Portfolio 1: Major Research Project

The Impact of Hotel Accommodation on the Mental Health of Asylum Seekers in the UK

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Submitted to the University of Hertfordshire in partial fulfilment of the requirement of the degree of

Doctor of Clinical Psychology

June 2024

Word Count: 29,955

Acknowledgements

I am immensely grateful to the participants who generously and courageously shared their stories with me. Without you, this research would not have been possible. Thank you for your time, ideas, and zeal to improve housing for asylum seekers.

To the Helen Bamber Foundation, my sincere thanks for your partnership, support, and for providing invaluable data and access to participants. I would like to give a special thank you to the remarkable housing team for making time for this project despite your high workloads.

To my incredibly erudite supervisory team, Dr Hannah Wright and Dr Kemi Komolafe, your knowledge, kindness, and encouragement were manna that sustained me through the wilderness of writing this thesis. Thank you for inspiring me through what you do and who you are.

To my parents, thank you for your unwavering support throughout the years. Your love is the anchor for which I will always be grateful.

To Will and Bertie, thank you for forgiving me for my constant moaning during the years of this doctorate. You have sustained me through rough seas, and I look forward to sailing through calmer waters together.

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Glossary

Asylum seeker- a person who makes a claim to be recognised as a refugee under the Refugee Convention.

Collective accommodation- accommodation that is shared by multiple occupants from different families.

Contingency accommodation- a type of accommodation provided by the Home Office for asylum seekers that is usually hotels. Contingency accommodation functions as a temporary way of filling gaps in provision of initial accommodation or dispersal accommodation.

Dispersal accommodation- a type of accommodation provided by the Home Office for asylum seekers that is usually self-catered flats and house shares. Asylum seekers are normally moved to dispersal accommodation after a short stay in initial accommodation.

Initial accommodation- a type of accommodation provided by the Home Office for asylum seekers that is usually fully-catered hostel style, lasts for three to four weeks, and is designed to house asylum seekers after they first submit their asylum application.

Institutional accommodation- government-provided collective accommodation for asylum seekers in which asylum seekers live while they wait for their asylum claim to be processed.

Private accommodation- accommodation that is solely for a single person or one family.

Refugee- a person whose asylum application has been approved so that he or she is officially recognised as a refugee.

Abstract

In a global context of war and instability, more asylum seekers are seeking refuge in the UK. Due to backlogs in processing asylum applications, the Home Office is increasingly housing asylum seekers long-term in accommodation that was intended to be short-term, including hotels. A systematic literature review found that asylum seekers are subjected to poor living conditions, which adversely impact their mental health due to a lack of autonomy, feeling unsafe, and lack of support. Building on these findings, this study aimed to understand the impact of a specific type of accommodation, hotels, on asylum seekers' mental health. The sequential explanatory mixed methods design involved quantitative data drawn from 147 asylum seekers' mental health screening questionnaires and qualitative data drawn from interviews with 16 asylum-seeking participants who lived in hotels. The study found that hotels negatively impact asylum seekers' mental health, with asylum seekers living in hotels experiencing higher levels of housing problems, psychological distress, and depression compared to asylum seekers living in alternative housing. Reflexive thematic analysis of interview transcripts revealed three themes to explain why hotel accommodation negatively impacts asylum seekers' mental health: lack of safety, lack of autonomy, and social isolation. Participants' survival strategies and ideas for changing the housing system were also explored.

Asylum seekers reported that hotel accommodation both caused and exacerbated mental health difficulties, raising important policy recommendations, including reducing asylum seekers' time in hotels, increasing flow through the asylum system, and prioritizing vulnerable asylum seekers for community housing. Clinical implications include the importance of assessing the impact of housing on mental health, considering hotel

accommodation as a risk factor for self-harm and suicidal ideation, and referring asylum seekers to community groups and religious organisations, as these connections were identified as survival strategies.

1. Introduction

1.1 Overview of Introduction

This research explored the impact of hotel accommodation on the mental health of asylum seekers in the UK. This mixed methods study utilised inferential statistics to analyse mental health screening questionnaire data and reflexive thematic analysis (Braun & Clarke, 2006, 2013, 2019) to analyse qualitative interview data. This chapter begins by explicating the researcher's epistemological position and relationship to the research topic, followed by an overview of background information to ground the study in its context, including definitions and relevant literature. Next, a systematic literature review is presented focusing on the association between housing and asylum seekers' mental health. The chapter concludes with the rationale for the current study and a statement of the research aims and question.

1.2 Personal and Epistemological Position

1.2.1 Positionality

My positionality influenced every stage of the research process, including topic selection, interactions with participants, and data analysis. My positionality also affected how participants viewed me and what knowledge was generated in interviews. Thus, rather than trying to erase potential bias due to my influence, I have endeavoured to be transparent and reflexive about my positionality.

I was drawn to the topic of asylum seekers' mental health because I come from a family of refugees. My family fled Austria during the Holocaust and started a new life in the United States, experiencing great joys and great tribulations, which naturally impacted their mental

health. Thus, researching asylum seekers' mental health was a way of honouring my family and other families who have experienced forced migration.

When positioning myself in relation to the topic and participants, I reflected on my insider-outside status (Breen, 2007). Coming from a family of refugees made me an insider, yet not being a refugee myself made me an outsider. The advantages and disadvantages of being an insider or outsider researcher have been debated (Dwyer & Buckle, 2009). For example, insiders may have superior knowledge of the topic; however, their familiarity may lead to making erroneous assumptions based on their prior knowledge.

Throughout the research, I danced between my insider and outsider positions, trying to draw advantages from each. As my insider position is invisible to others, I had to decide whether to allow it to remain invisible and unvoiced (unknown to others) or invisible and voiced (known to others) (Burnham, 2012). I voiced my insider status to my supervisory team and Experts by Experience, yet did not do this with interview participants in an attempt to minimise the influence of my insider status on what was shared in interviews. However, despite not explicitly stating my insider status, my family background positioned me as being supportive of refugees and asylum seekers and wanting to honour their human rights; this likely came across in the way I interacted with interview participants and may have influenced how comfortable they felt and what they shared. I was also aware of differences in aspects of my identity compared to participants' identities. Participants may have experienced me as a highly educated, English-speaking professional, which likely influenced power dynamics in the room and what they chose to share.

I also worked clinically with refugees and asylum seekers while conducting this research. Hearing clients' stories deepened my understanding of the topic and influenced what drew my attention during data analysis. My clinical work informed my research whilst my research simultaneously informed my clinical work, shaping my understanding of how hotel accommodation impacts asylum seekers' mental health.

1.2.2 Epistemology

Philosophical assumptions influence the pursuit of knowledge; therefore, when considering this study's pursuit of knowledge, it is important to clarify its philosophical assumptions and epistemological stance. As this mixed methods study aimed to understand the impact of hotel accommodation on asylum seekers' mental health in the UK, I adopted a critical realist epistemological stance because it fit with the research's aims and could accommodate mixed quantitative and qualitative methods (Harper & Thompson, 2020).

Critical realism occupies a useful middle ground between positivism (often more aligned with quantitative methods) and postmodernism (often more aligned with qualitative methods) (Pilgrim, 2020); therefore, it was ideal for this mixed methods study. Regarding ontology, critical realists believe in the existence of a mind-independent reality (Wikgren, 2004), although they acknowledge the difficulties of gaining knowledge about reality using fallible human senses. A critical realist lens allowed me to triangulate and use different sources of data (i.e. mental health screening questionnaires and interview data) to answer the research question and get closer to reality.

1.2.3 Reflexivity

In line with a critical realist approach, researchers should be reflexive and address the role of the researcher in the analytic process (Willig, 2001). In addressing my role in the research process, I have been transparent about my preconceived notions, assumptions, and personal relationship to the topic. Moreover, throughout the research process, I continually reflected on my impact on the research and the research's impact on me. I used the following methods to practice reflexivity.

1) Reflexive journal: I kept a reflexive journal (see Appendix A for extracts) to record my thoughts, questions, and ideas throughout the research process. After supervisory discussions and interviews with participants, I documented my thoughts and feelings and later returned to review them.
2) Consultation: My supervisor (KK) and I were led by Experts by Experience when selecting the focus of this research (housing for asylum seekers). We (KK and JS) met again with Experts by Experience when we held a focus group in which three asylum seekers shared about their experiences and provided ideas and feedback about the interview schedule (detailed in Chapter 2). Consultation with Experts by Experience ensured that this research was relevant and meaningful.

1.3 Background Literature

1.3.1 Refugees and Asylum Seekers in the UK

In a global context of war and instability, more people are seeking asylum in the UK. Post-pandemic, from June 2021 to June 2022, 75,181 people applied for asylum (Home Office, 2022a). Compared to 2019 (pre-pandemic), there were 77% more applications – the highest number of applications for nearly two decades (Home Office, 2022a). In 2023, there were similarly high numbers, with 67,337 asylum applications (Home Office, 2024b). An asylum

seeker is ‘someone who makes a claim to be recognised as a refugee under the Refugee Convention and receive protection and assistance’ (Home Office, 2022a). After submitting an asylum application to the Home Office, asylum seekers wait to receive a decision, which can be a grant of refugee status, humanitarian protection, another form of permission to stay, or a refusal.

Of people who submitted asylum applications in 2021, 94% were still awaiting an outcome at the end of June 2022. Compared to 2019, nearly 2.4 times as many people were still awaiting a decision on their asylum application. In 2022 (post-pandemic), the number of initial asylum decisions fell from 2019 (down 29%) while the number of asylum applications increased (up 77%). This created the perfect storm in which more asylum applications entered the system than left it, resulting in an increase in people in the asylum system awaiting a decision. Although the Home Office is attempting to address the problem of lack of flow through the asylum system, the latest available data still shows a total of 215,518 cases as ‘work in progress’ in the asylum system (Home Office, 2024b).

1.3.2 Challenges that Refugees and Asylum Seekers Face

Asylum seekers are a vulnerable group of people who often arrive in the UK with multiple undiagnosed and untreated physical and mental health difficulties. They are at high risk for mental health difficulties related to psychological trauma as well as physical illnesses related to torture and strenuous migration journeys (Waterman et al., 2020). A study on premigration trauma and postmigration stress found that 80% of asylum seekers reported exposure to traumas (e.g. having their life threatened, witnessing murders) and 25% had experienced torture (Sinnerbrink et al., 1997). Ongoing postmigration stresses included fear of being

returned to their country of origin, being unable to work, family separation, and problems with the asylum-seeking process (Sinnerbrink et al., 1997).

A systematic review and meta-analysis of mental health difficulties in refugees and asylum seekers across 15 countries found that the prevalence of Post-Traumatic Stress Disorder (PTSD) was 31.46%, depression was 31.5%, anxiety disorders was 11%, and psychosis was 1.51% (Blackmore et al., 2020). Depression prevalence was higher for asylum seekers compared to refugees, and anxiety prevalence was higher for people living in temporary accommodation (Blackmore et al., 2020). Siolve et al. (1997) identified several post-migratory stressors that are associated with anxiety, depression, and PTSD in asylum seekers and refugees. Anxiety was associated with poverty and conflict with immigration officials; anxiety and depression were associated with loneliness and boredom; PTSD was associated with delays in processing asylum applications, obstacles to employment, difficulties dealing with immigration officials, discrimination, and loneliness and boredom. Moreover, a mixed methods study focusing specifically on asylum seekers' mental health found that psychological distress was linked to post-migration living difficulties (Bernardes et al., 2010). In the literature, the term post-migration living difficulties (PMLDs) is frequently used to capture the impact of various stressors, such as interpersonal stressors (e.g. social isolation, racism, discrimination), emotional stressors (e.g. loneliness, lack of control), asylum process stressors (e.g. inability to work, insecure legal status), and migration-related stressors (e.g. language barriers, family separation, housing difficulties) (Schiess-Jokanovic et al., 2021).

While it is important to recognise premigration trauma as a predictor for mental health difficulties, it is also important to acknowledge PMLDs as key predictors of mental health difficulties (Schweitzer et al., 2006). Bernardes et al. (2010) found that the PMLDs that

negatively impacted asylum seekers' mental health included problems with language, money, being unable to work, and housing problems. An ethnographic case study highlighted that asylum seekers face challenges in the domains of safety/security, bonds/network, justice and human rights, roles and identity, and existential meaning (Chase & Rousseau, 2018). Factors that contributed to deterioration in asylum seekers' mental health included social isolation, lack of community, and precarious and impoverished living conditions. Poor housing was described as posing a serious threat to the domain of safety/security and negatively impacting mental health.

1.3.3 Housing for Asylum Seekers

Adequate housing is recognised as a human right, and the World Health Organization (WHO) states that 'adequate' encompasses more than just physical shelter (United Nations, 1976). Adequate housing is to 'have a home, a place which protects privacy, contributes to physical and psychological wellbeing and supports the development and social integration of its inhabitants' (Bonnefoy, 2007, p. 413). In the UK, asylum seekers are not eligible for welfare benefits, but if they are destitute, they can apply to the Home Office for 'asylum support,' which includes housing and subsistence (cash support) (Home Office, 2022a). In 2012, the Home Office began outsourcing the procurement and management of asylum accommodation to private companies who must met the basic requirements for asylum accommodation being 'safe, habitable, fit for purpose and correctly equipped' (Home Office, 2022c, p. 24). Since March 2020, the Home Office has increased its use of 'contingency accommodation' to house asylum seekers due to 'a lack of flow' through the asylum system with more applications coming in and not enough decisions being made (Refugee Council, 2021).

Regional contractors provide asylum accommodation in different parts of the UK. Contractors provide short-term (usually full-board hostel style) 'initial accommodation', which lasts three to four weeks and is designed to house people while they wait for their asylum support eligibility to be assessed. After this, normally people are moved to 'dispersal accommodation' (self-catering flats and house shares), in which people live until they receive an asylum application decision. 'Contingency accommodation' (usually hotels) functions as a temporary way of filling gaps in provision of initial accommodation or dispersal accommodation. The Home Office aims to move people from initial accommodation to dispersal accommodation within 35 days. Due to growing numbers of people in the asylum system and lack of dispersal accommodation, asylum seekers are increasingly being housed in hotels for long stays rather than the short stays for which they were originally intended (Refugee Council, 2021). A Freedom of Information request to the Home Office revealed that the number of asylum seekers in hotels almost tripled during 2021, with 26,380 people living in hotels by the end of 2021 (Refugee Council, 2022). The latest Home Office statistics reveal that by the end of December 2023, 45,768 people were housed in hotels, which equates to 41% of the people receiving asylum support (Home Office, 2024b).

Asylum seekers living in dispersal accommodation receive £49.18 per week per person to pay for essentials like food, clothing, and toiletries (Home Office, 2024a). However, asylum seekers living in accommodation that provides meals (including hotel accommodation) are not eligible to receive this. After concerns were raised about asylum seekers living long-term in accommodation that was originally only intended to be short-term (up to 35 days) and having no access to financial resources, in 2021 the Home Office agreed to provide asylum seekers living in hotels with £8.00 per week per person to cover the cost of essentials,

including transportation, clothing, and non-prescription medication (Refugee Council, 2022). This number has risen to £8.86 per week per person as of May 2024 (Home Office, 2024a).

1.3.4 Housing and Health

Research demonstrates a clear link between housing and health, with poor housing being a postmigration risk factor that impacts health (e.g. Nutsch & Bozorgmehr, 2020; Dudek et al., 2022). A systematic review of studies examining the relationship between housing and health for refugees and asylum seekers found that housing is directly linked to physical and mental health (Ziersch & Due, 2018). A qualitative study exploring the relationship between housing and health found that housing impacts health and wellbeing through numerous pathways including physical aspects (such as condition and neighbourhood) and psychological aspects (such as feelings of safety, belonging, security, and lack of control) (Ziersch et al., 2017).

A meta-analysis of pre-displacement and post-displacement factors associated with the mental health of refugees found that vulnerability to mental health difficulties was connected to their experiences after seeking asylum, including living in institutional accommodation (Porter & Haslam, 2005). A German study found that living in collective accommodation had a worse impact on asylum seekers' mental health compared to living in private accommodation (Dudek et al., 2022). However, the study did not include hotels (a specific type of collective accommodation), as hotels are not widely used to house asylum seekers in Germany.

Housing impacts refugees' and asylum seekers' integration as well as their mental health. According to a conceptual framework for integration of refugees and asylum seekers into society, one of the key domains for 'successful' integration is access to housing (Ager &

Strang, 2008). Housing impacts refugee' and asylum seekers' physical and mental wellbeing, their ability to feel 'at home' in their new country, and social and cultural aspects of integration (Ager & Strang, 2008). Furthermore, research demonstrates that successful integration into society improves mental health (Whitehouse et al., 2021; British Red Cross, 2021). Therefore, housing, integration, and mental health are closely linked. As a specific type of accommodation, hotels pose numerous problems for asylum seekers' integration and mental health.

1.3.5 Hotels and Asylum Seekers' Health

Refugee Council (2021) highlighted numerous problems with housing people in hotels for long periods in the UK, including the negative impact on people's mental health, lack of clothing and shoes, lack of access to cash, lack of access to health services (including GPs and mental health services), lack of education for children, lack of cooking facilities, poor quality food, unsafe environment, digital exclusion, and lack of legal advice. Staff who work with asylum seekers reported that asylum seekers' mental health deteriorated as they lived in hotels with no certainty about when they would be moved to dispersal accommodation.

Building on these findings, A Doctors of the World report involving 313 people housed in hotels and barracks from 2020-2021 in the UK found that accommodation conditions failed to meet basic standards, contributing to poor health (Jones et al., 2022). Relevant factors included poor quality food and lack of medical care. The report found that people's mental health was impacted by loneliness, isolation, and feeling like they were imprisoned. Approximately 32% of people residing in hotels reported having a mental health difficulty, which is higher than rates reported in the general UK population, of which approximately 16.7% experiences a common mental health difficulty (e.g. anxiety and depression) (Baker &

Kirk-Wade, 2024). Asylum seekers housed in hotels experienced anxiety, depression, PTSD, sleep difficulties, self-harm, and feeling suicidal, and participants reported that their mental health difficulties were caused and exacerbated by their living conditions.

Additionally, a British Red Cross (2021) report detailing the experiences of over 100 people living in asylum accommodation in the UK found that social isolation, feeling unsafe, poor facilities, and barriers to accessing healthcare impacted asylum seekers' wellbeing. People who felt suicidal did not receive support, which contributed to them attempting suicide. From January 2020-February 2021, British Red Cross teams supported over 400 asylum seekers who had suicidal ideation or suicide attempts documented in their case notes. Participants cited issues they found distressing, such as the lack of privacy and independence in hotel accommodation. Some participants described hotel staff entering their bedrooms using a master key without their consent. This left people feeling scared, particularly vulnerable women when male staff entered their bedrooms.

Similar findings were generated in a qualitative study with 14 people who had experienced living in asylum accommodation (Action Foundation et al., 2021). Participants reported a decline in their mental health, which they attributed to lack of safety, fear of other residents, and fear of far-right extremists who targeted asylum accommodation. Participants also described the impact of lack of funds, which resulted in them being confined to their accommodation and unable to integrate into the community, travel to medical appointments, and visit places of worship. Other problems that contributed to distress included being treated poorly by staff when they tried to raise concerns, a loss of autonomy and ability to exercise agency in their lives, poor quality food, and lack of agency in being able to choose and cook their own food.

Families with children described additional challenges when living in hotels, such as being confined to one room, lack of space for children to play and study, difficulties accessing education for children, and children going hungry when they refused food provided by the accommodation and were not offered alternative provisions (Action Foundation et al., 2021). In another study, asylum-seeking parents described the impact of living in cramped conditions with their children and reported feeling unsafe, unfree, and unheard in hotels (British Red Cross, 2021). They spoke about poor living conditions, including unclean rooms and bugs, and having to sign in and out whenever they left the hotel. When they raised issues with staff or asked for help, they felt unheard, leaving them feeling frustrated, angry, and depressed. This contributed to an overall decline in parents' mental health and the mental health of their children.

Stevens & Sivasathiaseelan (2022) highlighted the importance of safeguarding asylum-seeking children housed in hotels and emphasized that local authorities have a duty to safeguard all children in their area under the Children Acts of 1989 and 2004. Regarding asylum-seeking children, local authorities have a duty to work alongside the Home Office and accommodation providers to safeguard children, ensure that they are not harmed, and provide them with essentials, including adequate food, education, and healthcare. The current literature indicates that asylum seekers, including adults and children, are not being sufficiently safeguarded and provided for in hotel accommodation (British Red Cross, 2021; Action Foundation et al., 2021; Refugee Council, 2021; Jones et al., 2022).

1.4 Rationale for the Systematic Literature Review

As poor housing is a postmigration risk factor that impacts health (e.g. Nutsch & Bozorgmehr, 2020; Dudek et al., 2022), it is important to understand how and why housing

impacts health. A systematic review found that for refugees and asylum seekers, housing is directly linked to physical and mental health (Ziersch & Due, 2018). Most research on the relationship between housing and health focuses on mixed samples of refugees and asylum seekers (Ziersch et al., 2017). However, there are fundamental differences between asylum seekers and refugees, which have important mental health implications (Bernardes et al., 2010). Research demonstrates that asylum seekers have higher levels of anxiety, depression, and PTSD (Toar et al., 2009). Thus, it is important to understand more about asylum seekers' mental health and the postmigration risk factors that affect their mental health, including housing.

A systematic review on the relationship between housing and health included thirty studies, none of which focused solely on asylum seekers (Ziersch & Due, 2018). The authors concluded that there is an urgent need for research on the impact of housing on asylum seekers' health. Therefore, this systematic literature review focused on the association between housing and asylum seekers' mental health.

Systematic Literature Review

1.5 Overview of Systematic Literature Review

Systematic literature reviews aim to identify, critically appraise, and synthesize all relevant findings from studies on a particular topic (Boland et al., 2017; Centre for Reviews and Dissemination, 2009). By combining data from many studies, systematic literature reviews provide new insight into a topic and assess the reliability and validity of the evidence base. In healthcare, systematic literature reviews are considered the gold standard of literature reviews because they adhere to strict scientific design and combine the results of several studies to give a more reliable answer to a question compared to solely examining the results of one study (Centre for Reviews and Dissemination, 2009). This systematic literature review aimed to identify and critically evaluate all studies relevant to the research question: 'What is the association between housing and asylum seeker's mental health?' The secondary question was: 'What are the relevant aspects of housing that impact asylum seekers' mental health?' The review was pre-registered with PROSPERO (ID: CRD42023430982).

1.6 Method

1.6.1 Search Strategy

A scoping search to identify all studies relevant to the research question was conducted in May 2023. The following databases were searched: Scopus, Embase, APA PsycNET, PubMed, EBSCO, MEDLINE, CINAHL, Open Dissertations, Cochrane Library, and EThOS. Studies from published literature and 'grey' literature were considered to fully capture the evidence base. Search terms (see Table 1) were informed by similar systematic reviews and were structured according to the 'SPIDER' criteria (Methley et al., 2014) (Table 2).

Publication dates were limited to 2017 to 2023 because a similar systematic review (Ziersch & Due, 2018) included all studies published prior to 2017.

Table 1

Search terms

Sample	Housing	Mental health
'asylum seeker*'	hous* accommodation	'mental health' 'mental illness' anxiety depress* ptsd stress distress

Table 2

Overview of the SLR search strategy

SPIDER Criteria	
Sample	Asylum seekers
Phenomenon of Interest	Housing
Design	Qualitative study design, quantitative study design, or mixed methods design
Evaluation	Association on mental health, impact on mental health
Research Type	Qualitative method, quantitative method, or mixed methods

1.6.2 Study Selection

All studies were assessed according to the eligibility criteria in Table 3.

Table 3

Systematic literature review inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
Participants are asylum seekers	Participants are migrants/immigrants. Participants were previously asylum seekers, but are now refugees
Study considers housing	Study does not consider housing
Study considers mental health	Study does not consider mental health
Published between January 2017 and May 2023	Published prior to January 2017 or after May 2023
English language	Non-English language

1.6.3 Screening Procedure

Search results from different databases were combined and duplicates were removed using Covidence software. Two reviewers (JS, DK) independently screened study titles and abstracts, and studies that did not meet the inclusion criteria were removed. The full text of the remaining articles was then independently assessed for eligibility. The reviewers met to discuss and resolve discrepancies.

1.6.4 Quality Assessment

As studies included in the review utilised different designs, the Mixed Methods Appraisal Tool (MMAT) (Hong et al., 2018) was selected to assess the quality of studies because of its capacity to appraise studies with quantitative, qualitative, and mixed method designs. The MMAT was utilised to assess study characteristics, such as sample representativeness, appropriateness of measurement used, and completeness of outcome data (Appendix B).

1.6.5. Synthesis Method

Given the heterogeneity of the studies, the authors performed a comprehensive narrative synthesis of the data. According to Popay et al's (2006) guidance on conducting narrative synthesis, the authors included three out of four main elements of narrative synthesis. Table 4 describes the included elements from Popay et al.'s (2006) framework and the corresponding techniques the authors used. The fourth element, aimed at developing a theory of how, why and for whom an intervention is effective, is optional and was deemed not relevant for this review.

Table 4

Overview of data synthesis method (Popay et al., 2006, pp. 11-22)

Element	Aim	Techniques Used
1. 'Develop a preliminary synthesis'.	To organise the findings of the included studies.	Tabulation: a table that contains an overview of all study details was created.
2. 'Explore relationships in the data'.	To consider relationships between studies and to consider factors that explain differences between studies.	Thematic analysis: thematic analysis was used to map how the findings of different studies relate to one another and to the review question.
3. 'Assess the robustness of the synthesis'.	To provide an assessment of the strength of the evidence and generalise conclusions to different populations or contexts.	Quality assessment: the quality of the individual studies and strength of the review was assessed and critically reflected on.

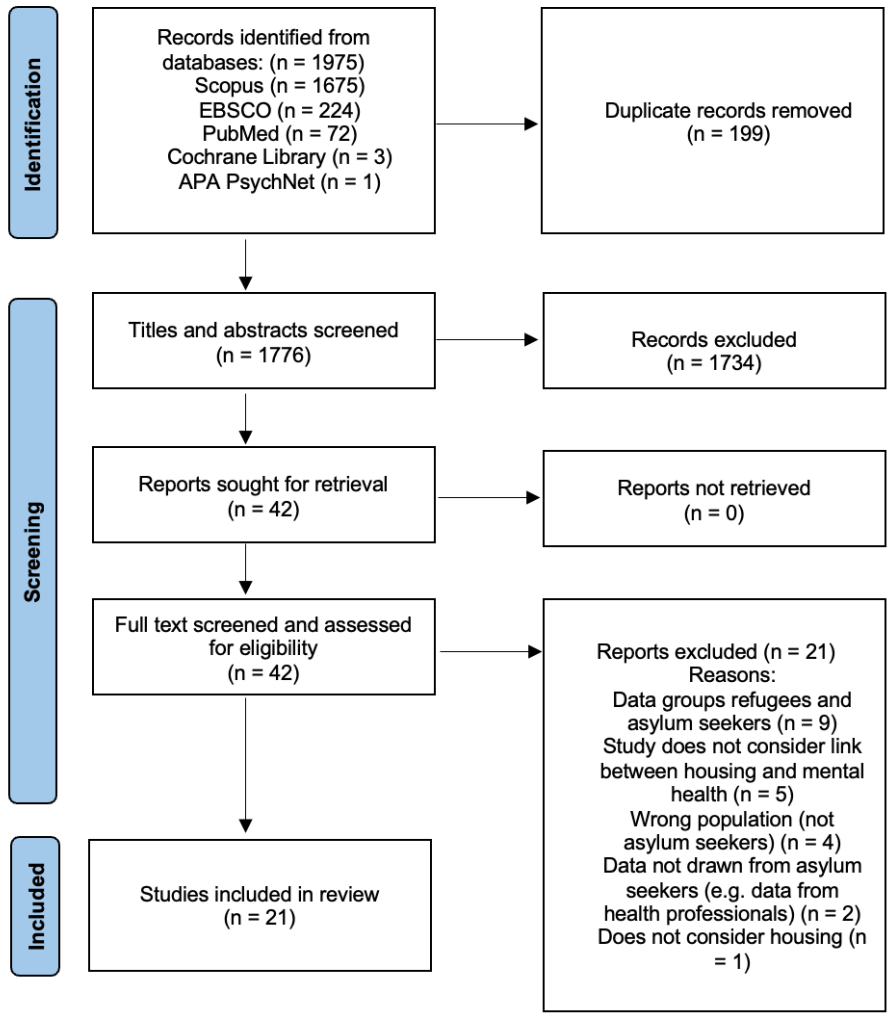
1.7 Results

1.7.1 Study Selection

Searches identified a total of 1,975 articles. After removing duplicates, 1,776 titles and abstracts were screened against the eligibility criteria. Of these, 42 articles were selected for full-text review. Of these studies, 21 met the inclusion criteria and were included in the current review. Figure 1 shows an overview of the study selection process according to Page et al.'s (2021) The PRISMA 2020 statement: An updated guidance for reporting systematic reviews.

Figure 1

PRISMA flowchart of the study selection process



1.7.2 Study Characteristics

Of the 21 studies included in the review, 9 used quantitative methods and 12 used qualitative methods. Table 5 provides an overview of the quantitative studies' characteristics and methodology, a summary of the findings, and the main strengths and limitations. Table 6 provides this information for the qualitative studies. Studies were conducted across a range of countries, including Australia (n=5), the USA (n=4), Germany (n=3), Sweden (n=2), Belgium (n=2), Greece (n=2), Norway (n=1), Mexico (n=1), and Ireland (n=1). The studies included different types of housing, including collective/shared housing (n=13), community housing (n=8), private housing (n=7), refugee camps (n=3), detention centres (on-shore) (n=3), detention centres (off-shore) (n=2), and hotels (n=1).

Study sample sizes ranged from 62 to 2,399 participants for the quantitative studies and from 2 to 50 participants for the qualitative studies. Data collection methods varied depending on the studies' methodology, with quantitative studies drawing data from mental health service outcome measures (n=4), national surveys (n=4), and longitudinal projects focused on refugees and asylum seekers (n=1). Qualitative studies mainly used interviews (n=12), although ethnography (n=3) and auto-photography (n=1) were also employed. When ethnography and auto-photography were used to collect data, they were combined with interviews. Analytic methods similarly varied based on the studies' methodology; they included thematic analysis (n=6), regression (n=6), content analysis (n=3), descriptive statistics analysis (n=2), bivariate analysis (n=1), narrative analysis (n=1), and grounded theory (n=1). The analytic method in one study was not clearly defined (n=1).

Table 5

Overview of quantitative studies included in the systematic literature review

Authors and year	Title	Country	Housing type	Sample	Study design	Key findings	Strengths and limitations
Whitsett & Sherman (2017)	Do resettlement variables predict psychiatric treatment outcomes in a sample of asylum-seeking survivors of torture?	USA	Collective / shared; Private; Community	Participants: 105 (60% female). Mean age: 34.8 years. Recruitment: participants were patients at a MH clinic for torture survivors.	Harvard Trauma Questionnaire (HTQ) and the Hopkins Symptom Checklist (HSCL) measured trauma, anxiety, and depression symptoms. Housing was coded as: 'Unstable and/or overcrowded' or 'Stable and appropriate'. Regression analysis.	Stable, uncrowded housing conditions significantly predicted lower depression, anxiety, and trauma symptoms.	Diverse sample and robust outcome measures to assess MH. However, small sample limits generalisability.
Kashyapa, et al. (2019)	Post-migration treatment targets associated with reductions in depression and PTSD among survivors of torture seeking asylum in the USA	USA	Collective / shared; Private; Community	Participants: 323 (36% female). Mean age: 37.92 years. Recruitment: data drawn from archive database of patients at a treatment centre for torture survivors.	Depression (Patient Health Questionnaire-9) and PTSD (Harvard Trauma Questionnaire) were measured after 6 months of treatment. Relationships between pre- and post-migration factors, and changes in symptom levels from intake to 6-month follow-up were evaluated using regression.	Stable housing and employment significantly moderated the relationship between lower chronic pain and reduced PTSD. Neither housing nor employment were directly associated with reduced PTSD or depression severity.	Large, diverse sample. However, housing was categorised as 'stable' or 'unstable', which is reductionistic and fails to account for other potentially relevant factors that could impact MH, such as safety and lack of privacy.

