The asylum-integration paradox: comparing asylum support systems and refugee integration in the Netherlands and the UK

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Abstract: This paper explores the impact of asylum support systems on refugee integration focusing on the UK and the Netherlands. Both have adopted deterrent approaches to asylum support. The Dutch favour the use of asylum accommodation centres, segregating asylum seekers from the general population. The UK disperses asylum seekers to housing within deprived areas, embedding them within communities. Both countries have been criticized for these practices which are viewed as potentially anti-integrative: something of a paradox given that both promote the importance of refugee integration. We analyse national refugee integration surveys in both countries and provide original empirical evidence of negative associations between asylum support systems and refugees' health which differ in relation to mental and physical health. The integration and asylum policy implications of these findings are discussed.

Keywords: refugee, integration, asylum support system, dispersal, social network, health.

Introduction

The rise in the number of individuals seeking asylum has attracted a great deal of political, policy and public attention over the past two decades. Across Europe (EU27), asylum applications rose from 200,000 in 2006 to 320,000 in 2012 (Eurostat[i]). With the ongoing crisis of asylum systems in Europe states have found themselves torn between their obligations under the 1951 Convention relating to the Status of Refugees to confer refugee status on those with a well-founded fear of persecution, and increasing concerns about the costs of supporting refugees, and the impact of swelling numbers upon social cohesion. While attempts to agree a common European asylum and refugee policy have largely been resisted, most EU countries have separately developed both asylum and integration policies.

The UK and Netherlands share many common features in their response to asylum-seeking. Both offer a rhetoric that portrays their nations as having a long history of offering sanctuary and being tolerant of difference, and until recently, supported multiculturalism (Vertovec & Wessendorf 2010). However, as a consequence of increasing numbers of asylum seekers, both countries have witnessed the emergence of negative popular and media attitudes

towards asylum seekers. With arrivals being portrayed as falsely, claiming they had been persecuted in order to access housing, benefits and employment and, in doing so, taking advantage of allegedly generous welfare states. Despite the lack of evidence about asylum seekers being attracted by welfare provision (Robinson & Segrott 2002), both countries acted in a bid to reduce asylum numbers and associated costs, and to placate an increasingly anxious population. A common theme is the adoption of deterrent approaches to asylum support wherein access to benefits, employment and housing is restricted, in an attempt to become less attractive asylum-seeking destinations. Such an approach sits within the context of an increasingly restrictionist approach to welfare provision for migrants which responds to moral panic around welfare tourism (Sales 2002).

Paradoxically, both countries also place importance upon the integration of recognised refugees with equal access to work, health, and education, and development of a wide range of social networks as well as local language proficiency seen as policy priorities (Home Office 2005; 2009; Ministry of Social Affairs 2011). These can be considered 'dual policy goals': on the one hand deterrent and exclusive during the asylum procedure and on the other inclusive integration goals for those granted leave to remain.

While the thinking underpinning policy and many of the objectives of both countries converge, their approaches to supporting asylum seekers and to facilitating integration differ markedly. The combination of sharing a dual-policy approach whilst adopting divergent approaches to integration provides potential for valuable contrasting case studies. Thus, an opportunity for cross-national comparison into the ways that asylum support and refugee integration interact in the two countries to produce variable outcomes. We look at the ways in which asylum seekers are housed in the two countries as part of the asylum support system and then focus upon how integration is facilitated in both countries, hereon described as the integration support system. With respect to asylum-seeker housing provision the Dutch favour

the use of asylum accommodation centres, essentially segregating asylum seekers from the general population. The UK either disperses asylum seekers to housing in deprived areas across the country, embedding them within communities where they frequently experience prejudice, harassment or isolation (Stewart 2012) or allows them to reside with friends and family on a 'subsistence-only' basis. With regard of integration, in the Netherlands refugees are transferred to state subsidised housing once leave to remain is granted and obliged to pass an integration exam. In contrast, the majority of UK refugees are evicted from their asylum accommodation within 28 days after leave to remain is granted and have no access to a state integration programme.

