Race Equality Framework for Scotland

Health and Home

Evidence Paper (Updated May 2016)

This paper is divided into three parts:

1. Background
2. Key terms
3. Evidence and context
4. Appendix: Key underpinning threads and questions

Part One: Background

The Scottish Government has renewed its approach to race equality, having worked in partnership to develop a Race Equality Framework for Scotland to promote equality and tackle racism. This Framework will be in place for 2016-2030.

The Scottish Government led on this work with involvement and input from key stakeholders and with support from the Coalition for Racial Equality and Rights (CRER).

In the lead up to the development of the Race Equality Framework for Scotland, an Interim Evidence Paper collating a range of evidence and information on health and home[1] in the context of race equality was provided to stakeholders to assist in engagement and help frame discussion and further research.

This Evidence Paper has now been updated following additional research. The information provided is accurate and up-to-date to the best of CRER's knowledge at the time of publication.

Please note, the information contained in these evidence papers has been gathered by CRER across a range of sources including the Scottish Government and its Agencies research publications and National or Official statistics, in order to inform the development phase of the Race Equality Framework for Scotland. Scottish Government and its staff are not responsible for any content in these papers outside its own publications.

Why take action on health and home?

'Health and home' was identified as one of the five priority areas[2] in the development of the new Race Equality Framework for Scotland due to the range of evidence demonstrating that minority ethnic groups are disadvantaged on a range of measures and indicators throughout these areas.

Health and home are closely linked policy areas, with disadvantages in one area often being linked to disadvantages in another. For example, family breakdown is one of the major causes of homelessness, whilst homelessness and poor quality housing correlate with poor health. Research suggests that minority ethnic people are more likely to experience disadvantaged housing circumstances, overcrowding, poor living conditions and homelessness. It also shows significant differentials in the self-reported health status of

[1] Please note, in this evidence paper, issues dealing with the family (e.g. informal caring and child protection) are dealt with under the heading of "Home".
[2] The other priority areas within the Framework are: community cohesion and safety; participation and representation; education and lifelong learning; and employability, employment and income

ethnic groups, with poor mental health emerging as a major issue particularly affecting asylum-seekers and refugees and exacerbated by destitution.

The evidence gathered on these subjects can be found in Part Three of this evidence paper.

Key issues:

- Although minority ethnic groups are less likely to have long-term limiting health conditions and disabilities, there are differences among minority ethnic groups, with worse outcomes in particular for Gypsy/Traveller and Pakistani communities.

- Minority ethnic groups are less likely to report health damaging behaviours such as smoking, excessive alcohol consumption and drug misuse. However, there is a mixed picture in relation to other health and wellbeing indicators, such as participation in physical activity and obesity levels.

- Some specific health conditions are more likely to be experienced by people in particular minority ethnic groups, but data on these issues for Scotland is patchy.

- Minority ethnic households are generally younger, more likely to be experiencing overcrowding and more likely to be privately renting (with associated higher financial costs).

- Non-white individuals are more likely to be homeless than white individuals.

- Lack of effective data collection and small sample sizes mean reliable data is lacking in home-related policy areas, particularly focusing on family units.

- Qualitative studies show continuing concerns about the accessibility and suitability of services for minority ethnic people in many health and home related policy areas.

Part Two: Key terms

What do we mean by health and home?

This section sets out the key terminology and context regarding health and home, as well as related areas, for the development of the Race Equality Framework for Scotland.

Health and health inequalities

Health can be defined as, "the state of being free from illness or injury," and refers to "a person's mental or physical condition."[3] The World Health Organisation (WHO) takes this definition further and states, "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[4] According to the National Health Service (NHS) Scotland, public health refers to, "the science and art of promoting and protecting health and wellbeing, preventing ill health and prolonging life through the organised efforts of society."[5]

The Scottish Government aims to "help people sustain and improve their health, especially in disadvantaged communities, ensuring better, local and faster access to health care."[6] Compared to other European countries, people in Scotland experience relatively poor health. While the health of Scots overall is improving, challenges persist to help people live healthier lives and reduce smoking, alcohol and drug misuse.[7] Areas of particular concern to the Scottish health services include preventative healthcare, combatting diseases and infections, addressing long-term conditions, addressing drug and alcohol misuse and rehabilitation, preventing and decreasing smoking, increasing blood and organ donations, improving dentistry, improving sexual health and improving mental health.[8]

The NHS Scotland notes that health inequalities are unfair differences in the health of a population.[9] In Scotland, many people die earlier than their peers or live with preventable illnesses. As an example, those living in Scotland's most deprived areas have a life expectancy 13 years fewer than those who live in the least deprived areas.[10] Research from the Scottish Public Health Observatory (SPHO) suggests that people who are most affected by inequalities in society (such as those with lower incomes, women, people from minority ethnic groups, older people and disabled people) are more likely to have poorer mental and physical health than the rest of the population.[11]

Statistics about health in Scotland can be found in Scotland's Census, which categorises general health, long-term health problems and conditions, disability and unpaid care by sex, age, socio-economic status, ethnicity and more.[12] The Scottish Health Survey also provides

[3] Health. Oxford English Dictionary.
[4] WHO definition of health. World Health Organisation.
[5] NHS Education for Scotland. Public Health.
[6] The Scottish Government. Health.
[7] The Scottish Government. Health Services.
[8] Ibid.
[9] NHS Health Scotland. Health inequalities.
[10] Ibid.
[11] Scottish Public Health Observatory. Health inequalities.
[12] Scotland's Census.

a comprehensive picture of health in Scotland within households and is designed to identify gaps in provision and groups at particular risk for ill health.[13] Research about specific areas, such as care experience, mental health and the health of older people is also contained in the report.[14]

Wellbeing

There is no single definition of wellbeing. The Carnegie Truest notes that definitions are very broad, taking into account social, economic and environmental factors.[15] There are also narrower definitions. For example mental wellbeing explores the concept of wellbeing from a mental health perspective.[16] For the purposes of this paper, we would regard someone's wellbeing as their level of health and satisfaction with life. Although we do not refer specifically to wellbeing measures such as satisfaction and contentment, or to other important aspects of wellbeing such as prosperity, many of the factors which contribute to wellbeing are reflected throughout this paper.

