# Health and wellbeing - challenges and recommendations for New Scots integration

Chapter extract from ‘The New Scots Refugee Integration Strategy: A report on the local and international dimensions of integrating refugees in Scotland’.

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# Terminology and list of abbreviations

In line with Scottish Government policy, this report uses the term ‘New Scots’ to refer to: individuals and family members who arrive in Scotland under various refugee resettlement schemes; people who are claiming asylum and resident in Scotland; individuals who receive refugee status or another form of leave such as Humanitarian Protection or Discretionary leave and their family members; people who arrive in Scotland to be reunited with a family member who is a refugee; young people who are claiming or have claimed asylum or have been trafficked into the UK. The New Scots Refugee Integration Strategy is also relevant to other displaced groups such as survivors of human trafficking and people who are stateless.

BAME – Black, Asian and Minority Ethnic

COSLA – Convention of Scottish Local Authorities

LA – Local Authority

LtR – Leave to Remain

NGO – Non-Governmental Organisation

NHS – National Health Service

NSRIDP – New Scots Refugee Integration Delivery Project

NSRIS 2 – New Scots Refugee Integration Strategy (second iteration)

SRC – Scottish Refugee Council

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# Introduction

This publication is a chapter extract from ‘The New Scots Refugee Integration Strategy: A report on the local and international dimensions of integrating refugees in Scotland’.[[1]](#footnote-1) In the main report, we provide interpretive frameworks through which integration can be understood, a comprehensive overview of research findings concerning refugee integration in Scotland, and a series of recommendations to inform the development of the third iteration of the New Scots Refugee Integration Strategy. The findings and recommendations presented in this chapter are based on academic research conducted by the University of Glasgow as part of the New Scots Refugee Integration Delivery Project (NSRIDP), a partnership project led by the Scottish Government with the Convention of Scottish Local Authorities (COSLA), the Scottish Refugee Council (SRC) and the UNESCO Chair in Refugee Integration through Languages and the Arts (RILA) at the University of Glasgow. The project sought to expand good practice and innovation in the context of integration in Scotland, as well as conduct primary research on refugee integration in Scotland to support the development of the third iteration of the New Scots Refugee Integration Strategy (NSRIS).

This chapter extract is focused on the health and wellbeing challenges that New Scots face

which are directly related to their circumstances as people seeking sanctuary in the UK. The reasons for ill health amongst New Scots, and mental ill-health in particular, are numerous and stem in considerable part from the immobilising effects of the asylum process and the housing and support policies adopted by the UK government. In order to ensure the health and wellbeing of New Scots, the NSRIS 2 aimed to ensure that:

* Refugees and asylum seekers understand their rights, responsibilities and entitlements, and are able to exercise them to pursue full and independent lives.
* Refugees and asylum seekers are able to access well-coordinated services, which recognise and meet their rights and needs.
* Policy, strategic planning and legislation, which have an impact on refugees and asylum seekers, are informed by their rights, needs and aspirations.[[2]](#footnote-2)

# Health and Wellbeing

*“Because we’re talking about dignity, and we’re talking about valuing people, people’s life and I think that’s it’s really important.” (Hakim, community group)*

Waiting for asylum claims to be processed involves separation from mainstream society with regular interaction with the Home Office and its ‘culture of disbelief’.[[3]](#footnote-3) The time spent waiting for an asylum claim to progress through the abovementioned stages has been continuingly increasing, with an almost tenfold increase between 2010 and 2020.[[4]](#footnote-4) For each additional year spent waiting for an asylum decision, research has found that a person’s likelihood of obtaining available social support decreased by 12-14%.[[5]](#footnote-5)

*“The long waiting times for decision making - you’re talking about a year wait, two-year wait […] and people are stuck in a system, so we don’t want people to be waiting until they become refugees to access those services because it’s mental like. What the actual wait does to people, is actually, it’s mental” (Hakim, community group)*

Poor housing conditions within the asylum system are consistently linked to ill-health.[[6]](#footnote-6) Aside from the substandard quality of housing provided, the instability concerning housing – including regular movements, being housed on a no-choice basis without the ability to onward migrate or choose where to live, and the likelihood of losing housing and financial support following an initial refusal – all add to feelings of uncertainly related to lack of stability, fear and insecurity.[[7]](#footnote-7) People seeking asylum are also often housed with people they don’t know, many of whom are also enduring similar hardships and instability. Moreover, people are often housed in areas with little history of immigration and where incidents of racism directed at New Scots increase feelings of insecurity.

