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Lancashire

Healing Canvas

Full Project Report

Restoring Lives Beyond Borders

Using Arts-Based Narrative Inquiry to understand
trauma experienced by asylum seekers in
Blackburn with Darwen

An Independent Report by
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FOREWARD

This project has been funded by Blackburn with Darwen Borough Council, to whom we express our appreciation for commissioning and supporting this study. It is important to highlight that the views expressed in this report are those of the authors and not necessarily the funders.

We would like first to thank everyone who contributed directly or indirectly to this research project at different stages. Your support, insights and participation were invaluable, making this work possible.

Most importantly, we would like to share our sincere thanks to all participants who are seeking asylum, and who generously shared their experiences. Without their collaboration, this research project would not have been possible.

Also, special thanks to service providers' representatives who contributed as participants to this investigation. We acknowledge that the co-design of this project was possible thanks to all research participants, as their knowledge deepened and reinforced the outcome of the research.

We also acknowledge the contribution of all agencies and community organisations who helped with the study recruitment, sincere thanks for what was an amazing collaboration.

Finally, we are most grateful to the research team, whose tireless efforts and unwavering commitment have made this project possible. From the early stages of conceptualisation through to the finalisation of this report, ensuring that this work leads to meaningful change.

The photographs and artworks in this report are from the Healing Canvas coproduced research project, used with participants' informed consent.

Special thanks to Sarah Jose (Community Research Practitioner & Art Designer), who developed the design of the Healing Canvas toolkit and infographics.



PROJECT TEAM AND INFORMATION

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Supporting Community Organisations

Community Harmony Project – [Community Harmony Project Blackburn |](#)

Darwen Asylum Refugee Enterprise (DARE) – [Darwen Asylum Refugee Enterprise \(DARE\) |](#)

Asylum and Refugee Community (ARC) Blackburn – <https://arcblackburn.org.uk/>

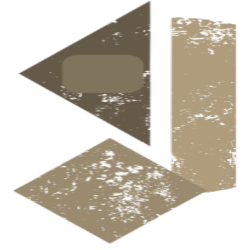


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FOREWORD



It is a privilege to introduce Healing Canvas, a project that captures the resilience, creativity, and courage of asylum seekers and the communities that stand beside them.

Blackburn with Darwen has always been a place of welcome and diversity, but recent years have tested our collective strength, assets and resilience. In the aftermath of the COVID pandemic, division and trauma, Healing Canvas has shown us how creativity can become a bridge; a way to reconnect, rebuild trust, and rediscover hope.

This work reminds us that healing is not confined to clinics or counselling rooms. It happens when people are seen, heard, and given space to express their experiences in their own voices and in their own art. The drawings, stories, and shared creations within these pages speak powerfully of both pain and possibility.

This report is both an inspiration and a call to action. It asks us to recognise that wellbeing begins in communities, that cultural expression is central to recovery, and that every person has the right to heal in ways that honour who they are.

To everyone who took part, the artists, our asylum seeker communities, the facilitators, and our community partners, I would like to say thank you. Your courage and creativity remind us what true inclusion looks like. You have shown that even in times of adversity, when facing severe challenges, healing can begin when we listen, co-create, and imagine a better brighter together.

Abdul Razaq

Director of Public Health

Blackburn with Darwen Borough Council



EXECUTIVE SUMMARY

Seeking asylum in the UK can be a long, complex and difficult process shaped by tough immigration policies (Haggar & Kienzler 2025; Mental Health Foundation, 2025). Asylum applications in the UK reached record highs, with nearly 90,000 applications (110,000 people) in the year ending September 2025 (Gov.UK, 2025). Asylum seekers and refugees are at higher risk of experiencing mental health problems, further exacerbated by repeated exposures and extreme violence related to their pre- and post-migration experiences, evidence supported by wider international research (Mental Health Foundation, 2025).



The 2025 Policy landscape: A perfect storm

The contemporary policy environment represents what can only be described as a "perfect storm" for asylum seeker mental health. *The Government's May 2025 Immigration White Paper* proposes extending the qualifying period for settlement from five to ten years, raising English language proficiency standards, and implementing stricter visa controls that will profoundly impact asylum seekers' pathways to stability and integration.

Simultaneously, the *Border Security, Asylum and Immigration Bill 2025* introduces expanded criminal offences that could easily apply to asylum seekers, while maintaining harmful provisions from the *Illegal Migration Act 2023*, including expanded detention powers and reduced protections for modern slavery survivors (UK Parliament, 2025), and all of them fundamentally reconfigure UK asylum law.

These policy shifts occur amid evidence that mental health services for asylum seekers are experiencing unprecedented strain. Current service infrastructure relies predominantly on mainstream NHS pathways. However, asylum seekers and refugees face many barriers to achieving and sustaining good mental health, facing linguistic difficulties, cultural misunderstandings about mental health, and institutional mistrust (Mental Health Foundation, 2025).

National policy context and mental health inequalities

The *Healing Canvas report* is published at a moment of acute crisis for asylum seekers in the United Kingdom, characterised by escalating hostility, sustained policy austerity, and significant gaps in trauma-informed mental health provision. Participants in this study consistently described the waiting period for support as psychologically destabilising,



triggering anxiety, hopelessness, an escalation of traumatic symptoms, and fear of emotional “crisis” before care is ever accessed. Although rates of PTSD and depression are substantially higher amongst asylum seekers and refugees than in the general population (Hameed et al., 2018), asylum seekers continue to experience profound mental health inequalities (Mental Health Foundation, 2025; 2020).

Access to mainstream mental health services remains highly limited. Participants in this study consistently described the waiting period for mental health support as psychologically destabilising, triggering anxiety, hopelessness, escalation of traumatic symptoms, and fear of emotional “crisis” before care is ever accessed.

These systemic gaps intersect with broader structural barriers, including housing instability (Refugee Action, 2023), employment restrictions (Mental Health Foundation, 2025), digital poverty (Migrant Art Archive, 2024), and language barriers. Together, these factors reduce access to timely, appropriate, and culturally competent care for those with the greatest psychological need.

National guidance, including NICE (2018), emphasises the importance of accessible, trauma-informed, and evidence-based care. However, for asylum seekers, structural barriers frequently undermine the realisation of these principles in practice.

Local dispersal context and service gaps in Blackburn with Darwen

Blackburn with Darwen (BwD) has served as a major dispersal area for asylum seekers and refugee communities for several years. The borough is an active member of the Regional Strategic Migration Partnership (RSMP), including representation on the RSMP Executive Board, as well as the Lancashire Refugee and Asylum Seeker Strategic Partnership. BwD is a diverse and multicultural borough, with over 70 languages spoken and a long history of migration spanning more than 60 years.

More recently, migrants from across Europe, the Middle East, and Africa have resettled in the area. Despite this significant role in dispersal and integration, local evidence indicates critical gaps in the provision of culturally appropriate mental health support for asylum seekers living in the borough.

In BwD, national pressures are reflected locally through stretched statutory services, limited culturally adapted interventions, and prolonged waiting times for psychological therapies. As a result, asylum seekers often rely on informal or voluntary support while experiencing high levels of distress, with limited structured early intervention pathways available. However, limited funding, workforce constraints, and the absence of specialist therapeutic capacity restrict their ability to respond effectively to complex trauma-related needs.



Summary of methodology

The Healing Canvas project used *qualitative, multi-methods design, grounded in Arts-Based Narrative Inquiry and informed by an ethos of co-production, community-based participatory research (CBPR)*. The multi-methods used involved 47 participants (n=16 professionals and n=31 asylum seekers) and helped analysed collected data to provide much needed information on the key objectives pursued in this study: (i) Raising trauma and mental health awareness amongst asylum seekers in Blackburn with Darwen; (ii) Raising awareness and strengthening Trauma-Informed Practice amongst service providers in Blackburn with Darwen; (iii) Pilot and evaluation of co-designed early intervention trauma models.

Primary research activities

- Three focus group discussions (FGDs) engaging asylum seekers, frontline practitioners, and community partners.
- Arts-based narrative research (ABNR) techniques enabling creative expression through visual arts, (i.e., self-portraits, timeline, drawings).
- Co-design workshops involving service providers and individuals with lived experience
- Professional consultations with practitioners from statutory and non-statutory organisations conducted *via an online survey*.

The research project adopted a *trauma-informed approach* throughout. *Arts-based methods* were deliberately selected due to their demonstrated capacity to facilitate the expression of experiences that may be difficult to articulate verbally, particularly amongst individuals facing language barriers or significant psychological distress. Such approaches enable participants to communicate embodied, affective, and fragmented dimensions of trauma that may not emerge through traditional interview-based methods (Huss et al., 2016). Furthermore, arts-based inquiry is recognised as a rigorous qualitative methodology that supports inclusive knowledge production, particularly with marginalised communities (Leavy, 2015).

Ethical approval for this study was gained from the University of Lancashire Ethics Review Panel (Reference No: HEALTH 01114 FR).



Key Research Findings

Objective One: Raising trauma and mental health awareness amongst *asylum seekers* in Blackburn with Darwen

Key Findings:

- ✓ Trauma awareness **cannot be assumed** and is shaped by cultural stigma, fear of disclosure, and asylum uncertainty.
- ✓ Conventional psychoeducation alone is **insufficient and potentially inadequate** for asylum seekers.
- ✓ Creative, non-verbal, and group-based approaches:
 - Enabled *safer engagement*
 - Supported recognition of *trauma as cumulative and ongoing*
 - Maintained emotional safety and agency
- ✓ Raising awareness **without accessible support pathways risks increasing distress**, especially given long waiting times for therapy.
- ✓ When asylum seekers are treated as **partners rather than passive recipients**, engagement, insight, and early stabilisation improve.
- ✓ Valuing cultural knowledge alongside professional expertise strengthens therapeutic engagement.

Implication: Trauma awareness programmes must be paired with early intervention pathways and delivered using culturally responsive, non-clinical methods.

Objective Two: Raising awareness and strengthening Trauma-Informed Practice amongst *service providers* in Blackburn with Darwen

Key Findings:

- ✓ Staff and volunteers show high commitment but **limited confidence** in responding to complex trauma.
- ✓ Training:
 - Increased understanding
 - Reduced anxiety
 - Was most effective when experiential and locally grounded
- ✓ Practical tools and supervision were critical for sustained implementation.
- ✓ High levels of:
 - Vicarious trauma
 - Moral distress linked to systemic barriers
- ✓ Without organisational support, trauma-informed practice becomes:
 - Individualised rather than shared
 - Emotionally unsustainable

Implication: Trauma-informed practice requires organisational investment in supervision, wellbeing, and practical implementation tools, not training alone.



Objective Three: Pilot and evaluation of *co-designed early intervention trauma models*.

Key Findings:

- ✓ Creative group interventions were:
 - Feasible
 - Acceptable
 - Valued as early intervention pathways
- ✓ Particularly beneficial for individuals awaiting mainstream mental health services.
- ✓ Participants valued:
 - Reliability and consistency
 - Choice and autonomy
 - Engagement without forced verbal disclosure
- ✓ Creative methods:
 - Reduced performance pressure
 - Supported grounding
 - Enabled identity beyond the “asylum seeker” label
- ✓ Gender-informed design improved engagement:
 - Women engaged through relational and ritual-based approaches
 - Men engaged through action-oriented and culturally familiar activities
- ✓ Lower male engagement in conventional therapy reflects *service-design variance*, not lack of motivation.

Implication: Gender-sensitive, creative stabilisation groups offer a cost-effective early intervention model that reduces pressure on secondary care.

Co-produced toolkit and practice-based outcomes:

The Healing Canvas Toolkit

Core Components of the toolkit:

- Trauma-informed awareness session for professionals
- C.A.R.E.R.S. Framework slide deck
- Multilingual, culturally sensitive asylum seeker guide
- Self-help and reflective tools addressing vicarious trauma and staff wellbeing

Impact:

- Resources were co-designed and culturally validated.
- The multilingual guide was actively shared within participant networks.
- Co-production enhanced cultural relevance, accessibility, and sustainability.

Implication:

Practical, adaptable tools increase the likelihood of sustained implementation across services.



The following table presents a *summary of key research findings* across the three objectives:

Objective	Core Finding	System Gap Identified	Implementation Implication
1. Trauma Awareness (Asylum Seekers)	Awareness requires creative, culturally responsive approaches	Psychoeducation alone is insufficient; lack of support pathways increases risk	Pair awareness with early intervention and stabilisation
2. Trauma-Informed Practice (Providers)	Staff committed but under-supported	Vicarious trauma and lack of supervision	Invest in supervision, wellbeing, and practical tools
3. Early Intervention Model	Creative groups feasible and acceptable	Long waiting times; poor male engagement in conventional therapy	Implement gender-informed creative stabilisation groups
Toolkit Outcome	Co-produced resources increase uptake	Training alone insufficient	Embed adaptable tools across services



Key Recommendations: for policy and practice

At a time when asylum seekers face increased policy restriction and community hostility, these recommendations are grounded in evidence demonstrating that creative expression is not supplementary to healing but can function as a central therapeutic modality. This project further demonstrates that when asylum seekers are recognised as creative agents rather than passive recipients, engagement, stabilisation, and meaning-making are strengthened.