Armstrong & Borschmann (2019)	Self-harm in the Australian asylum seeker population: A national records-based study	Australia	Collective / shared; Community; Detention centre (on shore); Detention centre (offshore)	Participants: 949 self-harm episodes were included in the analyses. Recruitment: all self-harm incidents in asylum seekers recorded as occurring between 1st August 2014 and 31st July 2015 were included.	Staff must report incidents of self-harm in asylum seekers housed in state-provided accommodation. The incidence of self-harm across the asylum seeker population was statistically assessed to determine whether self-harm rates vary by housing arrangements and gender.	Self-harm rates were highest among asylum seekers in detention facilities and lowest among asylum seekers in community-based arrangements. Calculated rates of self-harm among asylum seekers in off-shore detention were 52x higher than the lowest recorded self-harm episode rates for community-based asylum seekers.	First study to examine incidence of self-harm across entire Australian asylum seeker population by processing arrangements. However, it is likely that rates of self-harm reported understate the incidence of self-harm among asylum seekers, as the data relied on staff formally reporting incidents.
De Montgomery, et al. (2019)	Asylum-seeking parents' reports of health deterioration in their children since fleeing their home country	Greece	Refugee camp	Participants: 143 asylum-seeking parents. Recruitment: data came from the REHEAL general survey for asylum seekers residing in official camps in Greece.	Analysis used descriptive statistics and the calculation of odds ratios through logistic regression. The outcome variable was parents' assessment of whether their children's health had deteriorated since fleeing their home country.	Most parents (56%) described their children's health as having deteriorated to a 'considerable' or 'great' degree. Feeling safe at the current location and access to basic amenities were alleviating factors. Most parents felt 'not very' or 'not at all' safe in their current location.	Study provides insight into the MH of asylum-seeking children. However, the small and homogenous sample limits the possibilities of statistical inference and generalisability.

Hedrick et al. (2020)	Self-harm among asylum seekers in Australian onshore immigration detention: How incidence rates vary by held detention type	Australia	Detention centre (on shore)	Participants: 560 self-harm episodes were included in the analyses. Recruitment: all self-harm incidents in asylum seekers in detention recorded as occurring between 1st August 2014 and 31st July 2015 were included.	A content analysis was conducted of all self-harm incidents reported among asylum seekers in Australian onshore immigration detention according to held detention type, as well as individual facility.	There were a total of 560 self-harm episodes among asylum seekers in Australian onshore immigration detention. Calculated self-harm episode rates were highest among asylum seekers in Immigration Transit Accommodation facilities, Alternative Places of Detention, and Immigration Detention Centres.	Large sample, which permitted examination of incidence of self-harm by detention type and individual facility. However, it is likely that rates of self-harm reported understate the incidence of self-harm among asylum seekers, as the data relied on staff formally reporting incidents.
Eisen et al. (2021)	The impact of post-migration factors on posttraumatic stress and depressive symptoms among asylum seekers in the United States	USA	Collective / shared; Private; Community	Participants: 78 (58% female). Mean age: 34.1 years. Recruitment: data came from archived records at an agency that provides psychological and case-management services for asylum seekers.	Quality of Life/Functioning Progress Scale for Asylees/Asylum Seekers (QOLS) provided information about quality of life domains, including housing, employment, and asylum status. The Harvard Trauma Questionnaire and The Hopkins Symptom Checklist measured PTSD, anxiety and depression. Multiple regression analysis.	Changes in housing status were not associated with a change in PTSD symptom levels ($p = .236$) or a change in depressive symptom levels ($p = .318$).	Longitudinal study. However, sample included refugees granted status during the study, which could have impacted MH. It is also possible that the study was not sufficiently powered and with more participants a significant effect would have been detected.

Dudek et al. (2022)	Association between housing and health of refugees and asylum seekers in Germany: explorative cluster and mixed model analysis	Germany	Collective / shared; Private; Community	Participants: 1535 (37% female). Mean age: 36 years. Recruitment: data came from the IAB-BAMF-SOEP Survey of Refugees.	Cluster analysis of population-based, cross-sectional secondary data identified clusters of refugee accommodation. Health disparities were assessed across clusters by performing bivariate analysis and linear mixed model regression analysis. Main outcome variables were the MH component score and the physical health component score.	Compared to private housing, collective housing was significantly associated with poorer MH. Collective housing sheltered more asylum seekers and differed from private housing regarding space, area, level of restrictions, neighbourhood safety, social connections to other asylum seekers and neighbourhood locals, and respondent satisfaction. Collective housing residents spent more time in boredom and had the lowest satisfaction and belonging scores.	Large sample size. Differentiated between collective and private housing and demonstrates how different kinds of housing impact asylum seekers' MH. However, cross-sectional design of the study does not allow conclusions on causality of the associations identified.
Martino, et al. (2022)	Between liminality and a new life in Australia: What is the effect of precarious housing on the MH of humanitarian migrants?	Australia	Private	Participants: 2399 humanitarian migrants. The comparative Australian population included 21,462 respondents. Recruitment: data came from Building a New Life in Australia (BNLA) survey and comparative data came from Household, Income and Labour Dynamics in Australian (HILDA) survey.	The effect of precarious housing on humanitarian migrants' MH was compared to the greater Australian population. In the BNLA, the Kessler Psychological Distress Scale (K6) measured mental distress. The Kessler Psychological Distress Scale (K10) was collected in the HILDA. Fixed effects regression analyses were used to model the relationship between each exposure measure of precarious housing (housing affordability, housing suitability, and housing security) and MH (K6 or K10).	Modelling revealed a negative MH effect attributed to unaffordable and unsuitable housing for both humanitarian migrants and the Australian population, with humanitarian migrants at greater risk of poor MH due to unsuitable housing. Humanitarian migrants were 60 % more likely to suffer from worse MH when they experience unaffordable housing compared to their counterparts in affordable housing, with a 2.4x increased risk for those in unsuitable housing.	Large sample and regression accounted for potential confounding factors. However, variables were based on self-report questionnaires, which are vulnerable to bias. Access to more objective housing and financial data would have strengthened the study.

Amarasena et al. (2023)	Offshore detention: cross-sectional analysis of the health of children and young people seeking asylum in Australia	Australia	Detention centre (offshore)	Participants: 62 children and young people (CYP) who were in offshore immigration detention between 2013-2019. Recruitment: clinicians enrolled eligible CYP into the study with caregiver consent.	CYP health outcomes were categorised as physical, mental or neurodevelopmental conditions. Risk and protective factor data were collected using the adverse childhood experiences (ACE) and refugee-specific adverse childhood experiences (R-ACE) tools. Descriptive statistics described absolute and relative frequencies. Categorical variables were analysed using the Pearson's $\chi 2$ test or Fisher's exact test.	Physical and MH concerns were found in almost all asylum-seeking CYP (89% and 79% respectively) subjected to offshore immigration detention. Most frequent symptoms were low mood (47%) and sleep difficulties (47%). Most diagnosed MH conditions were pervasive refusal syndrome (15%), post-traumatic stress disorder (13%) and depression (13%). Almost half had suicidal ideation/attempt or self-harm (45%). MH concerns were more likely in CYP held in detention for ≥1year ($p=0.01$).	Study highlights the impact of detention on CYP's MH. However, small sample made multivariable regression analysis unstable. Restricted access to CYP's health status prior to the period they were held in detention resulted in limited comparative data.

Table 6

Overview of qualitative studies included in the systematic literature review

Authors and year	Title	Country	Housing type	Sample	Study design	Key findings	Strengths and limitations
Ziersch et al. (2017)	Exploring the relationship between housing and health for refugees and asylum seekers in South Australia: A qualitative study	Australia	Collective / shared; Private; Community	Participants: 50 (20% female). Recruitment: over 400 asylum seekers and refugees were surveyed as part of a larger study, then participants were invited for interviews.	Interviews thematically analysed using the framework approach.	Housing impacted MH through a range of pathways including the suitability of housing in relation to physical elements, social aspects, and security of tenure. There was a perceived difficulty in addressing housing concerns, which contributed towards a sense of lack of control and contributed to MH difficulties. Overcrowded shared housing negatively impacted MH, particularly for single male asylum seekers due to lack of space, privacy, and incompatibility with housemates. Housing that was clean and in good condition positively impacted MH. Some participants said relocating to more suitable housing provided relief from depression.	Mixed sample included refugees and asylum seekers; however, the results specified findings relevant for asylum seekers. All asylum-seeking participants came from the Middle East, which limits generalisability.
Gewalt et al. (2018)	Psychosocial health of asylum-seeking women living in state-provided accommodation in Germany during pregnancy and early motherhood: A case study exploring the role of social determinants of health	Germany	Collective / shared	Participants: 9 female asylum seekers were interviewed during pregnancy and early motherhood. Recruitment: participants were recruited during midwifery consultations at two reception centres.	21 semi-structured interviews conducted with 9 women. Inductive approach to thematic analysis.	1) Psycho-social stressors: minimal ability to influence their living situation caused psychological stress. 2) Stressful living circumstances: lack of self-determination and privacy, verbal and physical threats, experiences of powerlessness, and disturbances by other residents. 3) Social support: building social support proved difficult because of short stays in reception centres, frequency of transfers between accommodations, and many nationalities and language barriers. Participants described feeling isolated. Coping with psychosocial stressors was easier with support from peers or professionals. 4) Coping styles: included acceptance of the current circumstances, faith, and hope for an improvement of their situation in the future.	Match between the WHO's Conceptual Framework for Action on the Social Determinants of Health and the data lends credibility to the findings. However, small sample from one state in Southern Germany limits generalisability.

Gewalt et al. (2019)	"If you can, change this system" - Pregnant asylum seekers' perceptions on social determinants and material circumstances affecting their health whilst living in state-provided accommodation in Germany - A prospective, qualitative case study	Germany	Collective / shared	Participants: 9 female asylum seekers were interviewed during pregnancy and early motherhood. Recruitment: participants were recruited during midwifery consultations at two reception centres.	21 semi-structured interviews conducted with 9 women. Inductive approach to thematic analysis.	1) Housing quality: wellbeing was negatively impacted by poor housing quality. 2) Neighbourhood quality: lack of privacy, inability to lock rooms, and sharing with unknown and aggressive people caused anxiety. 3) Consumption potential: accommodation regulations, including insufficient financial allowances and not being allowed to cook for themselves, were viewed as restrictive and contributed to lack of autonomy. 4) Nutrition: catered food was perceived as unsatisfactory. Participants reported loss of appetite due to bland food, limited variety and choice, and unfamiliar tastes. 5) Physical activity: lack of opportunity for physical activities caused concern for their health and wellbeing and for that of their unborn child.	Match between the WHO's Conceptual Framework for Action on the Social Determinants of Health and the data lends credibility to the findings. However, small sample from one state in Southern Germany limits generalisability.
Murphy et al. (2018)	Erosion of meaning in life: African asylum seekers' experiences of seeking asylum in Ireland	Ireland	Collective / shared; Hotel	Participants: 16 African asylum seekers (56% female). Recruitment: participants were recruited from two MH services.	Narrative study. Holistic-content approach for data analysis.	Participants described a diminishment of components required to achieve meaning in life while seeking asylum. 1) Diminishment of efficacy: rules imposed reduced self-efficacy. Participants compared their accommodation to a prison due to their behaviour/choices being controlled (e.g. having to sign in and out, activities being prescribed, decisions made for them about what to eat and when to eat it). 2) Diminishment of purpose: unable to work, study, or fully parent their children. 3) Diminishment of self-worth and value. 4) Diminishment of love and sense of belonging.	Findings are useful for considering what therapeutic interventions are needed post-migration. However, small, homogenous sample limits generalisability.

Moreira et al. (2020)	Lives on hold: The experiences of asylum seekers in Moria refugee camp	Greece	Refugee camp	Participants: 15 (20% female). Mean age: 28 years. Recruitment: Kara Tepe refugee camp residents were invited to participate.	Thematic analysis of interviews. Researchers completed field observations in two refugee camps.	1) Divisions within the camps: people with different nationalities and cultures were forced to live together, causing conflict and aggression. 2) Sense of safety and security: participants felt insecure in the camp. 3) Living conditions: poor living conditions include overcrowding, poor nutrition and food quality, and insufficient housing conditions (cold, absence of beds, loud noises). 4) Psychological and physical distress: poor living conditions caused sadness, fear, insomnia, and uncertainty.	Combination of interviews with participants and researcher observations lends credibility to the findings. However, small sample limits generalisability.
Lietaert et al. (2020)	Families on hold: How the context of an asylum centre affects parenting experiences	Belgium	Collective / shared	Participants: 9 asylum-seeking parents. Recruitment: participants living in an asylum centre were selected through their participation in parent psychoeducation sessions.	Researchers observed psychoeducation sessions and completed interviews. Qualitative content analysis.	1) Limited parental agency: parents needed to ask and be given permission for many things, including care for their children. 2) Timetables, use of time, and temporality: asylum centre rules and strict timings (e.g. canteen hours) prevented parents from responding to their children's needs. 3) Condition of the building: the state of the building, including dirty showers and toilets, caused stress. 4) Allocation of space: lack of space for family life. Everything was witnessed by children, including inappropriate things. 5) Parents felt powerless in protecting their children from dangers, including other residents who displayed aggression and physical and sexual violence towards their children.	Combining interviews and observations enriched the dataset. However, small sample limits generalisability.

Whitehouse et al. (2021)	A qualitative exploration of post-migration stressors and psychosocial well-being in two asylum reception centres in Belgium	Belgium	Collective / shared	Participants: 41, including 29 asylum seekers and 12 reception centre staff. Recruitment: participants were recruited from two reception centres.	Thematic analysis of interviews.	1) Poor living conditions: lack of privacy, overcrowding, lack of cooking facilities, unpalatable food, and conflict when sharing rooms caused stress. 2) Lack of engagement, integration and autonomy: barriers prevented engagement in education/work, causing asylum seekers to become bored and frustrated. Participants felt like 'prisoners' or 'children.' Coping strategies included keeping active, spending time outside the centre, helping others, and integration within the community. 3) Inadequate capacity and resources to provide psychosocial support: poor communication between staff and asylum seekers. Asylum seekers reported insensitivity to their needs.	Study was enhanced by including both asylum seeker and staff perspectives; however, it was unclear how conflicting views were dealt with when analysing the data.
Hedstrom et al. (2021)	Exploring parenting narratives in asylum seeking populations in Sweden: Examining the effect of post-migration stress on families through grounded theory	Sweden	Private; Community	Participants: 17 asylum-seeking parents. Recruitment: participants attended a local day care setting open to children 0–5 years.	Interviews analysed using grounded theory.	1) Lack of agency: parents felt a lack of agency over their life choices. 2) A new normal: the structure of day-to-day life was linked to lack of agency. Families were unable to choose where they lived, when and what they ate, there were significant financial constraints, as well as restrictions on work/study. 3) Poor physical and MH: participants spoke of sleep problems, feeling tired, crying, and feeling isolated, suggesting feelings of depression. Parents tried to shield children from distress by not talking openly in front of them; however, this negatively impacted parents' wellbeing. Parents described symptoms of anxiety and worry in their children.	Theoretical sampling allowed researchers to gain feedback from participants regarding constructed categories. Homogenous sample limits generalisability.

Grønseth, & Thorshaug (2022)	Struggling for home where home is not meant to be: A study of asylum seekers in reception centers in Norway	Norway	Collective / shared; Community	Participants: 2. 'Sara', age 20, from Ethiopia and 'Abel,' age early twenties, from East-Africa. Recruitment: researchers conducted ethnographic fieldwork at an asylum centre and invited participants to an interview and auto-photography.	Data from ethnography, interviews, and auto-photography.	Pictures demonstrate the smallness and messiness of participants' rooms, where items of clothing, food, and furniture are cluttered. There is little space left for activities, meals, or visitors. Pictures could be seen as representing an existential and emotional worry, a longing and struggle for home in a physical, emotional and existential sense, while they are confined to material structures that challenge their hopes and struggles for home and fight for self. Lack of social interaction with others underlines an existential emptiness and the struggle of making a home for themselves at the reception centres. Asylum seekers nevertheless negotiate the centre as home by engaging with things, memories, images, and persons that provide meaning.	Auto-photography combined with interviews and observation enriched the data. However, data analysis was unclear, and it was unknown what data came from researcher observations and what data came from asylum seekers' words and photographs.
Domínguez et al. (2022)	"They treat us like we are not human": Asylum seekers and "la migra's" violence	USA	Detention centre (on shore)	Participants: 7 Latinx asylum seekers (43% female). Mean age: 29 years. Recruitment: asylum seekers in detention centres were invited to participate.	Testimonio research, which allows participants to document their experiences with oppression. Thematic analysis.	1) No compassion. 2) Detention violence: included physical violence, ethnoracial violence, psychological violence, and violence against children. 3) Post-detention trauma and health concerns: included nightmares, disrupted sleep, depression, "el llanto" [weeping], intrusive thoughts, flashbacks, avoidance of internal reminders, anxiety, feeling lost and detached, somatic manifestations, and re-traumatisation of court. 4) Resilience: included reliance on "Dios" [God] for survival, family and friends, gratitude for survival and life's blessings, reminders of worthiness, avoidance, and desire for liberation.	Robust approach to thematic analysis and reflexivity. However, small, homogenous sample (all participants were non-Black Latinx) limits generalisability.

van Eggermont Arwidson et al. (2022)	Living a frozen life: A qualitative study on asylum seekers' experiences and care practices at accommodation centers in Sweden	Sweden	Collective / shared	Participants :14 (43% female). Age range: 22–62 years. Recruitment: asylum seekers in activities or support programs run by local non-government organisations were invited to participate.	Interviews analysed using inductive qualitative content analysis.	1) Frozen life: participants experienced a frozen life with limited agency due to environmental and social constraints, geographical isolation, financial limitations, and limited access to the wider host society. Life was so heavily restricted that it was compared to being a prisoner. Lack of privacy and sharing rooms with strangers caused insecurity. 2) Constant worrying and 'overthinking': this harmed participants' MH. Being a parent added worries about children's wellbeing and providing for them with limited resources. 3) Distractions and peer support: coping strategies included distraction, self-medicating with drugs, alcohol and medication, religion, prayer, exercise, reading books, volunteering, and expressing care and concern for other asylum seekers.	Culturally diverse sample. However, the study only included asylum seekers from two accommodation centres, which limits generalisability.
Laughon et al. (2022)	Health and safety concerns of female asylum seekers living in an informal migrant camp in Matamoros, Mexico	Mexico	Refugee camp	Participants: 43 female asylum seekers. Mean age: 33.5 years. Recruitment: participants were recruited from a tent encampment in Matamoros, Mexico.	Thematic analysis of interviews.	1) Constant vigilance: participants lived in a state of constant vigilance, which impacted their wellbeing. Concerns about interpersonal violence, fear for their children's safety, and lack of security in the camp. 2) The effects of constant vigilance: to enhance safety, women kept their children near them and stayed in places they considered safer. Many women and children could not sleep and suffered from nightmares. Sadness and depression were common in children. 3) Lack of resources: women lived in temporary camping tents, which impacted safety. 4) Uncertainty: participants lacked information about free legal aid services and did not know where or how to report violence.	Study is one of few to describe the conditions along the US border. However, the sample was homogenous (Spanish speaking women from one camp), which limits generalisability.

1.7.3 Quality Assessment

All studies provided a meaningful contribution to the literature and were of sufficient quality to be included in the review. Whilst nearly all the studies identified a clear research question, two studies (Murphy et al., 2018; Grønseth & Thorshaug, 2022) did not clearly define a research question; however, the aim of these studies was still able to be deduced. All studies used an appropriate methodology to address the research aim.

Most studies' samples were composed solely of asylum seekers; however, some studies had mixed samples. Three studies' mixed samples included both refugees and asylum seekers (Ziersch et al., 2017; Eisen et al., 2021; Dudek et al., 2022); however, the results were presented so that findings relevant for asylum seekers could be extracted. One study employed a mixed sample with asylum seekers and staff from the accommodation centre where the asylum seekers were housed (Whitehouse et al., 2021). Although having multiple perspectives enhanced the research findings, insufficient detail was provided about how conflicting views were dealt with when analysing data from the mixed sample.

Most studies sought to understand the experience of adult asylum seekers, but seven studies focused on specific groups of asylum seekers, such as parents (n=3), women (n=3), pregnant women (n=2), and children and young people (n=1). Small sample size (less than 10 participants) was a limitation for numerous qualitative studies (Gewalt et al., 2018; Gewalt et al., 2019; Lietaert et al., 2020; Grønseth & Thorshaug, 2022; Domínguez et al., 2022).

Multiple studies employed purposeful recruitment at only one or two sites, such as a day care centre for asylum-seeking parents (Hedstrom et al., 2021), a reception centre (Grønseth & Thorshaug, 2022; Lietaert et al., 2020), a detention centre ((Amarasena et al., 2023), or two

accommodation centres (van Eggermont Arwidson et al., 2022; Whitehouse et al., 2021). Most studies adequately reflected on the homogeneity of their sample and how this limited the generalisability of their findings, but some studies did not sufficiently acknowledge this limitation (Grønseth & Thorshaug, 2022).

Although most qualitative studies solely used interviews to collect data, three studies used ethnography (Grønseth & Thorshaug, 2022; Moreira et al., 2020; Lietaert et al., 2020) and one study used auto-photography (Grønseth & Thorshaug, 2022) combined with interviews. Additional data collection methods enriched the findings, but insufficient information was provided about how the researchers combined data from interviews, ethnography, and auto-photography. It was unclear what findings came directly from asylum seekers (e.g. quotes from interviews) compared to what findings came from the researchers themselves (e.g. field observations). It was also unclear how conflicting findings were managed, such as if asylum seekers' statements contradicted the researchers' observations.

Many qualitative studies relied on the use of interpreters; however, only some acknowledged this as a limitation. For example, van Eggermont Arwidson et al. (2022) reflected that some nuances may have been lost in translation. Gewalt et al. (2018) and Gewalt et al. (2019) also critically reflected on the use of interpreters, recognising that the interpreter's presence may have impacted participants' statements. One study conducted interviews entirely in English (Moreira et al., 2020), which limited the pool of participants and may have influenced the study's findings, as English-speaking asylum seekers may have different views/experiences compared to non-English speaking asylum seekers. Researchers for one study conducted both interviews and data analysis in the native language of participants (Spanish) (Laughon et al.,

2022). This prevented nuances from getting lost in translation; however, it also created a homogenous sample (only Spanish speakers), which limited generalisability.

Most qualitative studies would have benefited from greater reflexivity, in particular reflecting on the relationship between researchers and asylum-seeking participants and how power dynamics may have influenced participants' decision to partake in the study and what they disclosed in interviews. A notable exception was Domínguez et al. (2022)'s study, which stood out due to its robust approach to thematic analysis, which included a description of reflexivity and how peer debriefing was used to reflect on potential biases related to researchers' shared identities with participants. Lietaert et al. (2020) also demonstrated excellent reflexivity; the researchers had very different identities to their participants and reflected extensively on this, considering how their identities as white Belgian females influenced data analysis.

A challenge faced by some quantitative studies (Kashyapa et al., 2019; Eisen et al., 2021; Whitsett & Sherman, 2017) was measuring 'housing' for asylum seekers in a bifurcated manner (e.g. 'stable' vs 'unstable') so that housing could be used as a factor for regression analysis. Some studies did not clarify how they defined 'stable' housing (Kashyapa et al., 2019, Whitsett & Sherman, 2017), whereas other studies classified housing as 'stable' based on whether asylum seekers had their own room/apartment (e.g. Eisen et al., 2021). Focusing solely on whether asylum seekers had their own room/apartment fails to account for other factors that affect stability, such as whether asylum seekers face a constant threat of displacement from their accommodation, as is often the case for asylum seekers with ongoing asylum claims. Most studies did not adequately reflect on the problem of classifying housing in a reductionist manner as 'stable/unstable' (Kashyapa et al., 2019; Whitsett & Sherman,

2017); however, Eisen et al. (2021) acknowledged this problem, admitting the possibility that housing classified as 'stable' may actually have had a negative impact on participants' mental health due to other factors relevant to housing, such as overcrowding, unfriendly roommates, or neighbourhood safety.

Quantitative studies that recruited participants from mental health services (Whitsett & Sherman, 2017; Kashyapa et al., 2019; Eisen et al., 2021) used valid and reliable outcome measures to measure symptoms of anxiety, depression, and trauma, such as the Harvard Trauma Questionnaire (HTQ), the Hopkins Symptom Checklist (HSCL), and Patient Health Questionnaire-9 (PHQ-9). The use of robust outcome measures that have been evaluated across cultures (Renner et al., 2006; Kaaya et al., 2002; Lotrakul et al., 2008) enhanced these studies and allowed for comparison to clinical populations in other mental health services.

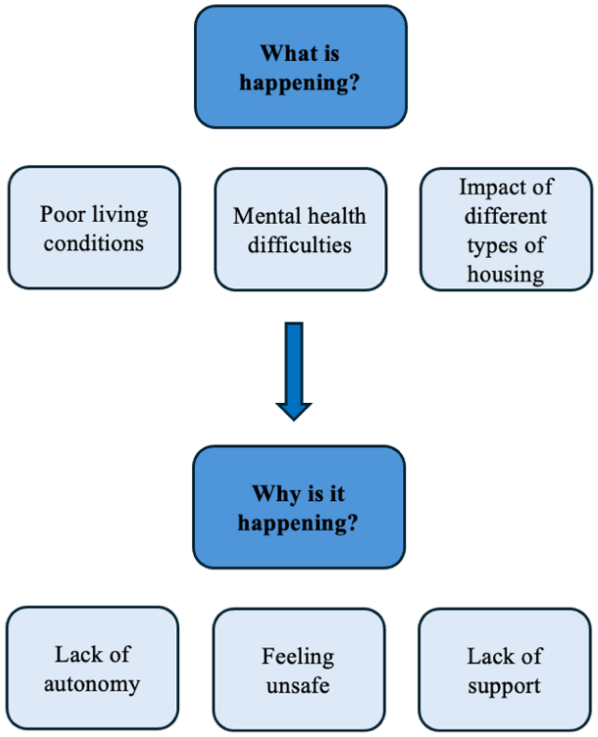
All studies provided a clear statement of findings related to their research aim and considered this in the context of the wider literature. Overall, while there were some limitations to the quality of the studies, the findings made a valuable contribution to the literature and had important implications for clinical practice and policy. Therefore, the studies were deemed to be of sufficient quality for inclusion in the narrative synthesis.

1.7.4 Synthesis of Findings

Popay et al.'s (2006) narrative synthesis framework was used to identify themes to answer the research question: 'What is the association between housing and asylum seeker's mental health?' For clarify, themes have been grouped under two headings: 'What is happening?' and 'Why is it happening?' (see Figure 2).

Figure 2

Themes from systematic literature review



1.7.4.1 What is Happening?

Three themes explain what is happening: poor living conditions, mental health difficulties, and the impact of different types of housing.

1.7.4.1.1 Poor Living Conditions

Asylum seekers reported that poor living conditions negatively impacted their mental health. Poor living conditions included lack of space (Grønseth & Thorshaug, 2022; Ziersch et al., 2017), poor hygiene standards (Gewalt et al., 2019), fear of disease (Gewalt et al., 2019), dirty showers and toilets (Lietaert et al., 2020), overcrowding (Moreira et al., 2020; Ziersch et al., 2017), loud noises (Moreira et al., 2020; Gewalt et al., 2019), cold (Moreira et al., 2020; Ziersch et al., 2017), and damp (Ziersch et al., 2017). Poor living conditions were a major

source of stress for asylum seekers who linked deterioration in their mental health to their living conditions (Whitehouse et al., 2021).

Whether housing was deemed suitable or unsuitable depended on the presence of poor living conditions (e.g. damp and cold) and the absence of good living conditions (e.g. sufficient space and good hygiene standards). Unsuitable housing impacted asylum seekers' mental health, causing new mental health difficulties and exacerbating pre-existing mental health difficulties.

1.7.4.1.2 Mental Health Difficulties

Asylum seekers living in unsuitable housing reported a myriad of mental health difficulties. The most cited mental health difficulties across studies included anxiety, depression, PTSD, self-harm, suicidal ideation, and sleep difficulties. In a clinical sample of 105 asylum seekers in the USA, stable, uncrowded housing conditions significantly predicted lower depression, anxiety, and trauma symptoms (Whitsett & Sherman, 2017), demonstrating the impact of housing on asylum seekers' mental health. An Australian study comparing 2,399 asylum seekers to 21,462 Australian citizens found that asylum seekers were at a greater risk of poor mental health due to unsuitable housing (Martino et al., 2022). Asylum seekers in unsuitable housing were 2.4x more likely than asylum seekers in suitable housing to experience poor mental health.

Clean housing in good condition positively impacted mental health, whereas unsuitable housing negatively impacted mental health (Ziersch et al., 2017). Participants reported that poor living conditions exacerbated psychological distress, causing sadness, fear, insomnia, anxiety, and depression (Moreira et al., 2020). Numerous studies reported that asylum

seekers' mental health deteriorated to the point that they experienced suicidal thoughts or self-harmed (Lietaert et al., 2020; Hedrick et al., 2020; Amarasena et al., 2023; Hedrick et al., 2019). Domínguez et al. (2022) described mental health deterioration as a form of 'psychological violence', which encompassed the descent into anxiety, hopelessness, dehumanization, fear, and helplessness. Participants reported an increased prevalence of mental health symptoms, including nightmares, sleep difficulties, crying, intrusive thoughts, flashbacks, avoidance, and detachment. Living in a state of constant worrying and 'overthinking' harmed mental health. Furthermore, being a parent with children worsened anxiety, as parents experienced additional worries about their children's wellbeing (van Eggermont Arwidson et al., 2022).

In the only study that focused solely on children's wellbeing, mental health concerns were found in nearly 4 out of 5 asylum seeking children (79%) subjected to Australia's offshore detention policy (Amarasena et al., 2023). Children's most frequent symptoms included low mood (47%), sleep difficulties (47%), and suicidal ideation or self-harm (45%). The most commonly diagnosed mental health conditions in children included depression (45%) and PTSD (13%). Laughon et al. (2022) also found that parents reported a high prevalence of mental health difficulties in their children, with sadness and depression being frequently reported.

1.7.4.1.3 Impact of Different Types of Housing

Different types of housing impact asylum seekers' mental health differently. In a German study that examined the impact of different types of housing on 1,535 participants' health, living in collective housing was significantly associated with poorer mental health compared to living in private housing, adjusting for age, gender, country of origin, and current

work/education (Dudek et al., 2022). The study found that collective housing differed from private housing regarding space, neighbourhood, level of restrictions, social connections, contact with neighbourhood locals, and feelings of safety. Asylum seekers in collective housing reported being more socially isolated than their private housing counterparts and spent more time feeling bored. They also reported the lowest scores on belonging and satisfaction with their living situation. Ziersch et al. (2017) also found that collective housing harmed mental health, particularly for single male asylum seekers due to lack of space, privacy, and incompatibility with roommates.

Detention was identified as another type of housing that harmed mental health. A study focused on asylum-seeking children found that children held in detention for over a year were more likely to experience mental health difficulties (Amarasena et al., 2023). Moreover, a nationwide Australian study that examined self-harm rates among adult asylum seekers found that self-harm rates were the highest among asylum seekers in detention facilities and the lowest among asylum seekers in community housing (Hedrick et al., 2019). Rates of self-harm among asylum seekers in off-shore detention were 52x higher than the lowest recorded self-harm episode rates for community-housed asylum seekers. An American study focused on asylum seekers in detention identified ‘detention violence’ as an overarching theme with four subthemes of physical violence, ethnoracial violence, psychological violence, and violence against children. These studies demonstrate the deleterious impact of detention on asylum seekers’ mental health.

Although nearly all the studies found a significant association between housing and mental health, two studies presented contrary data. Eisen et al. (2021) found that changes in housing status were not associated with a change in PTSD symptom levels ($p = .236$) or depressive

symptom levels ($p = .318$). However, this was a small study (78 participants), so it is possible that the study was not sufficiently powered to detect a significant effect. Additionally, housing was measured in a reductionistic manner as 'stable' or 'unstable', which may have missed other factors that impact mental health that were identified by other studies, such as lack of space, privacy, and incompatibility with roommates (Ziersch et al., 2017). Thus, it is possible that housing categorized as 'stable' by the study still negatively impacted asylum seekers' mental health because of other factors. Kashyapa et al. (2019) also found that housing was not directly associated with reduced PTSD or depression severity, but it had the same problem as the previous study, in that it classified housing in the reductionistic manner of 'stable' or 'unstable'.

In summary, most studies found a significant association between housing and mental health, with some types of housing being viewed as more detrimental than others. Collective housing was identified as more damaging for mental health than private housing. Detention was highlighted as the worst form of housing, associated with the highest levels of self-harm. Private housing and community housing were viewed as better alternatives, and relocating to more suitable housing improved mental health, providing relief from symptoms of depression (Ziersch et al., 2017).

1.7.4.2 Why is it Happening?

Three themes explain why housing impacts asylum seekers' mental health: lack of autonomy, feeling unsafe, and lack of support. The fourth theme explores coping strategies.

1.7.4.2.1 Lack of Autonomy

Many studies reported that lack of autonomy regarding housing caused psychological stress. Subthemes included dependence, lack of privacy, and lack of resources. Asylum seekers expressed frustration about being unable to choose where they lived (Hedstrom et al., 2021) or improve their living conditions, causing them to feel powerless (Gewalt et al., 2018). Asylum seekers living in accommodation centres were subjected to austere regulations, such as strict timing for canteen hours (Lietaert et al., 2020), having to sign in and out (Murphy et al., 2018), and not being allowed to choose or cook their own food (Gewalt et al., 2019). Parents faced additional challenges and reported limited parental agency, such as having to ask and be given permission for basic things, including meeting their children's needs (Lietaert et al., 2020). This resulted in loss of autonomy and self-efficacy as parents. Asylum seekers compared their accommodation centre to a prison (Whitehouse et al., 2021; Murphy et al., 2018) because their choices and behaviour were similarly controlled and decisions were made for them (e.g. what to eat and when to eat it). This caused them to feel like dependent children (Murphy et al., 2018).

