

## Positive Action in Housing Findings Report

Lead Author: Iona Taylor.

Co-Authors: Aine Beattie, Catriona Bruce, Sarah Birnie, Adam Paterson.

Researchers: Aine Beattie, Catriona Bruce, Adam Paterson, Iona Taylor.

---

Introduction.....	2
Methodology.....	3
Overarching Themes.....	3
1. The Asylum System .....	4
1.1 The asylum system as a source of stress.....	4
2. Institutionalised Accommodation .....	5
2.1 Cooking Facilities .....	6
2.2 Meal Times.....	7
2.3 Communal Meals .....	7
2.4 Quality and Quantity of Food .....	7
2.5 Difficulties with Staff .....	9
3. Low Rates of Home Office Support .....	10
3.1 Poverty .....	10
3.2 Motherhood .....	10
3.3 Culturally Appropriate Food .....	11
4. The Impacts of Diet.....	11
4.1 Physical Health .....	12
4.2 Mental Health .....	13
5. Understanding Eating Disorders .....	13
5.1 Mental Health .....	13
5.2 Eating Disorders.....	14
6. Challenges to Accessing Support .....	14
6.1 Legal/Status Barriers.....	15
6.2 Awareness of Services.....	15
6.3 Stigma .....	16
Recommendations for Change .....	16
Concluding Statement.....	18

## Introduction

In February 2024, 10 service users of Positive Action in Housing aged over 16 contributed their experiences and reflections on food, eating disorders and health services. Eight of the participants took part in small, semi-structured focus groups, facilitated by Positive Action in Housing staff members. The other two participants contributed written testimony, due to structural barriers to travel. We held three sessions, with two to three participants each, in our city centre office between the 26th and 28th of February 2024.

The groups were formulated based on shared language and/or experiences. The Advocacy and Casework teams at Positive Action in Housing had prior engagement with all of the participants, so the groups were put together based on the staff understanding of the participants' experiences. The following gives a breakdown of the formation:

- Group 1: We invited four women who had been pregnant while in the asylum system to our first focus group. All four women are still in the asylum system at the time of writing. All are fluent in English. This group was composed to explore the gendered experiences of the asylum system.
  - Participant A claimed asylum in 2016. With no family in the UK, she and her young son have lived in Home Office accommodation for six years. She has been diagnosed with sickle cell disease, giving her extreme fatigue.
  - Participant B has been in the UK for six years, claiming asylum. Throughout this time, she has consistently lived in Home Office accommodation. She received no financial support from the Home Office throughout her pregnancy.
  - Participant C came to the UK to claim asylum in 2017. Her son is nearly one year old.
  - Participant D provided written testimony on her experience of living in Home Office hotels as someone who has been seeking asylum for several years.
- Group 2: The second group was composed of three Arabic-speaking men who have experienced the UK asylum system. The Advocacy and Campaigns team had previously worked with these men to hear their experience of and explore issues in institutionalised accommodation. Unfortunately, one member was unable to attend due to issues with public transport - without the right to drive or work, people seeking asylum often face barriers to travel. We instead asked for his written testimony, which is included in this report.
  - Participant E was in the asylum system for 19 months before being granted asylum in late 2023. During this time, he had lived in seven different hotels. He now lives in temporary accommodation with refugee status.
  - Participant F first arrived in Ireland before spending around 18 months in a hotel in Scotland whilst seeking asylum. He now lives in a flat after being granted refugee status.

- Participant G shared his written testimony with us. He is claiming asylum. He lived in institutionalised accommodation and has now been relocated to a house.
- Group 3: The third group was composed of Ukrainian-speakers. Those from Ukraine often have a different experience of immigration policies in the UK, due to the specific resettlement scheme available to them. This means that they arrive in the UK as a refugee, rather than people seeking asylum. They therefore have access to the welfare system. This may become clear from some of the testimony shared.
  - Participant H has lived in Scotland since 2022 and was moved between hotels after experiencing difficulties. They live with their two children.
  - Participant I has also lived in Scotland since 2022 and was a resident of hotel accommodation for 18 months. They have recently moved to a house.
  - Participant J has lived with their two children in a variety of ship and hotel accommodations throughout her time in the UK.