The following recommendations resulting from the project findings invite policymakers, commissioners, and providers to move beyond conventional, verbally dominant mental health

To Government and Policy Commissioners

paradigms towards culturally responsive, evidence-based models.

1. Recognise Arts-Based Interventions as Evidence-Based Practice

The exclusion of creative mental health provision from mainstream commissioning frameworks represents a false economy. Arts-based interventions have demonstrated outcomes comparable to established trauma treatments in certain contexts, particularly for populations facing linguistic and cultural barriers, and this was demonstrated in this research.

There is a need to *establish dedicated funding streams that recognise arts-based interventions as evidence-based therapeutic practices within trauma pathways, not optional enrichment.*

2. Address structural and digital exclusion in service design

Mainstream reliance on talking therapies and digital access models risks excluding culturally and linguistically diverse populations. This project demonstrates that: (i) asylum seekers face significant barriers to digital healthcare access, including limited device ownership, language barriers, and digital literacy challenges. (ii) creative and non-verbal approaches offered viable alternatives that go beyond linguistic limitations. Consider *integrating creative, non-verbal interventions into local mental health strategies as primary access routes* for digitally excluded and linguistically marginalised populations, particularly for asylum seekers.

3. Embed Healing Canvas Model within integrated, barrier-responsive pathways

Gaps between arrival, community provision, and statutory services, alongside housing instability, poverty, and transport barriers, compounded trauma and limited the effectiveness of therapeutic support. *Commission an integrated, culturally adapted early-intervention pathway that embeds the Healing Canvas model across mental health, voluntary, housing, early help, and asylum accommodation services, while proactively addressing structural barriers to participation.*



Key Recommendations: for policy and practice

Structural determinants such as housing, poverty, and access should be treated as core mental health risk factors within pathway design.

To Mental health services and providers

1. Reconsider the hierarchy of therapeutic modalities: Use Healing Canvas Model as an early “bridge” to formal trauma services

NICE guidelines recognise trauma-focused therapies as first-line for PTSD (NICE, 2018), yet implementation must consider accessibility. This research showed that arts-based methods provided alternative trauma-processing pathways for asylum seekers, particularly where verbal disclosure was unsafe or culturally constrained. *Embed creative-integrated approaches as preliminary steps that increases readiness, confidence, and trust for populations experiencing barriers to conventional therapy, particularly for individuals seeking asylum, before referral to NHS or specialist trauma therapy.*

2. Establish a floating, culturally adapted early-intervention triage service

This project identified a critical gap between arrival in Blackburn with Darwen and access to mainstream mental health services, as participants experienced significant delays and barriers. Raising trauma awareness without accessible follow-on support risked increasing distress. *Develop a flexible, psychologically safe, floating early-intervention triage and navigation service available from point of arrival in Blackburn with Darwen.* The suggested service should:

- Provide rapid-access, community-based balanced support
- Integrate creative and culturally adapted therapeutic approaches
- Offer multilingual engagement
- Operate across community venues rather than fixed clinical sites
- Bridge individuals into appropriate statutory or voluntary services

This model would reduce escalation of distress, close pathway gaps, and strengthen early containment within the local trauma-informed system.

3. Co-produce assessment and engagement frameworks

Participatory research approach used in this project demonstrated that lived experience expertise enhances service design and improves engagement. In this study, participants used creative expression not only as intervention but also as assessment, indicating the approach helped express affective dimensions of distress that might not emerge in structured screening tools.



Key Recommendations: for policy and practice

Develop arts-based mental health assessment tools alongside conventional screening measures, co-designed with individuals with lived experience of forced displacement and recovery, in this instance people seeking asylum.

To Workforce Leads and training providers

1. Embed inclusive Trauma-Informed training with ongoing implementation support

Training delivered part of this project improved understanding and reduced anxiety amongst professionals, but sustained practice change required supervision, practical tools, and culturally grounded support. *Move beyond one-off trauma awareness sessions and establish an inclusive trauma-informed training model* that combines (i) co-produced implementation tools, (ii) ongoing supervision and reflective practice, (iii) culturally competent facilitation with safeguarding oversight, (iv) and cross-sector engagement to ensure sustained and accountable practice change.

The evidence from this project demonstrates that awareness alone is insufficient to sustain trauma-informed practice. Workforce development must combine training, containment, and implementation infrastructure to achieve meaningful system change.

2. Treat vicarious trauma as an organisational responsibility: Embed supervision into staff workload to support their wellbeing and professional boundaries.

Professional participants indicated experiences of significant vicarious trauma and moral distress, driven by both traumatic disclosures and systemic barriers.

Safeguard staff wellbeing through provision of protected clinical supervision; team reflection safe spaces, and leadership accountability.

This research demonstrates that without structural support, trauma-informed practice becomes emotionally unsustainable.

3. Embed lived experience in workforce development

Co-production with asylum seekers strengthened cultural relevance, engagement, and service design. *Involve individuals with lived experience in training design; delivery where appropriate; development of practical tools.* This study shows that lived experience should be recognised as professional knowledge, not an optional add-on.



Key Recommendations: for policy and practice

To Community organisations and local partnerships

Equip community organisations as core mental health infrastructure

Evidence in this study demonstrated that asylum seekers engaged most safely and consistently in trusted community settings. Creative groups delivered through community partners worked as effective early intervention and stabilisation pathways. *Commission and integrate community organisations as essential components of local trauma pathways, recognising their role in prevention and early intervention*, not only as charitable add-ons.

1. Sustain co-production and Peer-led knowledge sharing

The multilingual Healing Canvas asylum seeker guide was positively evaluated and actively shared within participant networks, demonstrating strong peer uptake and cultural relevance. *Maintain co-production and support peer-led dissemination by funding translation, adaptation, and structured community feedback mechanisms to sustain engagement.*

2. Develop a structured Peer Mentoring Programme

Participants highlighted the value of culturally familiar reassurance, shared language, and peer support. This study evidenced that informal peer networks strengthened engagement and reduced isolation. *Establish and commission a trained peer mentoring programme as a sustainable, community-led extension of early intervention.* As indicated by participants, the programme should equip asylum seeker volunteers to provide trauma-informed peer support and integration guidance, with appropriate supervision and safeguarding structures in place. Peer mentoring should be recognised as preventive mental health infrastructure that strengthens trust, access, and community resilience.

3. Scale the Healing Canvas Model as a preventive approach

The co-designed, gender-informed creative model was feasible, acceptable, and particularly valuable for individuals awaiting mainstream services. *Adapt and scale the Healing Canvas approach across dispersal areas as a transferable, preventive early intervention model that complements statutory provision.*

The evidence is clear: sustainable trauma-informed systems must be creative, co-produced, community-embedded, and structurally supported. Together, these perspectives provide a coherent and evidence-based framework for long-lasting, locally embedded mental health provision in Blackburn with Darwen.



National policy context

The *Healing Canvas report* is published at a moment of acute crisis for asylum seekers in the United Kingdom, characterised by escalating hostility, sustained policy austerity, and significant gaps in trauma-informed mental health provision. Participants in this study consistently described the waiting period for support as psychologically destabilising, triggering anxiety, hopelessness, an escalation of traumatic symptoms, and fear of emotional “crisis” before care is ever accessed. Although rates of PTSD and depression are substantially higher amongst asylum seekers and refugees than in the general population (Hameed et al., 2018), asylum seekers continue to experience profound mental health inequalities (Mental Health Foundation, 2025; 2020).

Mental health inequalities

Access to mainstream mental health services remains highly limited. Participants in this study consistently described the waiting period for mental health support as psychologically destabilising, triggering anxiety, hopelessness, escalation of traumatic symptoms, and fear of emotional “crisis” before care is ever accessed. These systemic gaps intersect with broader structural barriers, including housing instability (Refugee Action, 2023), employment restrictions (Mental Health Foundation, 2025), digital poverty (Migrant Art Archive, 2024), and language barriers. Together, these factors reduce access to timely, appropriate, and culturally competent care for those with the greatest psychological need.

Psychological Trauma has become a widely recognised concept with significant interests in academic and community research, clinical practice, public domain, and the media. Trauma often refers to potential events that expose individuals to death or other life-threatening danger, serious harm or related significant injuries, actual or threatened sexual violence (WHO, 2018). The complex trauma experienced by many asylum seekers further intersects with health inequalities, reducing access to and uptake of health services, as well as timely, suitable, and culturally competent care for those with the greatest psychological need.

National guidance, including NICE (2018), emphasises the importance of accessible, trauma-informed, and evidence-based care. However, for asylum seekers, structural barriers frequently undermine the realisation of these principles in practice.



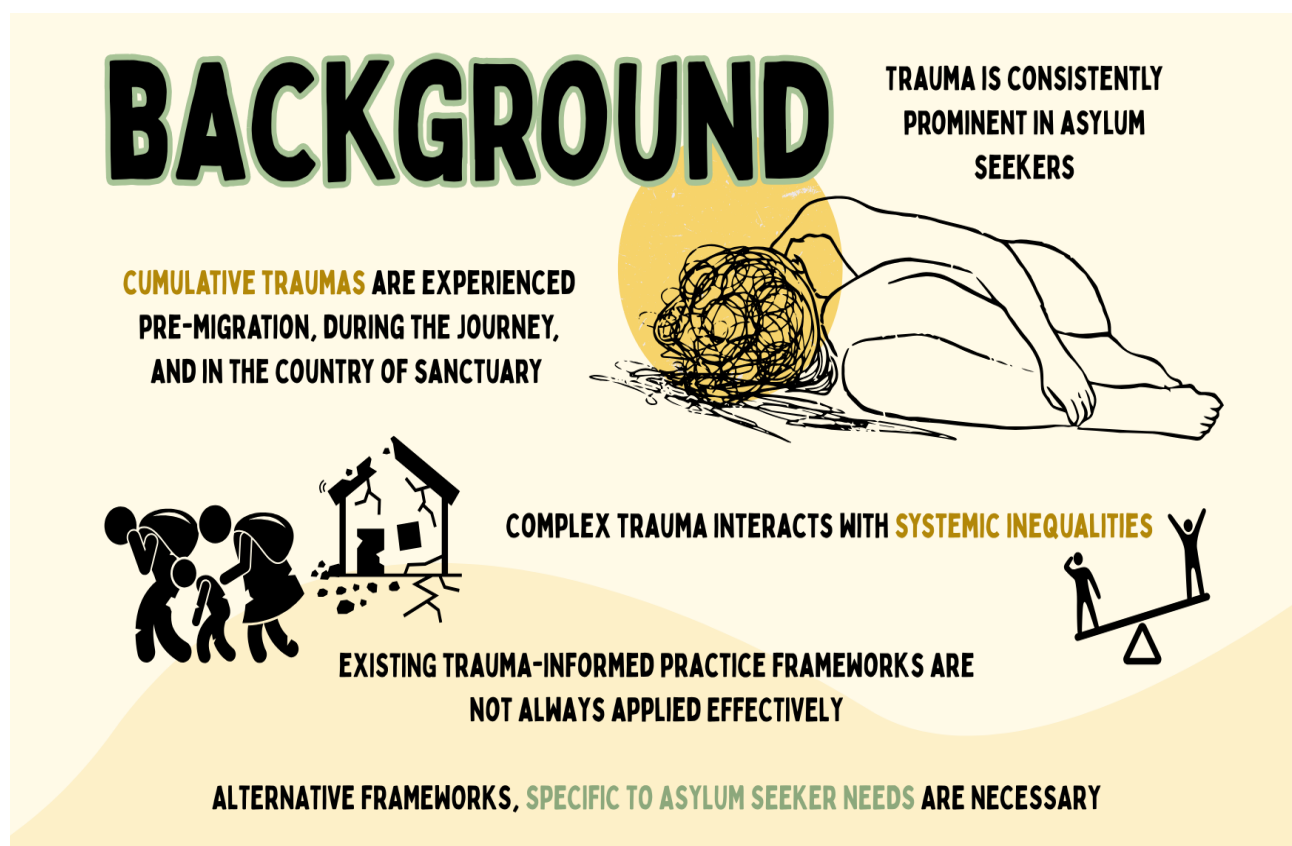
Local dispersal context and service gaps in Blackburn with Darwen

Blackburn with Darwen (BwD) has served as a major dispersal area for asylum seekers and refugee communities for several years. The borough is an active member of the Regional Strategic Migration Partnership (RSMP), including representation on the RSMP Executive Board, as well as the Lancashire Refugee and Asylum Seeker Strategic Partnership.

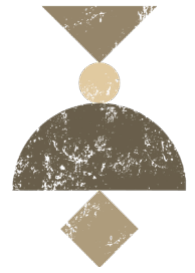
BwD is a diverse and multicultural borough, with over 70 languages spoken and a long history of migration spanning more than 60 years. More recently, migrants from across Europe, the Middle East, and Africa have resettled in the area. Despite this significant role in dispersal and integration, local evidence indicates critical gaps in the provision of culturally appropriate mental health support for asylum seekers living in the borough.

In BwD, national pressures are reflected locally through stretched statutory services, limited culturally adapted interventions, and prolonged waiting times for psychological therapies. As a result, asylum seekers often rely on informal or voluntary support while experiencing high levels of distress, with limited structured early intervention pathways available. However, limited funding, workforce constraints, and the absence of specialist therapeutic capacity restrict their ability to respond effectively to complex trauma-related needs.

