is to overcome many of the stereotypes local people have of resettled

¹⁰³ There are serious ethical and data protection issues with this proposal. Considering that many refugees move through a number of countries before settling in the UK, these health records might be out-of-date. Also, to what extent might this be dangerous when regimes are involved (including their health services) that do not have the best interest of people fleeing in mind?

¹⁰⁴ 'Sanctuary Kitchen provides professional development and employment at an above-market wage for immigrants, refugees, and asylum seekers in the Greater New Haven area. Currently, 100% of Sanctuary Kitchen chefs are women. Sanctuary Kitchen chefs have reported reduced social isolation, increased financial stability, improved English language skills, professional culinary skills, and new relationships and networks that provide sustained holistic support. Since its establishment, they have also hosted more than 700 refugee/immigrant-led culinary events, which have reached thousands of community members in New Haven, and across the world'. See: <https://www.sanctuarykitchen.org/>

¹⁰⁵ Ermansons G, Kienzler H, Asif Z, Schofield P (2023) 'Refugee mental health and the role of place in the Global North countries: A scoping review', *Health & Place*, 79, 102964. UK: <https://www.sciencedirect.com/science/article/pii/S1353829223000011>

¹⁰⁶ Sona Circle (2023) Five Great Initiatives Supporting Refugee Integration in the UK. Available at: <https://sonacircle.com/5-great-initiatives-supporting-refugee-integration-in-the-uk/>

refugees. In setting up local community initiatives it is advisable that they seek guidance from UNHCR. The agency has a toolkit and resource to support this.¹⁰⁷

These small scale and local initiatives are vital. They encourage public opinion to push for a more empathetic asylum-process. It is the case that most people in England do not know or interact with refugees or asylum seekers and therefore do not have an accurate idea of the issues they face.

8) **Changing perceptions and the narrative:** Academics, NGOs and the media must coordinate to shape narratives to be more welcoming and positive about refugees and asylum seekers to counter the growing social discrimination. We have to prevent the MH issues and not only respond to ones that have developed. Mass media and awareness campaigns using positive case-studies is one method to raise awareness and understanding of challenges refugees and asylum seekers face. These are important mediums by which to begin to dispel and challenge misconceptions surrounding refugee behaviours and attitudes. However, there is a need to avoid ‘preaching to the choir’ in terms of raising awareness and changing public attitudes. Information and media campaigns should challenge mis-information and ‘bad’ statistics where they exist. Reporting should be balanced to take account of local residents' views, government representatives, frontline staff and refugee and asylum seekers. *We are producing two advocacy films to document the humanitarian and policy challenges in supporting refugees and issues with the asylum process in the UK.*

9) **Increase funding support to successful employment interventions:** such as the integration of refugee medics such as the [Lincolnshire Refugee Doctors Project](#) (LDRP).¹⁰⁸ More widely this involves supporting initiatives such as the [Medical Support](#)

¹⁰⁷ UNHCR (2023) Promoting integration through social connections. Integration handbook. Available at: <https://www.unhcr.org/handbooks/ih/social-connections/promoting-integration-through-social-connections>

¹⁰⁸ See University of Cambridge (2020) Syrian refugee health workers can help Europe cope with COVID-19. Available at: <https://www.cam.ac.uk/research/news/syrian-refugee-health-workers-can-help-europe-cope-with-covid-19>

[Worker](#) scheme which was established during COVID-19 to allow refugee doctors and International Medical Graduates in the UK to work for the NHS (with some restrictions to practise) while undertaking registration with the General Medical Council.¹⁰⁹ In 2023, though the scheme is to continue with central funding, as of June 2023, the release of funds from the treasury is awaited, leaving many refugee doctors, particularly from Sudan and Ukraine in limbo. The Syrian British Medical Society and the Syria Public Health Network, continue to advocate for the continuation of this scheme.