## **Methodology**

Once we had formulated these three groups, our Advocacy and Campaigns team developed a plan for facilitated sessions, tailored to each group. We intended to better understand each participant's relationship with food, the impact of the immigration and asylum system on this, and the awareness and experiences of eating disorders amongst the participants. Through this exploration, we hoped to gain a better understanding of the accessibility of healthcare and, specifically, eating disorder services for the groups.

Due to language barriers and different cultural contexts, we were unsure of the general level of awareness of eating disorders among the participants. We, therefore, employed a semi-structured focus group approach to ensure that we gathered the information we needed whilst also leaving space for participants to explore and convey their experiences. Group 1 spoke in English, whilst the other two groups had interpreters. Using the first half of the session to explore experiences of food in the asylum system and in temporary accommodation, we then provided some background information to the project and offered up some definitions of eating disorders. This allowed us to steer the conversation towards a focus on eating disorders and services.

After each session, we followed up with each participant, providing space for feedback, written additions and aftercare. We signposted participants to BEAT for further support, and to other asylum and refugee charities across Scotland.

## **Overarching Themes**

Throughout our focus groups, we identified a series of overarching themes. This report examines each of these in turn, whilst acknowledging that they are intersecting. We have separated our findings into:

1. The Asylum System
2. Institutionalised Accommodation,
3. Low Rates of Financial Support,
4. The Impacts of Diet
5. Understanding Eating Disorders
6. Barriers to Support.

Once we have explored each theme, this report will provide some recommendations from our findings before our concluding statement.

### 1. The Asylum System

“The stress of the asylum system is filling my head.” *Participant A*

“The sense of instability and not knowing what’s going to happen tomorrow can take a toll mentally, physically, and spiritually”, *Participant C*

“To live in this constant stress all the time impacts my appetite”. *Participant B*

“It was very difficult as an asylum seeker in the system. You cannot stand up for yourself, you cannot say anything that comforts yourself”, *Participant D*

Those in Group 1 and Group 2 had spent time in the UK asylum system. Those in Group 3 had access to a resettlement scheme specific to Ukraine. This means that those in Participants A-G were only able to apply for asylum once they reached the UK, and were therefore subject to lengthy waiting times, indefinite stays in institutionalised accommodation, and lived with the threat of detention and deportation. This experience is described by many as all-encompassing. Much of the discussion in these focus groups therefore emphasised the stress of the asylum system. Participants H-J were also subject to some similar policies as refugees which will be discussed in later sections.

#### 1.1 The asylum system as a source of stress

The experiences of those in the asylum system are characterised by fear, intimidation and stress. Participant C stated ‘the asylum process is exhausting. I am personally quite content, but at the end of the day, the sense of instability and not knowing what’s going to happen tomorrow can take a toll mentally, physically, and spiritually’. She went on to highlight how fleeing persecution, war and torture impacts mental health and can also change a person’s relationship with food. She had recently received a refusal on her asylum claim without appeal, and connected this with her increased appetite, which she

described as a 'coping mechanism'. This report will continue to emphasise the impacts of the asylum system on the mental health of people seeking safety as a key finding from our research.

General to all participants, whether seeking asylum or refugees, was the stress and concern about what was happening in their country of origin. All had fled persecution and war, and many had been forced to leave family members behind. Participant A told us that, as she is constantly thinking about her situation and her children in her country of origin, she is unable to have an appetite, telling us that 'there is just too much on my head'. As Participant I explained to us, the knowledge that Kharkiv was under strikes whilst she was living in a hotel had a huge impact on her mental health. Residual trauma from experiences of persecution and war is often brought to the fore by poor living conditions. Participant K's daughter had been caught in an airstrike when leaving Ukraine. Her daughter suffered from panic attacks due to this experience and yet, despite asking the council for two rooms, was only provided with one room in a hotel.

## 2. Institutionalised Accommodation

"The Home Office and me are not friends".

*Participant D*

"It is not easy as an asylum seeker when you are in a situation in the hotel when there is no proper food. You cannot say anything; what they give you is what you have to accept..." *Participant D*

In 2020, the Home Office rolled out the use of institutionalised accommodation for people seeking asylum. Presented at the time as a measure to mitigate the spread of COVID-19, thousands of people were taken out of their forced dispersal accommodation and moved into hotels across the UK. Some were given as little as 15 minutes' notice for this change. More recently, hotel accommodation has also been used for those who are in need of temporary accommodation — participants in Group 3, despite having refugee status, were also housed in hotel accommodation.