Figure 1: Summary of the project background



AIM AND OBJECTIVES



Aim of the Healing Canvas Project

The *Healing Canvas project* aimed to identify gaps in understanding and responding to trauma amongst people seeking asylum in the UK, specifically those residing in Blackburn with Darwen (BwD). The project aimed to translate these findings into a co-designed, educational trauma-informed toolkit to inform policy and frontline practice.

Objectives:

The specific objectives included:

1. To raise awareness amongst the asylum community in BwD around trauma and mental health, helping them to recognise signs and symptoms of trauma and poor mental wellbeing, and knowing how to access support for this locally.
2. To raise awareness and train local staff and volunteers in BwD around trauma and trauma informed practises specific to asylum seekers for them to respond more appropriately to the needs of their clients.
3. To pilot and evaluate the feasibility, acceptability, and preliminary mental wellbeing impacts of a trauma-informed, culturally adapted model of trauma intervention co-designed with asylum seeker participants in this research.



Research Methodology

Overarching research questions

The primary research questions for this study were as follows:

1. How do asylum seekers living in Blackburn with Darwen understand, experience, and express trauma and its impact on their mental wellbeing?
2. What culturally meaningful, accessible, and safe methods can support asylum seekers in recognising trauma symptoms and understanding available support pathways?
3. How equipped do local staff and volunteers feel to recognise and respond to trauma amongst asylum seekers, and how can trauma-informed practices be strengthened?
4. What are the key components of a co-designed, culturally responsive trauma intervention model, and how feasible, acceptable, and impactful is this model for asylum seekers in Blackburn with Darwen?
5. How can insights from asylum seekers' lived experiences and creative expression inform local policy and practice around trauma support, mental health, and community integration?



stu

Figure 2: Summary of the primary research questions for this



HOW DO ASYLUM SEEKERS LIVING IN BWD UNDERSTAND, EXPERIENCE, AND EXPRESS TRAUMA?



WHAT CULTURALLY MEANINGFUL METHODS CAN BE USED TO SUPPORT THEM?

HOW EQUIPPED DO LOCAL STAFF AND VOLUNTEERS FEEL IN TRAUMA-INFORMED APPROACHES?



WHAT ARE THE KEY COMPONENTS OF A CO-DESIGNED TRAUMA INTERVENTION MODEL?

HOW CAN LIVED EXPERIENCE INFORM LOCAL POLICY ON TRAUMA SUPPORT AND COMMUNITY INTEGRATION?



Research Methods and Design

Participant recruitment

Recruitment was conducted through collaboration with relevant community organisations in Blackburn with Darwen. 40 participants, respectively 16 professionals and 24 asylum seekers were recruited. Several information sessions were held in local community centres and at local events, where recruitment flyers were also distributed to explain the purpose of this study and invite participation. Recruitment targeted specifically (a) professionals working alongside asylum seekers; (b) women (15) and men (9) asylum seekers who were aged 18 years and above living in Blackburn with Darwen.

Consent and ethics approval

Ethical approval for this study was gained from the University of Lancashire Ethics Review Panel (Reference No: HEALTH 01114 FR). Our approach ensured that participants were fully aware of the study's purpose and procedures, as well as of their rights as participants. All participants provided informed consent prior to participating. The project was performed in accordance with all relevant guidelines and regulations. Participants were given opportunities to ask questions and discuss any concerns before giving their consent. For participants with limited literacy and those who spoke languages other than English, we provided multilingual support to ensure that these participants fully understood the consent process.



Ethical consideration and Trauma-Informed safeguards

All sessions were conducted with strict attention to emotional safety, cultural sensitivity, voluntary participation, non-disclosure of personal trauma, and pathways to immediate support. Participants were given information explaining the nature of the research, what their participation would involve, the possible risks and benefits, and the measures taken by the University of Lancashire research team to ensure confidentiality and data protection. The Research team ensured that participants maintained control over lived experience sharing to reduce bias. Confidentiality is necessary to protect the identities of the participants. As such, all data collected were anonymised, and stored securely in protected files, which were accessible to the research team only.

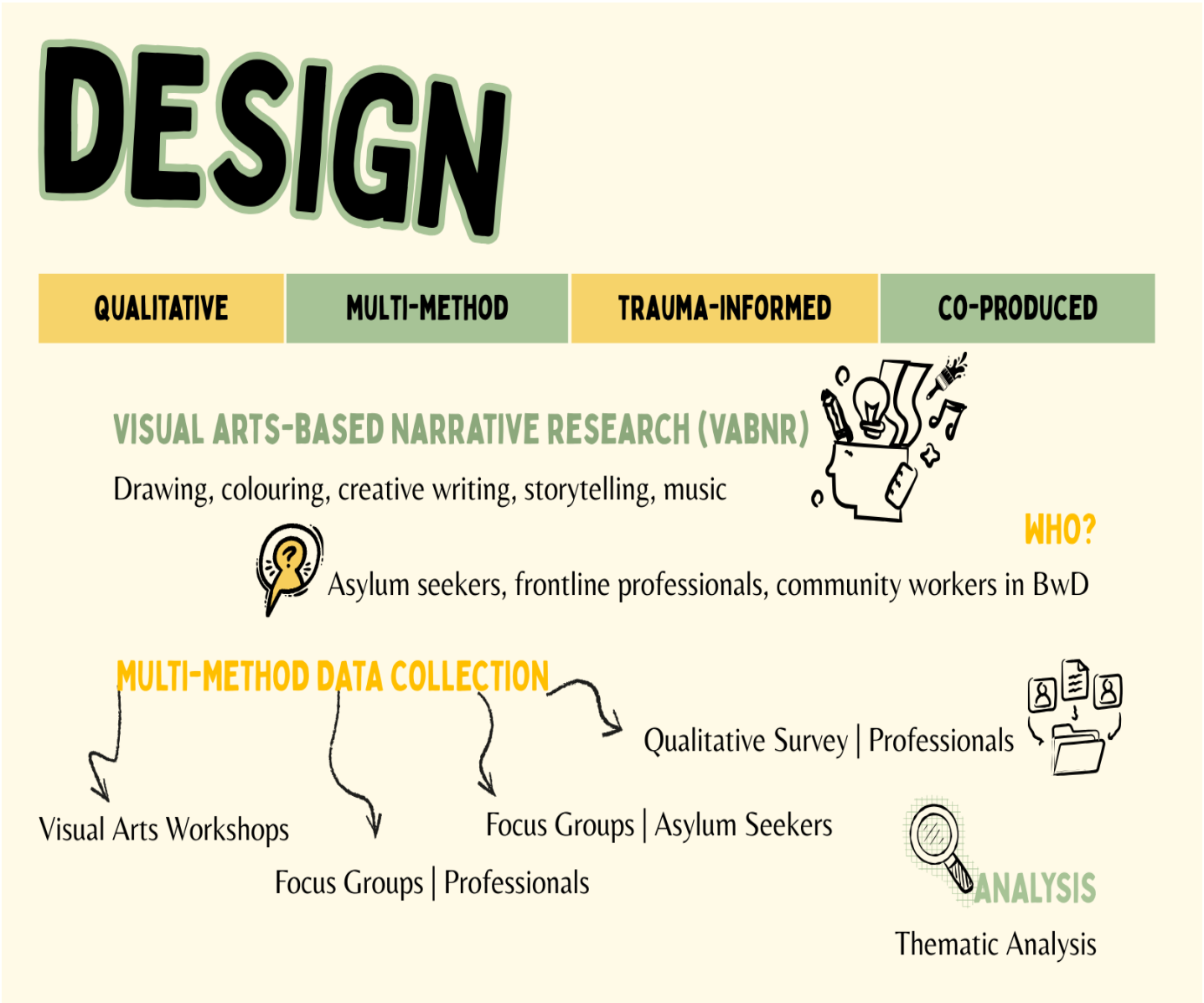
Study period

This was a 20-month study running from February 2024 to December 2025, divided into three main phases, respectively; (i) the development phase; (ii) the implementation phase; (iii) the dissemination and evaluation phase.



Study Design

Figure 3: Summary of the Research Design



This approach encouraged collaboration between the research team (University of Lancashire), asylum seekers, frontline professionals, and local third sector organisations working with asylum seekers in Blackburn with Darwen (NIHR, 2021). The aim was to ensure that all voices were well captured in a balanced, trauma-informed, and rigorous way; an iterative process, incorporating research, reflection, and creative action in a cyclical process.



Research approach

Multi-Method Data Collection – Four complementary data streams were used:

- ✓ **Arts-Based Narrative Approach** – We used Visual Arts-Based Narrative Research (VABNR) to support asylum seeker participants to express trauma, identity, and resilience through non-verbal, symbolic, and creative means (i.e., drawing, colour, creative writing, storytelling, music). This trauma-informed method enabled safe emotional expression, allowing participants to engage in structured creative sessions and help communicate experiences that are often difficult to verbalise due to language barriers, cultural stigma, or fear related to discussing trauma verbally.

The visual arts workshops also helped creating a safe and inclusive environment for participants, ensuring inclusivity, identity, cultural and linguistic ease of understanding. Additionally, these sessions helped minimise re-traumatisation and generate genuine, participant-led insights. The researchers conducting the focus groups were experienced in VABNR and consequently confident in the suitability of this methodology.

- ✓ **Three Focus Group Discussions (FGDs) with asylum seeker participants complemented the VABNR workshops.** Each FGD-VABNR workshop was conducted face-to-face in community settings to allow for both non-verbal and verbal communication. These sessions deepened understanding of the meanings participants gave to their creative outputs, allowing for shared interpretation between participants to reflect on their experiences collectively. Participants helped coproduce the cross-cultural trauma training toolkit, in line with this study's objectives.

- ✓ **Two Focus Group Discussions (FGDs) with professionals** – The research team conducted two FGDs with professionals working alongside asylum seekers to assess staff awareness and level of understanding of trauma-informed practices and interventions for asylum seekers. The FGDs also helped gather insights on trauma-informed practice gaps and potential solutions that could help address the mental health needs of asylum seekers.

- ✓ **Professional Survey (Qualitative):** A survey was distributed to local staff and volunteers working alongside asylum seekers. The free-text responses provided qualitative insights into staff confidence; perceived trauma behaviours, readiness for trauma-informed practice; training needs; gaps in local provision. This information strengthened the co-design process by incorporating frontline perspectives.

Together, these datasets provided a '*360-degree understanding*' of trauma from both asylum-seeking participants and professional perspectives.





Data Analysis

All qualitative data (VABNR, FGDs, survey) was processed and analysed using Thematic Analysis (Braun & Clarke, 2006; 2022). This involved identifying themes and patterns through an iterative process of reading and re-reading the transcripts, coding topics and grouping these codes into broader themes, which were reviewed and validated with participants to ensure authenticity and accuracy.

Triangulation and Co-design

Following data analysis, triangulation was used to validate the various findings and to ensure consistency and credibility, comparing the data from VABNR, FGDs, and survey datasets, resulting to the collaborative development of the Healing Canvas toolkit and the coproduced guidance to pilot a culturally creative trauma-informed group therapy for asylum seekers in Blackburn with Darwen.



The Healing Canvas

The Four Staged Approach



Introduction

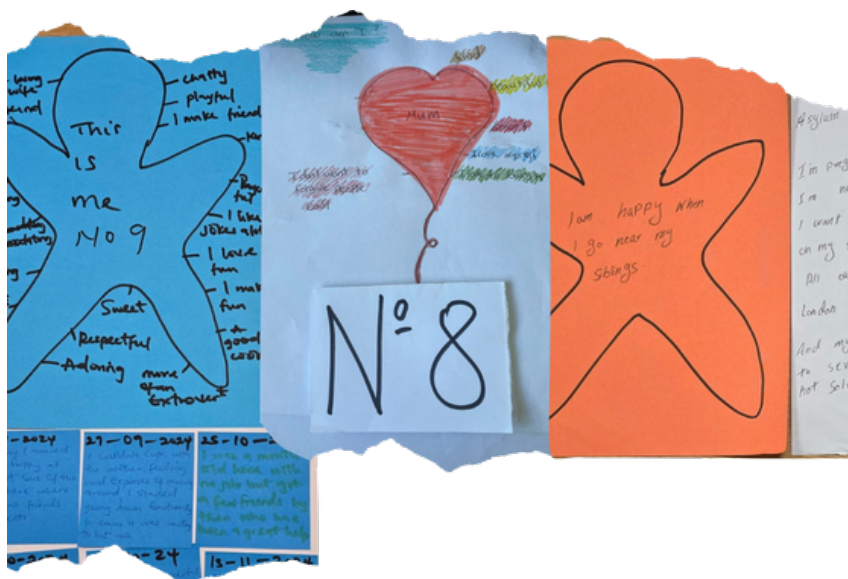
The Healing Canvas project followed a structured staged approach designed to move from early exploration of trauma experiences through to collaborative development, piloting, and system-level reflection. This approach allowed the research team to work ethically and sensitively with asylum seekers, integrate creative methods that reduced language and cultural barriers, and include professionals at key points of the design and delivery process.

