



Public Health England: Social Prescribing approaches for migrants: call for evidence

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1. Executive summary

1.1 This submission is built on Social Prescribing (SP) and Migration research conducted through a co-production design (two roundtables). The aim of the co-production roundtables was to identify barriers and facilitators of health service access and satisfaction among migrants, and recommendations for using SP with migrant populations.

1.2 The submission focuses on four key topics which are discussed in detail within the main body of this submission below:

- A holistic approach to the health needs of migrant populations
- Barriers to health service access, satisfaction with healthcare and implications for SP
- Unique Challenges for SP Delivery
- Strategies to improve service access and migrant satisfaction with services

1.3 A day-long event was held in December 2019 at Nottingham Trent University. 40 participants attended, including members of charity organisations working with vulnerable migrants (refugees, trafficked people, etc.), migrants with a range of lived experiences, Social Prescribing Link Workers, academics researching migration and Social Prescribing, and Local Authority representatives.

1.4 Our roundtable participants emphasised the importance and potential benefits of SP to address the health needs of migrant populations. This is in recognition of the multiple needs migrants face, which includes housing, safety, poverty, migration status, language, adaptation to a new culture and country, access to education, employment and participation in cultural, political and social life. As such, SP initiatives need to be responsive and flexible to accommodate the unexpected changes and crisis points that many migrants face (e.g. around legal application stage, homelessness etc.). Involving those with lived experience in SP can help recognise and identify successful strategies to address such crisis points and challenges.

1.5 For SP to be effective it needs to be fully accessible to migrants. The participants in the roundtable recognised barriers relating to lack of awareness among migrants and health workers about migrants' rights to healthcare. This led to reluctance to health care access among migrants and issues with registration with primary care services. In addition, this impacted quality of health provided as some primary care practices used the limited appointment times to ascertain migrants' right to healthcare, and migrants felt they were not believed, or their health concerns were not taken seriously. Barriers to healthcare access and SP initiatives could also relate to migrants being in precarious employment, time and resource limitations to attend SP initiatives, and practical issues around care responsibilities.

1.6 It is essential for migrants and those referring to SP to have a good understanding of the link between health needs and SP, which can lead to higher engagement, trust and satisfaction with SP. At times, transfer of this knowledge is inhibited by language and cultural understanding of health and health systems. Some of these challenges can be overcome by increasing buy-in and referrals to SP through involving trusted community organisations, and referrers and Link Worker with lived experience. Making Every Contact Count initiative can also increase access amongst the hardest to reach migrant populations. Time must be allocated within SP for building rapport and engaging in conversations using language that both sides are comfortable with and enable shared understanding.

1.7 There are also potential issues regarding appropriateness, safeguarding, and the values of the community groups that SP initiatives refer to. There needs to be careful consideration of the ability of groups to meet needs of some of the most vulnerable migrants such as victims of trafficking, gender violence, torture survivors etc. Where trauma or sensitive issues are discussed, there needs to be adequate expertise with the groups and Link Worker, to ensure the disclosure is addressed with sensitivity and appropriate support is signposted. At present, community groups were unclear about who is responsible and contributes to these regulation and developments, which are expensive, require specialist input and time consuming for individual organisations.

1.8 Many migrants report the value of group participation in terms of meeting needs relating to belonging and connection. However, an essential part of these benefits relies on participation and connection with communities. As part of SP, more effort should be placed to increase community acceptance of migrant populations and integration into community life, which will benefit migrant participation, enhance their social capital and intergroup trust. Integration of migrants in community activities should be managed with care in recognition of their need for paid work, meaningful activities and prior skills, as well as potential safeguarding issues.

1.9 In response to this call for evidence we recommend that prior to applying SP to migrant population care should be taken in relation to their holistic needs, crisis points, safeguarding needs, economic and other practical needs, and the experiences of distrust and stigmatisation in relation to health services and communities. Integration of existing successful initiatives, organisations already supporting migrants (e.g. faith groups, schools etc.) and those with lived experience in the design of new SP initiatives would improve access and satisfaction with what the SP have to offer. If the responsibility for health and wellbeing is shared with

communities, this needs to be matched with funding and resources required for them to carry on their work especially if referrals become successful and sustained.