The use of institutionalised accommodation has been highly controversial, leaving people isolated from support services, without cooking facilities, and in cramped and overcrowded conditions. Furthermore, for those living in institutionalised accommodation where food is provided, financial support rates decrease from £49.18 to £8.86 per week. As the testimony gathered through the focus groups demonstrates, the cycles of poverty

and isolation that are woven into the UK asylum and immigration system have catastrophic impacts on the lives and welfare of those crossing borders.

There are many issues present in these hotels that shape, and therefore begin to explain, experiences of food and eating in institutionalised accommodation. Firstly, many residents are subjected to a culture of insecurity and fear whilst in institutionalised accommodation. Those who are housed in hotels are not given any timeline of their situation, left indefinitely in sites which often lack security. Participant H told us that their hotel accommodation would be closing down over the next few months, and yet there is no further plan for their accommodation in the aftermath. Hotels often lack effective safeguarding procedures; Participant H spoke to us about a man who used to harass her daughter and other girls under 18 in a hotel they lived in. Despite this being reported, no further action was taken.

Many residents are also subjected to overcrowding — Participant K, for example, explained that despite sharing a hotel room with her two children, they were only given two beds. She told us that her children gained weight due to the food provided at the hotel, and there was little space when sleeping. Participant H was also forced to share one room with her two children, sharing two beds between the three people. In recent months, the rolling out of a policy called 'Hotel Maximisation' has seen increasing numbers of unrelated people sharing rooms in hotels without safeguarding procedures in place, despite the pressure this places on their mental health.

The remainder of this section will explore the testimony gathered through the focus groups to explore the impact of institutionalised accommodation on the participants' relationships with food and eating.

## 2.1 Cooking Facilities

In several of the descriptions of institutionalised accommodation, participants focused on a lack of cooking facilities. For many participants, this, combined with the low rates of financial support, forced a reliance on the, often poor quality, food provided in the hotel. As Participant D highlighted to us, there were no cooking facilities in their hotel, and no oven or microwave. There was, however, one kettle in each room, which, they informed us, some people would use to cook eggs by placing a small bag inside the kettle and boiling the egg inside it.

This participant went on to explain how, without access to cooking facilities, they would often use their £8.86 per week to buy sour cream and bread and ration this for days. They were not, however, permitted to use the fridge in the hotel, so they would keep the window open in their room to attempt to stop the cream from going off. Participant K confirmed this further, saying that they were unable to warm food up.

Participant H, whilst a resident at a hotel, asked if they could buy a microwave to heat ready meals, but were prevented from doing this. When they bought ready meals, they would leave them by the windows in the room to preserve them. However, the participant said that management of the hotel would dispose of the meals, despite them being bought by the residents. This participant explained that the management would shout and curse at not only their family but many other residents in the hotel.

## 2.2 Meal Times

Participant E was very vocal about the difficulties that they had experienced with the times when food was provided. Residents of hotels are given short windows in which food is made available. Outside of these hours, there is no food available to them. This participant struggled with this restrictive schedule, particularly given that these eating times were not the same as he was accustomed to in his home country. Because he was attending college, the participant would also miss the timeslots for lunch and dinner, only leaving him access to breakfast at the hotel. Throughout this period, he was living on less than £9 per week, and so had limited funds to buy his food as a substitute.

This participant also explained that, since dinner was scheduled for 5 pm and breakfast at 8 am, there were large intervals between meals. Whilst residents would try to save food from the mealtimes to consume in between meal times, as demonstrated above by Participants D and K, this was often disrupted, and they were often still left hungry.

## 2.3 Communal Meals

Whilst in institutionalised accommodation, residents are also often expected to eat together in shared canteen areas. Participants explained to us that many of the tangential issues embedded in the asylum system would rise to the surface during these mealtimes. Participant E, for example, spoke to us about the mealtime discussions about removals to Rwanda. This led this participant to put a chair up behind his door for fear that police would push his door open to deport him in the night. He pointed to his hair and identified his white hair as a result of this stress. Throughout this period, he struggled to sleep due to this anxiety. This participant stopped sitting in the hotel restaurant, instead taking food to his room for fear of hearing bad news or rumours.

## 2.4 Quality and Quantity of Food

By far the biggest chunk of these focus groups was taken up with discussions of the quality and quantity of food provided in institutionalised accommodation.