In this paper we focus on two integration outcomes: social networks and health. Social integration is the degree to which migrants and refugees participate in social networks. Such participation has been shown to enhance access to other indicators of integration such as employment, education and local cultural awareness (Phillimore 2012). Health is a much neglected indicator of integration and yet key for successful integration (Ager & Strang 2008). It has been found that pre-migration, as well as post-migration experiences can significantly affect refugees' health (Allsop et al. 2014). Health is widely acknowledged to be closely aligned with ability to access work (Ager & Strang 2008). Poor health can increase the risk of social exclusion representing multi-faceted and often enduring barriers to full participation in society (Wilson 1998).

The existing comparative literature on refugee integration has focused on either labour market (Bevelander & Pendakur 2014) or social participation (Korac 2009). Our paper is the first study to examine how the asylum support systems in the Netherlands and the UK relate to refugee integration across multiple domains including health as an original indicator for integration. The central research question of this paper is: how does the asylum and integration support systems in the Netherlands and the UK relate to refugee integration in

terms of social networks and mental and physical health? It does not seek to develop the concept of integration further but to provide empirical evidence on the connection between asylum practice and refugee integration.

We use quantitative data collected in state-implemented national refugee integration surveys to systematically assess the relationships between individual characteristics, asylum practice and refugee integration outcomes in both countries. Our quantitative approach brings a rigorous and valuable addition to qualitative studies which have highlighted the importance of employment, health and social networks. The paper is original and rigorous in bringing a longitudinal dimension into integration studies by exploring the relationships between asylum accommodation experiences and the integration of those who later gain refugee status. While direct comparison is not advisable due to different sampling structures of the two datasets, this is the first empirical study providing insight into two different asylum support systems and their relationship with refugee integration and as such brings significant new insight into how asylum and integration support systems operate individually and interact to shape opportunity structures for new refugees. In the context of the current asylum crisis understanding how asylum support shapes refugee integration is more important than ever.

Defining integration

The concept of integration has long been the focus of academic attention and, as the numbers of refugees settling within Europe has risen, it has become of increasing interest to policymakers. There is no agreed definition of integration. Some consider it to be a linear process, others a multi-dimensional and two-way process involving migrants and host societies (Berry 1997). Others argue integration is a negotiation between contexts and cultures, past and present, and country of origin and country of refuge, wherein identity is contested and constantly moving (Bhatia and Ram, 2009). Acknowledging the variability of

integration processes builds upon some of the thinking around segmented assimilation which highlights the possibility of different pathways leading towards multiple mainstreams (Schneider and Crul, 2011). The idea of integration as non-linear accounts for interruptions that may occur, for example as a consequence of asylum or refugee support systems, and may impede aspects of integration and supports Berry's argument that a wide range of actors have a role (which may be disruptive) in integration. Schneider and Crul (2010) in introducing the notion of comparative integration contexts highlight the ways in which integration in Europe is shaped by different social and political contexts.

Much work has focused upon identifying factors that could be used as indicators of integration. Policymakers in the EU have tended to focus upon wage equivalence (Lundborg 2013). Drawing upon the multidimensionality of integration some have attempted to identify specific social, economic, civic and cultural domains in which progress is required in order for integration to occur (Phillimore 2012; Mulvey & Council 2013). The role of functional dimensions of integration: education and training, the labour market, health, and housing, are viewed as critical (Ager & Strang 2008). They and others argue that migrants must progress in functional areas before they can engage with other dimensions (Kearns & Whitely 2015). These aspects are of greatest interest in policy terms as, at least in theory, progress can be quantified (Korac 2009). Further interest has been shown in social networks and capital, often described as cohesion in policy terms. However success in measuring progress beyond advancement in language skills or access to employment has been limited and as yet the multi-dimensionality of integration has defied measurement and health in particular has been neglected despite well-established evidence in the public health literature that functional aspects of integration are in fact social determinants of health (Dahlgren & Whitehead 2015).

Most governments argue that integration can only begin once some kind of refugee status has been received. This contradicts the notion in the literature and arguments from

NGOs that integration starts on arrival (Malloch & Stanley 2005; Refugee Council 2006) given that asylum seekers cannot avoid integration as they encounter a new culture, must communicate in a new language and interact with local people while they utilise health services and their children attend school. Work around refugee mental health suggests that the asylum process itself can be anti-integrative in that the combination of uncertainty, anti-asylum sentiment and poor access to services can have long-term impacts upon mental health then effect access to wider integration (Bakker et al. 2013; Phillimore 2011b). At the current time there is a lack of rigorous evidence to indicate exactly what effect the asylum process has upon refugee integration.

