

# **Vulnerability, migration, and wellbeing:**

investigating  
experiences,  
perceptions,  
and barriers

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# Summary

## Rationale and Background

This project explores the wellbeing profile of groups at risk of vulnerability, undocumented migrants, and asylum seekers, as well as factors associated with wellbeing. The need for this project arose from the overall lack of an evidence base about the wellbeing of groups at risk of vulnerability about whom very few datasets exist.

We conducted this project in partnership with Doctors of the World (DOTW) UK (part of the Médecins du Monde international network). They have been a registered charity in England and Wales since 1998 and run clinics providing medical care, information, and practical support to people unable to access NHS services. They have provided us with data from their clinics and opportunities interview their volunteers.

## What do we mean by vulnerability?

By individuals at risk of vulnerability, here we refer to individuals who are at significant risk of harm while substantially lacking the ability or means to protect themselves. Degrees of vulnerability for an individual will vary in different contexts and at different points in time. Asylum seekers and undocumented migrants have generally been considered at particular risk of vulnerability.

## What do we mean by wellbeing?

The project is based on an understanding of wellbeing as multidimensional, involving physical, material, psychological, social, and spiritual needs. We use Sumner and Mallett's (2013) dimensions: material wellbeing (e.g., income), relational wellbeing (e.g., relationships), and subjective wellbeing (e.g., self-reported health).

## Structure of the project

This project is divided into three main parts: 1) the project as originally envisaged, focusing on DOTW UK service user data from 2011-2018; 2) an investigation of the wellbeing of migrants at risk of vulnerability during the COVID-19 pandemic, and 3) a nested sub study of asylum seekers in institutional and contingency accommodation (ICA). Qualitative interviews with DOTW UK volunteers provide context across the project.

## Main objectives of the project

- To profile the wellbeing of individuals at risk of vulnerability;
- To identify the multiple factors associated with wellbeing;
- To understand how wellbeing can be monitored;
- To describe the health and access to care of asylum seekers living in “temporary” housing; and
- To inform policy and practice about actions that might influence vulnerability and wellbeing for migrants at risk of vulnerability.

## How we conducted the research

### Research design

We used a mixed methods approach that employs both secondary (quantitative and qualitative) and primary (qualitative) data and analysis, as well as a co-production approach with policy stakeholders. Whereas the quantitative strand allows us to provide a general overview of service users' wellbeing before and during the pandemic, adding to the existing evidence base, the foray into caseworker notes and interviews with volunteers brings depth to our analysis. It allows to contextualise the wellbeing situation of the service users as well as the experiences of the volunteers undertaking the work. It highlights the wellbeing challenges that service users and volunteers alike have faced in the years covered by the data.

### Data sources & analysis

The data used for the project comes from two sources: (1) secondary data originally collected from service users by DOTW UK volunteers between 2011 and 2018 and in 2020, in the form of questionnaires and consultation (free-text) notes; and (2) primary data from semi-structured interviews with volunteers who were involved in collecting the data. Descriptive statistics and regression analyses were used to analyse the quantitative data and thematic analysis was applied to the qualitative data. Note that service users and interviewees consented to have their anonymised data used for research purposes.

## Findings

### Quantitative strand

**Sample description:** The service users in the 2011-2018 dataset (total sample size of 11,381) were split relatively evenly along sex lines, mostly located in London, mostly aged 25-44. Close to two-thirds of the service users were classified as undocumented, with over a third of service users having been in the UK for under 2 years. Most service users engage with the DOTW UK clinics for the purposes of GP registration and help with NHS costs. Most often mentioned barriers to accessing healthcare include lack of knowledge of the system, administrative barriers, and language barriers.

We identified a slight change in the main characteristics of service users during the COVID-19 pandemic (sample sizes of 321 and 313): a younger age profile, a much larger share of asylum seekers, and a high share of individuals in precarious economic and housing situations and without GP registration. In the case of housing, and in conjunction with the ICA work we have done, this is also likely linked to the increase in the number of people in ICA contacting DOTW UK for consultations. In terms of reasons for consultations during the pandemic and for service users in ICA, these also remained relatively similar to the 2011-2018 findings.

**Indicators of wellbeing:** We assessed wellbeing from three different dimensions as per Sumner and Mallett's (2013) dimensions and available indicators in the data: subjective (self-reported general, physical, and psychological health), relational (emotional support), and material (poverty).

In the 2011-2018 data, descriptive analyses show that around just under 4 out of 10 service users were giving positive or fair evaluations of their general health, and around a quarter gave negative evaluations of general health. Their general health profile is much lower than that of the general population according to latest figures from the Health Survey for England. Similar patterns were found for physical and psychological health and varied according to immigration status, with asylum seekers tending to have lower evaluations of their subjective health. In terms of relational wellbeing, around half of service users indicated that they could rely on someone for emotional support very frequently or frequently, and around 10.1% stated that they did not have any support. Regarding economic wellbeing, 84.1% of service users were living under the poverty threshold. Again, this is in sharp contrast with population-level figures, where 18-22% of people were living in poverty. Moreover, asylum seekers tended to have lower levels of economic wellbeing.

During the pandemic, descriptive analyses of the subjective wellbeing of service users in the early stages of the pandemic showed that the figures were more or less similar to the 2011-2018 period, with just over a quarter of service users reporting bad or very bad general health. Asylum seekers were, again, found to report more negative subjective wellbeing. The health status of individuals in ICA was again low, especially if compared with population-level data, echoing our findings on the health status of service users reported above. Mental health was a major concern, with over a third of individual residing in hotels having a mental health need.

**Role of contextual factors:** We explored the association of a range of factors (immigration status, age, sex, years since arrival, and housing situation) with the three dimensions of wellbeing in the 2011-2018 data. We found that the wellbeing situation of asylum seekers and undocumented migrants was more negative than for other migrants, with asylum seekers' situation being worse than that of other migrants for all outcomes. Those who reported having been denied access to healthcare and living under the poverty threshold had a lower probability of positive subjective wellbeing. However, a more favourable housing situation appeared to lead to significantly better wellbeing, especially regarding relational wellbeing and self-reported psychological health. There was a negative association between most indicators of wellbeing and male service users. Years since arrival had a negative association with subjective wellbeing, but a positive association with relational wellbeing. The association between the various factors and wellbeing for the different immigration statuses remained relatively similar.

The results from this strand of the research show that overall wellbeing status is a concern when it comes to individuals at risk of vulnerability, regardless of the period under examination. The factors associated with wellbeing are manifold, with immigration status appearing to play an important role on the level of wellbeing, at least in terms of its association with lower levels of wellbeing. The association between wellbeing and housing and access to healthcare are also worthy of consideration.

## Qualitative strand

Findings in this strand add valuable context to the results above, especially where different contextual factors overlap and reinforce each other. They also provide a snapshot of the service user's current situation in terms of their health (including any attempts to access care), material resources, social relations, and migration journey.

**Health situation:** Out of 363 service users included in the analysis of consultation notes, 220 came to DOTW UK with an immediate physical or mental health concern. About half of physical health concerns were those causing pain while a few service users had symptoms that indicated a potentially serious health problem. Regarding psychological health, a few had been previously diagnosed with a mental health condition. Others were recorded as having had traumatic experiences, feeling down, or having a low mood, difficulties sleeping or nightmares.

**Accessing healthcare:** Some service users had never been registered with a GP while others had lost their registration for example on moving address; 25 said they had tried to access a GP and been refused. Twenty-three had privately paid for healthcare. For some, this was to access a one-off prescription, for others this led to substantial cost or needing follow-up care. Thirty-nine had already accessed secondary care in the UK. Some were treated by A&E or at the Walk-in centre where they were told that they needed to register with a GP. For others, hospital treatment resulted in them seeking help from DOTW UK with the charges they had incurred.

**Migration journey:** The qualitative data suggested that the personal histories of migration could have an impact on wellbeing. While the majority said they had moved for better earning potential or to join existing family, 55 service users said they had to leave their home country because of state persecution, fleeing war or threats of violence. Additionally, 82 service users said that they had spouses or children abroad, and for some, sending money back to their family was the main reason for seeking work in the UK.

**Financial situation:** This closely mirrored the quantitative data outlined above in that many service users were recorded as having no or only occasional work. However, the free-text notes also showed

that many were informally supported by family members, friends, and fellow church goers, especially with a place to live and food. For some, there was a blurring between friendship support and informal employment. This suggests that relational and material wellbeing could be closely linked.

**Housing:** Free-text notes provided additional explanations for the close relationship between housing and both material and relational wellbeing found in the quantitative data. Most service users lived with other people (partners/spouses, family, friends, flatmates) and most said that their accommodation was reasonably stable and that they felt safe where they were. However, problematic situations could arise where housing was tied to work, was very temporary or where conflicts arose which could result in loss of accommodation.

**Monitoring wellbeing:** Our analyses suggested that the combination of numerical and free-text data collection could allow organisations to gain insights into the wellbeing of their service users and the factors that influence it. Interviewees however also mentioned more problematic aspects such as service users being reluctant to answer sensitive questions or those that were not closely related to their immediate problem. They also discussed a process of trust building where these questions could be addressed during follow-up contacts with the service user.

**Wellbeing during the pandemic:** The examination of the consultation notes provided additional depth to our understanding of the situation during the pandemic. In terms of health status and housing, the notes indicated that issues were similar to the main study. A few had potential symptoms of COVID-19 or other related needs such as help with food during lockdown; some felt isolated and lonely due to the pandemic. For some, cash-in-hand work (e.g., in restaurants or as cleaners) dried up; an impact of the pandemic on people in already precarious circumstances which was also stressed by the volunteers. COVID-19 also made it more difficult to access health services as GP practices moved their registration online and it was difficult to talk to reception staff. Volunteers also discussed the added difficulty to their work as it was much easier to interact, build trust and make sure the service user was safe in a face-to-face environment.

The profile and numbers of service users changed substantially during the early stages of the pandemic as DOTW UK shifted to a telephone service. There is clear evidence that service users' financial and living conditions deteriorated at this stage and it is likely that some users were unable to make contact. The pandemic increased service users' barriers to accessing healthcare and removed face-to-face contact, thereby making the job of volunteers more difficult.

**Wellbeing of individuals in ICA:** Caseworkers noted that service users' mental health needs could be complex and include suicidal thoughts, depression, and self-harm. There was also a greater amount of chronic, urgent, or multiple conditions that required further action by DOTW UK. Important barriers to accessing healthcare were lack of knowledge about the system, language and administrative barriers and digital exclusion.

Service users reported feeling fearful and unsafe; poor quality living conditions; poor quality food with little regard to special/medical dietary needs; low levels of help and support with access to medical treatment and medications; and a lack of distraction when living in isolation. DOTW UK volunteers' role expanded beyond their usual remit of securing access to healthcare to trying to address the wider needs of service users in considerable distress.

The analysis of the data from service users in ICA shows that this type of accommodation appears to present major concerns for the health status of its residents and their access to healthcare. There are a broad range of unmet health and housing needs, including the impact of such accommodation and the food provided on mental and physical health, that need to be taken into consideration, especially if such a provision is to carry on in the future.

## Recommendations & next steps

The results generated by the project have highlighted the specific circumstances in which migrants at risk of vulnerability have faced regarding their wellbeing. The project has generated a range of recommendations at the policy and practice level, which are as follows:

- All people resident in the UK, regardless of immigration status, should be registered with a GP.
- Information about access to healthcare should be clearly communicated to all migrants at risk of vulnerability, especially regarding:
  - Rights to access to services (including prescription medication); use of services and information; and
  - Having information provided in multiple languages.
- Further work is needed to ensure that GP surgeries are aware that they cannot refuse registration on the basis of an absence of documentation or immigration status.
- Asylum seekers should be automatically registered with a GP service on arrival in the UK on an opt-out basis.
- Asylum seekers should automatically be issued with a HC2 certificate that is valid for a minimum of 12 months.
- Information about access to healthcare should be issued to all asylum seekers, in their own language, when they submit their claim for asylum.
- Health providers, including GP surgeries, should account for variations in access to telephones and data when providing their services offering alternatives to online provision for those vulnerable groups unable to connect through digital mechanisms.
- Wi-Fi should be provided in asylum accommodation to enable individuals who can utilise digital services to connect with them.
- ICA accommodation should be a last resort and short-term measure and individuals should be assessed before being transferred to ICA to identify whether such accommodation is likely to exacerbate existing health conditions.
- Asylum seekers resident in ICA should have automatic access to a GP arranged by the accommodation provider.
- Accommodation providers should be obliged to provide food that is nutritious and, where necessary, meets special dietary requirements.
- Provision must be made to assist asylum seekers residing in ICA to access emergency, secondary and ancillary health services as needed.

We have also included specific recommendations for UK government bodies based on the above on page 37.

Our project has shown that the collection and analysis of wellbeing data about migrants at risk of vulnerability is needed and essential. Yet, the process through which this can occur is not without its challenges. This project has demonstrated what is possible in terms of analysis but has only just scratched the surface in terms of potential. Investment is needed into the analytical capability of NGOs to ensure ongoing monitoring of the health access and experiences of vulnerable migrants.



# Introduction: rationale and background

This report highlights results arising from the “Vulnerability, migration, and wellbeing: investigating experiences, perceptions, and barriers” project. The need for this project arose from the overall lack of an evidence base and available (quantitative) data about the wellbeing of groups at risk of vulnerability with a focus on undocumented migrants and asylum seekers about whom very few datasets exist. The original aim of the project was to use a mixed methods approach to examine the wellbeing of these groups and identify the factors shaping it, using data from our research partner Doctors of the World UK (DOTW UK) between the years 2011 and 2018. A pilot study showing promising results, issues, and challenges arising from a brief analysis of the data (see Lessard-Phillips et al. (2019) for details) had indicated that a broader project would be feasible and would yield important findings.

*Our research partner for this project, Doctors of the World (DOTW) UK, is part of the Médecins du Monde international network, an independent humanitarian movement. Doctors of the World UK has been a registered charity in England and Wales since 1998 and runs clinics providing medical care, information and practical support to people unable to access NHS services. The main clinic is located in London (with a former clinic located in Brighton); outreach clinics and remote consultations also take place outside of the main clinic's location. Their patients include refugees, people seeking asylum, people who have been trafficked, people experiencing homelessness, sex workers, migrants with insecure immigration status and Roma, Gypsy and Traveller communities. They have provided us with the data from their clinics and opportunities to interview their volunteers in order to conduct the research project.*

The project started in uncertain times in May 2020, during the first period of national lockdown in the UK. Whilst the pandemic meant that changes were required, including how we ended up conducting a large part of the research, the research team were able to adapt the project to the altered circumstances, bringing unique insight into the situation of vulnerable migrants in the early stages of the pandemic. We made use of our (unfortunate) timing and additional funds from the Nuffield Foundation and the University of Birmingham to expand the reach of our research. This included investigations of the wellbeing of migrants at risk of vulnerability during the early months of the pandemic in the UK, as well as the wellbeing of asylum seekers in institutional and contingency accommodation (ICA) during the pandemic. These findings, which we are able to add to analyses originally planned, have already generated outputs (Fu et al., 2021; Jones et al., 2022; Lessard-Phillips et al., 2021) and are going to be covered in this report.

The results generated by the additional projects, which we outline in this report, highlight that the wellbeing of migrants at risk of vulnerability is relevant now more than ever. By individuals at risk of vulnerability, here we refer to individuals who ‘face a significant probability of incurring an identifiable harm while substantially lacking ability and/or means to protect oneself’ (Schroeder and Gefenas, 2009, p.117). Vulnerability is regarded as a dynamic concept: the degree of vulnerability for an individual varies in different contexts and at different points in time (Médecins du Monde, 2015). Migrants, and especially asylum seekers and undocumented migrants, have generally been considered at particular risk of vulnerability (Willen et al., 2017).