“My experience in the hotel when I was pregnant was terrible, and the food was horrible. Sometimes I cannot eat for the food they are making is not the food I like. But the way I find myself in the situation, I can only eat the egg and bread, sometimes spaghetti.”

*Participant D*

Multiple participants gave some shocking descriptions of being served raw meat in the hotels. Participant E spoke of finding blood on the chicken they were served. Rather than it necessarily being an issue with the ingredients the hotel chefs would use, several participants explained that it was the way it was cooked. They told us that the food was often going straight from the kitchen to the table to the bin. Participant F also remembered having been served meat with feathers on it, which also smelled unhygienic. Whilst he managed to quit smoking, he later took the habit up again as a means to cope with the hotel conditions. He refused to eat the food he was served, losing over 30kg when he moved to a new hotel. Overall, he told us that he had lost around 70kg whilst living in hotels due to the poor quality of the food.

Along with refusing to eat the poor-quality food, Participant E also attempted to buy food outside of the hotel. Yet due to the low levels of financial support he was receiving, he found himself increasingly in debt as he borrowed money to be able to afford basic food items to sustain himself.

Several people referred to the poor quality of food as a demonstration of the failures of the Home Office and Mears to account for cultural differences, suggesting that if an Arabic chef were hired, residents would eat well enough to be nourished. This is not only due to better quality cuisine, they said, but also food that suits the dietary requirements and cultural expectations of the residents. Participant F told us that the rice served in the hotel is often undercooked and unpredictable. Since he was moved out of a hotel and into a private flat, Participant F has invited residents of the hotel to his house to eat, despite still having a meagre income, recognising the hunger of those still resident in the hotel.

These experiences were a little different for those from Ukraine who lived in a hotel whilst they had refugee status. For example, Participant K explained that there were Ukrainian cooks on the ship they were resident in. Nonetheless, they stated that this food was still fatty and fried, and did not suit the requirements of her or her children. This was corroborated by Participant H, who stated that much of the food provided in the hotel was fried and that they bought ready meals from supermarkets instead of taking hotel food. Participant I stated that since moving to Scotland the changes in the food they must eat have left her and her children with stomach issues as they are not eating very well.

In response to the poor food quality, one participant in Group 1 spoke to us about going on a hunger strike. Whilst other hotel residents were being moved out of the hotel after being deliberately disruptive, he did not want to cause difficulties. Instead, he decided to 'strike and not eat' as he 'wants to be able to leave and can't take this anymore'. This participant also told us he had medical files already accessible to hotel staff related to psychiatry. He was moved out of the hotel 20 days later.

This report looks in more detail at the impact of diet and its relationship with mental health later on, but it is important to note here that this poor quality of food provision in asylum hotels generated feelings of severe stress and anger among the participants. Participant E felt this was ubiquitous amongst all 70 of the residents at his hotel. He recalled regularly witnessing people tasting food and refusing to eat any more. He explained that his mental health has improved significantly since leaving the hotel, but remembering his time there can trigger a period of depression. He suggested this caused fluctuations in his weight.

## 2.5 Difficulties with Staff

"The residents would give a report to Mears about the food but would get no answers, nobody cares. The Mears Officer claimed they would change, but three days later, things would be the same."

*Participant E*

Participants also expressed their frustration with staff at the institutionalised accommodation centres, primarily with their failure or unwillingness to listen to residents. Participant E told us that the Mears staff members were not listening to complaints about the quality of the food, arguing that if even one of the cooking staff learnt an Arabic style of cooking, there would be significantly less wastage and improved quality of life for residents. Nonetheless, nothing has changed. This participant recalled one chef at a hotel asking the residents what food they wanted — it took 10 months for their request for culturally appropriate food to be met. Throughout this period, the chefs continued to prepare food residents were unable to eat, without alternatives available. Even when engaging with the proper routes to make a change, through engaging with an advisory panel available at the hotel, Participant E explained that no further action was ever taken. Participants from a different focus group, I and H, told us that they complained many times about the food, but no changes were made for them either.

The participants in Group 1 seemed unanimous in their feeling that Mears staff did not care about them. They often referenced rudeness from staff, with Participant F telling us

that he often felt he was being insulted but could not communicate as he did not speak fluent English.