Asylum and integration support systems in the Netherlands and the UK

While trends in asylum numbers and associated public and political responses are similar in the two countries, they diverge in approaches adopted around support of asylum seekers and recognised refugees. Below we discuss their asylum support system before arguing how these regimes may influence refugee integration.

The Netherlands: 'secure but segregated'

On arrival, asylum seekers in the Netherlands must report at the central reception centre in Ter Apel where the asylum procedure starts. After initial legal and medical advice, the Immigration and Naturalisation Office (IND) assesses the need for further investigation. Cases requiring further investigation are moved to one of the asylum centres (AZC) where they await a decision which can formally take up to six months. A small proportion stays with friends or family.

Asylum seekers are dispersed without choice to an AZC, usually situated in rural areas. Life is tightly controlled with movement outside permitted subject to regular reporting.

Units are designed for five to eight people, with shared kitchen and bathing facilities. Where possible, families share a unit while singles share with strangers. Everyone has about five square meters of personal space. All daily activities take place in the company of a large group of others meaning that privacy and autonomy are limited (ten Holder 2012). Asylum seekers have limited access to the (formal) labour market (for 24 weeks a year), but adults no access to education[ii] or social security. Their basic needs are provided for by the state.[iii]

Once asylum seekers gain leave to remain, they can remain for five years. The state provides them, officially within 14 weeks, social housing, usually in the same region as the AZC. Some may be housed further away for work, study or family reasons. They can access social security and have full rights to work. New refugees must take an integration course and pass the integration exam which tests language abilities, institutional knowledge such as social rights and Dutch history. Studies show that these integration courses contribute directly to migrants' language proficiency (Dourleijn & Dagevos 2011). Without passing the exam refugees cannot apply for permanent residence.

The United Kingdom: 'dispersed but precarious'

In 1999 the then National Asylum Support Service (NASS[iv]) was introduced to support and co-ordinate both asylum and integration policy. After initial processing in reception centres most asylum seekers choose between dispersal, on a no choice basis, to state provided housing, or staying with friends and family on a 'support-only' basis. Over half of those in self-arranged housing stayed in the South-East and London. The remainder were dispersed, largely to deprived areas where there was an over-supply of cheap, often poor quality housing in areas of housing market failure (Phillips 2006).

Although most asylum seekers in NASS housing were given their own bedroom, all single individuals had to share houses with strangers. Families were generally allocated self-

contained housing. Asylum seekers received a small weekly stipend to cover food and clothing costs. In the early stages of the dispersal program, this was paid in the form of vouchers (later withdrawn following widespread criticism about stigmatization) which had to be spent in certain shops leaving them unable to buy cheaper goods elsewhere. Asylum seekers could, until 2011, attend free language classes and further education courses, although provision was poor and waiting lists lengthy (Phillimore 2011a).

Once a positive decision was received, asylum seekers had 28 days to leave their NASS housing. Within this period they had to register for a National Insurance Number (NINO), in order to access benefits. Only those deemed 'priority', largely families with children or the disabled, could access social housing. Many families were housed in temporary accommodation such as bed and breakfast hotels where they lived in one room without access to cooking or laundry facilities. Non-priority refugees had to locate their own housing in the private sector. This was problematic since they lacked cash to pay the deposit demanded by landlords and had no access to benefits while awaiting their NINO, a process which could take months. Unsurprisingly many refugees ended up homeless, living rough or sharing illegally with asylum seeker friends (Phillimore et al. 2004). Those who accessed social housing continued to experience deprivation, since housing was supplied unfurnished and they lacked resources with which to purchase necessities such as furniture and white goods (Phillips 2006). The UK did not have an integration programme. In the period in which the research was undertaken UK refugees did not have to pass the Citizenship test in order to remain, and most could stay permanently after gaining refugees status.

Asylum and refugee integration support systems in a comparative perspective

Given the contrasting asylum support systems in the Netherlands and the UK we hypothesise that they will lead to different refugee integration outcomes. We utilise a system approach in

our analysis since the separate aspects, i.e. housing, integration policy and institutional arrangements, are interrelated. Our starting point is that both asylum support systems can be regarded as a mechanism of social exclusion (Madanipour 2003) which shapes refugees' integration.