The pandemic has further highlighted and heightened the difficult situation of individuals at risk of vulnerability. This is unsurprising given that migrants were considered by the UN as being particularly vulnerable to exposure from COVID-19 (UN Regional Risk Communication and Community Engagement Working Group, 2020). Note that COVID-19 as disease exposure is a specific type of vulnerability, but it is not the only one that has affected migrants, and especially migrants in precarious or uncertain situations, during the pandemic (or even prior to it). Recent research found that migrants tended to be more likely to work in frontline positions. Such work includes positions in the health and social care sectors and in the retail and service industries. Thus, migrants were at greater risk of infection. Research has also found that those without documents often found themselves in crowded and unsafe housing conditions. During the pandemic migrants also found it harder to access health care as they were afraid to reveal their whereabouts, while remote interaction and digitisation created additional barriers to access (Galam, 2020; Knights et al., 2021). The increased use of temporary accommodation (e.g., hotels, barracks) to house asylum seekers during the pandemic brought additional challenges (Guma et al., 2021).

As we emerge from the most intense phases of the pandemic, we are encountering new societal challenges. These include, but are not limited to, a cost-of-living crisis, increased pressure on the healthcare system, the mainstreaming of online provision, and changes to the immigration system. Given these, understanding the wellbeing challenges faced by some most at risk of vulnerability is of utmost importance to help us respond to complex needs that are likely to increase in the near future.

## Understanding wellbeing

The project is based on an understanding of wellbeing as “the fulfilment of physical, material, psychological, social/relational, and spiritual needs at various levels” (La Placa et al., (2013) referenced in Lessard-Phillips et al., (2019, p.7)). Often operationalised around health, with a particular focus on physical and mental health indicators, wellbeing is understood to encompass broader aspects, such as social, economic, political, and environmental factors (Dooris et al., 2018). It is thus conceptualised as comprising multiple dimensions (Dodge et al., 2012). In this project, we use Sumner and Mallett’s (2013) dimensions to guide our research: material wellbeing (e.g., material resources such as income), relational wellbeing (e.g., relationships), and subjective wellbeing (e.g., evaluations of health). Research on migrants’ wellbeing has found that that migration in itself can result in increased vulnerability and undermine wellbeing in all of Sumner and Mallett’s dimensions (Médecins du Monde, 2015; Phillimore and Cheung, 2021; Cheung and Phillimore, 2013; Weller et al., 2019). Structural factors resulting from the UK Government’s increasingly hostile environment, such as the introduction of the Immigrant Health Surcharge in 2015, have been shown to restrict access to healthcare and to generate living conditions that undermine general wellbeing, particularly for undocumented migrants and asylum seekers (Weller et al., 2019; Soye and Watters, 2022).

This multifaceted understanding of wellbeing and the dynamic nature of vulnerability require a comprehensive research approach that allows for an in-depth exploration of the topic. In this project, such an approach involves the use of data, analytical methods and tools that enable us to capture the broad dimensions of wellbeing from various perspectives. This enables us to provide a wide-ranging and nuanced account of the way in which we understand, measure, monitor, and analyse wellbeing for a population on whom little data exists.

In this report, our aim is to highlight results from the project, where we have used unique data and an engaged methodological approach to provide an examination of the wellbeing of migrants at risk of vulnerability. We do so by first presenting the objectives of the research, discussing the methodological approach, highlighting the main results, and discussing the results and their implications for research, policy, and practice.



# Objectives

The objectives set below are specific to the individual projects that were conducted, but their main guiding principle is that of investigating the wellbeing of migrants at risk of vulnerability: one set of objectives focuses the original project, another set of objectives was adapted to examine wellbeing during the pandemic and the last set of objectives focuses on the wellbeing of individuals in initial and contingency accommodation (ICA). Details of the sub-projects involved in fulfilling the objectives below are explained in detail in the next section.

## Wellbeing-based objectives

The so-called ‘wellbeing-based objectives’ are linked to the work on the overall, original project, as well as the pandemic project. These aim to examine the wellbeing status of groups at risk of vulnerability and identify the factors shaping wellbeing. Most of the five objectives below are linked to the specific research questions which guided our analyses.

### Objective 1

**To profile the wellbeing of individuals and groups at risk of vulnerability, with an emphasis on identifying differences and associated factors across groups, areas, and time.**

This objective is based on the overall lack of available quantitative data and evidence about the wellbeing of individuals and/or groups at risk of vulnerability. Engaging with this objective, which is done primarily through the analysis of secondary quantitative data (see methodology section for details), allows us to identify the wellbeing gaps and needs of individuals at risk of vulnerability in a systematic manner, using comparable data over time. Building this evidence base is important for both policy and practice in that it provides knowledge as to what the gaps are, how they may vary across groups and have changed (or not), and where to direct future research and interventions.

### Objective 2

**To identify the multiple factors associated with wellbeing.**

This objective focuses on whether specific factors appear to be associated with the wellbeing of individuals at risk of vulnerability and uses quantitative and qualitative data to highlight (or identify) specific groups or circumstances that may have a particular association with wellbeing. It also examines the barriers that may impede the wellbeing for individuals at risk of vulnerability. This is important for both policy and practice in identifying factors and barriers and attempting to tackle these.

### Objective 3

**To assess the nature and effectiveness of tools used to monitor wellbeing for individuals at risk of vulnerability.**

This objective addresses the specific use of questionnaires in the monitoring of wellbeing, as used in the DOTW UK consultations, the advantages and disadvantages that these generate, and the potential usefulness of using these tools for more general monitoring. The fulfilment of this objective is primarily undertaken through primary qualitative data collection and analysis eliciting the experiences

and reflections of DOTW UK volunteers. This is important to help shape the way in which wellbeing is monitored, especially for individuals at risk of vulnerability, and to provide best practice for data collection outside of the DOTW UK environment.

## Objective 4

### **To inform policy and practice about actions that might influence vulnerability and wellbeing.**

Finally, our last objective for this part of the work engages with generating impact from the knowledge generated, through interaction with relevant stakeholders and the dissemination of results via presentations, reports, and academic papers. Both with short- and long-term impact, this objective not only relates to sharing the knowledge generated but also ensures that, during the lifetime of the project (and the production of this report), knowledge from the stakeholders is fed back into the project to inform our results and recommendations. Further, the findings enable DOTW UK to have access to evidence which could support their advocacy work.

## COVID-19-project objectives

The COVID-19-project objectives are linked to those of the original project and focus on the analysis of data in the early stages of the pandemic/lockdown in the UK.

### Objective 1

#### **To profile the wellbeing of individuals and groups at risk of vulnerability during the pandemic.**

Herein we look at specific wellbeing indicators and examine variations across immigration statuses, using the secondary quantitative data.

### Objective 2

#### **To identify whether the pandemic appeared to have been linked to wellbeing.**

This objective uses quantitative and qualitative data to highlight (or identify) specific groups or circumstances that may have a particular association with wellbeing. This allows us to examine the barriers that may impede on the wellbeing of individuals at risk of vulnerability and whether risks of vulnerability differ from before the pandemic.

## Institutional and contingency accommodation (ICA) Project objectives

The objectives based on the work focusing on the wellbeing of asylum seekers in ICA relate to urgency work that was carried out in spring 2022. The aim of this subproject was to use secondary quantitative and qualitative data from DOTW UK collected from service users in ICA during the pandemic in order to profile their health conditions and access to healthcare. This project provided DOTW UK with evidence to advocate for better access to healthcare and highlighted the health implications associated with use of ICA. This work was important from a policy perspective given that the numbers of asylum seekers and refugees in ICA had increased from around 12,000 pre-pandemic to 37,000 during the pandemic with the vast majority remaining in ICA for several months (Gentleman, 2022). The work speaks to concerns expressed by DOTW UK and others such as Refugee Action about the suitability of such accommodation for lengthy stays.

### Objective 1

#### **To describe the state of health of asylum seekers living in “temporary” housing.**

This first objective sought to provide evidence of the health situation of DOTW UK service users residing in ICA. We engaged with this objective by analysing the secondary quantitative and qualitative data provided by DOTW UK, with a focus on health outcomes.

## Objective 2

### **To identify levels of access to different forms of healthcare.**

The second objective focused on healthcare access for individuals in ICA. Again, we engaged with this objective through our analysis of the secondary quantitative and qualitative data.

## Objective 3

### **To build the capacity of DOTW UK to undertake future analyses of this nature.**

This objective focused on supporting staff at DOTW UK to develop the research skills needed to sample and analyse the secondary qualitative data. The intention was to build capacity to undertake such work in the future. This was done through one-on-one tutoring.

## Objective 4

### **To co-produce a report, briefing, blog and journal article with DOTW UK detailing findings.**

This objective is linked to the production of outputs used to generate impact. Such outputs help disseminate results and increase the reach and impact of research. We produced outputs including a report, a policy brief, and seminar presentations.

## Objective 5

### **To work with DOTW UK to share findings with key partners such as the Royal Colleges and NGOs.**

The goal of this objective was to collaborate in the dissemination of findings with main stakeholders. This is done through the presentation of results in online workshops and through a session with the Expert Consortium for Migrant Health which includes many Royal Colleges as part of its membership.

## Objective 6

### **To work with DOTW UK, partners, and the media to lobby the Home Office to cease long-term use of “temporary” accommodation.**

DOTW UK and partners were pushing for the cessation of accommodation of asylum seekers in ICA for more than four weeks on the grounds of the negative effect on wellbeing of living in such accommodation. They wanted to move beyond “anecdotal” evidence to an independent analysis of the quantitative data.

## Summary

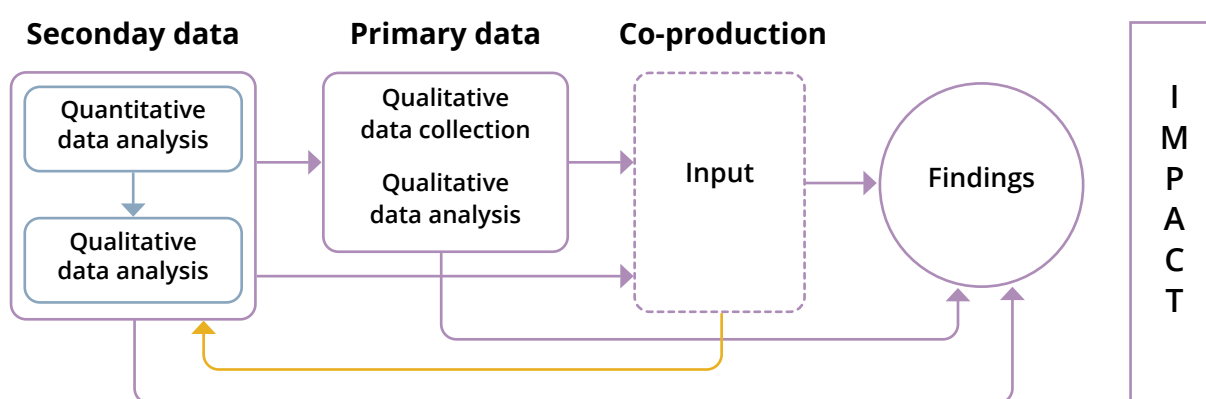
There are thus objectives that deal with each aspect of the project, with the overall aim being to improve and further our knowledge of the wellbeing of individuals at risk of vulnerability. The emphasis here is on examining factors and barriers related to wellbeing, reflecting on the instruments used to measure and monitor wellbeing, and informing policy and practice. In the section that follows, we go into more detail to explain the methodological approach that we used to engage with the objectives.



# Methodology

The methodological approach of the project can be summarised in Figure 1. In the project, we used a mixed methods approach that employs both secondary and primary data, as well as a mixture of convergent approaches – where quantitative and qualitative data analyses are combined to generate results – and explanatory sequential approaches – where quantitative data analysis informs qualitative data collection and analysis (Creswell, 2018). Moreover, given the co-production approach to the project (see below for details), results from the research have been shaped and considered by policy stakeholders throughout. We unpack aspects of the methodological approach below.

**Figure 1** The project's methodological approach



## Data

The data used as part of the project come from two sources: secondary data collected from service users of the DOTW UK clinics and primary data collected from interviews with the DOTW UK volunteers who are involved in such clinics. In this section, we expand further on the two types of data.

### Secondary data

Quantitative secondary data come from records of consultations with the DOTW UK volunteers at their outreach clinics. By ‘consultations’ we mean the interaction, in-person or remotely, between a service user and a DOTW UK volunteer (who can be a non-medical caseworker or a general practitioner). The data from the consultations can be separated into two types: questionnaire data (quantitative secondary data) and the notes associated with each consultation (qualitative secondary data). The quantitative secondary data are taken from different forms that are completed as part of the consultations: an administrative form including consultation information and basic demographic information; a social form with information about the “social situation, immigration status, living conditions, self-reported health status and barriers to health care” (Chauvin et al., 2009 as cited in; Lessard-Phillips et al., 2019, p.9); a medical form with health-related information gathered during the medical consultation (if one has occurred); and, in the case of the ICA work,

a form specific for individuals residing in hotel accommodation. Details about of the questions used in the various years can be found in the Appendix. As noted in a previous report (Lessard-Phillips et al., 2019), the data collected arise from conversations occurring during the consultations and are entered by the volunteer. Not all questions may be asked in all circumstances generating some missing data.

The qualitative secondary data come from samples of notes or comments written in a free-text box by the volunteer, generated during their conversation with the service user. These contain additional information to the questions included and tend to cover a brief summary of the situation of the service user (why they decided to move to the UK, how they got here, their migration status, employment, and housing), their health concerns and any interaction with health services in the UK. This is followed by a report of the caseworker's actions (e.g., identifying staff at a GP practice who would register the service user) and plans for follow-up. The notes contain a record of actions and communications undertaken by DOTW UK caseworkers until the case is resolved or the service user becomes uncontactable.

Thus, three different data sources were used, comprising information from the questionnaires as well as a sample of free-text notes. We outline these below.

### **Secondary data about service users for the years 2011-2018**

This is the main data source utilised throughout the project. From this data, two different datasets were produced<sup>1</sup>:

1. Pooled information from the administrative, social, and medical questionnaires of service users from 2011 until 2018. This resulted in a dataset of 14,040 consultations with 11,381 unique service users (i.e., service users using the service for the first time where we were able to match the information from the administrative and social questionnaires) who were not UK nationals;<sup>2</sup> and
2. A sample of free-text notes from consultations held between 2015 and 2018 (the only years where the free-text notes were available), resulting in a sample of 368 cases.

The process of pooling the quantitative data required the gathering of datafiles within and between years and the harmonisation of variables across years. This process was shaped by two main aspects, which were impacted by the level of detail of available data. One aspect is the difference in the availability of data formats. Data from 2011-2014 were available from the Médecins Du Monde online data depository and variables were already harmonised with similar international data, as they were used for producing comparative reports (Médecins du Monde, 2014). Data from 2015 onwards were made available directly from DOTW UK, with information from the administrative, social, and medical questionnaires kept in separate datafiles. This required merging the datafiles based on user ID and consultation date – note that service users with at least some information from administrative and social questionnaires were selected as part of the sample to maximise variable completeness<sup>3</sup>. This implies that whilst we do not have the complete population of service users for those years who provided consent for their data to be used, we have a large proportion of them<sup>4</sup>. The second aspect is linked to changes made to the questionnaires over the years, either in terms of question or answer choices. This meant that the creation of pooled variables (i.e., variables consistent over time) was influenced by these two aspects. The list of variables generated by this process are found in the Appendix.

