Health and wellbeing of refugees resettled in Lancashire

An assessment of needs for Lancashire Refugee Resettlement Programme

July 2018

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Acknowledgements

This work was commissioned by Lancashire County Council through Rethink Rebuild Society and Lancashire Care Foundation Trust, and was coordinated by Alison Summers and Mustafa Alachkar.

We would like to express our gratitude to all of those from the refugee community who participated. We would like to thank also the caseworkers, interpreters and other professionals who shared their perspectives and facilitated the interviews; the practitioners who conducted the interviews along with AS and MA (Anna Clancy, Helen Gowling, Jamaica Idica, Christina Kaewchaluay, Mariam Khairat, and Carly Smith); the professionals from outside Lancashire who gave time to share their expertise, particularly Jude Boyles, Jackie Wright and Anne Burghgraef; the volunteers who contributed to coding and analysis of interviews (Rukyya Hassan, Christina Kaewchaluay, Zoya Alhaswani, Hosam Elhamoui, Laura Manzie); Rukyya Hassan who commented on earlier drafts of this report; Haytham Alhamwi who made possible the feedback gathering; and Saulo Cwerner and Ahlam Hasan who have provided advice and support throughout.

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Executive Summary

METHODS

Health needs of refugees resettled in Lancashire were assessed through 71 face to face interviews with individual adult refugees, supplemented by analysis of the 48 letters written as a result of these interviews, additional informal interviews with 21 professionals who work with the refugees, discussion with professionals from three specialist refugee services outside Lancashire, a review of published literature and an open meeting with refugee families. The approach taken was predominantly a qualitative one.

KEY FINDINGS

A majority of participants reported physical health issues and a similar number reported psychological health issues. Amongst those with health issues, a majority mentioned at least one unmet need in relation to these.

The way in which refugees conceptualise and express health, wellbeing and related needs may differ from UK norms, particularly in relation to mental health. Being strong, being with family, being part of a community, all came across as crucial aspects of wellbeing, alongside more practical aspects of life, in particular safety, language, work, income and housing. Many in the refugee community have not previously had access to mental health care systems and tend not to discuss emotional challenges in terms of mental health but instead often speak of them as challenges to wellbeing.

For a majority of participants, benefits of resettlement are mixed with an undermining of their resources by multiple routes. Ten such areas where people experience significant difficulty are: dealing with UK systems; learning English; separation from family; worries about family in the UK; specific worries about children; not feeling part of a community; hostility and hate crime; work; finances and housing. Almost all participants made links between issues of this kind and their emotional wellbeing.

Although some participants talked of feeling psychologically well, the majority described experiencing difficult emotional states such as sadness, anger, fear, worry, forgetfulness and loss of interest. Around 40% of participants reported that such difficulties were having an adverse impact on their daily lives, or were affecting them in multiple domains.

Participants described mixed experiences of care. Problem areas included access to interpreters and instances of discrimination along with disappointments with the same aspects of the health service that are problematic for all NHS users.
RECOMMENDATIONS

Five areas for action are suggested:

1. **Addressing remediable factors in the ten areas where refugees' resources are undermined**, doing this as a culturally informed means to improving health outcomes as well as for more specific benefits.

2. **Developing a 'resource building service'** where individual consultations offer opportunity to address emotional and practical difficulties together, supporting this by developing referral pathways and educational initiatives.

3. **Addressing deficits in interpreting provision to bring this into line with established standards of good practice.**

4. **Addressing areas of health care where refugees are particularly disadvantaged**, such as racial discrimination.

5. **Developing training, supervision and support for staff and volunteers who work with refugees.**

Four overarching principles are outlined, which are relevant to actions in all of the above areas:

1. **Involving refugees in planning, delivery and monitoring of services**, including developing mechanisms by which refugees can be well informed about actions taken on their behalf and opportunities available to them.

2. **Reviewing how the public sector equality duty is being fulfilled**, and addressing deficits, recognising how problems that are not in themselves refugee-specific can have different impacts for refugees.

3. **Reviewing training provision in the light of findings from this needs assessment.**

4. **Establishing systems to monitor progress in addressing health needs**, fully involving refugees in this.
Methods

This report presents methods, findings and recommendations from an assessment of the health needs of the refugees who were resettled in Lancashire during 2016 and 2017 through the Vulnerable Persons Resettlement Scheme (VPRS) and the Vulnerable Children Resettlement Scheme (VCRS). They numbered approximately 300 at the time of the work, and were predominantly Syrians. Our focus was on mental health, on unmet need, and on opportunities for improving refugees’ health.

The assessment was conducted between March and July 2018 using the following methods.

1. We interviewed 71 of members of the refugee community, 40 men and 31 women.

   We conducted semi-structured interviews, enquiring about health problems before and after arrival in the UK, with additional probes for emotional difficulties and factors that might affect these. We also asked participants about the health of others in their household.

   We interviewed all the eligible adults who accepted the offer of an interview. A number of issues may have biased sampling. Although we were keen to talk to everyone, with and without health problems, it seems that sometimes people sought interviews mainly to try and get help with a problem, and sometimes people avoided interviews because they saw them as being about mental health and were uncomfortable about this. Also, caseworkers in different areas had different views on the interviews - about who would want one, who would be suitable, and how easy it would be to promote the project.

   65 interviews were conducted in English by female interviewers working with non-specialist male or female interpreters, who were often previously known to the interviewees. Six interviews were conducted in Arabic by a male interviewer. All interviewers were mental health professionals, had an interest in working with refugees and had participated in a short training session on the project. During the course of the interviews the project coordinators (AS and MA) discussed the process in regular supervision with an independent mental health practitioner with extensive experience in working with refugees and asylum seekers.

   Interviewers were asked to take notes during each interview, to capture responses as close to verbatim as possible, and to type these up following each day’s interviewing. We used largely qualitative research techniques to analyse the findings, employing an iterative process to identify themes, led by RW. Initial open coding was conducted by AS, MA and RW, who then cross coded interviews until a
coding paradigm was agreed upon, representing key themes emerging from the analysis. Following this, a team of coders with an interest in refugee mental health coded all interviews into the identified themes. We then conducted focused coding within each of the themes, using constant comparison and checking emerging themes against the data through iterative thematic coding procedures (Braun & Clarke, 2006).

2. We conducted a content analysis of the 48 letters written as a result of the interviews to general practitioners (GPs), caseworkers and the resettlement scheme coordinator.

3. We also spoke to 21 professionals working with resettled refugees in Lancashire, enquiring about their views about how health needs among refugee families are being addressed and what might be helpful. These included 16 caseworkers and caseworker managers, nine contacted by phone, two face to face individually and five as a group. We also spoke to five other professionals, including the resettlement scheme’s health support worker. Relevant comments made by practitioners encountered in the course of the study were also noted.

Findings from these interviews and from the remaining methods (4-6 below) were analysed using the themes identified from the interviews with refugees.

4. We spoke to professionals from three organisations that currently offer psychological support to VPRS and VCRS refugees. These were: The Haven, based in Hull; The Refugee Council service based in Sheffield, and Solace, based in Leeds. We have provided more detailed information about these services in Appendix 2.

5. We conducted a brief narrative review of published literature on health of Syrian refugees, focusing particularly on mental health. For brevity, we have made only brief references to this large literature but have provided further information as an Appendix. We were unable to identify any other surveys of health needs of Syrian refugees in the UK, or any published evaluations of services provided to VPRS and VCRS refugees in the UK.

6. We invited all the families to an event at the Syrian organisation Rethink Rebuild, where preliminary findings of the needs assessment were presented by MA and participants were invited them to comment on them. Approximately 25 people attended, including children.
Patterns of health and unmet need

FREQUENCY OF HEALTH ISSUES

As ill health and disability are criteria for selection into the VPRS and VCRS, participants and their families are expected to have a relatively high frequency of health problems.

The nature of the interviews means that participants’ self-reports of health issues provide only a very approximate guide to their frequency and cannot be taken as indicative of prevalence of a particular issue. The figures here are offered to provide context to the rest of the findings.

43 (61%) of 71 participants reported that they had at least one issue with their physical health. 25 of these mentioned 2 or more issues. 24 of the 43 were male.

45 (63%) reported at least one issue with their psychological wellbeing. 14 of these mentioned 2 or more issues. 22 of the 45 were male.

Prior to coming to the UK, 40 (56%) participants had had at least one physical health problem with 22 mentioning 2 or more past problems. 7 (10%) participants told us that they had had a mental health problem.

Of the 50 participants who answered questions about a spouse, 24 (48% of participants) said their spouse had at least one physical health issue, 9 said their spouse had at least one mental health issue.

Of the 158 children discussed by participants, 60 (38% of children) were reported to have a physical health problem, 25 (16%) a mental health problem.

Both physical and mental health issues varied greatly in severity.

Additional information is available to the Resettlement Programme from International Office of Migration documentation on health problems that were present at the time of people’s departure for the UK.
TYPES OF HEALTH ISSUES

Mental health issues are discussed in detail in Part 4 below, and in the rest of this section we consider just physical complaints.

Physical problems mentioned were of a wide range of severity, including serious disabilities, injuries and illnesses and also minor self-limiting conditions.

Participants spoke of traumatic injuries resulting both from accidents and from violent incidents, including war-related incidents. In some cases traumatic experiences were associated with post-traumatic stress symptoms.

Pain was a common\(^1\) complaint.

Dental problems were also often mentioned, and were highlighted by workers as an issue for many refugees.

Some participants were experiencing symptoms for which no medical explanation had been found, raising the possibility of a psychological cause. Sometimes people themselves linked their physical symptoms to a possible underlying psychological cause. Some people mentioned symptoms where psychological contributory factors are common, for example headache and pain. Although identifying psychological factors in physical complaints was beyond the scope of the interviews, these findings do raise the possibility that some of these complaints are physical expressions of emotional issues. This is particularly likely as in cultures where mental health is stigmatised, physical complaints may be a culturally sanctioned way of expressing emotional distress (Hassan et al., 2015). Given the frequency of emotional distress described in the previous section, it is possible that significant numbers of people are affected in this way. However identifying a psychological component to physical symptoms is fraught with difficulty especially when there are also language barriers and discussion of the possibility can be experienced as insulting and stigmatising.

The majority of physical health problems preceded the participants’ arrival to the UK and participants continued to suffer them after they arrived. However some people commented on having health problems that they had not had prior to coming to the UK.

For many participants physical health problems seem to significantly affect their quality of life and limit their ability to carry out their activities of daily living effectively. Some

\(^1\) We have used the terms ‘many’ and ‘common’ when an issue has been encountered in at least 10 interviews. It is important to note that the number of interviews where a particular issue is mentioned cannot be taken to indicate the prevalence of opinions or themes in the community, as the data is derived from a selective sample using largely open questions, and refugees were not systematically questioned about many of the themes discussed.
significant impacts on people's lives were ones that would not be apparent to others, for example erectile dysfunction in a young man.

REPORTED PATTERNS OF UNMET NEED

29 participants indicated an unmet need in relation to at least one physical health issue, 25 an unmet need related to a psychological issue.

Of the unmet needs reported, 27 were for help from health services, including 5 related to dental care, 5 to treatment of a physical health problem, 4 to help for a mental health problem, 7 to other aspects of primary care.

