ScotPHN report

Scottish Public Health Network (ScotPHN)

Improving the Health of Migrants to Scotland:

An update for Scottish Directors of Public Health

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Foreword

The Scottish Public Health Network has developed this document to support public health practitioners working locally to meet the needs of migrant and asylum seeker populations. It provides an overview of migration in Scotland including the current issues in migrant health and areas for potential development and action by NHS Boards.

Migrants make up a variety of diverse, small populations. Therefore NHS Boards will wish to understand the characteristics of individual groups (age, gender, ethnicity, SES and so forth) in order to anticipate and meet their needs. Person-centred care means sensitivity to address need relating to many characteristics, not least migrant status and what that may entail.

The numbers of migrants coming to Scotland are relatively small, and the picture is constantly changing. NHS Boards should be aware that there are limitations to the data available at local level. In addition, NHS Boards must learn to co-operate and network across boundaries to ensure effective learning on migrant health nationally.

One area of particular concern that this report flags is the mental health of asylum seekers and refugees, especially women. The Scottish Migrant and Ethnic Health Research Strategy Group (SMEHRS), a well-established public health resource, is specifically focussing its research on this issue in the coming year.

Local NHS Boards will wish to assess the make-up of their own local migrant populations, focussing on those who are most vulnerable, and seeking to meet their needs. This report provides a helpful starting point.

Andrew Fraser
Director of Public Health Science, NHS Health Scotland

Executive Summary

In 2009 the Scottish Public Health Network (ScotPHN) produced its Migrant Health Action Resource (1) . This focused on local service and research resources and has been recently revised following its transfer to the new ScotPHN website. However, in recent years work by the Scottish Migrant and Ethnic Health Research Strategy Group (SMEHRS) group and by CoSLA on its Migration Matters resource, amongst others, has overtaken the original ScotPHN work.

In this report we focus on providing an update to the Scottish Directors of Public Health (SDsPH) on current themes and issues in migrant health in Scotland and identify areas for possible development / action within Health Boards. The report is divided into four sections:

1. Describing Migration

- Migration comes in waves. As such it is likely to be of considerable importance to understand the local make up of any migrant population, how long they have been within Scotland, the reasons for the migration, and the social and cultural expectations that were translated with the population in seeking to describe the health needs of the population.

- Migrants into Scotland may be defined as:

  "Those who have come to the UK within the last five years specifically to find or take up work, whether intending to remain permanently or temporarily and whether documented or undocumented." (2)

  However, other definitions are commonly used and care should be taken in any discussion that the terms used to define "Migrant" are transparent and agreed between agencies.

- It is not possible to simply define migrants or to consider them to be a homogeneous group for which a single solution to meet health needs is likely to be possible. Consideration needs to be given to identifying which migration communities have settled in a given Health Board area and generate community specific health care needs assessments.

- In the UK, an asylum seeker is defined as someone who has lodged a formal application for protection on the basis of the Refugee Convention or Article 3 of the European Convention on Human Rights.

2. An epidemiological overview of migration in Scotland

- Historically, Scotland has been a country of outward migration. However, in 2013-14 immigration reached 17,600 people which is the biggest increase since 2006-07.

- The most common countries of birth outside of the UK for people resident in Scotland at the time of the 2011 census (3), were Poland, India, Republic of Ireland, Germany, Pakistan, United States, China, South Africa, Nigeria, Canada, Australia, Hong Kong, France, Italy and Spain in descending order of population size.

- At the 2011 Census, the vast majority of migrants reported being in good or very good health, although established migrants (i.e. usually older) were more likely to report poorer health.

- In the year ending March 2015, the top five countries from which asylum seekers to the UK came were: Eritrea (3,552 applied, 85% protection granted); Pakistan (2,421, 22%); Syria (2,222, 85%); Iran (2,000, 56%); and Sudan (1,603, 79%). In the same year, on average one in four asylum applicants also sought asylum for dependents. Applications from unaccompanied asylum-seeking children to the UK, number 1,986.

- The data on asylum seekers does not include routine published data on the health of asylum applicants or their dependants.

- There is little routine data that can be used to directly assess the health needs of migrants. Significant work is needed to ensure a consistency of definitions across Scotland. Data linkage may provide a way forward, but work will be needed to enhance the existing technical fixes that can identify ethnicity, so they can delineate migrant status.

- The Scottish Health Ethnicity Study (SHELS) looks at the relationship between ethnicity and health; there may be overlap with issues of migrant health. Phase 4 of SHELS work will be completed in the summer of 2016.

- A nationally developed health need assessment template may be need to be developed to allow consistency of local data collection and synthesis.