The process of generating the sample of qualitative secondary data was as follows. We used free-text notes completed by DOTW UK caseworkers and with the help of a DOTW UK data officer, we sampled a random

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<sup>1</sup> Note that given the nature of the data, datasets are not publicly available.

<sup>2</sup> Here we exclude UK nationals but keep all other type of non-UK nationals (including EU) even if not classified as migrants in the legal sense of the term when the consultation occurred.

<sup>3</sup> Given that fewer service users have a completed medical questionnaire, we used completion of the administrative and social forms as a benchmark for inclusion in the sample. This is also linked to the fact that most questions/variables of interest for the project were included in the social questionnaire.

<sup>4</sup> We matched over 90% of service users with their social forms.

10% of cases from the year 2018 (198 cases) and an additional 5% of cases from the year 2016 (87 cases) and 2017 (83 cases). This decision was taken by the research team, where the selection started with 10% to get a wide range of cases and service users' demographics and health needs, but the team found when completing one year that 5% were enough as patterns emerged pretty quickly. Five service users were excluded as they were UK citizens. Sets of notes ranged from a few lines to several pages and outlined details of service users' health concerns and life situations. Notes were imported into the software analysis programme NVivo for ease of coding and data management.

### **Secondary data about service users from January until September 2020**

This is the data source that allowed for the analysis of the wellbeing of service users during the pandemic (Fu et al., 2021). Data from the questionnaires as well as the free-text notes were made available for service users who attended the clinics for the first time between January and September 2020, but the focus of the data was between March and September 2020. Given the beginning of the lockdown in the UK, consultations from 17 March 2020 were conducted over the telephone. As above, data from the administrative, social, and medical (when available) questionnaires were merged for each service user, and service users with administrative and social questionnaires were used as part of the dataset. Based on this method, a total of 750 service users were included in the quantitative dataset, with 321 of these service users having a consultation between 17 March and September 2020. Despite changes in the questionnaire in 2019, this dataset also comprised variables that matched the variables covered in the 'original' dataset (which allowed for comparisons).

All free-text notes from April and July 2020 were retained as part of the sample. This resulted in a total of 96 free-text notes being used, out of a total of 107 available (the notes which were excluded were due to the service users being UK nationals or containing no data, see Fu et al. (2021) for details).

### **Secondary data about service users in ICA from April 2020 until January 2021**

This data source was also used to examine the wellbeing of (mainly) asylum seekers in ICA,<sup>5</sup> either through visits to hotels and barracks, or via telephone consultations. Data from the questionnaires and the free-text notes were available for service users in ICA between April 2020<sup>6</sup> and December 2021. Again, setting up the quantitative dataset involved the merging of the administrative, social, and medical questionnaires (when the latter existed) keeping service users with completed administrative and social questionnaires. For service users residing in hotels, there was an additional questionnaire, available via a Google form (please see the Appendix for details), that was merged to the other questionnaires which was completed by a volunteer. This resulted in a dataset comprising 313 service users.

For the free-text notes, 10% of the notes were initially randomly sampled to create the data analysis framework (see below for details), and an additional 23% were randomly selected to create a selection of free-text notes from the data source (Jones et al., 2022) meaning that in total a third of all notes were analysed.

## **Primary data**

Semi-structured interviews were conducted with 5 DOTW UK volunteers (3 caseworkers, 2 clinicians) covering both the pre-pandemic and pandemic periods. The topic guide included volunteers' experiences of interacting with service users (including those most at risk of vulnerability), their experiences of completing the social and medical forms including free text notes, and their views of the changes made to their services during the pandemic (from March 2020). We compared the case notes and interviews with DOTW UK volunteers, reflecting on what we could learn about the usefulness of volunteer-completed social forms and free text notes as methods to provide data about the kinds of factors that could impact on wellbeing.

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<sup>5</sup> 94.8% of service users in the data were classified as asylum seekers, whereas the remaining 5.2% were classified as 'other'.

<sup>6</sup> Only telephone consultations were conducted between April and July 2020, as face-to-face consultations started in ICA started in July 2020.

## Stakeholder engagement/co-production

In order to optimise the outcomes of the work for those organisations working with populations at risk of vulnerability we adopted a co-production approach. This involved close partnership with DOTW UK, who collected the data, and engagement with an expert interdisciplinary Advisory Board which included NGOs, policymakers, and migrant health experts. We had proposed to run workshops with key organisations in London to help shape our analyses, but the early stages of the project coincided with the most difficult stages of the pandemic (the period of tightest restrictions) and key partners had to prioritise their responses to COVID-19 and had no time for additional activities. However, working with the Advisory Board from the outset of the project enabled us to ask questions and undertake analyses that are most useful to users. We ran multiple stakeholder events to allow reflection on our findings and connected with the DOTW UK National Health Advisers, all of whom had personal experience of attempting to access healthcare as migrants who advised us on key questions to ask of the data and key messages to share in our webinars and press releases. One-to-one feedback sessions were held with the Home Office on the COVID-19 and ICA projects through our existing contacts and all findings of those projects were shared with the Expert Consortium for Migrant Health.

## Methods of analysis

### Secondary quantitative data

All data manipulations were performed using Stata. For the descriptive statistics, frequency distributions and measures of central tendency were generated depending on the nature of the variables. When relevant, cross-tabulations between different variables were also generated. To examine the presence of statistical associations between variables, chi-squared tests were performed, and confidence intervals generated to look at differences between proportions. To analyse the factors associated with wellbeing, logistic regression analyses were performed, where the wellbeing indicators were transformed into binary outcomes that indicated: good or very good general/physical/psychological health (subjective wellbeing), frequent or very frequent emotional support (relational wellbeing), and being above the poverty line (economic wellbeing). For each outcome, we controlled for immigration status, demographic characteristics (age, age squared, sex, years since arrival, location of residence), year of consultation, as well as the accommodation situation of the service users given the importance of such factors present within the literature (Aube et al., 2019; Ziersch et al., 2017; Gerritsen et al., 2006; Porter and Haslam, 2005; Derosé et al., 2007; Rivera et al., 2015; Isaacs et al., 2022). Factor analysis was used to construct the accommodation variable (using indicators about the type of accommodation, stability of accommodation, and the safety of accommodation) and a factor score was generated, standardised, and used as a variable. In the case of subjective wellbeing, we added a variable indicating the service user's experience of denial of healthcare access given existing evidence pointing to the influence of such barriers on wellbeing (Kang et al., 2019; Hiam et al., 2019). We also explored the association between economic wellbeing and subjective wellbeing. Results are presented using average marginal effects (Mood, 2010).

### Secondary qualitative data

We carried out a content analysis, focusing on a) factors that were expected to be associated with wellbeing and b) contextual factors outlining service users' experiences with the health service and any difficulties with GP registration while they were being supported by DOTW UK.

For the COVID-19-specific analyses, we carried out a content analysis on 96 sets of notes consisting of two stages: first, we summarised characteristics of the individual case focusing on 1) service users' current health status, 2) the health services required, 3) their life situation, 4) any barriers and facilitators to accessing health services and 5) how their health concerns were resolved (or not). Then, we compared across cases to understand the range of concerns faced by service users.

### Primary qualitative data

To explore the context in which questionnaires were completed, and to elicit DOTW UK volunteers' perspective on service user wellbeing and related factors, we completed a "domain summary" type of

thematic analysis (Braun & Clarke 2019) focusing on the range of topics and meaningful responses raised in the main domains of “Service users’ life situation and wellbeing”; “Views on vulnerability”; “Asking questions”; “Communicating with service users” and “Completing the form”. While these domains were driven by the main topic areas of the interview, some of the subthemes within them were newly identified from the data, (e.g., “Building trust”). We then compared our findings from the free-text notes to the corresponding domains and subthemes to add context and try to unpick more complex issues often only hinted at in the notes.

## Ethical considerations

We obtained ethical approval from the University of Birmingham’s Ethics Committee before commencing the research. We received approval from DOTW UK’s own ethical review process. Note that all data used in the project are from service users who have agreed to have their data used for research purposes. We followed the principles for research with small sample sizes, vulnerable populations, and undocumented migrants, taking great care that participants are not be identifiable or localisable to the area they live in in both the quantitative and qualitative research. Service user data from the questionnaires was already anonymised and analysed on encrypted, password protected University laptops. Free-text notes were anonymised on DOTW UK premises to ensure security and confidentiality and then securely sent to the research team. Interview participants’ data was anonymised and identifying information kept separately from the data on encrypted files and stored on University of Birmingham servers. Qualitative interviews were digitally recorded after informed consent was granted then transcribed and transferred to encrypted memory sticks, and anonymised. Data generated will be archived and kept securely using existing University resources and following established guidelines which currently require data retention for 10 years.

A key concern throughout the project has been the tension between “giving voice” to the stories of DOTW UK clients and ensuring the highest standards for consent. The handwritten notes provided rich detail about the experiences of DOTW UK clients when seeking to access healthcare and while in ICA. While we were also keen to use “vignettes” or longer quotations from the free-text notes to provide a human perspective on the experiences we were reporting, DOTW UK were concerned that the nature of consent agreed between clients and themselves did not extend to the reporting of individual stories. The time-consuming nature of this task and difficulty accessing past clients meant our ability to give voice to such stories has been much reduced. The permissions received from DOTW UK volunteers has enabled us to use quotations from the interviews to give voice to such stories.



## Key findings

**In this section, we highlight the main findings from the project, focusing on results emerging from the three strands of the research: (1) the wellbeing of migrants at risk of vulnerability in the years 2011-2018; (2) wellbeing during the pandemic; and (3) the wellbeing of asylum seekers in ICA.**

### Wellbeing of migrants at risk of vulnerability, 2011-2018

Here we focus on the results from the original project. These are linked to objectives profiling wellbeing, identifying associated factors, and assessing monitoring tools.

#### Quantitative strand

##### Sample description: Demographics, consultation needs, and access to healthcare

Table 1 highlights the demographic characteristics of the service users in the 2011-2018 data. The table shows that the dataset contained 48.8% female service users and 51.2% male service users. Unsurprisingly given the location of DOTW UK clinics highlighted above, 88.8% of service users were located in various boroughs of London. The mean age of the service users was 36.82 years, with most service users between the ages of 25 and 44. Regarding immigration status, 64.3% of service users were classified as undocumented, 13.9% as asylum seekers, and 21.8% in the other migrant group. Individuals in this last group are quite heterogeneous and include EU/EEA nationals, non-EU/EEA nationals on visas, individuals granted refugee status, and other individuals having used the clinics without a clear immigration status. The mean time spent in the UK at time of consultation was 5.23 years; with just over a third having been in the UK for under 2 years. The consultations were distributed relatively equally across years, with some differences across years.

We now look further into the consultation needs of service users. GP registration was the most often mentioned reason for engaging with DOTW UK, with 85.7% of service users mentioning this. Needing help with NHS costs was the second most often mentioned (55.4%), followed by immigration advice (13.9%), how to access A&E/walk-in centre (5.4%), how to access a dentist (5.2%), how to get destitution support (4.5%), antenatal care referral (3.3%), advice about charging for secondary care access (3.3%), foodbank referral (2.2%), access to optometrist (2.1%), access to counselling (2%), termination of pregnancy referral (0.7%); and advice about secondary care access (0.3%).

Given the large share of service users needing registration with a GP, and the fact that 82.3% of service users were reported as having no healthcare coverage, we looked further into the barriers impeding access to healthcare mentioned. Of the service users mentioning such barriers, the most frequently occurring were lack of knowledge of the system/rights (25.4%), administrative and documentation barriers (25.1%), language barriers (13.6%), fear of arrest (10%), denial of health coverage (7.5%), financial barriers (3.5%), other barriers (1.8%), and being deterred by previous experience of discrimination (1.5%). Moreover, just over 15% of service users reported having their access to healthcare denied.

**Table 1** Descriptive statistics of the sample

<b>Sex (N=10,813)</b>	<b>%</b>	<b>Age groups (N=10,935)</b>	<b>%</b>
Female	48.8	0-17	3.0
Male	51.2	18-24	11.0
<b>Total</b>	<b>100</b>	25-29	15.7
<b>Location: London (N=10,875)</b>	<b>%</b>	30-34	16.7
No (including unknown and missing)	12.3	35-39	15.5
Yes	87.2	40-44	12.7
<b>Total</b>	<b>100</b>	45-49	10.3
<b>Immigration status (N=10,106)</b>	<b>%</b>	50-54	6.3
Undocumented/illegal	64.3	55-59	4.2
Asylum	13.9	60-64	2.2
Legal/other (including EU)	21.8	65+	2.3
<b>Total</b>	<b>100</b>	<b>Total</b>	<b>100</b>
<b>Year (N=11,381)</b>	<b>%</b>	<b>Time spent in the UK (N=9,655)</b>	<b>Mean /Median</b>
2011	12.7		5.2/3.9
2012	13.1		
2013	9.2	<b>Healthcare coverage (N=9,640)</b>	<b>%</b>
2014	11.2	No	82.3
2015	11.5	Yes (at least some)	17.7
2016	13.5	<b>Total</b>	<b>100</b>
2017	13.1		
2018	15.8		

Source: DOTW UK data, 2011-2018.