Each stage informed the next, ensuring that all outputs, including the trauma intervention model, trauma toolkit, multilingual brochure, and the training programme were grounded in lived experience, aligned with professionals' realities, and feasible for implementation within Blackburn with Darwen.

Stage 1: Early exploration of Trauma and Lived Experience



The project started by working directly with asylum seekers through a series of *Visual Arts-Based Narrative Research (VABNR)* workshops. These creative sessions enabled participants to express trauma, fear, loss, identity, and resilience using art, colour, self-portraits and timeline drawings (methods chosen specifically to minimise language barriers and protect emotional safety).



Three parallel *focus group discussions* enabled participants to interpret their creative work collectively, deepening the research team's understanding of how trauma was experienced, and how it affected wellbeing, trust, communication, and engagement with local services.

To complement this lived experience data, a dedicated *professional focus group discussion* and a qualitative *professional survey* were conducted. These activities identified knowledge gaps, training needs, and systemic challenges in responding to trauma within asylum-seeking communities.

Together, these insights laid the foundation for the early structure of the Healing Canvas trauma-informed model and highlighted the need for accessible trauma information in multiple languages, later developed into the Trauma Brochure.

Stage 2:

Co-design, development, and refinement of the trauma toolkit and model

Building on Stage 1, the research team facilitated a series of *co-design workshops* with asylum seekers to refine the initial ideas and ensure that the developing model was culturally meaningful and emotionally safe. Participants contributed directly to shaping the trauma intervention's structure, language, imagery, and recommended methods.

Professionals were also invited to review the emerging toolkit, offer feedback on feasibility, and highlight practical considerations for implementation in community and statutory contexts. This professional engagement ensured that the model addressed real-world barriers such as time constraints, resource levels, safeguarding duties, and cross-cultural communication.

A series of *internal pilot sessions* involving lived experience advisors, interpreters, and community partners allowed the research team to test specific exercises, refine facilitation techniques, and strengthen trauma-informed safeguarding protocols, based on feedback received. This iterative process resulted in a more robust, user-informed trauma toolkit and clearer guidance for facilitators.



Stage 3:

Professional training and pilot delivery of the Healing Canvas



To support long-term sustainability, the project introduced a *Train-the-Trainer* programme for professionals and volunteers across Blackburn with Darwen. This training equipped participants with the knowledge and skills to deliver the Healing Canvas model safely, including trauma awareness, creative facilitation skills, emotional containment strategies, and cultural humility principles.

Following this capacity-building phase, professionals who attended the Train-the-Trainer programme piloted the sessions in Blackburn with Darwen borough. They were consulted to discuss their experiences in raising awareness and using the creative trauma-informed toolkit, their confidence in delivering the sessions, and the perceived impact on professionals attending the sessions. This feedback contributed to refining the toolkit and improving practical guidance for future facilitators.

Stage 4:

Dissemination and recommendations for sustainability



The final stage brought together asylum seekers, practitioners, commissioners, and community organisations in a *Stakeholder Discussion Forum / Healing Canvas Conference*. This event enabled participants to validate the findings, review the trauma model, and discuss its relevance across different services.

Stakeholders explored how the codesigned Healing Canvas toolkit could be embedded into existing provision, including asylum support, community mental health activities, and early engagement pathways. Barriers and potential solutions to implementation, such as limited resources, interpreter access, practitioner confidence, and referral routes were examined.

Insights from this final stage informed a set of *policy, practice, and recommendations*. To ensure sustainability, measurable impact, and to maintain local capacity, stakeholders recommended the implementation of an ongoing delivery of the Healing Canvas toolkit through *Train-the-Trainer* programme to raise awareness, support professionals and asylum-seeking communities across BwD, and evolve through ongoing evaluation and stakeholder contribution.

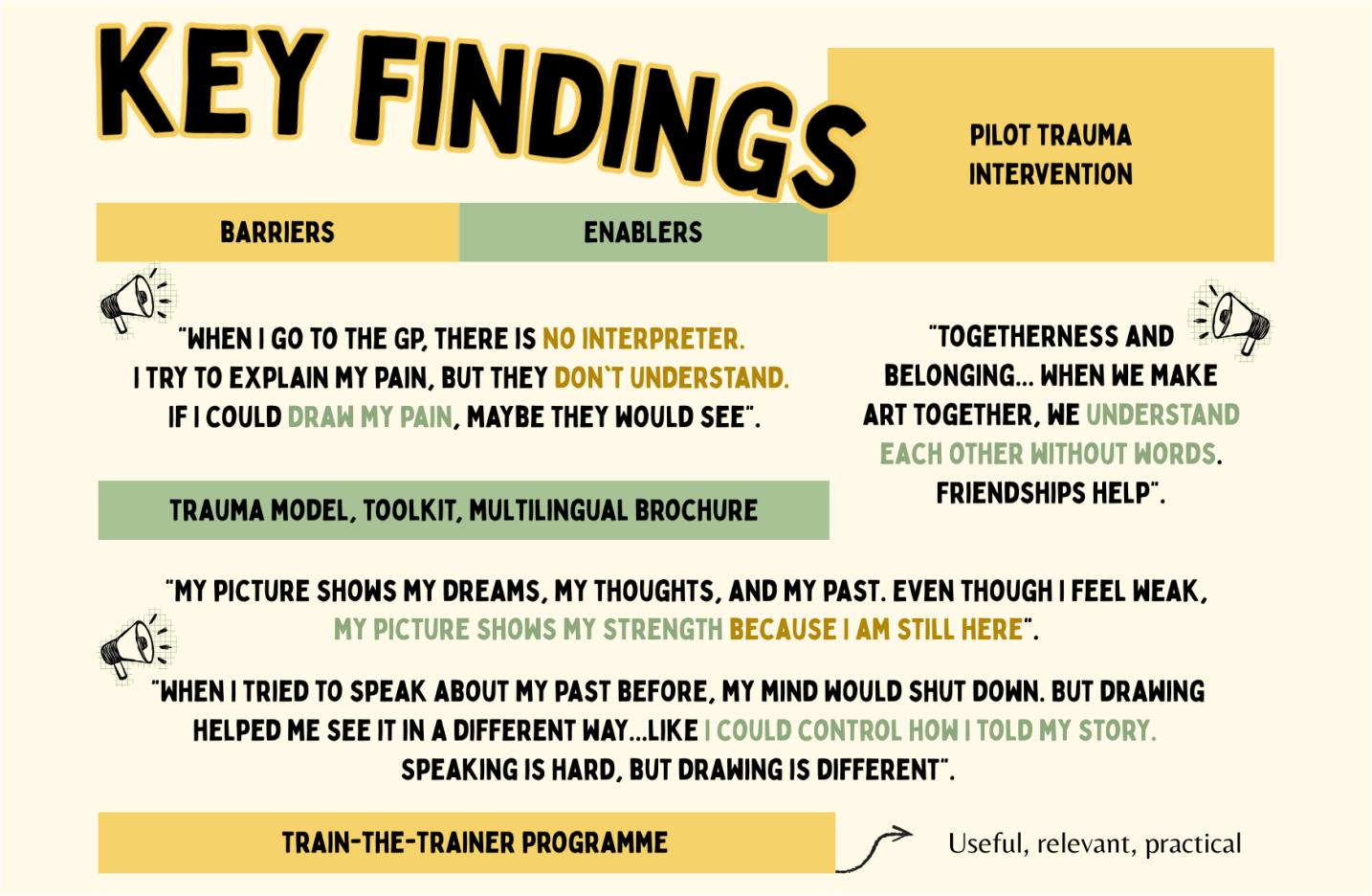


Healing Canvas used trauma-informed approaches throughout, recognising that traditional research methods can be re-traumatising for asylum seekers. Arts-based methods were specifically chosen as they are evidence-based and they demonstrated in this project their effectiveness in enabling participants to communicate experiences that were difficult to verbalise otherwise, particularly for those with language barriers or severe traumatic events.



KEY FINDINGS

Figure 4: Summary of the Key Findings



The Healing Canvas project successfully applied a creative, arts-based approach to explore trauma amongst asylum seekers and to co-design a culturally responsive trauma intervention model and toolkit for Blackburn with Darwen. Through creative workshops, focus group discussions, professional engagement, and a pilot intervention, several key themes emerged relating to the lived experience of trauma, barriers to support, and opportunities for trauma-informed practice.

| Objective One |

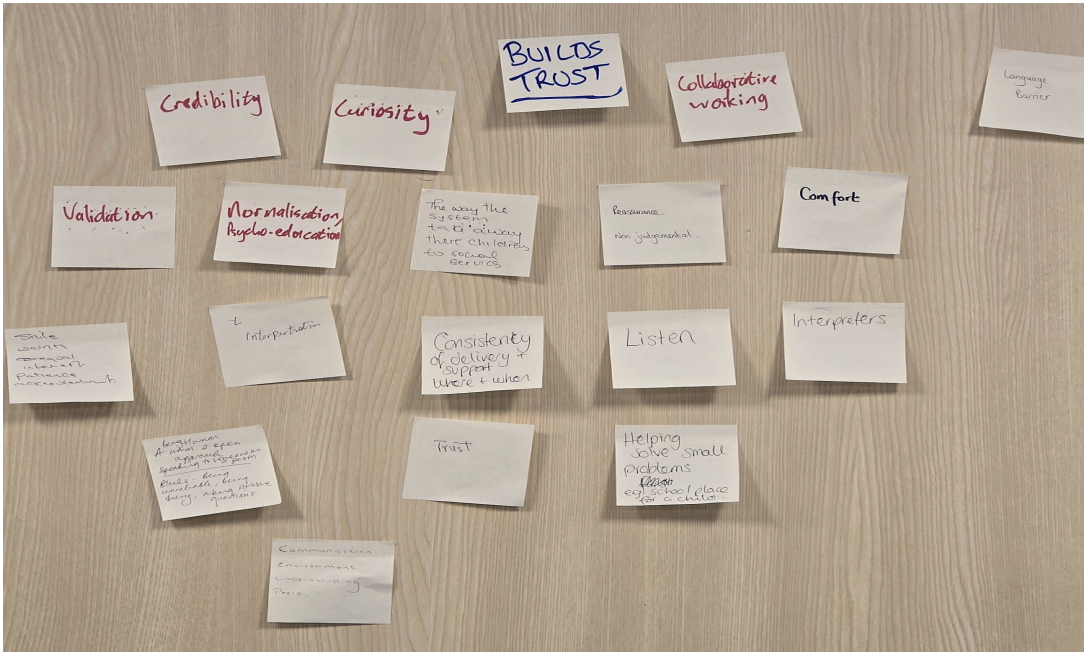
Raising trauma and mental health awareness amongst asylum seekers in Blackburn with Darwen

Purpose and scope of Objective One

The purpose of this objective was to raise awareness amongst asylum seekers in Blackburn with Darwen (BwD) about trauma and mental health, with a specific focus on supporting participants to (a) recognise signs and symptoms of trauma and poor mental wellbeing, and (b) understand how and where to access support locally. This objective was intentionally positioned as a foundational stage of the Healing Canvas project, recognising that awareness, understanding, and emotional safety are prerequisites for meaningful engagement with any trauma-informed intervention.

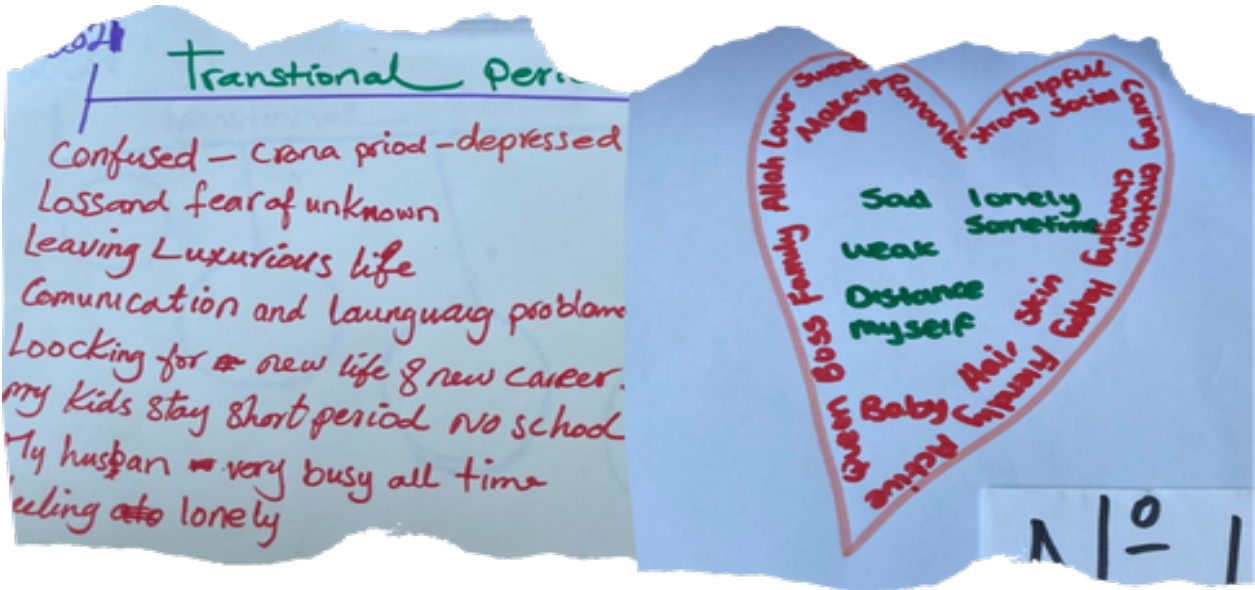
Rather than relying on didactic psychoeducation or clinical language, Objective One was actioned through creative, arts-based narrative workshops, designed to reduce linguistic, cultural, and emotional barriers while protecting participants from re-traumatisation. This section critically examines the extent to which Objective One was met, the mechanisms through which awareness was developed, and the barriers and enablers identified through participants lived experiences.