Lack of privacy also undermined asylum seekers' autonomy and negatively impacted their mental health (Gewalt et al., 2018 Ziersch et al., 2017). Being forced to share their bedroom with strangers created feelings of insecurity (van Eggermont Arwidson et al., 2022) and often resulted in conflict exacerbated by different cultural expectations and lack of a common language (Whitehouse et al., 2021). For vulnerable pregnant women, having to share their room with unknown and sometimes aggressive people caused them to feel anxious, especially at night (Gewalt et al., 2019).

In addition to lack of privacy, lack of resources also contributed to asylum seekers' autonomy loss. Many studies reported a lack of financial resources (Gewalt et al., 2019; Hedstrom et al., 2021; van Eggermont Arwidson et al., 2022; Whitehouse et al., 2021). Insufficient finances caused psychological stress, particularly for parents who felt guilty about being unable to provide for their children (Hedstrom et al., 2021). Mothers expressed frustration about their restricted ability to respond to their children's needs, causing them to feel like they were failing as mothers (Murphy et al., 2018). Asylum seekers also experienced a lack of opportunity for meaningful activities, such as work and study (Hedstrom et al., 2021). This resulted in a diminishment of purpose and meaning in life (Murphy et al., 2018). Parents attempted to protect their children by not talking about stresses in front of them; however, maintaining a false pretence of normalcy damaged parents' mental health (Hedstrom et al., 2021).

1.7.4.2.2 Feeling Unsafe

The second theme that explains the association between housing and mental health is feeling unsafe. Many studies described housing replete with violence and aggression (Gewalt et al., 2018; Gewalt et al., 2019; Laughon et al., 2022; Lietaert et al., 2020; Moreira et al., 2020). Violence was reported across the spectrum of types of housing included in this review, from refugee camps to accommodation centres. In a Greek study in which most parents described their children's health as deteriorating, feeling safe was an alleviating factor (De Montgomery et al., 2019). Feeling unsafe caused asylum seekers to live in a state of constant vigilance (Laughon et al., 2022) and be hyperalert to verbal and physical threats of violence. Constant vigilance and feeling unsafe caused restless sleep, particularly for vulnerable women and children (Gewalt et al., 2019). Parents described their children suffering from nightmares

(Laughon et al., 2022) and displaying symptoms of anxiety, anger, and behavioural problems (Hedstrom et al., 2021).

Furthermore, sharing housing with strangers exacerbated feeling unsafe. In accommodation centres, parents felt powerless and unable to protect their children from other residents who reportedly displayed concerning behaviours, including insulting people, fighting, and physical and sexual violence towards their children (Lietaert et al., 2020). In refugee camps, people from different nationalities and cultural backgrounds were compelled to live together, often resulting in violent conflict and aggression (Moreira et al., 2020). For asylum seekers with mental health difficulties related to past traumas, living with unknown people aggravated re-experiencing symptoms of pre-migration traumas (van Eggermont Arwidson et al., 2022).

1.7.4.2.3 Lack of Support

The third theme that explicates the association between housing and mental health is lack of support. Asylum seekers' housing fostered a lack of support from asylum-seeking peers, the local community, and professionals. Many asylum seekers reported feeling socially isolated (Gewalt et al., 2018) and experiencing a lack of belonging in their community (Murphy et al., 2018). Attempts to build social support with other asylum seekers proved challenging due to short stays in reception centres, the frequency of transfers between accommodations, and language barriers (Gewalt et al., 2018). Some asylum seekers described feeling wearied by interacting with people who constantly came in and out of their lives (Grønseth & Thorshaug, 2022), preventing the formation of support networks.

Moreover, asylum seekers struggled to connect with locals in their community. An Irish study described asylum seekers' difficulties forming new relationships due to their stigmatised 'asylum seeker' identity, which prevented them from feeling part of the Irish community (Murphy et al., 2018). A Germany study found that 70% of collective housing residents had no contact with neighbourhood locals (Dudek et al., 2022), which demonstrates the insularity of asylum housing. Factors that contribute to limited access to the wider community included restricted public transport networks and prohibitive costs (van Eggermont Arwidson et al., 2022). Lack of social support from asylum-seeking peers and the local community created a sense of social isolation for asylum seekers, which impacted their mental health (Ziersch et al., 2017).

In addition to lack of support from peers and the local community, many asylum seekers reported lack of support from professionals. Moreira et al. (2020) described limited access to health care professionals, which impacted health. Laughon et al. (2022) found that asylum seekers lacked information about free legal services and about procedures for reporting violence. A Belgian study, which included both asylum seekers and accommodation staff, found poor communication between asylum seekers and staff (Whitehouse et al., 2021). Asylum seekers thought that staff communicated disrespectfully, causing them to respond with animosity towards the system or the staff enforcing it. Asylum seekers also reported that staff were insensitive to their needs, which engendered feeling of worthlessness and social isolation.

1.7.4.2.4 Coping Strategies

The fourth and final theme, coping strategies, describes the ways in which asylum seekers attempted to prevent housing difficulties from negatively impacting their mental health

Subthemes include faith, hope, and social support. Many asylum seekers found solace in their faith and relied on religion and prayer to cope with difficulties (Domínguez et al., 2022; (Gewalt et al., 2018) (van Eggermont Arwidson et al., 2022). An American study that examined sources of resilience reported that asylum seekers relied on 'Dios' [God] for survival (Domínguez et al., 2022). Asylum seekers also coped by maintaining a desire for liberation (Domínguez et al., 2022) and holding onto hope that their situation would improve in the future (Gewalt et al., 2018).

In addition to their internal resources (faith and hope), asylum seekers also looked externally, finding comfort in social support from family and friends (Domínguez et al., 2022), helpful professionals (Gewalt et al., 2018), and people in their community (Whitehouse et al., 2021). Expressing care and concern for other asylum seekers improved mental health (van Eggermont Arwidson et al., 2022), as well as spending time outside the centre and integrating into the local community (Whitehouse et al., 2021). Helping others created a sense of connectedness and satisfaction at doing something meaningful (van Eggermont Arwidson et al., 2022), which was protective for mental health.

1.8 Conclusions

To the best of the authors' knowledge, this is the first systematic literature review to critically examine the association between housing and asylum seekers' mental health. Key strengths include the scope of the review, which encompassed all study designs, including quantitative, qualitative, and mixed methods designs. Moreover, the literature was thoroughly explored using multiple databases with peer-reviewed research and grey literature. Selection and publication bias was minimized by using two independent reviewers in both title/abstract screening and full-text review of the studies (Stoll et al., 2019). The review filled a gap in the

literature by focusing specifically on asylum seekers, as prior research indicates a dearth of studies and knowledge pertaining to the association between housing and asylum seekers' mental health (Ziersch & Due, 2018). Asylum seekers are often considered 'hard to reach' (Enticott et al., 2018), which reflects the lack of research on this population. However, this review identified numerous recently published studies on asylum seekers, which is indicative of increased interest in researching asylum seekers in the context of increasing numbers of asylum seekers worldwide (UNHCR, 2023).

The review is not without limitations, including limitations pertaining to the inclusion criteria and methodological issues pertaining to the included studies. The inclusion criteria was limited to studies published in English, which presents a potential bias and could have resulted in relevant studies published in other languages being excluded. Future research would benefit from including studies published in other languages, particularly given the population being studied (asylum seekers who speak different languages). Methodological issues pertaining to the included studies was a further limitation. There is no universally agreed upon definition of 'stable' or 'unstable' housing, which made comparisons between studies challenging. Housing classified as 'stable' in one study could have been classified as 'unstable' in a different study because each study used a different definition of housing stability. Furthermore, studies used a myriad of different mental health measures with asylum seekers who originate from diverse cultures. A lack of validated and culturally appropriate measures for use with asylum seekers made cross-cultural comparisons challenging and limited the generalisability of the findings.

Despite these limitations, the review still made a meaningful contribution to the limited literature on the association between housing and asylum seekers' mental health. The review

identified three themes (poor living conditions, mental health difficulties, and the impact of different types of housing), which indicate that asylum seekers are subjected to poor living conditions, which impact their mental health. The review found that some forms of housing for asylum seekers are particularly detrimental for mental health, and other types of housing can improve mental health. Collective housing was identified as more damaging for mental health than private housing. Detention was highlighted as the worst form of housing, associated with the highest levels of self-harm. Private housing and community housing were viewed as better alternatives for asylum seekers' mental health. Finally, relocating to more suitable housing was found to improve mental health, providing relief from symptoms of depression.

These findings have clear policy and clinical implications. Policy implications include the need to safely house all asylum seekers with an emphasis on safeguarding the most vulnerable asylum seekers, including pregnant women, families with children, and mentally unwell asylum seekers. Collective housing and detention should be avoided for all asylum seekers, as these types of housing are detrimental for mental health. Placing asylum seekers in private and community housing may improve mental health outcomes. Furthermore, the review identified three themes to explicate why housing impacts asylum seekers' mental health: lack of autonomy, feeling unsafe, and lack of support. Unsuitable housing fosters a lack of autonomy and causes asylum seekers to feel unsafe, engendering mental health deterioration. Lack of support from asylum-seeking peers, the local community, and professionals contributes to a sense of social isolation that further destabilizes mental health.

These findings indicate the need for clinical interventions that go beyond psychiatric treatments and target psychosocial wellbeing, addressing issues of social isolation and supporting asylum seekers to manage psychosocial difficulties, including housing problems. Social isolation could be addressed through initiatives such as social prescribing and community support groups. Psychosocial difficulties, including feeling unsafe in one's accommodation, could be addressed by ensuring that housing placements are in safe neighbourhoods and providing asylum seekers with information to address behaviours that make them feel unsafe (e.g. process for calling the police, access to interpreters to raise issues, complaints procedures). This would empower asylum seekers to address housing issues and help restore their autonomy.

The review found that asylum seekers use three coping strategies to reduce the impact of housing difficulties on mental health: faith, hope, and social support. As faith and hope are internal resources, clinicians should keep these in mind and encourage their asylum-seeking clients to seek solace in their faith and maintain a sense of hope for the future. As social support was identified as the third coping strategy, it is important to note barriers that prevent asylum seekers from accessing social support, including frequent accommodation transfers, language barriers, stigmatization, restricted public transport networks, prohibitive costs, lack of access to professionals, and poor communication between asylum seekers and staff. Policy changes should be implemented to address these barriers, such as providing interpreters to enable communication between asylum seekers and staff, increasing access to public transportation (e.g. free bus passes), and language classes in the community to reduce stigmatization and promote integration.

Overall, this systematic literature review reinforces the importance of housing for asylum seekers' mental health. It fills a gap in the literature and has clear policy and clinical implications for addressing the impact of housing on asylum seekers' mental health.

1.9 Rationale for the Current Study

Research indicates an urgent need for studies on the impact of housing on asylum seekers' health (Ziersch & Due, 2018). The Home Office is increasingly housing asylum seekers in temporary accommodation (mainly hotels) for prolonged periods; therefore, it is crucial to evaluate the impact of this specific type of accommodation on asylum seekers' mental health. Very little research has been published about the impact of living in hotels, and most studies have focused primarily on physical health rather than mental health (Refugee Council, 2021; Jones et al., 2022; Action Foundation et al., 2021; British Red Cross, 2021). Therefore, this research aims to fill the gap by focusing on the impact of living in hotel accommodation on asylum seekers' mental health. Clinical psychologists often assess the mental health of asylum seekers for their asylum claims and support asylum seekers who access their local NHS services (Beck et al., 2019); therefore, this research is highly relevant for clinical psychologists.

1.10 Current Study Aims and Research Question

This research aims to understand the impact of hotel accommodation on asylum seekers in the UK, considering the impact on their mental health and ability to engage with the asylum-seeking process. The research question is 'What is the impact of hotel accommodation on the mental health of asylum seekers in the UK?'

2. Methodology

2.1 Overview of Methodology

This chapter describes the study's mixed methodology. Firstly, it details the quantitative methodology used to measure whether there was a difference in mental health screening questionnaires for asylum seekers living in hotels compared to asylum seekers living in alternative accommodation. Secondly, it details the qualitative methodology used to explore the impact of hotel accommodation on asylum seekers' mental health.

2.2 Design

A mixed methods sequential explanatory design (Creswell & Creswell, 2018) provided a structure for the collection of quantitative data drawn from mental health screening questionnaires. This was followed, sequentially, by in-depth interviews, which were used to explain and add meaning to the quantitative data. While the quantitative data answered the research question, 'What is the impact of hotel accommodation on asylum seekers' mental health?', the qualitative data added deeper understanding and contextualisation, answering the question of why hotel accommodation impacts asylum seekers' mental health. Figure 3 illustrates the design.

Figure 3

Mixed methods sequential explanatory design

2.2.1 Epistemology and Positionality

A critical realist epistemological framework was selected because it can accommodate mixed quantitative and qualitative methods (Harper & Thompson, 2020). Critical realism has been described as a useful middle ground between positivism (often more aligned with quantitative methods) and postmodernism (often more aligned with qualitative methods) (Pilgrim, 2020); therefore, it was ideal for this study. A critical realist epistemology has been successfully used for other mixed methods psychological studies (e.g. Roberts et al., 2017; Wright et al., 2019), demonstrating its utility for this study. A critical realist lens allowed me to triangulate and use different sources of data (i.e. mental health screening questionnaires and interview data) to answer the research question.

It is also important to consider how my positionality influenced the methodology. As previously mentioned (see 1.2.1 on Positionality), coming from a family of refugees but not being a refugee myself gave me insider-outsider status (Dwyer & Buckle, 2009). I did not reveal my insider status to participants because it could have influenced what they shared in interviews. For example, if they felt an urge to protect me, they may not have shared as many details with me. Thus, occupying an outsider position in relation to participants impacted interview data. My insider position became more evident during data analysis because my background influenced my assumptions, values, and understandings, which influenced my interpretation of participants' accounts. When using reflexive thematic analysis (TA) (Braun & Clarke, 2019) researcher subjectivity is viewed as a strength rather than a liability if the researcher takes a values-aware stance (Gough & Madill, 2012) and acknowledges her influence on the research. I aimed to do this throughout the research process.

2.2.2 Rationale for a Mixed Methods Approach

When researching asylum seekers who originate from many cultural backgrounds and have different cultural idioms of distress, it has been argued that a mixed-methods approach is superior because it incorporates quantifiable data about participants' symptoms and subjective data about their lived experience (Bernardes et al., 2010). The current study's quantitative component provided data about participants' mental health symptoms and post-migration living difficulties using mental health screening questionnaires, and the qualitative component provided an in-depth exploration of participants' lived experience.

Within the field of research on refugees and asylum seekers, there is an abundance of quantitative and qualitative studies; however, there is a lack of mixed methods research. The systematic literature review in this thesis demonstrates this, as it contained 9 quantitative

studies, 12 qualitative studies, and 0 mixed methods studies. Although mixed methods studies are more labour-intensive, as they require the collection and analysis of quantitative and qualitative data, they provide results that neither quantitative nor qualitative studies could provide on their own (Creswell & Creswell, 2018). In mixed methods research, data integration allows the research to incorporate an understanding of both breadth (quantitative data) and depth (qualitative data), allowing for new insight.

When combining quantitative and qualitative data, researchers often use the strategy of triangulation, which involves investigating a phenomenon from different vantage points (Brannen, 2005). However, triangulation does not always result in corroboration, as the quantitative and qualitative data may not reflect the same result. When quantitative and qualitative data are integrated in mixed methods research, there are various possible results, including corroboration, elaboration, complementarity, and contradiction (Brannen, 2005). Corroboration involves deriving the same results from both the quantitative and qualitative data. Elaboration involves the qualitative data analysis illustrating how the quantitative findings apply in specific cases. Complementarity involves the qualitative and quantitative results differing, but generating new insights when viewed together. Lastly, contradiction involves the qualitative and quantitative findings conflicting (Brannen, 2005). In this study, data integration resulted in corroboration and elaboration, as the quantitative data answered the research question (What is the impact of hotel accommodation on asylum seekers' mental health?) and the qualitative data corroborated the quantitative data and provided deeper understanding and contextualisation.

2.2.3 Expert by Experience Consultation

Experts by experience (EbE) shaped this study's focus and refined its methodology. The study was done in partnership with the Helen Bamber Foundation (HBF), a human rights charity that supports refugees and asylum seekers who have experienced extreme cruelties, including torture and trafficking. HBF supports refugees and asylum seekers by providing holistic, specialist support, including therapeutic care, medical consultation, legal protection, counter-trafficking support, and practical support, including welfare and community integration work. The researchers first consulted the HBF research panel, which includes EbE, about potential research topics. EbE recommended that we focus the study on housing, as housing deeply impacts asylum seekers' lives. After agreeing to focus on housing, we met again with EbE; on 10/4/2023 we held a focus group in which two researchers (JS and KK) met with three EbE. The EbE shared about their experience living in hotels and consulted about interview questions. The findings from this focus group helped refine the interview schedule, ensuring that the questions were relevant and meaningful.

Quantitative Methodology

2.3 Participants

Participants were drawn from HBF's client database, which contains demographic data and routinely collected mental health screening questionnaires.

2.3.1 Inclusion and Exclusion Criteria

Table 7 depicts the inclusion and exclusion criteria.

Table 7

Quantitative data inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
• Asylum seekers referred to HBF between August 2021 and August 2023 • Adults (over 18 years old) • HBF clients who consented for their data to be used for research purposes	• Asylum seekers who were not referred to HBF between August 2021 and August 2023 • Children (under 18 years old) • HBF clients who did not consent for their data to be used for research purposes

2.3.2 Recruitment

When clients are referred to HBF, they sign a consent form to indicate if they consent for their anonymized data to be used for research purposes. According to the inclusion and exclusion criteria, only clients who consented had their data included in the study.

2.4 Ethical Considerations

This study was approved by the University of Hertfordshire's Health, Science, Engineering & Technology Ethics Committee (protocol number LMS/PGR/UH/05301) (Appendix C). Key ethical considerations for the quantitative component of the study included consent, confidentiality, data sharing, and storage.

Regarding consent, an important ethical consideration was whether HBF clients might feel compelled to participate in research and share their data. Therefore, at the point of being referred to HBF, clients were informed of their right to not participate in research and the consent form (Appendix D) explained that this would not affect the service they received from HBF or their asylum application.

The confidentiality of participants was protected by anonymising demographic and mental health screening questionnaire data and storing the data securely, first on HBF digital storage, then on University of Hertfordshire storage on a password-protected university OneDrive account that only the research team could access.

2.5 Data Collection and Measures

Data was collected by HBF as part of routine clinical care. At the point of data transfer (13/12/2023), the external supervisor (KK) who works for HBF transferred the anonymised data to the primary researcher (JS), who stored the data securely on a university OneDrive.

Data included demographic data (age, gender, and country of origin), information about housing (whether clients were living in hotel accommodation or alternative accommodation), and routinely collected mental health screening questionnaires (CORE-10, PHQ-9, and PMLD). The next section contains background information about the questionnaires.

2.5.1 CORE-10

The Clinical Outcome in Routine Evaluation-10 (CORE-10) is a validated measure for common presentations of psychological distress (Barkham et al., 2013). It contains 10 questions, and each question is given a score between 0 and 4, with 4 representing the highest level of distress (McInnes, 2018). CORE-10 has good internal reliability ($\alpha = .90$) and a criterion validity of .94 in a clinical sample and .92 in a non-clinical sample (Barkham et al., 2013). It also has good cross-cultural validity (Biescad & Timulak, 2014; Kristjánsdóttir et al., 2015), making it an appropriate instrument to measure psychological distress in a diverse sample of asylum seekers.

2.5.2 PHQ-9

The Patient Health Questionnaire 9 (PHQ-9) is a standardised and validated measure of the severity of symptoms of major depressive disorder (Kroenke et al., 2001). It has been evaluated across cultures (Lotrakul et al., 2008) and contains 9 questions; each question is given a score between 0 and 3, with 3 representing the highest level of depressive symptoms. PHQ-9 has good internal consistency in clinical samples (α = .90) (Lowe, 2004) and good criterion and construct validity (Kroenke et al., 2001) in clinical populations. Additionally, it has good cross-cultural validity (Lotrakul et al., 2008), making it an apropos tool to use with a diverse sample of asylum seekers.

2.5.3 PMLD

The Post-Migration Living Difficulties Questionnaire (PMLD) is a self-rated questionnaire used to assess adverse life experiences in the host country after migration (Silove et al., 1997). It consists of 23 possible post-migration living difficulties, such as discrimination, isolation and housing problems, and respondents indicate to what extent they are troubled by these difficulties on a five-point Likert scale from ‘no problem at all’ (1) to ‘a very serious problem’ (5). The PMLD contains a subsection called ‘housing problems’ that contains four questions regarding concerns about homelessness, the threat of eviction, lacking a stable place to stay, and facing major accommodation problems which threaten health and safety (e.g. rats, flooding). Higher PMLD scores indicate higher difficulties in the host country (Lenferik et al., 2021), and higher scores on the ‘housing problem’ subsection indicate more problems with housing. The PMLD has consistently been identified as a predictor of mental health among displaced populations (Schick et al., 2016; Nickerson et al., 2011; Schweitzer, et al., 2006) and has demonstrated good internal consistency in other studies (α = .87) (Wicki

et al., 2021), making it an appropriate tool to measure post-migration housing difficulties in this sample.

2.6 Data Analysis

SPSS Version 24.0 was used to analyse the data. Multiple regression was used to determine how much of the variation in total CORE-10 scores was explained by age, gender, and hotel accommodation. Multiple regression was also used to determine how much of the variation in total PHQ-9 scores was explained by age, gender, and hotel accommodation. For the PMLD, a Mann-Whitney U test was run to assess if there were differences in housing problem subscores between people living in hotel accommodation and people living in alternative accommodation.

Qualitative Methodology

2.7 Why Reflexive Thematic Analysis?

To determine which analytic approach was the best fit for the research question, reflexive TA (Braun & Clarke, 2006, 2019) was considered alongside other qualitative approaches, including grounded theory (Charmaz, 2014) and interpretive phenomenological analysis (IPA) (Smith et al., 2009). This is summarised in Table 8.

Table 8

Rationale for reflexive TA

Qualitative Methodology	Description	Reason for Rejection
Grounded theory (Charmaz, 2014).	• Aims to develop a theory regarding a particular phenomenon derived from the data • Results in a conceptual or theoretical model	• Research did not aim to develop a theory or model from the data set and analysis
Interpretive phenomenological analysis (Smith et al., 2009)	• Aims to understand the meaning of individuals' experiences • Idiographic approach with a small, homogenous sample	• Large, heterogenous sample (16 interviews) did not fit with IPA • Research question called for a focus on themes across all participants rather than analysis of unique details of each participant

Reflexive TA was selected because it fit with the study's research question, mixed methodology, and critical realist epistemology. Reflexive TA acknowledges the researcher's active role in the analytic and interpretive process, as codes are developed into themes. TA can incorporate deductive (top-down) approaches and inductive (bottom-up) approaches when coding and developing themes. I chose to analyse from a primarily inductive position, sticking closely to the data; although, I did acknowledge and reflect on how my prior knowledge and research may have influenced the coding and theme development process.

2.8 Participants

Interview participants were recruited from HBF according to the inclusion and exclusion criteria in Table 9.

2.8.1 Inclusion and Exclusion Criteria

Table 9

Qualitative data inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
• Asylum seekers who have experienced living in UK hotel accommodation for at least 6 weeks • Asylum seekers receiving HBF support • Adults (over 18 years old)	• Asylum seekers who have not experienced living in hotel accommodation for at least 6 weeks • Asylum seekers not receiving HBF support • Children (under 18 years old) • Asylum seekers who are not psychologically stable enough to talk about their housing experiences

2.8.2 Recruitment

The HBF Housing Lead (who supports HBF clients with housing difficulties) identified a list of 35 clients who met the inclusion criteria in May 2023. From this list, we eliminated clients deemed by HBF staff as not being psychologically stable enough to talk about their housing experiences. From May-June 2023 the Housing Lead contacted potential participants by phone or in person if the client was attending regular HBF appointments. The research poster, which contained information about the research and contact information for the researchers, was provided to potential participants to help them decide if they wanted to participate (see Appendix E). The poster also contained information about how potential participants could indicate their interest in participating. Once clients indicated an interest, there was a cooling off period of 48 hours before they were contacted to arrange an interview appointment time.

We aimed to recruit 15 participants based on the use of reflexive TA, time and budget limitations, and the size of the research team. It has been recommended that qualitative studies require a minimum sample size of twelve to reach data saturation (Clarke & Braun, 2013; Vasileiou et al., 2018); however, the concept of data saturation in qualitative research

has been challenged and criticised for not being universally applicable (Levitt et al., 2018). In a systematic analysis examining the justification of sample size sufficiency in qualitative research, Vasileiou et al. (2018) recommended that qualitative researchers be more transparent about evaluations of sample size sufficiency and focus on assessing data adequacy. For this study, a sample size of 15 was viewed as sufficient to obtain an adequate amount of data for reflexive TA. The mixed methods nature of the study was also considered when determining sample size because the quantitative data combined with the qualitative data allowed for triangulation when answering the research question.

Thirty-five HBF clients were eligible to be interviewed, according to the inclusion and exclusion criteria. Aiming to complete fifteen interviews, we scheduled interviews with the first fifteen clients who expressed an interest. Six did not attend their interview on the day, so additional clients from the list were scheduled for interviews. Ultimately sixteen interviews were conducted; the remaining potential participants were thanked and informed that the study no longer required additional participants.

2.9 Ethical Considerations

Key ethical considerations for the qualitative component of the study included consent and confidentiality, data sharing and storage, and potential distress. On the day of the interview informed consent was obtained from interview participants using interpreters and checking for understanding before proceeding with the interview. Participant documents, including the participant information sheet (Appendix F), consent form (Appendix G), and debrief form (Appendix H), were simplified to make them more accessible for participants with varying levels of education and English language skills. Participants were informed of their right to

not participate and withdraw from the research at any time; it was explained that this would not affect their support from HBF or their asylum application.

Confidentiality was protected by anonymising demographic forms and storing interview recordings and transcripts on a password-protected university OneDrive account that only the research team could access. Interpreter confidentiality was ensured by asking interpreters to sign a confidentiality agreement (Appendix I). Pseudonyms were used when transcribing data and personally identifying details (e.g. names of specific locations) were removed to protect participants' confidentiality.

Potential distress was carefully considered, given the possibility that interviews could elicit emotional responses from participants. The participant information sheet (Appendix F) explained that participants did not have to talk about anything they did not wish to and could pause or end the interview if they desired. Participants' emotional wellbeing was closely monitored throughout interviews with regular check-ins and a debrief at the end in which they were signposted to sources of support, including an on-call HBF clinician.

Considering interpreter wellbeing, only HBF interpreters who had training in trauma-informed approaches and experience working with asylum seekers were used. Interpreters were briefed about the research before the interview started and had a post-interview debrief with the researcher. The researcher also prepared signposting materials for interpreters (Appendix J).

The researcher's experience as a clinical psychologist in training was used to identify and respond to distress in interpreters and participants. For example, when a participant began

showing signs of distress, the researcher paused the interview, offered the participant water, and used grounding techniques to support the participant's wellbeing. After taking a break, the participant was asked if she wanted to end or recommence the interview, and she chose to recommence.

2.10 Data Collection

2.10.1 Resources

Interviews were conducted in-person and recorded using an encrypted recording device. The researcher kept a reflective journal and regularly recorded thoughts and ideas after interviews. The researcher transcribed all interviews and used NVivo 12 software (QSR International, 2018) to analyse interview transcripts.

2.10.2 Interview Schedule

The researcher developed the interview schedule (Appendix K) by generating a list of questions based on prior research related to asylum seekers' mental health and housing. This was first shared with the supervisors, who provided feedback and suggested additional questions. The interview schedule was further refined through conducting a focus group with Experts by Experience. As previously described, this consultation ensured that the interview questions were relevant and meaningful.

2.11 Interview Modality and Procedure

Individual semi-structured interviews were used to collect qualitative data. Individual interviews compared to focus groups allowed for the inclusion of non-English speaking participants (with interpreters) who might otherwise be excluded from contributing to research. The semi-structured interview format allowed for flexibility and adaptation, giving

both participants and the researcher freedom to explore answers to questions in-depth and collaborate to identify and interpret relevant meanings (Reid et al., 2005).

Sixteen interviews were conducted between 14 July 2023 and 1 September 2023 by the primary researcher in person at the HBF office in central London. Participants were reimbursed for their travel expenses to attend the interview. For participants who did not speak English, HBF interpreters were provided and interpreters were briefed to stick to the exact language used by participants.

Firstly, the researcher introduced herself, provided information about the study, and asked participants to sign a consent form. If participants needed assistance reading the participant information sheet and consent form, the interpreter translated the material and ensured that consent was fully informed. Demographic data was collected from participants, including age, gender, nationality, arrival date in the UK, time spent living in hotels, and whether they had children living with them. Participants were encouraged to ask questions and were reminded that they could stop the interview at any time.

The researcher asked participants if they felt ready to commence the interview and started the audio recording. In keeping with a reflexive TA approach, the researcher aimed for interviews to flow like a natural conversation. Therefore, the order of the interview schedule varied for different participants, depending on which questions fit best with the flow of the conversation. Follow-up questions were regularly asked to elicit more in-depth responses.

At the end of the interview, participants were informed that the audio recording was stopped. During the debrief, participants were offered a debrief sheet (Appendix H) with signposting

resources. Participants were also given an envelope that contained money for their travel expenses to get to the interview and a £10 voucher to thank them for participating in the study. After the participant left, a similar debrief was held with the interpreter in which signposting resources were offered and the interpreter was thanked for their assistance.

2.12 Data Analysis

The researcher used qualitative software NVivo 12 (QSR International, 2018) to analyse the data using reflexive TA. The process of analysis followed Braun & Clarke's (2006, 2013, 2019) six-phase process of reflexive TA, as detailed in Table 10. The six-phase model places an emphasis on acknowledging and reflecting upon the researcher's role throughout the analytic process (Braun & Clarke, 2019). Extracts of coding and theme development are shown in Appendix L.

Table 10

Six-phase process of reflexive TA

Phase	Procedures
Phase 1: Data familiarization	• The researcher listened to interview audio recordings and transcribed them by hand to become familiar with the data. • The researcher read and reread the transcripts to immerse herself in the data and begin to identify trends across interviews.
Phase 2: Generating initial codes	• A single coder, the researcher, coded the data using NVivo software. As the researcher went through the transcripts, she continually returned to the research question to ensure that all data relevant to the research question was captured and coded. • Extracts from transcripts were shared with the supervisory team to discuss initial codes and ideas. • The researcher reflected on how her own knowledge and biases might influence her interpretation of the data and choice of codes.
Phase 3: Generating themes	• The researcher used a combination of top-down and bottom-up processes to generate themes based on the initial codes. She took a primarily bottom-up approach, sticking closely to the data when generating themes; however, she acknowledged that her prior knowledge of the topic provided a top-down lens that influenced the coding process and theme generation. • As Braun & Clarke (2020) state, theme generation is an active and creative process in which the researcher plays a central role; therefore, the researcher's knowledge inevitably influenced theme generation. The researcher reflected on this in her reflective journal, considering her influence on the research and the research's influence on her.
Phase 4: Reviewing potential themes	• The researcher met with the supervisory team to discuss potential themes and how they related as patterns of shared meaning. • The researcher continued reviewing potential themes and subthemes until it was felt that the themes and subthemes meaningfully answered the research question. • The researcher met again with the supervisory team to review themes.
Phase 5: Refining, defining and naming themes	• The researcher and supervisory team refined, defined, and named themes to ensure that each theme meaningfully reflected the data (Braun & Clarke, 2006). They considered which participant quotes were the most relevant to capture the essence of each theme.
Phase 6: Writing up	• When preparing to write up the findings, the researcher took time to consider how to convey themes as stories about patterns of shared meaning across the dataset (Braun & Clarke, 2019). The researcher reflected with the supervisory team on her own understanding and position in relation to the chosen themes. • Quotations were discussed and selected to ensure that they portrayed an accurate description of participants' experiences so that the meaning they ascribed to these experiences could be fully expanded upon when writing about themes and subthemes.

According to the study's sequential mixed methods design, the quantitative and quantitative results were analysed separately, then combined through integration in which the qualitative results were connected to the quantitative results (Creswell & Creswell, 2018). The two strands of enquiry were merged, relationships were sought within the theoretical framework, and reflection strategies were used before integrating findings into a coherent whole.