3. Key themes from the updated literature review

- Migrants tend to be relatively healthy and, whilst there are issues with accessing services, their general health is comparable with that of their home populations. Attitudes towards risky health behaviours remain much the same and only slowly change over time. How far these health needs change as the migrant becomes more socially integrated is variable.

- For asylum seekers, mental health needs and the long-term consequences of trauma, both physical and mental, are major health needs which may need to be met. These are not helped by the way in which they are subject to the asylum processes. Those provided with forms of protect are then subject to relocation, often in national groups, which can be a further cause of social dislocation and isolation. These may perpetuate existing health needs.

- What is clear is that the health needs of migrant and asylum seeker populations should not be conflated. The needs of migrants in a local area will be highly dependent on the composition of the local migrant population.

4. Accessing web resources to support local action.

- In the years since the publication of the ScotPHN Migrant Health Action resource, the resources available to Health Boards has increased, albeit with identified problems. This report therefore only updates what was needed and signposts what is now available elsewhere in support of assessing the health needs of people who are migrants.

- One area which has been updated is the links to useful web-based resources for identifying health needs and data. In addition to the websites on sources of data, the most useful ones which this work has identified are listed in Section 5.

1 Background

Providing effective approaches to the meeting the health and health care needs of migrant populations has been a public health challenge since before the first consolidated legislation on Public Health was enacted in Scotland in the mid-19th century. Now, as we are well into the second decade of the 21st century, the drive to understand and meet the needs of such migrant populations remains a concern for public health agencies.

In 2009 the Scottish Public Health Network (ScotPHN) produced its Migrant Health Action Resource (1). This focused on local service and research resources and has been recently revised following its transfer to the new ScotPHN website. However, in recent years work by the Scottish Migrant and Ethnic Health Research Strategy Group (SMEHRS) and by CoSLA, amongst others, has overtaken the original ScotPHN work, so in this report we focus on providing an update to SDsPH on current themes and issues in migrant health in Scotland and identify areas for possible development / action within Health Board areas.

The information contained within this report was derived from a series of specific exercises aimed at identifying and reviewing significant areas of migrant health policy and research for Scotland. This involved:

- revisiting the previous literature search and proving a selective update on health needs and models of care (where required);
- identifying current policy and activity in the field of migrant health; and
- collaborating with the SMERHS group.

This was undertaken during mid 2015 by ScotPHN staff.

The report is divided into four sections:

1. describing migration;
2. an epidemiological overview of migration in Scotland
3. key themes from the updated literature review; and
4. accessing web resources to support local action.

2 Describing Migration

2.1 Patterns of Migration

Population migration into (and from) Scotland has been a constant feature of the social background though-out the late 19th and 20th century. As is the nature of migration, there has been both a background level of migration, punctuated by more specific "waves" of migrants which bring larger number of migrants in a short time period.

Notable amongst these waves in Scotland are the migrations associated with European religious intolerance in the immediate pre- and post- World War II period, the enforced migration of Eastern European people in the immediate post-war period (notably amongst the Polish and Czech communities). From the late 1940s and into the 1950s, what has been background migration from Commonwealth nations (both from the West Indies and the Indian and new Commonwealth) accelerated into a significant migration wave.

Finally, the last major migration wave was associated with the European Union "A8" nationals from Poland, the Baltic States and the former Eastern bloc. Added to these waves of formal migration, there have been several large communities which have become resident in Scotland as refugees or in seeking "political" asylum. Notable amongst these groups have been the relocation of the Ugandan Asian community in the 1970s and the refugees from the conflicts in Somalia (late 1980s to 1990s) and Kosovo (late 1990s).

Against such a background it is likely to be of considerable importance to understand the local make up of any migrant population, how long they have been within Scotland, the reasons for the migration, and the social and cultural expectations that were translated with the population in seeking to describe the health needs of the population.

2.2 Defining "Migrant"

Given these patterns of migration, it is unsurprising that the term "migrant" is ill-defined, or rather over-defined. Even in everyday usage it can be used both for someone who was born outside the UK, but who has since become a British citizen, as well as a foreign any citizen, irrespective of how long they have been a UK resident

The International Organisation of Migration provides a very wide range of definitions for migrants, in varying in terms of legal status in and between countries. The SMEHRS has also looked at definitions. These are all set out in the appendix.

The main definition in use in Scotland though not the only one used in policy and research documents in Scotland) is that used by the National Records of Scotland agency. They define a migrant as:

""Those who have come to the UK within the last five years specifically to find or take up work, whether intending to remain permanently or temporarily and whether documented or undocumented." (2)

This is the definition which is used in this document. However, care should be taken in any discussion that the terms used to define "Migrant" are transparent and agreed between agencies.

What is clear, is that it is not possible to simply define migrants or consider them to be a homogeneous group for which a single solution to meet health needs is likely to be possible. What is more likely is that consideration would need to be given to which migration communities have settled in a given Health Board area and generate community specific solutions.