Awareness of trauma: From abstract concept to lived recognition

A key finding from Objective One was that many asylum seekers initially had limited or fragmented understandings of trauma, particularly when framed through Western mental health terminology. Participants often associated trauma exclusively with extreme past events and did not initially recognise ongoing symptoms such as hypervigilance, sleep disturbance, emotional numbness, or persistent fear as trauma related.





I thought trauma is only war or prison. I didn't know that not sleeping, always scared, always thinking, this is also trauma. (Participant, Creative Workshop)



This aligns with existing evidence that trauma amongst asylum seekers is frequently understood in culturally specific, non-clinical ways and shaped by stigma, fear of labelling, and distrust of systems (WHO, 2025; Mental health Foundation, 2025).

Through creative workshops, participants were able to move from abstract definitions towards experiential recognition of trauma as cumulative and ongoing. Through self-portraits, visual timelines, colour symbolism, and collective reflection, this marked the first moment in which many participants were able to connect current distress (i.e., anxiety triggered by the asylum process, isolation in accommodation, or fear following the August 2024 race riots) to trauma rather than personal weaknesses or failures.



“When I see my drawing, I understand this feeling did not start yesterday. It is following me everywhere.” (Participant, Group Reflection)



Crucially, this awareness emerged without requiring verbal disclosure of traumatic events. Creative expression allowed participants to externalise experiences and express distress safely, without being required to recount experiences in detail, an approach that supports recognition while preserving dignity and control. This finding reinforces trauma-informed principles that awareness should be built through choice, agency, and cultural relevance, rather than forced narration (Abbas et al., 2021).



“I don't want to explain my story again. With the picture, I can show how I feel without saying everything.”



Creative methods as awareness-raising mechanisms

The arts-based narrative approach functioned as both a research method and an awareness-raising intervention. **Visual timelines revealed trauma as ongoing and cumulative, rather than something confined to the past**, with participants often marking repeated “red” periods corresponding to post-migration stressors such as housing instability, legal uncertainty, and community hostility. **Self-portrait activities facilitated identity exploration beyond the asylum label**, enabling participants to recognise strengths, aspirations, and resilience alongside vulnerability.

Participants consistently described creative methods as enabling expression where words were limited or unsafe. These methods were particularly effective in overcoming language barriers, a major obstacle to trauma awareness in mainstream services. Participants repeatedly noted that they could “show” what they were experiencing without needing the right words, interpreters, or clinical vocabulary.



“I don’t have the words in English for this, but if I draw with colours, I can explain myself.”

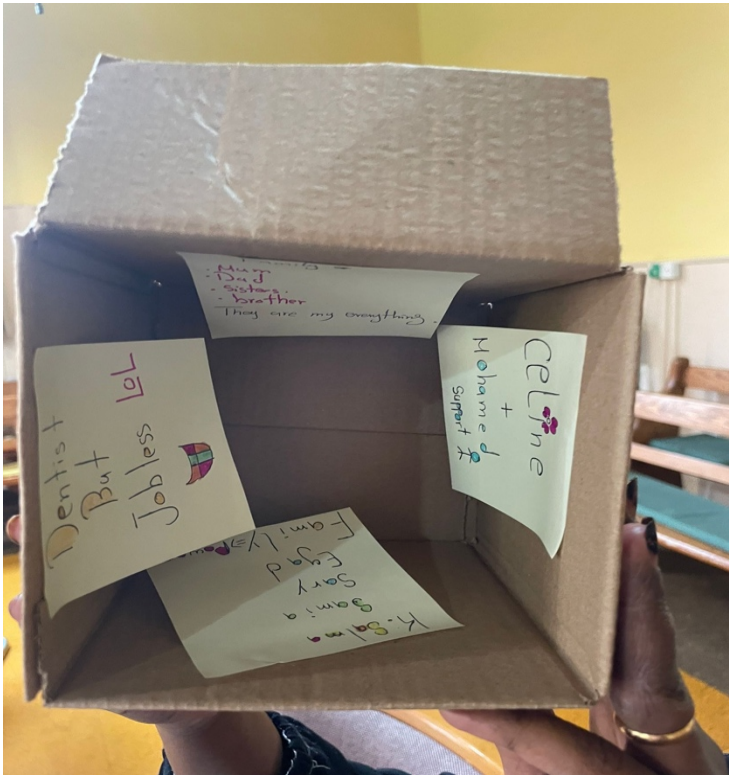
This is consistent with evidence that trauma is often stored and expressed somatically and symbolically, making non-verbal approaches especially suitable for people with limited English or who find verbal recall overwhelming (Zadeh et al., 2023; Morina et al., 2018).

Collective sharing of artwork normalised distress and reduced isolation. Hearing others describe similar emotions normalised distress, reduced self-blame, and supported peer learning. Participants started to recognise trauma symptoms not only in themselves but in others, strengthening peer understanding and mutual empathy.

“When I hear others, I realise I am not weak. Many people in the group felt the same, I was reassured.”



These findings reinforce that creative, non-verbal approaches are not merely complementary but central to safe trauma awareness amongst asylum seekers.



Awareness of support pathways: knowledge, trust, and realism

Objective One also aimed to improve understanding of how to access mental health and trauma support locally. Findings indicate that while some participants were aware of NHS services in principle, this awareness was often accompanied by fear, mistrust, or uncertainty. Barriers included uncertainty about eligibility, long waiting times, lack of interpreters, digital exclusion, and anxiety about the implications of disclosing mental distress within statutory systems.

“

“I know there is GP, but I don’t know if I am allowed to talk about mental health. I worry it can affect my case.”

”

The co-produced trauma brochure emerged as a key output addressing this gap and improved clarity around support options. Developed using jargon free language, visual cues, and participant-informed messaging, the brochure reframed support-seeking as a legitimate response to trauma rather than a sign of weakness. Importantly, it distinguished between



different types of support (community-based, voluntary sector, NHS pathways), helping participants understand that seeking help does not necessarily mean immediate clinical intervention.

However, participants were clear that awareness alone did not equate to confidence in accessing services. Many described previous experiences of feeling misunderstood, stigmatised, rushed, or culturally unsafe.

“

“Knowing the service is there doesn’t mean I feel safe to go.”

”

This highlights an important limitation of awareness-raising in isolation and the need for relational, community-based pathways.

Barriers identified



Several intersecting barriers to trauma and mental health awareness were identified:

Cultural stigma and gender norms, particularly around emotional expression and mental health, shaped how distress was recognised and discussed. Participants described strong expectations to remain emotionally contained. This was particularly pertinent amongst male participants.

“Where I come from, you don’t talk about these things. If you say you are not okay, people think you are weak.”

Fear linked to immigration status was a significant barrier, with participants expressing concern that acknowledging mental health difficulties could negatively affect their asylum claims.

“I worry that if I say I have mental problems, they will think I am lying or it will affect my case.”

Language and literacy barriers limited access to written or verbally delivered information about trauma and mental health, particularly when materials relied on clinical terminology or complex English.



“Even when they explain, the words are too difficult. I don’t understand what they mean by mental health.”

Distrust of institutions, rooted in experiences of past persecution and reinforced by encounters with hostility or exclusion in the UK, reduced willingness to engage with formal services.

“In my country, authorities were dangerous. Here it is different, but my body still doesn’t trust.”

Structural stressors, including poor housing conditions, enforced inactivity, and social isolation, both contributed to distress and reduced participants’ capacity to engage with awareness initiatives.

“I am in one room all day, doing nothing. When you live like this, it is hard to think about healing.”

These barriers reflect well-documented post-migration stressors that compound pre-migration trauma and significantly affect mental wellbeing (Blanton, 2025; Gleeson et al., 2020).

Enablers of awareness and engagement



Despite the challenges identified, several strong enablers of trauma and mental health awareness emerged:

Creative expression as a culturally flexible, emotionally safe medium enabled participants to communicate experiences that were difficult or unsafe to articulate verbally.

“With drawing, I can explain my feelings without finding the right words.”

Group-based formats reduced isolation and supported normalisation of distress through shared experience and mutual recognition.

“When I hear others talk, I feel I am not alone anymore.”

Culturally sensitive facilitation, characterised by empathy, non-judgement, and respect, was central to creating emotional safety and trust.

“They did not push me to speak. That made me feel respected.”

Participant control, including the ability to share selectively or not at all, enabled engagement without fear of exposure or re-traumatisation.



“I could choose what to say and what to keep for myself.”

Hope-oriented framing, which balanced acknowledgement of trauma with recognition of strengths and future possibilities, supported motivation and emotional resilience.

“For the first time, I felt my life is not finished — there is still something ahead.”

Creative and group-based methods created the conditions for trust and meaning-making, while participant control and non-judgemental facilitation mitigated risks of re-traumatisation and disengagement.

These insights directly informed subsequent co-production processes, including the design of the Trauma Brochure, which adopted simplified language, visual elements, and strengths-based framing to reflect how participants best engage with sensitive content.

Evaluating Objective One

Co-production emerged as a central enabler of awareness, engagement, and trust throughout Objective One. Participants were active contributors rather than passive recipients enhanced relevance, cultural safety, and acceptability of both the awareness-raising activities and subsequent outputs.

Participants’ lived experience directly shaped the language, imagery, pacing, and boundaries of engagement, ensuring that trauma was approached in ways that prioritised dignity, choice, and emotional safety. This collaborative process not only strengthened engagement but also mitigated power imbalances and reduced the risk of extractive or re-traumatising practice, which are well-documented risks in trauma research and service design (Gov.UK, 2023; Woods-Jaeger et al., 2023).

The principles and insights generated through **co-production informed the co-design of the Trauma Brochure**, ensuring it reflected how participants understand and seek support, and underpinned the design of the pilot intervention models in Objective Three, embedding lived experience as a driver of feasibility, acceptability, and ethical practice rather than an add-on. This aligns with growing evidence that co-produced, trauma-informed interventions are more likely to be effective, equitable, and sustainable, particularly in marginalised populations (Gov.UK, 2023; Taylor & McBride, 2022).

Taken together, the findings indicate that Objective One was met in a manner that was ethically sensible and methodologically appropriate for a trauma-affected population. Awareness was conceptualised not as information transmission but as a relational and experiential process, grounded in participants’ lived realities. The **creative workshops increased recognition of trauma symptoms, reduced stigma, and improved**



understanding of local support options, while simultaneously revealing the limits of awareness-raising in the absence of accessible, culturally safe interventions.

Crucially, Objective One generated both **tangible resources** (creative outputs and informational materials) **and applied insights that directly shaped the co-design and pilot phases reported under Objective Three**. Its contribution therefore lies not only in immediate awareness outcomes, but in establishing the conceptual, emotional, and cultural foundations necessary for subsequent intervention development.

| Objective Two |

Raising awareness and strengthening Trauma-Informed Practice amongst service providers in Blackburn with Darwen

Purpose and scope of Objective Two

Objective Two examined the extent to which local staff and volunteers in Blackburn with Darwen were aware of trauma and trauma-informed principles as they relate specifically to asylum seekers, and whether targeted engagement could strengthen their confidence and capacity to respond more appropriately to clients' needs.

This discussion addresses the relevant primary research question:

How equipped do local staff and volunteers feel to recognise and respond to trauma amongst asylum seekers, and how can trauma-informed practices be strengthened?

It also contributes indirectly to the research question concerning how insights from asylum seekers' lived experiences can inform local policy and practice.



Barriers identified

1. Limited confidence in applying Trauma-Informed Practice

Baseline awareness and confidence amongst service providers

Findings from Objective Two indicate that while service providers were generally familiar with trauma-informed terminology, **many lacked confidence** in applying it within asylum contexts. Participants commonly described feeling confident in recognising overt distress but **less equipped to understand complex trauma presentations shaped by forced migration**, prolonged uncertainty, cultural difference, and the structural constraints of the asylum system.

“I know the theory of trauma-informed practice, but I don’t always know what that looks like with asylum seekers in real life.” (Frontline worker participant)



Participants frequently **expressed uncertainty about how to interpret behaviours** such as withdrawal, emotional dysregulation, missed appointments, or apparent disengagement, often questioning whether these reflected lack of motivation or non-compliance rather than trauma-related coping responses.

“Sometimes I’m not sure if I should push, pause, or refer, and I worry about getting it wrong.” (Frontline worker participant)



This finding aligns with existing evidence that frontline workers often lack opportunities to translate trauma-informed principles into practice within constrained service environments (Dores et al., 2024).

