

ADAPTING SOCIAL PRESCRIBING TO MEET THE NEEDS OF MIGRANT POPULATIONS: CHALLENGES AND SOLUTIONS TO SERVICE ACCESS AND EFFICACY

Blerina Kellezi*, Juliet Wakefield*, Mhairi Bowe*,
Kay Bridger* and Kirsty Teague*

Experiences of international migrants in host countries are very diverse. However, many migrants face cumulative challenges to their health and wellbeing which can be best supported by health initiatives aiming to a) address needs derived from socio-political context where they live and b) increase meaningful connection with community. This paper discussed the value and challenges of using one such health initiative to support the needs of vulnerable migration populations: 'Social Prescribing'. Data was collected from two roundtables with forty participants from organisations working with migrants in the UK and those with lived experience of migration and analysed using thematic analysis. Several challenges to accessing health support were identified including issues around acceptability, appropriateness, and quality of care. Participants emphasised the importance of holistic and culturally appropriate approaches which address health needs while recognising legal, economic and other challenges migrants face. To successfully implement initiatives such as Social Prescribing, there needs to be flexibility, shared understanding between service users and providers, community buy-in, attention to safeguarding and direct involvement of migrants in their development and implementation.

Keywords: Migration, health access, social prescribing, participatory research, co-production of services.

1. Introduction

A migrant is defined as any person outside of their state of origin/nationality. There are an estimated 272 million international migrants around the world (3.5% of the world's population), and numbers continue to grow (United Nations [UN], 2020). Migrants are seen as homogeneous, although motivations and migration experiences can be very varied. For example, a considerable proportion (79.5 million, or nearly 1% of the world's population) are forcibly displaced people, including over 26 million refugees, and 4.2 million asylum seekers (UNHCR, 2020a). A refugee is defined as a person who has fled their home country due to fear of persecution and serious human rights violation, and whose government is either unwilling or unable to protect them, leading to them applying to be granted refugee status or international protection in a different country (Goodwin-Gill & McAdam, 2007). Some migrants are asylum seekers: these individuals have made a formal application to be recognised as refugees but have not yet been granted that status (Amnesty International, 2020). Other groups of migrants include those who have been forcibly trafficked for sexual or labour exploitations (International Labour Organization [ILO], 2016), and those who work under temporary and exploitative conditions (Adams & Prassl, 2018). Although a high proportion of international migrants are documented, many remain undocumented, meaning that they do not have valid documents to reside in the host country (Cuadra, 2012), although some would qualify for refugee status, while others have had their application for asylum refused. In addition, many temporary migrants are

* School of Social Sciences, Nottingham Trent University, UK

often employed for seasonal work which is substantially reduced in winter months (Culp & Umbarger, 2004).

Immigration is also an important subject in the UK: data from December 2019 show that 14% of the population (9.5 million) were born outside the country (UNHCR, 2020b). The number of undocumented migrants in the UK is estimated to be between 800,000 and 1.2 million (Connor & Passel, 2019), a significant proportion of whom are still waiting for their asylum cases to be decided.

2. Positive experiences of migrants

Many migrants have very positive experiences while living in their host country, especially those who can live with family members, access education, develop careers, and participate in community, political, religious, cultural, and social life. Migrants can bring many positive and lasting contributions to host countries. Examples include benefiting the local labour market (e.g., filling important job positions in fast growing and declining sectors of the economy), making higher contributions to taxes and social life than they receive in benefits/welfare support, and contributing to economic growth through providing their skills and boosting working-age populations (Organisation for Economic Co-operation and Development [OCDE], 2014). Migrants also benefit host country health services: international migrants are less likely to use health services than local populations (Steventon & Bardsley, 2011), yet they contribute substantially to the healthcare workforce. For example, 20% of all healthcare workers in the UK, including 30% of doctors (when locums are included), and 31% of agency cover staff for nursing; Kings Fund, 2021 are migrants.

3. Negative experiences of migrants

Despite these many positive experiences and contributions, migrants can face multiple life changes, such as loss of family support/networks in their country of origin, as well as the stress of having to adapt to the host country, which in many cases will involve a new culture, way of living, language, and climate. There is variation across the different categories of migrant in terms of the extent to which individuals can adapt and overcome such challenges. For example, those with higher skills, better networks in the host country, and those who chose to migrate (rather than being forced to) tend to adapt better (Bhugra, 2004). The fact that successful adaptation is common amongst migrants is testament to their resilience and emotional strength. However, it is also the case that migrants' feelings of resilience and positivity can decline, as research investigating the 'migrants' health paradox' indicates. For example, while migrant populations often report better health outcomes than local populations, this difference tends to narrow over time (Luthra et al., 2020).

The socio-economic status is also an important predictor of health outcomes and engagements with health services (Sundquist, 2001). Thus, structural inequalities deriving from poverty, racism and discrimination can affect differently the diverse groups of migrants, which requires different community and healthcare strategies to address the diverse needs (Bhopal, 1997; Pemberton et al., 2019). It is therefore important to consider what may cause health-related problems and vulnerabilities in migrants and how can the challenges be overcome. The present paper explores one such issue: the systematic social barriers that can prevent migrants from obtaining high-quality healthcare and being satisfied with the care they receive and ways these barriers can be overcome.

3.1. Systematic barriers faced by migrants

The systematic barriers faced by migrants in their host countries, as well as the potential health-related impacts of these barriers, can be numerous. For instance, as migrants arrive and settle in the host country, they need to gain new employment, education, and accommodation, and learn to comply with new legal and health systems. However, they are often met with hostility (McGinnity & Gijsberts, 2016), and are frequently portrayed as a threat to the native populations' heterogeneity, security, and economic stability; a trend which increases with nationalist movements (Larsen, Krumov, Van Le, Ommundsen & Van der Veer, 2009). Conflict and distress experienced when adapting to a new language/culture, as well as stigma and racism can lead to confusion, alienation, loneliness (Bhugra & Avonrindé, 2004; Kellezi, Bowe, Wakefield, McNamara & Bosworth, 2019a) and poor wellbeing (Herbert, 2016). Such challenges can be particularly pronounced for those who have experienced forced migration, which itself is often motivated by war, violence, and persecution (Herbert, 2016). These issues, combined with the upheaval to a new country and loss of group-level connection and resources (e.g., family, community) (Smit & Rugunan, 2015) can lead to socio-economic disadvantage (Jennissen, 2004), health inequalities (Malmusi et al., 2010), and identity disruption and threat (Timotijevic & Breakwell, 2000).

While the perceived socio-economic threat of migration to the host population is well documented (McLaren, 2003), migrants' experiences of threat following acts of discrimination and hostility directed towards them, as well as implications of this hostility for their health and wellbeing, are poorly understood. For example, immigration detention can lead migrants to disengage from formal help-seeking and health services (Kellezi & Bosworth, 2017). The same research also shows that one way to overcome this distress and isolation is through building shared connections with those who are going through the same experience (i.e. fellow detainees), as predicted by Social Cure research (Kellezi et al., 2019a).

Thus, migrants undertake active and strategic efforts to cope with long-term uncertainty and distress, and to build social connections in challenging conditions (Kellezi et al., 2019a). There is evidence that migrants' mental health is enhanced when they are able to psychologically adjust to their new environment over a period of months or years, and especially when they are able to build strong group connections within their new country (Dolberg et al., 2016). Such findings support the idea that health should not just be understood as simply 'absence of disease'. Health is vital for achieving human wellbeing, is interconnected with other human rights (Mann, 1996), and it involves addressing social needs such as sense of belonging and connection. Once health is defined in these terms, the potential benefits that holistically-focused initiatives such as Social Prescribing (SP) could provide to the migrant population start to become clear.