2.3 Defining Asylum Seekers

In the UK, an asylum seeker is defined as someone who has lodged a formal application for protection on the basis of the Refugee Convention or Article 3 of the European Convention on Human Rights (Refugee Council).

In principle, this could relate to any individual or group of any nationality. However, the UK Visa and Immigration section of the UK Home Office have detailed guidance on some 35 states on which Immigration officials may have to make asylum decisions (see: https://www.gov.uk/government/collections/country-information-and-guidance)

The health needs of asylum seekers represents a very specific case of Migrant Health and is not considered specifically in this document. Guidance on meeting the healthcare needs of Asylum Seekers moving *as a population group* (e.g. in the case of seeking safety outside of a war zone or escaping from persecution) has been published by the UK Faculty of Public Health (see http://www.fph.org.uk/uploads/bs_aslym_seeker_health.pdf). Guidance for medical practitioners regarding migrants seeking healthcare is available from Public Health England (see: https://www.gov.uk/guidance/assessing-new-patients-from-overseas-migrant-health-guide).

Since 2012 the Home Office contract for the provision of accommodation and associated services for refugees in Scotland has meant it is possible to accommodate refugees not only in Glasgow but across Scotland. This is now happening in the case of the Syrian refugees (4).

3 Epidemiological Overview

In this section of the report a brief overview of the sources of data on which to base a local epidemiological assessment is presented.

We also consider four major themes relating. These are:

- migration trends from National Records of Scotland;
- data on migration from the 2011 Scottish Census at Scotland and Council Area level;
- asylum seeker and refugee data (to 2015); and
- evidence gaps, limitations and caveats of data relating to migrants.

Asylum seekers and refugees have been considered separately as not only are they likely to present with more immediate healthcare needs, their legal status also affects their mobility, work practices and residency.

3.1 Sources of Routine Data

There are few routine sources of data on migrant health. This is not least because of the lack of an effective data system which records migration. As the Office for National Statistics (ONS) notes;

"There is no single, all-inclusive system in place to measure all movements of people into and out of the UK or to determine if they meet the definition of a long-term migrant." (5)

The ONS uses a combination of the International Passenger Survey (IPS), Home Office data, and the Labour Force Survey in order to estimate trends in migration. Migrants to Scotland in the ONS dataset is based on the Labour Force Survey (6). Other sources of migration data which are detailed below run into similar problems given that most measurement of trends is UK-wide (7). This holds true for the UK Census (2011) (8) and for some of the NHS Central Register (see below)

In Scotland the major sources of data are:

- Scottish Government – which publishes a number of bulletins on topics regarding migration (see: http://www.gov.scot/Topics/Statistics/Browse/Population-Migration);
- National Records for Scotland – which produces mid-year population estimates of which migration is a part and also trends and geographical distribution of migrants (see http://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/migration);
- Scottish Longitudinal Study – which uses data linkage approaches to create a data set that monitors trends in migration from routine administrative data (e.g. the 2001 census, the registers for births, marriages and deaths and the NHS Central register)
  (See: http://www.lscs.ac.uk/);
- NHS Scottish Central Register – the NHS Scottish Central Register records people resident in Scotland who are either born in Scotland and/or registered with the a GP. Using this as a source for migrant health will only catch those migrants who have registered with a GP or a local authority, so it is self-selecting (see: http://www.nrscotland.gov.uk/statistics-and-data/nhs-central-register);
- The Scottish Census 2011 – The Scottish Government has undertaken an analysis of the 2011 census in relation to migration (see: http://www.gov.scot/Resource/0047/00473606.pdf); and
- Home Office Migration Statistics – the UK Government publishes data from the UK Visas and Immigration (formerly UK Border Agency) on asylum seekers and the outcome of asylum applications. (See: https://www.gov.uk/government/collections/migration-statistics)

In using these data sources, care should be taken to note the variation in definitions used by each source. This means that it is difficult to give an entirely accurate picture of the migrant situation in Scotland.

3.2 Trends in International Migration

The National Records of Scotland uses the Long-Term International Migration Statistics, which are produced by the Office of National Statistics, in order to produce estimates of Long-Term International Migration to and from Scotland. In this instance, long-term is defined as for a year or more. Although various sampling techniques are used to alleviate the limitations of these surveys, the numbers can only ever be close estimates.

Figure 1: Trends in International Migration to Scotland 2001-2011

Source: National Health Service Central Register (NHSCR) patient movements, Office for National Statistics Long-Term International Migration, and the National Records of Scotland rebased international migration estimates for mid-2001 to mid-2011. From the year 2001-2002 onwards, the migration estimates do not include movements to/from the Armed Forces.