2.13 Quality, Validity, and Self-Reflexivity

2.13.1 Assessing Quality and Validity of the Methodology

The researcher evaluated the quality of the study using the Mixed Methods Appraisal Tool (MMAT; Hong et al., 2018), as described in Chapter 1. The MMAT was selected because of its capacity to appraise studies with mixed methods designs. Additionally, the researcher evaluated the qualitative component of the study according to Braun & Clarke's (2019) Tool for Evaluating Thematic Analysis Manuscripts for Publication, which contains twenty questions to guide assessment of TA research quality, covering categories such as adequate choice and explanation of methods and methodology and well-developed and justified analysis. To enhance the rigor of the qualitative analysis, codes and themes were shared and reflected upon with the supervisory team multiple times, facilitating reflection on researcher subjectivity.

Investigator triangulation was also considered, given the study's critical realist epistemology and ontology, which posit that a mind-independent reality exists (Wikgren, 2004). Creswell & Creswell (2018) emphasize the importance of considering all possible options for how the quantitative and qualitative data may relate to one another when triangulating. Integration of quantitative and qualitative data may result in corroboration, elaboration, complementarity, or

contradiction (Brannen, 2005). In this study, integration resulted in corroboration and elaboration, as the quantitative and qualitative data had the same results, and the qualitative data further illustrated the quantitative findings. Corroboration and elaboration between the study's quantitative and qualitative data were viewed as evidence that the data was suggestive of the participants' reality. Furthermore, when considering the validity of the qualitative data, consistency with the quantitative data was viewed as a further mark of quality assurance.

2.13.2 Self-Reflexivity

Quality reflexive TA requires the researcher to engage reflectively and thoughtfully with their data and the analytic process (Braun & Clarke, 2019). My own experiences and knowledge influenced my approach toward the research topic. My insider-outsider status (Dwyer & Buckle, 2009) due to being from a family of refugees but not being a refugee myself shaped how I positioned myself in relation to participants and the topic. Thus, it was crucial for me to continually reflect on my own understanding of the research and how this developed and changed as the research progressed. Meeting with Experts by Experience and my supervisory team helped me stay grounded and focused on answering the research question. Regularly writing in my reflective journal and re-reading what I previously wrote also facilitated self-reflexivity.

During the latter period of the study, I worked clinically in a service for refugees and asylum seekers, which further shaped my views and understanding of the impact of housing on asylum seekers' mental health. In my reflective journal I documented my thoughts and feelings as I witnessed clients living in hotels and saw first-hand the impact this had on their mental health. I took this to supervision and reflected with my supervisory team on the

overlap between my clinical work and research; as my research informed my clinical work, my clinical work also informed my research.

3. Results

3.1 Overview of Results

Firstly, this chapter presents demographics for the quantitative and qualitative samples. Secondly, under the heading 'What is the impact of hotel accommodation on asylum seekers' mental health?' this chapter details the quantitative analysis of the CORE-10, PHQ-9, and PMLD. Thirdly, under the heading 'Why does hotel accommodation impact asylum seekers' mental health?' this chapter presents the qualitative analysis from 16 semi-structured interviews; these findings expand upon the results of the quantitative analysis, providing insight into why hotel accommodation impacts asylum seekers' mental health. Five main themes were constructed using reflexive TA (Braun & Clarke, 2019): lack of safety, lack of autonomy, social isolation, survival strategies, and ideas for changing the housing system. Each theme comprises several subthemes, discussed in detail and explicated using quotes from interviews.

3.2 Demographics of the Quantitative Sample

The quantitative sample included 147 participants, of which data for the CORE-10 was available for 110 participants, data for the PHQ-9 was available for 111 participants, and data for the PMLQ questionnaire was available for all 147 participants. Table 11 contains demographics for the quantitative sample.

Table 11

Quantitative participant demographics

Gender	Age	County of Origin	Living in Hotel Accommodation
73 females (49.7%) 74 males (50.3%)	Mean = 33.30 (SD = 9.33)	Albania (12.9%), Iran (8.2%), Nigeria (8.2%), Eritrea (6.8%), Sri Lanka (4.8%), Afghanistan (4.1%), Cameroon (4.1%), Ethiopia (3.4%), Turkey (3.4%), Ivory Coast (2.7%), El Salvador (2.7%), Kenya (2.7%), Vietnam (2.7%), Algeria (2.0%), Democratic Republic of the Congo (2.0%), Jamaica (2.0%), Palestine (2.0%), Somalia (2.0%), Bangladesh (1.4%), Brazil (1.4%), China (1.4%), Saudi Arabia (1.4%), Uganda (1.4%), Bahrain (0.7%), Chad (0.7%), Egypt (0.7%), Georgia (0.7%), India (0.7%), Iraq (0.7%), Kazakhstan (0.7%), Kosovo (0.7%), Kyrgyzstan (0.7%), Lebanon (0.7%), Liberia (0.7%), Mali (0.7%), Morocco (0.7%), Myanmar (0.7%), Namibia (0.7%), Pakistan (0.7%), Philippines (0.7%), Russia (0.7%), Rwanda (0.7%), Sierra Leone (0.7%), Sudan (0.7%), Syria (0.7%), Yemen (0.7%)	Yes = 48 (32.7%) No = 99 (67.3%)

3.3 Demographics of the Qualitative Sample

The qualitative sample included 16 participants (see Table 12) from a diverse range of countries including Iran (3), Ivory Coast (2), Cameroon (1), Sudan (1), Palestine (1), Albania (1), Eritrea (1), El Salvador (1), Iraq (1), Uganda (1), Yemen (1), Chad (1), and Ethiopia (1). The average age was 37.88 years with a range of 26 to 52. Participants had lived in a hotel for an average of 1 year 5.44 months. Most participants were male (68.75%), and three participants were living in the UK with children (18.75%). Four participants spoke English fluently (25%), and twelve did not speak English (75%).

Table 12

Interview participant demographics

Pseudonym	Age	Gender	Months living in a hotel
John	52	Male	9
Leah	34	Female	23
Aaron	31	Male	11
Joseph	35	Male	14
Micah	36	Male	24
Naomi	31	Female	20
Isaiah	43	Male	24
Abel	33	Male	18
Jeremiah	43	Male	9
Noah	44	Male	2
Benjamin	50	Male	19
Maria	44	Female	18
Rachel	42	Female	25
Deborah	31	Female	19
Elijah	31	Male	24
Peter	26	Male	20

3.4 Quantitative Results: What is the Impact of Hotel Accommodation on Asylum Seekers' Mental Health?

Quantitative analyses indicate a statistically significant association between hotel accommodation and asylum seekers' mental health.

3.4.1 Quantitative Analysis of CORE-10

A multiple regression was run to determine how much of the variation in total CORE-10 scores was explained by age, gender, and hotel accommodation. There was linearity as assessed by partial regression plots and a plot of studentized residuals against the predicted values. There was independence of residuals, as assessed by a Durbin-Watson statistic of 2.116. There was homoscedasticity, as assessed by visual inspection of a plot of studentized residuals versus unstandardized predicted values. There was no evidence of multicollinearity, as assessed by tolerance values greater than 0.1. There were no studentized deleted residuals

greater than ±3 standard deviations, no leverage values greater than 0.2, and values for Cook's distance above 1. The assumption of normality was met, as assessed by a P-P Plot. The multiple regression model statistically significantly predicted total CORE-10 score, $F(3, 106) = 4.347$, $p = .006$, adj. $R^2 = .084$. There was no statistically significant association between either age or gender and total CORE-10 score, but there was a statistically significant association between hotel accommodation and total CORE-10 score ($p = 0.025$). According to the regression model, predicted total CORE-10 scores for asylum seekers living in hotels was 3.301 points greater than predicted for asylum seekers not living in hotels (with all values of other independent variables being held constant). This indicates that asylum seekers living in hotels are predicted to have higher total CORE-10 scores, indicating higher levels of psychological distress, compared to asylum seekers not living in hotels. Regression coefficients and standard errors can be found in Table 13.

Table 13

Multiple regression results for total CORE-10 score

Total CORE-10 score	*B*	95% CL for *B*		*SE B*	β	R^2	Δ R^2
		LL	*UL*				
Model						.110	.084
Constant	19.362**	13.539	25.186	2.937			
Age	.139	-.009	.286	.074	.177		
Gender	-2.060	-5.032	.911	1.499	-.130		
Hotel Accommodation	3.301*	.431	6.171	1.448	.210		

Note. Model = "Enter" method in SPSS Statistics; *B* = unstandardized regression coefficient; CI = confidence interval; *LL* = lower limit, *UL* = upper limit, *SE B* = standard error of the coefficient; β = standardized coefficient; R^2 = coefficient of determination; Δ R^2 = adjusted R^2.
*p < .05 **p < .001

3.4.2 Quantitative Analysis of PHQ-9

A multiple regression was run to determine how much of the variation in total PHQ-9 scores was explained by age, gender, and hotel accommodation. There was linearity as assessed by partial regression plots and a plot of studentized residuals against the predicted values. There was independence of residuals, as assessed by a Durbin-Watson statistic of 2.153. There was homoscedasticity, as assessed by visual inspection of a plot of studentized residuals versus unstandardized predicted values. There was no evidence of multicollinearity, as assessed by tolerance values greater than 0.1. There were no studentized deleted residuals greater than ±3 standard deviations, no leverage values greater than 0.2, and values for Cook's distance above 1. The assumption of normality was met, as assessed by a P-P Plot. The multiple regression model statistically significantly predicted total PHQ-9 score, $F(3, 107) = 4.125$, $p = .008$, adj. $R^2 = .079$. There was no statistically significant association between either age or gender and total PHQ-9 score, but there was a statistically significant association between hotel accommodation and total PHQ-9 score ($p = 0.046$). According to the regression model, predicted total PHQ-9 scores for asylum seekers living in hotels was 3.306 points greater than predicted for asylum seekers not living in hotels (with all values of other independent variables being held constant). This indicates that asylum seekers living in hotels are predicted to have higher total PHQ-9 scores, indicating higher levels of depression, compared to asylum seekers not living in hotels. Regression coefficients and standard errors can be found in Table 14.

Table 14

Multiple regression results for total PHQ-9 score

Total PHQ-9 score	*B*	95% CL for *B*		*SE B*	β	R^2	Δ R^2
		LL	*UL*				
Model						.104	.079
Constant	9.917**	4.515	15.319	2.725			
Age	.125	-.006	.256	.066	.184		
Gender	-1.598	-4.182	.987	1.304	-.118		
Hotel Accommodation	3.306*	.063	6.548	1.636	.186		

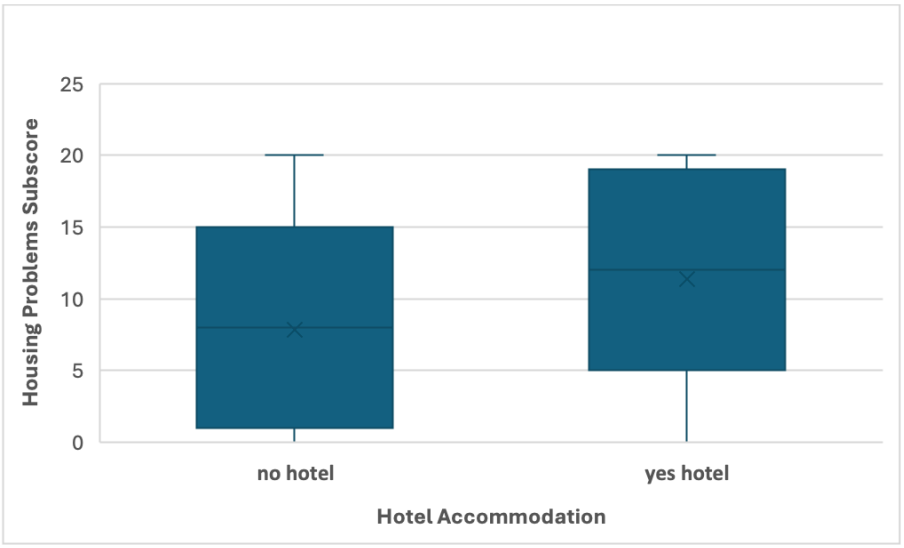
Note. Model = "Enter" method in SPSS Statistics; *B* = unstandardized regression coefficient; CI = confidence interval; *LL* = lower limit, *UL* = upper limit, *SE B* = standard error of the coefficient; β = standardized coefficient; R^2 = coefficient of determination; Δ R^2 = adjusted R^2.
*p < .05 **p < .001

3.4.3 Quantitative Analysis of PMLD

The Shapiro-Wilk's test (p > 0.5) was used to assess whether the housing problem subscore for each level of hotel accommodation was normally distributed. As the data was found to be non-parametric, a Mann-Whitney U test was run to determine if there were differences in housing problem subscores between people living in a hotel and people not living in a hotel. Distributions of the housing problem subscores for people living in a hotel and people not living in a hotel were similar, as assessed by visual inspection. Housing problem subscores were statistically significantly higher for people living in a hotel (Mdn = 12.00) compared to people not living in a hotel (Mdn = 8.00), $U = 3074.00$, $z = 2.899$, $p = 0.004$, using an exact sampling distribution for U (Dineen & Blakesley, 1973). Figure 4 depicts housing problem subscores for people living in hotels compared to people not living in hotels.

Figure 4

Boxplot of housing problem subscore based on hotel accommodation



3.5 Qualitative Results: Why Does Hotel Accommodation Impact Asylum Seekers' Mental Health?

As the quantitative data explained 'What is the impact of hotel accommodation on asylum seekers' mental health?', the qualitative data sought to answer the question 'Why does hotel accommodation impact asylum seekers' mental health?' This section presents the qualitative analysis from 16 semi-structured interviews; these findings expand upon the results of the quantitative analysis, providing more nuanced insight into why hotel accommodation impacts asylum seekers' mental health. Firstly, an overview of the qualitative findings compared to the quantitative findings will be presented. Secondly, the five main themes derived from the qualitative data will be presented.

3.5.1 Comparing Quantitative and Qualitative Results

All interview participants reported that living in a hotel adversely impacted their mental health, which fits with the quantitative findings that demonstrated higher levels of mental

health difficulties for asylum seekers living in hotels compared to asylum seekers living in alternative housing. Interview participants' most commonly reported mental health difficulties included depression (21 references), suicidal ideation (14 references), anxiety (12 references), trauma (8 references), and sleep difficulties (5 references). This fits with the quantitative findings, which demonstrated higher levels of depression and distress for asylum seekers living in hotels compared to asylum seekers living in alternative housing.

Interview participants described how hotel accommodation exacerbated pre-existing mental health difficulties and created new mental health difficulties. For example, for many participants, living in a hotel worsened pre-existing mental health problems (most commonly PTSD and depression) and created new mental health difficulties (most commonly suicidal ideation, depression, and anxiety). Participants also spoke about difficulties they faced in the hotel, such as difficulty sleeping due to sharing rooms with noisy roommates, and the negative impact this had on their already fragile mental health. This fits with the quantitative results, which found that asylum seekers living in hotels had higher levels of housing problems compared to asylum seekers living in alternative accommodation. Interview participants connected higher levels of housing problems to increased mental health difficulties, describing the cumulative impact of housing problems and other psychosocial problems on their mental health.

In sum, the qualitative findings corroborate the quantitative findings, both demonstrating that hotel accommodation adversely impacts asylum seekers' mental health, as illustrated by Table 15.

Table 15

Comparing quantitative and qualitative results

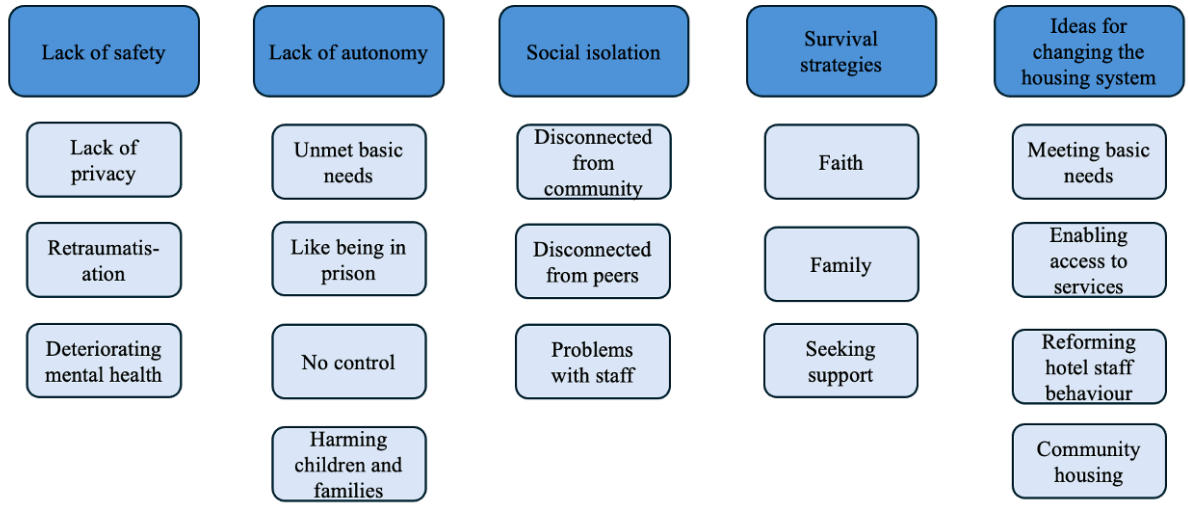
Research Finding	Quantitative Data	Qualitative Data
Hotel accommodation negatively impacts asylum seekers' mental health.	Hotel accommodation was a statistically significant predictor of total CORE-10 scores.	All interview participants (n=16) reported that living in a hotel negatively impacted their mental health.
Asylum seekers living in hotels experience higher levels of depression than asylum seekers living in alternative housing.	Hotel accommodation was a statistically significant predictor of total PHQ-9 scores.	Depression was the most frequently reported mental health difficulty described by asylum seekers living in hotels (21 references). Hotel accommodation was viewed as both causing and exacerbating depression.
Asylum seekers living in hotels experience more housing problems compared to asylum seekers living in alternative housing.	Housing problem subscores on the PMLD questionnaire were statistically significantly higher for asylum seekers living in hotels compared to asylum seekers living in alternative housing.	Interview participants described hotels as worse than alternative housing and described experiencing many housing problems, such as lack of safety, lack of autonomy and social isolation (the first three themes).

Despite expectations that the quantitative data might be too blunt a tool to detect differences between the mental health of asylum seekers living in hotels compared to alternative accommodation, the quantitative data demonstrated a difference and converged with the findings of the qualitative data. No substantial differences or variations were found between the quantitative and qualitative data. The quantitative and qualitative data found that there is a difference between the mental health of asylum seekers living in hotels compared to alternative accommodation; however, this does not fully explain why hotels negatively affect asylum seekers' mental health. Therefore, in the next section themes derived from the qualitative data will be presented. These themes answer the question 'Why does hotel accommodation impact asylum seekers' mental health?'

Five main themes were constructed using reflexive TA (Braun & Clarke, 2019): lack of safety (subthemes: lack of privacy, retraumatisation, impact on mental health), lack of autonomy (subthemes: unmet basic needs, like being in prison, no control, harming children and families), social isolation (subthemes: disconnected from community, disconnected from peers, problems with hotel staff), survival strategies (subthemes: faith, family, resistance, seeking support), and ideas for changing the housing system (subthemes: meeting basic needs, enabling access to services, reforming hotel staff behaviour, community housing). Figure 5 visually depicts the themes and subthemes, and in the following section each theme is explicated using quotes from interviews.

Figure 5

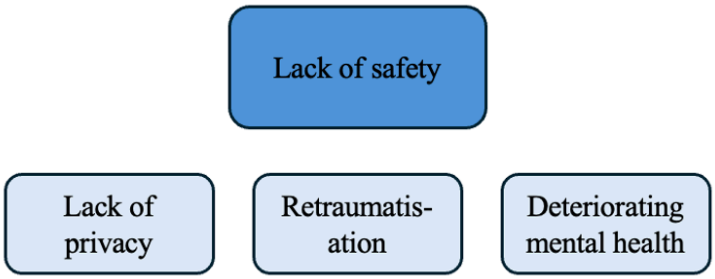
Themes and subthemes from qualitative interviews



3.5.2 Theme 1: Lack of Safety

Figure 6

Theme 1: Lack of safety



Theme 1 captures the challenges participants faced due to living in hotel accommodation. This theme encompasses three subthemes: lack of privacy, retraumatisation, and deteriorating mental health.

3.5.2.1 Lack of Privacy

This subtheme illustrates how hotel accommodation created a lack of privacy, which adversely affected participants' wellbeing. Participants described how hotel accommodation created a lack of privacy in numerous ways. First, hotel accommodation created a lack of privacy by forcing asylum seekers to share their bedrooms with strangers.

> *Regarding my mental health, in my situation, as a victim of torture, I've been mixing with people in the room of eight people. I don't know them; they don't know me […] It was a nightmare. Because on the second day, I got some of my stuff stolen. Because I've got my suitcase, two suitcase. I went out and when I come back, it was open. And then no one come to me, I be very upset […] I feel very unsafe. (John)*

> *When I was living in the hotel I couldn't speak with my kids by phone because someone is next to me sharing my room […] In the hotel you can't do anything at all […] Everybody is everywhere. You can't, you can't, I mean, find any space, any private area to talk with your family. (Joseph)*

> *They announced to us saying that two people will sleep in each room. So I'm even worried about that. Maybe they can, they can bring someone to me […] I'm worried about that because maybe they can break some stuff or someone who doesn't speak my language. […] Maybe the person is not the same religion as me. The person doesn't pray like me at night. Maybe I want to wake up and pray I can't make the light on. All these things are problem to me. (Deborah)*

Participants described how sharing their bedroom deprived them of privacy and created problems, such as being unable to speak to family and worrying about sharing their bedroom with incompatible strangers. This triggered anxiety and made participants feel unsafe in their bedroom, the same place where they are expected to live, sleep, dress, undress, and spend their time because they lack other places to go. Numerous participants spoke about the importance of privacy and safety for mental health, connecting the presence of privacy and safety to improved mental health and the absence of privacy and safety to damaged mental health.

> *If you didn't have [privacy], the impact is so very worse because it's viewed if you look as your right. You feel powerless and you feel dehumanized […] that impact your mental health. (John)*

It makes me feel unsafe. Not a human, not a human being. (Leah)

In addition to creating a lack of privacy by forcing asylum seekers to share their bedrooms with strangers, hotel accommodation also created a lack of privacy by preventing participants from locking their doors and allowing hotel staff and professionals to enter participants' bedrooms without their consent.

I was asleep and I feel that somebody's trying to open the door, my door. And that's what's happening twice. And then I just look at the door. I saw somebody's behind the door and said 'Don't worry, don't worry. I want to check that everything is okay'. But it's not true because that was three o'clock in the early morning. That was a bad experience. And also they said you are not allowed to close your door and lock your door. Basically, that was another issue […] After the bad experience usually when I see the window is open anywhere or the door is open, I'm going to be nervous. And I scared. I think that I'm not safe at that place. (Rachel)

The police come maybe 3am or maybe 4am, maybe in the night, anytime […] People come into my room. It wasn't just a policeman, everybody. Everybody was coming to my room […] I wasn't safe, and I told them I don't want to see no one in my home. (Noah)

[Hotel staff] get into your room without informing you. […] And there's nothing you can do about it […] You don't have a home. Because no one can just get into your house without informing you. You don't have a home. (Leah)

Participants conceptualized their hotel room as more than just a room; they viewed it as their home. Therefore, being unable to lock their door and control who accessed their hotel room was viewed as a form of home invasion. This invasion caused participants to feel like their privacy had been violated and they lacked a safe home.

3.5.2.2 Retraumatisation

This subtheme explicates how hotel accommodation retraumatises asylum seekers. Retraumatisation involves people who have experienced traumas being exposed to people, places, or situations that remind them of past traumas. This can cause them to relive past traumas as if they are fresh, resulting in psychological distress. Participants described specific aspects of hotel accommodation as retraumatising, including witnessing fighting and shouting.

> *I am scared always. When I see people fighting, I always get scared because I remember all the things that have happened to me […] I don't want to hear all that when people are fighting or shouting. I don't like it completely. I just lock myself in my room. I just remember the past. (Deborah)*

For asylum seekers who experienced traumas in their home countries, being exposed to new traumas in the hotel was extremely distressing and retraumatising. Hotel accommodation also contained physical features, such as security guards, that reminded participants of past traumas.

> *In the past when I was in prison, there are always people who got someone to hurt you when you walk in and out with beating and torturing. Now here whenever I go in*

> *and out of the hotel, when I see the security guys outside, they remind me of those people because they look similar so that's why I feel like I'm still in prison […] It takes me back to the past to... it reminds me of the people who used to torture us, the security guys. (Isaiah)*

Isaiah connected his present living conditions with his past experience of being imprisoned and tortured in his home country, linking the presence of security guards to the psychological threat of harm. Thus, participants with past traumatic experiences viewed the physical environment of the hotel as retraumatising, reminding them of past experiences of imprisonment and torture.

Numerous participants drew a distinction between physical and psychological wellbeing, emphasising the impact of living conditions on their psychological wellbeing.

> *You don't feel comfortable at all. You feel like you are tied up and you cannot be free. You don't feel like you're living in your house and that is a problem. So your brain always thinks you are not free. Not comfortable because someone is around you and it's not your accommodation. So sometimes I feel like it reminds me of my past. I know that it's not torture, but I feel like it's like a prison. (Isaiah)*

> *No one beats me but my mind be tortured a lot. (Maria)*

Although participants acknowledged that they were physically well (e.g. not physically beaten or physically tortured), they invoked the language of ‘torture’ to describe how they were being treated, arguing that they were being psychologically tortured. Participants

employed powerful metaphors and images to describe the psychological torture of living in a hotel; for example, Jeremiah called it ‘hell’.

> *The other thing which causes me to be upset because of my past, you know, I am clearly very confident that they have access to my room. The minute they start to open the door and they could come and look or reach another cause of distress for my mental health. So I don't know where to start and end really. This is a difficult situation for me. It is too much for me as a person, this hell. (Jeremiah)*

3.5.2.3 Deteriorating Mental Health

This subtheme elucidates how lack of safety in hotel accommodation caused deterioration in asylum seekers’ mental health. Participants described safety as essential for mental health and lack of safety as detrimental for mental health.

> *Safe place mean that is safe situation to recover. No safe place, bad housing is like a prison. So if it is like a prison such you bring back your own nightmare. Very bad memory. So it don't, it doesn't help. It make things worse. (John)*

> *[It impacts you] physically and mentally because you don't feel comfortable at all. You don't feel secure. (Joseph)*

> *If you feel safe, that improve your mental health. Make you to catch up, to bring back, back to your mental health. Very stabilized. Make you to bring back, take back your, your life in your hands. You can move on. (John)*

Although the presence of safety was seen as protective for mental health, the absence of safety was seen as damaging. This was particularly relevant for asylum seekers like John who shared about ongoing mental health difficulties with PTSD and depression due to past traumas. Although they expressed strong desires 'to recover' from their mental health difficulties, recovery proved very difficult in the hotel environment, which brought back their traumatic memories and made 'things worse'. Thus, hotel accommodation interfered with recovery from mental health difficulties and caused a decline in asylum seekers' mental health. All participants recalled their mental health worsening while living in hotel accommodation, with many reporting increases in depression.

> *It had a great impact on my mental health. Because in the first place I had my own problems and then living there added to the problems I had. (Elijah)*

> *It is huge negative impact on my mental health. Of course I'm more distressed. (Jeremiah)*

> *When I was in the detention, I was prescribed antidepressant medication. I used to take it. So when I was released from prison, I stopped them because I hope I was assuming that, you know, I'm out of prison and I will start to, you know, I will start my activities again, you know, as a normal person. It has been now already four months, I went back to antidepressants, I have to take them every day. (Aaron)*

> *I'm pulled down in deep depression. […] My voice disappeared. I cannot say anything. I cannot help myself. I feel so heavy all my body. I cannot help my children. (Maria)*

Some participants' mental health deteriorated to the extent that they considered ending their lives.

> *I had very strong suicidal thoughts, and I tried three times. I was out and one day I went to the underground station, and I was about to throw myself in front of the train […] My mental health was totally destroyed during the time I stayed there. (Benjamin)*

> *The previous hotel, my situation there wasn't good. Basically, the atmosphere wasn't good for me. And couple of times I try to suicide. (Rachel)*

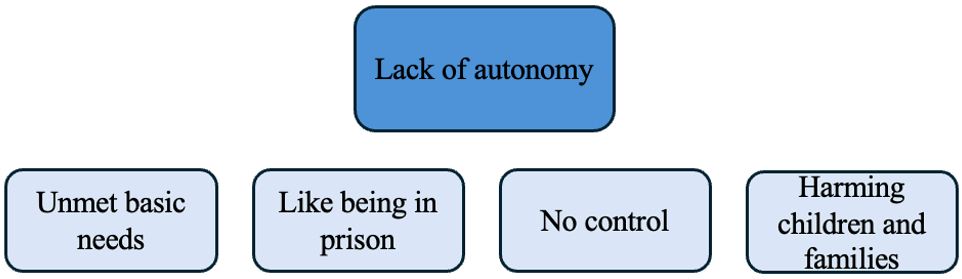
> *I wanted to kill myself. (Micah)*

Overall, this theme demonstrates how living in hotel accommodation created challenges for asylum seekers, including lack of safety, lack of privacy, and retraumatisation. This impacted asylum seekers' mental health, exacerbating pre-existing mental health difficulties, such as PTSD and depression, and creating new mental health difficulties, such as suicidal ideation. Moreover, lack of safety in hotel accommodation also prevented recovery from pre-existing mental health difficulties, leaving participants feeling trapped in a state of psychological torture.

3.5.3 Theme 2: Lack of Autonomy

Figure 7

Theme 2: Lack of autonomy



Theme 2 illustrates how hotel accommodation created a highly restricted environment that denied participants autonomy over their own lives. This theme comprises four subthemes: unmet basic needs, like being in prison, no control, and harming children and families.

3.5.3.1 Unmet Basic Needs

This subtheme depicts how hotel accommodation failed to meet asylum seekers' basic needs, including finances, food, and living conditions. Regarding finances, participants lamented that they lacked money for essentials.

> *We would be given only eight pounds. Eight pounds is not enough to buy the things we need. (Elijah)*

> *Eight pound a week doesn't do anything for you. What can you buy with eight pound a week from supermarket? (Joseph)*

Participants budgeted their weekly allowance, yet often went without essentials because they had to spend their money on travel to mandatory appointments, such as with the Home Office or their solicitor.

> *Sometimes you use it to buy a toiletries kind of thing. To buy a pad, toothpaste, toothbrush and at the end of the day you don't have anything else. Just need to plan if I'm going to see my solicitor. (Leah)*

In addition to lacking finances, participants also described food as an unmet basic need. Hotel accommodation provided participants with daily meals, but participants viewed these as inadequate.

> *The food is so spicy you cannot even eat it. You can't even go to the toilet after that. It burns your stomach. (Benjamin)*

> *I would stay for a long time without eating because the food they would provide would make me feel sick or ill. Every time I would eat from it, I wouldn't feel well. And on some occasions, I would throw up. (Elijah)*

> *I never felt myself full before I go to sleep. I always feel hungry. (Joseph)*

Participants lacked access to cooking facilities and had insufficient funds for groceries, which made them dependent on the hotel for food. This engendered frustration, especially when the hotel food was unhealthy. Participants expressed concern about hotel food impacting their health.

I don't know really how to have peace in my mind, especially with regard to diet, food, regarding my condition, suffering from this condition. I don't consider this diet is right for me, as a citizen, as a person, a human. (Jeremiah)

In addition to the unmet basic needs of finances and food, participants also reported poor living conditions.

You can see the rats everywhere […] this is what make you worried because you can see the rat outside the kitchen that mean maybe the rat touch your food, eat from the food, the same food you eat. (Joseph)

The children generally don't have anywhere to sleep. They sleep on the floor. […] What is the freedoms for the children? What is the right for the children? When my son sleeps on the floor? It will be cold in the winter with dirty carpet. (Maria)

Participants worried about the impact of poor living conditions on their health and their children's health; however, they lacked autonomy to improve their living conditions. They also could not meet their other needs, including finances and food. They were forced to be dependent on the hotel, but the hotel failed to meet their needs, leaving them feeling frustrated, anxious, and hopeless.

I mean, is this a life? Not at all. (Joseph)

3.5.3.2 Like Being in Prison

This subtheme captures how high levels of restrictions in hotel accommodation made participants feel like they were imprisoned. Participants described hotels' strict routines and rigid rules, particularly for meals and returning to the hotel at night.

> *They say, 'No, food is finished, so you're late, no food'. So they should put some foods for people who come late. And when you came, you can get a takeaway. But they don't do that. […] No flexibility. You must eat on time, otherwise nothing. (John)*

> *Our returning back to the hotel was restricted. We have to be back to the hotel before 11pm, so if you arrive later than 11pm, you have to sleep on the street. One time I arrived late, and I had to sleep on the street in front of the hotel. (Benjamin)*

To explain what it was like to live under high levels of restrictions in hotel accommodation, numerous participants invoked the analogy of prison.