### 3. Low Rates of Home Office Support

“We struggle with it [...] my little boy’s needs are coming first”

*Participant A*

“I want to eat fries and meat and ice cream, but for now, ice cream is £3, and I can buy Vaseline for my son with that”

*Participant B*

“If you are not OK, your child is not going to be OK, and that is taken for granted.”

*Participant B*

As mentioned throughout this report, the low support rates provided are a direct barrier to people in the asylum system from getting the food they want and need. People seeking asylum are not allowed to work. Accordingly, when the food provided was raw, undercooked or culturally inappropriate, many of the participants were unable to find alternative sources of food.

N.B: Those in Group 3 had access to the Ukrainian resettlement scheme. Accordingly, they had the right to work, had access to Universal Credit and other benefits, and were not subjected to these low levels of asylum support. Nonetheless, given the low rates of benefit payments, and other tangential factors associated with migration, many also struggled in poverty upon arrival in the UK.

#### 3.1 Poverty

Participant E was outspoken about his experience spending money on food. He had stayed in many different hotels and lived on financial support of £8.86 per week for a long time. He told us that with the poor quality of food, being forced to skip meals to attend college, and the general stress of the hotel, he often attempted to find food outside of the hotel setting. Nonetheless, the cost of travel and essentials meant that he often struggled on his £8.86 per week to get any food, an issue that increased in severity with the cost of living crisis.

#### 3.2 Motherhood

In Group 1, comprising mothers who were pregnant whilst in the asylum system, all participants spoke to us of the challenges they faced balancing their budget and ensuring

they and their child were able to eat. Participant A received £45 per week during her pregnancy and while raising her child. She told us that “we struggle with it [...] my little boy’s needs are coming first”. She explained that she could not buy him new clothes, and expressed her outrage that some playgrounds require payment. She told us of one example in the Glasgow Fort Shopping Centre costing £5 for every twenty minutes in the playpark. As her son gets very lonely in their house and feels very isolated, she feels like it is important for him to have access to these spaces. School uniform was another additional cost mentioned by this participant.

Participant B also has a young child. She told us that she buys small cuts of meat that can be put in a soup, does not buy any fruit, and solely makes and eats food that will make her feel full. The budget is too tight, she told us, and she must buy baby milk, nappies and clothing. She expressed stress about buying food for her son, who is six months old. She explained that she is balancing costs in her head, and her child is the priority. Upon listening to the other women in the session, she also told us that she is saving long-term for school uniforms now.

A participant in Group 3, who had access to different entitlements due to having refugee status, also struggled financially. Whilst she was able to access Universal Credit when living in a hotel, they did not have a kitchen to cook the food. Her daughter also developed medical issues during this period and needed treatment which cost money. She was balancing the budget between her daughter’s medical treatment and her family’s food.

### 3.3 Culturally Appropriate Food

Participant A spoke to us about the difficulties she has faced getting culturally appropriate food. To get Halal meat, she is forced to take two buses, costing her extra to acquire the food she needs. Participant B also expressed that she was not able to enjoy the relationship with food that she had in Africa, speaking of the joy and community food had brought her before migrating. She spoke about how meat was integral to meals in her community at home, but that she was unable to afford this here.

## 4. The Impacts of Diet

“I was losing weight. When I went to the hospital, my midwife said the baby is not growing because I do not have enough food to eat. So, when I come to the hotel again, I told that the midwife said the baby is not growing because of lack of food. I was just eating chips chips chips, there is no protein.” *Participant D*

“I would get back pain, the bed is not good, the food is not good, the children are suffering at that time, crying for food. But what they have, is what they gave us. We have to manage it and accept it” *Participant D*

This report has explained how, for our participants, poor food provision in institutionalised accommodation and low support rates impacted diet and relationships with food. This section will explore how the changes to diet created by hostile immigration policies impacted our participants, both physically and mentally.

#### 4.1 Physical Health

All participants expressed the impact of their diets on their physical health. For some participants with health issues, this was more pronounced. Participant A, who has sickle cell disease, expressed her difficulties in finding and buying food that could mitigate some of the worst symptoms of her illness. Whilst she had been told that high levels of protein could be helpful, the price of meat was too high. As she was also looking for Halal meat, which required a long and costly journey to acquire, she was often unable to eat in a way that could help her control her symptoms.