2. Submission (all information is currently unpublished)

2.1. The submission responds to the key areas laid out in the open consultation call, published on Wednesday 1 July 2020. It is focused on responding to issues of effectiveness of current social prescribing models for migrants and their impact on physical and physical health as well as changes to health care utilisation in the UK. The data is derived from two roundtables with 40 participants including members of charity organisations working with vulnerable migrants (refugees, trafficked people, etc.), migrants with a range of lived experiences, SP Link Workers, academics interested in migration and SP, and Local Authority representatives. The full results are written for a peer-reviewed academic journal which yet to be published. The roundtable was informed by Social Prescribing research conducted by the authors (Kellezi et al., 2019b; Wakefield et al., 2020; Bowe et al., 2020) and migration research conducted by the authors (Kellezi et al., 2019a; Bosworth & Kellezi, 2012; 2015; Kellezi & Bosworth, 2016; 2017; Patel, Kellezi & Williams, 2014; 2016; Kellezi et al., under review)

2.2. A holistic approach to the health needs of migrant populations

Our roundtable participants emphasised that migrant populations' health and wellbeing are clearly connected to their other rights. More specifically, asylum seekers, undocumented migrants, those with temporary status and even those with newly permanent status (e.g. refugees) are concerned with housing, safety, their immigration status (i.e., whether they have permission to stay in the host country for an extended period), language issues, acculturation, and access to education, employment and health. Without recognising and meeting these needs, interventions like Social Prescribing can be ineffective, and even undermine trust and relationships with health providers. Migrant service users might become offended, feel misunderstood or feel ignored if the SP they are offered does not meet what they believe to be their most essential needs. If the situational needs of the individual (such as their immigration status) are not addressed by SP, then support for mental health becomes invalid and temporary. Similar findings are reported in detailed interviews with migrants inside Immigration Removal Centres (Kellezi et al., under review). The SP initiatives provided to migrant populations thus need to differentiate between situational distress (due to migration status) and other types of distress (long term health conditions). On the other hand, as SP interventions are designed to address social and psychological needs, they can help recognise the realities of peoples' lived experience.

Another important part of the context of migration is the temporality of resources and challenges that migrants face. There are important pressure points in the migration journey which SP referrers and providers need to understand and account for. For example, there are crisis points that can come even from positive outcomes such recognition of legal status, which can lead to involuntary changes in accommodation, schooling, financial support etc. Thus, SP providers needs to acknowledge the need for an intervention which is flexible enough to address the unique crisis points in the

migrants' experiences. There will be different pressure points for asylum seekers (e.g. application stage, homelessness, etc.) compared to victims of trafficking, or torture survivors. Issues around safety and security might be more relevant for some groups than others. The challenge for health intervention providers, including people who deliver SP, is to understand how support can be provided, sustained, and re-established for people who are going through a crisis. Health models in third sector organisations do address and prioritise the crisis needs which they see as part of their support intervention. Hence, a personalised and holistic approach to health care is essential, which SP can deliver if managed well.

2.2. Barriers to health service access, satisfaction with healthcare and implications for SP

For SP to be effective it needs to be fully accessible to migrants. There are a number of challenges faced by migrants in terms of being able to access healthcare services that relate to availability (non-discriminatory, physically accessible, affordable, informational accessible), acceptability, appropriateness, and quality.