## Assessing wellbeing and comparing outcomes

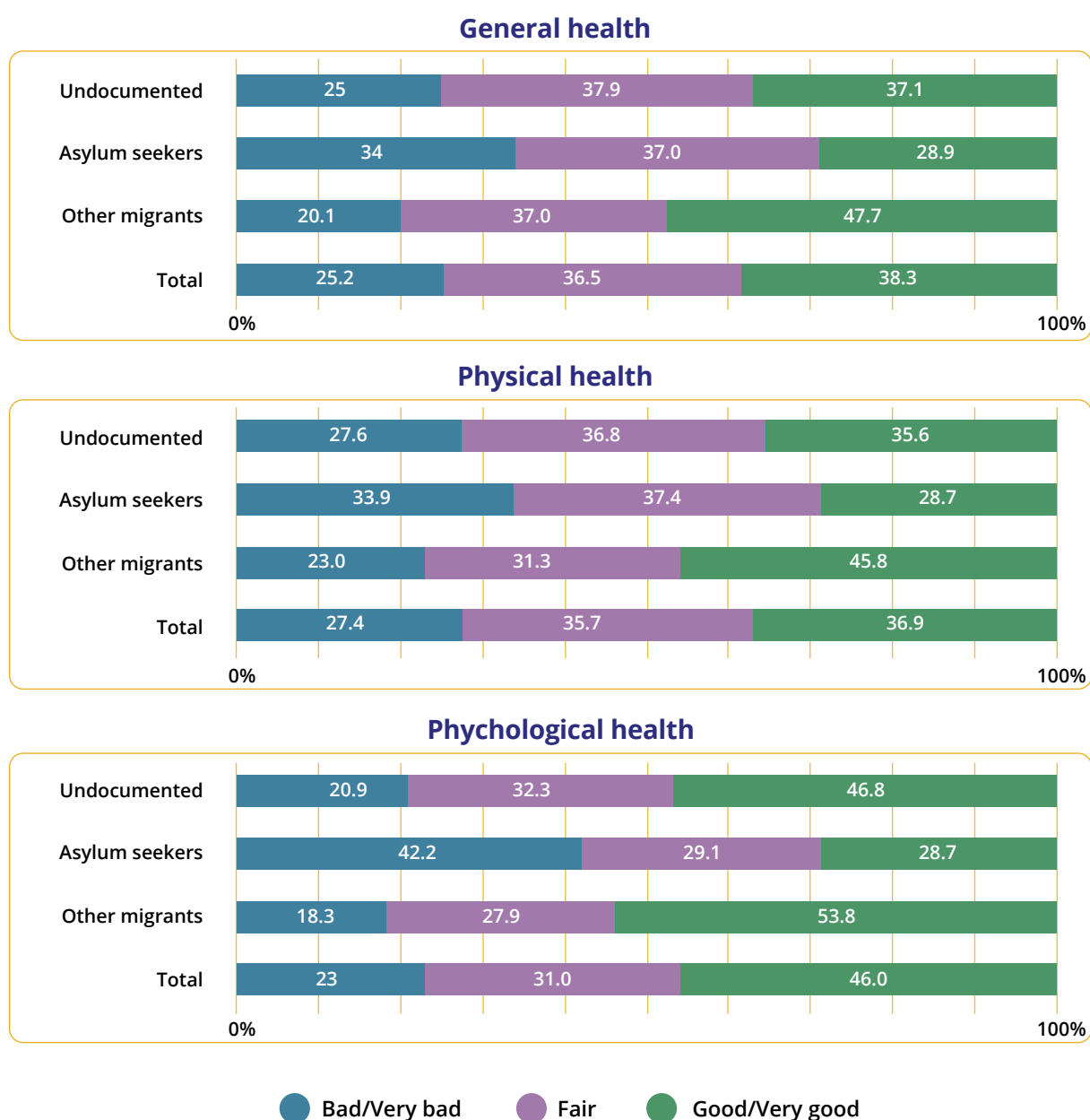
We assess wellbeing from Sumner and Mallett's (2013) three different dimensions and available indicators in the data. For subjective wellbeing, we look at indicators of general health (2011-2018), physical health (2013-2018) and psychological health (2013-2018). For relational wellbeing we look at the presence of emotional support. Finally, for material wellbeing, we look at the financial situation of service users. Here we use a multidimensional approach in the simplest sense of the term, where we consider individual indicators across different domains of wellbeing so as to provide an in-depth picture of wellbeing. We also focus on differences across immigration statuses, and between men and women, and age groups.

We first look at subjective wellbeing indicators, as shown in Figure 2. Overall, we can see that regarding general health, 38.3% of service users were reported as having good or very good health (positive evaluations of health), 36.5% as having fair health, and 25.1% as having bad or very bad health (negative evaluations of health). Assessments of physical and psychological health follow a relatively similar path, apart from a larger share of service users stating good or very good psychological health. If we compare with similar data at the general population level from the Health Survey for England, levels of reporting good or very good general health among adults are at around 75-76% (NHS Digital, n.d.).

There are striking differences in health indicators across immigration statuses. Regarding general health, asylum seekers exhibit the highest rates of negative health evaluations, followed by undocumented migrants and other migrants. The reverse holds for positive evaluations of general health. There are also differences for physical health along similar lines, with asylum seekers and undocumented having lower perceived health (33.9%/27.6% respectively) than the other group. The starkest group differences are regarding psychological health, with asylum seekers having much lower health evaluations than their peers in the other

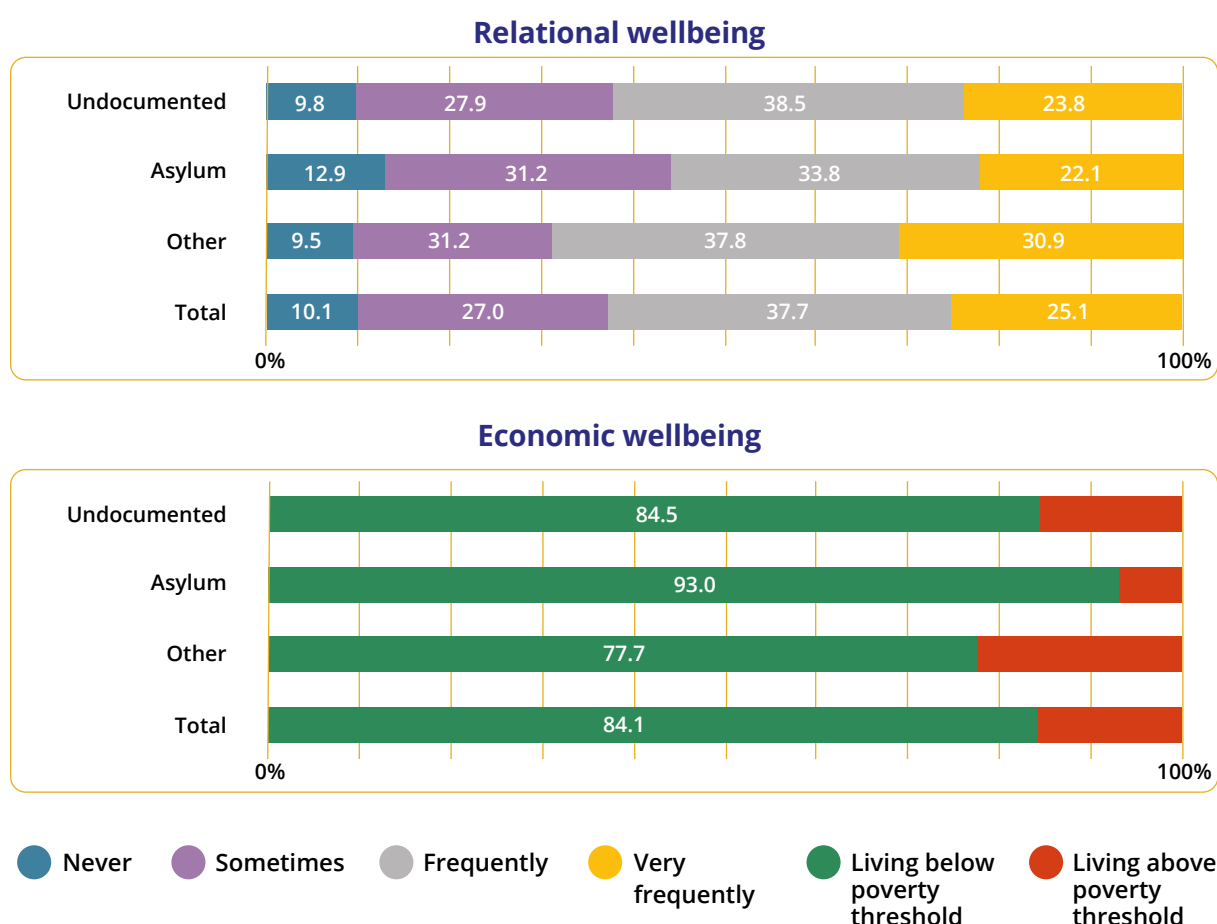
two groups. Differences in health-related indicators are also present between men and women, with men having more negative evaluations of their general, physical, and psychological health compared to women. When investigating differences between men and women according to immigration status, we see that the trend of men having more negative evaluations of health holds in terms of general and physical health for undocumented and other migrants, but not for asylum seekers (the rates are similar). Regarding differences in health-related indicators, service users in the older age groups tend to have more negative evaluations of their general and physical health, but the trend is not as clear cut for psychological health.

**Figure 2 Subjective across immigration status**

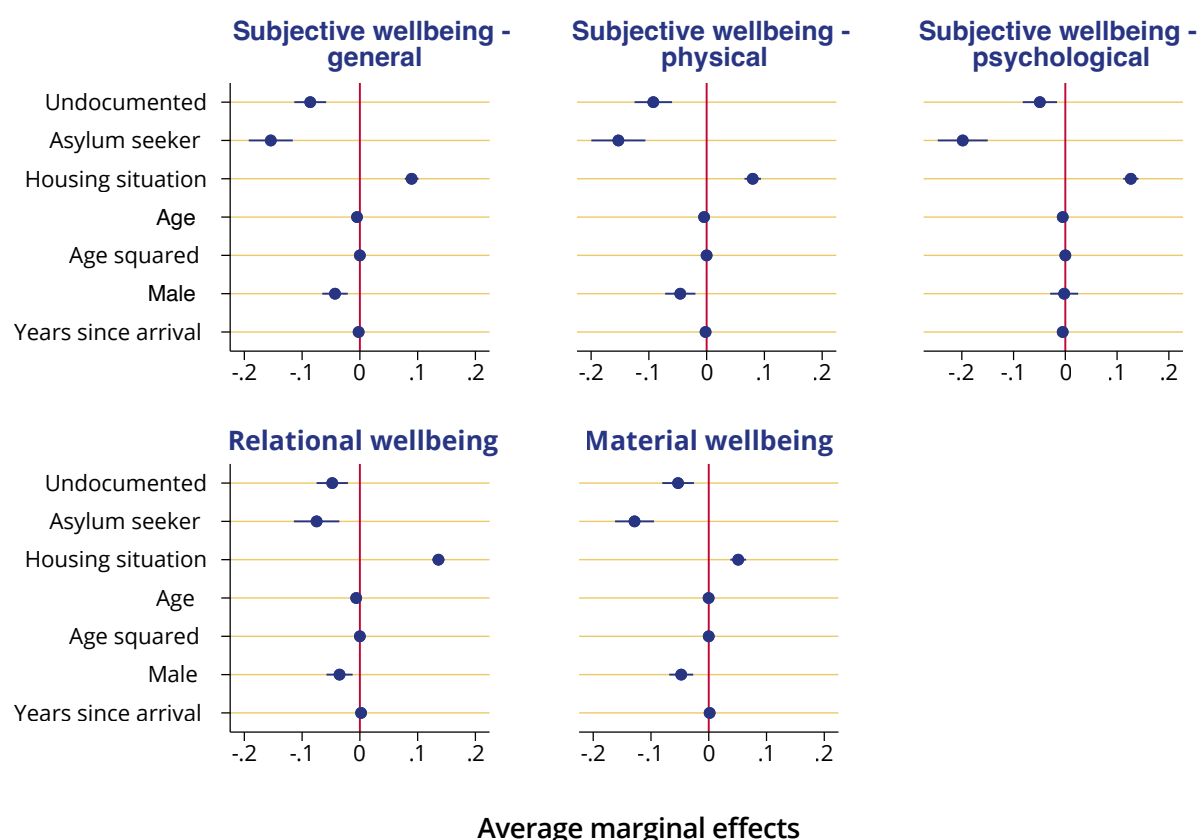


We next turn to relational and economic wellbeing indicators (Figure 3). In terms of relational wellbeing, 25.1% of service users indicate that they can rely on someone for emotional support very frequently, 37.7% frequently, 27% sometimes, and 10.1% never. Again, the percentages vary by immigration status, with asylum seekers having a higher percentage in the 'never' category, and both asylum seekers and undocumented migrants having a high rate of very frequent support. Male service users also tend to have lower rates of emotional support, especially within the undocumented migrants group. Emotional support is also most present among the younger and older service users. Regarding economic wellbeing, 84.1% of service users were living below the poverty threshold. This is in sharp contrast with population-level figures, where 18-22% of people live in poverty (Francis-Devine, 2022). This is much higher among asylum seekers (93%) and, to a lesser extent, undocumented migrants (84.5%). Male service users are more likely to live below the poverty threshold, especially among undocumented migrants and other migrants.

**Figure 3 Relational and economic wellbeing indicators, by immigration status**



The results above have shown us that the wellbeing status of migrants at risk of vulnerability points toward hardship, especially when compared with data from the general population. We have also seen that asylum seekers appear to be at particular risk of vulnerability compared to other groups, and that male and female service users have different wellbeing outcomes.

**Figure 4 Factors associated with wellbeing by immigration status**

Source: DOTW UK data, research team's analyses

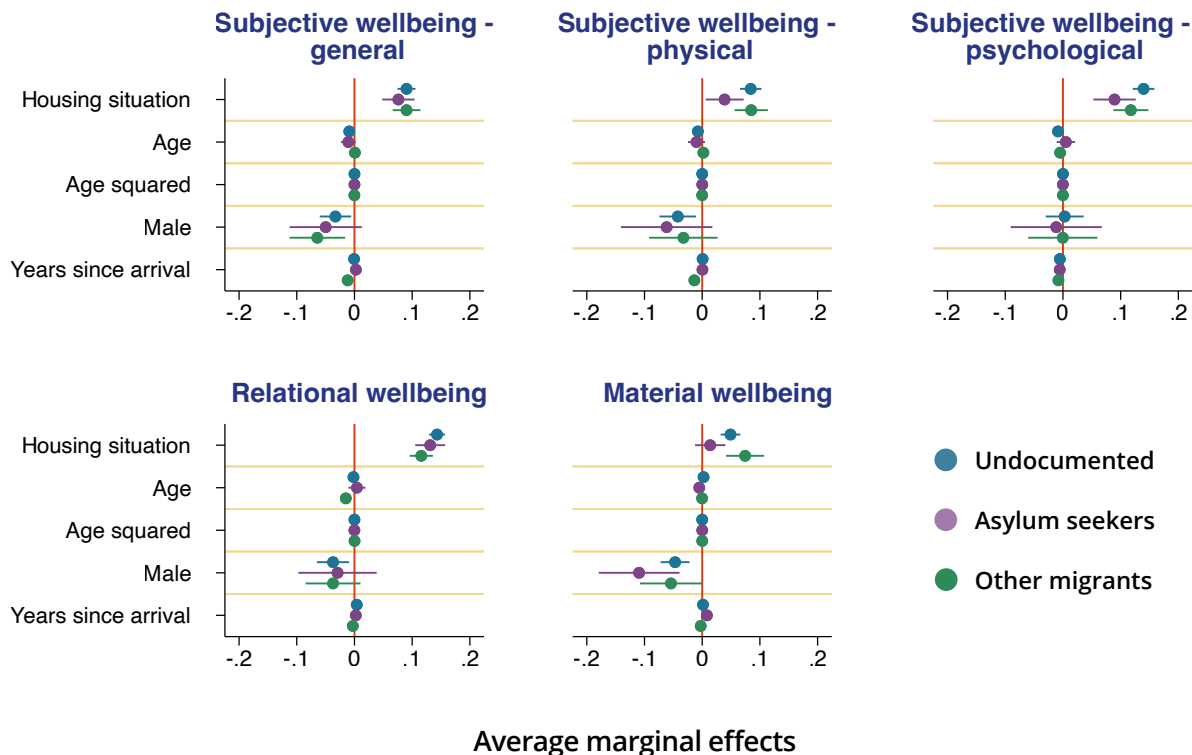
Notes: Models also include controls for year of consultation and location of residence. Average marginal effects presented. Not all outcomes cover the full date range of the data because of variable availability. General subjective wellbeing and relational wellbeing cover the 2011-2018 period whilst the other outcomes cover the 2013-2018 period.

## Factors associated with wellbeing

Results of the analyses examining the factors associated with the selected wellbeing indicators can be found in Figure 4 for the full sample and Figure 5 for the different immigration statuses. The results presented here are the average marginal effects,<sup>7</sup> which represent the average change in the probability of the outcome for a change in one unit in the independent variable. For ease of interpretation, here we show graphical displays of the results, where the focus is on the position of the symbols in the graph: if it is to the left of the line, it indicates a decrease in probability of wellbeing; if it is to the right of the line, it indicates an increase in the probability of wellbeing. Any symbol or line (representing the confidence interval of the average marginal effect) that crosses the 0 line indicates lack of association.