4. Social Prescribing

Social Prescribing (SP) is a non-clinical model of health service delivery. It aims to address the social, emotional, and practical needs of service users, which cannot be met by existing health services (Kellezi et al., 2019b), through linking vulnerable and at-risk individuals to local community support (Kimberlee, 2016). It focusses on service users whose clinical treatment for diagnosed chronic psychological and physical illness (e.g., depression, anxiety, type 2 diabetes, etc.) can be complemented by engaging in treatment of a social and/or community nature which aim to address the challenges deriving from social-political stressors such as loneliness and discrimination, or that can be overcome through social connections, support and empowerment (Bowe et al., 2020; Wakefield et al., 2020).

The central premise of SP is that individuals' wellbeing would improve if we could tackle the key social predictors of ill-health, such as loneliness, alienation and isolation, which at present remain outside of regular healthcare provision (Hawkley & Cacioppo, 2010). This need to address social issues is reflected in SP initiatives in several countries. For example, NHS England has commitment to investment and roll out of SP across England (NHS England, 2019).

SP has a strong social element: it involves health professionals (e.g. Link Workers) encouraging service users to join social activities and groups situated in the voluntary and community sector (Kimberlee et al., 2016). Link Workers (LWs) are involved in both identifying community groups that suit those participating in SP and supporting them in joining and attending these groups (NHS England, 2019). The better the LWs' knowledge of the networks within their community, the more they are able to match individual needs to community provisions (NHS England, 2019, South et al., 2008). The community support is delivered through a number of different voluntary and community-based organisations, but common examples include social or lunch clubs, befriending groups, walking groups, gardening groups, and arts, cultural and crafts groups. In this way, SP bridges the gap between primary healthcare and the community sector, providing service users and vulnerable community members with opportunities for greater social integration and more personal support that is tailored to their individual needs (South et al., 2008). However, it should be noted that SP initiatives in general do not aim to draw on community resources to address wider issues of social injustice or discrimination.

There is growing evidence that SP can provide service users with numerous health- and wellbeing-related benefits, such as improved quality of life and increased satisfaction with their healthcare (e.g., Bertotti & Frostick, 2017), as well as reductions in loneliness (e.g., Mann et al., 2017) and anxiety (e.g., Palmer et al., 2017). SP has also been linked with other psychologically beneficial outcomes via the voluntary opportunities it offers. This is because SP programmes often not only involve connecting individuals with community groups, but also encouraging them to eventually volunteer for those community groups (Kings Fund, 2017). This is beneficial as volunteering is known to improve community belonging, sense of community support, and health and wellbeing (Bowe et al., 2020; Thoits & Hewitt, 2001; Van Willigen, 2000), as well as helping to increase the sustainability of community groups (Lee, 2017).

Initial evidence of volunteer-led SP models has shown approaches that empower community members to volunteer have health benefits for both the volunteer and the community (Halder, et al., 2018). These findings have led to some authorities creating 'Volunteering by Prescription' programmes. These are particularly useful for vulnerable populations who may experience health inequalities. For example, volunteering has been shown to improve outcomes for disadvantaged and hard to reach populations (including migrant communities and refugees) in terms of enhancing confidence, self-esteem, wellbeing, employment opportunities (Bashir et al., 2013), and community belonging (Carlton, 2015).

Recent research (Kellezi et al., 2019b; Wakefield, et al., 2020) has applied a specific theoretical framework in order to evaluate SP initiatives: The Social Cure approach (Stevenson et al., 2019). The Social Cure approach posits that people's social group memberships (e.g., their family, friends, community, fellow refugees, etc.) have the potential to enhance their health and wellbeing, but only if they feel a sense of belonging to (or *identification* with) the group in question (Haslam et al., 2018). Group identification is then argued to predict enhanced health and wellbeing via numerous psychological processes, such as reducing group members' feelings of loneliness, and encouraging them to believe that they will receive support from their fellow group members during times of stress (Haslam et al., 2018). Since SP interventions focus on encouraging service users to join social groups, the Social Cure approach is an ideal

theoretical perspective from which to understand and evaluate SP (Kellezi et al., 2019b; Wakefield, et al., 2020).

Research has evidenced the applicability of the Social Cure approach to understanding the pathways through which SP exerts its benefits, as well as the general health-related benefits offered by increasing community belonging through building service users' membership with community groups. For instance, research has shown that the increase in number of group memberships service users experienced during their engagement with an SP programme predicted reductions in primary healthcare use, and that this relationship occurred via increases in participants' feelings of community belonging and reductions in loneliness (Kellezi et al., 2019b). This increase in group memberships also predicted improvements in participants' health-related quality of life, and this relationship was explained by increased feelings of community belonging and social support, and reductions in feelings of loneliness (Wakefield, et al., 2020). These studies thus do not simply highlight the SP intervention's efficacy (i.e., by reducing primary care use and increasing health-related quality of life): they also shed light on the centrality of the social context in which these benefits occur.

While evidence for how SP works to benefit service users health is growing, it has also become clear that care should be taken before applying SP to groups such as vulnerable migrants. Such groups can face unique challenges in accessing and engaging with current health services, which must be considered by SP providers. For example, undocumented migrants fear that accessing health services could have implications for their legal status (by making the authorities aware of their presence and/or by impacting negatively on their immigration status; Kellezi, Wakefield, Bowe, Stevenson & McNamara, 2021). Moreover, migrants' experiences of loneliness and distress, which SP addresses, are often defined by multiple losses, transitions, and stressors, and any migrant-focused SP initiative would have to address these complexities.

These challenges notwithstanding, SP initiatives have the potential to address important issues faced by migrants, such as allowing them to harness support at the social/community level in order to psychological symptoms caused by social factors (such as loneliness and alienation) (Summerfield, 2008). Thus, while there are challenges involved in delivering SP to migrant populations, there are also clear potential benefits, and the present paper explores both. The research focuses specifically on a) the challenges faced by migrants when attempting to access SP and related healthcare services, and b) when access has occurred, the potential benefits and challenges of using SP within migrant populations.

5. Methodology

5.1. Design

A co-production design was used to identify barriers and facilitators of health service access and satisfaction among migrants, and recommendations for using SP with migrant populations. A common criticism of healthcare intervention design and delivery is that these processes often fail to consider the opinions and lived experiences of the populations for whom the interventions are created, as well as the populations who deliver the interventions: an issue addressed in this instance by the use of co-production (Heron & Reason, 2006). As the name suggests, co-production involves asking all key stakeholders (providers of services, referrers, collaborating organisations, and commissioners of services), including members of the relevant group (i.e., migrants and those involved with migrant issues) to input into the intervention creation process. The importance of consulting people with relevant lived experience when designing services, as well as the need to include the diverse perspectives of key stakeholders

when evaluating services, is increasingly acknowledged in healthcare service delivery and research (National Institute for Health and Care Excellence [NICE], 2011; Rycroft-Malone et al., 2016). An additional value of co-production is the ability to hear opinions from stakeholders who provide a range of services, as this also enables issues of interservice communication and cooperation to be explored. Despite its advantages, the use of co-production is currently under-utilised, particularly in the field of mental health (New Economics Foundation, 2013).