In relation to the accessibility of health services and facilities, many migrants are not aware of their health rights. Sometimes migrants have been told they must pay for services they are freely entitled to, or to show a certificate that exempts them from paying. This makes them reluctant to access services. In addition, undocumented migrants fear that accessing health services would have implications for their legal status (by making the authorities aware of their presence and/or by impacting negatively on their immigration status; Kellezi et al., under review; Kellezi et al., 2019a). There is also confusion among health providers and community organisation around what services can be accessed and by whom. Confusion over rights to healthcare access can lead service providers and community organisations to decide to not make referrals if they believe that access to further required services is not available (e.g., a community organisation may choose not to refer a migrant to their GP if they know that the migrant actually needs specialised secondary services). GPs can spend almost all of the 10-minute appointment trying to establish the migrant's rights to health care access, which makes the experience frustrating and ineffective for both parties. Migrant organisations have reported instances of GP practices being unwilling to register migrants as patients, or ambulance services questioning migrants' entitlement to receive NHS healthcare. In addition, some migrants may not be registered with GP services, so GPs cannot be the only point of access or referral to SP.

Many migrants have to rely on limited financial support from the state (e.g. asylum support is currently £35.37 p/w; UK Government, 2020), and may only be able to find poorly paid jobs with limited contracts. Many temporary migrants are often employed for seasonal work which is substantially reduced in winter months (Culp & Umbarger, 2004). Zero-hours contracts could also be an impediment to health service uptake, as migrants have limited control over times they work and when they can visit health services which require advance booking (Adams & Prassl, 2018). These challenges have implications for any service access or potential interventions supporting these populations, including SP. For example, migrants may be in precarious work and cannot regularly attend SP sessions. For some, attending community groups can be very difficult when they are time and resource poor. Often they are required to care

for family and children without recourse to the networks of support that they would normally have in their home country. All these barriers to healthcare access raise concerns about accessing SP initiatives predominantly through health services and without additional support.

2.3. Unique Challenges for SP Delivery

Like other populations referred to SP, migrants' will often be motivated to attend a GP appointment if they expect to receive medication which will help their chronic ailment. If the GP refers the migrant to a community group as part of an SP initiative, the migrant might fail to understand the reasoning behind this decision, and feel they have been 'cheated'. However, if the referral is arranged by a Link Worker, the migrant might benefit from the personalised approach, and have the opportunity to better understand the link between health needs and SP, which can lead to higher engagement. Understanding the value of SP can thus be essential to increase migrants' uptake of SP, and to enhance their opinions of it. Care should be taken that the referral is not perceived as a way to avoid providing medical support to migrant populations, especially since many migrants already experience discrimination and alienation in many areas of life, including healthcare services.

Given the problematic language barriers faced by many migrants, migrant organisations suggested the need for more investment in (and opportunities for migrants to attend) ESOL (English for Speakers of Other Languages) classes, or for SP initiatives to include interpreting services. However, it should be noted that the use of interpreters can bring its own challenges (e.g., cultural differences, inability to translate live group interactions, etc.).

There are also potential issues regarding appropriateness, safeguarding, and the values of the community groups that SP initiatives refer to. There needs to be careful consideration of the ability of groups to meet needs of some of the most vulnerable such as victims of trafficking, gender violence, torture survivors etc. Migrants (like all those referred to SP) might have complex needs that require serious risk control. While it is very difficult to ensure that community groups are regulated, it is important to acknowledge that some types of vulnerable migrants should only be referred to groups that have the required level of skills and structures in place to support those with complex needs. For example, there needs to be careful considerations towards particular groups that might be at risk of grooming and trafficking. Questions should be asked around appropriateness of the group for an individual, and what could be the potential safeguarding implications. At present community groups were unclear about who is responsible and contributes to these regulation and developments, which are expensive, require specialist input and time consuming for individual organisations.

Part of the considerations around safeguarding relates to the high prevalence of trauma among some groups of migrants. Introduction to groups which might bring expectations around explaining stories of migration might be potentially re-traumatising and even offensive as it can remind service users of home office legal interviews. Where trauma or sensitive issues are discussed there needs to be adequate expertise with the groups and Link Worker, to ensure the disclosure is addressed with sensitivity and appropriate support is signposted. For this, there

needs to be a clear system of re-referral to professional support and minimisation of harm, where needed specialised support should be provided in parallel with SP. The organisations identified two types of risks. The first related to potential harm, and the second to the danger of not maintaining appropriate boundaries between service users and service providers. The community groups discussed the example of services based on befrienders who undertake tasks they're not qualified to do and create boundary issues. This regulatory system should also be responsible for monitoring and removing from approved list of SP referrals organisation or groups where issues are identified.