24 of the unmet needs discussed were unrelated to health services. These included 7 related to housing, 3 to family reunion, 3 to work, 3 to learning English, and 2 to finances. In 21 of the 24 cases these needs were linked to a mental health issue.

REQUESTS FOR HELP MADE THROUGH INTERVIEWERS

Where interviewers felt that a health issue might be worth mentioning to the GP they wrote in confidence to the GP providing the participant consented to this. Interviewers did not proactively offer to write other letters on participants' behalf, but if a participant asked them to write to the caseworker or programme coordinator, then a letter was written.

Letters often seem to be prompted by people feeling their concerns had not been heard, or that they had not understood the response of the service to their needs.

30 letters were written to GPs, some mentioning concerns relating to the participant, some mentioning concerns about other family members. 19 of these letters mentioned a clearly physical complaint, 12 a clearly psychological complaint.

In the GP letters there were 12 mentions of communication problems (40% of letters), 5 of these with requests for additional help around interpreting. Among those wanting help with interpreting, one person had not made a GP appointment because of uncertainty about what gender the interpreter would be. One was worried whether their concerns had been adequately communicated using telephone interpreting. One felt that they had been unable to fully explain their concern when they saw the doctor without an interpreter. In addition to requests around interpreting, 4 participants were wanting more information or an explanation and 3 were wanting to know the outcome of tests or referrals.
12 of the GP letters included requests for additional help, including two requests for a referral and one for a check-up. Three letters requested help with mental health problems. In five cases, the participant wanted the GP to know their treatment was not working.

Twelve letters were written to caseworkers, and six to the resettlement scheme coordinator. Without exception these were written in response to an unsolicited request from the participant.

In the letters to caseworkers and the scheme coordinator, the most common issues that participants asked to be raised were health issues. Physical and psychological concerns were mentioned with approximately equal frequency. In addition, six letters mentioned concerns about housing, including one linked to mental health concerns for the participant and her husband. Three letters were about learning English, three about issues around children's education, two about financial needs. Two people asked for help in making complaints (about racial discrimination, about health care and about a caseworker). There were also mentions of: wanting an interpreter at the dentist, missing family and feeling no-one listens.
What does health and wellbeing mean to refugees?

There is no single agreed way to define health or wellbeing and refugees may not conceptualise health and wellbeing in ways that are usual in the UK.

Refugees responding to interview questions about their health spoke to us not just in terms of physical and psychological health, but instead talked about wellbeing in a much broader sense, particularly when speaking about mental health. This broader concept of wellbeing involves personal strength, family and community alongside practical aspects of life, in particular safety, language, work, income and housing.

All of these can be thought of not just as aspects of wellbeing but also as resources that contribute to health, resilience factors or determinants of health.

This way of thinking about health was not encountered in interviews with workers, who spoke about health in a way that appeared to us consistent with UK norms.

**EFFORTS TO REBUILD**

In describing health, many participants talked of efforts to be strong, and very often about doing so for the sake of others in the family. Such efforts included hiding distress from others and making efforts to care for others, to be busy and self-reliant and to look to the future. These can also be seen as efforts to build a life in the UK.

Some people made specific reference to faith, and philosophies that may link to faith.

Trying to learn English, to find work and to address difficulties with work, finances and housing can also be seen as part of this drive to be strong and to rebuild a life in the UK.

Many people spoke about how important it was to them to find work. They mentioned being accustomed to working hard, feeling useful, contributing to society and not depending on others.
FAMILY AND COMMUNITY

Many participants spoke of the importance to them of both emotional and practical support from family members.

Children seemed to play a significant role in helping people feel better and giving purpose to their lives, a motivation to keep going and a reason to look forward rather than back. When children are doing well, this can clearly have benefits for their parents too.

Participants spoke about feeling better for having social contact with friends and neighbours, and through having friends to confide in.
Undermining of refugees' resources

For a majority of participants, benefits of resettlement are mixed with an undermining of their resources in multiple ways. Each of these ways can be seen as one way in which the health and wellbeing of refugees may be impaired, and their capacities to rebuild their lives correspondingly reduced.

In the health interviews people discussed ten areas of difficulty that undermine their wellbeing and resources. These were:

- Dealing with UK systems
- Learning English
- Separation from family overseas
- Worries about children
- General worries about family in the UK
- Not feeling part of a community
- Hostility and hate crime
- Work
- Finances
- Housing.

Practitioners from specialist refugee counselling services in other areas highlighted similar concerns.

Many families in Lancashire have concerns in these areas and feel blocked in their attempts to address them. Some participants requested help with these issues. Interviewers had not offered to write letters on participants' behalf requesting help with these matters (only GP letters to GPs were offered) but 18 interviews led to such letters being written to caseworkers and the resettlement scheme coordinator. Families who took part in a consultation event where a preliminary draft of our findings was presented responded by emphasising that people need help with practical matters and that they feel it crucial that the needs they identify are properly addressed.

Many participants described how these socio-economic difficulties discussed affected their health, and in particular their emotional wellbeing. This is in line with research on determinants of health. A health strategy that addresses these psychosocial determinants of health would also be in line with current guidance (Hassan et al., 2015).

Some of these difficulties are specific to being refugees. Some difficulties discussed however are not refugee-specific, for example financial pressures and concerns about

“We come from pain, we flee from pain to find a safe haven, but we find difficulties” (male participant)

“Since being here I have felt in a black hole” (male participant)
quality of housing. Refugees’ struggles with such areas sometimes attract less empathy and support than those which are refugee-specific but may nevertheless be more challenging for refugees than non-refugees when they come on top of major loss and trauma and on-going challenges in multiple areas. In other words, the intersection of multiple issues can turn what might seem an everyday problem into something much more major.

Difficulties may be more pronounced for some groups of refugees than others, for example for older people, and single mothers.

Here again, some of the areas of great concern to the refugees we spoke to did not emerge in interviews with workers, in particular issues around missing family, not feeling part of a community, and struggling with finances. In part this discrepancy will be due to the context and the questions asked, but it may also indicate areas where workers are less aware of the families concerns.

UNDERMINING ROUTE 1: DEALING WITH UK SYSTEMS

The refugees we interviewed described huge difficulties in dealing with UK systems. Difficulties in this area (together with difficulties in learning English) are clearly likely to have an impact on many of the other eight areas.

We heard repeatedly about people asking for help that is not given, and feeling unable to influence things. There were examples of this in relation to work, housing, disability, bus passes and transport costs, and with supporting children. Further examples relating to health care are discussed later.

Not feeling listened to was a recurrent theme, sometimes linked to a sense of needing to try harder to get people to listen. Participants told interviewers they had previous experiences of being asked about their needs and nothing happening as a result, and they sought assurance that participating in the study wouldn’t be a waste of time.

For a few participants this sense of not being listened to was linked to suspicions of this being deliberate. It is likely that suspicions of this kind are aggravated by difficulties in understanding how things work in the UK, and what different professionals (for example caseworkers) are able to do, and also by the atmosphere of fear that refugees may have experienced prior to coming to the UK. It may perhaps be also fuelled by expectations by workers that refugees should cope with non-refugee specific issues in the same way that host community members do.
Acquiring the information needed is not necessarily a straightforward process. Some people said they did not know enough about how certain things work or felt they had been given wrong information, while others talked of feeling overloaded with information.

People described receiving decisions that they didn’t understand, feeling vulnerable and being worried about appealing decisions for fear of negative consequences.

They spoke about the help they received from caseworkers, both positively and negatively. Negative views tended to be concentrated in particular localities. Practitioners from specialist refugee services elsewhere mentioned how people can feel abandoned when the level of caseworker support reduces after the first year.

Many people have come with expectations that the reality of life in the UK does not live up to. This was an issue that case workers were very much aware of and they commented on how many families have previously had a good quality of life.

Struggling to get everyday things done can undermine feelings of personal strength, agency and self-respect, can lead to mistrust of officials and, in particular, can sap motivation.

Caseworkers also spoke about how people can be overwhelmed by having so many different things to attend to. They highlighted that difficulties may be particularly marked for those not literate in Arabic.

Caseworkers also spoke of their own frustrations with refugees’ difficulties in becoming independent. Some mentioned refugees having what seemed to them unreasonable expectations (for example, “they expect everything to be two minutes walk away”). They spoke of refugees being more dependent on help than expected, but also of some not seeking help when appropriate. They suggested that refugees’ attitudes might sometimes be a barrier to learning; “resistance” and “defensiveness” were mentioned.

Practitioners from specialist refugee services suggested that fear of authorities may be an additional issue making it difficult for people to navigate systems. We heard about individuals who seem to have been deterred from contacting authorities by fears of Social Services taking children into care, as people are aware that methods of disciplining one’s own children which may be normal within Syrian culture can be seen as unacceptable in the UK. Rumours about such matters seemed to have spread rapidly. With other professionals also, including General Practitioners, trust was felt to be an issue as professionals can be seen as agents of the state. People may have been offered resettlement on the basis of a health issue and may worry about their grounds for resettlement being weakened by things they say once here, or by putting the
wrong thing on a form. This seems linked to limitations in understanding of their rights, and of the 'rules' around seeking help.

Workers also had ideas of what might help. They suggested that more time with people would be more helpful than giving booklets. They commented on how information is spread by word of mouth. This is consistent with research conducted with Syrian refugees living in Jordan, where written materials were described as culturally inappropriate, especially regarding emotional issues (Wells et al., 2018).

In one locality, mention was made of attempts that have already been made to help people find their way around UK systems, mentioning the City of Sanctuary website, a Whatsapp group for the families and a Red Cross booklet.

**UNDERMINING ROUTE 2. LEARNING ENGLISH**

Many participants expressed huge concern about how their limited English affected their ability to integrate, for example to be independent, to be part of the community, to work, to pass the driving test, to look after their children’s wellbeing. They spoke too about how difficulties with language affect their children.

Using interpreters is not necessarily seen as a satisfactory solution even on a temporary basis.

Some people reported specific barriers to learning, most frequently concentration and memory problems, but also caring responsibilities, illiteracy in Arabic, limited prior education, and hearing problems.

Some subgroups had particular language needs around their occupation, particularly people coming from a professional background.

Refugees have a wide range of views on what might help them learn English more quickly, but the only common theme that emerged was of wanting more teaching than is currently available. Workers also thought that more use could be made of volunteers, and that childcare provision would help and they mentioned one instance of a Syrian woman assisting the learning of English by teaching about the Arabic language to other Syrians with less education.

Refugees identified various ways in which difficulties with English have an impact on their emotional wellbeing. Feelings of anger, sadness, fear and loss of motivation were mentioned, and were linked to the effect that limited language skills have on people’s potential to integrate and feel productive.
UNDERMINING ROUTE 3. SEPARATION FROM FAMILY

Many participants spoke of painfully missing family members they had left behind. Some people mentioned more general homesickness, and the loss of homes and businesses, but what stood out amongst all of this was how refugees miss the people they have left.

Separation from family also means the loss of support that people have been accustomed to expect from extended family.

These issues of missing family and missing the support of family were however not mentioned in interviews with the professionals who work with the refugee community.

Many people told us about worrying about those left behind, about their being in danger, unwell, or in need of support. Some workers also mentioned this and thought it particularly an issue for Kurds. Practitioners from specialist refugee services elsewhere talked about how people can be very preoccupied with events at home in Syria, continually frightened and stressed by news, perhaps feeling they have failed someone left behind. At the same time they may feel a need to keep connected, in some cases driven by survivor guilt.