Social work services and social care

Scotland has a wide range of services in place which are focused on supporting and protecting people or helping them to deal with challenging circumstances in their lives. These services include but are not restricted to: local authority social work services; care home and care at home services for adults; services for young children (e.g. nurseries and after-school clubs); adoption and fostering; residential care for children; and additional support services.[17] Within this paper, these policy areas are addressed in separate sections – adult-focussed services (within the section on health) and support for families and children (within the home section).

The Scottish Government works with service users, carers, local authorities, the NHS Scotland, the Care Inspectorate and other improvement bodies and voluntary and independent organisations to develop and improve social care services. Areas of current policy focus in Scotland in regards to social care include self-directed support for those who need social care, adult rehabilitation, support and protection for vulnerable adults, bereavement care, support for unpaid carers, independent living for those with health conditions, self-management of long term illnesses and a range of support for children and families.[18]

Integration of health and social care in Scotland is currently underway. This integration is designed to ensure that people get the right care and support throughout their health and care journey.[19] The Public Bodies (Joint Working) (Scotland) Act was granted royal assent on 1st April 2014, and put in place national outcomes for health and social care and created Health and Social Care partnerships. These partnerships will be accountable to Scottish Government Ministers, local authorities, NHS Board Chairs and the public for delivering the

[13] The Scottish Government. Scottish Health Survey.
[14] The Scottish Government. Health statistics.
[15] Carnegie Trust (2013) Shifting the Dial in Scotland
[16] NHS Inform: Mental Health and Wellbeing Zone
[17] Scottish Social Services Council. Definitions.
[18] The Scottish Government. Support and social care.
[19] The Scottish Government. Integration of health and social care.

outcomes.[20] The outcomes aim to encourage people to look after and improve their own health and wellbeing, focus health and social care services on improving or maintaining the quality of life for service users, reduce health inequalities and use resources effectively.[21]

Home, housing and homelessness

Housing refers to people's accommodation and, in Scotland, can encompass areas such as social housing, home ownership, residential property conveyancing, private renting, landlords, housing associations, sustainable housing and homelessness. The Scottish Government aims to deliver high quality, sustainable and affordable housing, and to tackle homelessness in Scotland.[22] Scottish Planning Policy defines affordable housing as housing of a reasonable quality that is affordable to people on modest incomes.[23]

Social housing is housing owned and operated by public authorities (often local authorities) and housing associations (registered social landlords). Anyone can apply for social housing, however the criteria for allocating it focuses on supporting those who need it most, for example those on low incomes or with particular needs.[24] Social housing is usually cheaper than renting from a private landlord. Housing types include houses, flats, supported accommodation and sheltered accommodation.[25]

The private rented sector refers to housing owned and let by private landlords on the open market; most tenancies are short assured tenancies.[26] In contrast, a housing association is a not-for-profit organisation that rents out houses and flats with the aim of providing good, low cost accommodation for those who need it. Housing associations are run by committees of volunteers elected by tenants. Some accommodation is for particular groups, such as older people, disabled people or young people. All registered social landlords (such as housing associations) are regulated by the Scottish Housing Regulator.[27]

Independent housing allows those with a disability and older people to live independently in their own homes where possible. This requires support and the ability to adapt houses to make them suitable for those with reduced mobility and other needs.[28]

Overcrowding occurs in situations in which too many people live in a home based on the numbers of rooms (including any living room but not a kitchen or bathroom), the size of the rooms and the ages of the people who live there. According to Shelter Scotland, as a general rule, two people can live in a one room house, three people in a two room house, five people in a three room house, 7.5 people in a four room house and two people per room in a house with five rooms or more. The ages of people living there and their relationship, as well as the size of the room, also matter.[29] Houses in multiple occupation (HMOs) are living accommodations occupied by three or more unrelated persons as their only or main

[20] The Scottish Government. Integration of health and social care.
[21] Ibid.
[22] The Scottish Government. Built environment.
[23] The Scottish Government. Scottish Planning Policy.
[24] The Scottish Government. Social housing.
[25] Shelter Scotland. Council housing.
[26] The Scottish Government. Private renting.
[27] Shelter Scotland. Housing associations.
[28] The Scottish Government. Independent living.
[29] Shelter Scotland. Overcrowding.

residence and who share kitchen and/or bathroom facilities. A license is required to let a HMO accommodation.[30]

Homelessness means lacking a home. People who are homeless may be staying with family or friends, in hostels, in hotels or in other temporary shelters. Less frequently, they may have no shelter and be sleeping rough. Factors that may lead to homelessness include relationship problems, a drop in income resulting in rent or mortgage arrears, health problems, harassment by neighbours or an inability to stay in the home (for example due to poor or unsuitable housing conditions, overcrowding or a disaster such as fire or flooding).[31]

Due to a commitment made by the Scottish Government that all those assessed as unintentionally homeless would be entitled to settled accommodation from the end of 2012, Scottish local authorities now have a statutory responsibility to find settled accommodation for all people who are assessed as being unintentionally homeless. This removes the distinction between priority cases of homelessness and other cases which would not previously have been prioritised for settled accommodation.[32]

General housing statistics in Scotland can be found in the Housing Statistics for Scotland quarterly and annual reports and in Scotland's census.[33] [34]

Family

In this research paper, family refers to social units of individuals (for example parents and children) who have a family relationship. This includes both families who live together (including family units with one or more parents and children) and families who do not live together (for example families where children are looked after by the state, adults who live apart from their parents or a family which has separated). Topics which will be explored include looked after children, child protection, unpaid care and violence against women within the home / family context.