5.2 Research recommendations

- 1) **Establish an assessment (updated each month) of available MH service provision across the UK** (County by county), creating an online and realtime platform for healthcare professionals to triage patients and map service availability and providing translation in key languages where possible. *Frontline service staff who attended the workshop said this would be a valuable resource for domestic and refugee groups. It currently does not exist. An example from London is the Mental Health and Psychosocial Support Directory for Refugees and Migrants: <https://www.kcl.ac.uk/research/mhpss-directory>.*¹¹⁰
- 2) **Develop the economic case for employing refugees and asylum seekers:** From case study interventions and programmes such as the refugee employment initiative Na'amal and the LRDP, it is possible to develop an economic case for participation of professional groups of refugees and asylum seekers in host communities in the Middle East and the UK labour markets. Therefore we propose that research should be commissioned through organisations such as [Elrha](#) and the new *The International Science Partnerships Fund* (ISPF) of the [UKRI](#). Research should explore (a) the appetite

¹⁰⁹ National Health Service (2023) Medical support worker role helps hundreds of refugees to become NHS doctors. Available at: <https://www.england.nhs.uk/2022/06/medical-support-worker-role-helps-hundreds-of-refugees-to-become-nhs-doctors/>

¹¹⁰ See the directory at: <https://www.kcl.ac.uk/csmh/assets/csmh-mhpss-refugee-migrant-directory-v2-june22.pdf>

of UK employers to hire remote talent from the refugee community and (b) explore how much of refugee and asylum seeking is now economically driven as much as it is war and displacement driven, the latter which can be led in partnership with frontline actors working with the refugee community. This will generate evidence on 1) the cost-effectiveness especially Return on Investment (ROI) and Value for Money (Vfm) of interventions to support refugees particularly the provision of MH services to asylum seekers in frontline humanitarian countries and in domestic settings such as the UK. 2) research is needed on the fiscal contribution of employing displaced professional groups such as medics and nurses in the NHS and for the UK economy.

5.3 Next steps for the community of practice will be to:

- 1) **Advocacy strategy and engagement plan:** Organise a series of follow up meetings to propose an advocacy strategy and engagement plan. There is an opportunity to strengthen these networks and knowledge exchange between researchers and practitioners, particularly in supporting a group initiated during the workshop.
- 2) **Policy professionals inclusion:** Future workshops must ensure participation of policy decision makers and those on-the-ground. For such a complex challenge as mental health service design and delivery, it is proposed that further and more focussed workshops are organised to address service issues such as system interoperability and data sharing agreements across the spectrum of contexts (IOM, UNHCR, UK Home Office).
- 3) **Organise resources and formalise network:** Create a central repository of resources, a virtual group (ie. LinkedIn group) and a directory of individuals and organisations working in the field.
- 4) **Further funding:** Prepare a grant application to conduct an audit of MH service provision and access across England.

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- 5) **Impact evaluation:** Conduct a pre/post evaluation of the local UK sentiment towards Refugees and Asylum Seekers to measure whether public and media campaigns have been successful in improving social cohesion and general public attitudes and views.

6. Appendices

6.1 Workshop programme

Improving the design and delivery of mental health services for vulnerable groups in the United Kingdom – the experiences of refugees, asylum seekers and local populations at risk.

An academic-policy knowledge exchange workshop

March, Tuesday 21st - 9 am to 6 pm

The Royal Society of Medicine,
The Seminar room, 1 Wimpole Street - London.

If you would like to join online, you can access the link below for the morning sessions (09:20-12:40)

<https://meet.google.com/kzb-anvs-ybk?hs=224>

and the link below for the afternoon feedback session (17:00-18:00)

<https://meet.google.com/zbq-rqzz-zst?hs=224>

The rest of the sessions will be small group workshops only for participants attending in person.

Agenda

0900 **Registration and refreshments.**

0920 **Introductions, ‘setting the scene’ and key policy challenges.**

Research for Health in Conflict (R4HC) in the Middle East and North Africa: Main findings and recommendations

- Mr James Watt, CVO, Chair, R4HC-MENA International Advisory Board.
- Professor Simon Deakin, Centre for Business Research, University of Cambridge.
- Dr Fouad M Fouad, Associated Professor of Public Health, American, University of Beirut - Chair, IDRC Forced Displacement Program for the Middle East.