Contacting relatives back home by phone may thus be a source of additional stress, as well as sometimes difficult practically because of poor connections.

Several people described frustration over family reunion applications, sometimes feeling that they have had insufficient help with this. Sometimes people seemed to have wrong information about what is possible.

People described how missing family could affect them psychologically, leaving them lonely and sad. Workers also mentioned guilt as an issue for some, which is in line with experience elsewhere.

UNDERMINING ROUTE 4. WORRIES ABOUT CHILDREN

For those looking to children as a source of comfort and purpose, worries about their children’s health, their needs and their future may be particularly stressful. The workers we spoke to also spoke of refugees focusing on the children’s needs and future, being concerned about children’s behaviour, and being affected by responsibilities as carers.

Some refugees mentioned other specific worries including about their children being isolated, bullied and unsafe.

Children’s behaviour was a source of concern for some. In one locality, caseworkers had arranged a session on parenting, although this had not been attended by the family.
who they thought most needed it. There were plans in the same area to invite a Syrian child psychologist to deliver a workshop on parenting and it was felt that a family support worker could also be helpful. Practitioners from specialist refugee services elsewhere thought that classes on parenting in the UK would be valuable.

Practitioners from specialist refugee services elsewhere highlighted difficulties that arise for children in school when they are placed with a year group appropriate for their age with no account taken of their lack of English, having been out of school for several years, and being traumatised. They mentioned traumatised children responding to any hint of intimidation with an apparently disproportionate fight or flight response and a variety of responses from schools, ranging from organising helpful multi-agency support, to excluding the child.

Women raising children alone may experience particular difficulties, for example around children's behaviour.

Two refugee families expressed great concern about their children not yet being settled in an appropriate school.

Practitioners from specialist refugee services elsewhere mentioned issues that were not raised in Lancashire but may nevertheless be relevant here. These included: consequences of girls marrying as young as 13-14 and long-term fears of children marrying outside the community.

**UNDERMINING ROUTE 5. GENERAL WORRIES ABOUT FAMILY IN THE UK**

Many participants were worried by the problems of other family members. They described how this can interfere with relying on each other for support, and how one person's problems may have knock on effects for others in the family.

Some families were affected by tension and conflict or feeling unsupported by relatives from whom they expected help. Sometimes this seemed linked to irritability and anger. This is consistent with research among Syrian refugees in Jordan, who described how psychosocial stressors related to displacement led to frustration and family conflict, increasing distress for the whole family (Wells et al., 2016)

Some participants described challenges caring for family members with disabilities or chronic illness. For some, this was limiting how far they could participate in other activities, including learning English.

Workers were aware of instances of domestic abuse and marital problems, which in contrast refugees did not speak to us about. Practitioners from specialist refugee services elsewhere talked of how difficult it may be to disclose domestic abuse, for
example mentioning one victim of domestic violence who attended twelve weeks of therapy without speaking about this at all.

Workers also commented on challenges to traditional gender roles.

UNDERMINING ROUTE 6. NOT FEELING PART OF A COMMUNITY

For some participants, not feeling part of a community was a very significant issue. People commented that this was not what they are used to, and that it contributed to them feeling unsupported, and also to seeing the caseworker as their only support. This was not an area of concern that workers raised.

There were some suggestions that relationships with the Muslim community may be developing more easily than with white British people. Syrians use the same Mosques, and caseworkers in one locality noted that all the Syrians who were working had found jobs with Asian small businesses.

People identified various barriers to feeling part of a community with others from the same culture. One issue that refugees raised was living too far away from each other. Another issue was that of tensions with other Syrians, including fears of being judged.

Workers also commented on this and on their additional worries that providing something for one family would lead to others wanting this too. There may be particular difficulties for women alone.

Barriers to feeling part of the wider community included not speaking English, not having a job, and having mobility problems. Hostility is a major issue and discussed separately.

Workers mentioned additional barriers to becoming part of a community including childcare responsibilities and people being too busy for additional activities particularly because of language classes.

Workers raised several themes that were not discussed by refugees. They referred to positive experiences of the host community in some areas, and to individual acts of welcome. They spoke of women being "more confident and sociable" than men. Some caseworkers spoke of instances where refugees' ideas diverged from their own, for example talking about how Syrians' meeting together could lead to "looking on the dark side", and about Syrians "having issues about skin colour".

UNDERMINING ROUTE 7. HOSTILITY AND HATE CRIME

While some people spoke of how feeling safe had helped them psychologically, for others any feeling of safety has been destroyed by the behaviour of the local community.
In some areas this has been a major issue, and has included significant violence, and has left people extremely distressed. Even when police and council have been involved, some people are left feeling that the measures taken to protect them are wholly inadequate.

In the localities where hate crime has been most prominent, this was an issue that caseworkers were very much aware of. Caseworkers also spoke of at least one instance where a family had not wanted to report an incident, and of another where a head-teacher had blamed a Syrian child for provoking racist remarks.

People described feeling shocked and upset, too frightened to go out, and desperate to move to a new area. Women who cover their heads can feel particularly vulnerable.

Practitioners from specialist refugee services elsewhere suggested that discovering the full extent of experiences of racism is likely to require detailed probing about daily experience and that women’s experiences of racism are likely to be worse than men’s.

In some cases, hate crime seems to be causing significant psychological effects.

Undermining Route 8. Work

Not being able to find work was a huge concern for many people, especially but not exclusively, men. It was an issue which caseworkers were very much aware of.

People generally identified language as the main barrier. Lack of childcare was also an issue for some.

There were also barriers to being engaged in other meaningful activity, particularly not having a garden to work on, which many people have been used to.

People mentioned various ways in which lack of work and inactivity was affecting them. These included loneliness and boredom, being unable to forget the past, and loss of motivation and hope. One person said they felt others viewed them critically because they were not working. One caseworker also told us that one man had directed their anger at the situation towards the caseworker.
A related difficulty is the loss of an imagined future, as people come to terms with disappointed ambitions.

Practitioners from specialist refugee services elsewhere told us of people whose mood improved significantly when they started work, even when this was voluntary work.

Some people also spoke of feeling under pressure to find a job when they felt they could not work

Workers thought that an additional adverse effect of not working was that it aggravated unhealthy lifestyles ('smoking and drinking coffee all day').

In discussing barriers to work and work-related activities some caseworkers thought that some refugees were reluctant to take up certain employment opportunities. They mentioned people being reluctant to volunteer, someone turning down a job, and people being unwilling to use a community allotment because they felt stigmatised by working there alongside people with learning disabilities.

In contrast to the refugees, workers spoke of things that seemed to have helped, and ideas for other initiatives. In this respect they mentioned people finding work with Asian small businesses; organising shadowing opportunities for 15-17 year olds; getting an allotment on a community farm. They referred to other resettlement programmes where roles are found for Syrian volunteers, and one person suggested that the Council invest in a business where Syrians could be employed despite language problems.

**UNDERMINING ROUTE 9. FINANCES**

Several people discussed the financial pressures they felt. They spoke about the high cost of living in the UK and disappointments over their standard of living here. In this context, many people mentioned their wish to work. Financial worries may be a particular issue for single parents.

People seemed especially concerned about how limited finances meant they could not provide for their children as they wished. Concerns about the cost of transportation were also common, and people talked about how this restricts their going out.

Several people felt that caseworkers did not understand their frustration. It is possible that this is linked to financial pressures being an issue that is not specific to refugees. In our own conversations with workers, financial pressures were not raised as an issue.

In some cases financial worries were affecting people's health. For example one person said they had started smoking again when their benefits were reduced, and another had
Caseworkers raised an additional issue of inequities in families’ resources, commenting for example that some families had come with gold. There was also mention of one instance where a man’s on-line gambling had caused major financial problems for his family.

UNDERMINING ROUTE 10. HOUSING

For some individuals housing was a major stressor, sometimes linked to a sense of injustice.

In some localities, people told us how they were desperate to move because of hostility and attacks against them and how powerless they feel because they are unable to manage this. Some people wanted to move because their location made it difficult to address cultural needs such as going to the Mosque or buying Halal food, or everyday needs such as going to the supermarket.

For some the quality of their homes was an issue. They described problems that were often equivalent to those that might be experienced by people who are not refugees, for example houses that were small, dirty, damp or cold, with no space for children to play safely. In one locality, there had been problems with loud music, prostitution, “young men throwing their weight around” and beer cans thrown in the garden.

Moving was sometimes seen as a solution to problems, but sometimes as risking something worse, or as having its own adverse effects on people’s health.
Responses to loss, trauma and stress

FREQUENCY OF PSYCHOLOGICAL DIFFICULTIES

Although some participants talked of feeling psychologically well, the vast majority referred to experiencing difficult emotional states - sadness, anger, worry, fear, upsetting memories, loss of interest, or problems with concentration and forgetfulness. Some mentioned seeing equivalent problems in their children. Around 40% of participants reported that such difficulties were having an adverse impact on their daily lives, or were affecting them in multiple domains. 43% of this group were male, compared with 55% in the overall sample. The finding of a high frequency of psychological difficulties is in line with published literature (Vostanis, 2014).

Workers also recognised psychological difficulties among refugees as an important issue, though they said relatively little about specific kinds of difficulty.

Despite these high levels of difficulties, the nature of the needs assessment combined with the likelihood that some people will have been reluctant to discuss psychological difficulties mean it is possible we have underestimated the extent and severity of psychological problems.

CAUSES OF PSYCHOLOGICAL DIFFICULTIES

People describe their suffering as very much linked to the on-going stressors of life in the UK, but also see links to past experiences of trauma and to physical health problems. These are interpretations that are echoed by Syrians elsewhere and which also make sense in terms of the research evidence on normal responses to loss, trauma and on-going daily hassles and on how on-going stressors can magnify the effects of previous loss and trauma (Miller & Rasmussen, 2010).

In the previous section there are multiple examples of how difficulties experienced in the UK affect how people are feeling. There we focused on effects of individual difficulties but commonly people described how different problems link together and reinforce each other.
In addition to talking about current stressors, many participants referred to extremely traumatic experiences in the past.

Sometimes events that many people might regard as extremely traumatic were described as though they were not particularly traumatic. Practitioners from specialist refugee services elsewhere suggested that people may sometimes not make links between their past trauma and current symptoms because the threshold for defining an incident as traumatic may be different or because the traumatic incident took place several years prior to arrival into the UK.

Some people described how traumatic experiences in the past were continuing to affect them, and some of these have related symptoms and could well meet criteria for a diagnosis of PTSD (but the interviews were not designed to assess this). Workers also saw clear links between people having been exposed to traumatic experiences and having difficulties now. Practitioners from specialist refugee services elsewhere spoke of how traumatic experiences people have had back home and during journeys to the UK can continue to affect them long after they arrive, along with the impact of loss of relatives and of generations-old connection with the land.

Some participants also described how physical ill health could affect their emotional wellbeing in a variety of ways.

**The Impact of Psychological Difficulties**

Many people told us about different ways that psychological difficulties could have a significant effect on their lives.

A very common theme was of tiredness and loss of motivation and interest leading to people not doing things they needed to, for example attending to their physical health.

Another common theme was withdrawing from contact with others and going out less. For some this was affecting family relationships.