Another challenge of SP is the careful balance between establishing a group identity which can bring many benefits in the short and long term (increased belonging, reduced loneliness, improved health and wellbeing) and the ethos of some organisations to not create dependency, or over-reliance especially when it is clear that migrants might have to relocate. To address this issue, group participation that enables increased efficacy can be especially beneficial, and this can be enacted by the group or Link Worker. Similarly, some charitable groups (homeless shelter for example) have a mission to get people through the worst but not encourage dependency. Again, the Link Workers can help "scaffold" small groups of service users to other possible SP services when appropriate. There was reference to Opportunity and Change (Opportunity & Change, 2020) which was suggested to be a good model for acute issues, but also help service-users with multiple and complex needs.

SP often relies on referral and collaboration with community organisations. These are however regularly struggling with limited resources. Where people (including migrants) are referred to existing services, care must be taken not to overwhelm these services, and not to change their dynamic if working well. As part of this, SP needs buy-in from all agencies, and careful discussion of time, resources, and responsibilities for each side on the collaboration. The community organisations raised serious concerns about their ability to cope with an efficient referral system which would increase their demands, while they feel they are under-funded and under-staffed. They also raised concerns about the dynamic changes should there be a large influx of new users as most groups rely on older users to provide support and manage running the groups. They suggested that conversations with the Link Worker and community services are key to ensure the groups are not overloaded.

SP needs to be person-centred in recognition of the fact that the diverse migrant groups are not homogenous. This can be challenging especially given the limited resources and the need to manage different priorities. Addressing holistic needs can be expensive and smaller organisations might struggle to receive contracts to maintain existing groups or increasing demands. There is widely debated issue about the positions and responsibility that community and third sector organisations can and should carry in terms of addressing health and wellbeing. If the responsibility for health and wellbeing is shared with communities, this needs to be matched with funding and resources required for them to carry on their work especially if referrals become successful and sustained. Once adequate funding has been provided, there needs to be investment in ensuring ways to make SP sustainable with limited resources in the future. The community organisations are concerned that they have not been consulted about the cost implications to their participation in SP.

Finally, while there is evidence for SP with vulnerable groups (Dayson, & Bashir, 2014; Kellezi et al., 2019b; Wakefield et al., 2020), there needs to be more research on the unique needs and benefits for these type of interventions with migrant populations.

2.4. Strategies to improve service access and migrant satisfaction with services

The organisations and migrants that took part in the symposium, strongly advocated for the benefits of using those with lived experiences of migration in the design and/or implementation of SP initiatives. This will enable establishing trust and feeling a stronger sense of connections at a time when migrants feel lost and overburden with the new environment. Lived experience engagement should be present both at the stage of designing SP services for migrants to meet their unique needs, but also in increasing accessibility and update of services once they are in place. Given the issues of distrust migrants experience in relation to health providers, care should be taken on how even such earlier stages of input are negotiate to ensure a wide and meaningful participation. The next challenge is to ensure that eventually the uptake is extended to the wider groups of potential beneficiaries. A further way to increase meaningful engagement is through employment of Link Worker who are representative of target communities. Thus, those with lived experienced can be engaged in design, delivery, as well as become champions/role models for SP. This model of integration of those with lived experience is widely recognised as very beneficial in health research. In addition, many asylum seekers and refugees are professionals in their country and have expertise and valued skillset. This professional identity is often stripped from them when they come to the UK, so re-engaging with such skills and identities, can bring value to the community and the individual.

A further approach to improve service access and effectiveness would be to increase collaboration and communication between services. Organisations that work with migrants are well informed (and very experienced) on the holistic needs that migrants have, and they can become an important source of information and connection between migrants and health services. In fact, one of the advantages of the SP is the reliance and benefits of sustainable community and third sector organisations. Careful consideration should be given to GDPR issues and transfer of information from health services to the third sector (and vice versa), although this issue applies to all SP provisions.