> *Being in the room without TV, without talking to anybody, without having a mobile. It feels like a prison. Just in a room with four walls surrounding you. (Benjamin)*

> *The negative point is that you're instructed. You cannot leave the hotel and come in whenever you want. The food is one type of food, and you have to eat it. It doesn't change. It's always the same. You cannot do any activities. There are no activities to do outside the hotel that you can do other than staying in your room […] I feel like I'm in prison. (Aaron)*

> *It is not easy living in the hotel […] you're just locked up somewhere and you cannot do anything. When you have your home, it is like your freedom. During living in the hotel you're going out, they're asking you where you're going to, when you're coming back, what's the room number, what's the date. And this is something that you've never ever witnessed when you are going out of your house, no one ask you anything. No one ask you anything. Even if I'm going to buy toothpaste, they ask me at the hotel. I say I am not going anywhere, man. I'm just taking a walk […] It's like a prison. (Leah)*

Lack of freedom caused participants to feel like they were living in prison. Leah contrasted the idea of prison to the idea of home, arguing that prisons deprive people of freedom, whereas homes enable people's freedom. In hotel accommodation, she lacked freedom; thus, she felt living in a hotel was more like living in a prison than a home. Aaron highlighted how living in a hotel infantilised him because he was 'instructed' to do everything at a particular time rather than being free to make his own decisions and act according to his own schedule. This resulted in a diminished sense of autonomy.

3.5.3.3 No Control

This subtheme focuses on asylum seekers' lacking control over their lives in hotel accommodation. Participants expressed frustration about not being able to make their own choices about daily life.

> *Our food is just almost the same thing every day. Also, there's nothing they will change. And when we just tried to tell them to change, maybe, they don't accept. They just say you have to eat that. (Deborah)*

> *We would tell them that the food is not okay. Please try to change it but then they would make us feel well, this is what you... you get what you get. […] You need only to accept it. (Elijah)*

Not only did participants lack choice about their daily lives, but also, they lacked the ability to change their daily lives. When they tried to negotiate with hotel staff to improve their food, they thought that staff did not listen to them. This led to the belief that their needs were ignored and devalued by staff. One participant who previously lived in hotel accommodation and recently moved to community housing contrasted the different types of housing.

> *They used to choose what we eat, and we have to eat at a certain time. But now I can go for what I want to eat, and I can eat whenever I want to eat. (Peter)*

In community housing Peter experienced an increase in choice over aspects of his daily life, which he found liberating. Instead of someone else controlling his life and making decisions for him, he was able to control his own life and make decisions for himself.

Participants also spoke about the psychological impact of lacking control over their home environment in hotel accommodation.

> *I feel that I am in danger […] sometimes they decided to transfer people to somewhere else or another hotel. […] that's what's happened for my friends. (Rachel)*

> *You can't keep hairdryer in the hotel. They restrict you. You don't have a fridge. Imagine live without a fridge. You can't. It's hard. It's hard. Keep you here without any fridge, without any hair dryer. (Leah)*

> *When you ask to get the washing powder to wash your clothes, they don't give you enough amount. They give you a small, small thing just to wash your T-shirt. I say give me more I need to wash all my clothes, I have three shirts for example. No, they don't like that. […] Even if you want to buy from outside from your own money, it's not allowed. (Joseph)*

For Rachel, lacking control over her home and knowing she could be forced to move at any time engendered fear. For Leah, lacking control over what she could and could not keep in her room made her feel hopeless. For Joseph, lacking control over washing his clothes caused frustration. Thus, lacking control over aspects of daily life impacted participants psychologically, particularly when they were prevented from controlling many aspects of their daily lives.

3.5.3.4 Harming Children and Families

This subtheme examines the challenges faced by asylum seekers living with children in hotel accommodation. Participants with children explained how living in a hotel impacted their children's physical and mental health.

> *The children they don't have anything, only milk powder, and I get problem for my children. They get sickness. (Maria)*

They are very stressed. They can't take it every day. (Naomi)

They say so many times we don't have good food, we don't have good place. […] They understand that they can do nothing. (Naomi)

It affected especially my older child a lot. He had been treated by a psychologist because of it. […] It affected him really a lot. It affected even his education in school. And of course this makes me even feel more guilty, you know? (Abel)

Participants viewed hotel accommodation as the cause of physical sickness and psychological distress in their children. Parents struggled to respond to their children's distress because they lacked the power to change their situation and improve their children's living conditions. Expanding on the impact on families, parents expressed that the hotel environment prevented them from being able to take care of their children, which made them feel guilty. Being unable to care for their children impacted parents' mental health and how they viewed themselves.

It's affecting my mental health […] I feel a lot of stress at the time of the mealtime when meals comes because I keep thinking, 'What about the children? Are they going to eat it? What if they don't like it? Like they like it or not?' And to be honest, they lost a lot of weight since they came to this hotel because they just eat bread and, you know, jam. That's the only thing, but most of the time they don't like the food at the hotel, and they just eat bread and jam or bread and cheese. (Abel)

> *There's nothing like frustrating when you've been living a life that you can take care of yourself. You can take care of you and your daughter and then you in this point you can't even look after your own self. (Leah)*

> *The other kid he don't seem to understand. Sometimes he say, 'You bad mom. We don't have food. We don't have home.' But what can I do? (Naomi)*

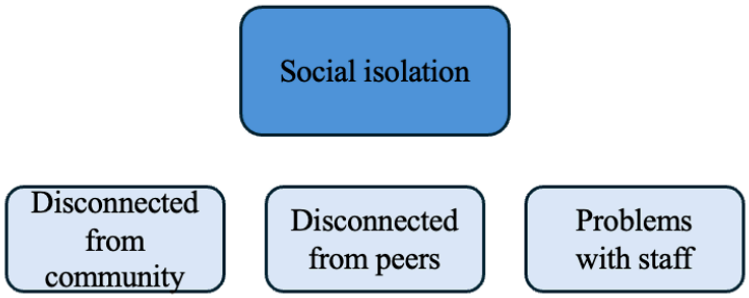
Living in highly restricted hotel accommodation led to the infantilisation of parents and deprived parents of their ability to care for their children. For some families, this led to conflict, such as when Naomi's son accused her of being a 'bad mom' because he did not have 'food' or a 'home'. Naomi acknowledged her powerlessness in the situation, saying 'But what can I do?' Even though parents wanted to meet their children's needs, hotel accommodation with its strict rules and regulations prevented them from being able to meet their children's needs. This negatively impacted both children and parents, damaging parents' mental health and causing them to feel a diminished sense of parental autonomy.

Overall, this theme outlined how hotel accommodation created a highly restricted environment that denied participants autonomy over their lives. Hotels failed to meet their basic needs for essentials; additionally, hotel rules and regulations prevents participants from being able to meet their own needs and control their daily lives. This led to participants feeling like they were living in a prison rather than a home. Lack of control over their daily lives harmed both children's and parents' mental health. Moreover, being unable to meet their children's needs led parents to feel distressed and inadequate as parents.

3.5.4 Theme 3: Social Isolation

Figure 8

Theme 3: Social isolation



Theme 3 explores how hotel accommodation prevented asylum seekers from accessing social support. This theme comprises three subthemes: disconnected from community, disconnected from peers, and problems with staff.

3.5.4.1 Disconnected from Community

This subtheme illustrates how hotel accommodation separated asylum seekers from the wider community and prevented them from accessing social support. Participants described the hotel's location as problematic because it prevented them from engaging with their community.

> *If you want to go maybe to city centre, I don't have money. So I just stay in the hotel or when I come into [charity] but that's it. I don't go any other place […] I could be happy if I could go somewhere even. Maybe like the city if, you know, any place maybe. But I can't go because I don't have any transportation. (Deborah)*

The hotel's location and lack of money for transportation prevented Deborah from leaving the hotel and interacting with people in her community. She stated that she would be 'happy' if she could 'go somewhere', demonstrating the connection between mood and isolation. Being isolated because of hotel accommodation affected Deborah's mood, hindering happiness.

Moreover, hotel restrictions prevented participants from interacting with the community and obstructed friendships. Benjamin reported that hotel staff prevented him from seeing his friend.

> *I felt I was isolated. I mean, I have my friend of mine who it was very close friend from [home country]. I haven't seen him for 30 years and he lives in Manchester […] He came all the way from Manchester to see me. They didn't allow him to enter the hotel. He just waved to me from the window. And I say hi to him, but we couldn't see each other. (Benjamin)*

Benjamin went on to describe unequal treatment, which he ascribed to hotel staff from particular ethnic backgrounds favouring asylum seekers from the same background.

> *But the Indians when they have people that come, they can salute them, they can go to their room even they're allowed to take their food, their meals, to their room, but we are not allowed. (Benjamin)*

Being prevented from seeing his friend while witnessing other asylum seekers seeing their friends angered Benjamin. By commenting on the injustice, Benjamin reflected his belief that staff should support all asylum seekers to engage with their friends and the community.

Numerous participants described living in a hotel as a barrier to integrating into their community even if they had strong desires to integrate into the UK.

> *Living in a hotel you don't feel like you are integrated with the people or with the community. Because if you live isolated in one place, not free. So I hope in the future that's what I'm hoping to be free outside and integrate and become part of the community in the area. But for now, it is like isolation, or I feel isolated. (Isaiah)*

> *To integrate in the community you have to live between them. Here I'm living with the same people. (Aaron)*

Aaron viewed living in a hotel as problematic because it prevented him from being able to forge connections and integrate into the community. Isaiah expressed a longing to 'become part of the community' in the UK, but acknowledged that it was very challenging to do this while being 'isolated' in the hotel.

Leah spoke about living in a hotel as a barrier that prevented her from connecting with people in the community.

> *How can you connect with people that when they ask you where you live, you live in a hotel. It's like, it's like I'm not complete. I don't even tell people about myself […] I don't want them to ask. They will say why are you living in the hotel, what happened and that, that's going to bring you back to your memories, so it's better to be cool and sort yourself out. (Leah)*

Living in a hotel caused Leah to feel 'not complete' and unable to connect with others because she feared discussing where she lived would prompt questions that brought back traumatic memories. Thus, she avoided social interactions and decided to stay isolated, not because she wanted to, but because she felt this was the only way to protect her mental health.

Jeremiah also commented on mental health, describing the connection between social isolation and psychological wellbeing.

> *I just feel psychologically they are torturing me, in psychological way, emotionally, socially, you know? (Jeremiah)*

He described his social isolation in the hotel and equated social isolation with psychological torture.

3.5.4.2 Disconnected from Peers

This subtheme illustrates how hotel accommodation led to participants feeling disconnected from other asylum seekers. Many participants expressed a desire to connect, but explained that their mental health deterioration since living in the hotel made it difficult for them to interact with others.

> *I cannot stay with other people. Mentally I am not okay. I'm not ready to have any conversation with the people. I can't. (Micah)*

I don't like to mix with people. I don't like, I'm just isolating myself just in my room. I don't feel like talking to people or make any relationship or any friendships. (Aaron)

Living in close proximity with strangers who spoke different languages and came from different cultural backgrounds also frequently led to conflict between asylum seekers.

People in the accommodation, the ethnic side, so we, we don't speak the same language. (Noah)

I went to the toilet and then there was someone that was going into toilet […] when he came out, everything was so messed up in the toilets. He damage everything […] I say to him, 'Please, you left the toilet in such a mess, why?' 'Because I was waiting for you spoilers to clean it'. And then he was attacking me on my chest basically tapping on my chest. (Noah)

Lack of understanding and different standards led to conflict between asylum seekers. Frequent conflict undermined their ability to form connections and sometimes resulted in violence and theft.

Like you live in a jungle. Yeah. So if you don't defend yourself, you really… it could kill you. (John)

When I see people fighting, I always get scared. (Deborah)

> *I got some of my stuff stolen. […] I went down to the, to the reception to complain about it and then the reception that day said go to the security, come back to me. And by the end of the day, I went back to ask him he says to keep you investigate he asked me what I lost. I said two T-shirt, one pair of trainers. And they said we'll give you a time […] then the next day nothing, so I didn't waste my time. (John)*

> *Last time I complain was when someone stole my personal things from inside my room. It happened to me two times […] Makes me feel angry, makes me feel that like I live in unsafe place, unsecure place, especially when you have only this T-shirt and only this pants or jacket. You don't have, I mean, other clothes to wear. What makes me angry as well, the reaction from the housing, the hotel manager. Because the action was very, very bad he said to me 'I didn't see anybody on the camera holding your money or stealing your stuff'. (Joseph)*

When John and Joseph reached out to hotel staff in distress about their stolen belongings, instead of being met with support, they were met with indifference. This reinforced their belief that the hotel was 'unsafe' and that other asylum seekers could not be trusted. Feeling unsafe and not trusting others led to asylum seekers withdrawing from their peers and becoming more socially isolated.

3.5.4.3 Problems with Staff

The subtheme focuses on problems between asylum seekers and hotel staff, including communication difficulties and poor treatment. Participants who did not speak English described struggling to communicate with staff.

They don't provide any interpreter. We don't communicate because of the language barrier. (Isaiah)

It's very stressful especially in the beginning because the language barrier. We don't speak English at all, me and my wife […] The whole time that we lived in the hotel they brought interpreters only twice. And it was because of some problems that we faced with some other residents in the hotel. And after that, whenever we asked for interpreters, they just ignore us. (Abel)

I cannot do anything. I'll wait until my friend who speaks English to come and to help. […] You feel you are helpless. […] I know an Egyptian guy he needs desperately an appointment with a doctor because he's sick and no one… he cannot go to reception to expand opportunities and get an appointment for the doctor. (Aaron)

Lacking interpreters and being unable to communicate prevented asylum seekers from accessing services, including healthcare. It also led to feelings of helplessness. Participants who spoke English often helped non-English speaking asylum seekers to communicate.

I saw one lady she was trying to say something in French. No one understand it. […] So when I spoke French, she cried. […] She said she's been here for a week, but she hasn't eaten because when she come to say something, no one listen. So each time she's going to want to say something, she will come to my room and take me downstairs to interpret. I can't imagine how day to day she would be if I was not there. (Leah)

In addition to communication difficulties, participants also reported being treated poorly by staff. Benjamin spoke about discrimination, with staff treating some asylum seekers better than others.

> *I have some [home country] friends. My friend they sometimes they will cook food, and they will bring the food […] When they give it to the staff member, the staff member they don't pass it to us. They will give it to their own people. Most of the staff members in the hotel they were Indian, and they will give to the, to these people from the same nationality. (Benjamin)*

Participants also expressed that staff did not listen to them, leading them to perceive staff as uncaring.

> *When you tell them, you want them to come and do something or any changes in the room, they don't accept. They don't listen to you. (Deborah)*

> *They management, you go and talk to them, they just say 'Ok, I'm going to do it.' But they don't change anything. (Maria)*

Participants highlighted their dependence on hotel staff and their disappointment and frustration when staff failed to meet their needs.

> *At the reception they don't help us completely. Whenever we tell them to call GP on behalf of us. They just say they will do it, but they don't do it. (Deborah)*

As an asylum seeker I have... I have only one resource to go to make a complaint, only with my housing manager. If he didn't do anything, there's no other option you can do. (Joseph)

Hotels position staff as the sole resource providers. Thus, when asylum seekers sought and did not receive support from staff, they did not have other options, leading them to feel hopeless. Participants also reported that staff behaved unprofessionally and without accountability.

They didn't respect us. They will talk to you shouting all the time. (Noah)

Charities they used to bring us new clothes and new shoes and [staff] used to take them. They will take them for themselves, and they will give us old stuff instead. (Benjamin)

In the winter they turn off the heating system at six or seven o'clock in the night […] It's very, very, very cold. […] They say to us, okay, you are men, you can deal with yourself anytime you want, any place you want, even if you don't have hot water. You are a man; you can deal with that. (Joseph)

They don't treat you like human being. (John)

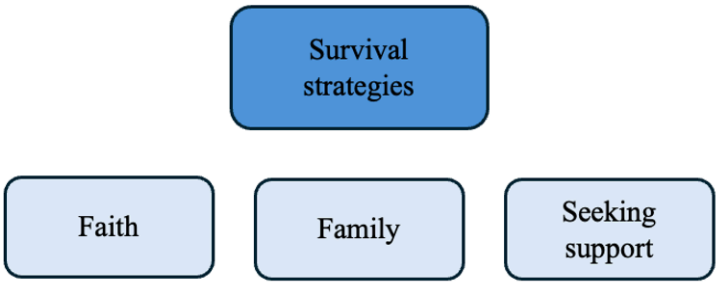
Staff lacked accountability for their actions because asylum seekers could only report problems to the very people who were causing the problems: staff. Lack of accountability enabled staff to behave unprofessionally without fear of repercussion.

Overall, this theme elucidated how hotel accommodation undermined asylum seekers' ability to seek social support. Participants faced disconnection from the wider community and their peers, leading to feelings of isolation and discontent. Moreover, problems with staff further contributed to isolation and hopelessness.

3.5.5 Theme 4: Survival Strategies

Figure 9

Theme 4: Survival strategies



Theme 4 identifies asylum seekers' survival strategies for living in hotel accommodation. This theme encompasses three subthemes: faith, family, and seeking support.

3.5.5.1 Faith

This subtheme details how asylum seekers derived strength from their faith. Participants from different faith backgrounds found comfort through prayer and through engaging with their religious communities.

> *I feel so sad inside in me, I say, 'Oh my God' […] God give me strength. (Maria)*

> *When I went to the church, that was very good atmosphere for me. […] Somebody was there, just talk to me regarding my situation, makes me feel better. (Rachel)*

> *When I go to the mosque, I'm very happy. I see people; I learned my, my religion. But then, later on, then I have to come back to the room. Okay, the same problem starts from there. (Deborah)*

Although participants found moments of solace in their faith, these moments were ephemeral because they had to return to their hotel accommodation after religious services. Despite this, participants still spoke about faith as a crucial source of hope in their lives.

> *I pray to God, and I say, 'God I hope for one day good life. Let me try to go on.' […] That hope makes me to go on. (Maria)*

> *As someone who pray I believe in God. I don't know. Maybe one day, I know, I believe one day I'll get my status. (Deborah)*

> *It keeps me, keeps me going on a positive note at church. I go, I listen to the word of God. It keeps me going. If not of that, oh my God… (Leah)*

Faith sustained participants even when they felt like they could no longer go on. Maria and Deborah referenced praying to God for a better life. Deborah yearned to get her 'status', which would enable her to move out of the hotel and get on with her life. Similarly, Maria longed for a 'good life' in which she would no longer have to face the many challenges she

faced living in one hotel room with two children. Thus, participants prayed that God would liberate them from their problems and provide a better life in the future.

3.5.5.2 Family

This subtheme illustrates how participants found strength in family. When asked what gave them strength to keep going when life was difficult, most participants cited family as their primary source of strength.

> *First, my daughter and my son. (Benjamin)*

> *My family, my children, my boys. (Abel)*

Participants with children viewed their children as powerful motivation to keep going when they faced challenges and felt like giving up.

> *What's making me to keep going… when I look for my children because I love them. I want them to be in good life. When I look at them that makes me to go on because I say, 'Okay, I'm fed up.' But when I'm dying here, who going to take care for my children? Who going to support them? (Maria)*

> *I have to wait, inshallah, something good is gonna happen because when I think what happened with me before I just wanted to save my kids […] I keep going for them. (Naomi)*

Parents' desire to care for their children overpowered their desire to give up. When faced with problems, Maria imagined what would happen to her children if she gave up and was no longer there for her children. Imagining her children without her support gave her the strength to endure and persevere through challenging life circumstances.

Numerous participants were living separately from their families because their families still lived in their home countries. For participants living alone in the UK, the hope of reconnecting with their family in the future provided them with motivation to keep going.

> *The only thing at the moment makes me more strong and is a good reason to continue my life is my mom. So otherwise, I couldn't continue, and I want a couple of times to kill myself because life was really difficult for me. The only hope and good reason that I have is my mom because I can go to see my mom in the future. (Rachel)*

> *Thing keeping me going is first of all my children. I have to do something productive, which is just a duty of care as a father. I consider this, I have to be there for them for their wellbeing and future […] I am still very determined to continue to live and to participate in this society […] for my children's future. (Jeremiah)*

Rachel's mother functioned as a protective factor, giving Rachel motivation to live when she felt suicidal. She described the thought of reuniting with her mother in the future as her 'only hope'. Similarly for Jeremiah, the thought of reuniting with his children motivated him to persevere when he felt discouraged.

3.5.5.3 Seeking Support

This subtheme highlights how participants survived by seeking support from the community, peers, and services. Although connecting with the wider community could be challenging, numerous participants actively sought community support.

> *Even though I live there I spend most of the time in the mosque. (Noah)*

> *I found the church. Then I'm going there every day because we got mass 10 o'clock. We got coffee, so for me, it's better to have your breakfast there. Better to have breakfast there than in the hotel because people there are more human, so you feel yourself a part of society. (John)*

> *I really appreciate the kindness. [Name] who is field director and then a female who been university teaching but retired. […] Many times, this lady, you know, they invite me for dinner and are getting in touch with me and positively, which I'm really happy about […] This is a golden opportunity to have those people in your life. I'm very happy to have them here. (Jeremiah)*

Noah and John spent time in their religious communities instead of the hotel because it helped them feel 'part of society.' John expanded upon this, saying that the people he met in the community were 'more human', which made him feel better. Jeremiah also forged friendships with people in the community, which made him feel connected and 'happy'.

In addition to seeking support from community, participants also sought support from peers.

Between asylum seeker is easy because the freedom is same about it. So we try to interact, to share the pain. (John)

I can talk to [home country] people. Exactly the same as me and the same as my situation; you can have conversation. […] I stay at the hotel basically at the reception area, so I can see lots of people. I can have a good conversation with them. Basically, I'm not alone. (Rachel)

Talking to other asylum seekers reminded participants that they were 'not alone' and allowed them to 'share the pain'. Participants felt understood by their peers because they were going through 'exactly the same' situation and could relate and empathise.

Participants also sought support from services, including charities and mental health services.

I have [charity]. I come here, I access all the activities, education. Even here in the UK, I'm better than others because I have access to... I received support from [charity]. (Peter)

They gave me mental health and psychological therapies and relief. […] This is the only time I used to feel really safe. They gave me a lot of support. (Benjamin)

I had a good time with [therapist]. I could talk about my emotional feeling or about everything that has happened to me. (Rachel)

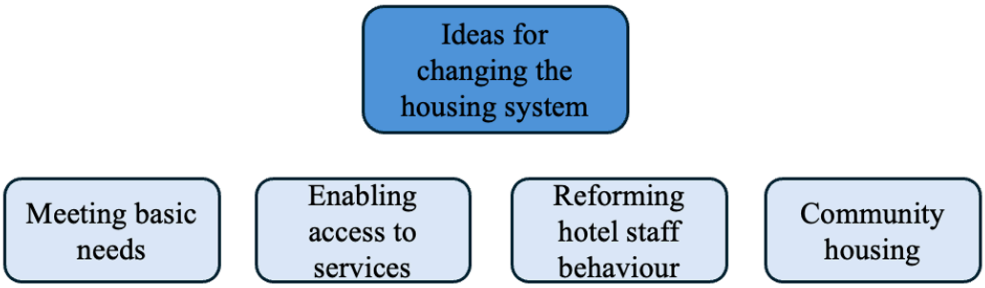
Peter took advantage of activities and education provided by a charity and viewed himself as privileged compared to other asylum seekers because of this support. Benjamin and Rachel accessed psychological therapy, which they saw as a safe place to discuss their feelings and find 'relief'.

Overall, this theme identified participants' survival strategies for living in hotel accommodation. Many participants found solace in their faith and looked to family as a source of strength and motivation to keep going when they wanted to give up. Participants also survived by actively seeking support from the community, peers, and services, including charities and mental health services.

3.5.6 Theme 5: Ideas for Changing the Housing System

Figure 10

Theme 5: Ideas for changing the housing system



Theme 5 captures participants' ideas for changing the housing system to meet asylum seekers' needs. This theme encompasses four subthemes: meeting basic needs, enabling access to services, reforming hotel staff behaviour, and community housing.

3.5.6.1 Meeting Basic Needs

This subtheme emphasises the importance of changing the housing system to meet asylum seekers' basic needs. Unmet basic needs were discussed as a subtheme for Theme 2 (lack of autonomy), which explained how hotel accommodation fails to meet asylum seekers' basic needs. When discussing their ideas for changing the housing system, all participants spoke about meeting the basic need for food. Participants agreed that the current hotel diet was insufficient to meet their nutritional needs and the needs of their children. They presented various ideas for improving the hotel diet. Many participants highlighted the importance of providing asylum seekers with healthier food.

> *There are so many people with health condition; they cannot eat the food they provide in the hotel. And I see them struggling. (Peter)*

> *If they just change the meal, or they improve the meal that they're giving, then the quality it will change a lot their lifestyle and their life. It could affect their health. (Benjamin)*

Participants suggested that hotels should provide asylum seekers with healthier meals because food affects people's 'health' and 'lifestyle'. Thus, better food was viewed as having the ability to significantly improve asylum seekers' lives. In addition to making meals healthier, participants also recommended increasing the variety of meals.

> *To change the meals, every day to give a different meal. Maybe one day chicken with rice, another day artisan style rice, another day hamburger, not every day the same*

meal. […] I swear when you when you change the food for the hotel, nobody make any problem. (Benjamin)

Benjamin viewed monotonous food as a key source of conflict between asylum seekers and hotel staff. Hence, he suggested that improving the food by providing more variety would reduce problems. Participants also proposed more flexibility instead of sticking to strict mealtimes.

People who come late, we would put your food on the path to take away on the table so you can save yourself. (John)

More flexibility would ensure that asylum seekers' health did not suffer because of missing meals due to other commitments, such as meeting with their solicitor or engaging in activities outside the hotel. Participants also recommended that asylum seekers should be allowed to cook for themselves.

As long as you can cook food, you can have your own life there. (Leah)

I'm going to [make] some good food for my children and myself to think I'm a woman, I'm somebody. (Maria)

Both Leah and Maria touched on the psychological impact of food, connecting being able to cook food for themselves and their children to having their 'own life' and thinking that you are 'somebody'. Being forced to eat unhealthy hotel food that failed to meet their needs and

being unable to cook alternative food impacted participants psychologically as well as physically.

3.5.6.2 Enabling Access to Services

This subtheme describes how hotel accommodation should enable, rather than hinder, asylum seekers' access to services. Participants reported that hotels do not provide transportation to essential appointments with solicitors, GPs, and the Home Office.

> *I wasn't able to go the solicitor who needed me to go to sign a paper, and they didn't allow me to go. (Benjamin)*

> *This hotel that I'm staying at the moment unfortunately is very difficult to access going for my health appointments. (Rachel)*

> *They wouldn't offer any help in the hotel. You have to figure it out. (Elijah)*

> *I need to go and see the dentist, but I'm not registered yet with them. […] [Hotel staff] said you should wait, and you can use the painkiller, but I think is not very good suggestion. I should see the dentist as soon as possible because the pain sometimes is very difficult to handle. (Rachel)*

Instead of hindering participants from accessing services, participants thought staff should 'help' asylum seekers access services. Participants also reported problems with transportation, which prevented them from accessing services. Many hotels did not provide transportation to appointments.

> *I went to the reception and said I have appointment to the Home Office to report tomorrow. The company have a van where they brought asylum seeker, or they transfer asylum seeker by hotel to hotel. I said you can use this guy to drop me […] They say no, we don't do that. So I had to make my own, find my own way. (John)*

> *No one is giving me any transport because what I do with the nine pounds that I receive every week, or eight pounds that I get, I add together, then I use that for transport. (Deborah)*

Participants used their small weekly allowance to pay for public transportation because the hotel did not provide transportation for essential appointments. Some participants described walking long distances because they could not afford transportation.

> *What I do the two times my appointment with solicitor, I go to library. I use the computer to track how long does it take me, so it would take me 2 hours and 50 minutes, so I print the map and then I walk. (John)*

> *I will go by my leg, my legs […] 45 minutes. (Aaron)*

Some hotels provided transportation, which was viewed positively.

> *The only good point that the previous hotel had. I had a facility like a transport going to see my GP there and coming back to the hotel. (Rachel)*

Among hotels that provided transportation, participants still faced difficulties because of unreliability.

> *Staff in the hotel usually when they can book, for example, the car or taxi for me I can go and come back, but sometimes they forget. (Rachel)*

> *There is always a problem for transportation […] there will be there will be delays for picking me up, or they don't pick me up. (Abel)*

Participants expressed that hotels should provide reliable transportation for essential appointments to enable asylum seekers to access legal and medical services.

3.5.6.3 Reforming Hotel Staff Behaviour

This subtheme focuses on the need to reform hotel staff behaviour. Participants recommended that hotel staff should have training on mental health and treating asylum seekers with care and respect.

> *They don't know the basic need regarding my health. They don't get it. So I wanted to point that it's not their fault because they don't have any training about mental health. (John)*

> *Ask them how they sleep, how they feel, if you need something, or if you're scared about something. We don't have that kind of communication […] I noticed that because for them they are not human [..] They don't care about us. (John)*

Numerous participants also emphasised the importance of hotel management.

> *I will change the manager. For example, if I am a manager for this hotel my duty is to let all the asylum seekers feel safe in the hotel. […] If someone has an issue or has a complaint against someone, I have to take it seriously. (Joseph)*

Hotel managers were seen as holding power in hotels and were, thus, viewed as key figures. Rachel explained how a better manager improved her life.

> *My situation at this hotel that I'm staying at the moment is better than the previous one. Basically, when I came to this hotel, the manager was very friendly to me, and suddenly we just became as good friends. I had jokes together. That was very nice time at the beginning because that was a good start for me who just changed the hotel. Previous hotel was very bad situation. (Rachel)*

Furthermore, many participants focused on the importance of accountability and recommended that the Home Office oversee hotel staff more closely.

> *Service has to be controlled, monitored […] What happened previously is that when some inspector come from the Home Office to do an inspection in the hotel […] They clean everything. They tidy everything. […] They work 24 hours day and the night just to show the guy from the Home Office that we are providing a very good service. (Joseph)*

> *Let the Home Office people come to this hotel to talk to people like me […] The managers, they just sit there […] They don't care for us […] They told us the Home Office will come tomorrow. They are cleaning too much. Outside they put everything tidy […] They don't allow you to talk to them. (Maria)*

> *This service has to be monitored. I mean, above this manager, the hotel manager, has to be another manager controlling this guy and look after him. I mean, see what he's done. Did he provide everything? Anybody has made a complaint against him? And also, this inspector has to talk to the asylum seeker […] They order the asylum seekers not to talk to him about their problem. (Joseph)*

Participants viewed Home Office inspections as cursory and insufficient to understand what was truly happening in the hotel; inspectors did not speak directly to asylum seekers and hotel staff tidied the hotel, leading to misleading perceptions during inspections. Participants, thus, recommended that the Home Office oversee hotels more closely and speak directly to asylum seekers.

3.5.6.4 Community Housing

This subtheme outlines participants' ideas for accommodation that would be more suitable than hotels: community housing.

> *It's more positive to live in communities than living in a hotel. (John)*

It could be better if they give us our own accommodation. You have your own freedom. When you want to go out, you go out. When you want to cook, you cook what you want to cook. No one is controlling you. (Deborah)

Any house that doesn't have any guard or security to come in and out. You don't feel like someone is watching or guarding you. So that's what I'm hoping… to live free. (Isaiah)

When you have family and children at least it's better for them to be in a place where they can, you know, will help them to integrate. At least it gives them the opportunity to integrate with the community and to, you know, to adapt to the new life. (Abel)

Participants longed for freedom and autonomy in community housing. Compared to hotel accommodation, community housing was viewed as promoting 'integration with the community' and helping asylum seekers, particularly families with children, to adapt to UK life.

Elijah and Peter, who had recently moved from hotels to community housing shared their belief that community housing was superior.

The place I'm living in at the moment is better than a hotel […] you feel more comfortable, you feel that you're living like in your own place, in your home. No one opens the door, no one knocks on the door and tells you need to wake up straight away. (Elijah)

> *I can cook my food, whatever I want to eat. And I've opened my window, so it's a lot better. (Peter)*

One participant suggested that asylum seekers should be given the option to live in the community with relatives or friends instead of hotel accommodation.

> *I got my brother here. […] Do you have a relative? Do you have a friend? As asylum seeker, you ask them, they choose the first option go to the relative because it's more safe […] because you know the person you're living with. They know what the person needs for him in terms of food, in terms of see a GP, intend to take him where he wants to go, so it takes the burden from the Home Office. (John)*

Another participant recommended having a time limit for how long asylum seekers reside in hotels.

> *I don't think that hotel is a place that people should live for more than six months […] I kept staying there for two years without fridge, without food. Can you live like that? Ask yourself, 'Can I be in this position?' You agree for others, ask yourself, 'Can I be like this? Can I live where I can't wash my hair and use a dryer to dry it off?' […] People just barge in. 'Can I stay where I cannot eat and cannot save food?' Ask yourself, 'Is okay for you?' (Leah)*

In sum, participants identified community housing as a superior alternative to hotels and recommended that policies be changed to limit time in hotels and move participants to community housing provided by the Home Office or friends and family.