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“I don’t feel as though people around me don’t always know how I am feeling inside because I try to hide this, so this sometimes shows in me becoming angry...I have been feeling negative feelings and often feeling sad and upset. This is when my mind wanders and I begin to think about the future and my current situation...I get lost in my thoughts and this makes things worse...Something that is really affecting my mood is the fact that my brother and his wife couldn’t make it to the UK with my family and I feel like without my family around me I am feeling unsupported ... I feel like my wife has been suffering and she has very low self-esteem. I think what is affecting her the most is that some of our family could not come here to the UK with us. She is not psychologically well, I try to help her as much as I can but it is difficult when I don’t know what to do. She needs support but I don’t know what can be helpful for her...” (male participant)

“I was tortured by Syrian security forces. My family don’t know, only my wife knows” (male participant)

“We left early so didn’t see much. When we went to Lebanon, there were severed heads, my husband told me not to look” (female participant)

“I was detained and have nightmares about that ... I avoid phone conversations because I get upset when I talk to family in Syria ... No need to talk about it. It was in the past. I try not to remember it” (male participant)

“I wake up and can’t breathe. Like drowning. This is since going through the war. It scares me and I can’t sleep properly” (male participant)

“If my physical health was better then I wouldn’t feel depressed” (female participant)

“I haven’t bothered with follow up for this or anaemia, because I am giving up” (female participant)

“When I have these problems I feel I can’t do anything and I want to give up” (female participant)

“I start to isolate myself when I feel like that and then I don’t like to go out and do things” (female participant)
A third common theme was of people becoming irritable with family members.

A fourth common theme was of how psychological difficulties affected refugees’ ability to learn. This is discussed below under forgetfulness and loss of concentration.

A fifth theme was that of fear of being harmed, which was preventing some people from going out.

Lastly a few people mentioned sexual problems and effects on physical health.

There were also concerns expressed about the impact of psychological problems experienced by participants’ children.

“"There is a complaint that he sleeps during the day at school... He’s still bed wetting” (male participant)

“Sometimes she gets so angry that no one can speak to her. She pinches her sister forcibly for no reason” (female participant)

There seemed to be some vicious circles operating. For example psychological difficulties were clearly undermining personal agency, family and community relationships and ability to learn English. Difficulties in the areas of personal agency, relationships and learning English in turn were aggravating psychological difficulties. This finding is line with published literature on how external stressors and psychological problems are likely to interact, each exacerbating the other (Wells, 2016).

SPECIFIC STATES OF MIND

Although many people mentioned several different emotional issues, some mentioned a single one only. Where a single state of mind was mentioned by at least 10 participants we explored its causes and effects. These states of mind were: feeling afraid, anger, forgetfulness, sadness and feeling good.

Feeling afraid was often attributed to harassment, feared harassment and concerns about family members’ reaction to harassment. People also described feelings of fear that they linked to past traumatic experiences. Many people described how fear of harassment led to them avoiding going out.

Anger was linked by participants to many of the difficulties described in the previous section, for example to arguments in the family, hostility and hate crime, language barriers and being unhappy with housing. Importantly, it was also suggested that anger could arise from trying to hide distress. People told us anger could lead to isolation, distress and adverse consequences for their families.
Forgetfulness was often mentioned alongside loss of concentration. Some had noticed the problem worsening since they had been in the UK. Many participants told us that their concentration and memory problems were affecting their ability to learn English. Caseworkers reported that they had seen people's level of English deteriorate as well as improve, which may perhaps also be attributed to people's psychological difficulties. Forgetfulness was sometimes attributed to age, but more often it was linked to past trauma, or to current stressors.

Sadness was the most frequently mentioned state of mind. It was generally attributed to loss and to stressors in the UK. People spoke of the impact that such sadness has on their lives, most commonly isolating themselves from others.

Some people talked about feeling good, which they often linked to the impact of family or community as discussed early. Comments about feeling good were often associated with other comments suggesting a more complex situation and it is difficult to know whether any of the people who stated they were feeling good were in fact unwilling to disclose more negative states of mind, perhaps feeling that they had to come across as strong and positive.

No participants reported active suicidal feelings. However some people talked of how they would not contemplate suicide because of their faith or because of children and it is likely that the lack of reported suicidality is not an indicator that people do not feel desperate. Given the religious and cultural implications of suicide, it is also possible that anyone who did have thoughts of suicide might feel inhibited from reporting these. In refugee populations generally, suicidal ideation has been found to be higher than in non-refugees (Vostanis, 2014)

In the interviews, we heard only one mention of self-harm, in the form of head banging by a child. The health support worker however told us of this being a much more widespread problem and mentioned people cutting and punching themselves. It is possible that this is also an issue that people felt particular reluctance to disclose.

**CHANGES OVER TIME**

Some participants said they had started to feel better as time went on.

Some people identified reasons for feeling better, including through family and community support, feeling safe in the UK, as well as having had time to get over traumatic experiences. There were only very occasional mentions of treatment having helped.
Some people described getting worse. While they gave a range of reasons, most were connected to current stressors discussed above, for example, separation from family, hostility in the host community, language barriers, and lack of work.

Workers also spoke of problems emerging only after people have been in the UK for some time. They linked this not just to problems developing over time, but also to people needing time before they feel able to seek help. This is in line with literature referring to a ‘honeymoon period’ that refugees go through once they reach safety before they start to connect with a less positive reality than they had initially expected.

We found no published research on how refugees’ psychological difficulties change over time in the UK.

NOT SPEAKING ABOUT PSYCHOLOGICAL DIFFICULTIES

The way that people conceptualise health and wellbeing will inevitably shape what they do and don’t present as a psychological difficulty. It may be, for example, that a difficulty that from a UK perspective might be conceptualised as a psychological problem from another perspective may be conceptualised as a problem in living circumstances.

Based on published literature, experience elsewhere, and reports of resettlement programme staff we anticipated that people would be reticent about discussing psychological problems. Cultural barriers to help seeking for mental health concerns in Arabic speaking communities are well documented (Gearing et al., 2013) although there is some indication that this may be changing (Wells et al., 2016).

There were signs of this as we conducted the study, for example in caseworkers’ reports of people being reluctant to participate. This seemed to vary between localities, for reasons that are unclear but may reflect the way that the interviews were presented and talked about.

Workers had much to say about people’s reluctance to disclose psychological difficulties. They suggested that this might be fuelled by cultural taboos and embarrassment, concerns about being judged by interpreters, and perhaps fears of what disclosure might lead to. It was also suggested that people may not disclose mental health problems easily due to the fact that their first priorities are housing, community and physical health.

We noticed that in the interviews people who disclosed difficulties often began by saying that things were fine. Also that people who went on to describe significant distress could sometimes appear untroubled.

We found that the structured questions about symptoms that we used (from a UNHCR instrument: WHO & UNHCR, 2012) could occasionally lead to participants sharing

By the end of the second year maybe they are able to say ‘yes I need help’” (worker)

“I had a male client who had been raped, it took him a year or two to tell, and at this point he went to mental health services” (worker)

They wouldn’t see it as struggling with their mental health in that they would see it as struggling with the UK (worker)

"I think the majority do have anxiety and depression issues but they conceal it well. They are embarrassed to show it but at certain times I can see it” (worker)

"No, normal like everybody, I forget certain things but it’s nothing" (male participant)
additional information but were often unclear to interpreters and participants, and time-consuming to use. Only around half of participants answered these questions however, and while this was due to time constraints in some interviews, it may also reflect problems with this form of questioning in refugee populations.

When structured questions were answered, some symptoms were less frequently reported than others, feeling like not wanting to carry on living was particularly uncommon (less than 10% of respondents) and anger also uncommon (20% of respondents) in comparison with the more frequent reports of fear, avoidance of reminders and loss of interest (each around 38%). Where symptoms are mentioned less frequently it is impossible to know if this is due to a lower prevalence or to a reluctance to report it.

Some psychological difficulties may be more difficult to discuss than others, for example self-harm and thoughts of suicide, as discussed above. No participants reported current suicidal ideation, despite a direct question, though some referred to having had such ideas in the past.

We heard how people also conceal their difficulties from others in the family.

Some people were specifically reluctant for caseworkers to know about emotional difficulties they were experiencing. Reasons given included not wanting to ask too much, and feeling that caseworkers would be unable to help or don't have capacity to help with issues which they regard as less relevant to their role, or of lower priority.

Caseworkers were correspondingly uncertain about how much they know about their clients' emotional wellbeing, particularly given the cultural differences. Some caseworkers spoke of not seeing signs of emotional problems in any of their clients.

Practitioners from specialist refugee services elsewhere talked of people being reluctant to speak to GPs about emotional issues or for others to know they are seeking help.

There were however indications that in the right setting people are willing to discuss psychological difficulties at least to some extent. The number of people reporting difficulties in the qualitative part of the interviews is probably an indication of this. Although we don't know what exactly helped people to talk about emotional issues, it seems possible that contributory factors may be the confidential setting, time, and the clearly expressed interest in how people are feeling.

Workers told us about various markers that they see as indication of possible hidden difficulties. These included: not coping well with everyday life; being socially isolated; displaying difficult behaviour; and having physical problems for which the doctor has not found a cause. Such ideas are consistent with knowledge of how psychological difficulties can manifest and were often expressed to us with sensitivity and a wish to help, for example one caseworker wondered whether a father's anger with workers was
linked to underlying distress. However, depending on how such suspicions are discussed they can easily also contribute to refugees feeling that their stated concerns and priorities are ignored.

Workers also talked about how concealing difficulties can mean others don't make allowance for these.

Lastly, workers raised the additional theme of gender differences. They suggested that men are more reluctant to disclose problems, and talked of one woman apparently being prevented by her husband from disclosing her difficulties.
Experiences of health care

MIXED EXPERIENCES OF HEALTH CARE

Refugees described good and bad experiences of health care, and workers echoed this.

Refugees had fewer criticisms of secondary care and some workers shared the view that secondary care had been less problematic.

Experiences of primary care seemed more mixed but still included some very positive experiences. Positive aspects of primary care mentioned by workers were GPs’ use of language line, helpful receptionists and good relationships with the GP.

Dental care on the other hand was not described in a positive light by any refugees that we spoke to. Caseworkers’ comments echoed these impressions.

COMMUNICATION PROBLEMS IN HEALTH CARE

A number of refugees described limitations to their access to interpreting. They described professional interpreters not being available and talked of family members being asked to translate. Caseworkers raised the same issues and also spoke of pressure from both primary and secondary care to use resettlement scheme interpreters who are not trained in health care interpreting. We saw the issue reflected even in the course of the project when one GP practice requested that we pass a message to a practice patient.

The problems people reported in secondary care although infrequent were sometimes very problematic. For example we heard about one woman undergoing a planned Caesarean section without an interpreter and we heard, second-hand, a report of someone whose baby had died following a delay in the ambulance arriving, which other refugees were attributing to difficulties communicating with emergency services.

In primary care, there were examples of people struggling to make appointments, of not having understood treatment options, of being anxious that they may not have had the correct treatment, of expecting results of tests that did not appear, and of being unsure of what had been said. Workers mentioned concerns about GPs using Google translate, and about female interpreters not being available.