Other key terms

The following are some terms and ideas that could be useful in framing discussion about health and home in Scotland.

Racial discrimination

Racial discrimination occurs when someone is treated unfairly or less favourably because of his or her race; this can occur in all spheres of public life. Racial discrimination does not need to be deliberate to be discrimination, and can take direct and indirect forms.[35] Treating someone less favourably than another person due to their actual or perceived race, or the race of someone with whom they are associated, is direct racial discrimination. Indirect racial

[30] Aberdeen City Council. Houses in multiple occupation.
[31] Shelter Scotland. What is homelessness?
[32] The Scottish Government. Homelessness.
[33] The Scottish Government. Housing Statistics for Scotland.
[34] Scotland's Census.
[35] Citizens Advice. Discrimination because of race.

discrimination occurs when there is a condition, rule, policy or practice in an organisation that particularly disadvantages people who share the protected characteristic of race.[36]

Institutional racism

The report following the Stephen Lawrence Inquiry, also known as the Macpherson Report, which scrutinised the Metropolitan Police's mishandling of their investigation into the 1993 murder of Black British teenager Stephen Lawrence, defined institutional racism as: [37]

> "… *the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people*."

In Scotland, research from CRER has shown that institutional racism is present throughout society, including in the criminal justice system, the NHS, housing, and education sectors.[38]

Intersectionality

Intersectionality considers the interaction of various aspects of identity that might be associated with a risk of inequality, such as race and ethnicity, sex, gender identity, age, religion, disability and sexual orientation. Additionally, economic class, skills, qualifications, being born in the UK and experience can change the meaning or impact that some demographic characteristics have.[39] Issues of poor equality monitoring, viewing minority ethnic groups and individuals as one group, and additional marginalisation and discrimination continue to affect minority ethnic communities.[40]

[36] Equality Law. Types of discrimination: definitions.
[37] The UK Government. The Stephen Lawrence Inquiry.
[38] Coalition for Racial Equality and Rights. Institutional Racism: Scotland Still Has Far to Go.
[39] Joseph Rowntree Foundation. Poverty and Ethnicity: A review of evidence.
[40] Centred. Intersectionality Literature Review.

Part Three: Evidence and Context

This section contains a summary of the context, key evidence and data available on health, and home for minority ethnic communities in Scotland. The focus is on the collation of statistical data, although the quality of the information gathered and its impact on practice is beyond the scope of this paper. It should be noted that evidence is lacking in several areas, or is not made publicly available or collected centrally.

With regard to ethnicity terminology, this paper reflects the research methods of its sources. There are differing definitions of the term 'minority ethnic'; some include only non-white groups, others encompass all groups who do not identify themselves as white British. In rare instances, all except for white Scottish are included. Where possible, we have stated that research is exploring differences between, for example, white and non-white ethnicity categories. However, many sources do not use clear definitions – for example using only 'minority ethnic', 'BME' or 'BAME,' without defining who exactly is included in these categories. In these cases we have used the terminology employed by the original authors (without judgement as to the suitability, appropriateness or validity of the terminology used).

It should be noted that this is not just an issue for research collation, but also for policy – broad headline categories fail to capture the intricacies of outcome and experience for specific minority ethnic groups.

Census Figures

The 2011 Scottish Census revealed that Scotland became more ethnically diverse from 2001 to 2011, with the non-white minority ethnic population doubling from 2% to 4% of the total population, or 210,996 people.[41] [42] Furthermore, 221,620 individuals identified as being non-British white (including white Irish, white Gypsy/Traveller, white Polish and 'other' white) accounting for approximately 4% of the population. Non-white minority ethnic groups also had a much younger age profile than most 'white' ethnic groups. [43]

Glasgow City and the City of Edinburgh are the largest Scottish local authorities, with approximately 20% of Scotland's population. Research shows that collectively, they house 51% of the minority ethnic population, with Glasgow having a minority ethnic population of 12% and Edinburgh 8%. Aberdeen City (8%) and Dundee (6%) also have a higher percentage of minority ethnic communities than other areas of Scotland.[44] [45]

Furthermore, according to the 2011 Scottish Census, minority ethnic households overall are more likely to be in urban areas in Scotland, with 85% of African households, 78% of Pakistani households and 77% of Chinese households living in large urban areas compared to 40% of all households. The 2010 Annual Population Survey reported that 0.8% of the population in rural areas were from a minority ethnic background compared with 4% of the population in urban areas.[46]

---

[41] Scotland's Census 2011. Ethnicity, Identity, Language and Religion.
[42] Scotland's Census.
[43] Ibid.
[44] Ibid.
[45] Joseph Rowntree Foundation. How has ethnicity changed in Scotland?
[46] Scottish Government. Ethnicity and Rural and Environment.