2. Generic training lacking contextual relevance

Trauma-informed awareness as contextual, not generic

A critical contribution of Objective two was demonstrating that trauma-informed practice cannot be meaningfully strengthened through generic training alone. Participants repeatedly emphasised that previous trauma training, where received, tended to be abstract or clinically framed, offering limited guidance on how to adapt practice for asylum seekers facing language barriers, cultural difference, fear of authority, and immigration-related stressors.





*“I’ve done trauma training before, but it was very theoretical. It didn’t really help me understand what to do differently with asylum seekers.”
(Frontline worker, voluntary sector)*

Engagement with lived-experience narratives and creative outputs generated through Objective One proved particularly impactful. Staff reported that exposure to asylum seekers’ visual and narrative expressions of trauma deepened their understanding of how distress is communicated indirectly and culturally mediated, particularly in the absence of verbal disclosure. Importantly, this process started to promote empathy in professional participants.



“Seeing the artwork helped me understand what distress looks like when someone can’t or won’t explain it in words.”

This facilitated a shift from procedural responses (“what service do I refer to?”) towards relational responses focused on safety, predictability, and dignity.



“It changed my thinking from ‘where do I send them?’ to ‘how do I make this moment feel safe?’”

This finding directly addresses the research question by evidencing that staff confidence is strengthened not through technical knowledge alone, but through contextualised, experiential learning that bridges theory and practice.

3. Vicarious trauma and moral distress

Vicarious trauma and emotional impact on staff and volunteers

Findings from Objective two indicate that exposure to the distress, uncertainty, and trauma narratives of asylum seekers often had a cumulative emotional impact on professionals working directly with asylum seekers, consistent with experiences of vicarious trauma. While participants did not always use clinical language to describe this impact, many reported feelings of **emotional exhaustion**, anxiety about causing harm, and difficulty maintaining appropriate professional boundaries in the absence of specialist training or supervision.



*“You **carry their stories home** with you. Sometimes I lie awake thinking, did I say the wrong thing, did I make it worse?” (Frontline worker participant)*



Staff described a tension between their commitment to providing compassionate support and their limited capacity to contain complex trauma responses within non-clinical roles. This was particularly pronounced amongst community-based and voluntary sector workers, who often operate in settings with fewer formal safeguards, with minimal or no reflective supervision, and high relational intensity. Without structured opportunities to process emotional impact, trauma-informed practice risks becoming emotionally unsustainable, increasing the likelihood of burnout, avoidance, or compassion fatigue and desensitisation.

Findings from Objective Two further indicate that **vicarious trauma amongst professionals working with asylum seekers is shaped by distinct contextual factors that differentiate it from work with other vulnerable groups**. In addition to exposure to traumatic narratives, staff described cumulative emotional strain arising from prolonged uncertainty, limited pathways for resolution, and repeated encounters with distress driven by structural conditions such as immigration processes, housing instability, and enforced inactivity. This contributed to **feelings of moral distress, helplessness**, and responsibility for situations beyond their professional control.



“It’s not just the stories. It is also knowing their situation won’t change any time soon, and there’s very little you can do about it.”
(Frontline worker participant)

Staff working in community and voluntary sector settings were particularly affected, as they often operate without formal clinical supervision or clear containment structures, despite high levels of relational intensity. The findings suggest that generic supervision and wellbeing approaches are insufficient in this context. Instead, staff emphasised the **need for tailored reflective supervision models that explicitly acknowledge systemic and policy-driven sources of distress**, legitimise emotional responses to injustice and uncertainty, and clarify role boundaries around what staff are (and are not) expected to hold.



“Sometimes the hardest part is feeling responsible for things that are completely outside your role or power.”

Recognising and addressing asylum-specific vicarious trauma emerged as a critical workforce safeguarding issue rather than an individual resilience concern. Embedding tailored, trauma-informed supervision that accounts for moral distress, cultural complexity, and prolonged uncertainty represents a clear opportunity for policymakers to strengthen service quality, staff retention, and ethical practice. Such approaches align with evidence that protecting workforce wellbeing is a prerequisite for safe, effective trauma-informed care and should be considered a core component of services supporting asylum seekers, rather than an optional add-on (Dodds & Hunter, 2022).



4. Structural and Organisational Constraints

Barriers to trauma-informed practice in real-world settings

Findings from Objective Two demonstrate that, despite increased awareness and commitment to trauma-informed principles, professionals and volunteers working with asylum seekers in Blackburn with Darwen face significant structural and organisational barriers that constrain their ability to translate knowledge into practice.

These barriers include persistent time pressures, high caseloads, unclear role boundaries, limited access to specialist supervision, and systemic constraints within housing, welfare, and voluntary-sector provision. Collectively, these factors restrict the relational space required for trauma-informed work and risk reducing such practice to an individual responsibility rather than an organisational and system-level commitment.

— “ —
“We’re expected to be trauma-informed, but there isn’t always the time or support to do it properly.” (Frontline worker, voluntary sector)

A recurrent concern amongst staff was ambiguity regarding role boundaries, particularly when working with highly distressed asylum seekers in non-clinical settings. Staff described uncertainty about how far to engage, when to pause, and when to escalate concerns, especially in the absence of clear referral pathways, confidence in timely specialist input, or regular supervision. This uncertainty contributed to anxiety about inadvertently causing harm or “opening something” they were not equipped to contain.

— “ —
“I worry about opening something I can’t contain.”

These findings highlight a critical tension: trauma-informed practice encourages relational engagement and empathy, yet frontline workers often operate without the structural containment necessary to safely hold such work. As a result, staff reported emotional strain and cumulative stress, consistent with experiences of vicarious trauma and moral injury. This was particularly evident in asylum contexts, where distress is not only rooted in past trauma but is continually reinforced by prolonged uncertainty, systemic delays, and conditions beyond the control of both clients and workers.

The analysis suggests that without organisational backing such as reflective supervision, clear role delineation, and realistic workload expectations, trauma-informed practice risks becoming unsustainable. Rather than mitigating harm, it may inadvertently increase emotional burden on staff, leading to burnout, avoidance,



or disengagement. This aligns with evidence from refugee and asylum settings that vicarious trauma is exacerbated when workers are exposed to chronic distress without adequate systemic support or opportunities for meaning-making and containment (Dodds & Hunter, 2022).

Overall, these findings emphasise the need to **reframe trauma-informed practice as a shared organisational responsibility rather than an individual skillset**. Effective implementation requires structural conditions that protect both service users and workers, including time, supervision, and institutional recognition of the emotional labour involved. Addressing these barriers is therefore essential not only for workforce wellbeing, but for the ethical and sustainable delivery of trauma-informed services to asylum seekers.

Enablers of Trauma-Informed Practice and Implementation

2.1. Enablers of improved practice and confidence

Despite the structural and organisational constraints identified as barriers, several clear enablers emerged as critical to strengthening trauma-informed responses amongst local professionals and volunteers. Most notably, participants emphasised the value of **reflective discussion spaces** in which uncertainty, emotional impact, and ethical dilemmas could be openly explored. They recognise that such spaces would enable staff to move beyond procedural compliance towards more thoughtful, relational forms of practice, particularly when working with asylum seekers whose distress is shaped by complex trauma and ongoing systemic stressors.

Practical, **locally grounded examples** were consistently identified as more impactful than abstract trauma theory. Participants reported that understanding trauma-informed practice as *'how they work'* rather than as an additional set of tasks reduced anxiety about "doing the wrong thing" and increased confidence in everyday interactions. As one participant articulated, *"It helped to hear that being trauma-informed is about how you listen, not having all the answers."* This insight reflects a shift from performance-based models of competence towards **relational and ethical competence**, is central to trauma-informed frameworks.



The **integration of creative and narrative material into training sessions** worked as a particularly powerful enabler. Importantly, this was not experienced as exposure to traumatic content, but as a mediated form of learning that supported empathy without voyeurism. Symbolic and anonymised creative outputs such as artwork or composite narratives allowed staff to engage with the *impact* of trauma rather than its explicit details. This protected both service users and workers from re-traumatisation, while still fostering deeper understanding. Such an approach aligns with established trauma-informed workforce development principles that emphasise psychological safety, reflective capacity, and shared responsibility for wellbeing (Gov.UK, 2022; SAMHSA, 2014).



Findings indicate that **trauma-informed practice is most effectively strengthened when training is grounded in local realities, informed by lived experience, and supported by organisational culture rather than delivered as standalone instruction**. However, the findings also highlight the limits of individual-level training in the absence of systemic support. Without clear pathways for supervision, escalation, and collaboration with mental health services and all relevant support services specialised in supporting asylum seekers in Blackburn with Darwen, staff and volunteers may remain constrained in their ability to respond fully to complex trauma presentations.

2.2. From lived experience to workforce practice: Training, Tools, and Sustainability

As part of Objective Two, a small number of professionals across Blackburn with Darwen participated in a **Train-the-Trainer programme** designed to support wider adoption of the Healing Canvas model within services working with asylum seekers. Participants represented a range of sectors, including voluntary and community organisations, housing, health, social care, and education.

Overall feedback indicated high levels of engagement and motivation to apply asylum-seeker related trauma-informed and creative approaches in practice. Participants consistently described the training as **relevant, accessible, and practically useful, particularly valuing the integration of lived-experience insights and creative methods** drawn from earlier stages of the study.

Several participants highlighted that the training helped to demystify asylum-seeker related trauma-informed practice and reduce anxiety about professional competence. One participant reflected:

“It helped to hear that being trauma-informed is about how you listen, not having all the answers, which is often the case when supporting asylum seekers.”



The use of creative and narrative material, particularly symbolic and anonymised outputs informed by Objective One was widely reported as an effective learning tool. Participants noted that this approach supported empathy and understanding without requiring exposure to detailed or graphic trauma narratives, which some identified as emotionally unsafe or ethically uncomfortable in previous training contexts.

Feedback also identified **challenges and areas for refinement**. Some participants experienced longer training sessions as emotionally demanding, particularly when engaging with trauma-related material over extended periods. Suggested improvements included delivering training in shorter, modular blocks and providing structured opportunities to practise facilitation skills with supervision and peer feedback.

Participants emphasised the value of practical resources to support implementation beyond the training sessions. **Toolkit developed through Objectives One and Two** included:

- Healing Canvas Trauma-Informed awareness session for professionals
- C.A.R.E.R.S. Framework slide deck for professionals
- A multilingual, culturally sensitive Healing Canvas guide for asylum seekers
- Self-help and reflective tools addressing vicarious trauma and staff wellbeing.

These resources were viewed as adaptable across professional contexts and supportive of consistent trauma-informed practice.

Implications for workforce implementation and sustainability

The above findings indicate that **context-specific training** can strengthen staff and volunteer confidence in responding to asylum seekers affected by trauma, particularly when training is grounded in lived experience and delivered through ethically mediated creative methods. Importantly, the evaluation demonstrates that trauma-informed practice was most effectively understood by participants not as a specialist clinical skill set, but as a **relational and ethical stance** that can be enacted within existing professional roles.



The strong engagement with the training reflects a previously unmet need for learning opportunities that move beyond generic trauma frameworks to address the specific realities of asylum contexts, including language barriers, fear of authority, prolonged uncertainty, and cultural difference. Exposure to symbolic and anonymised creative material enabled participants to **reflect on the impact of trauma while maintaining ethical boundaries and avoiding intrusive or extractive practices**. This approach aligns with trauma-informed workforce development principles that emphasise psychological safety for both service users and practitioners (SAMHSA, 2014).

At the same time, participants' **feedback highlights the importance of emotional pacing and organisational support**. The experience of longer sessions as demanding underscores the cumulative impact of trauma-related work and the risk of vicarious trauma if training is not



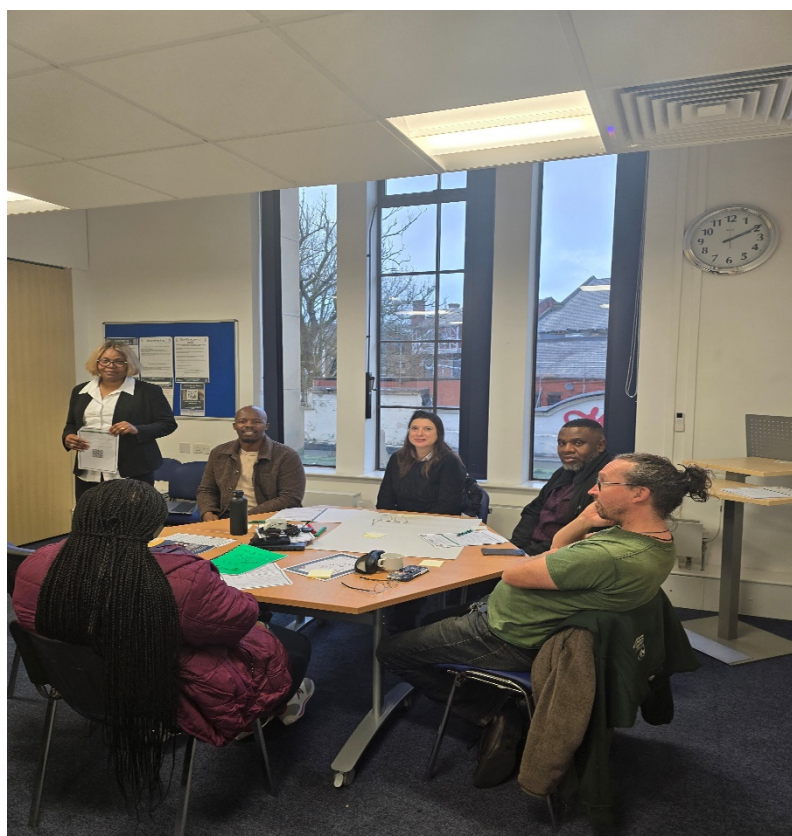
carefully designed. Requests for shorter sessions and supervised practice opportunities suggest that workforce development in this area should be iterative, reflective, and supported, rather than delivered as a one-off intervention.