"Today, the doctor called - something about an appointment for my daughter. I didn’t even know what they were saying, and they hung up" (female participant)
In dental care, lack of interpreters seems the norm despite language line having been made available to dentists. Some caseworkers have managed the problem by routinely taking people to an emergency dentist some distance away. We heard that the health support worker often ends up interpreting for dental appointments, taking him or her away from more appropriate activities. Workers thought this problem was most pronounced in private practice, and where European dentists are employed on short term contracts.

An additional issue was that of the limitations of telephone interpreting. Some people felt uncertain that translation had been adequate. Based on experience elsewhere and published literature, it is highly unlikely that telephone interpreting would be appropriate for discussion of difficult emotional issues.

For some, concerns about the gender of the interpreter present an additional barrier.

Workers raised the additional theme of interpreters’ skills. They noted interpreters struggling with medical terminology. Experience in services elsewhere also highlights that in mental health settings, training and support for interpreters are essential. Another additional theme raised by workers was that of refugees not always being aware of their rights to request an interpreter for medical appointments.

Workers also spoke of things that have been done to try and address the lack of interpreters, for example making language line available to dentists, and visiting practices to discuss the issue. They also had suggestions about more that could be done, including further meetings with the CCG and practice managers.

"My husband has asthma and finds it very difficult to breathe. At times, he wakes up at night and can't catch his breath. To be honest I am worried that he might die, because I heard of someone who died from this. He doesn't have his inhaler on a repeat prescription, and has to go to the doctor every time he wants a new inhaler. Last time he went to the doctor, the doctor said he doesn't have asthma. I think this was because of a language barrier, and he [the doctor] just didn't understand. I want an appointment with the doctor and an interpreter so he will be able to understand" (female participant)

DISCRIMINATION IN HEALTH CARE

A few participants alluded to a sense that they are not being treated adequately because they are refugees or Syrians, though did not discuss clear evidence of this.

We heard from one worker about a very concerning instance of one GP expressing racist views and displaying associated reluctance to offer appropriate help. The caseworker planned to follow this up with a formal complaint.
In relation to secondary care, workers spoke of problems arising from application of overseas visitor charging (https://www.gov.uk/government/publications/guidance-on-overseas-visitors-hospital-charging-regulations), including people being billed inappropriately, and one instance of a group of women attending for mammograms being questioned in a group about experiences of torture. Published literature suggests that problematic implementation of overseas visitor charging is a national issue, and since the introduction of new regulations in 2017, there has been an increase in the number of people being wrongly denied care, or finding their eligibility to care questioned on the basis of their appearance.

It is impossible to know if some of the negative experiences of health care discussed in other sections may arise from underlying hostile attitudes, but given the prevalence of hostile attitudes in the host community, this is a possibility that needs to be recognised. Related to this is evidence that health care staff have limited understanding of refugee issues, for example the vast majority of healthcare staff do not feel confident defining terms such as ‘asylum seeker’ and ‘refugee’.

OTHER DISAPPOINTMENTS IN HEALTH CARE

In addition to these issues with interpreting and discrimination, many people spoke about other pressing concerns about the health care they were receiving.

Some of the frustrations with health services were about difficulties that would be experienced in equal measure by people in the host community, for example delays in treatment, unsuccessful treatment and costs associated with getting care. However, such difficulties may have an added impact when people come with expectations of something better. Some difficulties were more specific to refugees, for example unmet needs for information, and frustrations at expectations not being met.

Many people were disappointed about the time they had to wait for treatment, and often spoke about not having expected this.

Some people mentioned unmet needs that seemed linked to lack of information.

Many people were concerned that they had not received the kind of treatment they expected. Sometimes this may have been due to differences in practice between the UK and Syria, for example in relation to referral to specialists or prescriptions for common complaints. (The term ‘General Practitioner’ in Syria refers to a medical doctor who has had no training beyond medical school and outpatient appointments can easily be made directly with a specialist without a referral or a lengthy wait). Sometimes where treatment had not led to the hoped for outcome, people were left concerned about whether they had been treated appropriately. In some instances it also seemed possible
that the problem was one of lack of information. Workers commented on how not having expectations met can lead to people feeling that things are not being done properly.

"Sometimes they don't agree with the treatment. The ways the doctor does things here are different from in Syria. I took one Syrian refugee to the doctor, the doctor listened for five or six minutes, then gave a prescription and the man said 'I don't think he's a doctor'. When you go to doctor in Syria they examine you, they press your belly, put a wooden thing in your mouth"  (worker)

A few mentioned costs and practical difficulties around treatment, particularly in relation to transport costs, especially when they have needed to go to a different city for specialist treatment. A few felt they had been treated unfairly.

Sometimes disappointment or negative experiences with health care on offer has led to people not using health services

For refugees, feeling unable to obtain health care of the kind hoped for seems to exacerbate the general frustrations and despondency that refugees can develop in response to experiences in the UK. The problems described here seem analogous to those described earlier (pp. 14-16) in non-health care settings. In this context, some participants made a link between their physical health problems, especially chronic ones, and their mental state of frustration, depression and helplessness.

Workers echoed many of the above concerns highlighted by refugees, and mentioned additional ones also, particularly around primary care provision and dental care.

Regarding primary care, workers related accounts of people struggling at reception, for example receptionists expecting people to bring their own interpreter or seeming unhelpful in other ways.

They spoke of problems refugees experience with appointment systems such as limited access to female doctors, limited availability of doctors generally, being only able to telephone for appointments at specific times, being on hold for long periods, and restrictions of one problem per appointment.

Workers mentioned other specific issues with GP care, one problem due to the Home Office not having shared information about prior TB testing, some problems through GPs not having been adequately prepared for dealing with new arrivals, and criticism of the attitude of two specific GPs.

In relation to dental care, issues raised included not only the lack of interpreting mentioned above, but also the short duration of appointments and dentures being all that is on offer when people want implants.

Practitioners from specialist refugee services elsewhere described people having difficulty getting appropriate health care because of the complexity of understanding where and how to seek help.
An additional theme that emerged in conversations with workers was that of seeing disappointments in primary care as attributable not to a problem in the service, but to the way that people use primary care. Workers commented particularly on people expecting to see a doctor in circumstances where this would not be the norm in the UK. They linked this to refugees’ expectations, in turn linked to their lack of education. It was mentioned as one of the frustrations for caseworkers. There were also occasional comments on people not taking up help that has been offered.

Another additional theme in conversations with workers was of attempts that have been made to try and address difficulties with primary care and dental care. Of note, the resettlement scheme’s health support worker has been providing sessions on how the NHS works, and caseworkers also reported that they talk about this to their clients.

MENTAL HEALTH CARE

Refugees only occasionally talked about experiences of health care for emotional problems, which we take to be because few have actually had such care. As with physical care, experiences were mixed, an impression that was echoed in caseworkers’ comments.

A small number of refugees had felt better through talking to a professional or through medication prescribed in primary care. We heard occasional comments from caseworkers about helpful input, including from a health visitor, and from a third sector counselling service.

We noted one instance of a refugee reporting a highly unsatisfactory experience of mental health care, which may perhaps have been related to actions advocated through Prevent.

"The caseworker asked if I wanted to see a psychological doctor. I saw them. I was given a number … and told if I’m going to commit suicide to let them know. I felt like they just think I am a Syrian criminal. I don’t think they really were a psychological doctor but wanted to find out if I am a terrorist. I am running away from all that stuff! There are a lot of questions they ask me about what I could do to harm myself or others. I’m not stupid. It is really frustrating that every time I talk about my feelings they turn it into me being a terrorist. I wouldn’t hurt anyone" (male participant)

We heard from workers about other unsatisfactory experiences of mental health care. In primary care, lack of follow up was mentioned as an issue. In secondary care, in one case someone thought to be a perpetrator of domestic violence with significant mental health needs was reportedly told by mental health services that his problems were not severe enough to be offered support.
The caseworker referred to Minds Matter. The caseworker rang and said there was a history of domestic violence. Then the man went and talked about housing and living in the UK... They said he was fine. Now his mental health is worse. Now he's not sleeping, is isolated from wife and other families, and irritable. Now he has an appointment for Single Point of Access [for the mental health service]. The caseworker is going to go to the appointment with him (worker).

There were comments about uncertainty about where help could be found, an issue that did not come up in relation to physical care.

Workers also spoke of people having seen mental health professionals but having little idea what the appointments had been for.

A concern raised by workers but not refugees was that there seems to be a lack of appropriate services to refer people to. This is in a situation where current referral options include: self-referral to the Lancashire Care NHS Trust (LCFT) service Minds Matter (a self-referral psychological therapy service which offers various short term therapies for common mental health difficulties); GP referral to the LCFT Single Point of Access for mental health services; self-referral to third sector counselling services, which do not have interpreters available; self-referral to the Freedom from Torture service in Manchester, which has extremely limited capacity. Other than Freedom from Torture, there are no services tailored to the psychological needs of refugees.

Workers commented on the need for mental health staff to have training in working with interpreters. This was a point very strongly emphasised by professionals in specialist refugee counselling services elsewhere.

Workers also commented on mental health care being often a low priority for refugees, or not wanted at all.

In the published literature, subgroups with specific mental health needs are identified (Hassan et al., 2015). Survivors of sexual and gender based violence are likely to have fears around confidentiality, shame, reprisal. For survivors of torture, shame and somatic symptoms may be particular issues. LGBTI individuals may have difficulty with trust and may come with expectations that others wish to 'cure' them (UNHCR).

**ATTITUDES TO PSYCHOLOGICAL THERAPIES**

We used the interview responses and interviewer comments to try and understand more about participants' perspectives on psychological therapy, which would be a recommended response for many of the problems people were reporting. As psychological therapy is relatively unknown in Syria (Wells 2018), it would be expected that many refugees would not be familiar with this, and might be reluctant to try it, sceptical or even suspicious.
Many people did express reservations about talking about their problems, and workers echoed this.

Refugees linked not wanting to talk to feeling a need to forget, to feeling it wouldn't help and to not having time to take on something extra. Workers suggested other possible reasons including lack of understanding of what therapy might be, preference for talking to people who have had similar experiences, and feeling that they would not be able to trust a therapist. One caseworker mentioned that an offer of contact with a Syrian psychologist had been refused for fear of feeling judged, but the experience of the Syrian interviewer in this project was that people were willing to talk to him, and one person said this was particularly so because of the shared background. Caseworkers also commented that with most people they had not discussed the option of counselling.

Some individuals on the other hand indicated that they might appreciate counselling. Among Syrian refugees in other countries, similarly, some have identified a need for counselling or psychological support, for example 13% in one study in Jordan (Eastern Mediterranean Public Health Network, 2013).

Sometimes participants’ reactions to the interview suggested that they valued talking, sometimes despite not having expected to. This changing of views in response to experiencing talking to a person who wants to listen is in line with experience in services in other parts of the UK and in Jordan, where when refugees have initially seen talking as unlikely to be of much help, interest in counselling services has seemed to grow rapidly as people understand what it is like, experience its benefits and spread the news by word of mouth.

Workers in Lancashire talked about being unable to suggest third sector counselling services because they lack interpreters. We heard of just one instance where someone seemed to have benefited from counselling in a third sector organisation, when interpreting was funded through the resettlement programme.