Results from Figure 4 confirm the wellbeing situation of asylum seekers and undocumented migrants as being worse than that of other migrants (the reference group) for all outcomes. The gap between asylum seekers and other migrants is bigger for subjective wellbeing, especially regarding psychological health. If we look at the association between housing and wellbeing, we can see that a more favourable housing situation appears to lead to significantly better probability of wellbeing, especially regarding relational wellbeing and psychological health. Note that we also performed analyses with material wellbeing as an indicator and there was a strong negative association between being below the poverty line and the probability of positive

<sup>7</sup> Detailed tables in the Appendix

**Figure 5** Factors associated with wellbeing by immigration status, logistic regression

Source: DOTW UK data, research team's analyses.

Notes: Models also include controls for year of consultation and location of residence. Average marginal effects presented. Not all outcomes cover the full date range of the data because of variable availability. General subjective wellbeing and relational wellbeing cover the 2011-2018 period whilst the other outcomes cover the 2013-2018 period.

subjective wellbeing. This slightly reduced the average marginal effect for housing situation, which remained significant. Age is negatively related to general health and relational wellbeing. As outlined earlier, male service users have a lower probability of wellbeing in all dimensions aside from psychological wellbeing. Years since arrival reduce the probability of good subjective psychological wellbeing, but increase the probability of good relational wellbeing (given the small but significant average marginal effect, this is not reflected in the Figure, but can be examined in the Appendix). There appear to be differences in wellbeing across years as well as across locations (see Appendix). We also looked further into the relationship between being denied access to healthcare and subjective wellbeing (see the Appendix) and have found that reporting having been denied access to healthcare leads to a decrease in the probability of subjective wellbeing. Living below the poverty threshold also lowers the probability of subjective wellbeing.

Figure 5 looks at the factors associated with wellbeing for each immigration status separately. What is presented here indicates that not all factors have the same level of association with wellbeing, even if the average marginal effects are relatively similar. The accommodation situation still has a positive association with wellbeing, but not to the same extent for all groups (it tends to be not as strong for asylum seekers, especially regarding subjective and material wellbeing). Age appears to negatively change the probability of subjective wellbeing for undocumented migrants and of relational wellbeing for other migrants. Wellbeing outcomes for male service users still tend to be negative, but to different extents across the immigration statuses. Finally, the examination of years since arrival fits the picture outlined above but with variations across groups, and with years since arrival having a positive association with material wellbeing for asylum seekers.

The results from the secondary quantitative data analysis show that wellbeing status is overall a concern when it comes to individuals at risk of vulnerability; this is consistently the case throughout the period covered by the data. The factors associated with wellbeing are manifold, with immigration status playing an important role on the level of wellbeing. The wellbeing of asylum seekers appears to consistently be worse than other groups. The housing situation also appears to play an important role, as does access to healthcare. These are some of the themes that have been further explored in the qualitative strand of the works, to which we now turn.

## Qualitative strand

Information relevant to wellbeing includes service users' current physical and mental health, housing situation, and migration status. Caseworkers' notes on the migration journey of some of the service users also included other factors potentially related to wellbeing such as service users' spouses or children living overseas or war/other conflict leading to them having to leave their home country.

### Current health situation and reasons for attending

Out of 363 cases analysed, 220 service users came to DOTW UK with an immediate physical or mental health concern (of the others, 100 wanted to register with a GP without an immediate health concern, 28 wanted to access maternity care, 10 wanted to access an optician or dentist, 23 had other concerns such as NHS charges or no information was recorded). About half of immediate physical health concerns were those causing pain (e.g., abdominal pain, back and shoulder pain, injuries). A few service users had immediately worrying symptoms (chest pain, blood in stools or urine, lumps or test results from non-NHS sources that indicated a serious health problem). One of the medical volunteers we interviewed reflected on whether service users' motivations to seek help could indicate the severity of their health problem:

“The question in one's head [when starting a consultation] is why now? What is it that allowed them to maybe pluck up courage or decide they need to seek medical help now, so we'll often be asking the question, so, you know, when did this start - and obviously for our own safety netting, is it getting worse?” [MW2]

However, there were some service users who had issues that were not painful or immediately worrying (e.g., coughs and colds, skin problems or ongoing health issues). A few were also seeking GP registration as their prescribed medication (e.g., for high blood pressure) had run out.

Sixty-two service users sought help for a mental health issue, either on its own or together with physical health problems. A few had diagnosis for a mental health condition that needed immediate treatment or reconnecting with services that they had previously accessed. Twenty-three service users discussed traumatic experiences in their country of origin or on in their journey to the UK that affected their mental health. Others discussed feeling down or having a low mood, difficulties sleeping or nightmares. For some, the caseworker also noted why they felt like this, for example worry about their immigration status, relationship or money difficulties or stress at work. One caseworker we interviewed discussed a general sense of malaise, being

“defeated by either the fact that they can't get secure immigration status in the UK and their health isn't going well, and they can't access health care and there's other things - obviously health is a holistic thing, so they might not be able to get food or water or shelter or education or housing so - so I don't know if it's the kind of overwhelming [...] way in which the hostile environment policies are restricting agency..” [CW2]

The complex and difficult life situations of service users, which were sometimes shared with volunteers (and viewed by volunteers as potentially impacting on their mental wellbeing), could also be indicated through the reason for moving to the UK that was noted for some of the service users. Reasons for migration were often complex and interlinked, including being forced to migrate because of persecution, violence or conflict and long-term separation from loved ones such as spouses and children. For some, there potentially was pressure to remit (send money) to family back home despite, as we establish above, the majority living below poverty thresholds.

## Aspects of service users' life situation with potential links to wellbeing

Migration status, housing, and financial resources were also included in the notes for most service users. The free-text notes suggested the interaction and overlap of different factors, for example housing, which we find to be important in our analysis of the quantitative data was also implicated both in material and relational wellbeing in our analysis of the free-text notes.

Regarding migration status, the largest group (123) had moved to the UK on a work, student or tourist visa which had since expired; 37 had come to UK via an irregular route. Twenty-six were current asylum seekers and 17 had applied for asylum but been refused. Thirty-five had a current visa or indefinite leave to remain in the UK. For the others, migration status was unclear or there was not enough information in the notes. The case notes also contain information on service users' struggle with migration status; for example, 38 said that their documents had been stolen, often by agencies who had organised their move to the UK. Some discussed their interactions with the Home Office, for example, having been detained or being 'stuck' partway through their attempt to regularise their status. Some service users expressed their reluctance to engage with healthcare because of fears that their address would be disclosed to the Home Office.

Regarding housing, most service users lived with other people (partners and spouses, family members, friends, flatmates) and said that their accommodation was reasonably stable and that they felt safe where they were. However, 20 were homeless or 'sofa surfing'; for others, accommodation was still clearly temporary, or they were sharing their room with others. Some saw this as 'safe' if they trusted their roommates and had a bed to sleep in, while others reported conflicts with others. Questioning about 'safety' and the need to identify the most vulnerable service users was also described by the volunteers: *"it's, who looks after your money. And who's got your passport, I mean not as bluntly as I'm saying it now [...] Are you afraid of anybody where you're living?"* [CW1] The volunteers we interviewed also illustrated the tension between the hospitality of the community and a less than ideal living situation: *"people sleeping on people's sofas [...] they couldn't go to bed until the family had gone to bed to sleep in the sitting room."* [CW1]

Some service users' housing was 'tied' to their jobs (e.g., as housekeeper or live-in carer) or they were living rent free with friends and did housework or childcare in return. Some saw this situation as acceptable and safe (one woman referred to her employer as her honorary 'daughter') and others described more exploitative situations or employers not permitting use of their address for GP registration. One volunteer described women in this type of situation as an example of the most vulnerable service users, in this case domestic workers *"who work – who would sleep in the same bedroom as the children that were looking after [...] they're vulnerable because their passports were taken away from them."* [CW1], reflecting the concerns expressed by organisations such as Kalayaan<sup>8</sup> but also indicating that such arrangements have implications for access to healthcare.

Case workers noted how most service users supported themselves. While most worked, others were unable to work or were supported by their family, friends, or religious community; a few said they lived on their own savings. There is information about existing earnings from work for 114 service users; most worked in sectors such as cleaning, building, childcare or restaurant work, some only part-time or 'occasionally'. However, a few service users were formally employed. Thirty-one service users said they were not currently working but looking for work. Others had formerly worked but were now unable to because of a health problem. Thirty-five said they had material support from their spouse, partner, or other family member. Thirty-four shared information on material support given by friends (e.g., being able to live rent free and/or being supported with food or money). A few (11) said they were being supported by their faith community, with money, food or by living 'with friends from church'. This support could be crucial to wellbeing, but when interviewed caseworkers indicated that such generosity could also place a burden on the service user: *"we've also had cases of people who are living with their friends and they [...] feel really terrible about the fact that their friend is supporting them. For that food, water, housing, clothing, transport costs, everything."* [CW2] There were a few references to purely social support by friendship networks, and about a quarter of the service users were helped to get to the DOTW UK clinic, or even accompanied by, a friend.

<sup>8</sup> <http://www.kalayaan.org.uk/>

## Experience of accessing health services in the UK

We have information on 72 service users' use (or non-use) of health services in the UK before they attended DOTW UK. Thirty said they had never registered with a GP even though some had been living in the UK for years. Some had not needed healthcare, but others were worried about declaring their address in case it was shared with the Home Office. A few were so concerned that they did not seek help for a painful problem. A caseworker we interviewed described their typical service user group as *"undocumented migrants who often have been here for a long time and fear to get reported to the Home Office. So basically, they have been living under the radar, sometimes for decades, never seen a doctor."* [CW2] However, 25 service users said they had tried to access a GP and been refused because they did not have the right kind of ID document or proof of address at all. A few had paid privately for healthcare. For some, this was to solve a relatively simple health problem with a prescription; however, for others this was problematic (e.g., when follow-up to a diagnostic scan became prohibitively expensive, or a prescription given by the private doctor ran out). Two service users had a cancer diagnosis from private testing which needed follow-up within the NHS. A few spent a substantial amount of money on dental services and wanted to register with an NHS dentist. Thirty-one service users had been registered with a GP before. Some were still registered and attended DOTW UK for a different reason (e.g., accessing another service or dealing with NHS charges). However, most had lost their registration upon moving address. Some were deregistered from their previous practice when their visa expired or when they were considered as out of their catchment area; a few were not given a reason. Thirty-eight had already accessed secondary care in the UK. For most, this was relatively straightforward with their problem treated by A&E or the Walk-in centre where they were told that they needed to register with a GP. For some however, hospital treatment resulted in being billed for treatment under the NHS charging regulations, especially for accessing maternity care, with one service user reporting being threatened with being reported to the Home Office over unpaid fees.

## Access to healthcare with the help of DOTW UK

A substantial subset of service users experienced difficulties with accessing primary care or other services after their initial contact with DOTW UK and for some, accessing all the services they needed was a lengthy process. Caseworkers' notes also indicated how easy or difficult it was to help the service users to register with a GP. For most, this was straightforward as the case worker noted they had called one surgery which agreed to register the service user or that a GP had been found or agreed. Some service users also went to register themselves with the backup that they should get in touch if they encountered a problem. For 69 service users, access to health services was more difficult. Interventions commenced with the case worker trying to identify a GP surgery to register the service user, noting several attempts when surgery receptionists could not be reached, referred the question to another member of staff who was not in, or outright refused to register the service user. For about half of the 69 service users, difficulties did not end when a surgery was identified as they were refused when they turned up to register. In these cases, the case worker got in touch with the surgery, discussed the situation with the receptionist or the practice manager and reminded practice staff of NHS guidelines for registering people without personal ID. This sometimes resolved the situation, or the caseworker found a way to help the service user to produce the information required. However, in a few cases, the service user was again refused when they came back to register. Where it was impossible to register the service user the case worker either attempted to find another surgery or escalated the case to NHS England to ask them to contact the surgery and remind them of their responsibilities. This worked in most cases, but 5 service users were lost due to incomplete follow-up before they could be registered.

## Completing the questionnaires

Qualitative analysis of interviews with DOTW UK volunteers enabled us to shed light on the context in which the questionnaires were completed (as outlined above, the caseworker entered the data that arose from a conversation with the service user), as well as assess the questionnaires used to monitor wellbeing.

## Questioning around housing and safety

One important aspect of the character of the questionnaire was its multiple roles for DOTW UK services. For example, one of the main tasks for the caseworker completing the form is to find out whether the service users are safe in their accommodation, work, and social situation. Completion of the questionnaire enables identification of people who need a safeguarding plan and urgent referral to other organisations, but the line between unsafe and less than ideal accommodation or work circumstances is very blurry and volunteers could struggle with deciding whether to offer additional support and advice routes to service users in potentially exploitative situations. While the social form asks the service user to identify their accommodation as 'stable' or 'temporary', the free-text notes reveal the shades of grey between these two and also introduce 'safety' as an important part of the living conditions which is not easily captured as living with friends or family or at the service user's place of work can be stable or temporary, safe or unsafe in ways that might not be immediately apparent. One volunteer noted that the level of dependence that some women had on individuals who housed them could influence their perception of the options they might have to act against potential or actual abuse and exploitation, i.e., that service users may not be willing to act because they perceived they had few choices.

As outlined above, the added detail in the free-text notes could give an indication of the highly individual factors that could make a similar situation liveable or intolerable to the service user.

## Asking difficult questions

Volunteers also discussed the potential for questions on topics such as accommodation, earnings, or experiences of violence to become difficult, and the service user might not want to answer these, at least not immediately:

“Some people don't want to tell us what their living arrangements are, are they getting help from friends [...] sometimes you can get a feeling for how the conversation is going to go [...] I just sometimes say to people, if you don't want to tell me everything that I'm going to ask you that's entirely okay.” [CW2]

There was a recognition that their understanding of the importance of these questions were not necessarily that of the service users, and that they needed to look at these questions from a service user perspective, who often contacted DOTW UK with an immediate medical concern that they wanted support with resolving. Some of these individuals sought resolution without GP registration and could be sometimes deterred from using services when DOTW UK could not offer clinical services directly. Already disappointed not to be “treated” such individuals were particularly reluctant to answer all DOTW UK's social questions:

“So then you're already kind of changing what they asked for, because they didn't necessarily want to register with a GP, they wanted to see a doctor. And so, I find then that asking lots of questions can be a bit off putting for them.” [CW3]

Strategies to deal with this included focusing on the usefulness of the questions to give service users the help they needed, even if they were not directly linked to the problem they sought help for. While volunteers agreed that they attempt to ask all the questions as instructed in their training, they discussed challenges experienced on whether to probe when the service user did not answer or gave evasive answers, and when it would be useful to skip a question and then come back to it later. Both medical volunteers discussed the necessity to proceed carefully with difficult questions such as experiences of violence, and the importance of safety-netting and minimising risks of re-traumatisation.

“I ask them whether they had traumatic experiences and experienced violence either in their home country or during their journey. And then I leave it to them how far they want to talk about it. [...]” [MW1]

## Potential for misunderstandings

When asked about misunderstandings experienced when completing the questionnaires, volunteers mostly referred to language barriers and the use of interpreters. A range of issues were discussed including the interpreter's ability to understand a question and the possibility that the consultation turned into a conversation between service user and interpreter which did not really address the

questions. Strategies to deal to reduce misunderstandings included having to repeat the question: *"I don't know whether the service user misunderstood, the interpreter misunderstood or what happened. But then often I have to say again, yes, but my question was so and so."* [MW1] Some service users wanted to communicate in English although it was not their first language but discussing complex issues could be tricky with someone whose English competencies did not extend to medical terminology.