5.2. *The coproduction event and its participants*

A free day-long event was held in December 2019 at Nottingham Trent University. The event was advertised widely to third sector and local authority organisations, as well as via contact networks of the event's organisers, which included the Civic Exchange Partnership at Nottingham Trent University. Forty participants attended, including members of charity organisations working with vulnerable migrants (refugees, asylum seekers, trafficked people, etc.), migrants working in these organisation with a range of lived experiences (around 25% of the total sample, which included refugees, asylum seekers, migrants separated from their families, migrants who migrated as professionals, and first and second generation migrants), SP Link Workers, academics interested in migration and SP (from different local universities), and Local Authority representatives. Representatives of different organisations ranged from CEOs to volunteer co-ordinators, support and outreach workers, and health professionals. These participants were all engaged in relevant projects operating within the UK (either locally to the event venue, or from further afield). As the attendees came from different types of services working with migrants, or were migrants themselves, their different opinions and suggestions were expected to help create a fuller picture of the challenges and opportunities involved in SP delivery within migrant populations.

In the morning, a range of presentations regarding SP and current evidence were provided to the whole audience (see Table 1 for more details). These presentations focused on the evaluation of two UK-based SP interventions conducted by the research team (Kellezi et al., 2019b; Wakefield, et al., 2020), research on the value of community volunteering on health and wellbeing (Bower et al., 2020), and research on the relationship between community belonging and loneliness (McNamara et al., 2021). In the afternoon, participants engaged in one of two simultaneous roundtable discussions. Local authority and charitable organisations who participated represented a range of foci, including refugee and asylum seekers, homeless people, community engagement issues, and the health needs of ethnic minorities. Detailed notes were taken by two research team members at each table, and the discussions were facilitated (with minimal input) by two other research team members. The main event organiser (the lead author) who also led one of the discussion groups is an international migrant herself, and the fourth author led the second group. Both facilitators were white women with extensive experience of working and researching access to services among vulnerable groups and traumatised populations. The discussions groups lasted around 120 minutes each.

5.3. *Materials*

Participants were invited to reflect on two topics during the roundtable discussions. The first topic related to the particular needs of the specific populations. Questions included: What are the main needs of migrant populations/migrant populations (including refugees, asylum seekers, undocumented migrants)? What needs are currently being met? Where are the biggest gaps in services? What are the reasons behind these gaps? The second topic related to when/how SP can be effective in addressing needs of these populations. Participants were asked to discuss the following: What do you think about applying SP to migrant population?

What are the challenges or barriers? What are the potential benefits? How can SP be effective with these populations? When can SP be effective with these populations.

Table 1. Summary of studies reported to participants

Study	SP Initiative Evaluated in Study	Target Population of SP Initiative	Activities Engaged in by SP Service Users	Study Findings
Kellezi et al., 2019	Let's Life Well In Rushcliffe	Chronically ill patients experiencing loneliness who lived in the local area	Goal-setting meetings with Health Coach; attendance of community group meetings/events	Increase in number of group memberships service users experienced predicted reductions in primary healthcare use, and this relationship occurred via increases in participants' feelings of community belonging and reductions in loneliness
Wakefield et al., 2020	Let's Life Well In Rushcliffe	Chronically ill patients experiencing loneliness who lived in the local area	Goal-setting meetings with Health Coach; attendance of community group meetings/events	Increase in group memberships service users experienced predicted improvements in health-related quality of life, and this relationship was explained by increased feelings of community belonging and social support, and reductions in feelings of loneliness
Bowe et al., 2020	N.A.	Study involved recruiting volunteers	N.A.	Number of hours of volunteering positively predicted volunteer wellbeing via increased community identification and perceived social support
McNamara et al., 2021	N.A.	Study involved recruiting community members	N.A.	Community identification predicted enhanced wellbeing via reduced loneliness, but not via increased social support

5.4. Analysis

Thematic analysis (Braun & Clarke, 2013) was used to identify common patterns and issues raised by the participants in the detailed notes taken during the two roundtable discussions. The analysis involved several steps. First, the first author became familiar with the data and coded the different sections of the data under specific categories (e.g., barriers to health access). The codes were used to identify the main patterns and issues discussed by the participants which would highlight common experiences identified by the participants, as well as the unique needs of specific groups or individuals. For example, the topic of health professionals needing to manage their expectations regarding migrants' engagement with SP was discussed by many participants, while the topic of migrants' potential misinterpretation of letters they receive from health professionals was only reported by one participant, but it nonetheless captured an important aspect of migrants' healthcare experiences. Next, the codes were organised under different themes which were worded to address the objectives of the present study: the challenges and benefits of SP provision for migrants. The first author conducted the initial coding of the data and all members of the team agreed on the final structure of the themes.

The analysis revealed that while participants identified issues that were specific to migrants, they also identified issues that related to health services in general (i.e., non-migrant specific issues). The analysis focuses on migrant specific issues raised. It is also important to note that the analysis does not focus on the experiences of individuals, because we wished to highlight patterns of similarity across migrant/stakeholder experience, thereby allowing us to draw conclusions and make recommendations that are likely to benefit a significant number of people. As the discussions were not audio-recorded, the quotes provided in the next section are taken from written notes taken during the discussions. All core issues identified in the two discussion groups are included in the following section, and a longer version of the analysis was distributed to all participants in the study who were invited to comment on the findings.

Table 2. Summary of themes and subthemes

Theme	Subthemes
A holistic approach to the health needs of migrant populations	Health needs strongly linked to other rights, and these need to be addressed holistically. Accounting for temporary of status and crisis points which can impact continuation of service provided and their effectiveness. Importance of safeguarding in community provision of support.
Barriers to health service access, satisfaction with healthcare and implications for SP	Lack of awareness or confusion about health rights from services users, service providers and supporting organisations. Informational, physical and practical access issues.
Unique Challenges for SP Delivery	Perceived appropriateness of service offered. Barriers to effective SP provision. Compatibility between the groups and service users.
Strategies to improve service access and migrant satisfaction with services	Meaningful participation of service users in service design, access and delivery. Increasing shared understanding and expectations.
Pathways to volunteering as an additional benefit of SP	Meaningful participation in community groups. The value of volunteering for individuals and community.

6. Results

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

Our participants argued that in the hierarchy of migrant needs, the ongoing process of applying for permission to remain in the host country for those who were undocumented or with temporary status tends to take precedence over all their other needs:

Before thinking about health, they have other needs. Often the situation is so desperate that they are thinking of housing, of safety, their immigration case, or where to get food.

The participants argued that if migrants are seeking asylum then it is their immigration status that is their major priority. This is also a practical issue, as many rights and services can only

be accessed once the legal right to remain in the host country (temporarily or permanently) has been granted. Another important part of the context of migration is that many migrants face unexpected or sudden challenges:

You need to be mindful of pressure points, crisis points. For example, even when the outcome is positive (refugee status granted), they might be required to change accommodation at short notice.

Thus, SP providers need to acknowledge the need for an intervention which is flexible enough to address the unique crisis points in some migrants' experiences. The exact nature of these crises will differ for different types of migrants: for instance, there will be different pressure points for asylum seekers (e.g., the complexity of applying for asylum, the stress of being made homeless, etc.) compared to victims of trafficking torture survivors (e.g., having one's post-traumatic stress triggered by a news story, or experiencing a flare-up of physical health problems caused by abuse). Issues around safety and security might thus be more relevant for some groups than others. The challenge for health intervention providers, including people who deliver SP, is to understand how support can be provided, sustained, and re-established for people who are going through unexpected changes or crisis.