Historically, Scotland has been a country of outward migration; however, from around 2001 the trend has been for net immigration until 2010 when a downturn occurred. More recently, in 2013-14, net migration rose by 7,600 to 17,600 which is the biggest increase since 2006-07.

3.2 Data on Migration from the 2011 Scottish Census

The 2011 Scottish Census (3) provides the most comprehensive routine data set on the everyday circumstances of migrants in Scotland. Even then, as the census did not ask about British citizenship, it is not possible to determine which of those defined as migrants have become British citizens.

At the national level, the census shows that there were 369,284 Scottish residents who described themselves as migrants, representing 8% of the population. Of these some:

- 63% had arrived in Scotland in 2001 or after;
- 67% were migrants were from A8 countries, all of these migrants were younger than the population as a whole;
- 2% reported having no skills in English;
- 50% of all migrants lived in Glasgow, Edinburgh and Aberdeen Council areas and 81% lived in urban areas;
- 50% of all migrants had degree level qualifications;
- 62% of migrants aged 17-64 were economically active and in full-time employment;
- of those defined as economically inactive, the majority were students. Overall 1 in 3 migrants fell into the lower socio-economic groups;

The most common countries of birth outside of the UK for people resident in Scotland at the time of the 2011 census, were Poland, India, Republic of Ireland, Germany, Pakistan, United States, China, South Africa, Nigeria, Canada, Australia, Hong Kong, France, Italy and Spain in descending order of population size.

The vast majority of migrants reported being in good or very good health, although established migrants (i.e. usually older) were more likely to report poorer health.

Frequency data on migrants by local authority area, country of birth and the net inflow are show in Table 1 below.

At the census, those Local Authorities with the highest number of migrants born in other countries outside the EU were the City of Glasgow at 50,651, the City of Edinburgh at 42,787 and the City of Aberdeen 19,726. The City of Edinburgh Council had the highest number of immigrants from EU countries (both A2 and A8 combined) at 14,803, while the City of Glasgow had the highest number of migrants from outside the EU at 50,651. Across the country, there was no discernible pattern to the residence of migrants, save that smaller Local Authorities have smaller populations of migrants.

The final Inflow columns in the table relate to those who have migrated to Scotland in the last year according to the 2011 Census and is divided by gender. The total number of these “recent” migrants was 61,399 with a roughly equal split of 30,922 men and 30,477 women. As with country of birth, the largest numbers go to the major cities in Scotland: Edinburgh (16,202); Glasgow (12,625); ad Aberdeen (7,580); after which the number falls quite sharply for Dundee (2,974). Across the country the male to female split is fairly even with generally slightly more men than women.

Table 1: Migrants by Local Authority Area, Country of Birth and Inflow

Local Authority	Total Population	Country of Birth Other than UK by Council Area				Inflow		
		Republic of Ireland	Other EU: Member countries in March 2001	Other EU: Accession countries April 2001 to March 2011 (A2&A8)	Other countries	Lived elsewhere one year ago; outside the UK	Male	Female
	5,295,403					61399	30922	30477
Aberdeen City	222,793	1378	4840	9523	19726	7,580	3779	3801
Aberdeenshire	252,973	572	2484	5040	7009	2,299	1,209	1,090
Angus	115,978	250	863	1645	2491	622	340	282
Argyll & Bute	88,166	327	879	896	2218	606	287	319
Clackmannanshire	51,442	154	407	587	997	199	103	96
Dumfries & Galloway	151,324	456	1084	1183	2539	554	270	284
Dundee City	147,268	572	2203	2785	7705	2,974	1,585	1,389
East Ayrshire	122,767	251	605	331	1597	312	151	161
East Dunbartonshire	105,026	428	642	218	3236	333	169	164
East Lothian	99,717	490	1033	1133	2662	787	309	478
East Renfrewshire	90,574	406	549	261	3158	303	152	151
Edinburgh, City of	476,626	4743	13461	14803	42787	16,202	7,734	8,468
Eilean Siar	27,684	50	186	118	459	92	48	44
Falkirk	155,990	394	893	1450	2925	636	320	316
Fife	365,198	1032	4264	3919	11514	3,197	1,446	1,751
Glasgow City	593,245	4339	7219	10475	50651	12,625	6,650	5,975
Highland	232,132	681	2544	4361	5632	1,372	727	645
Inverclyde	81,485	212	484	167	1267	236	122	114
Midlothian	83,187	277	755	571	1761	280	130	150
Moray	93,295	217	1497	1205	1979	628	339	289
North Ayrshire	138,146	361	852	348	1902	485	236	249
North Lanarkshire	337,727	746	1200	3122	5080	893	487	406
Orkney Islands	21,349	34	197	109	382	99	52	47
Perth & Kinross	146,652	576	1709	3305	4645	1,630	902	728
Renfrewshire	174,908	685	1139	1418	4273	991	538	453
Scottish Borders	113,870	410	1288	1580	2702	645	331	314
Shetland Islands	23,167	158	181	357	500	213	141	72
South Ayrshire	112,799	383	898	541	2021	533	284	249
South Lanarkshire	313,830	991	1682	1584	6427	1,173	665	508
Stirling	90,247	360	1216	1002	3826	1,706	789	917
West Dunbartonshire	90,720	509	382	444	1514	245	134	111
West Lothian	175,118	510	1395	3773	4175	949	493	456

Source: Scottish Census 2011.