Overall, this theme illuminated participants' ideas for changing the housing system. Participants emphasised the importance of meeting asylum seekers' basic needs and enabling access to essential services, including legal and medical services. Participants also recommended reforming hotel staff behaviour and increasing accountability and Home Office oversight of hotel management. Lastly, community housing was identified as a superior alternative to hotels.

3.5.7 Conclusion of Results

Firstly, the quantitative data demonstrated that hotel accommodation negatively impacts asylum seekers' mental health using mental health screening questionnaire data. Secondly, the qualitative data expanded upon these findings, using interview data to elucidate why hotel accommodation negatively impacts asylum seekers' mental health. In combination, the quantitative and qualitative data revealed that hotel accommodation exacerbates pre-existing mental health difficulties and creates new mental health difficulties. Three themes explained why hotel accommodation adversely affects asylum seekers' mental health: lack of safety, lack of autonomy, and social isolation. Participants' survival strategies and ideas for changing the housing system were also explored.

4. Discussion

4.1 Overview of Discussion

This chapter begins with a discussion of the findings in relation to existing research. Next, the chapter presents a critical appraisal of this study. Lastly, the chapter finishes with a consideration of policy, clinical, and research implications and concluding remarks.

4.2 Summary of Findings

This research aimed to explore the impact of hotel accommodation on the mental health of asylum seekers, given the limited body of existing research on the topic and the Home Office's increasing use of hotels to house asylum seekers. The research question was:

> **What is the impact of hotel accommodation on the mental health of asylum seekers in the UK?**

Quantitative data derived from mental health screening questionnaires (CORE-10, PHQ-9, and PMLD) demonstrated that hotel accommodation negatively impacts asylum seekers' mental health. Qualitative data derived from interviews expanded upon the quantitative findings to answer the question: 'Why does hotel accommodation impact asylum seekers' mental health?' Five themes were constructed: lack of safety, lack of autonomy, social isolation, survival strategies, and ideas for changing the housing system.

4.3 Relevance of the Findings to the Literature

The quantitative results found that hotel accommodation negatively impacts asylum seekers' mental health. This fits with the wider literature, which demonstrates that poor housing is a

postmigration risk factor that impacts mental health (e.g. Ziersch & Due, 2018; Nutsch & Bozorgmehr, 2020). Furthermore, studies from around the world demonstrate that asylum seekers, an already vulnerable group with high rates of mental health difficulties (Blackmore et al., 2020), are at risk of worse mental health due to unsuitable housing (e.g. Martino et al., 2022; Whitsett & Sherman, 2017).

This study found that asylum seekers living in hotels experience more housing problems and higher levels of depression compared to asylum seekers living in alternative accommodation. This is consistent with the wider literature, across different countries and with larger samples. For example, a USA study found that unstable, crowded housing significantly predicted higher depression, anxiety, and trauma symptoms (Whitsett & Sherman, 2017). Additionally, an Australian study comparing 2,399 asylum seekers to 21,462 Australian citizens found that asylum seekers were at greater risk of poor mental health due to unsuitable housing (Martino et al., 2022).

This reinforces the principle that asylum seekers' mental health difficulties should not be understood as resulting solely from their traumatic experiences. Rather, mental health difficulties also depend on the economic, social, and cultural conditions asylum seekers face in the country where they seek refuge (Porter & Haslam, 2005). This study's findings highlight the importance of housing for causing and exacerbating mental health difficulties. The qualitative results, which explore why hotels adversely impact mental health, will now be compared to the literature.

4.3.1 Theme 1: Lack of safety

In this study participants reported that lack of safety in hotels created and exacerbated mental health difficulties and prevented recovery. These findings are supported by the literature, which reinforces the connection between safety and mental health (e.g. Ziersch et al., 2017; British Red Cross, 2021, Action Foundation et al., 2021). The presence of safety is protective for mental health; whereas, the absence of safety is detrimental for mental health.

Psychological theory on recovering from mental health difficulties, particularly trauma, emphasises the importance of safety. According to Herman's (1992) Three Stage Model, the first stage of recovering from trauma is establishing safety. This should take place before progressing to further stages of trauma therapy, including re-telling the trauma (stage two) and reintegration (stage three). If someone cannot establish safety, he or she may be unable to progress with therapy and may never recover from trauma and other mental health difficulties.

Therefore, it is crucial to consider asylum seekers' safety. Participants reported a lack of safety in hotels, which may affect asylum seekers' ability to recover from mental health difficulties. Even if they are receiving mental health support, therapy may prove ineffective because they cannot progress beyond stage one of treatment (establishing safety).

In addition to undermining asylum seekers' ability to recover from mental health difficulties, hotels also risk retraumatising asylum seekers. In this study, participants reported that hotels were retraumatising by reminding them of past experiences of imprisonment and torture. Similarly, a Swedish study found that for asylum seekers who had experienced trauma, living with unknown people aggravated re-experiencing symptoms of traumas (van Eggermont

Arwidson et al., 2022). Numerous studies also highlighted how lack of privacy and hotel staff being able to enter bedrooms without consent is retraumatising and anxiety-provoking (e.g. British Red Cross, 2021; Refugee Council, 2021). This demonstrates how various features of hotels negatively impact mental health.

This study also found that hotels may create new mental health difficulties; many participants described developing severe depression, anxiety, and suicidal ideation, and some attempted to end their lives. This fits with the wider literature, which describes poor housing as exacerbating psychological distress and causing sadness, insomnia, anxiety, and depression (Moreira et al., 2020). Moreover, numerous studies have shown that when subjected to poor housing conditions, asylum seekers' mental health can deteriorate to the point that they experience suicidal thoughts or self-harm (Lietaert et al., 2020; Hedrick et al., 2020; Amarasena et al., 2023; Hedrick et al., 2019; British Red Cross, 2021). This reinforces the potential risks of continuing to house asylum seekers long-term in hotel accommodation, which was originally only intended for short-term use.

4.3.2 Theme 2: Lack of autonomy

This study found that lack of autonomy can adversely impact mental health. The subtheme of unmet basic needs is strongly supported by the literature, which highlights numerous problems with housing people in hotels for long periods, including lack of clothing, finances and access to health services, and poor quality food (e.g. Refugee Council, 2021; Jones et al., 2022). Hotels deny asylum seekers resources to care for themselves, creating a sense of dependency. By positioning themselves as parental figures who provide everything for their asylum-seeking children, hotels infantilize asylum seekers. Participants like Aaron commented on this; he described how hotels instruct asylum seekers to do everything at a

particular time, not allowing them to make their own decisions or follow their own schedules. This results in a diminished sense of autonomy, which fits with the wider literature. Other studies similarly report asylum seekers' frustration with regulations that infringe upon autonomy, such as strict timing for canteen hours (Lietaert et al., 2020), having to sign in and out (Murphy et al., 2018), and not being allowed to choose or cook their own food (Gewalt et al., 2019). Participants' reports of struggling to access services are buttressed by other studies, which found that living in hotels impaired asylum seekers access to health services, including GPs and mental health services (Refugee Council, 2021; British Red Cross, 2021).

Participants in other studies characterized their accommodation using the same language as participants in this study: 'like a prison' (e.g. Murphy et al., 2018; Action Foundation et al., 2021; Whitehouse et al., 2021). An Irish study's participants compared their accommodation to a prison because their behaviour and choices were controlled, resulting in diminished self-efficacy (Murphy et al., 2018). A UK study found that institutional accommodation involves a loss of autonomy, which harms mental health and makes asylum seekers feel depressed and deprived of fundamental liberties (Action Foundation et al., 2021).

Ziersch et al. (2017) identified lack of control as a key intermediary between housing and health, such that a perceived lack of control over housing negatively impacts health. Given that a sense of control is an established social determinant of health (Marmot, 2000), it follows that loss of control in hotels negatively impacts asylum seekers' mental health. Moreover, a Dutch study examined asylum seekers' living situation in relation to the idea of home, exploring what they lacked in terms of home, and found that a key factor was lack of autonomy; lack of autonomy made the reception centre 'unhomely' (van der Horst, 2004).

This mirrors statements from participants in this study who described hotel accommodation as being ‘not a home’.

Living in an unhomely hotel may cause specific difficulties for children and families. In this study participants stated that living in a hotel hindered their ability to care for their children. Although parents strove to meet their children’s needs, hotel restrictions prevented parents from meeting their children’s needs. Unmet needs adversely impacted both children and parents and were viewed as damaging for children and parents’ mental health. Parents linked a decline in their mental health to feeling a diminished sense of parental autonomy. The literature bolsters the concept of diminished parental autonomy, demonstrating how strict regulations prevent parents from responding to their children’s needs (Murphy et al., 2018). Additionally, research shows that being forced to ask and be given permission for basic things, including meeting their children’s needs (Lietaert et al., 2020), infantilizes parents and makes them feel like they are failing as parents (Murphy et al., 2018). This demonstrates the adverse impact of lack of autonomy in hotels on asylum seekers, particularly for children and families.

4.3.3 Theme 3: Social isolation

This study found that asylum seekers in hotels experience social isolation. This aligns with the literature, in which asylum seekers report feeling socially isolated (e.g. Gewalt et al., 2018; Doctors of the World, 2021) and experiencing a lack of belonging in their community (Murphy et al., 2018). In this study, asylum seekers described the location of hotels as problematic because it prevented them from accessing the community. Other studies derived similar findings and identified factors that contribute to asylum seekers’ limited access to the community, including restricted public transport networks (van Eggermont Arwidson et al.,

2022) and lack of funds to travel into the community, visit places of worship, and access services (Action Foundation et al., 2021).

In addition to feeling disconnected from community, participants in this study also reported feeling disconnected from peers. Other studies similarly reported that asylum seekers struggle to build social support networks with other asylum seekers (e.g. Gewalt et al. 2018; Ziersch et al., 2017). Whereas this study identified cultural barriers and conflict between asylum seekers as hindering connections, other studies identified different factors, such as language barriers (Gewalt et al., 2018), overcrowding (Hague et al., 2017), and frequency of transfers between accommodations (Gewalt et al., 2018).

In this study, asylum seekers' sense of isolation was also affected by problems with hotel staff who behaved unprofessionally and treated asylum seekers poorly. Whitehouse et al. (2021) similarly found that asylum seekers reported insensitivity to their needs and poor communication between staff and asylum seekers. Additionally, Action Foundation et al. (2021) found that asylum seekers were ignored and treated with disdain and threats when they tried to raise concerns with staff. Being treated poorly made them feel unwanted in the UK or 'considered less than human', which had a lasting impact on their mental health even after they moved to different accommodation (Action Foundation et al., 2021, p. 14). This aligns with this study's findings; participants reported that poor treatment impacted their mental health. For example, John spoke about feeling 'dehumanized' and Leah spoke about feeling 'not a human being.'

Problems with staff, disconnection from community, and disconnection from peers engendered social isolation. Research reinforces the link between social isolation and mental

health, demonstrating that social isolation and lack of connection with others causes distress and negatively impacts mental health (Ziersch et al., 2017; Chase & Rousseau, 2018). Moreover, Siolve et al. (1997) identified loneliness as a post-migratory stressor associated with anxiety, depression, and PTSD in asylum seekers. Hence, this study demonstrates that hotels contribute to social isolation, which is detrimental for mental health.

4.3.4 Theme 4: Survival strategies

This study identified three survival strategies: faith, family, and seeking support. Past research reinforces asylum seekers' reliance on religion and prayer to cope with difficulties (Domínguez et al., 2022; Gewalt et al., 2018; van Eggermont Arwidson et al., 2022). In addition to faith, participants also emphasised the importance of family; many participants cited family as their primary source of strength. Although other studies highlight the importance of asylum seekers receiving support from family (e.g. Schweitzer et al., 2006; Palmer & Ward, 2007; Domínguez et al., 2022), this study focused on asylum seekers giving support to family. Particularly for asylum-seeking parents, supporting their family functioned as motivation to persevere. This is noteworthy because family did not have to be in the same country to function as a source of strength. Numerous participants were separated from family, but still drew strength from them, such as Rachel, who held onto the thought of reuniting with her mother, and Jeremiah, who imagined creating a better future for his children. Whereas past research positioned asylum seekers as recipients of family support, this study identifies asylum seekers as providers of family support. The desire to support family motivated asylum seekers to endure.

The last survival strategy was seeking support from the community, peers, and services. Connecting with the community was rehumanising for asylum seekers who felt dehumanized

in hotels. For example, John shared that interacting with people in the community improved his mental health because the people he met were ‘more human’. The literature expands upon these findings, illustrating that community integration improves mental health (Whitehouse et al., 2021; British Red Cross, 2021). Palmer & Ward (2007) identified numerous activities that aid integration, including art, music, and group activities like sewing. This differed from this study, in which asylum seekers reported engaging with few or no community activities. Participants expressed a desire to participate, but could not access activities due to lack of funds and transportation. Thus, this study reveals that hotels function as a barrier to asylum seekers participating in community activities, which support wellbeing and integration.

Participants also sought support from their peers and services. Talking to other asylum seekers reminded them that they were ‘not alone’ and allowed them to ‘share the pain’. This aligns with past research, which showed that expressing care and concern for other asylum seekers improves mental health (van Eggermont Arwidson et al., 2022). Participants also sought support from services, including charities and mental health services. Other studies reinforce the helpfulness of professionals (Gewalt et al., 2018) and identify doctors and counsellors as particularly helpful for alleviating distress (Palmer & Ward, 2007). In sum, this study reveals asylum seekers’ resilience, as they employed numerous survival strategies to endure challenges while living in hotels.

4.3.5. Theme 5: Ideas for changing the housing system

Participants generated ideas for changing the housing system, including community housing, meeting basic needs, enabling access to services, and reforming hotel staff behaviour. The strongest recommendation was to move asylum seekers out of hotels and into community housing, as community housing was viewed as better for mental health than hotels. This

aligns with the global literature, including a German study which found that asylum seekers had better mental health outcomes when living in private community accommodation compared to collective accommodation (Dudek et al., 2022). It is also consistent with UK literature, including a report which emphasized numerous problems with hotel accommodation, included developing mental health difficulties, feeling disempowered and lacking a sense of control over one's life, and feeling dehumanized and traumatised (Neal, 2022). Participants in this study advised that policies should be changed to limit time in hotels and move participants to community housing provided by the Home Office or friends and family.

Community housing was found to promote integration, which is buttressed by the literature. A Norwegian study comparing community housing to 'centralized housing' (including hotels) found that community housing improved asylum seekers' wellbeing by supporting independence, reducing conflicts, and aiding integration by improving contact with the local community (Hague et al., 2017). However, the study also acknowledged that 'centralized housing' (such as hotels) had potential benefits compared to community housing, such as preventing loneliness among residents and being able to provide additional care for vulnerable asylum seekers, such as unaccompanied minors and asylum seekers with mental health difficulties. In contrast, this study did not find any benefits of living in hotels compared to community housing; this may reflect differences in the quality of hotels in Norway compared to the UK and the ability of hotels to meet vulnerable asylum seekers' needs. Thus, in the UK, participants advocated for moving asylum seekers into community housing as quickly as possible to improve their mental health and promote integration.

Acknowledging that it is not possible to immediately move all asylum seekers into community housing, ideas for improving hotel accommodation were also explored. Participants emphasised the importance of hotels meeting asylum seekers' basic needs, particularly the need for nutritious food. Other studies also commented on the negative impact of poor quality food (e.g. Refugee Council, 2021; Jones et al., 2022). Being compelled to eat unhealthy hotel food reinforced asylum seekers' lack of autonomy and adversely impacted their physical and mental health. Thus, they recommended that hotels should provide healthy food that meets dietary needs.

Participants also advised that hotels should enable, rather than hinder, asylum seekers' access to services. They described how hotels failed to provide transportation to essential appointments with GPs, solicitors, and the Home Office; thus, interfering with asylum seekers' ability to improve their health and progress with the asylum-seeking process. Previous research reinforces the finding that housing interferes with asylum seekers' access to healthcare (Nellums et al., 2018; British Red Cross, 2021); however, little research has been done on the impact of housing on asylum seekers' ability to progress with the asylum-seeking process. This is a key finding, which will be expanded upon in the recommendation section.

Participants also advocated for the reformation of hotel staff behaviour, citing numerous incidents of poor treatment. This is supported by a report by the Independent Chief Inspector of Borders & Immigration, which highlighted the problem of hotel staff's 'anti-social behaviour' (Neal, 2022). Participants linked staff behaviour to a lack of accountability to the Home Office. Moreover, they described Home Office inspections as cursory and insufficient to understand what was truly happening in the hotel because inspectors did not speak directly to asylum seekers and staff tidied the hotel before inspections, leading to misleading

perceptions. To reform hotel staff behaviour, participations recommended that the Home Office oversee hotel staff more closely and speak directly to asylum seekers.

4.4 Critical Review

The quality of the study was evaluated using the Mixed Methods Appraisal Tool (MMAT; Hong et al., 2018), as described in Chapter 1. The MMAT was selected because of its ability to appraise studies with mixed methods designs. According to MMAT criteria, the study was accessed as high quality (see Figure 11). The overall study was evaluated using the mixed methods criteria (MMAT section 5), and each individual component of the study was evaluated according to the appropriate section (MMAT section 1 for the quantitative component; MMAT section 3 for the quantitative component). Future studies could be improved by increasing the quality of available outcome data, including providing access to complete datasets and information about potential confounding factors. This would enable potential confounds to be accounted for in the research design and analysis.

Figure 11

Mixed methods appraisal tool (MMAT; 2018)

Category of study designs	Methodological quality criteria	Responses			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?	✖			
	S2. Do the collected data allow to address the research questions?	✖			
	Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.				
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?	✖			
	1.2. Are the qualitative data collection methods adequate to address the research question?	✖			
	1.3. Are the findings adequately derived from the data?	✖			
	1.4. Is the interpretation of results sufficiently substantiated by data?	✖			
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?	✖			
2. Quantitative randomized controlled trials	2.1. Is randomization appropriately performed?				
	2.2. Are the groups comparable at baseline?				
	2.3. Are there complete outcome data?				
	2.4. Are outcome assessors blinded to the intervention provided?				
	2.5 Did the participants adhere to the assigned intervention?				
3. Quantitative non-randomized	3.1. Are the participants representative of the target population?	✖			
	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?	✖			
	3.3. Are there complete outcome data?		✖		
	3.4. Are the confounders accounted for in the design and analysis?		✖		
	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?	✖			
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?				
	4.2. Is the sample representative of the target population?				
	4.3. Are the measurements appropriate?				
	4.4. Is the risk of nonresponse bias low?				
	4.5. Is the statistical analysis appropriate to answer the research question?				
5. Mixed methods	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?	✖			
	5.2. Are the different components of the study effectively integrated to answer the research question?	✖			
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?	✖			
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	✖			
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?	✖			

To enhance the rigor of the evaluation of the qualitative component of the study, it was also evaluated according to Braun & Clarke's (2019) Tool for Evaluating Thematic Analysis Manuscripts for Publication, which contains twenty questions to guide assessment of TA research quality, covering categories such as adequate choice and explanation of methods and methodology and well-developed and justified analysis (see Appendix M). According to these criteria, the qualitative component of the study and use of thematic analysis was evaluated as high quality.

4.4.1 Limitations

Both the quantitative and qualitative components of the study contained limitations. The quantitative component of the study was restricted by the data collection process. It used pre-existing, routinely collected mental health screening questionnaires from a charity, which resulted in numerous potential confounds. The variables were based on self-report questionnaires, which are vulnerable to bias. The data also did not include information about length of stay in hotel accommodation, therapy, and country of origin, which are potential confounds.

Although the data indicated whether asylum seekers were living in hotels or alternative accommodation when their mental health screening questionnaires were collected, the data did not include the length of stay in hotel accommodation. Therefore, someone living in a hotel for a short time (e.g. one week) was grouped in the same category as someone living in a hotel for a long time (e.g. two years). As discussed in the Results section, interview participants described living in hotels long-term as being detrimental to mental health;

therefore, it is problematic that the data did not allow for comparison based on length of stay in hotels.

Another potential confound was whether participants accessed therapy because this would likely affect their mental health screening questionnaire outcomes. The collected data included some information about whether participants had accessed therapy, but it was too inconsistent and limited to include in the regression analysis. For example, the data indicated that some participants had 'pre-stabilisation therapy', but it was unclear exactly what support they had accessed and what additional support they were waiting to receive. Other participants were marked as having finished therapy, but there was no information about what kind of mental health difficulty they accessed therapy for (i.e. trauma, depression, anxiety, etc.) and the type of therapy they received (i.e. Cognitive Behavioural Therapy (CBT), Narrative Exposure Therapy (NET), Eye-Movement Desensitization and Reprocessing (EMDR), etc.). Therefore, it was not possible to include therapy in the analysis.

Another potential confound was country of origin. Data was available for participants' country of origin, so including country of origin in the regression analysis was initially considered. However, most participants came from different countries and most countries had very small numbers of participants (n=1 or n=2). Due to small numbers and the need to protect participant confidentiality, country of origin was not included in the regression analysis. Previous research has included country of origin and found it to be an important factor (Blackmore et al., 2020), so not including country of origin in this study is a limitation.

Compared to the quantitative data, which was restricted by the data collection process, the qualitative data had fewer limitations. The most noteworthy limitation, which also applies to

the quantitative data, was recruiting interview participants from one London-based charity instead of multiple organisations spread throughout the UK. This could have affected the study's generalisability, as asylum seekers living in other areas may have different experiences. However, many of the charity's clients were living outside of London when they were referred and once they were accepted, the charity provided non-dispersal letters to ensure that clients were housed in London to assess care. Moreover, most interview participants reported living in hotels in multiple geographical areas, including outside of London, so the results may also reflect these experiences.

Additionally, the charity specializes in supporting survivors of extreme traumas, including torture and trafficking, so it is possible that participants in this study differ from asylum seekers who have not experienced extreme traumas, particularly in relation to mental health outcomes. In addition to providing therapy, the charity also provides practical support with housing, medical, and legal processes, which may impact wellbeing and levels of distress. As many asylum seekers lack access to the practical and therapeutic support the charity provides, this could also impact the study's generalisability.

4.4.2 Strengths

This study meaningfully contributes to the limited literature regarding the impact of housing on asylum seekers' mental health. To the authors' knowledge, it is the first study to specifically examine the impact of hotel accommodation on asylum seekers' mental health. It is timely and highly relevant, as the Home Office is increasingly housing asylum seekers in hotels and similar accommodation, such as barracks and barges. It is also pertinent for clinical psychologists, who regularly assess asylum seekers and must consider the impact of psychosocial factors, including housing, on their mental health.

Another strength of the study was its mixed methods design. It has been argued that a mixed methods design is superior when researching asylum seekers who originate from many cultural backgrounds and have different cultural idioms of distress because mixed methods incorporates quantifiable data about participants' symptoms and subjective data about their lived experience (Bernardes et al., 2010). This study's quantitative component provided data about participants' mental health symptoms and post-migration living difficulties using mental health screening questionnaires; whereas the qualitative component provided an in-depth exploration of participants' lived experience. This allowed for triangulation and enabled a richer and more nuanced answer to the research question.

Furthermore, the study contained good sample sizes for the quantitative data (n=110 for CORE-10; n=111 for PHQ-9; n=147 for PMLD) and qualitative data (n=16), comprising asylum seekers from different backgrounds, ages, and genders, which supports data sufficiency. The use of interpreters was a key strength because it allowed for the inclusion of non-English speaking participants whose perspectives are often excluded from research. Most participants in the study were non-English speaking (75%), which generated findings that may not have been possible if interpreters had not been used. For example, Theme 3 found that non-English speaking asylum seekers have communication difficulties in hotels due to lack of interpreters. It is important to acknowledge that interpreters' presence may have influenced the interview data; however, only trained, trauma-informed interpreters were used, which mitigated the extent of this.

The study's data analysis was also rigorously evaluated using appropriate tools (MMAT and Braun & Clarke's Tool for Evaluating Thematic Analysis Manuscripts for Publication).

Lastly, reflexivity was considered throughout the research process, and the researcher used various methods to practice self-reflexivity, including keeping a reflexive journal, consulting with experts by experience, and reflecting on insider-outsider researcher positionality.

4.4.3 Reflections

I will now share final reflections on the research, its impact on me, and my impact on it. I began the clinical psychology doctorate with the aim of doing meaningful research; I saw my thesis as a rare opportunity to dedicate considerable time, energy, and resources to a topic, and thus, wanted the topic to be worthwhile. Coming from a family of refugees, I have always been interested in refugees' experiences and improving refugees' mental health. Hence, when the opportunity to collaborate with the Helen Bamber Foundation (HBF) arose, I felt ecstatic.

During the early stages of the partnership, I initially planned to research a psychosocial intervention that HBF provides; however, due to the limited timeframe of my doctorate and service changes, this became unviable. The partnership with HBF nearly fell through (much to my dismay!), but we thankfully found another focus for the research. I am grateful to the service users who suggested housing as the focus and encouraged me to dive into exploring the connection between housing and mental health.

As I have shaped the research, the research has also shaped me. In my clinical work with asylum seekers, I found myself asking in-depth questions about their housing and witnessed first-hand the impact of housing on mental health. In contrast to my interactions with research participants, which ended after the interviews, my interactions with clients allowed me to do ongoing work to address their housing problems. I found it gratifying to advocate for clients

and improve their housing as a way of improving their mental health. Within my service, we developed pathways and resources for supporting clients with housing problems. I am thankful that I was able to bring my research into my clinical practice and hope to continue doing this in future roles. In the next section, I will expand upon the idea of bringing the research into practice and consider the research's policy, clinical, and research implications.

4.5 Policy, Clinical, and Research Implications and Recommendations

4.5.1 Policy Implications and Recommendations

Policy implications and recommendations will now be addressed, considering the context of this research. Since March 2020, the Home Office increased its use of hotels to house asylum seekers due to 'a lack of flow' through the asylum system with more applications coming in and not enough decisions being made (Refugee Council, 2021). Flaws in the asylum system, including delays in decision making, lengthy appeal processes, and lack of community housing, resulted in asylum seekers being increasingly housed in hotels for long stays rather than the short stays for which they were originally intended. This study demonstrated that hotel accommodation negatively impacts asylum seekers' mental health, highlighting how flaws in the asylum system are adversely affecting asylum seekers' wellbeing.

Adequate housing is recognised as a human right; furthermore, the World Health Organization (WHO) states that 'adequate' housing encompasses more than just the physical building. Adequate housing is to 'have a home, a place which protects privacy, contributes to physical and psychological wellbeing, and supports the development and social integration of its inhabitants' (Bonnefoy, 2007, p. 413). According to a conceptual framework for the integration of refugees and asylum seekers into society, one of the key domains for successful

integration is access to housing (Ager & Strang, 2008). Housing affects asylum seekers' physical and psychological wellbeing and social and cultural aspects of integration. For example, adequate housing helps asylum seekers feel settled and connect with locals, creating opportunities to learn about the culture from members of the community. This study demonstrated that hotel accommodation fails to meet the criteria for adequate housing, harming asylum seekers' mental health and integration into the community. Therefore, current Home Office policies can be viewed as violating asylum seekers' right to adequate housing.

Thus, it is recommended that flaws in the asylum system are addressed to ensure access to adequate housing. Ultimately, there is a need to speed up lengthy decision-making processes and increase flow through the asylum system to reduce the strain on community housing and prevent the Home Office from resorting to housing asylum seekers in hotels. In the meantime, vulnerable groups, including children, families, victims of torture and trafficking, and people with significant physical and mental health difficulties, should be prioritized for community housing. Research demonstrates that self-harm rates are the lowest among asylum seekers in community housing (Hedrick et al., 2019); therefore, asylum seekers who present with risks to themselves should be housed in the community.

Policy reform is also recommended for hotel accommodation. More accountability and better Home Office oversight is necessary to prevent abuses of power taking place in hotels. Home Office inspections should be unannounced, and inspectors should speak directly to asylum seekers using interpreters to gain an accurate report of whether hotel staff are treating asylum seekers humanely and meeting asylum seekers' basic needs, such as the need for nutritious

food. The Home Office should also establish clear pathways for asylum seekers to make complaints that can be investigated independently from hotel management.

Additionally, hotels should provide access to interpreters to improve communication between hotel staff and asylum seekers, which could improve relationships and reduce conflict. It is also recommended that hotels provide better support with accessing services, including providing information about registering for health services like GPs and dentists, and providing transportation for medical appointments. Hotels should be more accommodating for asylum seekers with additional needs, such as asylum seekers with health conditions or disabilities, and house them in rooms that meet their needs, such as ground floor rooms for people who cannot climb stairs.

This study found that hotel accommodation impacts asylum seekers ability to engage with the asylum process, such as attending appointments with solicitors and the Home Office. Therefore, it is essential that hotels support, rather than undermine, asylum seekers' ability to engage with the asylum process. For example, transportation to solicitor and Home Office appointments should be provided.

4.5.2 Clinical Implications and Recommendations

This study has clinical implications for health professionals, including GPs, mental health clinicians, and social workers. As GPs are the health professionals most likely to interact with asylum seekers living in hotels, they should ask asylum-seeking patients about their mental health and wellbeing. Given the high prevalence of depression and suicidal ideation found in this study, GPs should ask patients specifically about this, administer the PHQ-9 (validated

measure of depression) and CORE-10 (validated measure of psychological distress), and consider referring asylum seekers to mental health services for support.

Mental health clinicians should consider the findings of this study when assessing asylum seekers living in hotels. Mental health assessments should include an exploration of whether hotel accommodation exacerbated pre-existing mental health difficulties and/or caused new mental health difficulties. Clinicians should ask questions related to the themes of this study, including whether asylum seekers feel safe in their hotel accommodation, as lack of safety could inhibit their ability to engage with psychological treatment. Deteriorating mental health and transportation difficulties could also negatively impact engagement with services. The theme of social isolation in hotels is also relevant to explore, as this could impact asylum seekers' support networks and engender a lack of protective factors. Hotel accommodation should be considered a risk factor when assessing the risk of self-harm and suicidal ideation, as this study found high rates of depression and suicidal ideation among asylum seekers living in hotels.

As part of interventions, clinicians should consider referring asylum seekers to community groups and religious organisations, as these connections were key survival strategies for participants in this study. Clinicians should also consider supporting asylum-seeking clients through housing advocacy, such as writing support letters that demonstrate the impact of housing difficulties on mental health. However, it is important to acknowledge the limits of what clinicians can achieve working within the restraints of wider systems and Home Office policies.

On the topic of wider systems, many NHS services require clients who move to a different borough to stop therapy and be referred to their new local service. This often results in clients being added to the end of a long waitlist and waiting months or years to resume mental health treatment. For asylum seekers subject to frequent moves, services could consider allowing asylum seekers who have started therapy in one borough to complete treatment if they are moved. This would impact services and might require flexibility, such as offering video calls, but it would promote continuity of care and access to mental health treatment for vulnerable asylum seekers who might otherwise slip through the cracks in the system.

Social workers and other professionals with safeguarding duties should consider the risk of exploitation. This study found that asylum seekers living in hotels were pushed to the financial limit and struggled to meet their basic needs, leaving them vulnerable to exploitation and modern-day slavery. A recent UNHCR and British Red Cross report (2022) found that asylum seekers are at risk of exploitation and are being exploited in the UK, including being forced into domestic servitude, sexual and labour exploitation, and forced criminality. The report identified unsafe housing as a risk factor for exploitation, particularly for vulnerable asylum seekers, such as victims of trafficking and LGBTQI+ people. The report described examples of asylum seekers being recruited directly from their accommodation into exploitation, as asylum seekers needed money to support themselves and felt desperate, putting them at risk. Research has found that hotels fail to sufficiently safeguard asylum seekers due to inadequate ratios of staff to residents and lack of awareness among staff (UNHCR & British Red Cross, 2022). Additionally, a recent report found that in 2022 more than 800 children were incorrectly assessed as adults by the Home Office and placed alone in accommodation alongside adults, putting them at risk (Helen Bamber Foundation, 2023). Therefore, it is recommended that hotel staff be provided with

safeguarding training and professionals with safeguarding duties, including social workers, should assess asylum seekers' risk of exploitation.

4.5.3 Research Implications and Recommendations

This study highlights the need for more research regarding hotel accommodation, children and young people, and barges and barracks. This study focused primarily on examples of bad practice in hotels; however, a few participants highlighted examples of good practice, such as having a supportive hotel manager. It would be valuable for future research to examine good practice within hotel accommodation, particularly in relation to access to services. For example, future research could focus on pop-up clinics and outreach services in which health professionals visit asylum seekers in hotels; this could potentially reduce the problem this study found regarding participants' lack of access to services.

Future research on hotels could also explore the impact of racism and xenophobia, as previous research has found that asylum seekers living in hotels are harassed by far-right groups (Refugee Council, 2022). The interaction between racism and xenophobia could link with this study's findings on social isolation, disconnection from community, and lack of safety.