It is important to note an increase in the numbers of minority ethnic individuals who were born in the UK, rather than being recent migrants. The effects and impact of some aspects of race inequality for this group will differ in ways to that of recent migrants. According to the Scottish Government's analysis of the 2011 Scottish Census, half of Pakistani and Caribbean or Black groups were born inside the UK and over a quarter of Chinese, Indian and Bangladeshi individuals were born inside the UK.[47]

Only the white Polish group indicated that less than 80% (71%) spoke, read, and wrote English well. All other ethnic groups reported above 80% speaking, reading and writing English well.[48]

[47] Scottish Government. Analysis of Equality Results from the 2011 Census.
[48] Scottish Government. Analysis of Equality Results from the 2011 Census.

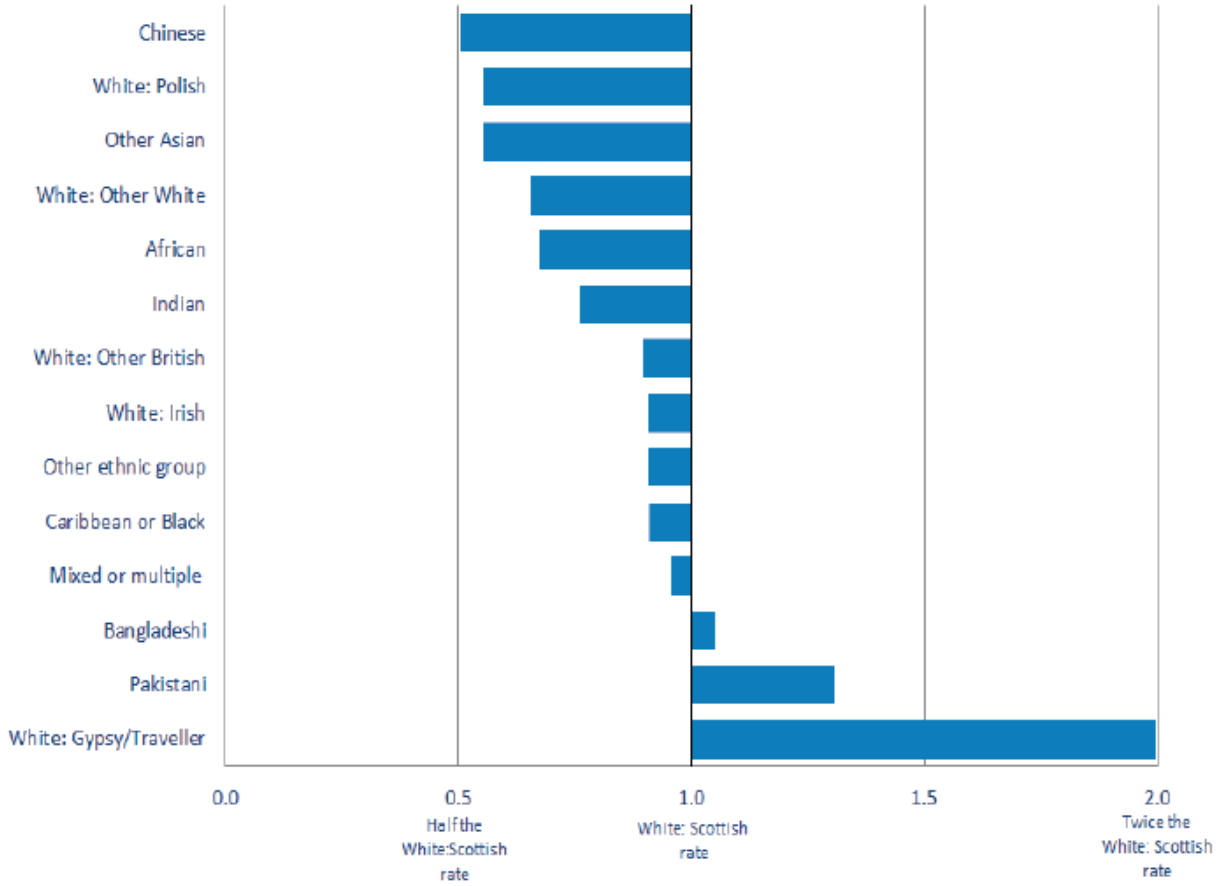
Health

Long-term health conditions and general health

As minority ethnic groups tend to be younger than the majority population, it is important to make adjustments for age to in order to analyse the health of minority ethnic groups and their comparable population. In August 2015, the Scottish Government published “Which ethnic groups have the poorest health?”[49] which used age standardised rates to compare ethnic groups of similar age.

The following graphs show the health differences using age standardised rates separated by ethnicity and gender to show a clearer picture of the health of minority ethnic groups.[50]