Workers also questioned the appropriateness of some of the therapeutic approaches on offer, for example wondering whether cognitive behaviour therapy, a therapy that is commonly offered, is suitable for people from different cultures. Elsewhere, a variety of interventions that have been suggested or found to be of possible value in refugee populations, including among Syrians, but there is limited research into their impact. On theoretical grounds, arguments can be made for a range of therapeutic approaches.

Individual workers also made suggestions: for sessions on wellbeing and confidence for women; for small activity groups, such as sewing groups led by someone able to facilitate both the activity and conversation; for a group teaching recovery techniques for refugees, as happens in Vauxhall. They mentioned a plan that was not carried through for a six week mental health course organised through Community Restart. Some on the other hand thought group work unhelpful.
LIFESTYLE AND PHYSICAL HEALTH

Very few refugees talked about ways they are trying to look after their physical health.

We asked a direct question about smoking and alcohol use. 38% said they smoked tobacco, 9% that they used alcohol. Smoking and alcohol use was mainly but not exclusively among men.

Workers had much more to say about refugees’ lifestyles than did the refugees themselves. They commented on most refugees being smokers, many men being overweight, people being less active than in their previous circumstances. Several commented on refugees eating a high sugar diet, including feeding sweet things to babies and toddlers, and on dental problems that they saw as a consequence of this.

Some workers attributed these behaviours to lack of education or reluctance to take advice. One worker told us that refugees don’t want to listen because they feel that they are being criticised and told that their way of doing things is bad

We heard from workers about attempts that have been made to try and help people develop healthier lifestyles. A significant intervention has been the health support worker’s provision of small group sessions on smoking, diet and exercise, and individual sessions for people with diabetes. Support provided by caseworkers was also mentioned, for example with stopping smoking. Other interventions referred to included: provision of free gym membership for the first year; provision of allotments; and booking people into NHS stop smoking services.
Additional contributions from professionals and from the literature

Some issues not discussed by refugees are nevertheless important to consider

INVolvEMENT OF REFUGEEs IN PLANNING AND DELIVERY OF SERVICES

There are strong arguments and authoritative recommendations that support involvement of refugees in the planning and delivery of both research and services (Hassan et al., 2015; Wells, 2016).

Despite wishing to follow this guidance, we did not manage to do so due to limited time and resources combined with a lack of existing involvement structures.

One or two participants did spontaneously volunteer that they would like to contribute to helping fellow refugees. Comments from others indicated scepticism about actions (for example participating in the needs assessment) leading to any actual change. Among the 25 or so individuals who attended the event to discuss preliminary findings, the majority of those who spoke focused on pressing needs that they themselves were experiencing.

WORK ALREADY BEING DONE IN LANCASHIRE

We did not set out to survey what is already being done to try and address health needs in Lancashire. Thus we do not have comprehensive information about this and assume there may well be relevant initiatives of which we are unaware.

It was evident however that efforts are already going into trying to address many of the issues discussed, some of which have been mentioned in the relevant sections above.

Of note, the resettlement scheme health support worker has attempted to respond to perceived health needs by offering teaching on health issues, responding to individual queries, and providing interpreting for health contacts where GPs or dentists are refusing to use telephone interpreting. Presentations have been made to GPs and dental practices about refugees and their needs. Teaching for the refugees themselves is
offered in groups of four or five, the smaller groups being felt to promote better engagement. The topics covered include: how the NHS works; healthy eating; smoking; medication and antibiotics; managing mental health (for example sleep problems; relaxation; anxiety and self harm. Individuals also seek individual help, for example wanting to know how to get medication or to have help negotiating over care. Much of the worker's time is however taken up with interpreting. This resource is limited to one full time post, which up to now has allowed around one day a week in each locality.

The refugee participants we spoke to in contrast to workers, had little to say about attempts already being made to address their concerns, which might reflect their lack of awareness of this, a general dissatisfaction, or both

The workers we spoke to pointed to additional possibilities for addressing needs. They mentioned capacities within the resettlement scheme, for example, caseworkers may have good relationships with schools, and interpreters with individual families. They mentioned other capacities within the host community, for example a Syrian doctor who knows many families in one area and has provided advice and support, a counsellor who has provided informal support to volunteers working with refugees, and individuals in different communities who have been active in working with refugees.

SUPPORT FOR THOSE WORKING WITH REFUGEES

"....Trauma is a bubble that bursts and reverberates through society" (worker)

Among those working refugees, vicarious traumatisation and burnout are recognised risks (Herman, 1997), and may be particularly likely when unmet needs among refugees create corresponding pressure for front-line staff. Support and supervision are widely regarded as important in reducing these risks.

Caseworkers working with refugee families talked of various stresses in their work including having too much to do, working with people with expectations they are unable to meet, and in some areas finding people venting their frustrations on them. An issue mentioned by practitioners from specialist refugee services elsewhere which might also be relevant is that of host communities assuming that people should be grateful for what they are given rather than dissatisfied, an assumption that may at times be shared by professionals.

Some felt their work tended to centre on responding to crises, rather than taking time to reflect and plan ahead. They commented on having limited opportunities to meet and learn from caseworkers in other areas.
Many people commented on caseworkers' needs for more information and support around understanding mental health, and NHS and Social Services. Where individual caseworkers have had a relevant background, this has been found valuable.

Some suggested that it would be helpful for caseworkers to have someone to consult when there are concerns about someone's mental health. Specialist refugee mental health services in other areas suggest that offering training and support to caseworkers can be a valuable part of their work.

There were also comments about volunteers' needs for support. Emotional demands were identified which may well affect paid workers also, and may lead to burnout.

Deciding where to draw boundaries can be a particular difficulty. Some, particularly volunteers, may be drawn to offer more than they can sustain. At the same time boundaries that protect a worker may for refugees exacerbate a feeling that people don't want to help.

Practitioners from specialist refugee services elsewhere who have been providing training and support for caseworkers suggested that training may usefully cover: worries about re-traumatising people or aggravating problems; responding receptively when people choose to talk about distress; differentiating between normal distress and trauma symptoms needing specialist help; responding when families report difficulties such as nightmares; recognising difficulties despite quietness and absence of overt problems; being open to cultural differences; avoiding vicarious traumatisation.

**EXPERIENCE ELSEWHERE OF PROVIDING PSYCHOLOGICAL SUPPORT FOR REFUGEES**

Three services in Yorkshire (The Refugee Council Service in Sheffield, the Haven in Hull and Solace in Leeds) have considerable experience of providing psychological support for Syrian refugees and have found that this has been welcomed and has seemed useful. In one service, in the first year of operation 39 of a total 132 individual refugees had been referred, there had been just two people who dropped out and few missed appointments. The impression gained by that service provider is that virtually all the adults arriving through resettlement schemes might benefit from access to psychological support. In another area where therapists were able to provide outreach to drop in centres around 50% of people accessed the service.

The kind of work offered in these services tends to be an initial assessment over one to three sessions, followed as appropriate by opportunity for people to talk freely about their concerns and experiences, with the therapist sometimes also drawing on specific techniques such as relaxation training or EMDR (eye movement de-sensitisation and re-sensitisation).
reprocessing, a talking therapy used for post-traumatic stress disorder and other conditions).

Therapists told us that what refugees seem to find useful is help to understand their responses to all that's happening and that these are normal in the circumstances, as well as help to develop a framework for understanding their difficulties and the kinds of things that might help. People seem interested in the opportunity to tell their stories and have a meaningful conversation. They seem to value a relationship with someone who wants to listen and to be less interested in learning symptom reduction techniques such as relaxation and breathing, which they may already have been exposed to in countries such as Lebanon.

People using such services are reported to find it helps with re-orientation, coping with loss, and imagining the future.

Some therapists commented on how Syrian people's use of psychological services may differ from other refugees and asylum seekers, with less long-term work, and people coming and going at different stages. Very few resettled Syrians are referred to NHS mental health services, though the NHS is used when people are acutely suicidal.

Certain features of the services are felt to contribute to their acceptability and success. These include: offering services as a means of building strength rather than treating illness; helping caseworkers develop a good understanding of what is being provided; offering training and support for interpreters; offering flexibility and a range of approaches; locating the service in a place where refugees already go such as a drop-in; having experienced therapists who have specifically chosen to work with refugees; meeting the family as well as the individual referred; developing a culture of the counselling room as space for privacy and no interruption.

Experience in providing these services has led to increasing recognition of the need for services to work with families rather than individuals. In many parts of Yorkshire all VCRS and VPRS families are now to be offered a child and family wellbeing programme, funded through a Home Office grant, with Local Authorities providing matched funding. This is the first service of its kind in the UK, and will be evaluated as a pilot project.

Different models have developed in different areas. In one area the CCG has contracted for 12 sessions to be offered to each family; in one GP practice, a therapist offers two days a week to any refugees or asylum seekers from that practice; in one area there is funding for complex clients who don't meet NHS criteria; in one area an NHS service has run a pilot stabilisation service for refugees. Two CCGs who initially opted not to commission a service later did so in response to hearing complaints from schools.

Practitioners in these services have generally not made much use of Arabic language written material, though the pages on Cultural Adaptation in the Home Office 'Welcome to the UK' booklet were suggested as potentially helpful. They thought people were
generally uninterested in written material but that a phone app with audio and video information might be more useful.

The practitioners suggested other initiatives that they had found helpful or thought could be helpful. These included: classes on parenting in the UK; a stress management group focusing on the stresses of adaptation; employing a development worker to increase awareness among caseworkers and GPs.

There is detailed guidance available on the provision of psychological support to Syrian refugees (Hassan et al., 2015) and this is outlined in more detail in Appendix 1.
Recommendations

We have considered the findings presented above in the context of the published literature (Appendix 1), specialist refugee services elsewhere (Appendix 2) and our own prior experience (mental health, work with refugees, research, public health).

On this basis, we suggest that the health needs of refugees resettled in Lancashire would be most effectively addressed by attending to each of following five areas: (1) addressing factors that undermine refugees’ resources; (2) introducing a resource building service for refugees (3) improving communication in health care; (4) addressing areas of health care where refugees are particularly disadvantaged; (5) developing support for people working with refugees. In addition, we suggest that in addressing each of these areas, some common principles are followed around: involvement; equality and rights; training and monitoring. At the end we have made some suggestions regarding possibilities for further work around health needs.

We recommend that the findings and recommendations of this needs assessment, or appropriate extracts from them should be shared with agencies able to make use of them, such as the District Councils, Clinical Commissioning Groups (CCGs), General Practitioners (GPs), secondary care Trusts and third sector organisations.

We recognize that since the start of the resettlement process considerable effort has been going into addressing the needs of resettled refugees in Lancashire and this health needs assessment has not included reviewing actions already tried or considered by the Resettlement Programme and other bodies. Thus each of the recommendations offered here needs to be considered in the light of knowledge of what has been attempted already.

PRINCIPLES

Involving refugees as fully as possible in the planning, delivery and monitoring of health service developments has many potential benefits. It is likely to help deepen understanding of needs and feasible solutions among non-refugee professionals, offer worthwhile activity for those refugees involved, and aid in disseminating understanding of UK systems. We strongly recommend that mechanisms be urgently established to support resettled families to share responsibility for identifying community needs and choosing and delivering solutions to these.

Other findings raise questions about fulfilment of the Public Sector Equality duty to avoid people being disadvantaged because of their protected characteristic. This is important as being a refugee has not only direct impacts on health, access to services and participation, but also on the effects of difficulties which are not in themselves refugee-
specific. Other findings from the interviews with refugees indicate possible training needs in relation to working with refugees, and the risk of refugees believing that the needs assessment has been valueless.