Some of the challenges that our research and other research has identified relates to the referral system. It is important for the referral systems to incorporate time and space where there is clear information and understand of how the SP pathways could work. Again, this is in recognition the context of migration but also cultural differences in understanding health and mental health. If migrants are provided clear information about the purpose of the referral and SP as intervention, and how it complements rather than addressed all health needs, it is more likely they will not feel offended, or feel that their concerns are being dismissed. Trust is essential for all the stages of SP to be carried out successfully. Trust need to be understood in a context where migrants (especially those that do not have permanent status) feel that all interactions with authorities are defined by an undertone of scrutinising the

veracity of migrants' accounts. More work needs to be done to increase trust between service providers and service users and to reduce intergroup barriers between them which may lead to stigmatising experiences and disengagement. Where members of the migrant population experience marginalisation, there may be reductions in trust and sense of community belonging. In order to address this issue it is important to increase access and referral to SP not just via health services but also through the wider community and third sector networks. If initial invitations to engage with SP come from charities, or jointly with the charities and health services, it might overcome some of the trust issues among migrant communities.

Where referrals are predominately initiated by GPs, SP is more effective when the GPs themselves and other gatekeepers, understand the benefits of the intervention and ways it is implemented. Buy-in from GPs is essential, as they need to understand which patients presenting with physical or psychological symptoms would be appropriate to refer to SP. A central part of the GP information is understanding the value of SP in supporting those presenting in primary care. This information needs to be clearly communicated to migrants' communities who might have difference conceptualisation of illness, wellbeing and even community relations. Thus, language and cultural differences and expectations might complicate already complex conversations. GPs and other frontline referrers need to be informed on how to best advise migrant communities and those visiting their practices about what SP is, what it can achieve and why are they being referred. Gatekeepers of frontline services should have an understanding of migrant/asylum seeker rights. All staff on frontline services should (ideally) Make Every Contact Count to signpost other services to migrants.

Current SP approaches to increasing access have pointed to the value of Making Every Contact Count initiative (NHS England, 2020). Thus a public sector employee may assess one particular set of needs but at the same time is encouraged to refer and signpost to other services where relevant. Other forms of contact relate to police and fire services being able to refer if they see a need, but in the case of migrants, care should be taken to ensure this is not done in a context of distrust and fear. Other community groups could also be particularly relevant for specific migrant populations, for example, many migrant populations will belong to a faith group and be part of that community, which can widen the reach to the populations. Similarly, faith group leaders can be provided with the information about the available other community organisations that could be relevant their members. Access can be increased thus, especially among those who are not registered with GPs, by Link Worker getting involved with community directly e.g. faith centres, schools via the school nurses, and libraries. Link Workers with lived experienced and/or embedded in the communities could act thus as an in-reach service for these even harder to reach populations. In addition, the participating organisations highlighted the importance of removing some of the barriers to access relating to caring responsibilities. The services and activities refugee services offer for example, provide childcare support but are also offered in an environment that is perceived to be neutral and independent from legal case decision-makers.

Migrant organisations advised on the different approaches and considerations when working with vulnerable migrants. They emphasised the importance of meaningful connection and services, where the only agenda is to support the health and wellbeing of this population. Time must be allocated within SP for building rapport

and engaging in conversations using language that both sides are comfortable with, and enable shared understanding. Many migrants engage with institutions and organisations without clearly understanding what their aims are, or what their rights are. Recognition that some of the issues they face cannot be addressed (loss of family and network in home country), but that interventions like SP can offer social connections and meaningful activities can be beneficial. This should be done in recognition that some forms of SP might not be appropriate for everyone and at every stage. Our own work with SP shows that for some people there is too much anxiety around joining groups and that initial focused work with Link Worker might be more appropriate (Kellezi et al 2019b). More research needs to be done to explore how vulnerable groups that experience loneliness and/or alienation feel about joining activity groups.