Asylum support systems, social exclusion and inclusion

Social exclusion is seen as simultaneously spatial and social (Madanipour 2003). It can be manifested in low social participation and/or feelings of discrimination, prejudice and segregation (Stewart 2005). This type of exclusion can occur when asylum seekers are physically separated from host society (Robinson et al. 2003). Such exclusion may occur in the Netherlands during the asylum procedure, since asylum seekers are mostly placed in rural asylum centres, away from local people wherein social network formation might be possible. We expect that asylum seekers will build a strong network *within* the asylum centre, most likely dominated by co-ethnic/national and co-religious communities.

Under UK dispersal policy, asylum seekers found themselves surrounded by strangers and separated from established social networks or ethnic communities who could offer social and emotional support and from a supportive local infrastructure. The vast majority of refugee support services were, and continue to be, based in London and the Southeast. Cities with less experience of diversity were often unaware of the rights and entitlements of asylum seekers who struggled to access services and experienced racist harassment. Similar to the Netherlands, we expect that living in state-provided asylum housing in the UK can function as a mechanism of social exclusion.

There are important differences in post-grant housing allocation. Refugees in the UK had to vacate NASS housing within 28 days of grant possibly moving towards their ethnic communities as soon as possible because they were heavily reliant on informal housing

provision by their peers. In contrast social housing in the Netherlands was assigned locally preventing movement towards ethnic communities. Arguably post-grant housing arrangements may lead to development of different kinds of social networks with UK refugees included in existing communities, while Dutch refugees experience social exclusion, at least until they are able to develop networks. Also, after leave to remain is granted the Netherlands' compulsory integration course has the clear objective of mainstream cultural inclusion covering Dutch language, customs, history and culture. While two refugee integration strategies have been published (Home Office 2005; 2009) which stress the importance of refugee integration (Ager & Strang 2008) the UK does not have a refugee integration programme[v] and in recent times has turned to the notion of social cohesion placing emphasis on local stakeholders to foster integration at local level (CLG 2012). ESOL classes in the UK are barely adequate, since they are not developed for migrants and are known for their high dropout rates (Phillimore 2011a).

In sum, asylum policies in both countries are largely socially exclusionary for refugees, although the situation in the UK may support social inclusion within local communities to some extent. Integration policy however has some inclusive characteristics in both countries.

Asylum support systems and health

Housing, employment and social networks are amongst the social determinants of health (Dahlgren & Whitehead 2015) known to influence, and be influenced by, individuals and community health outcomes. Economic, cultural and social exclusion can cause feelings of isolation and depression (Carter & El Hassan 2003). The combination of uncertainty, anti-asylum sentiment, unemployment and poor access to services can have long-term impact upon refugees' mental health which may also impact upon access to wider integration (Bakker et al.

2013; Phillimore 2011b). With regard to asylum accommodation we argue that the lack of privacy and autonomy in the Dutch asylum centres can negatively relate to refugees' mental health. Moreover, their dependent position in times of great insecurity can induce passivity and depression (ten Holder 2012). The location of social housing in rural areas, when leave to remain is granted, may further instil feelings of isolation. Additionally, the lack of receptiveness of local people may exacerbate feelings of exclusion, which can lead to further deterioration of refugees' mental health.

In the UK asylum seekers may be particularly vulnerable because of the threat of homelessness after leave to remain is granted. This is likely to be negatively related to their mental wellbeing. However, we expect the impact of the UK asylum support system to be more visible on refugees' physical health. Evidence shows that asylum seekers are generally housed in the poorest quality accommodation in highly deprived areas (Phillips 2006). Overcrowding and poor conditions have been argued to lead to an increased risk of physical health problems that may exacerbate existing health conditions or create new problems. Moreover, refugees are known to move frequently and to reside in poor housing and they lack access to resources to enable them to purchase basic household goods which can affect their health (Phillimore et al. 2004). So it is likely that the system itself could induce stress and health problems in the longer term (Garvie 2001).