Further research is also needed on children and young people in hotels. Although this study included participants with children, it focused more on the parents' perspective and the impact on parents' mental health. Future research should focus specifically on understanding children and young people's perspectives. Research is especially needed on unaccompanied asylum-seeking children, as reports have found that hundreds of children have gone missing from hotels and are suspected of being trafficked and exploited (Ioffe, 2023).

As the Home Office has started using barracks and barges to house asylum seekers, future research should also focus on the mental health impact of these types of housing, seeking to understand the similarities and differences between hotel accommodation and barracks and barges.

Lastly, two recommendations for better research practice are considered. For charities and NHS services that support asylum seekers, it is recommended that more outcome measure data be collected and that data collection procedures are followed more uniformly. This will support future research by providing access to higher quality data.

It is also recommended that research with asylum seekers should include funding for interpreters, as this allows for the inclusion of non-English speaking participants and can lead to new findings, as this study illustrated. An application was made to a university equality and inclusion fund to finance interpreters for this study. This demonstrates how universities can support access to interpreters through providing funding for increasing inclusion in research.

5. Conclusion

This thesis provided a critical review of current knowledge regarding the association between housing and asylum seekers' mental health, filling a gap in the literature and providing useful and highly relevant results, given the Home Office's increasing use of temporary housing, including hotels. The original in-depth research on the impact of hotel accommodation on asylum seekers' mental health in the UK revealed that hotels negatively impact asylum seekers' mental health, with asylum seekers living in hotels experiencing higher levels of housing problems, psychological distress, and depression compared to asylum seekers living in alternative housing. Three themes were identified to explain why hotel accommodation negatively impacts asylum seekers' mental health: lack of safety, lack of autonomy, and social isolation. Asylum seekers' survival strategies and ideas for changing the housing system were also explored.

Hotel accommodation was illuminated as both causing and exacerbating mental health difficulties, raising important policy recommendations, including reducing asylum seekers' time in hotels, increasing flow through the asylum system, and prioritizing vulnerable asylum seekers for community housing. Clinical implications include the importance of assessing the impact of housing on mental health, considering hotel accommodation as a risk factor for self-harm and suicidal ideation, and referring asylum seekers to community groups and religious organisations, as these connections were identified as survival strategies. Overall, this research focused on a highly relevant topic and generated new knowledge with the potential to influence policy, clinical practice in the NHS and charity organisations, and future research.

References

Action Foundation, Asylum Matters, Birmingham Community Hosting, Birmingham Refugee and Asylum Seekers Solidarity, Life Seeker's Aid Charity, & Stories of Hope and Home. (2021). '*In a place like prison': Voices from institutional asylum accommodation.*

Ager, A., & Strang, A. (2008). Understanding integration: A conceptual framework. *Journal of Refugee Studies*, *21*(2), 166–191. https://doi.org/10.1093/jrs/fen016

Amarasena, L., Samir, N., Sealy, L., Hu, N., Rostami, M. R., Isaacs, D., Gunasekera, H., Young, H., Agrawal, R., Levitt, D., Francis, J. R., Coleman, J., Mares, S., Larcombe, P., Cherian, S., Raman, S., Lingam, R., & Zwi, K. (2023). Offshore detention: Cross-sectional analysis of the health of children and young people seeking asylum in Australia. *Archives of Disease in Childhood*, *108*(3), 185–191. https://doi.org/10.1136/archdischild-2022-324442

Baker, C. & Kirk-Wade, E. (2024). Mental health statistics: Prevalence, services and funding in England. *House of Commons Library*.

Barkham, M., Bewick, B., Mullin, T., Gilbody, S., Connell, J., Cahill, J., Mellor-Clark, J., Richards, D., Unsworth, G., & Evans, C. (2013). The CORE-10: A short measure of psychological distress for routine use in the psychological therapies. *Counselling and Psychotherapy Research, 12*(1), 3-13.

Beck, A., Saiqa, N., Brooks, M., & Jankowska, M. (2019). Improving access to psychological therapies (IAPT): Black, Asian, and minority ethnic service user positive practice guide. *BABCP*.

Bernardes, D., Wright, J., Edwards, C., Tomkins, H., Dlfoz, D., & Livingstone, A. G. (2010). Asylum seekers' perspectives on their mental health and views on

health and social services: Contributions for service provision using a mixed-methods approach. *International Journal of Migration, Health and Social Care*, *6*(4), 3–19. https://doi.org/10.5042/ijmhsc.2011.0150

Biescad, M., Timulak, L. (2014). Measuring psychotherapy outcomes in routine practice: Examining Slovak versions of three commonly used outcome instruments. *European Journal of Psychotherapy & Counselling, 16*(2),140-162.

Blackmore, R., Boyle, J. A., Fazel, M., Ranasinha, S., Gray, K. M., Fitzgerald, G., Misso, M., & Gibson-Helm, M. (2020). The prevalence of mental illness in refugees and asylum seekers: A systematic review and meta-analysis. *PLoS medicine*, *17*(9), e1003337.

Boland, A., Cherry, G., & Dickson, R. (2017). *Doing a systematic review: A student's guide.* SAGE Publications Ltd.

Bonnefoy, X. (2007). Inadequate housing and health: An overview. *Int. J. Environ. Pollut, 30,* 411-429.

Brannen, J. (2005). Mixing methods: The entry of qualitative and quantitative approaches into the research process. *International Journal of Social Research Methodology, 8*(3).

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 2*(2), 77-101.

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. Sage Publications Ltd.

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health*, *11*(4), 589-597.

Braun, V., & Clarke, V. (2020). One size fits all? What counts as quality practice in (reflexive) thematic analysis?. *Qualitative Research in Psychology*, *18*(3), 328-352.

Breen, L. J. (2007). The researcher 'in the middle': Negotiating the insider/outsider dichotomy. *The Australian Community Psychologist*, 19(1).

British Red Cross. (2021). *Far from a home: Why asylum accommodation needs reform.* British Red Cross Policy, Research, and Advocacy.

Burnham, J. (2012) Developments in Social GRRRAAACCEEESSS: visible – invisible and voiced – unvoiced. In I.-B. Krause, (ed.) *Culture and Reflexivity in Systemic Psychotherapy: Mutual Perspective*s (pp. 139–160). London: Karnac.

Centre for Reviews and Dissemination. (2009). *Systematic Reviews: CRD's Guidance for Undertaking Reviews in Heath Care.*

Charmaz, K. (2014). *Constructing grounded theory: A practical guide through qualitative analysis.* London: SAGE.

Chase, L. E., & Rousseau, C. (2018). Ethnographic case study of a community day center for asylum seekers as early stage mental health intervention. *American Journal of Orthopsychiatry*, *88*(1), 48–58. https://doi.org/10.1037/ort0000266

Creswell, J. W. & Crewswell, J. D. (2018). *Research design: Qualitative, quantitative, and mixed methods approaches*. Thousand Oaks: Sage.

De Montgomery, C. J., Stathopoulou, T., & Eikemo, T. A. (2019). Asylum-seeking parents' reports of health deterioration in their children since fleeing their home country. *Journal of Refugee Studies*, *32*(1), I52–I62. https://doi.org/10.1093/jrs/fez018

Dineen, L. C., & Blakesley, B. C. (1973). Algorithm AS 62: Generator for the sampling distribution of the Mann-Whitney U statistic. *Applied Statistics*, *22*, 269-273.

Domínguez, D. G., Hernandez-Arriaga, B., Noriega, M. A., García, D., & Martínez, D. A. (2022). “They treat us like we are not human”: Asylum seekers and “la migra’s” violence. *Psychology of Violence*, *12*(4), 241–251. https://doi.org/10.1037/vio0000434

Dudek, V., Razum, O., & Sauzet, O. (2022). Association between housing and health of refugees and asylum seekers in Germany: Explorative cluster and mixed model analysis. *BMC Public Health*, *22*(1). https://doi.org/10.1186/s12889-021-12458-1

Dwyer, S. C., & Buckle, J. L. (2009). The space between: On being an insider-outsider in qualitative research. *International Journal of Qualitative Methods*, 8(1).

Eisen, E., Howe, G., & Cogar, M. (2021). The impact of post-migration factors on posttraumatic stress and depressive symptoms among asylum seekers in the United States. *Journal of Immigrant and Refugee Studies*, *19*(4), 573–586. https://doi.org/10.1080/15562948.2020.1856457 https://doi.org/10.1080/15562948.2020.1856457

Enticott, J. C., Shawyer, F., Vasi, S., Buck, K., Cheng, I.-H., Russell, G., Kakuma, R., Minas, H., & Meadows, G. (2017). A systematic review of studies with a representative sample of refugees and asylum seekers living in the community for participation in mental health research. *BMC Medical Research Methodology*, *17*(1), 37.

Evans, C., Connell, J., Barkham, M., Margison, F., McGrath, G., Mellow-Clark, J., & Audin, K. (2002). Towards a standardized brief outcome measure: Psychometric properties and utility of the CORE-OM. *The British Journal of Psychiatry, 180*(1), 51-60.

Gewalt, S. C., Berger, S., Szecsenyi, J., & Bozorgmehr, K. (2019). ‘If you can, change this system’- Pregnant asylum seekers’ perceptions on social determinants and material circumstances affecting their health whilst living in state-provided accommodation in

Germany - A prospective, qualitative case study. *BMC Public Health*, *19*(1). https://doi.org/10.1186/s12889-019-6481-2

Gewalt, S. C., Berger, S., Ziegler, S., Szecsenyi, J., & Bozorgmehr, K. (2018). Psychosocial health of asylum seeking women living in state-provided accommodation in Germany during pregnancy and early motherhood: A case study exploring the role of social determinants of health. *PLoS ONE*, *13*(12). https://doi.org/10.1371/journal.pone.0208007

Gleeson, C., Frost, R., Sherwood, L., Shevlin, M., Hyland, P., Halpin, R., Murphy, J., & Silove, D. (2020). Post-migration factors and mental health outcomes in asylum-seeking and refugee populations: a systematic review. *European journal of psychotraumatology*, *11*(1).

Gough, B., & Madill, A. (2012). Subjectivity in psychological science: From problem to prospect. *Psychological Methods*, *17*(3), 374–384. https://doi.org/10.1037/a0029313

Grønseth, A. S., & Thorshaug, R. Ø. (2022). Struggling for home where home is not meant to be: A study of asylum seekers in reception centers in Norway. *Focaal*, *2022*(92), 15–30. https://doi.org/10.3167/fcl.2022.920102

Harper, D., & Thompson, A. R. (2020). *Qualitative Research Methods in Mental Health and Psychotherapy: A Guide for Students and Practitioners.* Wiley-Blackwell.

Hedrick, K., Armstrong, G., Coffey, G., & Borschmann, R. (2019). Self-harm in the Australian asylum seeker population: A national records-based study. *SSM - Population Health*, *8*. https://doi.org/10.1016/j.ssmph.2019.100452

Hedrick, K., Armstrong, G., Coffey, G., & Borschmann, R. (2020). Self-harm among asylum seekers in Australian onshore immigration detention: How incidence rates vary by held detention type. *BMC Public Health*, *20*(1). https://doi.org/10.1186/s12889-020-08717-2

Hedstrom, E., Kovshoff, H., Hadwin, J. A., & Kreppner, J. (2021). Exploring parenting narratives in asylum seeking populations in Sweden: Examining the effect of post-migration stress on families through grounded theory. *Journal of Refugee Studies*, *34*(3), 3381–3398. https://doi.org/10.1093/jrs/feaa136

Helen Bamber Foundation. (2023). *Disbelieved and denied: Children seeking asylum wrongly treated as adults by the Home Office*. Helen Bamber Foundation, Asylum Aid, Humans for Rights Network.

Herman, J. L. (1992). *Trauma and Recovery*. From domestic abuse to political terror. London: Pandora.

Home Office. (2022a, September 23). *How many people do we grant asylum or protection to?* UK GOV. https://www.gov.uk/government/statistics/immigration-statistics-year-ending-june-2022/how-many-people-do-we-grant-asylum-or-protection-to

Home Office. (2022b, February 2). *Letter from the Second Permanent Secretary at the Home Office to the Home Affairs Select Committee*. UK GOV. https://committees.parliament.uk/publications/8784/documents/88934/default/

Home Office. (2022c). Asylum Accommodation and Support Schedule: Statement of Requirements. https://data.parliament.uk/DepositedPapers/Files/DEP2018-1112/AASC_-_Schedule_2_-_Statement_of_Requirements.pdf

Home Office. (2024a). Asylum support. UK.GOV. https://www.gov.uk/asylum-support/what-youll-get

Home Office. (2024b, February 29). *How many people do we grant protection to?* UK GOV. https://www.gov.uk/government/statistics/immigration-system-statistics-year-ending-december-2023/how-many-people-do-we-grant-protection-to

Hong, Q. N., Fàbregues, S., Bartlett, G., Boardman, F., Cargo, M., Dagenais, P.,

Gagnon, M.-P., Griffiths, F., Nicolau, B., & O'Cathain, A. (2018). The Mixed Methods Appraisal Tool (MMAT) version 2018 for information professionals and researchers. *Education for Information*, *34*(4), 285–291.

Immigration and Asylum Act. (1999). Legislation Gov UK. https://www.legislation.gov.uk/ukpga/1999/33/contents

Ioffe, Y. (2023). Unaccompanied asylum seeking children: Hotel accommodation, removal from child welfare system and risk of trafficking. *SSRN*.

Jones, L., Phillimore, J., Fu, L., Hourani, J., Lessard-Phillips, L., & Tatem, B. (2022). 'They just left me': Asylum seekers, health, and access to healthcare in initial and contingency accommodation. *Doctors of the World*.

Kaaya, S. F., Fawzi., M. C. S., Mbwambo, J. K., Lee, B., Msamanga, G. I. & Fawzi, W. (2002). Validity of the Hopkins Symptom Checklist-25 amongst HIV-positive pregnant women in Tanzania. *Acta Psychiatrica Scandinavica, 106*, 9-19.

Kashyap, S., Page, A. C., & Joscelyne, A. (2019). Post-migration treatment targets associated with reductions in depression and PTSD among survivors of torture seeking asylum in the USA. *Psychiatry Research*, *271*, 565–572. https://doi.org/10.1016/j.psychres.2018.12.047

Kristjánsdóttir, H., Sigurðsson, B.H., Salkovskis, P., Ólason, D., Sigurdsson, E., Evans, C., Gylfadóttir, E.D. & Sigurðsson, J.F. (2015). Evaluation of the psychometric properties of the Icelandic version of the Clinical Outcomes in Routine Evaluation–Outcome Measure, its transdiagnostic utility and cross-cultural validation. *Clinical Psychology and Psychotherapy, 22*(1), 64-74.

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: validity of a brief depression severity measure. *Journal of general internal medicine*, *16*(9), 606–

613. https://doi.org/10.1046/j.1525-1497.2001.016009606.x

Laughon, K., Montalvo-Liendo, N., Eaton, S., & Bassett, L. (2023). Health and safety concerns of female asylum seekers living in an informal migrant camp in Matamoros, Mexico. *Journal of Advanced Nursing*, *79*(5), 1830–1839. https://doi.org/10.1111/jan.15511

Levitt, H. M., Bamberg, M., Creswell, J. W., Frost, D. M., Josselson, R., & Suárez-Orozco, C. (2018). Journal article reporting standards for qualitative primary, qualitative meta- analytic, and mixed methods research in psychology: The APA Publications and Communications Board task force report. *American Psychologist*, *73*(1), 26-46.

Lietaert, I., Verhaeghe, F., & Derluyn, I. (2020). Families on hold: How the context of an asylum centre affects parenting experiences. *Child and Family Social Work*, *25*(S1), 1–8. https://doi.org/10.1111/cfs.12706

Lotrakul, M., Sumrithe, S., & Saipanish, R. (2008). Reliability of the Thai version of the PHQ-9. *BMC Psychiatry*, *8*(46).

Lowe, B., 2004. Comparative validity of three screening questionnaires for DSM-IV depressive disorders and physicians diagnoses. *J. Affect Disord. 78,* 131–140.

Marmot, M. (2000). Social determinants of health: from observation to policy. *The Medical Journal of Australia*, *172*(8), 379–382.

Martino, E., Li, Y., Kali-Opio, J., & Bentley, R. (2022). Between liminality and a new life in Australia: What is the effect of precarious housing on the mental health of humanitarian migrants? *Cities*, *131*.

McInnes, B. (2018). *Made to measure: CORE.* Therapy Meets Numbers. Retrieved from http://therapymeetsnumbers.com/made-to-measure-core/

Methley, A. M., Campbell, S., Chew-Graham, C., McNally, R., & Cheraghi-Sohi, S.

(2014). PICO, PICOS and SPIDER: a comparison study of specificity and sensitivity in three search tools for qualitative systematic reviews. *BMC Health Services Research*, *14*(1), 1–10.

Moreira, A. L., Barbosa, M., Maia, M., Veiga, E., Martins, F., & Santos, M. (2020). Lives on hold: The experiences of asylum seekers in Moria refugee camp. *Community Psychology in Global Perspective.*, *6*(1), 92–107.

Murphy, R., Keogh, B., & Higgins, A. (2019). Erosion of meaning in life: African asylum seekers' experiences of seeking asylum in Ireland. *Journal of Refugee Studies*, *32*(2), 278–301. https://doi.org/10.1093/jrs/fey027

Neal, D. (2022). An inspection of contingency asylum accommodation. *Independent Chief Inspector of Borders and Immigration.* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1074799/An_inspection_of_contingency_asylum_accommodation.pdf

Nellums, L. B., Rustage, K., Hargreaves, S., Friedland, J. S., Miller, A., Hiam, L., & Le Deaut, D. (2018). The lived experiences of access to healthcare for people seeking and refused asylum. *Equality and Human Rights Commission*, 122.

Nickerson, A., Steel, Z., Bryant, R., Brooks, R., & Silove, D. (2011). Change in visa status amongst Mandaean refugees: Relationship to psychological symptoms and living difficulties. *Psychiatry research*, *187*(1-2), 267–274.

Nutsch, N., & Bozorgmehr, K. (2020). Der Einfluss postmigratorischer Stressoren auf die Pravalenz depressiver symptom bei Gefluchteten in Deutschland. Analyse anhand der IAM-BAMF-SOEP-Befragung 2016. *Bundesgesundheitsbl,* 63, 1470-1482.

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., & Mulrow, C.D. (2021). The PRISMA 2020 statement: an updated guideline for

reporting systematic reviews. *BMJ*, 372.

Palmer, D., & Ward, K. (2007). 'Lost': Listening to the voices and mental health needs of forced migrants in London. *Medicine, Conflict and Survival,* 23(3), 198-212.

Pilgrim, D. (2020). *Critical Realism for Psychologists.* New York: Routledge.

Pocock, D. (2015). A philosophy of practice for systemic psychotherapy: The case for critical realism. *Journal of Family Therapy*, *37*(2), 167–183. https://doi.org/10.1111/1467-6427.12027

Popay, J., Roberts, H., Sowden, A., Petticrew, M., Arai, L., Rodgers, M., Britten, N., Roen, K. & Duffy, S. (2006). *Guidance on the Conduct of Narrative Synthesis in Systematic Reviews*. ESRC Methods Programme.

Porter, M., & Haslam, N. (2005). Predisplacement and postdisplacement factors associated with mental health of refugees and internally Displaced Persons: A Meta-analysis. *JAMA*, *294*(5). www.jama.com

QSR International. (2018). *NVivo qualitative data analysis software (Version 12).* https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/home

Refugee Council. (2021). *I sat watching my life go by my window for so long: The experiences of people seeking asylum living in hotel accommodation*. Refugee Council.

Refugee Council. (2022). *Lives on hold: Experiences of people living in hotel asylum accommodation. A follow-up report.* Refugee Council.

Reid, K., Flowers, P., Larkin, M. (2005). Exploring lived experience. *The Psychologist, 18*(1), 20-23.

Renner, W. Salem, I., & Ottomeyer, K. (2006). Cross-cultural validation of measures

of traumatic symptoms in groups of asylum seekers from Chechnya, Afghanistan, and West Africa. *Social. Behaviour and Personality, 34*, 1101-1114.

Roberts, C. A., Hunter, J., Cheng, A-L. (2017). Resilience in families of children with autism and sleep problems using mixed methods. *Journal of Paediatric Nursing, 37*.

Schick, M., Zumwald, A., Knöpfli, B., Nickerson, A., Bryant, R. A., Schnyder, U., Morina, N. (2016). Challenging future, challenging past: The relationship of social integration and psychological impairment in traumatized refugees. *European Journal of Psychotraumatology*, 7.

Schiess-Jokanovic, J., Knefel, M., Kantor, V., Weindl, D., Schäfer, I., & Lueger-Schuster, B. (2021). Complex post-traumatic stress disorder and post-migration living difficulties in traumatised refugees and asylum seekers: The role of language acquisition and barriers. *European Journal of Psychotraumatology*, *12*(1). https://doi.org/10.1080/20008198.2021.2001190

Schweitzer, R., Melville, F., Steel, Z., & Lacherez, P. (2006). Trauma, post-migration living difficulties, and social support as predictors of psychological adjustment in resettled Sudanese refugees. *The Australian and New Zealand journal of psychiatry*, *40*(2), 179–187. https://doi.org/10.1080/j.1440-1614.2006.01766.x

Silove, D., Sinnerbrink, I., Field, A., Manicavasagar, V., & Steel, Z. (1997). Anxiety, depression and PTSD in asylum-seekers: Associations with pre-migration trauma and post-migration stressors. *The British Journal of Psychiatry, 170*(4), 351–357.

Sinnerbrink, I., Silove, D., Field, A., Steel, Z., & Manicavasagar, V. (1997).

Compounding of premigration trauma and postmigration stress in asylum seekers. *Journal of Psychology: Interdisciplinary and Applied*, *131*(5), 463–470. https://doi.org/10.1080/00223989709603533

Smith, J. A., Flowers, P., Larkin, M. (2009). *Interpretative phenomenological analysis: theory, method and research*. London: SAGE.

Spitzer, R. L., Kroenke, K., Williams, J. B. W., & Löwe, B. (2006). Brief measure for assessing generalised anxiety disorder: the GAD-7. *Archives of International Medicine., 166*, 1092-7.

Stevens, A. & Sivasathiaseelan, D. (2022). Safeguarding asylum-seeking children housed in contingency accommodation is everyone's responsibility. *BMJ*.

Stoll, C. R. T., Izadi, S., Fowler, S., Green, P., Suls, J., & Colditz, G. A. (2019). The value of a second reviewer for study selection in systematic reviews. *Research Synthesis Methods*, *10*(4), 539–545. https://doi.org/10.1002/jrsm.1369

Toar, M., O'Brien, K. K., & Fahey, T. (2009). Comparison of self-reported health & healthcare utilisation between asylum seekers and refugees: An observational study. *BMC Public Health*, *9*. https://doi.org/10.1186/1471-2458-9-214

UNHCR & British Red Cross (2022). At risk: Exploitation and the UK asylum system. *British Red Cross*.

United Nations (1976). Article 11.1 of the international covenant on economic, social and cultural rights. https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-economic-social-and-cultural-rights. Accessed on 28 November 2022.

van Eggermont Arwidson, C., Holmgren, J., Gottberg, K., Tinghög, P., & Eriksson, H. (2022). Living a frozen life: A qualitative study on asylum seekers' experiences and care practices at accommodation centers in Sweden. *Conflict*

and Health, *16*(1). https://doi.org/10.1186/s13031-022-00480-y

Vasileiou, K., Barnett, J., Thorpe, S., & Young, T. (2018). Characterising and justifying sample size sufficiency in interview-based studies: systematic analysis of qualitative health research over a 15-year period. *BMC medical research methodology*, *18*(1), 1-18.

Waterman, L. Z., Katona, C., & Katona, C. (2020). Assessing asylum seekers, refugees and undocumented migrants. *BJPsych Bulletin*, *44*(2), 75–80. https://doi.org/10.1192/bjb.2019.67

Whitehouse, K., Lambe, E., Rodriguez, S., Pellecchia, U., Ponthieu, A., Van den Bergh, R., & Besselink, D. (2021). A qualitative exploration of post-migration stressors and psychosocial well-being in two asylum reception centres in Belgium. *International Journal of Migration, Health and Social Care*, *17*(3), 241–258. https://doi.org/10.1108/IJMHSC-08-2020-0082

Whitsett, D., & Sherman, M. F. (2017). Do resettlement variables predict psychiatric treatment outcomes in a sample of asylum-seeking survivors of torture? *International Journal of Social Psychiatry, 63(8),* 674-685.

Wicki, B., Spiller, T. R., Schick, M., Schnyder, U., Bryant, R. A., Nickerson, A., & Morina, N. (2021). A network analysis of postmigration living difficulties in refugees and asylum seekers. *European Journal of Psychotraumatology*, *12*(1).

Wikgren, M. (2004). Critical realism as a philosophy and social theory in information science. *Journal of Documentation, 61*(3), 11-22.

Willig, C. (2001). *Introducing Qualitative Research in Psychology: Adventures in Theory and Method*. Buckingham: Open University Press.

Wright, H., Wellsted, D., Gratton, J., Besser, S. J., Midgley, N. (2019). Use of the

strengths and difficulties questionnaire to identify treatment needs in looked after children referred to CAMHS. *Developmental Child Welfare*.

Ziersch, A., & Due, C. (2018). A mixed methods systematic review of studies examining the relationship between housing and health for people from refugee and asylum seeking backgrounds. *Social Science and Medicine, 213*, 199–219. https://doi.org/10.1016/j.socscimed.2018.07.045

Ziersch, A., Walsh, M., Due, C., & Duivesteyn, E. (2017). Exploring the relationship between housing and health for refugees and asylum seekers in south Australia: A qualitative study. *International Journal of Environmental Research and Public Health*, *14*(9). https://doi.org/10.3390/ijerph14091036

Appendices

Appendix A

Reflective Research Journal Extracts

Extract from Journal Following Initial Research Planning

2.3.23

I have been reflecting on why I chose this topic. My family history makes the topic personal; in discussing this with a friend, he encouraged me to consider how hearing the stories of others could trigger intergenerational trauma for me. Although there is certainly a risk of that, I still want to do this research because I think it is worthwhile and has the potential to create change. I am aware that I am going to be constantly navigating my insider-outsider positionality as I do this research. There are advantages and disadvantages to both positions, so I hope to be able to harness the good and minimize the bad.

Extracts from Journal Following Interviews

21.7.23

After my second interview, I am reflecting on how the research is being shaped. I noticed a difference between my first and second participant regarding how emotionally challenging they found the interview, and I want to keep this in mind for future interviews. The first person used to live a hotel, but is now living in alternative accommodation. In contrast, the second person is still living in a hotel. I believe this may be why the second person responded more emotionally to the questions, as the questions relate to issues that are very much a part of her daily life. For the first person, the questions related to memories, and he is literally in a better place now. Physical space affects mental state. I am keeping this in mind for interviews with other participants who may or may not still be living in hotels.

11.8.23

The UK has now started using barges to house asylum seekers, and this has been in the news this week. I worry about my participants being suddenly uprooted and sent to a barge. Today one interview participant was distressed because he received an eviction letter. I hope he will not be forced to live on a barge. This makes me reflect on the timing and meaning of the research I am doing.

10.10.23

I am thinking about the diversity of my sample. Most of my participants are male and most came to the UK on their own rather than as a family. Thus, I was especially curious to interview two female participants with children today and a man who came to the UK with his family, including his wife and children. I wondered how their experiences would compare to the experiences of the single male participants. In my interviews with parents, I noticed feelings of guilt among parents about the living conditions their children face. I also noticed stories about parents trying to hide their distress from their children, but their children noticing and trying to provide their parents with comfort and reassurance. This was heart-breaking, but also speaks to the family's strengths in caring for one another.

Extracts from Journal During Transcribing and Coding

8.1.24

As I work on transcribing interviews, I am conscious of ongoing stories in the media about asylum seekers' experiences. I read a story this week that focused on an asylum seeker who had been 'stuck' in a hotel for years and felt that his mental health was severely declining. This story aligned with the experiences participants in my study described. It was interesting to reflect on this more sympathetic depiction of an asylum seeker in the news because other news headlines present very negative stories about asylum seekers.

4.2.23

I started the long and tedious process of coding and awoke today to find more stories in the news about asylum seekers. This week's headlines focus on stopping small boats coming to the UK. It seems that hostility towards asylum seekers is increasingly, particularly in the context of the government's efforts to send asylum seekers to Rwanda. This makes me think about asylum seekers in my study who referenced their fears about this.

Appendix B

Mixed Methods Appraisal Tool Study Evaluations

Authors	All: Are there clear research questions?	All: Do the collected data allow to address the research questions?	1.1 Quantitative descriptive: is the sampling strategy relevant to address the research question?	1.2 Quantitative descriptive: is the sample representative of the target population?	1.3 Quantitative descriptive: are the measurements appropriate?	1.4 Quantitative descriptive: is the risk of nonresponse bias low?	1.5 Quantitative descriptive: is the statistical analysis appropriate to answer the research question?
Whitsett & Sherman, 2017	Yes	Yes	Yes	Yes	Yes	No	Yes
Kashyapa et al., 2019	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Hedrick et al., 2019	Yes	Yes	Yes	Yes	Yes	No	Yes
De Montgomery et al., 2019	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Hedrick et al., 2020	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Eisen et al., 2021	Yes	Yes	Yes	No	No	Yes	Yes
Dudek et al., 2022	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Martino et al., 2022	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Amarasena et al., 2023	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Authors	All: Are there clear research questions?	All: Do the collected data allow to address the research questions?	2.1 Qualitative: is the qualitative approach appropriate to answer the research	2.2 Qualitative: are the qualitative data collection methods adequate to address the	2.3 Qualitative: are the findings adequately derived from the data?	2.4 Qualitative: is the interpretation of results sufficiently substantiated by data?	2.5 Qualitative: is there coherence between qualitative data sources, collection, analysis and interpretation?

			questions ?	**research question?**			
Ziersch et al., 2017	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Gewalt et al., 2018	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Gewalt et al., 2019	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Murphy et al., 2018	Can't tell	Can't tell	Can't tell	Yes	Yes	Yes	Yes
Moreira et al., 2020	Yes	Yes	Yes	Yes	Yes	Can't tell	Can't tell
Lietaert et al., 2020	Yes	Yes	Yes	Yes	Yes	Yes	Can't tell
Whitehouse et al., 2021	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes
Hedstrom et al., 2021	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Grønseth & Thorshaug, 2022	No	No	Yes	No	Yes	Yes	Yes
Domínguez et al., 2022	Yes	Yes	Yes	No	Yes	Yes	Yes
van Eggermont Arwidson et al., 2022	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Laughon et al., 2022	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Appendix C

Ethical Approval for Study

University of Hertfordshire UH

HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA

ETHICS APPROVAL NOTIFICATION

TO	Janelle Spira
CC	Hannah Wright
FROM	Dr Simon Trainis, Health, Science, Engineering & Technology ECDA Chair
DATE	11/04/2023

Protocol number:	**LMS/PGR/UH/05301**
Title of study:	The Impact of Hotel Accommodation on the Mental Health of Asylum Seekers in the UK

Your application for ethics approval has been accepted and approved with the following conditions by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

Kemi Komolafe (external supervisor at the Helen Bamber Foundation)

General conditions of approval:

Ethics approval has been granted subject to the standard conditions below:

Permissions: Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

External communications: Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Invasive procedures: If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and copies of your completed consent paperwork to this ECDA once your study is complete.

Submission: Students must include this Approval Notification with their submission.

Validity:

This approval is valid:

From: 11/04/2023

To: 30/06/2024

Please note:

Failure to comply with the conditions of approval will be considered a breach of protocol and may result in disciplinary action which could include academic penalties.
Additional documentation requested as a condition of this approval protocol may be submitted via your supervisor to the Ethics Clerks as it becomes available. All documentation relating to this study, including the information/documents noted in the conditions above, must be available for your supervisor at the time of submitting your work so that they are able to confirm that you have complied with this protocol.

Should you amend any aspect of your research or wish to apply for an extension to your study you will need your supervisor's approval (if you are a student) and must complete and submit form EC2.
Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1A. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1A may need to be completed prior to the study being undertaken.

Failure to report adverse circumstance/s may be considered misconduct.
Should adverse circumstances arise during this study such as physical reaction/harm, mental/emotional harm, intrusion of privacy or breach of confidentiality this must be reported to the approving Committee immediately.

Appendix D

Consent Form for Quantitative Data

Bruges Place, 15-20 Baynes Street, London, NW1 0TF (Entrance via Randolph St)
T: 020 3058 2020 | E: reception@helenbamber.org | helenbamber.org | @HelenBamber

HELEN BAMBER FOUNDATION
strength to fly

CLIENT CONSENT FORM (MoIC)

Name .....

HBF Ref .....

As set out in our client privacy notice (which is provided to you along with this consent form, and which you should read very carefully) the Helen Bamber Foundation needs to process, store, use and share your personal information in a number of ways to enable us to support you within our Model of Integrated Care. We request your consent to allow us to do this.