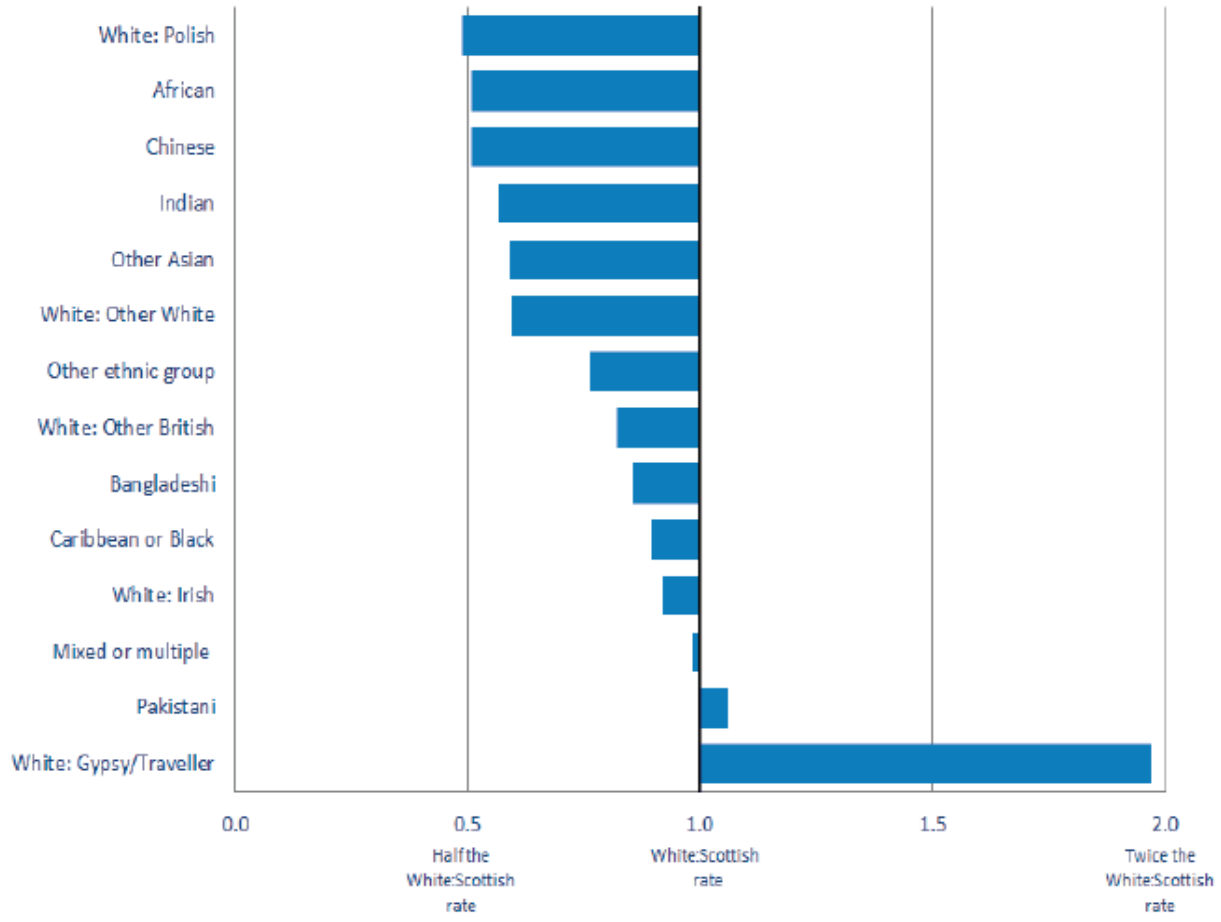
Ethnic Inequalities in health for women, 2011 - Age-standardised ratios of long-term limiting health problems or disabilities for ethnic groups compared to the 'white: Scottish' group



Source: Scottish Government (2015) Which Ethnic Groups Have the Poorest Health?

[49] Scottish Government (2015) Which Ethnic Groups Have the Poorest Health?
[50] Ibid.

Ethnic Inequalities in health for men, 2011 - Age-standardised ratios of long-term limiting health problems or disabilities for ethnic groups compared to the 'white: Scottish' group



Source: Scottish Government (2015) Which Ethnic Groups Have the Poorest Health?

This data, which has been separated by gender and ethnicity, broadly mirrors the top line findings from the Scottish Census 2011 with some additional points of interest: [51]

- Bangladeshi and Pakistani women are roughly 10% more likely to suffer from health inequality than white women.
- Ethnic inequalities in health are most pronounced at older ages:
    - 56% of all women aged 65 or older reported a limiting long-term illness, but over 70% of Pakistani, Bangladeshi and Gypsy/Traveller women at this age reported a limiting long-term illness.
    - Arab and Indian older women also reported high percentages of limiting long-term illness (66% and 68% respectively).
    - 50% of all men aged 65 or older reported a limiting long-term illness, but 69% of Bangladeshi and Gypsy/Traveller older men reported a limiting long-term illness.
- The Chinese ethnic group reported persistently better health in 1991, 2001 and 2011, with half or under half the white ethnic group illness rates for both men and women.

[51] Centre on Dynamics of Ethnicity (2013) Which Ethnic Groups Have the Poorest Health?

The Equality and Human Rights Commission (EHRC) also reported, based on analysis from the Scottish Government, that: [52]

- Older Indian, Pakistani and Bangladeshi women reported worse health than older men in the same ethnic groups.
- Gypsy/Travellers reported poorer health than the overall population, with a greater proportion of Gypsy/Travellers rating their health as bad or very bad (15%) compared to the average for Scotland (6%).
- The majority of recent migrants (those who have been living in Scotland for less than ten years) reported that their general health was good or very good.

In the Scottish Census 2011, individuals classified as having their day-to-day activities limited a lot accounted for 9.55% of the overall population aged 16 and over. 9.79% of the white population and 3.86% of the non-white population were classified as having their day-to-day activities limited a lot.[53]

Day to day activities limited a lot by general health and ethnicity, population aged 16 and over, 2011

	Day-to-day activities limited a lot: Total	Day-to-day activities limited a lot: Very good or good health	Day-to-day activities limited a lot: Fair health	Day-to-day activities limited a lot: Bad or very bad health
All white ethnic groups	9.79%	1.35%	3.68%	4.77%
All non-white ethnic groups	3.86%	0.67%	1.24%	1.94%
Mixed or multiple ethnic groups	3.69%	0.90%	1.11%	1.69%
Asian ethnic groups	4.14%	0.64%	1.38%	2.12%
African ethnic groups	2.22%	0.56%	0.57%	1.08%
Caribbean or Black ethnic groups	5.63%	1.18%	1.99%	2.46%
Other ethnic groups	3.84%	0.65%	1.12%	2.07%
Total	9.55%	1.32%	3.58%	4.65%

Source: Scotland's Census 2011

Overall, those from all white ethnic groups had a higher percentage of their population with day-to-day activities limited a lot.