Data & Methods

Data

The dearth of bespoke nationally representative surveys of refugees presents a challenge in studying integration outcomes. In this paper we use the best available quantitative data: Survey Integration New Groups (SING09) for the Netherlands and Survey of New Refugees (SNR) for the UK. SING09 is a cross-sectional dataset based on a nationally representative

sample gathered in 2009. It contains information on reception and integration in the Netherlands of Afghan, Iraqi, Iranian, Somali, Polish and Chinese individuals and has a Dutch reference group.

The Survey of New Refugees (SNR) is a longitudinal study of refugee integration in the UK, conducted between 2005 and 2007 with all new refugees over 18 who were granted leave (temporary or indefinite) to remain. The questionnaire was administered by post and involved four data collection points: baseline (Wave 1) (one week after leave to remain granted[vi]), after 8 (Wave 2), 15 (Wave 3) and 21 (Wave 4) months. A total of 5,678 valid baseline questionnaires were returned out of the 8,254 originally distributed, achieving a 70 per cent baseline response rate. Like most longitudinal surveys, the SNR suffers from high attrition rates. Only 939 respondents remain in the last wave in 2007 (Cebulla et al. 2010). Where appropriate, cross-sectional and longitudinal weights have been applied to adjust for possible non-response bias.[vii]

Both datasets contain detailed information on the asylum and refugee integration support system. While we acknowledge the differences in the sampling structures of our datasets and undertake separate country analyses, these datasets are the *only* data available for analyses of this sort. We assess the within-country differences of each asylum support system and then compare the different integration outcomes in light of their asylum and integration support systems. While comparing different institutional contexts would have added to our analysis, questions around these factors were not included in the survey.

It is important to note the composition of the samples is different. The Dutch survey SING focuses on the four largest refugee groups, whereas the SNR is a designated survey for new refugees. Thus we focus on the four groups with a refugee background who are present in *both* surveys – those from Afghanistan, Iraq, Iran and Somalia. Within each country of origin about 1,000 structured face-to-face interviews were conducted. In addition, around 70 per

cent of the SING sample had Dutch nationality at time of interview having been resident for 12 years on average, whereas SNR only contains information on respondents up to 21 months after they gained refugee status, although some had been in the UK over five years awaiting the outcome of case determination. Lastly, due to the lack of a comparison group in the UK (e.g. UK residents) we focus on the between-groups difference in integration outcomes within the refugee population in each country.

Method and Analysis

Ethical approval was received for the secondary analyses we undertook of the survey data. In this section we first present the summary statistics of both datasets for our dependent and independent variables in the multivariate analyses. For the SNR, we use data from the baseline (W1) and the third follow-up survey (W4). These respondents had leave to remain[viii] in the UK for 21 months at time of the last wave (n=921)[ix]. In the Dutch case we restricted the sample to refugee respondents (n=2980). In the multivariate analyses, we present separate country models to estimate within-country difference in integration outcomes. We conduct binary logistic regression for the dichotomous dependent variable of socio-economic participation. All other dependent variables are ordinal measures, thus ordered logistic regression is used. We report odds ratios in all models.

Measures

Similar questions in both surveys enable us to construct standardised measures. We focus on two key aspects of integration: social networks and health. The surveys provide a rich source of data on these factors and offer an original alternative to the traditional focus upon labour market outcomes. In the following details of all variables used are described.

For *social networks* we make a distinction between *personal social network* and *ethno-religious network.* We consider both personal and ethno-religious social networks as indicators of refugee integration. The first consists of having contact with family and friends. This can involve meeting, speaking on the phone and in the Netherlands also in writing. Ethno-religious networks consist of contact with co-ethnic people and visiting or having contact with a place of worship. Both are measured on a five-point scale ranging from (1) never to (5) every day. We argue that both types of networks can contribute to refugee integration as they provide valuable information about job vacancies, local cultural knowledge and social and emotional support.

For health integration we use three separate variables: general health, physical health and mental health. *General health* is measured on a five-point scale ranging from (1) very bad to (5) very good using the question: *How is your health in general?* The measure for *physical health* is based on the experience of physical problems that limit daily activities: such as walking stairs, cycling and doing housework. This is measured on a five-point scale ranging from (1) could not do daily activities to (5) no problems at all. The questions asked on *mental health* differ somewhat in the two surveys. In SING this is a mean scale of three items of respondents reporting feeling calm and peaceful, sad and gloomy, and nervous in the last four weeks. In the UK, respondents were asked to what extent they felt worried, stressed or depressed in the last four weeks, ranging from (1) all the time to (5) not at all.