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- **Keynote speech**
“Nothing about us without us”

Dr Ahmed Hankir, MBChB MRCPsych, Public Engagement and Education Lead, World Health Organisation. Collaborating Centre for Mental Health and Human Rights, Institute of Mental Health, Nottingham University

0950 The story of Alnarjes: What does it mean to be a refugee in the UK today?

- Alnarjes Harba, Student Ambassador, Global Mentorship Initiative Program

1010 Experiences of frontline workers from Syria and Lebanon: Challenges in accessing mental health care for refugees: what works?

- Bouthaina Almahmoud, Community Mental Health and Substance Use Supervisor, Médecins du Monde Lebanon
- Dr Vlad Chaddad, Health and Nutrition Advisor, Medair Syria
- Jihane Bou Sleiman, Coordinator MHPSS, International Medical Corps Lebanon
- Fadi Daccache, Deputy Coordinator MHPSS, International Medical Corps Lebanon
- Lorraine Charles, Co-founder and Executive Director of Na'amal

1120 Coffee

1130 Film screening: Lebanon - How politics made a nation sick

1140 Experiences of frontline workers in the United Kingdom: Challenges in accessing mental health services for migrants and asylum seekers: what works?

- Anna Miller, Head of Policy and Advocacy, Doctors of the World UK
- Fran Miller, Senior Psychotherapist, Complex Trauma Pathway South London and Maudsley NHS Foundation Trust
- Dr Rachael Brookes, Hospital for Tropical Diseases Charitable Fund Research Fellow
- Poppy Vernon, Inclusion and Infection Nurse Practitioner, Respond Service
- Anne Burghgraef, Clinical Director, Solace

1240 **Lunch**

1340 **Small group workshop**

- Mapping of the current state of the system for Mental Health services for refugees in the UK based on insights gathered through the Panel Discussion

1530 **Refreshments**

1545 **Small group workshop**

- Reflection on best practices and identification of policy - research opportunities.
- How can we design and deliver an improved system for mental health for refugees and asylum seekers across the migration spectrum - from MENA to the UK?

1700 **Conclusions, next steps and feedback.**

1800 Networking Reception.

6.2 List of participants

Ahmed Hankir	MBChB MRCPsych, Public Engagement and Education Lead, WHO. Collaborating Centre for Mental Health and Human Rights, Institute of Mental Health, Nottingham University
Alnarjes Harba	Student Ambassador, Global Mentorship Initiative Program
Ana Andronic	Recruitment advisor, Action West London
Anna Miller	Head of Policy and Advocacy, Doctors of the World UK
Anne Burghgraef	Clinical Director, Solace
Benedicte Duchene	Senior Regional MHPSS Officer, UNHCR MENA
Bouthaina Almahmoud	Community Mental Health and Substance Use Supervisor, Médecins du Monde Lebanon
Catherine Pellegrino	Senior Policy Officer Maternity Action
Diane Pochard	UK Department of Health and Social Care; Centre for Science and Policy University of Cambridge
Edda Costarelli	Task Manager Heath, EU Delegation for Syria
Edith Champagne	Film maker, Producer
Eoin Ryan	MHPSS TU International Medical Corps MENA
Fadi Daccache	Deputy Coordinator MHPSS, International Medical Corps Lebanon
Fouad Fouad	Associated Professor of Public Health, American, University of Beirut - Chair, IDRC Forced Displacement Program for the Middle East
Fran Miller	Senior Psychotherapist, Complex Trauma Pathway, South London and Maudsley NHS Foundation Trust
Frances Player	Senior Policy Advisor, International Affairs, British Medical Association
Francesca Cacuci	Volunteer Clinical Psychologist, Freedom from Torture
James Watt	CVO, Chair, R4HC-MENA International Advisory Board
Jane Hunt	Senior GP Adviser, Helen Bamber Foundation
Jihane Bou Sleiman	Coordinator MHPSS, International Medical Corps Lebanon
Khaoula Trigui	Facilitator, Leadership and innovation coach
Lorraine Charles	Co-founder and Executive Director of Na'amal
Luma Bashmi	Fullbright Scholar and PhD candidate in Psychiatry at the University of Cambridge; RCSI-Bahrain Lecturer, Co-Founder & Director - Elaa Beirut
Madita Weise	PhD Candidate, University of Cambridge
Milia Naissi	MHPSS Specialist, International Medical Corps Ukraine
Mona Jebri	Interdisciplinary Social Scientist, Research Associate, Centre for Business Research, University of Cambridge
Olivia Clark	Senior Policy Advisor, Population Health, British Medical Association
Poppy Vernon	Inclusion and Infection Nurse Practitioner, UCLH Respond