Data from the Scottish Survey Core Questions 2012[54] asked individuals to assess their own general health. The results were as follows:

[52] Equality and Human Rights Commission Scotland (2016) Is Scotland Fairer?
[53] Scotland's Census 2011.
[54] The Scottish Government. Scottish Survey Core Questions 2012.

Self-assessed general health by ethnicity, 2012

	Good / Very Good	Fair	Bad / Very Bad
White Scottish	72.6%	19.6%	7.8%
White Other British	74.3%	19.8%	5.9%
White Polish	90.3%	7.2%	2.5%
White Other	82.2%	12.9%	4.8%
Asian	80.9%	16.1%	2.9%
All Other Ethnic Groups	90.4%	6.5%	3.1%

Source: Scottish Survey Core Questions 2012

Overall, a higher percentage of those from other ethnic groups, Asian ethnic groups, 'other' white ethnic groups and the white Polish ethnic group reported being in good or very good health, compared to the white Scottish and other white British ethnic groups.

The survey[55] also asked respondents to identify any limiting long-term physical or mental health conditions. The results were as follows:

Limiting long-term physical or mental health conditions by ethnicity, 2012

	Limiting Condition	No Limiting Condition
White Scottish	25.2%	74.6%
White Other British	23.7%	76.3%
White Polish	8.1%	91.9%
White Other	15.1	84.8%
Asian	10.8%	89.2%
All Other Ethnic Groups	11.2%	88.8%

Source: Scottish Survey Core Questions 2012

Those from the white Scottish and other white British ethnic groups were more likely to report having a limiting long-term physical or mental health condition.

General Health and Mental Wellbeing

In 2012 the Scottish Government published "The Scottish Health Survey: Topic Report on Equality Groups," [56] which examined annual Scottish Health Survey data between 2008 and 2011. The question used to determine respondents' ethnic group was changed after the 2008 survey to match the harmonised ethnicity question which was being developed for the 2011 Census. In order to combine the data for 2008-2011, some of the categories were amalgamated where there were mismatches across the two questions.

[55] The Scottish Government. Scottish Survey Core Questions 2012.
[56] Scottish Government (2012) The Scottish Health Survey 2008-2011: Topic Report on Equality Groups.

This report considers general health and mental wellbeing by three indicators: self-assessed health, the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS)[57] and the General Health Questionnaire (GHQ12).[58] Findings from the Scottish Health Survey were broadly similar to those in the 2011 Scottish Census: [59]

- Those who reported their ethnic group as Pakistani were the least likely to rate their health as good or very good (66%), although due to small sample sizes this was not significantly different from the national average of 76%. However this does corroborate with other research which found that Pakistanis in Britain are less likely to report good health.
- Chinese respondents were the most likely to rate their health as good or very good (91%) which was significantly different from the national average.
- White British respondents had the lowest levels of wellbeing of all ethnic groups (mean WEMWBS score of 49.8). This was significantly lower than that the scores of 'other' white ethnic groups (51.2), African, Caribbean or Black ethnic groups (53.7) and 'other' Asian ethnic groups (53.5).
- 'Other' ethnic groups (25%), the Pakistani ethnic group (23%) and the African, Caribbean or Black ethnic groups (18%) had the highest proportion of respondents with high GHQ12 scores, but none of these were significantly different from the Scottish average (15%). Chinese and 'other' Asian ethnic groups had the lowest proportion of high GHQ12 scores (both 10%), which was not dissimilar from the national average (15%).

In 2013 the University of Edinburgh reported that minority ethnic populations in Scotland received varying levels of support for their mental health. Its findings reported that South Asian and Chinese individuals in particular were often much later in entering mental health support services than those from other ethnic groups. In most minority ethnic groups in the study, those that went to hospital were significantly more likely to be treated under the Mental Health Act.

The report authors noted that difficulties in diagnosing and treating mental illness among minority ethnic groups at an early stage goes some way to explaining their findings. In general, a lack of awareness of support services available and reluctance to seek medical help due to social stigma within minority groups also contributed to this.[60]

The EHRC reported that although higher proportions of adults from minority ethnic groups were at risk of poor mental health in 2008, this was not the case in 2012.[61] Further analysis of this was not available.

---

[57] WEMWBS is a scale used to assess positive mental wellbeing. Higher scores indicate a better mental wellbeing. The scale ranges from 14 to 70.
[58] The General Health Questionnaire 12 (GHQ12) is the most extensively used screening instrument for common mental disorders, in addition to being a more general measure of psychiatric well-being. Lower scores indicate a better state of mental health. The scale ranges from 0 to 12, with 4 or more (a 'high' score) indicating the presence of a possible psychiatric disorder.
[59] Scottish Government (2012) The Scottish Health Survey 2008-2011: Topic Report on Equality Groups.
[60] Bansal, N, Bhopal, R, Netto, G, Lyons, D, Steiner, MFC & Sashidharan, SP 'Disparate patterns of hospitalisation reflect unmet needs and persistent ethnic inequalities in mental health care: the Scottish health and ethnicity linkage study' Ethnicity and Health, vol 19, no. 2, (2013) pp. 217-239
[61] Equality and Human Rights Commission Scotland (2016) Is Scotland Fairer?

A scoping exercise with Pakistani and Chinese communities in Scotland in 2008[62] found that many dimensions of wellbeing are linked for these groups, e.g. family wellbeing, spiritual wellbeing and material wellbeing, with an emphasis placed on social connectedness. In general, community members viewed mental wellbeing as incompatible with mental illness, with mental illness defined in terms of severe mental illness and with more common mental health issues viewed as part of life.