“I said to them, we can call you back with an interpreter, it's fine, it won't cost you anything [...] and they'll say, oh no, thank you I'm fine, I'm fine. Speaking in English. And I find that really difficult to navigate” [CW3]

## Flexibility of the form

From volunteers' description of the ways in which they interacted with the social form it became clear that it was used as a collaborative and flexible tool. Both medical volunteers and caseworkers said that they would have a look at the form to find out what was 'going on' with the service user. On the other hand, responding to notes completed by other volunteers in a way that *"made sense to them"* [CW3] could be tricky. Interviewees also discussed sometimes having to amend information as they found that information in notes did not always reflect the current situation of the service user: *"it's the social form and then just updating anything that changes, when I speak to them, because I see not everything is always accurate from the initial phone calls they've had or things change"* [CW1]

One reason for the need to make amendments could be that service users would give a more detailed and open account when their trust in the caseworker had developed: *"sometimes people might not really tell you the story at the beginning. And then, as they realise that you're a kind of trustworthy person. The story changes a bit the moment you speak to them"* [CW3]. A medical volunteer discussed the way service user's stories might change in their interaction with DOTW UK: *"It's always like this, that's what we have experienced in all our professional lives – the narrative changes when people start to think about it."* [MW2]. Such findings illustrate the complex nature of the volunteer role and the importance of time and trust.

In the interaction with the service users the form was used flexibly, with the aim of asking all the questions while giving the sense of having an informal chat, with the social form as *"a framework to guide the conversation"* [CW2]. The separate questions on immigration status, income and housing could undermine the conversational nature of the interaction that was so important to enable the development of trust: *"if you then ask somebody a question about their living circumstances and they've already told you they don't have anywhere to live, it sounds like you're not really listening to them"* [CW3]. Thus, volunteers might not ask a question when the service user had already provided the information in an earlier part of the conversation. While volunteers appreciated that having the structured way of collecting data would be valuable for advocacy, they also felt the free-text was valuable to counteract 'tick box' character of the social form:

“People's situations are so are so complex that I don't think you'd ever reduce it down into like a Social Form type thing. I think you need to have that kind of storytelling element. There is often a very specific situation. [...] It does kind of rely on the skill of the caseworker, or the volunteer staff, to tell the story.” [CW2]

## Use of the 'How is your health' question

The question asking service users to rate their general, physical and psychological health is an important part of the quantitative analysis. However, from the qualitative work it appeared that it could be difficult to ask this question of a service user who was facing multiple challenges. All three caseworkers who regularly asked this question as part of the social form found it problematic – one said that most service users did not feel that their health was good, but these responses might have been coloured by them wanting to see a GP. Another caseworker said they would ask 'how are you' and probe until they thought they had a good understanding of how the service user felt about their health. The third said that people would see their health in the context of the rest of their life and what they felt was normal for them – but that they found it difficult to differentiate between physical and mental health.

## Changes in DOTW UK working during the pandemic

All but one of the volunteers we interviewed mentioned the loss of nonverbal communication as DOTW UK moved to a telephone-based, remote service in March 2020. This was important as they often had a 'feel' of how the service user was coping and whether they should worry about them: *"here is a big chunk of information missing. So I'm - the main thing is then how is their voice, do they sound tearful, do they sound very flat?"* [MW1]. Another medical volunteer felt that eye contact was the most important part that was missing. Two volunteers believed that nonverbal communication was especially important in interpreted consultations which took a lot longer as the facial expression of the service user indicated whether they had understood.

A further issue mentioned by almost all volunteers interviewed was the difficulty of building trust in telephone interactions. In the clinic, service users could interact with case workers and other service users, be given a cup of tea and, if they had an immediate health need, know they would be 'seeing a doctor'. A caseworker could also ring GP practices with the service user there, and then give them a letter to take to the practice that agreed to register them. On the phone, it was much more difficult to develop rapport or even recognition especially if the case worker needed to ring them back several times: *"maybe they'll be talking to 10 other different organizations throughout the week so by the time they get a call back from us, they don't remember who is who and who is what."* [CW2] *"I'm just a person ringing up, going okay I'll help you and I could be anybody."* [CW3]. It was also much harder to reach service users on the phone as the caseworker's call would come up as 'number withheld'. Some volunteers also found that they found it harder to ask difficult questions, for example about mental health, on the phone: *"it's actually harder to ask it remotely [...] When you've got them in a room, you know, and you've established that sort of a rapport."* [MW2] Similarly, a caseworker said that service users were less open in answering difficult questions over the phone: *"people are reluctant to give us the full picture at the beginning, and I find that more so being remotely now than it was in the clinic."* [CW3]

The physical clinic was useful in other ways; for example, people could bring paper documents rather than just discussing them on the phone which would reduce misunderstandings. It was easier to ensure confidentiality when it was possible to take the service user into a room where they could have privacy away from an individual who had brought them to the clinic, whereas on the phone it was impossible to know whether the service user could be overheard:

“When we call them, they might be in a very busy place, and you can hear voices in the background. Or you can hear they're outside. Then you probably don't want to be asking these questions about safeguarding things when they're not in a very private space.” [CW2]

“I always ask before I start whether they are on their own in the room for privacy [...] you have to be careful, we try and check that there's nobody else in the room, so - you don't know who's with them, who else might be hearing or might be telling them what to say or leading what they can say, that's a big worry.” [CW1]

Another advantage of the clinic was more direct contact to other caseworkers or supervisors, for information or debriefing which could help with addressing the service user's problems but also provided support to volunteers who said they needed to talk with colleagues in order to safeguard their own psychological wellbeing.

Opinions on the pandemic's impact on accessibility of DOTW UK services were mixed. One volunteer said that they had reduced services, and another said that it had become more difficult as it was no longer possible to just drop into the clinic and the only way to contact them was the advice line. On the other hand, two volunteers also identified advantages. One found it easier to work from home than travel across London on public transport which enabled her to give more time to volunteer, and the other said that the service being remote had opened up accessibility:

**“We had [...] people ringing from all over the country on not only from London. And for those people who often have very little money it would have been very difficult to travel to Stratford to the practice. And back. And so I think that has opened up the service to many more people than before.” [MW1]**

Our qualitative work shows that the context in which the questionnaire has been developed and is being completed shapes the way in which wellbeing is being discussed and understood. This is not unique to this part of the work and can also be linked to the way in which the questionnaire content (and changes over time) has had an impact on the nature of the quantitative analyses, which can be constrained by question availability and/or content. Caseworkers noted the tensions between the different rationales for completing items of the questionnaire, which included to obtain information needed for DOTW UK caseworkers supporting the service user, to inform safeguarding, to identify needs that could be addressed by other organisations, to build a picture of the overall situation of the service users to feed into reports and advocacy. On the other hand, they felt that some service users were focused on their immediate aim (e.g., ‘to see a doctor’) and were sometimes puzzled by questions. The impact of the pandemic tended to increase this sense of distance as the caseworker as a person and the workings of the clinic could not be immediately experienced by the service users. The impact of the pandemic on wellbeing is what we turn to in the next section.

## Summary

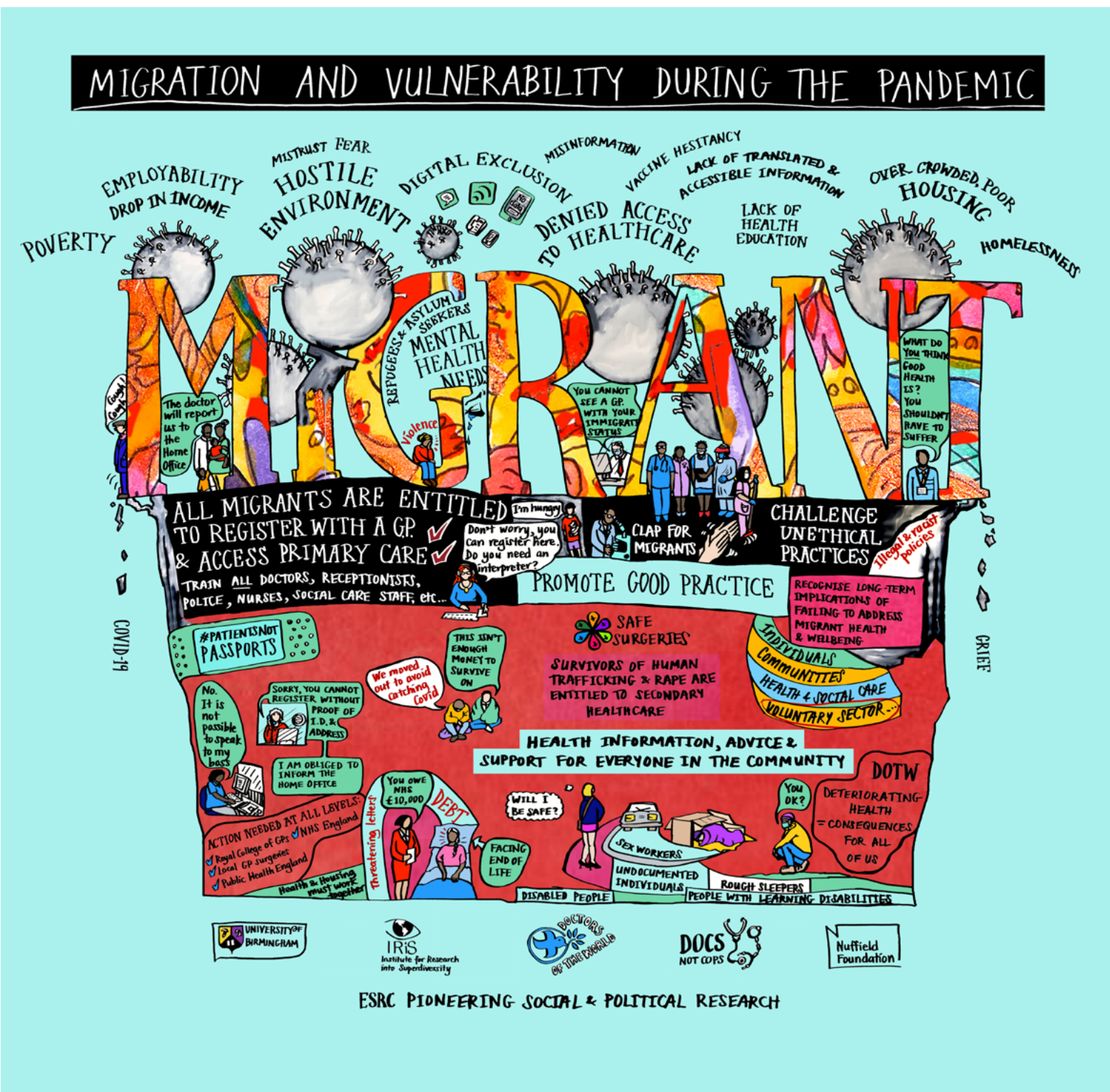
Overall, the findings highlighted here have looked in detail into the wellbeing of individuals at risk of vulnerability. Of particular importance is the situation of asylum seekers, especially when it comes to general and psychological wellbeing. The broadness of our understanding of wellbeing does provide a wide-ranging overview of the situation. Whereas the quantitative strand allows us to provide such a general overview, adding to the existing evidence base and confirming results from prior research, the foray into the consultation notes and interviews with DOTW UK volunteers brings more depth to our analysis. It allows the contextualisation of the wellbeing situation of the service users as well as the experiences of the volunteers undertaking the work. It highlights the wellbeing challenges that service users and volunteers alike have faced in the years covered by this dataset.

## Wellbeing during the pandemic

We now move on to the analysis of wellbeing during the pandemic. Results focusing on the experiences of migrants during the pandemic are mainly taken from published outputs: a publicly available report (Lessard-Phillips et al., 2021) and an open-access academic journal article (Fu et al., 2021). The illustration below (Figure 6) represents the presentation and discussion of preliminary findings of this strand of the work as part of the ESRC’s Festival of Social Science in November 2020.

We go further into these results by firstly summarising findings from the quantitative data. The level of service provided by DOTW UK during the pandemic was dramatically reduced due to a move to telephone-only consultations. This led, at least in the early months of the pandemic, to a sharp decrease in the number of individuals able to use the service (and to potential digital exclusion for people unable to use the service provided as a telephone consultation), more or less half the number of consultations compared to prior years. It may also have led to a change in the main characteristics of service users engaging with the service compared to earlier periods: a younger age profile, a much larger share of asylum seekers, and a high share of individuals in precarious economic and housing situations and without health coverage. In the case of housing, and in conjunction with the ICA work we have done, this is also likely linked to the increase in the number of people in ICA contacting DOTW UK for consultations. In terms of reasons for consultations, these remained relatively similar to the ones mentioned in the 2011-2018 project, with a high prevalence of the need for GP registration as an ongoing issue.

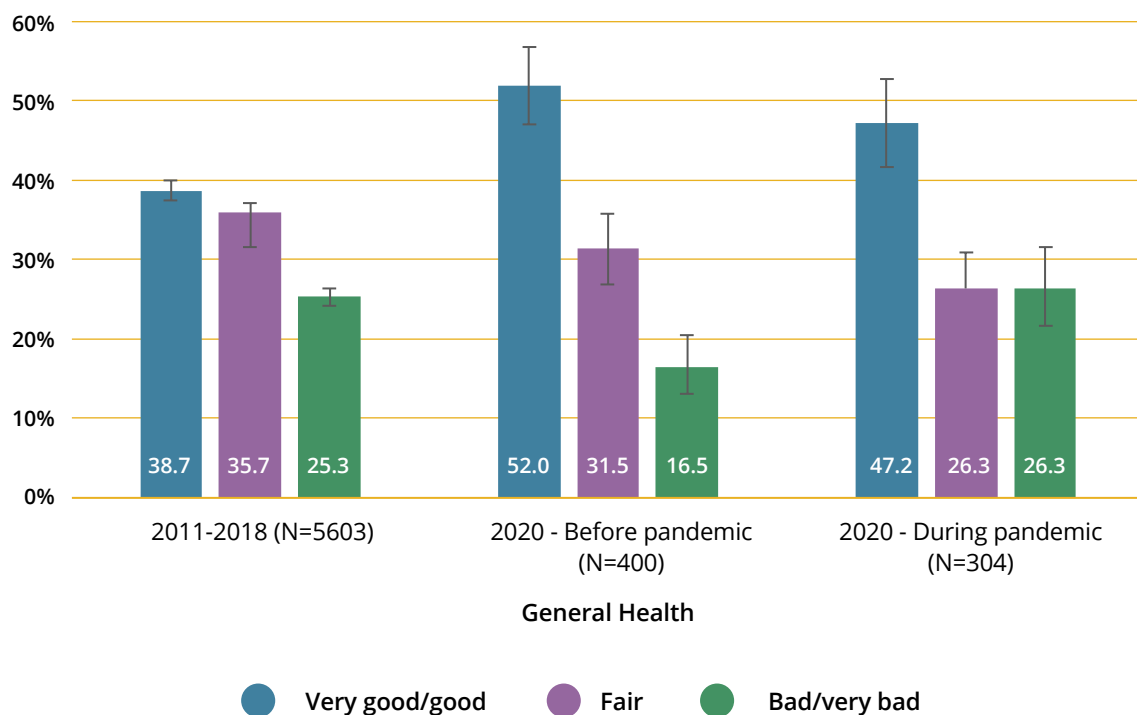
**Figure 6** Infographic representing the presentation & discussion of preliminary results in November 2020.