The support that New Scots receive while claiming asylum is less than standard income

support; this leaves people seeking asylum ‘locked into poverty’.[[8]](#footnote-8) Such poverty has direct effects on peoples’ physical and mental health. Physically it reduces the amount of healthy food that can be consumed, the number and variety of activities that people can partake in and creates practical problems for people seeking to travel anywhere beyond their place of accommodation.[[9]](#footnote-9) Poverty also reduces mental wellbeing, as it inhibits the creation of strategies for problem resolution and exacerbates isolation.[[10]](#footnote-10)

Furthermore, as a result of limited opportunities and poverty while seeking asylum, New Scots are unable to form intimate relationships with others from the receiving community, and few have the opportunity to develop reciprocal relationships.[[11]](#footnote-11) This goes against the aim of ‘integration from day one’ set out in the NSRIS. Because of enforced poverty, many people seeking asylum in Scotland are also deprived of opportunities for altruism which undermines their sense of self-esteem, purpose, belonging and mental well-being.

Research has also uncovered consistent pattern of ‘a dramatic emotional dip’ experienced by new refugees for a number of months shortly after receiving refugee status.[[12]](#footnote-12) Reasons for this dip include coming to terms with health problems that have previously been put on hold; being moved from their asylum accommodation to short term hostel accommodation; the financial complexities of the move-on period; loneliness; family separation and concern for family members; and pressure from Jobcentre Plus to find work immediately and not lose access to new support mechanisms:

*“Even after you get a status, the status itself, it’s another world […] it’s another challenge of you being in a system where you’ve been de-skilled, everything taken from you, you’re not in control of everything, not on your house, not on your heating, not on your expenses, not on everything. And once you’ve been left one day, take a decision, go and manage your own house, your own bills, your own things, everything in your life that people never had the experience of doing it.” (Hakim, community group)*

It is important to remember that New Scots have travelled to Scotland seeking safety from

dangerous and traumatic situations. Very often the journeys made to safety also involve

danger and further trauma. To this can be added the trauma inherent in experiencing the

‘hostile environment’ of the UK asylum and immigration system as it currently stands.[[13]](#footnote-13)

Trauma and its consequences are critical considerations in the context of health and wellbeing of New Scots. While many re-traumatising aspects of the asylum system are currently related to policy reserved to the UK Parliament, there are aspects of life for New Scots which can be improved through pathways related to powers reserved to the Scottish Parliament - such as healthcare, education and social care (see Recommendations below).

Regaining and maintaining trust is a key element in the process of healing from trauma as

well as in relationships between citizens, institutions and communities.

Gendered aspects of health and wellbeing also add to the uneven access to healthcare

for New Scots. In particular, single women with children are both more likely to suffer from

mental ill-health and to be affected by poor childcare and transport provision.[[14]](#footnote-14) For women who are pregnant and going through childbirth in Scotland, intercultural communication around expectations is key, as well as awareness and sensitivity among healthcare staff of issues related to FGM or other gender-based violence which may have been experienced by female New Scots.

In terms of referrals within the healthcare system, and support in understanding how the NHS works, research respondents spoke of a “local authority lottery”. In these cases, access

to healthcare for New Scots depends on where they are sent to live, on their social networks, on language barriers and on advocacy availability:

*“But quite often, it’s also about whether you have good Arabic-speaking support staff, who can help you get that referral from your GP as well. You know what I mean? You sometimes need that advocate, to get through that. Because everybody would be eligible for it, but it’s just getting there, isn’t it?” (Eleanor, Local Authority)*

Intercultural communication of how healthcare systems work, and of cultural expectations of healthcare, are key in managing relationships and expectations between New Scots and

healthcare providers. New arrivals in Scotland may not be aware of how the NHS works, what is available, the referral system between GPs and specialists, how to access services and how to communicate preferences. Conversely, service providers may not be aware of the healthcare entitlements of asylum seekers and refugees or of healthcare systems and expectations in the people’s cultures or countries of origin.[[15]](#footnote-15) Intercultural communication of idioms of distress is also a critical element in the interaction between New Scots patients and healthcare providers, with issues such as depression, trauma and anxiety being processed and communicated differently in different cultures.

# Recommendations

* Culturally informed training should be delivered to healthcare practitioners, with emphasis on intercultural communication practices (see best practice model from GRAMNet).
* Embed, at all levels and specialisms of healthcare provision, a trauma-sensitive approach to working with New Scots. This includes increasing awareness of the many complicating and re-traumatising issues which affect New Scots in their access to healthcare.
* Ensure that translation and interpreting services are better informed and aware of issues related to confidentiality and trust.
* Increase awareness across all sectors of gender-related issues relevant to New Scots and access to healthcare.