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

For SP to be effective it needs to be fully accessible to migrants. There are several challenges faced by some groups of migrants in terms of being able to access healthcare that is non-discriminatory, physically accessible, affordable, culturally acceptable/appropriate, and of high quality.

In terms of accessibility issues, many new migrants (especially those who do not have a right to reside in the host country) are not aware of their health rights. Sometimes migrants have been erroneously told they must pay for services they are freely entitled to, or that they must show a certificate that exempts them from paying. Unsurprisingly, this makes some reluctant to access services. There is also confusion among health providers and community organisation around what services can be accessed and by whom, which can lead to reduced referrals, especially for those without resident status:

In our organisation (refugee and asylum seeker support) we may not refer someone to their GP if we know that person needs specialised secondary services. There is no point in referring if they can't get the specialist care.

Migrant organisations reported instances of GP practices being unwilling to register migrants as service users, or ambulance services questioning migrants' entitlement to receive NHS (National Health Service) healthcare. They also reported instances of GPs spending almost all of the 10-minute appointment trying to establish the migrant's rights to healthcare access, which makes the experience frustrating and ineffective for both parties, and leaves migrants feeling that service providers are engaging in a 'tick the right boxes exercise' rather than providing high-quality healthcare. Some migrants have even highlighted their unwillingness to express their needs to health providers at all, as they fear they will not be 'believed,' or will be accused of just 'acting up' to stay in the UK.

There are also issues with information accessibility due to language and cultural barriers. Interpreters may be needed to attend medical appointments with the migrant, but such services are often unavailable, or difficult to access. Migrants sometimes bring family or friends to help with interpreting, but this can make reporting of sensitive health issues more difficult.

Physical/practical accessibility can also be a concern, especially if health services cannot be accessed on foot, or parking charges are very high. Some migrants rely on limited financial support from the state while they have no right to work (e.g. asylum support is currently £35.37 per week; UK Government, 2020), and others may only find poorly paid jobs with limited contracts. Zero-hours contracts could also be an impediment to health service uptake, as such workers have limited control over times they work and when they can visit health services which require advance booking:

Some migrants have to work all hours to make ends meet so they cannot take time out during the day to attend appointments.

There are also reports that sometimes migrant populations delay accessing clinical services, and often only access these at the latest/most serious stage of illnesses. In sum, the large obstacles that stand in the way of many migrants accessing general healthcare means that it will also be very difficult for them to access SP initiatives. This is because I) most service users join SP initiatives after a GP referral, and II) engagement with SP initiatives also involves attending scheduled events, such as community group meetings, and some migrant groups would face the same challenges in attending these events as they do in attending regular healthcare appointments.

6.3. Unique challenges for SP delivery

An additional challenge for migrant-focused SP initiatives involves the fact that, like other community members, migrants will often be motivated to attend a GP appointment if they expect to receive medication which will help their chronic ailment. This could create confusion and unhappiness if the GP suggests SP rather than medication (especially if a language barriers prevents the reasoning behind this decision from being properly discussed):

When GP refers to a community group, the migrants might feel cheated and feel like they do not want to help them or don't take them seriously.

However, if the referral is arranged by a Link Worker, the migrant might benefit from the personalised approach, and have the opportunity to better understand the link between health needs and SP, which can lead to higher engagement.

Given the problematic language barriers faced by many migrants (especially those who have recently arrived in their host country), migrant organisations suggested the need for more investment in (and opportunities for migrants to attend) ESOL (English for Speakers of Other Languages) classes, or for SP initiatives to include interpreting services. However, it should be noted that the use of interpreters can bring its own challenges:

We had a case of an interpreter coming from the same community as the service user, and the service user was really worried about things being shared in their community.

There are also potential issues regarding appropriateness, safeguarding, and the values of the community groups to which SP initiatives refer service users. There needs to be careful consideration of the extent to which these groups are able to meet the needs of vulnerable individuals such as victims of trafficking, gender violence, and torture:

We have to be very careful because we have had clients who were victims of trafficking and such groups can become a place for grooming and trafficking. You need to know if

the group can deal with the risk and are regulated and have the skills to deal with the issues. (...) There needs to be a list of which organisations have the right regulations where you can refer.

Some migrants (including those referred to SP) have complex needs that require serious risk control. While it is very difficult to ensure that community groups are regulated, it is important to acknowledge that some types of vulnerable migrants should only be referred to groups that have the required level of skills and structures in place to support those with complex needs. While this is a relevant issue for all potentially vulnerable SP service users, part of the specific considerations around migrant safeguarding relates to the high prevalence of trauma within certain migrant groups. This means that the Link Workers and community groups to which these migrants are referred to, must have adequate knowledge of how to address trauma disclosures with sensitivity and appropriate signposting. Where possible, a regulatory system should be established in order to provide trauma training to SP referral organisation/groups, as well as to maintain a list of SP referral organisations/groups who have engaged in this training, so that health professionals can be confident in their referral choices.

Another challenge faced by community groups who have gained migrant SP service-users via healthcare referral is the need to strike a careful balance between helping migrants to experience a sense of belonging to the group (which can bring many benefits, such as reduced loneliness and improved wellbeing)) whilst also ensuring that the migrants do not become overly-dependent on the group (especially in situations where the migrant may be forced to relocate at short notice):

We have to be careful with our clients (homeless people) and make sure after a while they are able to look after themselves so that we do not encourage dependency.

In order to overcome potential dependency, the Link Workers can refer small groups of service users to other SP services when appropriate. However, the community groups often experience their own struggles due to lack of resources, which can severely limit how many SP service users they can take on:

Care must be taken to not refer too many cases to groups that are already struggling with funding. We have not been asked if we can take these referrals or how SP should work.

The community organisations raised serious concerns during the roundtable about the problems that could arise within their groups should there be a large influx of new users, as most groups rely on older users to provide support and manage the group's running. To be successful, SP thus requires buy-in from all agencies, and careful discussions on time, resources, and responsibilities must take place.

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

6.4.1. Increasing access

Strategies to increase access include better introduction of SP to migrants, and better understand among those delivering SP of migrant rights. Thus, GPs and other frontline referrers need to be informed on how to best advise migrant communities and those visiting their practices about what SP is, what it can achieve, and why they are being referred onto an SP programme. In addition, gatekeepers of frontline services should also understand migrant/asylum seeker rights.

Access can also be increased, especially among those who are not registered with GPs, by Link Workers (LW) getting involved with community directly (e.g., by visiting faith centres, schools, libraries, etc.). Community groups themselves could also provide information about other local groups, including ones which might be particularly relevant to migrants (e.g., conversational English groups).

Because some migrants are very hard to reach, every opportunity to advertise support services should be taken, like for example strategies aiming to "Make Every Contact Count (MECC)".

Service access and effectiveness could also be improved by increasing collaboration and communication between services. Organisations that work with migrants are well informed about (and very experienced in addressing) migrants' holistic needs, and they can become an important source of information for migrants, as well as a source of connection between migrants and health services.

As various discussants noted, it is also important to remove some of migrants' barriers to SP access caused by caring responsibilities:

When we have services users join our activities, we make sure that they have childcare support, otherwise they cannot attend.