The analysis of wellbeing during the pandemic focuses on general and psychological/mental health as aspects of subjective wellbeing, the latter being measured differently than in previous years.<sup>9</sup> During the pandemic, 47.4% of service users reported having very good or good general health, 26.3% fair health, and 26.3% bad or very bad health. If we compare this with service users who had a consultation prior to the pandemic in 2020, there was an increase in the reporting of bad or very bad health. If we compare to the 2011-2018 figures, there was a higher share of service users reporting good or very good levels of general health, but there was no difference in the reporting of bad or very bad health (see Figure 7). The reporting of more negative health was again more salient among asylum seekers. Regarding psychological health, around 17% of service users reported feeling down, depressed, or hopeless more than half of the days or nearly every day and a slightly lower proportion reported having little interest in doing things more than half of the days or nearly every day. This is a picture that is consistent with the mental health of service users in the months prior to the pandemic. Finally, as per the situation prior to the pandemic, the important barriers to healthcare remained more or less the same, including knowledge of the system and administrative barriers, the latter including GP registration issues.

The examination of the consultation notes provided additional depth to our understanding of the situation during the pandemic. In terms of health status, the notes indicated that issues were similar to the main study, with a range of health issues from minor illnesses to more urgent or complex physical or mental health problems. A few had potential symptoms of COVID-19 or other related needs such as help with food during lockdown. A few felt isolated and lonely due to the pandemic; this was echoed by one of the volunteers we

**Figure 7** Health status of service users before/during the pandemic



<sup>9</sup> Using the Patient Health Questionnaire-2 (PHQ-2) about frequency of feeling down, depressed, or hopeless and having little interest or pleasure in doing things.

interviewed: *“those people, who are often very isolated, and so it has created more issues, and they’re sitting there on their own with the baggage of their previous experience.”* [MW1]

Regarding the health services required, a large proportion of service users wanted GP registration for a health concern or just in case. A few were pregnant and needed antenatal care, and some needed help with prescription payments and other NHS charges.

Just as in the main study, most service users were in safe accommodation with people they trusted; but some in more temporary or potentially exploitative situations. A few asylum seekers were in very temporary hotel accommodation, as we will see in the next section. Some service users were in formal work, but most were working cash in hand; some of these were affected by COVID-19 as work (e.g., in restaurants or as cleaners) dried up. The impact of the pandemic on people in already precarious circumstances was also discussed by the volunteers:

“People [are] just losing all their sources of income [...] and when people are living with friends, that kind of support network is very precarious. [...] So as soon as the pandemic hits, maybe the friends’ economic status might have changed and they’re not able to support people anymore.” [CW2]

“There was much more [to do] also for the support workers, to see that [service users] get food vouchers and things like this, because they had [...] more difficult access even to the basic needs, like food and accommodation and so on.” [MW1]

COVID-19 had most of an impact on barriers and facilitators to accessing health services as GP practices moved their registration processes online and it was difficult to talk to reception staff. One volunteer expressed a sense of frustration:

“we ask the service users to go to [practices] But [...] they’ll probably be like, oh no, our surgery doors are closed because of COVID-19 [...] so this person has to come in with a mask and they have to ring the bell which is kind of hidden underneath the undergrowth on the door, and they have to ring it and they have to open the door, and they have to hand in the envelope socially distanced and – I’m kind of exaggerating. But to someone who doesn’t know English who I’m trying to have a conversation with using an interpreter, it’s very, very difficult.” [CW2]

With this, and DOTW UK services also remote, technological problems could become very challenging (e.g., lost phone or unable to afford a phone at all; access to a computer/Wi-Fi to complete registration forms). According to the case notes, a few practices said they had stopped registering new patients due to COVID-19. It is important to note that most health concerns were resolved with GP registration and appointments with a GP, a midwife, or at the hospital. A few service users succeeded in getting crucial emergency care; however, others only needed support briefly (e.g., advice on how to register with a GP and encouragement to come back if they encountered difficulties). A few case notes ended with the service becoming uncontactable.

In conclusion, from the consultation notes, the profile and numbers of service users changed as DOTW UK shifted to a telephone service. There is clear evidence that service users’ financial and living conditions deteriorated in the early stages of the pandemic and it is also likely that some users were unable to make contact. The pandemic increased service users’ barriers to accessing healthcare thereby making the job of DOTW UK’s volunteers more difficult.

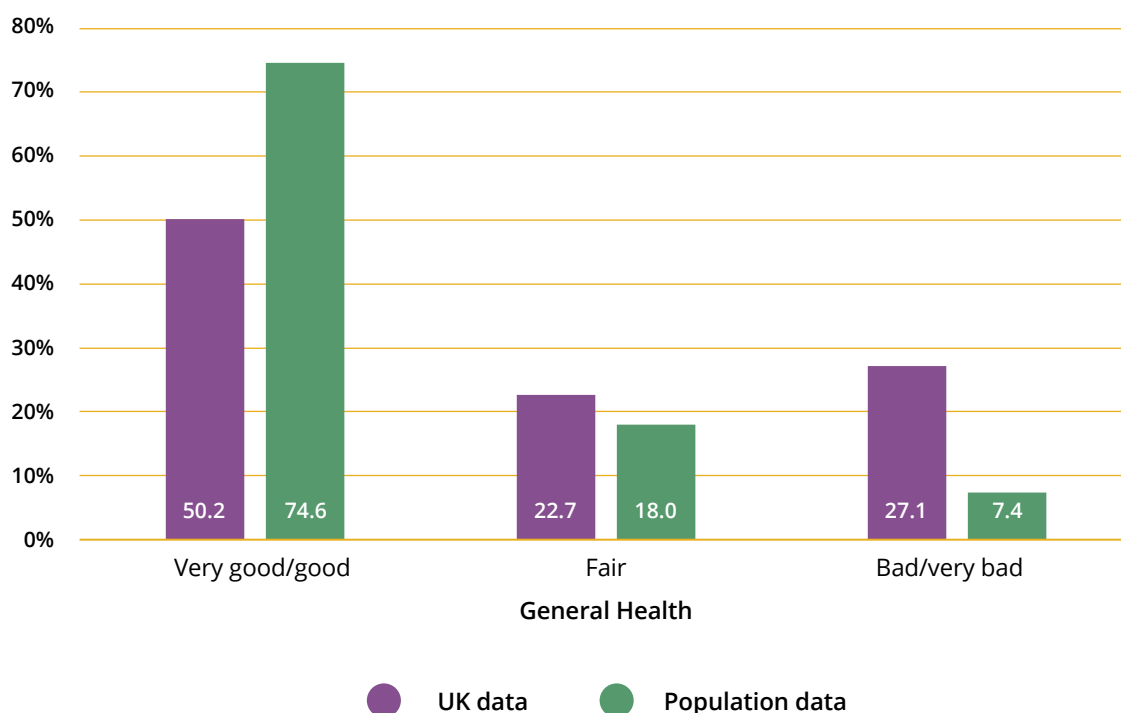
The work focusing on wellbeing during the pandemic reinforced the issues highlighted in the study of the data from 2011-2018. Even if the reported health status was more positive overall than in earlier years, the general trends remained, and a further examination of issues faced by service users emphasised the particular challenges faced during the pandemic, especially regarding access to primary care.

## Wellbeing of asylum seekers in Institutional and Contingency Accommodation (ICA)

We now turn to findings from data focusing on the specific situation of asylum seekers in ICA, which we covered in detail in a prior report (Jones et al., 2022). As mentioned, barracks and hotels have been increasingly used as temporary accommodation for asylum seekers, especially in the last couple of years. These are also expected to continue to be used as an avenue for accommodation in the foreseeable future with the Government planning to introduce accommodation centres as one of the provisions of the Nationality and Borders Act 2022 (Nationality and Borders Act 2022). The evidence provided by the existing literature on the link between health and housing conditions for asylum seekers highlights important issues but is based on a small sample of qualitative interviews. It covers the negative impact of unsuitable accommodation on health; how certain types of accommodation adversely affect mental health and the spread of diseases; and the struggles in accessing healthcare despite asylum seekers being entitled to free healthcare provision (see Jones et al., 2022 for details). Whilst most of the evidence focuses on more 'standard' type of accommodation, it does emphasise the importance of exploring the health and healthcare access of individuals<sup>10</sup> in ICA further.

Analyses from the data revealed that the health status of individuals in ICA tends to be relatively low, especially if we attempt to compare it with population-level data (see Figure 8) echoing our findings on the health status of service users reported above. General health status, however, only tells part of the story. Delving into the quantitative data a bit further, we can see that mental health was a major concern, with over a third of individuals residing in hotels having a mental health need. The consultation notes indicated that

**Figure 8** Reported health status among service users in ICA, with a comparison with population-level data



Sources: DOTW K data, NHS Digital

<sup>10</sup> Of which the overwhelming majority are classified as asylum seekers in the data (just under 95%).

some of those mental health needs could be quite complex, including issues such as suicidal tendencies, depression, and self-harm. There was also a prevalence of chronic and urgent conditions that required looking into by DOTW UK and the notes indicated that in quite a few instances, there was more than one health issue that needed addressing which could sometimes include a combination of physical and mental health issues. The need for consultations was linked to the need for help with GP registration (with just over a third of service users being registered with a GP at the time of consultation); help with completing the HC1 form for entitlement to help with healthcare costs; as well as help to access the dentist, counselling, and the optometrist. A further exploration of the notes indicated that help sought went beyond mere registration with a GP; it also included seeking information, for example, about obtaining prescriptions (few service users knew how to obtain one), accessing ante-natal care or health visitation or getting access to sanitary products.

The consultation notes allowed us to delve further into the impact of ICA on service users' mental and physical health. The issues mentioned included the food provided within ICA which was described as so poor that it was inedible or caused stomach problems and the length of time it took the hotel to get permission for special or medical diets leaving service users unable to eat for days; feeling fearful and unsafe; poor quality living conditions; low levels of help and support provided regarding access to medical treatment and medications including support to access Accident and Emergency in urgent situations; and the lack of distraction and isolation. Notably DOTW UK volunteers' role expanded beyond their usual remit of securing access to healthcare to trying to address the wider needs of service users clearly in considerable distress. They liaised extensively with charities, Migrant Help, the Home Office, the Local Authority, and hotel management to try to resolve service users' problems including trying to help service users to access schooling and housing. They worked with solicitors advocating for service users expressing suicidal ideation to be moved from ICA, providing medical evidence about the effect of ICA on the service users' condition.

As with results from the main project and the COVID-19 sub-project, barriers in accessing healthcare were present for individuals in ICA. Important barriers mentioned were lack of knowledge about the healthcare system, language barriers, and administrative barriers. For example, 83.1% of individuals with medications that needed prescription indicated that they did not know where to get their prescription. Knowledge about the financial support available for healthcare costs was also limited, which is illustrated by a low share of individuals in ICA having an HC2 certificate (26.7%). Moreover, a large proportion of service users stated that they would ask hotel staff for advice about healthcare, but case notes indicated that, quite often, hotel staff were reluctant to help with health-related issues. Language was also an important barrier, with 52.5% of service users in hotel accommodation stating that they had no access to COVID-19 information in their own language. Even when some of the barriers were removed, such as being registered with a GP, the notes show that issues with access to healthcare were present. This was especially linked to knowledge and communication barriers, but also regarding digital exclusion, including access to phones, to data and to a mobile phone signal.

The analysis of the data from service users in ICA shows that this type of accommodation appears to present major concerns for the health status of its residents and access to healthcare. There are a broad range of relatively unmet health and housing needs, and some evidence that the nature of accommodation generated additional health problems or exacerbated existing conditions. This evidence needs to be taken into consideration, especially if such a provision is to continue in the future.



## Conclusions and recommendations

**This report is the first to consider the wellbeing status of a large cohort of vulnerable migrants in the UK. We also highlight, through our interviews with volunteers, the challenges they face when seeking to collect social and medical information from vulnerable migrants who, in general, have low levels of trust in the healthcare system and are fearful of engaging with it. Yet the collection of this data is important because it enables analyses such as those undertaken for this project.**

The results generated by the project have highlighted the circumstances which migrants at risk of vulnerability have faced regarding their wellbeing in the years before and during the pandemic. We find specific challenges around poverty and housing, around levels of social support and being an asylum seeker or undocumented migrant, which are associated with mental and physical health problems. We use a multifaceted conceptualisation of wellbeing comprising material, relational, and subjective dimensions as well as the multiple barriers that exist for accessing healthcare. We show that vulnerable migrants faced particular challenges in the pandemic and when residing in initial and contingency accommodation. We highlight that the precariousness and contingent nature of ICA pose a serious threat to the physical and mental wellbeing, both exacerbating existing health problems and generating new ones. The work presented here has only scratched the surface in terms of what the data can help us understand regarding the wellbeing of migrants at risk of vulnerability.

Our report provides evidence for the importance of free healthcare for vulnerable migrants. We show how difficult it can be even for trained volunteers to facilitate GP registration and that DOTW UK's volunteers have had to assist thousands of migrants to access healthcare over many years. Given that thousands of asylum seekers are dispersed outside of London in places where DOTW UK are unable to offer a service, there is a strong possibility that many vulnerable migrants are not accessing the healthcare they need. In the next section, based on the results highlighted above, we make a series of recommendations.

### Recommendations

- All people resident in the UK, regardless of immigration status, should be registered with a GP.
- Information about access to healthcare should be clearly communicated to all migrants at risk of vulnerability, especially regarding:
  - Rights to access to services (including prescription medication); use of services and information; and
  - Having information provided in multiple languages.
- Further work is needed to ensure that GP surgeries are aware that they cannot refuse registration on the basis of an absence of documentation or immigration status.
- Asylum seekers should be automatically registered with a GP service on arrival in the UK on an opt-out basis.
- Asylum seekers should automatically be issued with a HC2 certificate that is valid for a minimum of 12 months.
- Information about access to healthcare should be issued to all asylum seekers, in their own language, when they submit their claim for asylum.
- Health providers, including GP surgeries, should account for variations in access to telephones and data when providing their services, offering alternatives to online provision for those vulnerable

groups unable to connect through digital mechanisms.

- Wi-Fi should be provided in asylum accommodation to enable individuals who can utilise digital services, to connect with them.
- ICA accommodation should be a last resort and short-term measure and individuals should be assessed before being transferred to ICA to identify whether such accommodation is likely to exacerbate existing health conditions.
- Asylum seekers resident in ICA should have automatic access to a GP arranged by the accommodation provider.
- Accommodation providers should be obliged to provide food that is nutritious and, where necessary, meets special dietary requirements.
- Provision must be made to assist asylum seekers residing in ICA to access emergency, secondary and ancillary health services as needed.

Given our findings, and building further on the above recommendations, we have, in consultation with DOTW UK, identified the following suggestions for specific public bodies:

### **NHS England (NHSE)**

- Introduce an accountability mechanism to ensure GP surgeries apply NHSE registration standards and discharge their duties in a non-discriminatory manner, in line with NHSE New Patient Registration Guidance.

### **Home Office**

- Mandate accommodation contractors to provide residents with direct assistance to register with a GP, access health screening and wider NHS services, and NHS orientation information including accessing a HC2 certificate.
- Ensure that this change is made by a variation to the Asylum Accommodation and Support Statement of Requirements and via the dissemination of clear guidance to all contracted providers and establish parity between the support available for arrivals across all variations of accommodation.

### **Quality Care Commission**

- Incorporate measures to ensure routine inspections of asylum accommodation to assess how accessible and responsive practices are to the health and health access needs of asylum seekers and make appropriate recommendations for improvement where necessary.