Frequency Data on migration for local authority area by age is shown in Table 2. In this table, migration relates to those “recent” migrants who lived outside the UK over one year ago, before the census. As numbers in some Local Authorities are small, the data has not been divided by sex.

At the census, the bulk of the recent migrant population was young, falling into either the 20-24 age group or the 25-34 age group. The number peaked at 20-24 and then decreased slightly before declining sharply beyond the age of 35. The number of migrants over the age of 65 was very small and was never into double figures for each local authority area. Overall there were 6,724 child migrants (ages 0-4 and ages 5-15), with the City of Edinburgh had the highest number of migrants under the age of four at 551. Child migration was higher than for those over the age of 50 (4,184).

Table 2: Recent Migrants by Local Authority Area and Age

Migration by Council area and by Age: People who moved into Scotland from outside the UK										
Council area	**All people**	**0 to 4y**	**5 to 15y**	**16 to 19y**	**20 to 24y**	**25 to 34y**	**35 to 49y**	**50 to 64y**	**65 to 74y**	**75y & over**
Scotland	61,399	2,646	4,078	4,757	19,282	18,562	7,690	3,310	727	347
Aberdeen City	7,580	436	621	639	1,953	2,389	1,135	366	26	15
Aberdeenshire	2,299	184	304	92	311	541	540	277	42	8
Angus	622	40	76	22	105	174	113	69	18	5
Argyll & Bute	606	31	59	21	82	172	113	93	26	9
Clackmannanshire	199	10	22	14	27	48	47	25	4	2
Dumfries & Galloway	554	40	40	19	108	154	98	68	16	11
Dundee City	2,974	74	91	259	1,285	934	222	74	23	12
East Ayrshire	312	33	40	6	42	78	72	37	3	1
East Dunbartonshire	333	20	36	8	54	94	69	34	10	8
East Lothian	787	26	67	91	243	198	85	56	15	6
East Renfrewshire	303	16	58	8	56	59	68	30	7	1
Edinburgh, City of	16,202	551	697	1,160	6,099	5,661	1,442	459	81	52
Eilean Siar	92	4	13	3	15	21	16	10	9	1
Falkirk	636	68	73	20	95	194	127	48	8	3
Fife	3,197	104	181	562	1,000	710	333	228	52	27
Glasgow City	12,625	442	601	1,022	5,018	3,972	1,155	294	68	53
Highland	1,372	74	121	44	204	432	268	154	57	18
Inverclyde	236	10	12	19	46	51	55	34	3	6
Midlothian	280	13	27	17	57	99	36	18	7	6
Moray	628	31	104	71	77	128	131	69	14	3
North Ayrshire	485	32	50	14	47	111	112	83	27	9
North Lanarkshire	893	61	121	33	135	245	196	72	19	11
Orkney Islands	99	4	8	2	15	34	20	9	5	2
Perth & Kinross	1,630	49	185	209	381	394	236	132	25	19
Renfrewshire	991	47	53	59	400	212	121	78	13	8
Scottish Borders	645	21	38	54	134	149	102	96	34	17
Shetland Islands	213	4	17	6	26	77	59	20	4	0
South Ayrshire	533	36	43	22	94	134	105	70	21	8
South Lanarkshire	1,173	66	102	59	190	341	249	116	39	11
Stirling	1,706	36	102	152	757	409	148	71	25	6
West Dunbartonshire	245	14	14	11	34	75	49	39	5	4
West Lothian	949	69	102	39	192	272	168	81	21	5

Source: Scottish Census 2011

Further data on migration to Scotland by NHS Board up to 2013-14 can be found at the National Records for Scotland.

3.3 Data on Asylum Seekers

The data on asylum seekers comes from UK Visas and Immigration, published by the UK Home Office in its Migration Statistics series. These data do not separate out asylum seekers relocated to Scotland or for whom Scotland is the first port of entry.