We recommend that all of these issues are held in mind when considering recommendations in each of the five areas highlighted.

**INVolvement**

**The Resettlement Programme should:**

- Involve refugees in deciding a response to these recommendations. This might usefully involve workshops in each locality where caseworkers, third sector agencies, families and other stakeholders can consider the local implications of the needs assessment findings. Separate meetings for women should be considered.

- Develop structures, recruitment strategies, training and ongoing support to enable refugees to contribute effectively to all areas of planning and also to training. This might usefully include supporting development of a small group of refugees who would work as community liaison officers liaising with the Council to represent refugee needs and views.

- Develop a strategy for regular communication with refugees, providing this material in both English and Arabic. Early on this should include informing refugees of the plans that are made on the basis of the needs assessments and ways that they can become involved. On an ongoing basis it should include providing information about actions that the programme takes to support refugees and about opportunities available to them in all sectors, for example for work, social and involvement activities.

- If plans are made to develop any of the paid and voluntary roles discussed in these recommendations, give careful consideration to whether being from a refugee background could be an essential or desirable selection criterion. Awareness raising, training and support arrangements should be established to enable refugees to fulfil such roles effectively. Prioritising roles that do not require fluency in English would enable refugees to participate more quickly.

**All agencies working with refugees should:**

- Actively seek opportunities for refugee involvement in service planning and delivery.

**Equality & Rights**

**All agencies planning and monitoring services for refugees should:**

- Review fulfilment of public sector equality duty under the Equality Act 2010. NB. This sees having due regard for advancing equality as • Removing or minimising disadvantages suffered by people due to their protected characteristics. • Taking steps to meet the needs of people from protected groups where these are different from the needs of other people. • Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

- In addressing issues that are not refugee-specific, give consideration to the potential for refugees to be differentially affected by non-specific problems (while recognising potential to exacerbate hostility if interventions appear to favour refugees over the host community).

- Give particular consideration to gender differences in needs, and to the particular needs of older people, those with caring responsibilities, women alone, people who have been victims of sexual and gender based violence, LGBTI individuals.
Training for professionals and others working with refugees should:

- Use findings from this survey as a resource for aiding understanding of refugees’ needs and reviewing gaps in current training provision.
- Involve refugees in planning and delivering training.
- Give particular consideration to the following points arising from the refugee interviews:
  - The intimate connection between health needs and practical needs
  - Areas where there is a mismatch between the expectations and aspirations of refugees and those of workers from the host community where limitations to awareness may lead to intolerance
  - Difficulties which may be less often discussed by refugees, such as missing family and community, traumatic experiences and emotional needs.
  - The likelihood of refugees not feeling listened to, linked to having limited experience of dealing with UK systems.
  - The possibility of problems which are not refugee-specific having additional impacts on people who have a refugee background.
- Use a rights-based approach.
- Use a psychologically informed approach (Herman, 1997; Miller & Rasco, 2004), recognising
  - The many ways in which trauma can affect people, including making it difficult to communicate needs effectively
  - The potential for services to inadvertently precipitate trauma symptoms and re-traumatising
  - That mental health concerns often occur when the tools people have at their disposal to meet their needs do not match the environments in which they live (often the case for displaced people).
  - That challenging behaviours may be adaptive strategies which people use to try and meet their needs.
  - That ways of asking for help in other cultures may be less direct than for the UK.

The Resettlement Programme should:

- Develop a means for refugee community members to contribute to ongoing monitoring of progress against all of the recommendations in this needs assessment.
- Consider as part of this
  - Periodic reviews where caseworkers systematically check with each individual their experiences of health and in each of the ten areas discussed, and feed this information back to the programme.
  - Periodic forums in each area where there is opportunity for refugees and caseworkers to discuss together what is and isn’t going well.

Area for Action 1. Factors that Undermine Refugees’ Resources

Addressing the ways in which refugees’ resources can be undermined is important both as a means to improving health and as a response to refugees’ expressed concerns, and is very much in line with current guidance on improving mental health of Syrian refugees (Hassan et al., 2015). All of the recommendations in this section are included here with the aim of improving health outcomes. Improvements in one of the areas discussed will
often have knock on benefits in other areas, and potentially on other goals of the resettlement programme.

**HEALTH STRATEGY**

All agencies developing strategies to improve the health of refugees should

- Include in health strategy not just traditional health interventions, but also interventions that address determinants of health and resilience, giving particular consideration to the ten areas identified: (1) Dealing with UK systems; (2) Learning English; (3) Separation from family; (4) Worries about children; (5) Worries about family in the UK more generally; (6) Not feeling part of a community; (7) Hostility and hate crime; (8) Work; (9) Finances; (10) Housing.

In many of the areas discussed below, developing strategies for addressing the needs identified will require additional expertise and the suggestions for action provided here should not be taken as a comprehensive or prioritised list.

**DEALING WITH UK SYSTEMS**

The Resettlement Programme and caseworker provider organisations should:

- Review current approaches to helping refugees understand UK systems including exploring with families what approaches have been useful, and what is lacking.

- Develop a strategy for improving refugees’ understanding of UK systems (NHS, Social Care, banks, education etc.), including ensuring that refugees are aware of what constitutes discrimination in law, and what they can do about it, and of constraints on service that affect everyone so that there is less chance of people feeling unfairly treated when they come up against these constraints.

- Consider as part of this
  - That taking time to help people understand systems may be crucial and written material of more limited value
  - Building on existing Resettlement Scheme website resources so that all FAQs are addressed by online video material.
  - Supporting refugees to use information available on line and through phone apps, particularly audio and video material.
  - Training individual refugees to themselves act as a resource for others
  - Training individuals within the host community to act as mentors
  - Ensuring families are aware of their rights, and able to communicate these for example through carrying cards stating rights to interpreting.
  - A regular bilingual newsletter type communication with all refugee families to inform of new opportunities and initiatives. This could be paper or via a phone app.

The Resettlement Programme should consider:

- Communicating with UNHCR staff about the experiences of refugees resettled in the UK, so that this can inform efforts to provide information about the UK to new applicants. One possibility would be a video of people here discussing their experiences. It may also be worthwhile consulting refugees already here about how to get this message across.

**LEARNING ENGLISH**

The Resettlement Programme and ESOL providers should

- Recognise that improving refugees’ learning of English will have potential benefits to health.

- Conduct an audit of the difficulties that individuals experience with language learning, considering perceived causes, variation with locality, gender, literacy in first language, prior education, possible specific difficulties for Arabic speakers.
learning English, and whether perceived difficulties are based on realistic expectations.

- Develop a strategy to enhance language teaching and learning, which should include steps to increase refugees' contact with fluent English speakers.

- As part of this consider:
  - Reviewing teaching currently provided
  - Increasing overall teaching provision
  - Improving access to English language learning apps for Arabic speakers
  - Developing individual plans for addressing identified barriers to learning, including mental and physical problems.
  - Providing flexible arrangements for those who have caring responsibilities or other difficulties which prevent them attending classes
  - Where people report problems with concentration and memory, or other unanticipated difficulties in learning English, providing further assessment of these to identify possible remediable factors, particularly those likely to be linked to trauma.
  - Following up other suggestions made by refugees: reduced emphasis on computer use in class; separate classes for men and women, supportive teaching approaches.
  - Involving third sector agencies, for example providing conversation clubs, linking families to volunteers in the host community, providing regular joint activities with the host community.
  - Training volunteers in the host community to provide additional language support, including in people’s homes.

See also Work (important as a means of increasing exposure to and practice with English) and recommendations from the Employment Needs Assessment.

The Resettlement Programme:

- Should consider giving feedback to the Home Office on how the 2014 introduction of a requirement for driving theory tests to be completed in English has presented an avoidable barrier to integration and to activities likely to increase wellbeing.

The Resettlement Programme should:

- Review whether there are people in the programme with unmet needs for support with family reunion applications and, if so, ensure prompt access to optimal support, including expert legal advice.

The Resettlement Programme should consider:

- Commissioning a pilot of small group sessions for refugees who are parents on raising children in the UK, perhaps offered through Children and Family Social Services with each new cohort of refugees.

- If not already doing so, monitoring the experience of children and young people in school and college and liaising with educational institutions regarding what would enhance their ability to support refugee children and young people. The Schools of Sanctuary programme could be considered as a framework for this.

The Resettlement Programme, casework provider agencies and CCGs should consider:

- Expanding support available to families by exploring with Relate, Homestart and carer agencies whether there is scope for extending services to refugees for training refugee volunteers, and consider offering training, support and interpreters to facilitate this.
The Resettlement Programme, Councils, casework provider agencies and third sector agencies should:

- Review how far existing provision provides opportunities for all adults who are interested to participate in activity-based community groups e.g. walking, cooking, sewing, craft, etc. and how far all agencies potentially able to contribute are already involved in working with refugees (e.g. churches).

- Consider investing in developing opportunities for contact, shared activity and community development, considering both initiatives with other Arabic speakers, and initiatives where English is the main language of communication.

- Consider offering training and support for refugees and volunteers who want to lead such activities, (e.g. training in facilitation, communication, conflict resolution, practical aspects of running groups).

The Resettlement Programme should consider:

- Developing a dedicated mobile app or group for sharing with refugees information about activities in Lancashire and consider supporting an individual from the refugee community to maintain this.

- Reviewing actions already taken to ensure people's spiritual needs are addressed (availability of Mosques, links with Imams etc.) and taking steps to address unmet needs.

- Consulting on an on-going basis with community organisations working with resettled refugees e.g. Rethink Rebuild Society.

- Developing a group of refugees who would have the role of linking new refugees with those who have arrived previously (e.g. using the community liaison officers suggested under 'Involvement' above).

The Resettlement Programme, LCC, district councils and Police should:

- Review actions taken to address hate crime, to ensure that all feasible steps have been taken to reduce this.

- Consider the following measures:
  - Rehousing where no other reasonable options exist
  - Optimising programmes in schools to improve understanding of other cultures and of refugees
  - Targeting of multicultural community development initiatives in areas where hate crime has been most problematic.
  - Organising joint events for resettled refugees, other minority communities, and the host community (around football, food etc.) with the aim of breaking barriers and reducing misunderstanding.

The Resettlement Programme should consider:

- Providing feedback to the Home Office on effects of dispersal to areas with no ethnic minority community and exploring the possibility of increased resources for these areas to pilot ways of supporting affected families more effectively, including rehousing where other options are exhausted.

The Resettlement Programme should:

- In deciding on plans to increase employment among refugees, recognise that increased employment will have potential benefits to health.
• In developing plans for acting on the employment needs assessment recommendations, consider also:
  o Creating opportunities for people to begin work experience and work-related activities as soon as possible after arrival, without waiting for fluency in English (recognising this as a useful step to gaining fluency)
  o Identifying work experience opportunities through links with local employers, including Syrian employers;
  o Identifying volunteering opportunities within the refugee community and with agencies that might serve the refugee community (e.g. Home Start, Carers’ organisations)
  o Identifying volunteering activities that do not require English proficiency.
  o Providing guidance and support around post-18 study in the UK, including perhaps inviting refugees who have achieved this to speak to groups or mentor individuals.
  o Ensuring that all refugees are aware of the Syria Relief Fund and that as many people as possible benefit from this.