6.4.2. Making SP more meaningful for migrants

The need for migrant co-production and representation was emphasised during the discussion. The discussants highlighted the need for migrants to be able to participate in the design and delivery of health interventions like SP. Moreover, they suggested that those with lived experiences of migration could be employed as Link Workers, and become champions/role models for SP. Many migrants were professionals in their home country and have expertise that could be put to good use through SP initiatives. Indeed, migrants' professional identities are often stripped from them after migration, so re-engaging with such skills and identities could bring value to both the community and the individual.

Participants also emphasised the importance of ensuring that services provide migrants with meaningful connection to others. Achieving this requires allocating enough time within SP programmes for building rapport and engaging in conversations that facilitate shared understanding. Additionally, migrants need to be made aware that some of the issues they face cannot be addressed during SP interventions (e.g., loss of family connections in their home country), but that SP still has the potential to facilitate significant improvements in their lives, such as wellbeing enhancement and loneliness reduction.

It is also essential to take a personalised approach to the needs of vulnerable migrants. Although legal concerns might be a priority for these individuals, addressing their social needs is also important, as doing so can enable and empower them to better address their economic and practical needs in both the short and long term.

6.5. Pathways to volunteering as an additional benefit of SP

Encouraging SP service users to eventually volunteer with the community groups which they have joined during the initiative is an important aspect of SP (Halder et al., 2018). Not only does it help to ensure the sustainability of the groups in question, it also allows the service-users to experience the numerous benefits of volunteering, such as wellbeing enhancement (Bowe et al., 2020). However: in order to avoid feelings of stress and the risk potential of drop-

out, it is important that migrants are not forced into volunteering positions before they are ready. Moreover, training and safeguarding needs must be carefully considered. The issue of trauma is also important here: for some, despite being willing to engage in volunteering, previous traumatic experiences can mean that full participation is difficult or impossible. Finances may be another issue: the ability to work for free is a luxury many of those migrants in poorly paid jobs simply cannot afford. This issue can be partially remedied by ensuring that volunteering roles provide the opportunity for skill development, which could help to enhance migrants' employment prospects:

We make sure in our organisation that we not just offer menial volunteering roles but that we use the many skills migrants bring with them and help them gain experience and further develop their skills.

7. Discussion

The roundtable participants provided in-depth examples of many potential obstacles which may prevent migrants becoming involved in SP, as well as ways in which these obstacles might be overcome. One of the key observations was that some migrant groups have specific health and wellbeing needs, as well as specific obstacles which may prevent them from meeting these needs. Without addressing these needs and putting plans in place in order to minimise health-related obstacles, SP interventions are unlikely to be effective at enhancing migrant wellbeing. For migrants who do agree to join SP, the nature of the intervention itself also has the potential to promote disengagement. SP is only likely to be effective in enhancing service users' wellbeing if it addresses their main everyday concerns, and since issues such as immigration status are often of primary concern to migrants, SP initiatives which cater for migrants will only be of limited use if they fail to include consideration of such issues. Indeed, this observation raises wider concerns about the extent to which general healthcare provides appropriately contextualised support to diverse populations (Kirmayer, 2012), and similar concerns have been voiced about the provision of healthcare in Immigration Removal Centres (Kellezi et al., 2021).

Our findings highlight a range of issues around service access. Referrals onto SP programmes tend to take place within GP surgeries, and there are numerous reasons why migrants may not access primary healthcare services, such as confusion about whether they are entitled to it, the responsibilities of work or childcare preventing them from keeping appointments, language issues, the belief that accessing healthcare can have a negative impact on their immigration application (Karl-Trummer et al., 2009; Holmes, 2012; Kellezi et al., 2021), and the belief that healthcare is inadequate because it does not address the socio-political causes of their illness (e.g., the discrimination and stigma surrounding their status as migrants, Kellezi et al., 2021). Existing research shows that migrants also often report feeling a lack of trust towards healthcare providers, and that their needs will not be taken seriously (Woodward et al., 2013). Migrants who do attend GP appointments sometimes mention how this sense of distrust negatively affects healthcare interactions (something which healthcare providers themselves have been shown to pick up on during interactions: (Kellezi et al., 2021; Castañeda, 2008; Nijhawan, 2005).

This distrust is partly informed by some migrants' concern that their medical data are being used to decide on their immigration status, which then leads to service disengagement (Kellezi & Bosworth, 2016; 2017; Kellezi et al., 2021). Perceptions of stigmatisation (a common experience for many migrants) can also fuel distrust, and thus hamper successful service engagement (Bowe et al., 2019; Stevenson et al., 2014). Although this can create complex and

fraught interactions between migrants and service providers, feelings of mutual trust can be enhanced by ensuring that migrants have a say in how healthcare services are designed and delivered (Peterson et al., 2019).

A greater awareness of migrants' rights to healthcare, both among healthcare providers and migrants themselves, will help to ensure that migrants get access to the health services to which they are entitled, as well as allowing communities to help support migrant residents, and reduce migrant-related misinformation. Future research should seek to explore other ways to overcome misunderstandings between practitioners and service users, and this research should involve hearing the voices of migrants and other vulnerable populations.

Even migrants who overcome these barriers and do attend GP surgeries are likely to experience obstacles to SP participation: again, language issues might prevent them from understanding what SP is, and why a GP might prescribe it instead of the medication or other health intervention they expected to receive. This could even make migrants feel misunderstood or ignored by people who are employed to support them, thus decreasing the likelihood of them seeking help in future. This again highlights the need for migrants to be involved in the design of healthcare provision (especially the design of SP interventions), so that potential misunderstandings can be minimised (Baker & Irving, 2016).

These numerous obstacles to SP engagement are especially troubling because SP has such great potential to benefit migrants' lives. The fact that SP involves addressing the social determinants of health by drawing on community resources means that it can address service users' needs in a more holistic and bespoke manner than the traditional medical model (Mays et al., 2020), and social factors (e.g., loneliness, alienation) are likely to play a particularly influential role in determining migrants' health. These positive effects of SP can be further enhanced if migrants eventually choose to volunteer for the community groups that they join through SP initiatives. This is because volunteering provides migrants with the opportunity to participate in community citizenship behaviours and is linked with the building of health-enhancing social capital, support, and trust (Pilkington et al., 2012). This sense of trust is a valuable collective resource that is capable of reducing feelings of threat and uncertainty (Siegrist et al., 2005), and volunteering programmes for hard-to-reach populations, including migrant communities, have been shown to increase people's feelings of trust in their local community (Bashir et al., 2013). Moreover, the sense of community belonging and shared community membership found to result from SP engagement (Wakefield, et al., 2019) is also helpful for enhancing feelings of trust and the belief that one will receive support from others during times of stress, which in turn benefits wellbeing (Jetten et al., 2012).

However, consideration should be given to the ability of existing community groups to deal with increased demands created by SP referrals, and it should not be up to community groups to address migrants' welfare needs, as these are the state's responsibility. Moreover, it should be noted that the process of community engagement must be two-way: while migrants are likely to benefit from joining and engaging with local community groups, it is also important that the local community exhibits feelings of acceptance towards migrants. Migrant-related stigma has been voiced within many communities (e.g., Hynie, 2018), and stigma awareness could lead to migrants becoming unwilling to engage with community resources (e.g., Stevenson et al., 2014).