Independent and control variables

The key independent variable in this paper is the *type of accommodation during the asylum procedure*. For both countries a dummy variable is constructed to represent state-provided asylum accommodation (1), AZC reception centres in the Netherlands and NASS

accommodation in the UK, and all other self-arranged accommodation (0) which includes staying with family or friends, own accommodation or other.

Language proficiency is an important control variable since it is known that this aspect is key to refugee integration. This variable is measured on a mean scale based on three items examining problems with speaking, reading and writing Dutch or how well they understand, speak, read and write English compared to native speakers. Both measures are standardised into the same three categories: 1 a lot of problems/not very well; 2 occasionally problems/fairly well; 3 no problems/very well. Further, our models control for *age* (in categories), *country of origin* (reference category = Somali), *gender* (female=1), having a *partner in the household*, having *children in the household*, *nationality* (Dutch only), *education* and *length of stay* in the host country. We use a standardised measure for the highest qualification attained irrespective of where it was obtained in both datasets (1 no qualification; 2 secondary education; 3 tertiary education). Length of stay in the host country is a continuous measure in years in SING but is only available in categories in SNR (<3 years, 3-6 years and >6 years).

Results

Tables 1A and 1B presents the summary statistics of the dependent and independent variables from the SING 2009 and SNR 2007 full samples. The proportion of contact with personal and ethno-religious network in both countries is broadly similar in both countries. The statistics on the health of refugees show a difference in physical and mental health in the Netherlands, with the latter at a lower level. The majority of Dutch refugees stayed in AZC accommodation (86%) compared to only 45% in the UK (Table 1B). About half of UK refugees in the sample were in employment compared to 38% of their Dutch counterparts. Dutch refugees are slightly older and a higher proportion holds a qualification from secondary or tertiary

education. Over half of the Dutch sample was living with a partner and with dependent children, compared to less than a quarter of the UK sample. The UK sample is dominated by younger males living on their own, about two-third of whom had no formal qualifications.

Table 1A: Summary statistics of dependent variables of SING and SNR

% in category	NL	UK
Personal social network		
Never	5	8
Few times a year	17	33
Each month	30	29
Each week	40	19
Each day	8	11
Ethno-religious social network		
Never	21	32
Few times a year	42	30
Each month	24	24
Each week	11	11
Each day	1	3
General health		
Very bad	4	3
Bad	14	8
Moderate	20	19
Good	39	35
Very good	23	35
Physical health		
Very bad	9	3
Bad	4	11
Moderate	12	15
Good	8	25
Very good	66	47
Mental health		
Very bad	1	2
Bad	11	17
Moderate	34	18
Good	36	27
Very good	18	35
N	2975	921

Table 1B: Summary statistics of independent variables

	NL		UK	
	%		%	
Asylum housing	86		45	
Employment	38		48	
Partner in household	52		22	
Children in household	55		23	
Gender (Women)	43		37	
Qualification (refcat=none)	32		61	
Secondary	44		25	
Tertiary	24		14	
Age (refcat=18-26)	17		23	
27-36	23		48	
37-46	35		20	
47-56	22		08	
66+	03		01	
Country of origin (refcat=Somalia)	28		14	
Afghanistan	26		03	
Iraq	25		09	
Iran	21		08	
Other groups			66	
Dutch nationality	71			
Length of stay in UK (refcat=<3 years)			59	
3-6 years			20	
>6 years			21	
	Min-Max	Mean (*Std*)	Min-Max	Mean (*Std*)
Length of stay in NL	1-42	12.53 (*4.75*)		
Language proficiency	1-3	2.13 (*.66)*	1-3	1.99 (*.66*)
N		2980		921

Multivariate analysis

Table 2 shows the results in odds ratios of multivariate analyses for the Netherlands, and Table 3 for the UK, on personal social network (M1), ethno-religious network (M2), general health (M3), physical health (M4) and mental health (M5). An odds ratio greater than one indicates a positive outcome in the dependent variables. For example in Table 2 an odds ratio of 1.48 for refugees with good language proficiency in Model 1 means that they are 1.5 times as likely to have a higher level of personal social network in the Netherlands. In contrast, in Table 3, an odds ratio of 0.47 for refugees in NASS accommodation in the UK (Model 1) means that they are less likely to have personal networks compared with those in self-arranged accommodation.