For others, the food that was provided or that was accessible caused physical ailments. Participant C informed us that when she was pregnant and made to eat the same food every day, she would regularly experience heartburn and pain inside her throat. When she ate new food, she would often experience what appeared to be acid reflux, stopping her from eating and causing her to feel close to vomiting. Participant E self-diagnosed with Vitamin B deficiency when he noticed paleness and greyness in his face, which he believed to be symptoms of lacking nutritious food. This participant also noticed an increased tiredness whilst eating the food in the Home Office hotel. Other participants referenced hair loss and chronic stomach issues as consequences of the poor quality of water and food provided. Participant K informed us that she still often gets sick after each meal.

The food in the hotels was also referenced as a reason for weight gain. Participant K told us that whilst living in hotels for a year, her son gained 50kg, and she gained 38kg. Since cooking for themselves in their kitchen, her son has lost 10kg. While weight can fluctuate healthily over time, the family perceived this weight gain in these particular circumstances to be negatively associated with the poor quality, unhealthy food being provided in the hotels.

## 4.2 Mental Health

As Participant E highlighted, 'eating and mental health are very closely linked'. Whilst he did not think he had suffered from an eating disorder, he suggested that he had very poor mental health in the asylum system as a result of multiple factors, including poor food provision. Whilst in college, he told us, his mind would wander towards food timings and thinking about whether there would be any food left for him when he returned. He told us that he could not think constructively about his future. Participant F corroborated this experience, stating that his mental health suffered severely due to the poor food provision. He told us of having suicidal thoughts and wanting to rip off doors and windows from his accommodation due to this protracted frustration.

## 5. Understanding Eating Disorders

"I have struggled with my weight a lot. ... I love Indomie, but it's not healthy to eat the same thing all the time. I used to like pasta, but moved to these noodles, and ate these constantly to feel the taste of home"

*Participant C*

"I would say it's common to have an eating disorder without knowing ... Being African, you are meant to just accept what you have technically so you might not understand you have this thing until you understand what it is."

*Participant C*

The participants of these focus groups had all migrated to the UK. Accordingly, many reflected on the shifts in their relationships with food. There appeared to be an interlinking series of factors that had forced participants' relationships with food to change, including some of the issues already mentioned in this report. Primarily, participants spoke about the joy of food being diluted through poverty, stress, and uncertainty. When the focus group was guided towards conversations about eating disorders, many participants expressed that there might also be cultural differences in understandings of eating disorders and mental health that should be considered.

## 5.1 Mental Health

Participant C was hopeful about the future of understanding of mental health but suggested that there was little awareness of mental health in Nigeria. She told us that she hopes the next generation can change things as she believes that it is important that there is a clearer awareness of these issues. Participant B explained that she believes

Namibians are the same, and teachers do not speak to young people about mental health, perpetuating old stigmas.

## 5.2 Eating Disorders

Most participants required facilitators to explain what an eating disorder was, and none overtly identified with the phrase. Participants from Group 3 told our facilitators that they had not heard of the term 'eating disorder'. Whilst many described a difficult relationship with food, none made it clear to facilitators that this was something they identified with. Instead, once they were provided with the definition, many opened up about their mental health, the stress of the asylum system and poor food quality in institutionalised accommodation.

Several participants suggested that their relationship with food had changed after migrating. Participant B reported losing her appetite when she was at home alone as a result of the memories of mealtimes with her extended family, and the absence of their company. For her, it was a lonely experience to eat at home. When she had attended events with other people where food was provided, she had not felt these feelings of loneliness which had resulted in a loss of appetite. Similarly, Participant A explained that the absence of family and community in her life meant that her relationship with food had been diluted. Food had been intrinsically connected to a social life, and her cultural identity, making it a source of happiness. Now, she only ate 'because you have to-joy doesn't come into it'.

Again, Participant C was very vocal about cultural differences in understandings of eating disorders. She told us that, in her experience, it's common to have an eating disorder without knowing, stating that 'being African, you are meant to just accept what you have [...] so you might not understand you have this thing until you understand what it is'. She went on to loosely describe an awareness of her changeable relationship with food, recalling periods where stress and uncertainty led her to overeat as a coping mechanism, and source of comfort.