8. Strengths and limitations

The present work's major strength is that it integrates the perspectives of multiple stakeholders, including people who work with migrants and people with lived experience of migration. However, it was the case that most of the migrants were also currently working with

migrant-related organisations, which may have affected their perspectives (e.g., their opinions may be coloured by the organisation for which they work). Participants also self-selected to attend the discussion by registering online, and the discussion itself took place in a university: both factors may have discouraged numerous migrants from attending. Future work should remedy this by recruiting a more diverse range of migrants, including migrants who do not belong to migrant-related organisations, migrants with a wider range of migration and health service use experiences (including those who refuse to access services and those who successfully engage with the services), and migrants from a wider range of host countries (including countries which have varying socio-political attitudes towards migrants). Moreover, future research should take place in a location that is fully accessible and appropriate to all.

9. Implications for practice and research

SP is a potentially useful way to meet the needs of migrants, especially because its delivery can be used to address social problems that migrants commonly experience (e.g., loneliness and alienation), and which can negatively impact upon their health. In doing so, SP offers one method for supporting migrant community members in line with several of Community Psychology's principles (e.g., the promotion of participation, community connection, well-being, and empowerment; Orford, 1992). As such it has the potential to complement existing participatory initiatives which also help address the challenges faced by these community members, such as peer support and peer mentoring (Paloma et al., 2020), community based-participatory action (Miranda et al., 2019), community volunteering and time-banking (Bashir et al., 2013; Timlon & Figueira, 2018), and collaborative community-based advocacy work (Rebelo et al., 2020) have all been shown to provide benefits to migrants. For example, in a study aimed at addressing powerlessness and vulnerability (Paloma et al., 2020), settled refugees were engaged as mentors for other refugees. Peer to peer support was first used to share migration narratives, then mentors progressed to offering peer mentoring to more recently arrived refugees. Over time, measures of mentor resilience and empowerment increased, and their transformative involvement in the refugee community continued after the intervention trial ended. Sourcing support workers within the migrant community itself satisfies the demand for significant investment in the community (Caxaj & Cohen, 2021). Fostering community empowerment in these ways may be particularly important where migrant groups have historically experienced inequalities of access to resources due to experiences of prejudice. In the case of the Roma in Spain (Miranda et al., 2019), a community based participatory action approach was used to gain an insider perspective on Roma perceived barriers to healthcare. The target population was consulted through a third party of university researchers which provided a buffer from any historical prejudices held by other stakeholders. Community based initiatives that follow these inclusive and respectful principles and methods are essential in building meaningful community bonds and social capital for migrants and their host communities (Esposito & Kellezi, 2020).

An important gap in the current literature that needs to be filled to enhance SP for these populations is a lack of knowledge regarding how vulnerable groups that experience loneliness/isolation feel about joining community groups. Although a fully-formed SP intervention involves service users being supported to join such groups, previous research evaluating SP initiatives shows that, for some service users, the high levels of anxiety they experience surrounding the activity of meeting new people and joining new groups can be prohibitive (Kellezi et al., 2019b). In such cases, focused goal-setting work in one-to-one sessions with a Link Worker might be more appropriate. This highlights the need to ensure that SP programmes are designed to be flexible, so that they can be adapted for service users'

specific needs and requirements, thus helping to maximise uptake and engagement. (Kellezi et al., 2019b).

Finally, the present study highlights how socio-political factors (e.g., stigma, discrimination, cultural differences, language barriers, concerns over immigration application status) affect migrants' access to healthcare, as well as their satisfaction with the care they receive. Future healthcare interventions (as well as the research which evaluates them) must therefore address these factors and consider how the obstacles they create to healthcare access and engagement might be overcome. Moreover, as SP interventions are not designed to address the structural inequalities and injustices within communities which are at the root of many of the challenges faced by migrants, healthcare providers and researchers must also consider how to help empower migrants in ways that might help them tackle these larger issues (e.g., through collective action). Ultimately, while SP interventions can help migrants to forge the connections, they need in order to enhance their health, it is only through fundamental social change that they can remedy the deeply-rooted problems that pose the largest challenge to their wellbeing.

References

- Adams, A., & Prassl, J. (2018). Zero-hours work in the United Kingdom. *Conditions of Work and Employment Series* (101). International Labour Organisation. https://www.ilo.org/travail/info/working/WCMS_624965/lang--en/index.htm
- Amnesty International (2020). Refugees, asylum seekers and migrants. <https://www.amnesty.org/en/what-we-do/refugees-asylum-seekers-and-migrants/>
- Baker, K., & Irving, A. (2016). Co-producing approaches to the management of dementia through social prescribing. *Social Policy & Administration*, 50(3), 379-397. <https://doi.org/10.1111/spol.12127>
- Bashir, N., Crisp, R., Dayson, C., & Gilbertson, J. (2013). *Final evaluation of the Volunteering for Stronger Communities programme*. Sheffield: Centre for Regional Economic and Social Research, Sheffield Hallam University. <https://www4.shu.ac.uk/research/cresr/final-evaluation-volunteering-stronger-communities-programme-pdf-951-kb>
- Bertotti, M., & Frostick, C. (2017). *The Social Prescribing service in London Borough of Waltham Forest final evaluation report*. Institute of Health and Human Development: University of East London. https://www.researchgate.net/publication/320280866_The_Social_Prescribing_service_in_the_London_Borough_of_Waltham_Forest_final_evaluation_report
- Bhugra, D. (2004). Migration and mental health. *Acta Psychiatrica Scandinavica*, 109(4), 243-258. <https://doi.org/10.1046/j.0001-690X.2003.00246.x>
- Bhugra, D., & Ayonrinde, O. (2004). Depression in migrants and ethnic minorities. *Advances in Psychiatric Treatment*, 10(1), 13-17. <https://doi.org/10.1192/apt.10.1.13>
- Bhopal, R. (1997). Is research into ethnicity and health racist, unsound, or important science?. *Bmj*, 314(7096), 1751. <https://doi.org/10.1136/bmj.314.7096.1751>
- Bowe, M., Gray, D., Stevenson, C., McNamara, N., Wakefield, J. R., Kellezi, B., ... & Costa, S. (2020). A Social Cure in the Community: A mixed-method exploration of the role of social identity in the experiences and well-being of community volunteers. *European Journal of Social Psychology*.
- Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. Sage.