The Train-the-Trainer model emerged as a key mechanism for sustainability within Blackburn with Darwen. By equipping a small number of professionals with adaptable tools and facilitation skills, the approach supports local ownership and reduces reliance on external expertise. However, the findings also indicate that training alone is insufficient. For trauma-informed practice to be sustained, organisations must provide permission, supervision, and alignment with safeguarding and referral pathways. Without these conditions, there is a risk that newly acquired knowledge cannot be consistently enacted.

Evaluating Objective Two

Objective Two demonstrates that incorporating asylum seekers' lived experiences in training resources and toolkit ethically mediated through creative forms can meaningfully inform staff practice while avoiding re-traumatisation through storytelling.

The integration of Objectives one and two enabled a coherent translation of asylum seekers' lived experiences into professional practice. The Healing Canvas toolkit exemplifies how awareness-raising within the asylum community can inform workforce development in ways that are ethically sound, culturally responsive, and practically meaningful. This approach strengthens the credibility and applicability of the training while creating a strong foundation for the interventions piloted in Objective Three.



| Objective Three |

Pilot and evaluation of co-designed Early Intervention Models

1. Purpose and scope of Objective Three

This section of the report focuses specifically on the piloting and evaluation of the trauma-informed, culturally adapted early-intervention model co-designed with asylum seekers. The pilot sessions reported here were not developed in isolation but were directly informed by findings from ‘Objectives one and two’, which explored asylum seekers’ understandings of trauma and mental wellbeing, as well as local staff and volunteers’ confidence and training needs in responding to trauma within the Blackburn with Darwen (BwD) context.

Building on this foundational work, the pilot intervention aimed to **translate insight into practice** by testing whether a co-produced, creative, group-based trauma model could be delivered safely and acceptably, and whether it showed early indications of benefit for their mental wellbeing. This evaluation reports on **a series of pilot sessions delivered as a practice-based feasibility and acceptability test**, allowing improvement of safeguarding protocols, delivery methods, and gender-informed adaptations prior to any wider implementation or commissioning.

2. Barriers and service gaps identified

2.1 Lack of early intervention pathways for asylum seekers



During visual art-based creative Focus Group Workshops conducted to meet objective One, participants consistently emphasised the **absence of early intervention trauma support tailored to asylum seekers in Blackburn with Darwen**.

The majority of participants suggested that having a culturally safe, early intervention support available from port of entry, when people feel totally “lost” and “hopeless, could have reduced deterioration and prevented mental health crises.



Participant women and men were separately offered three pilot group sessions each. Some of the participants were on waiting lists for counselling. **The piloted model acted as a safe, floating bridge, offering containment, connection, and reassurance.**

Participants identified the **lack of continuity following the pilot as a major concern**. Several expressed that offering short-term interventions risk to replicate feelings of abandonment and reinforcing mistrust in systems of care. Across both groups, all participants stressed a lack of early intervention trauma support tailored to asylum seekers in Blackburn with Darwen.

2.2 Gender and cultural mismatch in conventional therapies

Participants disclosed being **unlikely to engage in conventional talking therapies** due to language barriers, stigma, shame, distrust, and gendered norms of emotional expression. For some, **emotional disclosure in clinical settings was perceived as culturally unsafe** or incompatible with expectations around strength and composure.

The co-designed group therapy model contributed to creating psychologically safe pathways into support by offering an early-intervention model delivered in a community environment rather than a clinical setting. The findings indicate that **reduced engagement in traditional therapy formats should not be interpreted as lack of motivation, but as a mismatch between service design and culturally mediated expressions of distress.**

3. Enablers of feasible and acceptable early intervention

3.1. Trauma-informed safeguarding protocol (Gender-informed)

✓ Shared safeguarding principles (core protocol)

The safeguarding protocol was built around reliability, choice, control, and cultural humility, reflecting NICE (2018)'s emphasis on coordination, principles of care, and language/culture considerations. Activities were co-designed with participants so that they could benefit without recounting traumatic events. Each gender group received three pilot sessions delivered twice monthly. This rhythm supported trust-building while allowing emotional recovery between sessions. The community-based setting increased psychological safety and reduced stigma associated with clinical environments.



✓ *Culturally adapted grounding techniques and Regulation Practices*

Grounding techniques practiced at the start and end of sessions were treated as a safeguarding requirement, not an optional wellbeing activity. Opt-in choices were embedded throughout: participants could observe, participate non-verbally, work privately, or step out without explanation. The pilot programme maintained clear boundaries and signposting, framed as engagement support with further referral to NHS mental health services when risk escalated, or specialist therapy was indicated.

✓ *Gender-responsive - Embedded safeguarding mechanism*

For women, a common agreement was to use **tea-breath rituals and mindfulness**. Men suggested a **culturally adapted breathing-with-movement technique**.

Tea-breath rituals and mindfulness:

The culturally adapted tea-breath ritual was implemented as a brief, five-minute grounding technique at both the start and end of each session. At the beginning, it **supported emotional settling and safe arrival through guided breathing and sensory awareness embedded within the familiar practice of tea preparation**. At the conclusion of sessions, the same ritual was used to promote emotional regulation and closure, enabling participants to transition out of the session in a calm and contained manner.

Breathing-with-movement technique:

This is a culturally adapted breathing-with-movement technique that was used as a brief, five-minute grounding activity at the start and end of each session with men. **The practice combined simple, participant-selected physical movements** (i.e., standing, gentle stretching, walking-in-place) with paced breathing, introduced without therapeutic or clinical language, to support focus, regulation, and readiness to engage. Emphasis was placed on **physical action, simplicity, and everyday bodily experience rather than reflection or emotional disclosure, with instructions framed around strength, steadiness, and readiness rather than mental health or trauma**.

At the end of sessions, the same technique was used to support discharge and containment, enabling participants to leave the group feeling physically settled. Importantly, these practices were not generic mindfulness add-ons but culturally adapted safeguarding controls, co-designed with participants to reduce the risk of re-traumatisation in group settings, where emotions can otherwise be amplified.



✓ Gender-specific safeguarding adaptations

The group of women required explicit attention to the possibility of Gender-Based Violence histories, coercive control, and social risks of disclosure within their communities (Ludt et al., 2022; Borges, 2025). Safety was enhanced when activities emphasised relational trust, dignity, and culturally familiar rituals, while avoiding pressure to share personal trauma narratives.

Men's groups required a different safeguarding lens: emotional vulnerability often carried heightened shame, and "talking about feelings" could be culturally referred to as weakness. Safeguarding therefore included a deliberate prevention of forced verbal processing. Instead, the protocol framed emotional work through culturally acceptable methods: action, skill, contribution, and peer solidarity. This was not avoidance; it was an equity adaptation to enable access.

3.2. Co-designed pilot early-intervention models and findings

The pilot tested a set of group therapeutic activities co-designed with participants:

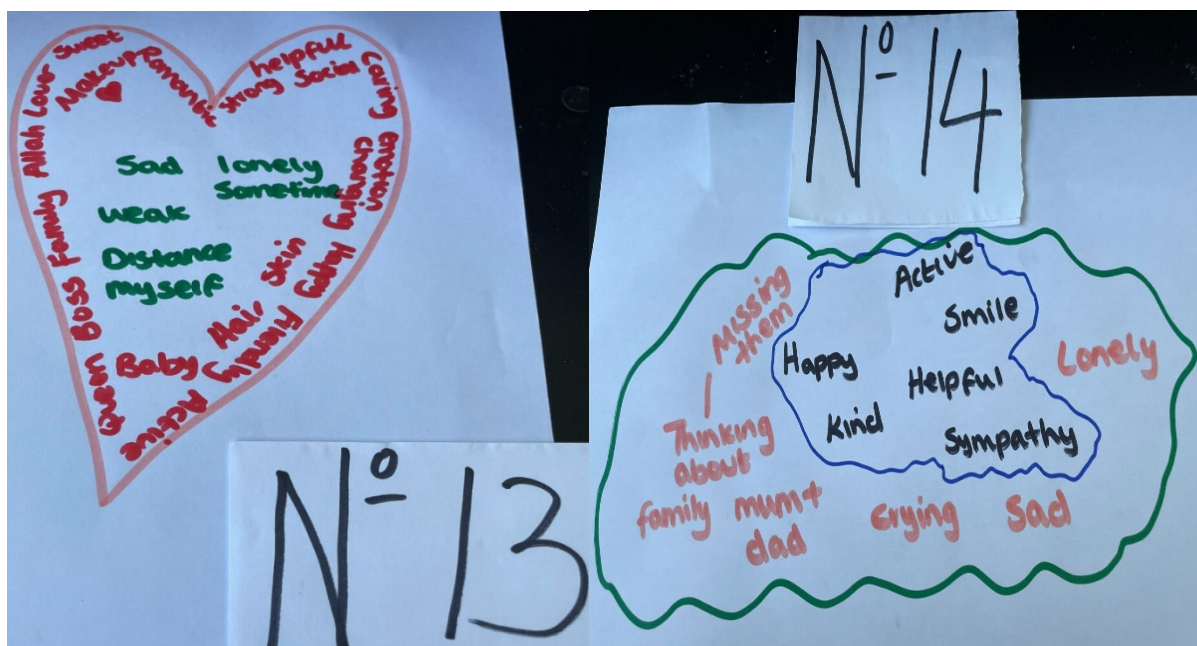
Model 1: The Self-Portrait of strength (identity reconstruction through self-portrait)

This model was used as a foundational activity in both groups, self-portrait supported self-identification across multiple life domains, not only trauma. Although encouraged to focus on positive identity, all participants found it difficult to ignore what they described as "dark zones" and included perceived weaknesses and less valued aspects of self. When sharing, participants discussed both facets and often expressed relief at being able to hold complexity without judgement.

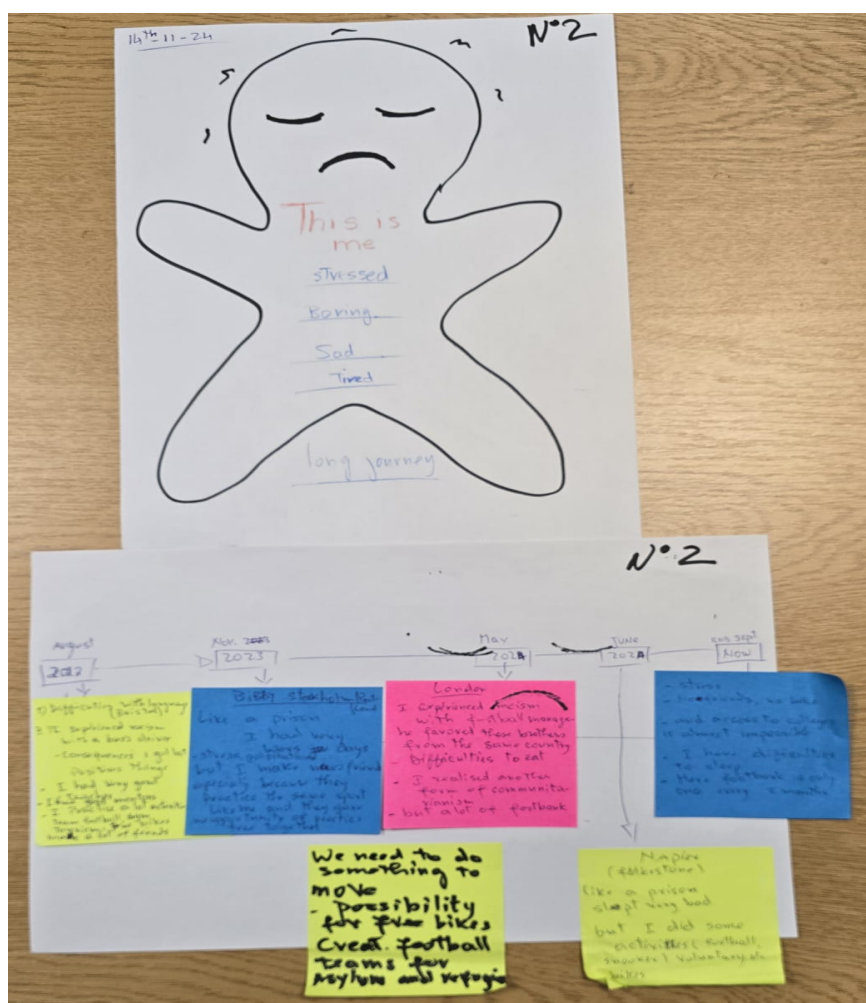
This finding is significant. It suggests that exclusively positive reframing may feel invalidating in contexts of ongoing adversity. Trauma-informed identity work must allow contradiction and ambivalence, supporting integration rather than enforced optimism.