## 6. Challenges to Accessing Support

"So, we don't have much power as an asylum seeker, because our opinion does not count, they do what they want to do at their own time. This is the thing. All we have is to be patient." *Participant D*

This report has detailed many of the overarching themes that came out of our conversations with participants in the asylum and immigration systems of the UK. The hostile environment has had a huge impact on their relationships with food and eating, especially given the enforced poverty that many have lived through. In this section, we will explore some of the barriers to accessing support that were noted by the participants.

### 6.1 Legal/Status Barriers

Some barriers to accessing health support appeared to emerge from the legal and immigration status of participants. Whilst Participant E spoke of having a good relationship with his doctor in the hotel, Participant F spoke of waiting 2-3 hours for an ambulance. Similarly, Participant H spoke about her son having a rash on his cheeks and her issues with blood pressure, with no one in the hotel who could support her through this. Participant I confirmed her difficulties attempting to see a doctor in the UK, telling us that she received her medication from her daughter, who sends it from Ukraine instead. Participant K also informed us of having to go elsewhere to get adequate medical care. Her daughter struggled severely with her mental health whilst in the UK, and was forced to travel to a psychiatrist in Germany for two weeks rather than wait the three years they were facing in the UK. The protracted stay in a single hotel room continues to badly affect her daughter.

We also heard from participants that the continued instability and insecurity of the asylum system, as detailed above, limits access to support. Participant B stated that she was attending counselling with Rape Crisis Scotland and the NHS, but due to health reasons, her GP cancelled her medication for depression when she became pregnant. In addition, she was informed that she would need to pack and leave her house on three occasions, despite having few places to go. She received no financial support for the first month after her baby was born.

### 6.2 Awareness of Services

When speaking about the asylum system, and after being provided with a definition of eating disorders, many participants expressed having little to no awareness of the support that was available to them. Participant K, for example, told us that she did not know what BEAT was, but that she believed it could be helpful for her daughter, who has been struggling to leave her bed or eat in a bout of depression. Participant H similarly stated that she was not aware of what services would be available to her or how to access them.

This might also be related to differences in the definitions or awareness of eating disorders among people who have migrated from other cultural contexts. Participant H and I, for example, had not come across the term 'eating disorder' before the session.

### 6.3 Stigma

Participant B said it was difficult not having meals with friends and family when she was pregnant. She didn't have anything whilst pregnant. She described how

*“You want your friends to come over but have nothing to offer them – they would come in and say ‘You don’t have any food, oh your fridge is empty, oh you’re eating bread again’, and I don’t know how to explain that I have no money to buy food, and so I lie and say I don’t feel like eating, as I am worried about judgement.”*

Rather than face these difficult questions and judgements from friends, she prefers instead to eat alone. Her limited income has affected both the food she can afford to buy for her and her son and has led to social isolation.

#### **Recommendations for Change**

Throughout this report, we have highlighted how experiences in the asylum system and as refugees have a direct impact on relationships with food and eating. This is due to enforced poverty, poor facilities and food quality, and the strain of navigating the UK system. Furthermore, there are more general cultural differences in perceptions of food and mental health to consider when tailoring services to those who have migrated. Below, we have given a series of recommendations for eating disorder service providers. Some of these are aimed towards ensuring services are accessible and recognised by communities that have migrated, and some look towards changing the material circumstances of those in the UK asylum and immigration system to mitigate some of the challenges they face.

##### 1. Ensure that resources are available in different languages.

Participants seemed generally unaware of the services that would be available to them. Navigating the asylum and immigration system whilst learning English can be hugely taxing, especially given the mental health pressures described in this report. Ensuring that resources are translated means that everyone can be more certain of the services provided and their eligibility for support. Translated resources can make people feel more comfortable in reaching out for support.

##### 2. Staff in health settings to undergo training on the asylum and immigration system.

As described by many of the participants, experiences of the hostile environment policies of the asylum and immigration systems shaped their mental and physical health. It is imperative that healthcare providers have an in-depth understanding of the policies impacting people who have migrated to the UK to ensure they can offer the best tailored services. This training must include considerations of poverty and poor food provision in

institutionalised accommodation settings — without this understanding, advice to clients could be misguided.

3. Healthcare services to provide culturally sensitive briefings, materials and resources.

Some of our findings show the importance of food as a connector between heritage and participants' lives after migrating. An awareness of the emotional role that food plays in the lives of all, and more specifically for those who have migrated, is necessary to provide the support needed. Furthermore, cultural awareness must be ingrained into the services provided and resources given out. This includes an awareness of the importance of certain food types and fasting and the possible impact this might have on eating patterns.