The Resettlement Programme should:

• Review availability to refugees of information on non-statutory sources of financial support (e.g. Syria Relief Fund, and develop a strategy for disseminating this. Such a strategy might include a mobile app or newsletter.)

District Councils should

• Review whether there is further scope for reducing unhappiness with location and quality of housing, taking into account the potential benefits for emotional wellbeing and integration.

  • Consider as part of this process
    o The needs of those families currently most distressed by their housing
    o That housing quality, local nuisance, access to gardens and proximity to extended family may for many refugees have an impact on their health and wellbeing over and above that for people in the host community
    o Whether earlier planning for new arrivals could allow more options to be identified.

AREA FOR ACTION 2. DEVELOPING A ‘RESOURCE BUILDING SERVICE’

We recommend that emotional distress is addressed primarily within a service where emotional and practical difficulties are considered together. This would be in line with refugees’ own priorities and approach to conceptualising emotional distress, would provide opportunities for people to discuss distress in a non-stigmatising context and could improve access to support for those reluctant to conceptualise their difficulties as psychological.

Such a service would be likely to work best if refugees and professionals working with them have a good understanding of the service and also of normal responses to loss, trauma and stress.

Addressing emotional distress more effectively would also help refugees in other aspects of life that are important to them, for example improving motivation, language learning, family and social relationships.
The Resettlement Programme using support from mental health specialists experienced in the relevant areas should consider:

- Developing a 'resource building service' for refugees. This would consist of an opportunity for every adult and teenager soon after their arrival, and at later points as needed, to speak in private to a professional with psychological therapy skills to tell their story, discuss how they are feeling, and identify ways in which their resources (personal strength, family etc.) may be undermined. The consultation could cover an agreed set of areas and would include discussion of what the person feels may help in each area and what opportunities are available for help, and for those who are finding talking with this professional helpful, a series of further counselling sessions could then be offered with the same person.

- As part of this service, aiming to:
  - Staff the service with professionals able to offer signposting to help with practical issues alongside skilled counselling, assessment of risk and referral to secondary care if needed.
  - Offer the service as part of routine provision for all adults and young people, and prioritise those identified by UNHCR/IOM to have mental health issues or risk factors for mental illness.
  - Offer the service as soon as possible to all currently resettled adults and young people.
  - Offer the service to future cohorts not long after arrival and again later if needed.
  - Agree with Lancashire Care Trust appropriate referral pathways to mental health services for the small minority who may require

- Taking account of learning from specialist refugee services elsewhere (Appendix 2), and of international guidelines (WHO & UNHCR), in particular considering the need to offer family as well as individual work, and to employ specially trained and supported interpreters.

- Piloting such an approach with individuals who feel that their learning of English is affected by problems with concentration and memory.

The Resettlement Programme should consider:

- Developing a strategy for ensuring that all refugee families have a basic understanding of normal responses to loss, trauma and stress, of measures that may help, of how to seek additional help and of what this may involve. This might include signposting to appropriate on-line audio and video information, along with face-to-face sessions with groups of refugees. Face to face sessions might build on the sessions on emotional health currently provided by the health support worker, but considering extensions to this e.g. three two hour sessions, with a certificate of completion at the end.

- Developing a strategy to enable caseworkers and volunteers to have a basic understanding of normal responses to loss, trauma and stress, of measures that may help, of how to seek additional help and of what this may involve.

- Piloting group sessions for men and women separately where refugees can explore their feelings, aspirations and stressors with the support of qualified counsellors or group therapists.
AREA FOR ACTION 3. COMMUNICATION IN HEALTH CARE

Although provision of interpreters in health care is often very good, there are clearly also instances where this is not the case, and where there is thus considerable scope for improving refugees' experience of health care, of accessing appropriate care, and having their health needs met.

CCGs, local NHS Trusts and GP and dental practices should consider:

- Reviewing the findings on communication in health care and the aims and functioning of their current provision, and developing a strategy for addressing gaps and providing training in order to bring all provision into line with the requirements of the Equality Act and with current guidance (https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/03/it_principles.pdf).
- Ensure that provision of interpreters to support mental health consultations and therapy meets the additional recommendations required for these, including for continuity and for specialist training and support for interpreters (Tribe & Thompson, 2008).

CCGs and GP practices should consider taking additional steps to ensure:

- Effective communication at GP receptions
- Robust arrangements for communicating test results and follow up arrangements, and ensuring understanding of these
- Provision of an interpreter of a specified gender when this is needed
- For discussion of mental health issues, provision of face-to-face interpreting and avoidance of telephone interpreting except in exceptional circumstances
- Rigorous avoidance of requesting family members to interpret.

The Resettlement Programme should:

- Develop a strategy for ensuring that every refugee is aware of their rights to interpreting in health care settings and has a means of communicating this, for example a card or a mobile app screen that states this right, and how an interpreter can be accessed.
- Consider whether interpreting in other settings (e.g. emergency services, police, social services requires equivalent attention).

AREA FOR ACTION 4. ASPECTS OF HEALTH CARE WHERE REFUGEES MAY BE PARTICULARLY DISADVANTAGED

Although there are good arguments for improving those aspects of health care which affect everyone, these are largely outside local control, and we recommend focusing on those areas of dissatisfaction that specifically disadvantage refugees, and that may be amenable to local action. We have included health promotion in this section because
high levels of smoking and sugar use, along with language barriers mean that refugees have specific needs beyond mainstream health promotion.

**ACROSS ALL HEALTH CARE PROVISION**

CCGs and all local NHS Trusts should:

- Give careful consideration to how eligibility to free health care is determined and to the risk of racial profiling.

- Consider using the experiences of health care reported here to develop a strategy for ensuring that refugees are not discriminated against by health services, and that provision is in line with the Equality Act 2010 and the NHS's own constitution. This could usefully include
  - Ensuring that all staff with patient contact have a basic understanding of the rights of refugees.
  - Reviewing Prevent training in the light of published literature on its potential for harms. (e.g. [https://www.opensocietyfoundations.org/sites/default/files/eroding-trust-20161017_0.pdf](https://www.opensocietyfoundations.org/sites/default/files/eroding-trust-20161017_0.pdf); [https://warwick.ac.uk/fac/soc/pais/research/researchcentres/irs/counterterrorisminthelhs/project_report_60pp.pdf](https://warwick.ac.uk/fac/soc/pais/research/researchcentres/irs/counterterrorisminthelhs/project_report_60pp.pdf))

- Consider the City of Sanctuary health provider award scheme as a means of supporting GP practices, dentists and secondary care services to become 'refugee friendly' and to make this apparent to refugees.

**CCGs should consider:**

- Reviewing guidance and training provided to GP and dental practices on working with refugees, with particular attention to the needs of reception and admin staff.

- Supplementing the initial review of IOM information by GPs with review of the same information by a mental health professional so that for this group wider options for support and building strength can be considered early.

- Designating specific practices as refugee friendly and encouraging refugees to register with these.

The Resettlement Programme and third sector agencies should consider:

- Training volunteers to act as health advocates, able to go with refugees to crucial health appointments.

**MENTAL HEALTH SERVICES**

CCGSs and Lancashire Care NHS Trust should consider:

- Developing appropriate referral pathways for people whose needs cannot be met by the resource building service recommended above.

- Ensuring that Trust guidelines and staff training take into account
  - Findings from the needs assessment generally and specifically around the points below.
  - Cultural differences in conceptualising emotional distress and in stigma, and the potential value of avoiding a diagnosis-based biomedical approach, instead working in ways congruent with patients' own models for describing, explaining and addressing distress (Kleinmann, 2008).
  - The likelihood of barriers to disclosure of emotional difficulties in general, and in particular for sexual and gender based violence, domestic violence, self-harm and suicidal ideation.
  - The potential for misunderstanding and mistrust of services and treatments.
  - Hazards of using standard structured assessment instruments and possible benefits of instruments tested in the relevant linguistic and cultural
HEALTH PROMOTION

CCGs and local NHS Trusts should consider:

- Reviewing the impact of measures already tried, such as gym membership and allotment provision, and considering making successful initiatives available to all refugees.

- Reviewing current health promotion activity by the health support worker, considering acceptability, impact and uptake of approaches tried and the scope for developing this work, including through reducing the time the support worker uses for interpreting.

- Prioritising healthy lifestyle initiatives that also contribute to developing social relationships.

- Ensuring that initiatives to promote health behaviours take into account the different reasons and meanings behind current behaviours, and refugees' priorities, for example: targeting smoking as a way to reduce financial pressure; walking or cooking groups as a means to socialise; learning about infant feeding and weaning as a means of securing new advantages for one's children.

- When commissioning or decommissioning health promotion interventions such as smoking cessation services, taking into account that the impact for refugees may be different from the rest of the community, for example given the high prevalence of smoking.

AREA FOR ACTION 5. SUPPORT FOR STAFF AND VOLUNTEERS

For those working with refugees to sustain their own emotional wellbeing, creativity and ability to respond effectively to refugees, appropriate support is essential, going beyond standard managerial support and supervision to include space for reflection and access to information about mental health and health services.

RESETTLEMENT PROGRAMME STAFF

The Resettlement Programme and Casework Provider agencies should consider:

- Reviewing existing supervision arrangements for caseworkers and the health support worker against a standard of all having regular supervision in a form which includes opportunity for considering families' health and emotional needs, and the emotional impact that the work has on themselves. One model would be a monthly reflective group facilitated by an experienced practitioner with relevant knowledge and skills.

- Providing more opportunities for caseworkers to meet with counterparts in other localities, for example around training on specific issues.

- Developing measures to monitor emotional wellbeing of those working with refugees.
EVERYONE WORKING WITH REFUGEES

All statutory and third sector agencies who work with refugees should consider:

- Ensuring that those working with refugees especially in a therapeutic capacity are familiar with different ways the work could affect them emotionally, e.g. vicarious trauma, burnout and compassion fatigue, and are aware of the early signs that they might themselves need help.

- Providing training to enable staff and volunteers to have a theoretical framework to understand what to expect, to understand behaviours they may find challenging, and to help increase the effectiveness of engagement with refugees. This would include understanding of trauma and its effects.

- Establishing arrangements for those working with refugees including in the voluntary sector to have access as a minimum to ad hoc emotional support, such as a named person to contact if issues arise.

- Ensuring that those offering therapeutic work have access to an appropriately skilled supervisor.

FURTHER WORK ON UNDERSTANDING NEEDS

To build on the work of this needs assessment, specific aspects of local needs could be explored in more detail, and much more could be learned from experience in other areas. The findings of this needs assessment are also likely to be of interest to professionals in other geographical areas.

The Resettlement Programme should consider commissioning further work including:

- Using UNHCR/IOM information and safeguarding referrals to assess how far those who were interviewed are representative of all refugees resettled in Lancashire.

- Further analysing interview material, including content analysis in relation to specific questions where more information is needed on frequency, gender, location etc.

- Reviewing approaches to learning from experience in other local authorities’ attempts to address the needs of refugees.

- Actively promoting participation of local professionals in the training event being planned by Rethink Rebuild for therapists working with resettled refugees.

- Dissemination of the findings of this study, considering possible relevance to other councils, to health and social care commissioners and providers, academic institutions, UNHCR, Home Office.
References