An evidence review by the Scottish Public Health Network (ScotPHN)[63] suggested that mental health may be more affected by migration than physical health. For example, alcohol and drug misuse, perhaps used to cope with the stress of migration, may cause migrants to be more vulnerable to mental health issues. Some mental health issues may be brought out more than in migrants' countries of origin due to the high stress culture of western societies. Stigma may also cause some groups of migrants to underuse mental health services.

Access to Healthcare

The EHRC's report "Is Scotland Fairer?" [64] noted that some ethnic groups may have problems accessing healthcare services. The report noted that across Britain, the physical and mental health of Gypsy/Travellers was poorer than the rest of the population and that this group had poorer access to primary care and GP practices.

The Scottish Parliament examined issues facing Gypsy /Travellers and observed that some GP practices would not register members of this group because they had no fixed address or photographic identification, or could not guarantee they would remain in the area for at least three months.[65] The inquiry from the Scottish Parliament's Equality Opportunities Committee highlighted a number of approaches by Health Boards to improve services for Gypsy/Travellers, including outreach initiatives and visits to sites.[66] The NHS Scotland has produced guidance for GPs on health issues and access to services for Gypsy/Travellers.[67]

The Scottish Inpatient Survey[68] did not find clear differences in experience based on ethnicity, although this may be due to the small number of respondents from individual ethnic groups. The survey also addressed language in relation to ethnicity, comparing patients who required an interpreter to patients who did not. Those requiring an interpreter generally gave less positive responses than other patients and were less likely to understand what medicines were for, feel confident in looking after themselves after leaving hospital and understand what was happening to them.

Refugees and asylum seekers also face barriers in access to health services, with reported problems including: [69]

- Unclear procedures for registering with a GP;

[62] Newbigging, K., Bola, M., and Shah, A. Institute for Philosophy, Diversity and Mental Health. Centre for Ethnicity and Health (2008). Scoping exercise with Black and minority ethnic groups on perceptions of mental wellbeing in Scotland.
[63] Millard, A. ScotPHN (2009). Migrant Workers' Health: Scottish Evidence in Perspective.
[64] Equality and Human Rights Commission Scotland (2016) Is Scotland Fairer?
[65] Equal Opportunities Committee (2012) Inquiry into the lives of Gypsy /Travellers.
[66] Ibid.
[67] The NHS Scotland (2015) Health issues and access to services: Gypsy / Travellers
[68] The Scottish Government. Equality Outcomes: Ethnicity Evidence Review.
[69] Ibid.

- GP registration complicated by personal circumstances (often in relation to asylum seekers whose applications have been refused);
- Receiving information from GPs that is difficult to understand (including language barriers);
- Difficulty receiving information due to change of address; and,
- Reluctance to seek help with mental health issues.

Separately, a 2010-2011 study found that while few refugees or asylum seekers had experienced problems accessing healthcare in Scotland, those who did were often asylum seekers whose applications have been refused. Reasons for non-registration included inability to produce a letter from the Home Office, being new to the area and not knowing where to register.[70]

Evidence gathered by ScotPHN[71] on migrant workers' health found that access to health care services in Scotland is restricted for migrant workers by:

- The language barrier;
- Their knowledge of access routes and rights;
- Problems in getting time off work; and,
- Their own and health professionals' cultural settings and expectations about the provision of health care.

The 2009 report[72] noted that emerging evidence suggests that some Polish migrant workers use healthcare in both the UK and Poland. There remains a need for interpreting and translation service for new migrants, particularly in emergency and maternity care. Migrant workers also reported being dissatisfied with GP care due to long waiting times, inconvenient hours and language barriers. In regards to sexual health care, migrants were often not fully aware of the different roles of primary care and specialist gynaecological care in Scotland.

Patient Experiences

The Scottish Government reports[73] that, according to the Scottish Patient Experience Survey of GP and Local NHS Services 2011/2012, there were generally no differences in the experiences of white and non-white patients; due to size, the groups were not broken down more specifically than this.

Comparisons among ethnic groups could be made for the patient primary care survey, which found that the effects of ethnicity on experience was generally weak, but where there were differences, certain ethnic groups (Asian, Asian Scottish or Asian British and 'other' ethnic groups) tended to report less positive experiences. African, Caribbean or Black patients reported a similar experience to white patients.

[70] Equality and Human Rights Commission Scotland (2016) Is Scotland Fairer?
[71] Millard, A. ScotPHN (2009). Migrant Workers' Health: Scottish Evidence in Perspective.
[72] Millard, A. ScotPHN (2009). Migrant Workers' Health: Scottish Evidence in Perspective.
[73] Scottish Government. Ethnicity and Health, Social Care and Sport.

Child Health

A review of health statistics of children aged 27-30 months [74] found that 25% of Asian, Black, Caribbean and African children had at least one developmental concern identified compared to 19% in the white Scottish ethnic group. Children from a minority ethnic background were also less likely to have meaningful assessment data recorded, but were more likely to have a developmental concern identified.

The Scottish Government's report "Growing up in Scotland: Birth Cohort 2" revealed the following:[75]

- 75% of children whose main carer was white had 'very good' health, with a further 20% having good health; in contrast, 65% of those with non-white carers had 'very good' health, with 31% reporting 'good' health.
- The mean number of different health problems was higher for children of white carers than for children of non-white minority ethnic carers (2.4 vs 2.2).
- Children with non-white carers were less likely to sleep through the night than children with white main carers (33% vs 21% respectively).