As a low-intensity psychosocial intervention, it complements stepped-care principles and supports wellbeing, self-efficacy, and social functioning outcomes.





Picture taken from women participants during the Self-Portrait Circle - Pilot Early Intervention



Picture taken from a man participant during the Self-Portrait Circle - Pilot Early Intervention



Model 2: The Shared Cup Circle (cultural food ritual as group therapy)



This model uses tea/food preparation and sharing as a structured therapeutic container. Cross-culturally, food rituals communicate safety, welcome, respect, and belonging; they also provide sensory grounding that can regulate encouragement without requiring verbal disclosure. For women participants, this approach mirrored familiar practices of communal care and offered a non-clinical route into connection.



Pictures taken during the Shared Cup Circle - Pilot Early Intervention Group workshop

The therapeutic method is not “food” itself; it is the restoration of agency and dignity through hospitality and mutual care. Safeguarding required attention to dietary and religious practices, and trauma-linked aversions; participation must never be liable to eating.

As an engagement-first model, it supports NICE (2018) priorities around access and culturally appropriate care and contributes to public health outcomes related to loneliness and social connection.



Model 3: Voices without Borders (multilingual empowerment song circle)

Participants co-created and recorded a collective song using phrases from their own languages, centred on strength, survival, and hope. Singing and rhythm are globally recognisable communal practices used in worship, protest, celebration, and mourning. Safety depends on consent and choice: vocal participation is optional; participants are supported to share without being placing them on the spot. They can contribute with words, rhythm, vibrating, or silent witnessing. The content is intentionally strengths-based to reduce risk of trauma activation.

Interpretation of the following lyrics from a famous song was co-produced in five different languages:, sang by all women in the Group.

English:

*'We shall overcome,
We shall overcome,
We shall overcome, some day.
Oh, deep in my heart,
I do believe
We shall overcome, some day.'*

Arabic:

سوف ننتصر يوماً ما.
آه، في أعماق قلبي أؤمن،
سوف ننتصر يوماً

Somali:

“Waan guuleysan doonnaa,
Waan guuleysan doonnaa,
Waan guuleysan doonnaa, maalin maalmaha ka mid ah.
Oh, qalbigayga gudihisa,
Waan rumeysanahay si dhab ah
Inaan guuleysan doonnaa, maalin maalmaha ka mid ah.”

Urdu:

“Hum honge kaamyab,
Hum honge kaamyab,
Hum honge kaamyab, aik din.
Mere dil ki gehraai mein,
Hai yeh pukhta yaqeen,
Hum honge kaamyab, aik din.”

French:

“Nous triompherons,
Nous triompherons,
Nous triompherons, un jour.
Oh, au fond de mon cœur,
Je crois vraiment
Que nous triompherons, un jour.”



This model aligns with NICE (2018) principles around language and culture (participants retain linguistic ownership rather than being “translated into” a clinical frame) and supports wellbeing and connection outcomes (PHOF, 2025).

Model 4: The Safe Container Workshop (boxes as symbolic containment)



Women adapted this model into a two-layered therapeutic structure. The *inside* of the box was used to contain memories and emotions they had never shared or had been unable to share verbally due to cultural unsafety, fear of being misunderstood, or lack of appropriate audiences. The act of containment itself was experienced as therapeutic, restoring control over what had previously felt overwhelming or silenced.

The *outside* of the box was deliberately used to display empowering memories, hopes, strengths, and coping resources. Sharing the outside first generated joy and vitality, laughter, singing, collective pride, future-oriented hope, and enabled women to experience themselves as agents regardless of immigration status.

A later session invited optional sharing of selected internal content. This session was emotionally intense and included collective crying, silence, singing, and, at times, vocal release. Women had agreed from the outset that such expression was culturally acceptable and necessary. Participants framed this as communal witnessing and ventilation, describing relief after long periods of isolation.



Picture taken during the Safe Container - Pilot Early Intervention Group workshop



This model illustrates that trauma-informed care does not require the absence of emotion; it requires containment, consent, pacing, and culturally adapted agreements. It is a clinically sensible stepping-stone for trauma work because it advocates approaching emotion safely rather than being submerged, while meeting women identified need for communal expression.

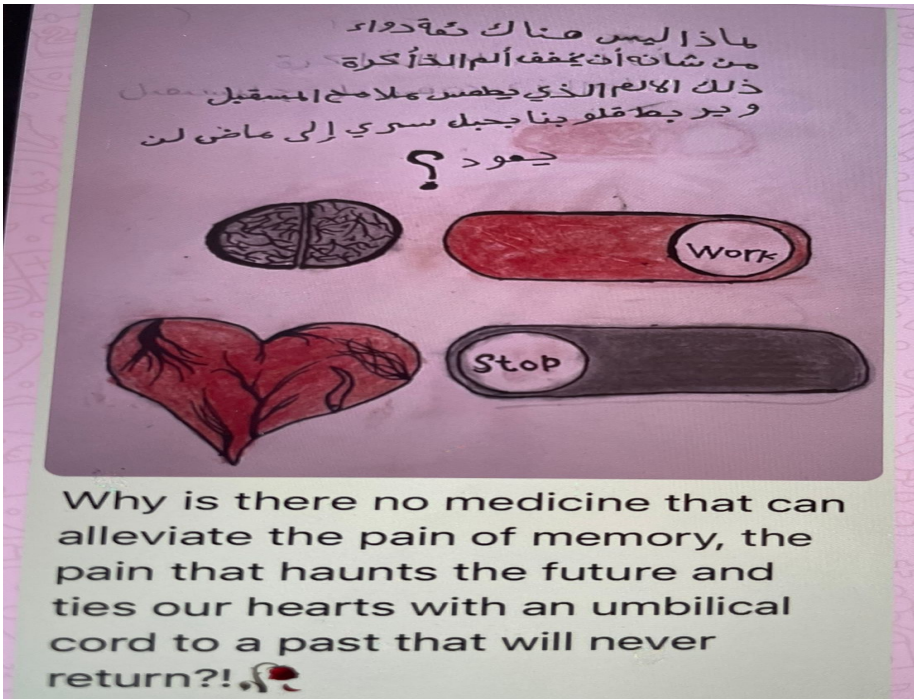
Model 5: The Men’s Ground Circle (men-only creative talking group)



This model was coproduced explicitly to address men identified difficulties with conventional talking therapies. It was a men-only group structured around themes such as purpose, strength, fatherhood, dignity, loss, and rebuilding. Drawing and writing were strongly perceived as essential means of communication, with emotions often first expressed through body language, creative output, and short reflective sharing.

The key insight from men’s feedback was not that they “refuse therapy,” but that dominant therapy formats can conflict with cultural expectations and shame dynamics. Creative mediation reduced pressure for immediate vulnerability and allowed emotional literacy to develop indirectly. This made the group an acceptable bridge into support. This model also aligns with NICE (2018) expectations about improving access where language and culture create barriers, and with NHS inequalities priorities under Core20PLUS5.

Model 6: Hands speak First (drawing/writing as gateway to words)



Drawing from a participant to the Hands speak First - Pilot Early Intervention Group workshop



This model formalises what men reported: visual or written expression makes it easier to talk. The session structure positions creativity as the primary language, and speech as optional. The ethical risk is inadvertent exposure; facilitators therefore use protective prompts and normalise silence. This supports NICE (2018) PTSD principles around adapting care where language/culture create barriers and improves engagement, an essential outcome under inequalities programmes.

4. Feasibility, system alignment and commissioning context

NICE (2018) guidance encourages flexible, culturally responsive delivery of care, particularly for those with complex needs, or where language and stigma create barriers. The co-designed early intervention models in this project are not substitutes for trauma-focused therapies but align with NICE guidelines' suggestions around avoiding stigma and **tackling health inequalities affecting vulnerable people with protected characteristics, including refugees, asylum seekers, and illegal immigrants (NICE 2018).**

The piloted co-designed therapeutic activities further support the NHS **Core20PLUS5** priorities that identifies and addresses in England (NHS England, n.d.; Brennan, 2024) and strengthens community-based support, including social prescribing approaches that focus on “what matters to me” and coproduced plans (NHS England, 2020). Finally, they map onto public health outcomes, especially **loneliness, social isolation and wellbeing**, tracked through PHOF-style indicators and commentary (PHOF, 2025).

Within this context, the programme was designed as a community-anchored, culturally flexible, trauma-informed pathway that can:

1. Reduce distress through co-regulation
2. Improve engagement and retention
3. Address inactivity and isolation
4. Build readiness for onward referral
5. Increase confidence and peer support



5. Feasibility, acceptability and early outcomes of the pilot intervention

The pilot aimed to test whether co-produced activities could be delivered safely and acceptably and whether they supported outcomes relevant to clinical pathways. Feasibility was demonstrated through sustained attendance, absence of safeguarding incidents, and strong participant endorsement. Acceptability was evidenced by repeated requests for continuation and recommendations for long-term provision.



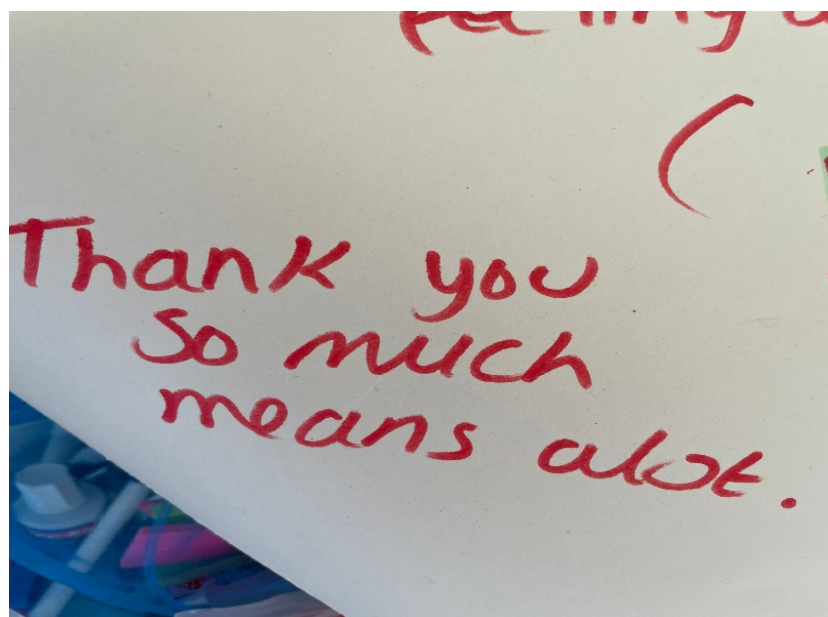
Participants reported **emotional relief, reduced isolation, improved regulation, renewed hope, and increased readiness to engage with further support.**

Gender-differentiated pathways were evident: women entered emotional processing through relational rituals; men engaged through activity-based approaches. These findings substantiate earlier insights from Objectives one and two and extend them into applied intervention design.

Evaluating Objective Three

Objective Three demonstrates that a co-produced, culturally adapted early-intervention model can be delivered safely and acceptably within a community setting for asylum seekers in Blackburn with Darwen. The pilot confirms feasibility, safeguarding integrity, and psychosocial benefit, while highlighting the risks associated with discontinuity and short-term provision. Importantly, the intervention functions not as a replacement for NICE-recommended trauma therapies but as a stabilisation and engagement pathway that addresses the gap between arrival and access to statutory services.

Objective Three therefore moves the project from insight to intervention, offering an empirically grounded and practice-ready framework aligned with trauma-informed principles and local inequalities priorities.



Written by women who took part in the Pilot Early Intervention Group workshop



OVERALL CONCLUSION



This evaluation examined how trauma and mental wellbeing are understood and addressed within the asylum-seeking community in Blackburn with Darwen, and how local systems can respond more equitably. Across three staged and co-produced objectives, the study demonstrates that effective trauma-informed practice in asylum contexts requires an integrated approach combining awareness, workforce capability, and culturally adapted early intervention.

Objective One showed that trauma awareness cannot be assumed or delivered through conventional psychoeducation alone. Creative, non-verbal approaches enabled recognition of trauma while preserving agency and safety, but awareness without accessible support pathways risks increasing distress.

Objective Two demonstrated that staff confidence improves when training is contextualised and grounded in lived experience. However, sustainable trauma-informed care depends on organisational supervision, safeguarding structures, and system alignment, not individual competence alone.

Objective Three evidenced that a co-produced, art-based, gender-informed early-intervention model can be delivered safely and acceptably within a community setting. The pilot supported emotional regulation, reduced isolation, and strengthened readiness for further support. Gender-responsive adaptations were central to equitable engagement. The model addresses the gap between arrival and access to statutory mental health services and complements, rather than replaces, NICE-recommended therapies.

Collectively, the findings indicate that asylum seekers' mental wellbeing is **shaped by both trauma exposure and ongoing structural stressors**. The Healing Canvas project provides practice-based evidence that integrated, community-embedded, and culturally responsive early-intervention pathways are feasible and aligned with inequalities and public health priorities.

This report offers a robust foundation for commissioning sustained, gender-informed trauma pathways in Blackburn with Darwen, with potential for wider adaptation. The evidence now supports system-level commitment to embed and sustain what has been demonstrated locally.



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