Table 3: UK Asylum Applications and Initial Decisions for Main applicants: 2010/11 to 2014/15

Year	All UK applications	Total initial decision*	No. (%) granted some form of protection**	No. (%) applications refused
2010/11	18,411	19,818	5,307 (27%)	14,510 (73%)
2011/12	19,826	16,970	5,778 (34%)	11,192 (66%
2012/13	22,635	17,561	6,592 (38%)	10,969 (62%
2013/14	23,803	15,151	5,435 (36%)	9,716 (64%)
2014/15	25,020	26,066	10,346 (40%)	15,720 (60%)

*Source: Home Office, Immigration Statistics. Asylum table as 01 q. Notes: *The number of total decisions is not a subset of the number of applications in a given year. ** Protection includes grants of asylum, humanitarian protection, discretionary leave, leave to remain under family life or private life rules, leave outside the rules and unaccompanied asylum-seeking children leave.*

Total UK applications for asylum (and other forms of protection) have been generally increasing over the last five years, with a 10% increase in those being offered some form of protection in the same period. These figures do need to be set in the context of the major policy shift in 2002 when full UK immigration controls were introduced in the French channel ports and subsequently in those in Belgium in 2004. In 2002 the number of asylum applications peaked in levels in excess of 80,000 applications.

In the year ending March 2015, the top five countries from which asylum seekers to the UK came were: Eritrea (3,552 applied, 85% protection granted); Pakistan (2,421, 22%); Syria (2,222, 85%); Iran (2,000, 56%); and Sudan (1,603, 79%).

In the same year, there were applications from 6,376 individuals who were dependents of main applicants; of these dependents 29% were granted some form of protection, with asylum being the most common decision (26%). Applications from unaccompanied asylum-seeking children to the UK, in the year to march 2015, were 1,986.

The data on asylum seekers does not include routine published data on the health of asylum applicants or their dependants.

3.4 Gaps and Limitations in Data on Migrant Health

Getting accurate data on the health and health care needs of migrants depends on being able to effectively identify who are within the migrant population. However, given the absence of accurate data by which the number or status of migrants in Scotland, even approaches such as data linkage will be problematic.

Ethnicity is often used as a proxy for migration. However, the absence of routine data on ethnicity in central registries (e.g. the NHS Central Register) is also a problem. Technical fixes – such as the use of name identification software on individual level data sets - to identify ethnicity may be of some use in the longer term. However, such approaches will not identify key features of migration that will affect health status and care needs.

In many cases research studies do not clearly delineate ethnicity and migration. For example, research on the black and minority ethic community in Scotland is likely to include migrants but will be unable to make the distinction between recent migrants, established first-generation migrants, or second generation migrants. Even data concerning migration from the A8 EU nations is not free from this problem as age data is needed to determine it a Polish migrant is part of the A8 migration or a second generation migrant from the wave of Polish migration in the late 19th century or a first-generation migrant from the mid-20th century.

Data for what is termed asylum seekers or refugees is difficult to quantify accurately and reliable data overall is hard to come by. The UK Home Office does not routinely provide figures separately for Scotland, and while Scottish local authorities may have data for those asylum seekers settled in their authority, the overall picture for l Scotland is difficult to find. The NHS Central Register is likely to have asylum seekers on their list, once the individual has appropriate residency permission and is registered with a GP. However the NHS Central Register does not record that an individual was a migrant or came to Scotland as an asylum seeker.

For asylum seekers, the process of claiming asylum creates a number of problems. Those in the process of applying for asylum have to leave to remain for 12 months. If they are in the community, they can register with a GP and receive NHS health and mental health care. However, those in the Dungavel Immigration Removal Centre have health care provided by an onsite team (unless secondary health or mental health care is required, in which case it is provided by the NHS). Asylum seekers whose claim has been disallowed but who have not left the country will not necessarily be counted by UK Visas and Immigration and may remain on the list of a local GP.

Taken in the round, there is little routine data that can be used to directly assess the health needs of migrants. Significant work is needed to ensure a consistency of definitions across Scotland. Data linkage may provide a way forward, but work will be needed to enhance the existing technical fixes that can identify ethnicity, so they can delineate migrant status.

A nationally developed health need assessment template may be need to be developed to allow consistency of local data collection and synthesis.

4 Rapid Literature Review

A rapid review of the peer-reviewed and grey literature was carried out to update the literature review published as part of the Migrant Health Action Resource. In presenting this update, it is suggested that it is read in tandem with the earlier literature review by Millard, A. (33)

Focusing on the years from 2009 to 2015, the databases searched included Ovid (Medline, Pubmed) PsychInfo, CINAHL, Web of Science. Search terms used included migrant, immigration, health, mental health, tuberculosis, gender and violence, cultural, and healthcare access, Scotland, UK plus equivalent terms with a focus on the most recent academic research and grey literature. References from articles were also followed up, as were government websites and information sources. A more detailed search protocol is available on request.