It is also essential to take a personalised approach to the needs of vulnerable migrants. This can be acknowledged from a flexible approach take to SP referral and community groups' attendance. This relates in part to the need to allow for referral to be discussed and agreed with the service user from the very first contact but also as those referred move from one service to the other. This flexibility is required because of the wider context of migration, whereby priority needs might take over at least in the short term. However, addressing social needs can still be very beneficial as it can enable and empower service users to better address economic and practical needs in the short and long term. Another challenge relates to the unpredictable nature of rights, housing and migration status. Migrants can be instructed from one day to another of where their accommodation and status will change. If this flexibility is recognised in the contract with groups, both sides will not feel disappointed: migrants not to carry the burden of broken promises, and group leaders will recognise the need for flexibility so that can plan. The flexibility should also recognise the different pressure points that migrants are put in, and the challenges that these pressure points bring. For example, even when the status is granted migrants might be relocated in other parts of the country with very short notice and have no say on the matter. The presence of flexibility can also introduce agency at a time when many decisions about migrants are taken out of their hands. Given some of the more practical and economical challenges of attending SP, where possible funding should be sought for face to face and remote delivery of interventions and activities to further increase the flexibility of services.

Many migrants report the value of group participation in terms of meeting needs relating to belonging and connection. However, an essential part of these benefits relies on participation and connection with communities. As part of SP, more effort should be placed on increase community acceptance of migrant populations and integration into community life. Prosocial behaviour, such as the volunteering involved in some models of SP, allows for participation in community citizenship behaviours and is linked with the building of health-enhancing social capital, support, and trust (Pilkington, Windsor & Crisp, 2012; Poortinga, 2006; Thoits, 2011). This sense of trust is a valuable collective resource capable of reducing threat and uncertainty (Siegrist, Gutscher, & Earle, 2005) and volunteering programmes for hard to reach populations, including migrant communities, have been shown to increase trust in the local area via involvement with local VCS organisations (Bashir et al., 2013). Moreover, the sense of community belonging found to result from SP engagement (Wakefield, et al., 2019) is helpful for improving trust and sense of support because these are facets of shared group membership (Jetten et al., 2012).

However, volunteering opportunities need to be developed and facilitated for those who are not ready yet, and training needs must be carefully considered. It is important to encourage migrants to volunteer who might not have the confidence to do so or who fear rejection. Some charities are not aware asylum seekers can volunteer, as they believe that DBS checks are not possible and language barriers persist.

Here again, the context of trauma is important. For some, despite the willingness to engage in volunteering, the traumatic experience can be challenging to fully participate while managing disclosure. In addition, care must be taken to recognise the potentially vulnerable situation migrants can be positioned when asked to volunteer. The ability to work for free is a luxury many cannot afford which is what is at the core of volunteering opportunities. Many migrant families have to work every hour they can in poorly paid jobs to support themselves so they cannot have the opportunity to engage in volunteering.

Where volunteering raises as part of SP engagement, it needs to be meaningful. There are positive examples with refugee organisations where migrants felt they are allowed to use their skills and not just do basic jobs that give them no satisfaction or opportunities for gaining experience and developing their skills. Negotiating meaningful volunteering might be key and essential for migrants who want to improve their wellbeing through social engagement as well as ability to obtain more meaningful and financially rewarding employment.

Another very important strategy is to learn from successful existing initiatives. Voluntary sector organisations are already successfully doing different versions of SP. Some models of delivery are successful of even overcoming languages barriers, as they are built around for example art, physical activity and food. There are however subsets of migrants, i.e. hidden/not visible population who aren't attending these types of groups due to one or more of the accessibility barriers highlighted in section 3.2. Assist programme (Leicester, 2020) could be a successful model for implementation. Finally, more research that is culturally appropriate and helps understand the different types of SP is needed.