Table 2: Ordinal logit models on refugees' social network and health for the Netherlands: Odds ratios

	M1 Personal Social network	M2 Ethno-religious network	M3 General health	M4 Physical health	M5 Mental health
Asylum housing	.69***	1.18	1.04	1.02	.80*
Language proficiency	1.48***	.99	1.95***	1.79***	1.47***
Employment	1.04	.87	2.42***	2.94***	2.00***
Qualification (refcat=no qual)					
Secondary	1.48***	.96	1.07	1.10	.90
Tertiary	1.63***	.97	1.38**	1.49**	.94
Gender (Women)	1.23**	.51***	.79**	.63***	.80**
Country of origin (refcat=Somali)					
Afghani	.84	.25***	.50***	.65**	.49***
Iraqi	1.05	.25***	.55***	.62***	.48***
Iranian	.77*	.17***	.52***	.72*	.38***
Pseudo R^2	.04	.06	.11	.14	.05
LR Chi^2 (df)	294 (17)	421 (17)	897 (17)	844 (17)	364 (17)
N	2857	2857	2857	2857	2857

***p<.001, **p<.01, *p<.05 All models control for age, partner/children in the household, length of residence in destination country and Dutch nationality

Table 3: Ordinal logit models on refugees' social network and health for the UK: Odds ratios

	M1 Personal Social network	M2 Ethno-religious network	M3 General health	M4 Physical health	M5 Mental health
Asylum housing	.47***	.88	.53***	.45***	.70
Language proficiency	1.04	1.19	1.79***	1.44*	1.22
Employment	1.01	1.12	2.23***	1.82***	1.49*
Qualification (refcat=no qual)					
Secondary	1.03	.85	.99	1.19	.69
Tertiary	1.24	.91	1.24	1.62	.78
Gender (Women)	.94	1.18	.43***	.56*	.67
Country of origin (refcat=Somali)					
Afghani	.52	.59	.85	.40	.85
Iraqi	.72	.15***	.56	.57	.61
Iranian	.29***	.18***	.40*	.41*	.64
Pseudo R^2	.06	.09	.10	.08	.04
LR Chi^2 (df)	104 (28)	137 (28)	152 (28)	119 (28)	70 (28)
N	646	651	657	653	655

***p<.001, **p<.01, *p<.05 All models control for age, partner/children in the household and length of residence in destination country

With regard to social networks (M1 and M2) our results show for both countries that having stayed in state-provided asylum accommodation is negatively related to refugees' personal social network as the odds are significantly below 1. Refugees who stayed in state-provided asylum accommodation may have less contact with their family and friends compared to those who stayed in other accommodation (frequently provided by family or friends). These are also the groups who maintained more regular contacts with friends and family over time. In both countries Iranian refugees were least likely to have frequent contacts with their personal social network while Somali refugees were more likely to maintain ethno-religious networks. In the Netherlands language proficiency and education are also significant in developing a personal social network. Women in the Netherlands were more likely to have a personal network and less likely to have an ethno-religious network compared to men.

We find a negative relationship between state-provided asylum accommodation and health. In the Netherlands we only find a significant negative relationship with mental health with those who stayed in state-provided asylum accommodation suffering from poorer mental health compared to those in other accommodation. Refugees who stayed in NASS accommodation in the UK also suffered more physical and mental health problems. Furthermore, woman and older refugees reported poorer health status, whereas those who were employed reported fewer health problems. In the Dutch case, residing with a partner and Dutch language proficiency were positively related to refugees' health.

Conclusion and Discussion

In this paper we asked the question how asylum support systems relate to refugee integration in the UK and the Netherlands and demonstrate empirically for the first time that there is a connection between the two. In both countries residing in state-provided asylum accommodation is negatively related to refugees' health. For the Netherlands, we find a relationship with mental health, which suggests that the lack of privacy and autonomy in asylum centres can negatively affect refugees' mental health. For the UK, the results empirically support previous arguments that the poor conditions of NASS accommodation can contribute to deterioration in refugees' physical health (Phillips 2006). This, in combination with the lack of integration policy after the granting of leave to remain, frequently involves homelessness and absence of even the most basic support (Phillimore et al. 2004). The asylum system and subsequent rehousing programmes may induce a great deal of stress and associated health problems which endure into the longer term with potential to be anti-integrative. These negative effects did not apply to nearly half of refugees in the UK, who lived in self-arranged housing.