The problem with much research on migrants is, as with data sources, one of definition as in many research articles there is no clear distinction made between migrant status and ethnicity. For example, in Scotland the largest migrant group, out with UK group, Polish, might not be separated out from a general white Scottish / white European category. Similarly, in research which focusses on the black and minority ethnic communities, the sampled population may include both first- and second-generation migrants, without this distinction being made clear. Other limitations with the research literature identified include:

- much research which *does* focus on first generation migrants is UK-wide and does not include specific Scottish data;
- most studies on migrant behaviour are cross-sectional in nature, giving only a snapshot picture (22); and
- many are qualitative using only small sample sizes (7).

The rest of this section is separated out into brief summaries of updates to the health and health care needs identified in the earlier literature review.

4.1 Risky Health Behaviours

Amongst recent migrants smoking rates may be commensurate with those of the home country, particularly amongst East European migrants. Aspinall *et al* (9) found that smoking rates for both men and women were higher in those who had poorer language skills. He also noted that although a number of the Polish migrants stated they wished to give up smoking, only 8% of those who had stated this thought of seeking medical advice about quitting.

Jaweera *et al* (10) found that both migrant mothers and those from the black and minority ethnic community were significantly less likely to smoke or drink alcohol. Bhala *et al* (11) , in a Scottish sample, found that while mortality from alcohol-related diseases is very low in Pakistani and Indian born individuals, it was higher than those classed as other non-UK born individuals but not as high as those classed as being of white Scottish birth. It is unfortunate that this work did not take into account the specific types of alcohol-related disease.

4.2 Mental Health

The Go Well project data was used to look at whether there was a difference in the mental health of different types of migrant compared to UK- born resident and if it was dependant on city regeneration areas and socio-economic circumstances. The data suggested that, with the exception of asylum seekers, there was no evidence found to support the supposition that migrants had greater problems with stress or mental health than other residents of these areas of deprivation. However, there was evidence to support lack of social inclusion particularly amongst asylum seekers and refugees (12).

Bansala *et al* (13) noted that among non-white minority ethnic groups, women had the highest risk ratio for hospitalisation from psychotic disorder, and that black and minority ethnic people where younger at first hospitalisation for mental disorder. This study was limited by the fact it used hospital records where the quality of recording for migrant status was low. More broadly, Chakraborthy *et al* (14) have shown an association between being racially discriminated and self-reported poor health.

4.3 Infectious diseases

The majority of cases of tuberculosis, malaria and enteric fever diagnosed in the UK are found in those who were born abroad (15). The incidence of tuberculosis in Scotland is generally stable and low (16), with alcohol abuse the most commonly reported behavioural risk factor in tuberculosis sufferers; this is predominantly found in those who are UK-born rather than migrants (17). NICE has suggested that migrant cases may be harder to reach because of language barriers or concerns about immigration status (18); however, Wagner *et al* (15) found that once reached, migrants were more likely to complete treatment (85%) than UK-born (81%).

4.4 Migrants as Users of Health Services

Migrants are generally low level users of health services, though data for this can be scarce, as status is not consistently recorded in health services (19). This may be due to the “healthy migrant” effect, in that young and healthy people choose to migrate (20). Rolfe et al (7) noted low rates of registration in primary care and with dental practices. One possible reason for this latter observation is that migrants could be more likely to use the dentist on visits to their country of birth.

While much research on migrants, or from a migrant point of view, is qualitative, there is a recurring theme of reliance on internal networks or word of mouth implying a lack of social cohesion with the UK born population and services (19), (7), (20). In accessing GP services children of longer established migrants are often in the position of translating for their parents, as more specialist English was beyond them. Families were also in the habit of returning to their home country to access routine medical care or to confirm treatment recommended by a Scottish GP with doctors from their birth country (19).

4.5 Accessing Health Care

While research suggests that migrants do not have a large impact on health care systems in Scotland (21), (22) one reason for this may be a lack of insight or understanding of how the health care system in Scotland works, or what knowledge the migrant has about how to access services. As with other research amongst migrants, there are gaps in the evidence base (10), (23) .

A Delphi study in 16 European countries, across 186 experts in various aspects of health (public health, medicine, policy-making, and sociology) (24), found that there was broad agreement between experts on those aspects of migrant health which were priorities: accessibility of services; patient empowerment; targeted outreach services; interdisciplinary working amongst service providers; and culturally sensitive care. In this case accessibility meant letting migrants know their rights regarding health care as well as providing high quality interpreters for patients. Yet, culturally-sensitive practice in care was looked upon differently depending on country. In the UK and Germany it was regarded as a way of focusing on the patient as an individual and not stereotyping their needs according their ethnic or national background. In other countries it was viewed as a way of creating healthcare ghettos away from mainstream service approaches.