3. About the authors

3.1. Dr Blerina Kellezi is an Associate Professor in Social and Trauma Psychology in the Department of Psychology at Nottingham Trent University. Dr Kellezi's research investigates how people collectively deal with and are affected by extreme life events from illness and accidents to war, torture and immigration detention. Dr Kellezi is leading a multi-disciplinary and multi-national research project exploring the role of transitional justice processes (like documenting trauma, reconciliation, recognition, redress, forgiveness and peace building) on mental health and the risk of further intergroup conflict. Dr Kellezi has also led research investigating the quality of life in Immigration Removal Centres in the UK, focusing on identity, coping, support, relationships, and mental health. She is exploring barriers to mental health access among undocumented migrants in detention and community, and the value of group-based interventions (including Social Prescribing) on health and wellbeing. This work has been written in a number of reports for the Home Office (Bosworth & Kellezi, 2012; 2015; Kellezi & Bosworth, 2016; 2017). Dr Kellezi's research is funded by

NIHR, British Academy, British Psychological Society, and a range of local organisations.

3.2. Dr Mhairi Bowe is a Chartered Member of the British Psychological Society and a Senior Lecturer in Social Psychology and Mental Health in the Department of Psychology at Nottingham Trent University. Dr Bowe's current research is focused on the links between social relationships and health, and how these impact upon the experience of community members undergoing challenges such as identity transition, social stigma, isolation, and poverty. Dr Bowe's research has been sponsored by the ESRC, third sector charities, and local councils; it currently focuses on foodbank use, community volunteering, and the effectiveness of social prescribing; and it has been published in the *European Journal of Social Psychology* and *Journal of Health Psychology*. Recent findings from Dr Bowe's work on foodbank use were submitted to the UN Special Rapporteur on Extreme Poverty and Human Rights as part of his visit to the UK in November 2018 (Wakefield & Bowe, 2018), and were included in a report entitled *Economic and Social Rights in Nottingham*, submitted to the United Nations in March 2019.

3.3. Dr Juliet Wakefield is a Senior Lecturer in Social Psychology and in the Department of Psychology at Nottingham Trent University. Dr Wakefield's current research is focused on the impact of group memberships on people's everyday lives, including aspects such as their health and well-being, and their help-giving and help-seeking behaviour. Dr Wakefield has received research funding from third sector charities and local councils: her recent projects explore issues such as foodbank use and foodbank volunteering, the lived experience of poverty, the effectiveness of social prescribing initiatives, and the social psychological dynamics of eating disorder recovery. Her research has been published in numerous journals, including the *British Journal of Health Psychology* and *Psychiatry Research*. Recent findings from Dr Wakefield's work with Dr Bowe on foodbank use were submitted to the United Nations Special Rapporteur on Extreme Poverty and Human Rights as part of his visit to the UK in November 2018 (Wakefield & Bowe, 2018), and were included in a report entitled *Economic and Social Rights in Nottingham*, submitted to the United Nations in March 2019.

4. References

Adams, A., & Prassl, J. (2018). Zero-hours work in the United Kingdom. *Conditions of Work and Employment Series* (101). International Labour Organisation.

Bashir, N., Crisp, R., Dayson, C., & Gilbertson, J. (2013). Final evaluation of the Volunteering for Stronger Communities programme. Sheffield: Centre for Regional Economic and Social Research, Sheffield Hallam University.

Bosworth, M., & Kellezi, B. (2012). Quality of Life in Detention: Results from the MQLD Questionnaire Data Collected in IRC Yarl's Wood, IRC Tinsley House and IRC Brook House, August 2010-June 2011. *Criminal Justice, Borders and Citizenship Research Paper*, (2448404).

Bosworth, M., & Kellezi, B. (2015). Quality of Life in Detention: Results from MQLD Questionnaire Data Collected in IRC Campsfield House, IRC Yarl's Wood, IRC Colnbrook, and IRC Dover, September 2013-August 2014.

Bowe, M., Gray, D., Stevenson, C., McNamara, N., Wakefield, J. R., Kellezi, B., ... & Costa, S. (2020). A Social Cure in the Community: A mixed-method exploration of the role of social identity in the experiences and well-being of community volunteers. *European Journal of Social Psychology*.

Bowe, M., Wakefield, J. R., Kellezi, B., McNamara, N., Harkin, L., & Jobling, R. (2019). 'Sometimes, it's not just about the food': The social identity dynamics of foodbank helping transactions. *European Journal of Social Psychology*, 49(6), 1128-1143.