-
- Castañeda, H. (2008). Paternity for sale: Anxieties over "demographic theft" and undocumented migrant reproduction in Germany. *Medical Anthropology Quarterly*, 22(4), 340e359. <https://doi.org/10.1111/aphw.12263>
- Carlton, S. (2015). Connecting, belonging: Volunteering, wellbeing and leadership among refugee youth. *International Journal of Disaster Risk Reduction*, 13, 342-349. <https://doi.org/10.1016/j.ijdr.2015.07.006>
- Caxaj, C. S., & Cohen, A. (2021). Emerging best practices for supporting temporary migrant farmworkers in Western Canada. *Health & Social Care in the Community*, 29(1), 250-258.
- Connor, P., & Passel, J. S. (2019) Europe's unauthorized immigrant population peaks in 2016, then levels off. <https://www.pewresearch.org/global/2019/11/13/europes-unauthorized-immigrant-population-peaks-in-2016-then-levels-off/>
- Cuadra, C. B. (2012). Right of access to health care for undocumented migrants in EU: a comparative study of national policies. *The European Journal of Public Health*, 22(2), 267-271. <https://doi.org/10.1093/eurpub/ckr049>
- Culp, K., & Umbarger, M. (2004). Seasonal and migrant agricultural workers: A neglected work force. *AAOHN Journal*, 52(9), 383-390. <https://doi.org/10.1177/216507990405200906>
- Dolberg, P., Shiovitz-Ezra, S., & Ayalon, L. (2016). Migration and changes in loneliness over a 4-year period: the case of older former Soviet Union immigrants in Israel. *European Journal of Ageing*, 13(4), 287-297. <https://doi.org/10.1007/s10433-016-0391-2>
- Esposito, F., & Kellezi, B. (2020) Border violence, migrant resistance, and acts of solidarity at individual, collective, and community levels: Critical reflections from a Community Psychology perspective. *Community Psychology in Global Perspective*, 6(1). <https://doi.org/10.1285/i24212113v6i1p1>
- Goodwin-Gill, G. S., & McAdam, J. (2007). *The refugee in international law*. Oxford University Press.
- International Labour Organisation (2016). Non-standard employment around the world: Understanding challenges, shaping prospects. https://www.ilo.org/wcmsp5/groups/public/-/dgreports/-/dcomm/-/publ/documents/publication/wcms_534326.pdf
- Halder, M. Stevenson; C., Kellezi, B., Wakefield, J., Bowe, M, McNamara, N., & Wilson. I. (2018). Evaluating the impact of Rushcliffe selfcare pathway. Nottingham Trent University
- Haslam, C., Jetten, J., Cruwys, T., Dingle, G., & Haslam, S.A. (2018). *The new psychology of health: Unlocking the social cure*. Routledge.
- Hawkey, L.C., & Cacioppo, J.T. (2010). Loneliness matters: A theoretical and empirical review of consequences and mechanisms. *Annals of Behavioral Medicine*, 40(2), 218-227. <https://doi.org/10.1007/s12160-010-9210-8>
- Herbert, J. (2016). *Negotiating boundaries in the city: Migration, ethnicity, and gender in Britain*. Routledge.
- Heron, J., & Reason, P. (2006). The practice of co-operative inquiry: Research 'with' rather than 'on' people. In P. Reason & H. Bradbury (Eds.), *Handbook of Action Research*, pp. 144-154. SAGE Publications.
- Holmes, S. M. (2012). The clinical gaze in the practice of migrant health: Mexican migrants in the United States. *Social Science & Medicine*, 74(6), 873-881. <https://doi.org/10.1016/j.socscimed.2011.06.067>
- Hynie, M. (2018). The social determinants of refugee mental health in the post-migration context: A critical review. *The Canadian Journal of Psychiatry*, 63(5), 297-303. <https://doi.org/10.1177/0706743717746666>
- Jennissen, R.P.W. (2004). *Macro-economic determinants of international migration in Europe*. Rozenberg Publishers.
-

-
- Jetten, J., Haslam, C., & Alexander, S. H. (Eds.). (2012). *The social cure: Identity, health and wellbeing*. Psychology press.
- Karl-Trummer, U., Metzler, B., & Novak-Zezula, S. (2009). Health care for undocumented migrants in the EU: concepts and cases. *Brussels: International Organisation for Migration*. http://c-hm.com/wp-content/uploads/2019/09/Health-Care-for-Undocumented-Migrants_Background-Paper6_Karl-Trummer-et-al.pdf
- Kellezi, B., & Bosworth, M. (2016). Mental health, suicidal thoughts and self-harm inside immigration detention. *University of Oxford and Nottingham Trent University, Forthcoming, Criminal Justice, Borders and Citizenship Research Paper, (2867358)*.
- Kellezi, B., & Bosworth, M. (2017). Mental health services inside immigration removal centres (access, perceived quality of health care and the ACDT process in IRC Morton Hall). Nottingham Trent University
- Kellezi, B., Bowe, M., Wakefield, J. R., McNamara, N., & Bosworth, M. (2019a). Understanding and coping with immigration detention: Social identity as cure and curse. *European Journal of Social Psychology, 49(2)*, 333-351.
- Kellezi, B., Wakefield, J. R. H., Stevenson, C., McNamara, N., Mair, E., Bowe, M., ... & Halder, M. M. (2019b). The social cure of social prescribing: a mixed-methods study on the benefits of social connectedness on quality and effectiveness of care provision. *BMJ open, 9(11)*, e033137.
- Kellezi, B., Wakefield, J., Bowe, M., Stevenson, C., & McNamara, N. (2021). Healthcare provision inside immigration removal centres: A social identity analysis of trust, legitimacy and disengagement. *Applied Psychology: Health and Well-Being*.
- Kimberlee, R. (2016). Gloucestershire clinical commissioning group social prescribing service: Evaluation report. <http://eprints.uwe.ac.uk/30293/3/Report%25406.pdf>
- Kings Fund. (2021) What do we know about the impact of immigration on the NHS? <https://www.kingsfund.org.uk/projects/verdict/what-do-we-know-about-impact-immigration-nhs>
- Kirmayer, L.J. (2012). Cultural competence and evidence-based practice in mental health: Epistemic communities and the politics of pluralism. *Social Science & Medicine, 75(2)*, 249-256. <https://doi.org/10.1016/j.socscimed.2012.03.018>
- Larsen, K.S., Krumov, K., Van Le, H., Ommundsen, R., & van der Veer, K. (2009). Threat perception and attitudes toward documented and undocumented immigrants in the United States: Framing the debate and conflict resolution. *European Journal of Social Sciences, 7(4)*, 115-134.
- Luthra, R., Nandi, A., & Benzeval, M. (2020). Unravelling the 'immigrant health paradox': ethnic maintenance, discrimination, and health behaviours of the foreign born and their children in England. *Journal of Ethnic and Migration Studies, 46(5)*, 980-1001. <https://doi.org/10.1080/1369183X.2018.1539287>
- Malmusi, D., Borrell, C., & Benach, J. (2010). Migration-related health inequalities: showing the complex interactions between gender, social class and place of origin. *Social Science & Medicine, 71(9)*, 1610-1619. <https://doi.org/10.1016/j.socscimed.2010.07.043>
- Mann, J. M. (1996). Health and human rights. *BMJ: British Medical Journal, 312(7036)*, 924-? <https://doi.org/10.1136/bmj.312.7036.924>
- Mann, F., Bone, J. K., Lloyd-Evans, B., Frerichs, J., Pinfold, V., Ma, R., ... & Johnson, S. (2017). A life less lonely: The state of the art in interventions to reduce loneliness in people with mental health problems. *Social Psychiatry and Psychiatric Epidemiology, 52(6)*, 627-638. <https://doi.org/10.1007/s00127-017-1392-y>