Second, we argue that integration policy is important. The provision of Dutch integration courses significantly enhanced the health outcomes of refugees while ability to speak Dutch aided social network development. Language proficiency is significantly associated with general and physical health and social networks in the UK. The restrictionist turn in the Netherlands and the UK which emerged after the implementation of the surveys is likely to have had a negative impact on integration outcomes. At the present time Dutch refugees are expected to pay for their own classes and fee remission has been removed for all but the poorest refugees in the UK. Cutbacks on the Dutch integration programme and the disbanding of the Refugee Integration and Employment Service which was introduced after the SNR in the UK are likely to have a negative effect on integration.

In this paper we have taken a first step in showing how different asylum support systems influence different refugee integration domains. Our findings suggest that there is a paradox between asylum and integration policy which may contribute to exclusion rather than inclusion. We show that both asylum and integration support systems shape refugees' networks and health: key social determinants which are known to impact upon employment (Dahlgren & Whitehead 2015) and invariably considered by policymakers and politicians as the most important integration indicator. These policies influence the extent to which refugees can achieve integration in either the functional areas highlighted by policymakers or the wider integration domains highlighted by integration theorists. Indeed we argue that asylum policy is institutionally exclusionist given that the exclusion from mainstream welfare provision, no-choice dispersal or housing in designated centres, and employment restrictions both demarcate asylum seekers as "other" and undeserving (Sales 2002) while restricting their access to the goods, services and opportunities that are necessary if refugees are to achieve equality of outcome. More research is needed on the impacts of integration policy and institutional arrangements to establish the influence of the presence, absence or nature of

policy and importantly, how asylum and integration regimes interact to impact on refugee integration outcomes.

In light of the current “asylum or refugee crisis”, where unprecedented numbers of asylum seekers must be housed in Europe while their claims for refugee status are assessed, this paper provides some valuable insights for policy and practice. Asylum support systems could be more inclusive with housing embedded in communities expected to increase the likelihood of social integration in the longer term. Further as suggested by Phillips (2006) asylum housing must meet the same quality standards as those expected for the general population and housing regularly inspected to ensure standards are met. Our work demonstrates there is a clear connection between the experiences of asylum seekers and their eventual integration that cannot be overlooked.

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Notes

[i] http://epp.eurostat.ec.europa.eu/statistics_explained/index.php/Asylum_statistics

[ii] Asylum seekers aged 18 or over must reside legally in the Netherlands if they wish to enrol for a study. This means that they should either have a residence permit or should be in procedure for a residence permit with permission to await the decision in the Netherlands. Under-age children are entitled to education in the Netherlands until their 18th year. Admission to education does not depend on legal residence in the Netherlands.

[iii] Further details of financial supplement for asylum seekers are available at RVA 2005 article 14, http://wetten.overheid.nl/BWBR0017959/geldigheidsdatum_25-06-2014.

[iv] Note that at the time of the study discussed in this paper the authority responsible for asylum seeker support was NASS, however since this time it has been renamed twice. First as UK Border Agency and then UK Visas and Immigration.

[v] There was for a brief period a programme called Refugee Integration and Employment Service which provide new refugees with advisors to connect them with mainstream services. However this was scrapped in the 2010 austerity cuts after less than 2 years

[vi] All types of refugee status were included whether permanent or temporary

[vii] For full technical details please see Cebulla et al (2010).

[viii] Asylum seekers were, at the time of the study, given one of the three refugee statuses: Humanitarian or Discretionary protection (both allowing an initial 3 years in the UK) or refugee status (permanent stay permitted). We are unable to identify the proportion that were in receipt of each type although we know that very small numbers received full refugee status.

[ix] Other countries of origin include Eritrea, Zimbabwe, DRC/Congo, Sudan, Turkey, Pakistan, Ethiopia and other Europe, Asia, and Middle East.