Rachael Brookes	Hospital for Tropical Diseases Charitable Fund Research Fellow
Simon Deakin	Director, Centre for Business Research, University of Cambridge
Sophie McCann	Migration Advocacy advisor, MSF UK
Sophie Oliveau-Morel	Research consultant
Stephanie Wauthier Albrand	Protection Associate, UNHCR UK
Vlad Chaddad	Regional health advisor (MENA), International Rescue Committee (IRC)
Warda Aljawahiry	Video Producer
Yoojin Seo	Research assistant

6.3 Attendees feedback

A survey was sent to participants after the workshop.

From 1 to 5 please rate your experience (0: I didn't find this workshop useful – 5: I found this session very useful, productive and would definitely participate in a follow up):

57% of participants rated 4, and 43% rated 5.

Which part of the day did you find the most useful?

Networking with other professionals. We rarely meet despite working on the same issues. It was very handy to meet government representatives. We need far more opportunities like this between UN, INGOs and UK government.

Learning about mental health care in the Middle East.

The discussion regarding MHPSS access in a humanitarian setting and its integration in the primary care whilst involving community health workers.

I learnt a lot and was impressed by the quality and commitment of those speaking.

Being able to talk freely with other people working in the same field, learning how they navigate issues.

There is often very little opportunity to do this face to face.

From the afternoon sessions: the intricate mesh of moving parts between society, health clinics and patients is very complex (...). It was important to take every variable into account to predict the best possible outcomes.

We have managed to discuss important topics related to actual issues that refugees face in the UK and have worked on finding palpable solutions.

There were barriers faced by refugees that I didn't know before.

What did you miss or would have liked differently?

More time for discussion after the first session.

I would have liked more time to discuss actual strategies for improving mental health services for refugees and asylum seekers in the UK as sometimes too much time is spent discussing the barriers that many of us are already familiar with.

Definitely more time. This 1-day event would have made a perfect 3-days workshop. I really did find it extremely useful.

I would have directed the second half of the day differently. The purpose seemed quite vague and abstract and moved away from the original issue. Mapping out a patient journey meant there were too many variables to be able to nail down concrete policy changes because the experience was too

broad. Were we meant to come up with solutions to the current system, or imagine a world where we could make any decisions? Thought it needed narrowing.

Would you be interested in participating in future discussions?

100% of participants replied yes.

Would you have any recommendations for the future?

To put this on a firm and continuous footing

GCRF and the Home Office should fund the scale up of the research. We have built a unique network of practitioners and frontline staff. There is so little evidence on MH services for refugees and asylum seekers.

Future initiatives will need to involve buy-in from Government departments, potentially small scale trials of initiatives to prove cost-effectiveness might be a way to successfully lobby for change.

Discussion of strategies with clear plans for follow up

To create a central repository of resources and a directory of individuals and/or organisations for those working in this field

To plan a field visit coupled with the conference, interaction with the field is important for healthy policy writing and implementation.

Targeted interviews with specialists who work with migrants and asylum seekers and refugees on targeted topics, and potentially publishing our findings.

The importance of having decision makers in such workshops.