Culp, K., & Umbarger, M. (2004). Seasonal and migrant agricultural workers: A neglected work force. *AAOHN Journal*, 52(9), 383-390.

Dayson, C. & Bashir, N. (2014). The social and economic impact of the Rotherham Social Prescribing Pilot: Main evaluation report. Sheffield Hallam University: Centre for Regional Economic and Social Research (CRESR). Retrieved from <http://shura.shu.ac.uk/18961/1/Dayson-SocialAndEconomicImpact-Rotherham%28VoR%29.pdf>

Jetten, J., Haslam, C., & Alexander, S. H. (Eds.). (2012). The social cure: Identity, health and well-being. Psychology press.

Kellezi, B., & Bosworth, M. (2016). Mental health, suicidal thoughts and self-harm inside immigration detention. *Criminal Justice, Borders and Citizenship Research Paper No. 2867358*.

Kellezi, B., & Bosworth, M. (2017). Mental health services inside immigration removal centres (access, perceived quality of health care and the ACDT process in IRC Morton Hall). Retrieved from <https://core.ac.uk/reader/82894270>

Kellezi, B., Bowe, M., Wakefield, J. R., McNamara, N., & Bosworth, M. (2019a). Understanding and coping with immigration detention: Social identity as cure and curse. *European Journal of Social Psychology*, 49(2), 333-351.

Kellezi, B., Wakefield, J. R. H., Stevenson, C., McNamara, N., Mair, E., Bowe, M., ... & Halder, M. M. (2019b). The social cure of social prescribing: a mixed-methods study on the benefits of social connectedness on quality and effectiveness of care provision. *BMJ open*, 9(11). doi: 10.1136/bmjopen-2019-033137

Kellezi, B., Bowe, M., Wakefield, J. R., Stevenson, C., McNamara, N., (under review) Healthcare provision inside immigration removal centres: A social identity analysis of trust, legitimacy and disengagement. *Applied Psychology: Health & Wellbeing*.

The assist practice (2020) Welcome to the Assist Practice. High quality healthcare for refugees and asylum seekers in Leicester. Retrieved from <https://assistpractice.co.uk/>

NHS England (2020). Making every contact count. Retrieved from <https://www.makeeverycontactcount.co.uk/>

Opportunity and change. (2020). What is opportunity and change? Retrieved from <https://www.opportunityandchange.org/>

Pilkington, P. D., Windsor, T. D., & Crisp, D. A. (2012). Volunteering and subjective well-being in midlife and older adults: The role of supportive social networks. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, 67(2), 249-260. Doi: 10.1093/geronb/gbr154

Poortinga, W. (2006). Social relations or social capital? Individual and community health effects of bonding social capital. *Social science & medicine*, 63(1), 255-270. Doi: 10.1016/j.socscimed.2005.11.039

Siegrist, M., Gutscher, H., & Earle, T. C. (2005). Perception of risk: the influence of general trust, and general confidence. *Journal of Risk Research*, 8(2), 145-156. Doi: 10.1080/1366987032000105315

Thoits, P.A. (2011). Mechanisms linking social ties and support to physical and mental health. *Journal of Health & Social Behavior*, 52, 145-161. Doi: 10.1177/0022146510395592

UK Asylum support (2020). Retrieved from <https://www.gov.uk/asylum-support/what-youll-get>

Wakefield, J. R., Bowe, M., Kellezi, B., McNamara, N., & Stevenson, C. (2019). When groups help and when groups harm: Origins, developments, and future directions of the "Social Cure" perspective of group dynamics. *Social and Personality Psychology Compass*, 13(3), e12440. Doi: 10.1111/spc3.12440.

Wakefield, J. R. H., Kellezi, B., Stevenson, C., McNamara, N., Bowe, M., Wilson, I., ... & Mair, E. (2020). Social Prescribing as 'Social Cure': A longitudinal study of the health benefits of social connectedness within a Social Prescribing pathway. *Journal of Health Psychology*, 1359105320944991.