-
- Mays, A. M., Kim, S., Rosales, K., Au, T., & Rosen, S. (2020). The Leveraging Exercise to Age in Place (LEAP) study: Engaging older adults in community-based exercise classes to impact loneliness and social isolation. *The American Journal of Geriatric Psychiatry*. <https://doi.org/10.1016/j.jagp.2020.10.006>
- McGinnity, F., & Gijsberts, M. (2016). A threat in the air? Perceptions of group discrimination in the first years after migration: Comparing Polish migrants in Germany, the Netherlands, the UK and Ireland. *Ethnicities*, *16*(2), 290-315. <https://doi.org/10.1177/1468796815616154>
- McLaren, L. M. (2003). Anti-immigrant prejudice in Europe: Contact, threat perception, and preferences for the exclusion of migrants. *Social Forces*, *81*(3), 909-936. <https://doi.org/10.1353/sof.2003.0038>
- McNamara, N., Stevenson, C., Costa, S., Bowe, M., Wakefield, J., Kellezi, B., ... & Mair, E. (2021). Community identification, social support, and loneliness: The benefits of social identification for personal well-being. *British Journal of Social Psychology*.
- National Institute for Health and Care Excellence. (2011). *Service user experience in adult mental health: Improving the experience of care for people using adult NHS mental health services. NICE guidelines [CG136]*. <https://www.nice.org.uk/guidance/cg136>
- New Economics Foundation. (2013). *Co-production in mental health: A literature review*. https://neweconomics.org/uploads/files/ca0975b7cd88125c3e_ywm6bp311.pdf
- Nijhawan, M. (2005). Deportability, medicine, and the law. *Anthropology & Medicine*, *12*(3), 271-285. <https://doi.org/10.1080/13648470500291436>
- NHS England. (2020). Making every contact count. <https://www.makeeverycontactcount.co.uk/>
- NHS England. (2020). *Long term plan*. <https://www.england.nhs.uk/wp-content/uploads/2019/01/universal-personalised-care.pdf>
- NHS England. (2019). Social prescribing and community-based support: Summary guide. <https://www.england.nhs.uk/publication/social-prescribing-and-community-based-support-summary-guide/>
- Organisation for Economic Co-operation and Development [OCDE]. (2014). *Is migration good for the economy?* <https://www.oecd.org/migration/OECD%20Migration%20Policy%20Debates%20Numero%202.pdf>
- Orford, J. (1992). *Community psychology: Theory and practice*. John Wiley & Sons.
- Palmer, D., Wheeler, J., Hendrix, E., Sango, P., & Hatzidimitriadou, E. (2017). "When I am out with her (befriender) I feel so good mentally and all my physical pains go unnoticed." *Social prescribing in Bexley: pilot evaluation report*. Canterbury Christ Church University.
- Peterson, P., Ali, S., Kenneh, A., & Wakefield, A. (2019). Community engagement with refugee-background communities around health: the experience of the Group of 11. *Australian Journal of Primary Health*, *25*(2), 113-117. <https://doi.org/10.1071/PY18139>
- Pemberton, S., Phillimore, J., Bradby, H., Padilla, B., Lopes, J., Samerski, S., & Humphris, R. (2019). Access to healthcare in superdiverse neighbourhoods. *Health & Place*, *55*, 128-135. <https://doi.org/10.1016/j.healthplace.2018.12.003>
- Pilkington, P.D., Windsor, T.D., & Crisp, D.A. (2012). Volunteering and subjective wellbeing in midlife and older adults: The role of supportive social networks. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, *67*(2), 249-260. <https://doi.org/10.1093/geronb/gbr154>
- Rebelo, D., Abdullah, A., & Hussein, M. (2020). Solidarity with refugees in Portugal: A collaborative research. *Community Psychology in Global Perspective*, *6*(1), 36-51. <https://doi.org/10.1285/i24212113v6i1p36>
-

-
- Rycroft-Malone, J., Burton, C. R., Bucknall, T., Graham, I. D., Hutchinson, A. M., & Stacey, D. (2016). Collaboration and co-production of knowledge in healthcare: Opportunities and challenges. *International Journal of Health Policy and Management*, 5(4), 221. <https://doi.org/10.15171/ijhpm.2016.08>
- Siegrist, M., Gutscher, H., & Earle, T. C. (2005). Perception of risk: the influence of general trust, and general confidence. *Journal of Risk Research*, 8(2), 145-156. <https://doi.org/10.1080/1366987032000105315>
- Smit, R., & Rugunanan, P. (2015). Transnational forced migration and negotiating emotional wellbeing: The case of women refugees in South Africa. *Social Dynamics*, 41(1), 184-203. <https://doi.org/10.1080/02533952.2015.1029749>
- Stevenson, C., McNamara, N., & Muldoon, O. (2014). Stigmatised identity and service usage in disadvantaged communities: Residents', community workers' and service providers' perspectives. *Journal of Community & Applied Social Psychology*, 24(6), 453-466. <https://doi.org/10.1002/casp.2184>
- Stevenson, C., Wilson, I., McNamara, N., Wakefield, J., Kellezi, B., & Bowe, M. (2020). Social prescribing: A practice in need of a theory. *British Journal of General Practice*.
- Steventon, A. & Bardsley, M. (2011). Use of secondary care in England by international immigrants, *Journal of Health Services Research & Policy*, 16(2), 90-94. <https://doi.org/10.1258/jhsrp.2010.010097>
- South, J., Higgins, T.J., Woodall, J., & White, S.M. (2008). Can social prescribing provide the missing link? *Primary Health Care Research & Development*, 9(4), 310-318. <https://doi.org/10.1017/S146342360800087X>
- Summerfield, D. (2008). How scientifically valid is the knowledge base of global mental health? *Bmj*, 336(7651), 992-994. <https://doi.org/10.1136/bmj.39513.441030.AD>
- Sundquist, J. (2001). Migration, equality and access to health care services. *Journal of Epidemiology & Community Health*, 55(10). <http://dx.doi.org/10.1136/jech.55.10.691>
- Timotijevic, L., & Breakwell, G.M. (2000). Migration and threat to identity. *Journal of Community & Applied Social Psychology*, 10(5), 355-372. [https://doi.org/10.1002/1099-1298\(200009/10\)10:5<355::AID-CASP594>3.0.CO;2-Y](https://doi.org/10.1002/1099-1298(200009/10)10:5<355::AID-CASP594>3.0.CO;2-Y)
- Thoits, P.A., & Hewitt, L. N. (2001). Volunteer work and wellbeing. *Journal of Health and Social Behavior*, 42(2); 115-131. <https://doi.org/10.2307/3090173>
- United Nations. (2020). *World migration Report 2020*. https://www.un.org/sites/un2.un.org/files/wmr_2020.pdf
- UNHCR. (2020a). Data on forced displacement populations. <https://www.unhcr.org/uk/figures-at-a-glance.html>
- UNHCR. (2020b). Does the UK have more asylum-seekers than most countries? <https://www.unhcr.org/uk/asylum-in-the-uk.html#:~:text=How%20many%20refugees%20are%20there,are%20hosted%20by%20developing%20countries.>
- Van Willigen, M. (2000). Differential benefits of volunteering across the life course. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, 55(5), S308-S318. <https://doi.org/10.1093/geronb/55.5.S308>
- Wakefield, J. R., Bowe, M., Kellezi, B., McNamara, N., & Stevenson, C. (2019). When groups help and when groups harm: Origins, developments, and future directions of the “Social Cure” perspective of group dynamics. *Social and Personality Psychology Compass*, 13(3), e12440.
- Wakefield, J. R. H., Kellezi, B., Stevenson, C., McNamara, N., Bowe, M., Wilson, I., ... & Mair, E. (2020). Social Prescribing as ‘Social Cure’: A longitudinal study of the health

benefits of social connectedness within a Social Prescribing pathway. *Journal of Health Psychology*, 1359105320944991.

Woodward, A., Howard, N., & Wolffers, I. (2013). Health and access to care for undocumented migrants living in the European Union: a scoping review. *Health Policy and Planning*, 29(7), 818-830. <https://doi.org/10.1093/heapol/czt061>