4. Healthcare services to run tailored outreach programmes for those who have migrated to the UK.

Whilst a presence on platforms like Instagram and Facebook is generally helpful for reaching wide audiences, there can be digital divides that prevent this information from getting to people seeking asylum. Alternative forms of outreach must be carried out to increase awareness of services. This could include outreach in institutionalised accommodation centres, translated leaflets and flyers, or a presence in community centres, doctors' surgeries, and libraries where institutionalised accommodation centres are based.

5. Communication with grassroots organisations and charities to be embedded into healthcare outreach and service provision strategy.

Collaboration and co-production with grassroots organisations and charities will root the work of healthcare providers in the lived experience of people seeking asylum. This is necessary for a clearer understanding of the needs and requirements of those in the asylum system. It will also ensure that the healthcare service meets the associated needs of those accessing their service — this might include bus fare, vouchers or other support packages detailed by those on the frontline.

6. Embed access requirements in service provision.

As demonstrated in our focus groups, many people we work with are living in severe poverty and sometimes destitution. Access needs could be diverse. These must be accounted for and budgeted for by the service provider to ensure that all barriers to accessing the service are mitigated. Access to healthcare should be as easy as possible for those in the asylum system.

7. Formulate lived experience panels.

As noted above, lived experience of the asylum and immigration system must guide the service provision. Accordingly, advisory panels should be established to offer guidance to service providers. These panels should include mothers, to ensure insight into childcare requirements is provided. These advisory panels should be compensated for their time and labour, whilst adhering to the ban on people seeking asylum from working. The panels established must include those from different backgrounds. All participants on the panels should have access to tailored care to ensure that participation does not cause distress or difficulties.

8. Communicate with decision-makers in local authorities and Government.

The research we have laid out here demonstrated the profound failures of the current asylum and refugee system in the UK. There are clear abdications of duty that are leaving people seeking asylum in a state of limbo and refugees in hardship. We recommend that healthcare providers and charities work together to communicate with decision-makers in local authorities and Government bodies to call for an end to the raft of hostile policies that are directly impacting the physical and mental health of people seeking asylum. This allows for an intersectional approach to combating the hostile environment and creating security for people seeking safety.

9. Support the call for the Right to Work for people seeking safety.

Similarly, we would recommend that healthcare providers and charities support the call for the right to work for people seeking safety. As demonstrated by this report, the impacts of poverty and enforced destitution are manifold and have been seen to have dire consequences for people's relationships with food and eating. People seeking safety must be able to earn in safe and inclusive environments, therefore accessing financial freedom and agency over food and eating.

### **Concluding Statement**

This research has drawn on three focus groups and two pieces of written testimony to explore the impact of the asylum and immigration systems in the UK on relationships with food and eating. Primarily, our findings have demonstrated the failures in provision for people seeking asylum and refugees in the UK. Our participants delivered some harrowing testimonies, with consistent references to the stress of the asylum system, the poor food quality, and their experiences of enforced poverty. For those who were mothers in the asylum system, there was an added level of difficulty attempting to balance the mental and physical health of their children against their low income and insecure immigration status. The strain of these experiences appears to have directly impacted their relationships with food and eating, with many citing the mental and physical consequences of the insecurity and isolation they faced.

We have also found a generally low awareness of support services among our participants, particularly of eating disorder charities. Many participants were confused at the mention of the phrase 'eating disorders', with some citing cultural differences as a reason for the different understandings. Whilst some participants related to struggling with food and eating, many attributed this to the strain of the asylum system and did not personally identify with the definition of eating disorder. Healthcare professionals and charities must work to ensure that communities seeking safety and refugees are well-informed about the resources and services available to them.

As suggested in our recommendations, charities and healthcare providers must be well-trained and informed about the experiences and cultural specificities of communities that are seeking safety and have refugee status. They must be well-acquainted with the challenging circumstances that people seeking safety grapple with, and be informed by those with lived experience of the asylum system on how best to meet the needs of these communities. Furthermore, charities and healthcare providers must enhance the fight for justice for people seeking asylum and refugees, by joining calls for the right to work and against the hostile environment that is having such catastrophic impacts on tens of thousands of lives.

We want to extend our thanks to all those who participated in this research and shared their experiences of hardship and poverty due to the UK asylum system.