### **UK Government**

- Suspend the NHS charging regulations and introduce a firewall between health services and immigration enforcement.
- Ensure that the agenda to eradicate race and ethnic health inequality includes a focus on structural, policy and practice led drivers of inequality. Enable space to document and reflect on the experiences of communities impacted by language barriers, the NHS charging regulations and associated data sharing implications and GP registration refusal, making appropriate system wide recommendations.
- In the event of a future public health crisis such as the COVID-19 pandemic, anticipate and respond to the emerging needs of communities who experience routine healthcare exclusion and/or whose socio-economic circumstances increase their risk of adverse outcome. Produce responsive, accessible, and regularly updated public health resources in a variety of languages to mitigate disproportionate impact.

### **Office for Health Improvement and Disparities and UK Health Security Agency**

- Develop and implement a comprehensive community engagement plan to monitor and respond to the harms of the NHS charging regulations and other systemic drivers of health inequality in order to rebuild trust within impacted communities and ensure public health and health promotion.

- Look beyond policies which dis-incentivise the uptake of screening and treatment for infectious diseases and take a system-wide approach to improve engagement in wider health services including access to primary care, immunisations, and routine screening services to proactively address health inequality.

### COVID Enquiry

- Ensure that the scope of the enquiry includes the experiences of migrants and people with insecure immigration status and how their immigration status and experience of the immigration system impacted their health and wellbeing during the pandemic.

## Next steps for understanding vulnerability, migration, and wellbeing

The collection of data about vulnerable migrants' access to healthcare and the health problems they face is essential. Such data enables analyses which can evidence structural and systematic barriers to healthcare and the ways in which certain policies and practices directly impact on individuals' wellbeing which would otherwise be invisible. Yet data is needed regarding the population of vulnerable migrants in general and in particular in relation to specific cohorts of migrants such as those living in ICA. Unfortunately, there is a dearth of data around vulnerable migrants' health and a clear need for a mechanism to collect such information that goes beyond DOTW UK's work in London.

While ensuring that the immigration status of individuals accessing healthcare is recorded could potentially yield some useful data from the NHS, our work has indicated that this is likely to omit those individuals most likely to be excluded from healthcare. Additionally, there are concerns that such data could be used for immigration enforcement purposes which would further discourage migrants from accessing healthcare. Should NHS England decide to collect such data, a firewall between the NHS and immigration enforcement would be essential. Consideration is needed around how to collect data about healthcare access and experiences of vulnerable migrants unwilling or unable to access the NHS, outside of DOTW UK's services. DOTW UK have considerable experience of collecting such data. Their social and medical questionnaires, or shortened versions of these, could be utilised by other organisations working with vulnerable migrants. Such an initiative would require additional funding for organisations, as completion of forms takes time, and the provision of training.

Finally, funding provision is required to ensure that data collected can be combined and analysed. This project has demonstrated what is possible in terms of analysis, but investment is needed into the analytical capability of NGOs such as DOTW UK to ensure ongoing monitoring of the health access and experiences of vulnerable migrants.

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# Appendices

## Appendix A: questions over time

**Table A1** Questions in the DOTW UK forms, 2011-2018, 2020

	Year								
	2011	2012	2013	2014	2015	2016	2017	2018	2020
Administrative information (present in social & medical forms)									
User id	●	●	●	●	●	●	●	●	●
Date of consultation (+ first year of consultation)	●	●	●	●	●	●	●	●	●
Sex	●	●	●	●	●	●	●	●	●
Date of birth	●	●	●	●	●	●	●	●	●
Age	●	●	●						●
Person unaccompanied minor					●	●	●	●	
Use of interpreter	●	●	●	●	●	●	●	●	●
Language of interpreter	●	●	●	●	●	●	●	●	●
Borough of residence/First part of postcode (2011-2013)	●	●	●	●	●	●	●	●	●
Have children in need of care	●	●							
Reason for coming to clinic	●	●	●	●	●	●	●	●	
How heard about service	●	●	●						
Social questionnaire									
Living conditions									
Type of accommodation	●	●	●	●	●	●	●	●	●
Stability of accommodation	●	●	●	●	●	●	●	●	
Accommodation: impact on health (+ reason as write in)	●	●	●	●	●	●	●	●	
Children: have any	●	●	●	●	●	●	●	●	●
Children: live with person			●	●	●	●	●	●	●
Children: how many			●	●	●	●			●
Children: where live if not with person			●	●					●
General health	●	●	●	●	●	●	●	●	●
Physical health			●	●	●	●	●	●	
Psychological health			●	●	●	●	●	●	
Little interest or pleasure in doing things									●
Feeling down, depressed or hopeless									●
Rely on someone for support	●	●	●	●	●	●	●	●	

Activities and resources									
Job/activity status	●	●	●	●	●	●	●	●	●
Support others with income	●	●	●	●					
Current income sufficient for daily life	●	●							
Average amount of money to live in past 3 months above poverty			●	●	●	●	●	●	●
Administrative/Immigration situation									
Nationality (+ country)	●	●	●	●	●	●	●	●	●
Ethnic group	●	●	●	●	●	●	●	●	
Date began living in UK						●			
Date of last entry in UK	●	●	●	●	●	●	●	●	
Length of residence (days & years)	●	●	●	●	●	●	●	●	●
Immigration status	●	●	●	●	●	●	●	●	●
Permit/visa end date (if applicable)	●	●	●	●	●	●	●	●	
Asylum: have (or plan to) claim	●	●	●	●	●	●	●	●	
Potential asylum claimants: current situation	●	●	●	●	●	●	●	●	
Travel documents when entered UK	●	●	●	●					
Agent brought R into UK	●	●	●						
Undocumented: limit movement for fear of being arrested	●	●	●	●	●	●	●	●	
Health reason for leaving country							●	●	
Reason for leaving country	●	●	●	●	●	●	●	●	
Health cover and obstacles to accessing healthcare									
Chargeable healthcare costs	●	●	●	●	●	●	●	●	●
Registered with GP	●	●	●	●					
GP: have ever tried register	●	●	●	●					
GP: ever been registered	●	●	●	●	●	●			
GP: how long without				●	●				
GP: ever tried registered with friends/family GP (+ info)	●	●	●	●	●				
GP registration: have proof of ID	●	●	●	●	●	●	●	●	
GP registration: have proof of address	●	●	●	●	●	●	●	●	
Not registered: accessed other services?	●	●	●	●					
Problems in accessing healthcare and healthcare services: last 12 months	●	●	●	●	●	●	●	●	●
Denied access to healthcare in past 12 months	●	●	●	●	●	●	●	●	
Given up seeking treatment in past 12 months	●	●	●	●	●	●	●	●	
Victim of racism by healthcare provider	●	●	●	●	●	●	●	●	



Relevant medical history					●	●		●	●
Children: vaccination history	●	●	●	●	●	●	●	●	●
Children vaccinated today							●	●	●
Children: parent informed about vaccination requirements	●	●							
Children: know how/where to access vaccinations				●	●	●	●	●	●
Medical examination									
Details of treatment (usual or ongoing)	●	●	●	●	●	●	●	●	●
Blood pressure	●	●	●	●	●	●	●	●	●
Pulse	●	●	●	●	●	●	●	●	●
Weight	●	●	●	●	●	●	●	●	●
Height	●	●	●	●	●	●	●	●	●
BMI	●	●	●	●	●	●	●	●	●
Preventative questions									
Discussed HIV HBC HCV TB							●	●	●
Tests: Hep C (including results + date)	●	●	●	●	●	●	●	●	●
Tests: Hep b (including results + date)	●	●	●	●	●	●	●	●	●
Tests: HIV (including results + date)	●	●	●	●	●	●	●	●	●
Tests: Tuberculosis (including results + date)	●	●	●	●	●				●
Serology and tuberculosis: wants tests			●	●	●	●	●	●	
Serology and tuberculosis: knows where to get tested			●	●	●	●	●	●	
Prescribed treatment (details)	●	●	●	●	●	●	●	●	●
Exam: Blood glucose level					●				
Exam: Respiratory rate									
Exam: Body temperature					●				
Health problem flag					●				
Work puts health at risk	●	●	●						
Date of the last smear test									●
Experiences of violence (detail + when occurred + further details)	●	●	●	●	●	●	●	●	●
Health problem/result of consultation: diagnosis required	●	●	●	●	●	●	●	●	●
Diagnoses: in words	●	●	●	●	●	●	●	●	●
Diagnoses: ICPC code	●	●	●	●	●	●	●	●	●
Diagnoses: waiting for diagnosis							●	●	●
Diagnoses: acute or chronic	●	●	●	●	●	●	●	●	
Chronic diagnosis: treatment/follow-up needed	●	●	●	●	●	●	●	●	
Treatment necessary: was there follow-up or under treatment?	●	●	●	●	●	●	●	●	

Accessed care before									●	●
Medicines accessed before									●	●
Health problem: prior knowledge	●	●	●	●	●	●	●	●	●	●
Health problem should have been treated earlier				●	●	●	●	●	●	●
Urgency of case	●	●	●	●	●	●	●	●	●	●
Need for close follow-up	●	●	●	●	●	●	●	●	●	●
Referral details	●	●	●	●	●	●	●	●	●	●
Have been vaccinated against Tetanus										●
Have been vaccinated against Hepatitis B										●
Have been vaccinated against Measles, Mumps and Rubella										●
Have been vaccinated against whooping cough										●
Have been vaccinated against Polio										●
If yes, are there any children currently at risk?										●
if yes, and a migrant, was this violence one of the reasons you came to the UK?										●
what actions have been taken today?										●
Hotels questionnaire										
How long have you lived in the UK										●
Are you currently registered with a GP?										●
Have you had any healthcare since arriving in the UK?										●
Where do you go if you or your family member feel unwell?										●
How many times have you moved since you claimed asylum?										●
Where do you get information about accessing healthcare?										●
If you or a family member has needed hospital treatment since you claimed asylum can you describe the process?										●
Do you take medication?										●
Do you know how to get your next prescription?										●
Do you have HC2 cert?										●
Do you receive S95 support?										●
Have you accessed Covid-19 support in your language?										●
Do you identify as having a mental health need?										●

Notes: The table indicates whether the questions are covered in the years, but there may have been a change across years in terms of response categories, question wording, or question placement. Not all questions present in the forms are in the datasets in 2011 and 2012.

## Appendix B: Regression tables

**Table B1 Regression results full sample, selected average marginal effects**

		Subjective wellbeing			Relational wellbeing	Material wellbeing
		General	Physical	Psychological		
Immigration status (ref: other)	Undocumented	-0.085***	-0.092***	-0.050***	-0.050***	-0.053***
	Asylum seeker	-0.152***	-0.149***	-0.196***	-0.076***	-0.127***
Accommodation situation		0.091***	0.081***	0.129***	0.139***	0.052***
Age		-0.005**	-0.004	-0.005*	-0.006***	0.000
Age squared		0.000	0.000	0.000	0.000**	0.000
Male		-0.043***	-0.045***	-0.001	-0.034***	-0.048***
Years since arrival		-0.002	-0.002	-0.005***	0.002*	0.002
Sample size		7710	5504	5416	7172	5012

Source: DOTW UK data, research team's analyses.

Notes: Models also include controls for year of consultation and location of residence. Average marginal effects presented. Not all outcomes cover the full date range of the data because of variable availability. General subjective wellbeing and relational wellbeing cover the 2011-2018 period whilst the other outcomes cover the 2013-2018 period. Full regression results available from the authors.

**Table B2 Regression results, undocumented migrants, selected average marginal effects**

		Subjective wellbeing			Relational wellbeing	Material wellbeing
Undocumented		General	Physical	Psychological		
Accommodation situation		0.092***	0.085***	0.143***	0.145***	0.050***
Age		-0.009***	-0.008*	-0.009**	-0.002	0.002
Age squared		0.000	0.000	0.000**	0.000	0.000
Male		-0.033**	-0.041**	0.004	-0.036**	-0.047***
Sample size		5032	3703	3650	4686	3390

Source: DOTW UK data, research team's analyses.

Notes: Models also include controls for year of consultation and location of residence. Average marginal effects presented. Not all outcomes cover the full date range of the data because of variable availability. General subjective wellbeing and relational wellbeing cover the 2011-2018 period whilst the other outcomes cover the 2013-2018 period. Full regression results available from the authors.

**Table B3 Regression results, asylum seekers, selected average marginal effects**

		Subjective wellbeing			Relational wellbeing	Material wellbeing
Asylum seekers		General	Physical	Psychological		
Accommodation situation		0.078***	0.042**	0.091***	0.138***	0.020
Age		-0.01	-0.01	0.005	0.004	-0.005
Age squared		0.000	0.000	0.000	0.000	0.000
Male		-0.051	-0.062	-0.007	-0.028	-0.106***
Years since arrival		0.003	0.001	-0.005	0.002	0.008***
Sample size		1025	642	626	945	445

Source: DOTW UK data, research team's analyses.

Notes: Models also include controls for year of consultation and location of residence. Average marginal effects presented. Not all outcomes cover the full date range of the data because of variable availability. General subjective wellbeing and relational wellbeing cover the 2011-2018 period whilst the other outcomes cover the 2013-2018 period. Full regression results available from the authors.

**Table B4** Regression results, other migrants, selected average marginal effects

Other migrants	Subjective wellbeing			Relational wellbeing	Material wellbeing
	General	Physical	Psychological		
Accommodation situation	0.091***	0.086***	0.120***	0.116***	0.074***
Age	0.000	0.002	-0.005	-0.015***	0.000
Age squared	-0.000**	-0.000**	0.000	0.000***	0.000
Male	-0.065***	-0.031	0.003	-0.035	-0.058**
Years since arrival	-0.012***	-0.014***	-0.008***	-0.003	-0.003
Sample size	1639	1138	1121	1524	993

Source: DOTW UK data, research team's analyses.

Notes: Models also include controls for year of consultation and location of residence. Average marginal effects presented. Not all outcomes cover the full date range of the data because of variable availability. General subjective wellbeing and relational wellbeing cover the 2011-2018 period whilst the other outcomes cover the 2013-2018 period. Full regression results available from the authors.

**Table B5** Regression results, selected average marginal effects, additional analyses looking at access and material wellbeing

		Subjective wellbeing					
		General		Physical		Psychological	
Immigration status (ref: other)	Undocumented	-0.088***	-0.084***	-0.095***	-0.092***	-0.053***	-0.049***
	Asylum seeker	-0.149***	-0.135***	-0.150***	-0.144***	-0.205***	-0.199***
Denied access		-0.068***	-0.071***	-0.095***	-0.100***	-0.083***	-0.082***
Lives under poverty threshold			-0.149***		-0.136***		-0.160***
Accommodation situation		0.090***	0.085***	0.081***	0.070***	0.126***	0.114***
Age		-0.005**	0.000	-0.005*	-0.002	-0.006**	-0.003
Age squared		0.000	-0.000**	0.000	0.000	0.000	0.000
Male		-0.044***	-0.02	-0.049***	-0.030**	-0.006	0.012
Years since arrival		-0.002*	-0.004***	-0.001	-0.002	-0.004***	-0.005***
Sample size		7332	4803	5324	4777	5239	4717

Source: DOTW UK data, research team's analyses.

Notes: Models also include controls for year of consultation and location of residence. Average marginal effects presented. Not all outcomes cover the full date range of the data because of variable availability. General subjective wellbeing and relational wellbeing cover the 2011-2018 period whilst the other outcomes cover the 2013-2018 period. Full regression results available from the authors.



The report is hosted here: <https://www.nuffieldfoundation.org/project/vulnerability-migration-and-wellbeing>

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