1. The full report can be accessed at <https://www.gla.ac.uk/media/Media_900243_smxx.pdf> [↑](#footnote-ref-1)
2. Scottish Government. (2018a), pp. 61-62. New Scots: Refugee Integration Strategy 2018 – 2022.

   Retrieved from: https://www.gov.scot/publications/new-scots-refugee-integration-strategy-

   2018-2022/ [↑](#footnote-ref-2)
3. Kearns, A., Whitley, E., Egan, M., Tabbner, C., & Tannahill, C. (2017). Healthy Migrants in an Unhealthy City? The Effects of Time on the Health of Migrants Living in Deprived Areas of Glasgow. *International Migration & Integration*, *18*, 675–698. [↑](#footnote-ref-3)
4. Refugee Council. (2021). Thousands seeking asylum face cruel wait of years for an asylum decision – fresh research shows. Online publication (2nd July 2021). Available at: <https://www.refugeecouncil.org.uk/latest/news/thousands-seeking-asylum-face-cruel-wait-of-years-for-asylum-decision-fresh-research-shows/> [↑](#footnote-ref-4)
5. Kearns, A. and Whitley, E. (2015). Getting There? The Effects of Functional Factors, Time and Place on the Social Integration of Migrants. *Journal of Ethnic and Migration Studies*, *41*(13), 2105–2129. [↑](#footnote-ref-5)
6. See Housing chapter in the main report (<https://www.gla.ac.uk/media/Media_900243_smxx.pdf>) [↑](#footnote-ref-6)
7. Strang, A., Baillot, H., & Mignard, E. (2015). *Insights into Integration Pathways: an evaluation of year two of the Holistic Integration Service*. Scottish Refugee Council Report. Retrieved from: <https://eresearch.qmu.ac.uk/bitstream/handle/20.500.12289/4140/eResearch%25204140.pdf?sequence=1&isAllowed=y>; Stewart, E. and Shaffer, M. (2015). *Moving on? Dispersal policy, onward migration and integration of refugees in the UK.* University of Strathclyde; Fisher, D.X. (2018). *The Border Enacted: Unpacking the everyday performances of border control and resistance.* PhD thesis. University of Edinburgh. [↑](#footnote-ref-7)
8. Asylum Matters. (2020). *Wake Up Call: How government contracts fail people seeking asylum*. Retrieved from: <https://www.refugee-action.org.uk/wp-content/uploads/2020/07/Wake-Up-Call-2020.pdf> [↑](#footnote-ref-8)
9. *Ibid;* Quinn, Neil. and Strang, A. (2014). *Integration or isolation? Mapping social connections and well-being amongst refugees in Glasgow.* Report. Retrieved from: <https://eresearch.qmu.ac.uk/bitstream/handle/20.500.12289/4139/eResearch%25204139.pdf?sequence=1&isAllowed=y> [↑](#footnote-ref-9)
10. ibid. [↑](#footnote-ref-10)
11. *Ibid.* [↑](#footnote-ref-11)
12. Strang, A., Baillot, H., & Mignard, E. (2015) [↑](#footnote-ref-12)
13. Pollard, T. and Howard, N. (2021) Mental healthcare for asylum-seekers and refugees residing in the United Kingdom: A scoping review of policies, barriers, and enablers, *International journal of mental health systems, 15*(1), 1–60; Mulvey, G. (2014). Refugee Integration Policy: The Effects of UK Policy-Making on Refugees in Scotland. *Journal of Social Policy*, *44*(2), 357–375. [↑](#footnote-ref-13)
14. Fassetta, G., Lomba, S. Da, & Quinn, N. (2016). *A Healthy Start? Experiences of pregnant refugee and asylum seeking women in Scotland*. British Red Cross and University of Strathclyde. [↑](#footnote-ref-14)
15. Da Lomba, S. and Murray, N. (2014), Women and Children First? Refused Asylum Seekers’ Access to and Experiences of Maternity Care in Glasgow. Retrieved from: <https://www.scottishrefugeecouncil.org.uk/wp-content/uploads/2019/10/Women-and-Children-First-Refused-asylum-seekers%E2%80%99-access-to-and-experiences-of-maternity-care-in-Glasgow-Executive-Summary.pdf> [↑](#footnote-ref-15)