Please read the following and let us know that you understand and agree to the processing described by ticking the box in each section and signing your name and date at the end of this form. Please be aware that if you do not provide your consent in relation to sections 1, 2 and 3, we will unfortunately not be able to provide you with any support or assistance.

1. Sharing necessary information about me, including (a) information about my physical and mental health, and (b) my legal and immigration status, with my legal representative and other specified third parties,

I agree to the Helen Bamber Foundation speaking to and sharing information about me, including information about my physical and mental health, and my legal and immigration status, with:

a) my legal representatives to help progress my immigration application, including preparing reports about me when requested to do so by a solicitor. I am aware that these reports may be given to a decision maker such as the Home Office or a Judge by my legal representative;

b) my doctor and other health care professionals within the NHS, within my school or college and with local authority officers as necessary (for example, lawyers, social workers, and benefits team officers) in the offices of the local authority where I live; and

c) my school or college.

d) the Home Office and its sub-contractors

Yes ☐ No ☐

2. Sharing information about me, where necessary, with organisations who may be able to assist me with accommodation

I agree to the Helen Bamber Foundation telling the Home Office, the Salvation Army (and its contractors), Migrant Help and/or other people and organisations who may be able to help with my accommodation, that the Helen Bamber Foundation is helping me. This may mean, for example, that I can receive assistance to stay in London and attend the Helen Bamber Foundation. I am aware that if I do not consent to this, the Helen Bamber Foundation may not be able to help me to find accommodation.

Yes ☐ No ☐

3. Obtaining further information about me from my legal representative and/or other organisations

I agree to the Helen Bamber Foundation speaking to and sharing information about me, including my mental and physical health, and my legal and immigration status, so that they can:

a) request and obtain information about my legal case from my solicitor to understand my legal protection needs and help progress my case;

b) request and obtain information about my therapy, medical, housing and welfare needs from my solicitor, GP/health professional or other third parties so they can understand my needs and provide the necessary support; and

c) be given full access to any information held about me by the Home Office, NHS, including medical notes (and those held by immigration removal centres), all Social Services departments, HMRC, Her Majesty's Prison Service and/or any other relevant Police Authority, Foreign and Commonwealth Office, upon request pursuant to the Data Protection Act 2018 and the Freedom of Information Act 2000 or other relevant data protection legislation.

Yes ☐ No ☐

4. Using my information to help the Helen Bamber Foundation continue and improve its services

I agree to the Helen Bamber Foundation using my personal data to help the Foundation to improve its service by telling people and organisations about the work that it does so that they will support their work. For example, information about your experiences may be used as case studies for policy and research work and fundraising applications.

Yes ☐ No ☐

5. Storing my information

I agree to the Helen Bamber Foundation recording and storing my personal information securely in paper and/or electronic files as necessary. I understand that my file will be electronically archived and eventually securely destroyed in accordance with the UK's data protection legislation and the Foundation's retention policy.

Yes ☐ No ☐

Important:
You are under no obligation to sign this consent form and have the right to withdraw your consent at any time. However, without your consent, this may prevent us from continuing to support you. We will not routinely provide any information to a third party unless your vital interest requires it (for example if there is a safeguarding need).

If you would like to withdraw your consent, you should discuss this with your key contact at the Helen Bamber Foundation either by phone 020 3058 2020 or directly by email.

When you confirm that you wish to withdraw your consent, we will ask you to sign a consent withdrawal form. We may ask if you would like to share your reasons for withdrawing consent from the Helen Bamber Foundation.

There are some legal exceptions to client confidentiality where data can or must be processed and/or shared without your consent. This is usually in order to protect someone from harm or in situations where a person is so unwell that they cannot give consent. Please see section 5 of our Client Privacy Policy for further examples of when this may be the case.

Version: February 2022

Signed .....

Dated .....

Translated by .....

HBF staff member .....

Signed .....

Appendix E

Research Poster

Appendix F

Participant Information Sheet

University of Hertfordshire UH Ethics Committee

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PARTICIPANT INFORMATION SHEET

Title of Study: The Impact of Hotel Accomodation on the Mental Health of Asylum Seekers

Introduction and purpose of the research

You are invited to participate in research. We want to understand how living in hotels impacts asylum seekers' health and wellbeing, so we are doing interviews with people about their experiences. You can participate if you are an adult (18+ years old) asylum seeker who has experienced living in a hotel for at least 6 weeks in the UK.

Do I have to participate?

No, you do not have to participate. Participating will not impact your asylum application or your Helen Bamber Foundation service.

What will happen if I participate?

You will be invited to attend an interview at the Helen Bamber Foundation. The researcher will have a conversation with you and ask you questions. You will be provided with an interpreter if you need one, and the interview will last approximately 1-1.5 hours and will be audio recorded.

What are the disadvantages and advantages of participating?

Talking about housing and health might bring up difficult emotions. If this happens, you can ask to pause or end the interview at any time. Participating in the research may help you understand your experiences and the results of the research may help change policies for housing asylum seekers.

Confidentiality

All data including your details and interview recording will be anonymised to protect your confidentiality. Your data and consent form will be stored on a secure University of Hertfordshire OneDrive (digital storage) until 2025, then it will be securely deleted. The data will not be used in any other studies.

University of Hertfordshire UH Ethics Committee

HELEN BAMBER FOUNDATION strength to fly

PARTICIPANT INFORMATION SHEET

What will happen to the results?

We will produce a report with the results of the research. This will be submitted to the University of Hertfordshire as part of Janelle Spira's Doctorate in Clinical Psychology. The results may also be published in an academic journal or media outlet. Your confidentiality will be protected so that you will not be identifiable in any report or publication.

Ethical approval

The study has been approved by the University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority. The UH protocol number is LMS/PGR/UH/05301.

Who can I contact?

If you have any questions or concerns about the research, please ask me in person or email me at j.spira@herts.ac.uk.

If you have any complaints or concerns about how you have been treated during the study, you can write to the below address:

Secretary and Registrar
University of Hertfordshire, College Lane
Hatfield Herts AL10 9AB

Thank you!

Janelle Spira, Trainee Clinical Psychologist, University of Hertfordshire
Supervised by Dr Kemi Komolafe and Dr Hannah Wright

Appendix G

Consent Form for Interview

University of Hertfordshire UH Ethics Committee

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CONSENT FORM

Please read the below information and sign the paper to indicate that you understand and consent to participate in the interview.

- I confirm that I have been given a Participant Information Sheet that contains the purpose of the study, how I can participate, advantages and disadvantages of participating, information about confidentiality and data storage, and what will happen to the results of the study.
- I understand that I do not have to participate and can withdraw before or during the interview. My participation will not impact my asylum application or my Helen Bamber Foundation service.
- I understand that the interview will be audio recorded.
- I have been told how information relating to me and the audio recording will be used and that it will be kept secure.
- I understand that the researcher has a duty of care and will provide a debrief and signposting to sources of support at the end of the interview.
- I have been provided with the contact details of the person conducting the interview (Janelle Spira) and received answers to any questions I had.

University of Hertfordshire UH Ethics Committee

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CONSENT FORM

Name:

Contact Details (address or email):

Signature:

Date:

Researcher's Name:

Researcher's Signature:

Date:

Approved by the University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority. Protocol number: LMS/PGR/UH/05301.

Appendix H

Participant Debrief Sheet

University of Hertfordshire UH

HELEN BAMBER FOUNDATION
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DEBRIEF SHEET

Thank you for participating in the study! Through this research we hope to understand the impact of living in hotels on asylum seekers' health and wellbeing.

If participating in the study brought up any difficult feelings for you, here are some resources that you can access for support.

For practical support

- If you have practical concerns about your housing, you can speak to the Housing Team at the Helen Bamber Foundation by asking for Zoe Dexter or Ellie Winn.

For emotional support

- If you are being seen by a therapist/counsellor at the Helen Bamber Foundation, you can speak to your assigned therapist/counsellor.
- You can speak to the on-call Helen Bamber Foundation clinician by calling 020 3058 2020.
- If you would like to be referred to a mental health service in your community, you can ask your GP for a referral.
- If you would like immediate support, you can call Samaritans to speak to a trained volunteer for free by calling 116 123.

If you have any questions or concerns about the research, please contact me at j.spira@herts.ac.uk. Thank you!

Janelle Spira, Trainee Clinical Psychologist, University of Hertfordshire
Supervised by Dr Kemi Komolafe and Dr Hannah Wright

Approved by the University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority. Protocol number: LMS/PGR/UH/05301.

Appendix I

Interpreter Confidentiality Agreement

Bruges Place, 15-20 Baynes Street, London, NW1 0TF (Entrance via Randolph St)

T: 020 3058 2020 | E: reception@helenbamber.org | helenbamber.org | @HelenBamber

HELEN BAMBER FOUNDATION
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Confidentiality Agreement

Introduction

The nature of the work of the Helen Bamber Foundation means that information relating to our work must be kept highly confidential. This is true of clients' personal information, but also of the operations of the organization, and data relating to employees and other parties associated with the Helen Bamber Foundation. Breaches of this agreement could have very serious implications for the affected individuals or organizations.

Definitions

1. "Confidential Information" in terms of this agreement shall include but not be limited to data (howsoever stored) relating to Clients of the Helen Bamber Foundation (including date of birth, country of origin, first name, surname, specific details of the human rights violations, clinical histories), employees of the Helen Bamber Foundation, other parties associated with the Helen Bamber Foundation and the operations of the Helen Bamber Foundation itself.

Terms of the Agreement

2. The Helen Bamber Foundation requires that each volunteer and staff member reads and understands the Foundation's internal data protection policies.

The signatory agrees that information obtained in performing his or her obligations under the agreed upon responsibilities will be treated as Confidential and further will:

i. keep the Confidential Information safe and confidential;

ii. not disclose the Confidential Information to any third party without prior written consent;

iii. not make any physical or digital copies of any Confidential Information without express permission from the Helen Bamber Foundation;

iv. only use or make copies, whether physical or digital, of the Confidential Information for the purpose of fulfilling his or her obligations in the agreed upon work;

v. inform the Data Protection Representative and Operations Coordinator about all confidential data stored on personal devices for the purpose of work for the Foundation;

3. Employees of the Helen Bamber Foundation are given access to the Confidential Information on a "need to know basis" and that such employees are informed of the confidential nature of the Confidential Information

Bruges Place, 15-20 Baynes Street, London, NW1 0TF (Entrance via Randolph St)

T: 020 3058 2020 | E: reception@helenbamber.org | helenbamber.org | @HelenBamber

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and, if applicable to the signatory's role, shall ensure that such employees enter confidentiality agreements similar to this agreement.

4. Disclosure to the employee of any information deemed Confidential would not vest or confer any intellectual property rights or copyright to the employee. Nor will disclosure be construed expressly or by implication as granting or conferring any rights by licence on any such information.

5. This agreement is and will be in addition to and not instead of any other written agreements between the employee and our organisation and is not limited by time. The signatory agrees to return all media and copies thereof containing any Confidential Information to the Helen Bamber Foundation and to remove all Confidential Information from any personal devices to the signatory upon completion of the work.

6. The signatory agrees to record and report promptly of any circumstances of which it becomes aware surrounding any potential confidentiality breach or unauthorised possession or use of the supplied information.

Signed on behalf of the employee / volunteer

Signature

_____

Printed Name:

_____

Signed on behalf of the Helen Bamber Foundation

_____
Line Manager or Volunteer Coordinator

_____
Date

Appendix J

Interpreter Debrief Sheet

University of Hertfordshire UH

HELEN BAMBER FOUNDATION
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DEBRIEF SHEET

Thank you for helping us! Through this research we hope to understand the impact of living in hotels on asylum seekers' health and wellbeing.

If interpreting for this study brought up any difficult feelings for you, here are some resources that you can access for support.

For emotional support

- If you would like to be referred to a mental health service in your community, you can ask your GP for a referral.
- If you would like immediate crisis support, you can call Samaritans to speak to a trained volunteer for free by calling 116 123.
- If you would like free, confidential support via text you can access Shout by texting 'Shout' to 85258. You can also view information on Shout's website about tips for coping with stress and anxiety (https://giveusashout.org/get-help/resources/stress-and-anxiety-support/).

For self-help

- If you would like self-help guides on common difficulties, such as anxiety, grief, depression, and work issues, you can view CALM's guides (https://www.thecalmzone.net/guide-list).

If you have any questions or concerns about the research, please contact me at j.spira@herts.ac.uk. Thank you!

Janelle Spira, Trainee Clinical Psychologist, University of Hertfordshire
Supervised by Dr Kemi Komolafe and Dr Hannah Wright

Approved by the University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority. Protocol number: LMS/PGR/UH/05301.

Appendix K

Interview Schedule

Interview Questions

1. How long have you been living in a hotel(s)? (Multiple hotels? Other types of accommodation?)
2. Can you describe your experince living in a hotel(s)? (good things, bad things)
3. Does living in a hotel(s) impact your health in any way? (physical health, mental health, sleep, taking disability, medical needs, history, and vulnerability into account, sharing space with others)
4. How easy is it for you to access services for your physical health or mental health? (Does living in a hotel(s) impact this?) (privacy, money for travel to appointments)
5. How does living in a hotel(s) make you feel? (feeling secure/insecure, safe/unsafe, in control/lack of control) (ability to raise complaints / be heard by staff?)
6. Since living in a hotel(s), have you felt anxious, sad, or depressed? Does this relate to where you are living?
7. Since living in a hotel(s), have you or anyone you know felt suicidal or wanted to hurt themselves? Does this relate to living in a hotel(s)?
8. Do you feel a sense of belonging in your local community in the UK? (Lack of support? Social isolation? Are there barriers to accessing support because of where you are living? What kind of housing would be a better alternative?)
9. Does living in a hotel(s) affect your ability to progress with the asylum-seeking process? (easier/harder to report, access to services, better Wi-Fi/no Wi-Fi, good phone connection/poor phone connection, access to interpreters, access to legal aid)
10. What do you think would improve housing for asylum seekers? What recommendations would you have?

Appendix L

Extracts from Coding and Theme Development

Transcript Extract with Coding in NVivo

Researcher 02:44
Did you have to share your room in the hotel with eight people?

John 02:48
Yeah, it was a nightmare. Because on the second day, I got some of my stuff stolen. Because I've got my suitcase, two suitcase. I went out and when I come back, it was open. And then no one come to me, I be very upset.

Researcher 03:13
How did it make you feel, your stuff

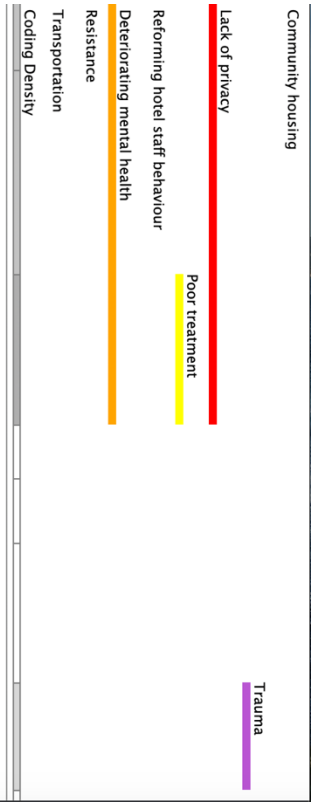
John 03:16
Unsafe. Unsafe. I feel very unsafe. Because of some of them... I feel very nervous. So like, I appease them for no reason. But it was obvious. So one of them they took my stuff. So I went down to the… to the reception to complain about it and then the reception that day said go to the security, come back to me. And by the end of the day, I went back to ask him he says to keep you investigate he asked me what I lost? I said two t-shirt and one or one pair of trainers. And they said we'll give you a time because you found out and then the next day nothing so I didn't waste my time. But as I said two of them but I don't have any proof. So my stuff is gone.

Researcher 04:27
I know you were saying that it made you feel unsafe.

John 04:30
Yeah, sure.

Researcher 04:31
You talked about the impact on your mental health and your past experiences. Did having this negative experience in the hotel bring back memories from the past?

John 04:43
Sure, sure. Yeah, sure it bring back my memory of prison. We share the same cell with people who some are very violent, some are very aggressive. So you have to deal with that kind of situation in prison. And then you come some another space. I mean, another country, safe country, democratic country, you feel yourself drop to have the same system. You said whoever in so I feel a bit dry and the same time have some hope for flashback hopeful memory trigger all this experience. Yeah.



Researcher 05:30
So you expect it to be safe here.

John 05:33
Exactly.

Researcher 05:34
You find that it's not safe,

John 05:35
Because it's not.

Researcher 05:37
And I imagine because you mentioned it reminded you of being back in prison with all of the tension in the prison. Did you feel anxious? Did it bring back some feelings of anxiety like not knowing what's going to happen?

John 05:50
More than anxious. Let's touch on depression. Depression. I lost my sleep. Because at the same time I come out of my sleep because I using anti-depression tablet. So I need a quiet space to sleep. At that time we got a TV in the room. In the morning, time to broke down the song, they refuse. So we watch the TV, TV on all morning, I mean 2 o'clock in the morning, can't sleep. So all the talking in the room so I start feeling my brain mess up and it start impacting my mental health.

Researcher 06:32
Yeah. And did it impact your physical health too?

John 06:36
Exactly. So as if you nervous, I lost my temper. I started lost my temper. And I feel very stuck, very weak, unable to do basic, daily things. So accept the fact that I according to my complaint, they send you right to the office. So we got to move me elsewhere. So we take some time so I had to be patient. So what I've done now I tried to do myself to say okay, on the morning when everyone go out so the room is quiet so I can have my sleep. Okay, so start then. So it's very sad because you plan something that is against your will. Accept the fact that nights, your nighttime, is a nightmare. So try your best to deal with that. You're good to read in the morning. You get back your sleep. So my time to sleep all day. It come to nighttime, I'm like a zombie sitting on the bed. Try to sleep

Researcher 08:10
In the midst of that.

John 08:11
Yeah, I've got this thing for survival because I used to have that in prison. In seven days you bring that memory is about prison, because I've been in detention as well. Have you detox from a system of... so come back on again to this same situation.

Researcher 08:34
What impact did that have on your mental health reminding you of detention?

John 08:40
Was I was suddenly afraid I don't want to do anything. All the time I'm being hot a lot. It was very toxic atmosphere. They're very toxic because I don't talk to them. Because I hate them.

Researcher 09:04
The people you were sharing with?

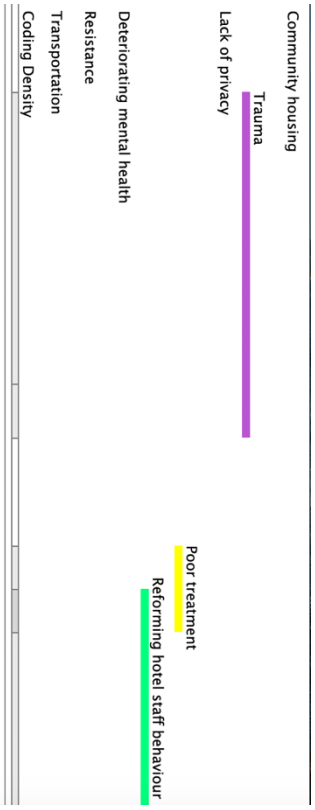
John 09:05
Yeah, hate them because all my complaints. They don't care about that.

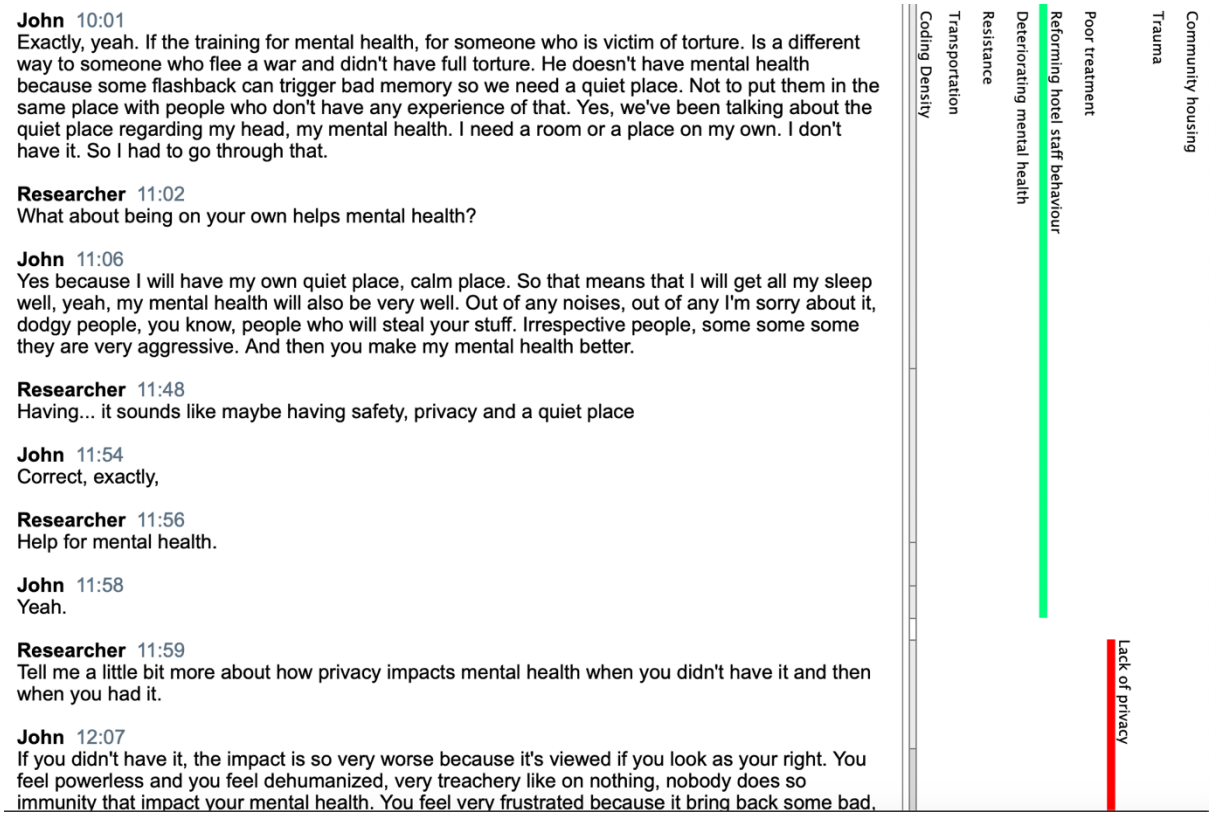
Researcher 09:10
And how about the staff, were they toxic too?

John 09:14
The staff they they are things offend them. They interference. They don't care. Yeah. So if suddenly upon my complaint I've found myself to be forced to express them my situation. But they don't know. They don't know. They don't know the basic need regarding my health. They don't get it. So I wanted to point that it's not their fault because they don't have any training about mental heath.

Researcher 09:58
So is that something you think would help if staff had training? You mentioned a quiet place would help as well. In any of the other accommodations that you've experienced, have things been better? Has there been quieter spaces?

John 10:01
Exactly, yeah. If the training for mental health, for someone who is victim of torture. Is a different





John 10:01
Exactly, yeah. If the training for mental health, for someone who is victim of torture. Is a different way to someone who flee a war and didn't have full torture. He doesn't have mental health because some flashback can trigger bad memory so we need a quiet place. Not to put them in the same place with people who don't have any experience of that. Yes, we've been talking about the quiet place regarding my head, my mental health. I need a room or a place on my own. I don't have it. So I had to go through that.

Researcher 11:02
What about being on your own helps mental health?

John 11:06
Yes because I will have my own quiet place, calm place. So that means that I will get all my sleep well, yeah, my mental health will also be very well. Out of any noises, out of any I'm sorry about it, dodgy people, you know, people who will steal your stuff. Irrespective people, some some some they are very aggressive. And then you make my mental health better.

Researcher 11:48
Having... it sounds like maybe having safety, privacy and a quiet place

John 11:54
Correct, exactly,

Researcher 11:56
Help for mental health.

John 11:58
Yeah.

Researcher 11:59
Tell me a little bit more about how privacy impacts mental health when you didn't have it and then when you had it.

John 12:07
If you didn't have it, the impact is so very worse because it's viewed if you look as your right. You feel powerless and you feel dehumanized, very treachery like on nothing, nobody does so immunity that impact your mental health. You feel very frustrated because it bring back some bad,

Example of Codes and Developing Themes

Name	Files	References
Changing the housing system	0	0
Community housing	13	18
Enabling access to services	4	5
Medical services	5	6
Transportation	5	9
Meeting basic needs	5	8
Reforming hotel staff behaviour	6	18
Lack of autonomy	0	0
Harming children and families	4	13
Like being in prison (restrictions)	9	21
No control	7	12
Unmet basic needs	0	0
Finances	5	6
Food	8	15
Poor living conditions	5	11
Lack of safety	0	0
Deteriorating mental health	10	20
Lack of privacy	9	13
Retraumatisation	5	7
Mental health	0	0
Anxiety	8	12
Depression	12	21
Sleep difficulties	4	5
Suicidal ideation	11	14
Trauma	5	8

Social isolation	0	0
Disconnected from community	9	11
Disconnected from peers	0	0
Disconnection	3	3
Theft	2	2
Violence and aggression	3	6
Problems with hotel staff	0	0
Communication difficulties	9	10
Discrimination	1	4
Poor treatment	10	16
Uncaring	6	9
Survival strategies	0	0
Faith	6	10
Family	6	9
Resistance	3	5
Seeking support	0	0
Community support	7	8
Peer support	2	3
Support from services	3	4

Example of Developing Themes

Theme 4: Changing the housing system

Subthemes: improve food, improve access to services, hotel staff behaviour, alternative housing.

Key quotes:

‘I don't know really how to have peace in my mind, especially with regard to diet, food, regarding my condition, suffering from this condition. I don't consider this diet is right for me, as a citizen, as a person, human. I really need help to be transferred from this place, you know, to a safer place.’ -Jeremiah

‘As long as I can cook food, you can have your own life there.’ -Leah

‘If they just change the meal or they improve the meal that they're giving, then the quality it will change a lot their lifestyle and their life. It could affect their health and their life.’ -Benjamin

‘Something that is very, very important in hotels is to have activities. So that asylum seekers, they can do some activities to distract themselves so they don't feel, you know, so they can stay active.’ -Aaron

‘It wasn't easy to access the services at all. I didn't know even how to access the services.’ -Elijah

‘Follow the wellbeing of asylum seeker in the hotel. Look what they eat. If you don't eat, try to find out why we didn't eat it and listen to the complaint, improve. That's the best way to treat people fairly and make them safe.’ -John

‘Train the hotel staff about asylum seekers’ right. That's it, first thing to respect them as human beings. Several things to train them about mental health or some of them we are victims of torture or human trafficking. It's… there be the place where they killed relative or in war zone, people in depression – that's the mental health – tell them about how to treat people that have this situation.’ -John

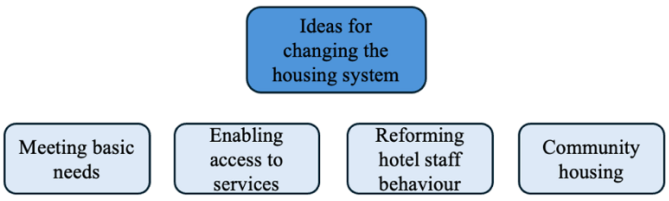
‘Let this Home Office people come to this hotel to talk to people like me […] The managers they just sit there in the morning […] they don't care for us. But the money you give, when I talk government you need to follow up this money. […] Go inside to see this hotel is good condition for the people to be in that hotel.’ -Maria

‘I mean this service has to be monitored. I mean above this manager, the hotel manager, has to be another manager controlling this guy and look after him, I mean, see what he's done. Did he provide everything? Anybody has made a complaint against him? And also this inspector has to talk to the asylum seeker, I mean he has to tell us our opinion but he didn't say anything at all because what happens sometimes when the inspector comes […] from the Home Office to the hotel and not see anybody. They order the asylum seekers not to talk to him about their problem.’ -Joseph

‘I will change the manager. For example, if I am a manager for this hotel my duty is to let all the asylum seekers feel safe in the hotel. My duty to make them eat a suitable food, delicious food every day because I have all the equipment I mean, I have a chef, I have a kitchen, I have you budget to buy grocery, I mean, why I don't cook very nice food, why not? It's all about management, about the person who has to deal with it. If someone has an issue or has a complaint against someone, I have to take it seriously. This is what I would do.’ -Joseph

‘Hotel don't give that because you have no communication or social life. Show you that. You got right, you are human being […] but out in the community it impact your confidence, impact your wellbeing, and you feel more enthusiastic that you are part of society, society. So it's more positive to live in communities than living in a hotel.’ -John

Theme 5: Ideas for changing the housing system



Appendix M

Tool for Evaluating Thematic Analysis Manuscripts for Publication

Table 1. A tool for evaluating thematic analysis (TA) manuscripts for publication: Twenty questions to guide assessment of TA research quality.

These questions are designed to be used either independently, or alongside our methodological writing on TA, and especially the current paper, if further clarification is needed.

Adequate choice and explanation of methods and methodology

1. Do the authors explain why they are using TA, even if only briefly?
2. Do the authors clearly specify and justify which *type* of TA they are using?
3. Is the use and justification of the specific type of TA consistent with the research questions or aims?
4. Is there a good 'fit' between the theoretical and conceptual underpinnings of the research and the specific type of TA (i.e. is there conceptual coherence)?
5. Is there a good 'fit' between the methods of data collection and the specific type of TA?
6. Is the specified type of TA consistently enacted throughout the paper?
7. Is there evidence of problematic assumptions about, and practices around, TA? These commonly include:
   - Treating TA as one, homogenous, entity, with one set of – widely agreed on – procedures.
   - Combining philosophically and procedurally incompatible approaches to TA without any acknowledgement or explanation.
   - Confusing summaries of data topics with thematic patterns of shared meaning, underpinned by a core concept.
   - Assuming grounded theory concepts and procedures (e.g. saturation, constant comparative analysis, line-by-line coding) apply to TA without any explanation or justification.
   - Assuming TA is essentialist or realist, or atheoretical.
   - Assuming TA is only a data reduction or descriptive approach and therefore must be supplemented with other methods and procedures to achieve other ends.
8. Are any supplementary procedures or methods justified, and necessary, or could the same results have been achieved simply by using TA more effectively?
9. Are the theoretical underpinnings of the use of TA clearly specified (e.g. ontological, epistemological assumptions, guiding theoretical framework(s)), even when using TA inductively (inductive TA does not equate to analysis in a theoretical vacuum)?
10. Do the researchers strive to 'own their perspectives' (even if only very briefly), their personal and social standpoint and positioning? (This is especially important when the researchers are engaged in social justice-oriented research and when representing the 'voices' of marginal and vulnerable groups, and groups to which the researcher does not belong.)
11. Are the analytic procedures used clearly outlined, and described in terms of what the authors actually did, rather than generic procedures?
12. Is there evidence of conceptual and procedural confusion? For example, reflexive TA (e.g. Braun and Clarke 2006) is the claimed approach but different procedures are outlined such as the use of a codebook or coding frame, multiple independent coders and consensus coding, inter-rater reliability measures, and/or themes are conceptualised as analytic inputs rather than outputs and therefore the analysis progresses from theme identification to coding (rather than coding to theme development).
13. Do the authors demonstrate full and coherent understanding of their claimed approach to TA?

A well-developed and justified analysis

14. Is it clear what and where the themes are in the report? Would the manuscript benefit from some kind of overview of the analysis: listing of themes, narrative overview, table of themes, thematic map?
15. Are the reported themes topic summaries, rather than 'fully realised themes' – patterns of shared meaning underpinned by a central organising concept?
    - If so, are topic summaries appropriate to the purpose of the research?
      - If the authors are using reflexive TA, is this modification in the conceptualisation of themes explained and justified?
    - Have the data collection questions been used as themes?
    - Would the manuscript benefit from further analysis being undertaken, with the reporting of fully realised themes?
    - Or, if the authors are claiming to use reflexive TA, would the manuscript benefit from claiming to use a different type of TA (e.g. coding reliability or codebook)?
16. Is non-thematic contextualising information presented as a theme? (e.g. the first 'theme' is a topic summary providing contextualising information, but the rest of the themes reported are fully realised themes). If so, would the manuscript benefit from this being presented as non-thematic contextualising information?
17. In applied research, do the reported themes have the potential to give rise to actionable outcomes?
18. Are there conceptual clashes and confusion in the paper? (e.g. claiming a social constructionist approach while also expressing concern for positivist notions of coding reliability, or claiming a constructionist approach while treating participants' language as a transparent reflection of their experiences and behaviours)
19. Is there evidence of weak or unconvincing analysis, such as:
    - Too many or two few themes?

    Too many theme levels?
    Confusion between codes and themes?
    Mismatch between data extracts and analytic claims?
    Too few or too many data extracts?
    Overlap between themes?
20. Do authors make problematic statements about the lack of generalisability of their results, and or implicitly conceptualise generalisability as statistical probabilistic generalisability (see Smith 2017)?