For migrants to have greater access to healthcare, there must be greater knowledge amongst migrants and healthcare staff of legal rights to access healthcare (25). In Europe right of healthcare access is incorporated in the European human rights legislation (26). In Britain this is mostly predicated on length of stay (27). Depending on the degree of diversity in the overall community, “cultural competence” training might be an effective means of improving access for healthcare workers and for healthcare organisations (25) . Whichever model is chosen there must be greater inclusion of the migrant community into models of care in order for it to be effective.(24)

Having access to sound information is central to effective access to healthcare. Social networks and word of mouth have been noted as strong information gathering tools amongst migrant communities. While younger migrants may be very happy to use information technology, an Australian study (28) noted that older migrants preferred to get information from family members or friends (often in their own language) or used younger relatives to use IT for them. Older members of smaller migrant communities can be very isolated due to lack of language skills (29). The provision of high quality interpreters for medical care is a repeated theme in the literature. In a qualitative study of the Somali community in Bristol, it was found that family members could not be relied on to interpret medical advice correctly, especially in the case of women, where medical advice might diverge from traditional practice (29) A similar observation was made in Newcastle, where a support worker from the local minority ethnic community was found to be reinterpreting health visitor’s instructions to first-time mothers in the light of traditional practices (30).

4.6 Special Needs of Asylum Seekers

The literature is clear that asylum seekers or refugees may have considerable physical or mental health needs arising from the types of trauma or persecution which enabled them to gain refugee status in the UK (31). In addition, the asylum process itself can be very demanding and the uncertainty would not help many health states (32). Asylum seekers do have the right to primary health care and emergency secondary care while waiting for their claim to be verified. This right continues even if asylum or another form of protection is refused (27). However, asylum seekers may not expect a universal health care system and so may not expect to use it. They may also be wary of organisation which they perceive as having a connection to the government and any data gathering as connected to their own application for asylum (26), (31).

4.7 Comment

The updated literature review has not identified many notably changes in what is understood about the health or migrants or asylum seekers.

Migrants tend to be relatively healthy and, whilst there are issues with accessing services, their general health is comparable with that of their home populations. Attitudes towards risky health behaviours remain much the same and only slowly change over time. How far these health needs change as the migrant becomes more socially integrated is variable.

For asylum seekers, mental health needs and the long-term consequences of trauma, both physical and mental, are major health need which need to be met. These are not helped by the way in which they are subject to the asylum processes. Those provided with forms of protection are then subject to relocation, often in national groups, which can be a further cause of social dislocation and isolation. These may perpetuate existing health needs.

What is clear is that the health needs of migrant and asylum seeker populations should not be conflated. The needs of migrants in a local area will be highly dependent on the composition of the local migrant population.

5 Accessing web resources to support local action

It was always ScotPHN's intent to update the action resource after five years; however, on staring that process it was realised that a large volume of work had been undertaken and – what had in 2008/09 been a relatively sparsely populated landscape – was now much more fully populated both within Scotland and across the UK. As a result the decision was taken NOT to update the original resource, but to use take the opportunity presented by the preparation of the report to update what was needed and signpost what was now available elsewhere in support of assessing the health needs of people who are migrants.

One area which has been updated is the links to useful web-based resources for identifying health needs and data. In addition to the websites on sources of data, the most useful ones which this work has thrown up are:

- CoSLA Strategic Migration Partnership – http://www.migrationscotland.org.uk/
- The Migration Observatory - http://www.migrationobservatory.ox.ac.uk/
- National Records of Scotland - http://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/migration/migration-statistics/migration-within-scotland
- Moving to Scotland – http://www.scotland.org/live-and-work-in-scotland/moving-to-scotland/
- Migration Watch UK – http://www.migrationwatchuk.org/
- Scottish Refugee Council – http://www.scottishrefugeecouncil.org.uk/
- Asylum Scotland – http://www.asylumscotland.org.uk/
- Shelter Scotland – http://scotland.shelter.org.uk/
- John Gray Centre (East Lothian Archives) - http://www.johngraycentre.org/wp-content/uploads/2014/05/Research-Guides-2_Emigration_final.pdf
- Health Protection Scotland – http://www.hps.scot.nhs.uk/internationalissues/migranthealth.aspx
- Public Health England – https://www.gov.uk/topic/health-protection/migrant-health-guide
- Medecins Sans Frontieres –http://www.msf.org.uk/about-msf
- UK Visas and Immigration (Formerly UK Border Agency) – https://www.gov.uk/government/organisations/uk-visas-and-immigration
- Migrants Rights Network - http://www.migrantsrights.org.uk/
- Scottish Government – Rights of access to healthcare – http://www.gov.scot/Publications/2008/03/14162503/3

APPENDIX

International Organisations of Migration Definitions

IOM Definitions

SMEHRS Definitions

Paper 2 Migrant terms and definitions

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