Dental Health

The Scottish Health Survey[76] found that white British and white Irish ethnic groups had the lowest proportion of adults with twenty or more natural teeth (both 71%). Indian (93%), Chinese (88%), African, Caribbean or Black (87%), Pakistani (86%), mixed ethnic groups (86%) and 'other' white ethnic groups (78%) all had significantly higher proportions of adults with twenty or more teeth than the national average (72%).

In terms of toothache, there were few significant differences between ethnic groups. Pakistani respondents had a significantly higher prevalence of toothache (24%) than the national average (13%), whilst white Irish respondents had a significantly lower prevalence (8%) of toothache. Previous studies of dental health in Scotland found that African and African-Caribbean people were more likely than the general population to brush their teeth twice a day and to have their own teeth.[77]

An evidence review by ScotPHN[78] found that the cost of dental care was often a barrier for migrant workers.

Data regarding access to dental care was not publicly available at the time of publication.

[74] Information Services Division (2015). Child Health 27-30 month review statistics.
[75] Scottish Government (2013). Growing Up in Scotland: Birth Cohort 2 – Results from the first year.
[76] Scottish Government (2012) The Scottish Health Survey 2008-2011: Topic Report on Equality Groups.
[77] NHS Health Scotland (2009) Health in our Multi-ethnic Scotland. Future Research Priorities.
[78] Millard, A. ScotPHN (2009). Migrant Workers' Health: Scottish Evidence in Perspective.

Alcohol Consumption

According to the Scottish Health Survey,[79] white ethnic groups were broadly similar to each other in terms of weekly alcohol consumption, generally consuming more alcohol than non-white minority ethnic groups. The study found that: [80]

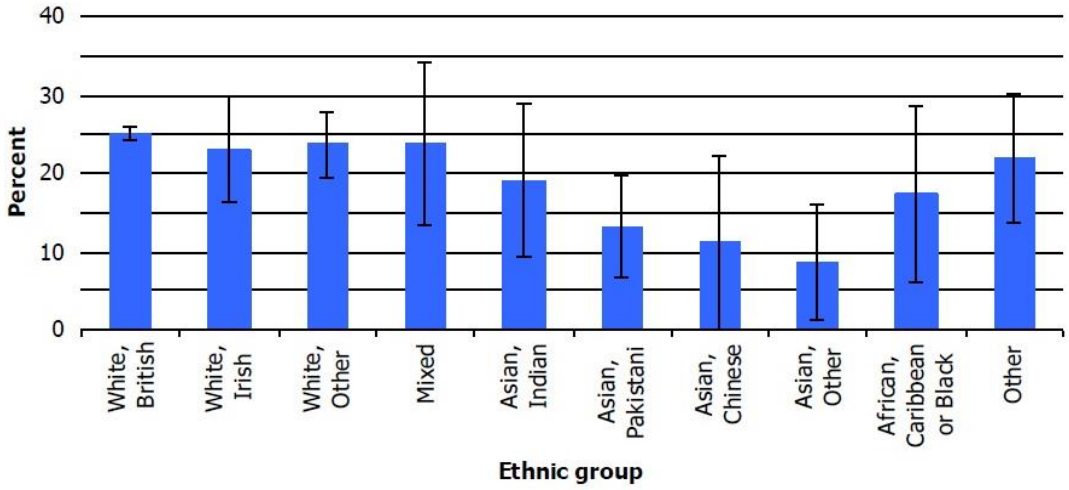
- Pakistani (3%), Chinese (4%), 'other' Asian (4%) and African, Caribbean or Black respondents (7%) were all significantly less likely to drink at hazardous or harmful levels than the national average (23%).
- In relation to exceeding daily limits, the picture was similar but in addition, the 'other' white group (27%) was significantly less likely to drink above limits than the national average (39%). African, Caribbean or Black respondents (19%) have also been identified as significantly less likely than to be drinking above daily limits than the national average.
- Pakistani and Chinese respondents (both 4%) were again significantly less likely than white British (40%) and white Irish respondents (41%) to have exceeded the daily limit on their heaviest drinking day.

Previous studies have found similar differences in drinking behaviour. For example, alcohol-related mortality in Scotland is higher in men and women born in the UK than those born in Pakistan.[81] Furthermore, Indian, Chinese and Pakistani youths in Glasgow were found to consume less alcohol than the general population.[82]

[79] Scottish Government (2012) The Scottish Health Survey 2008-2011: Topic Report on Equality Groups.
[80] Ibid.
[81] Bhala, N., Fischerbacher, C. and Bhopal, R.(2010) "Mortality for Alcohol-related Harm by Country of Birth in Scotland, 2000-2004: Potential Lessons for Prevention."
[82] Heim, D., Hunter, S.C., Ross, A.J., Bakshi, N., Davies, J.B., Flatley, K.J. & Meer, N. (2004) "Alcohol Consumption. Perceptions of Community Responses and Attitudes to Service Provision: Results froma Survey of Indian, Chinese and Pakistani Young People in Greater Glasgow," Scotland, UK. Alcohol and Alcoholism. Vol. 3, No 3. pp. 220-226

Smoking

Prevalence of smoking by ethnicity, 2008-2011 combined



Source: *Scottish Health Survey 2008-2011*

In the 2008-2011 Scottish Health Survey,[83] respondents from Pakistani and 'other' Asian ethnic groups were significantly less likely to smoke than the national average (prevalence of 13% and 9% respectively, compared to 25%).

The Scottish Government further reports[84] that, overall, smoking prevalence is 23% among those whose ethnicity is white compared to 15% for those who are from a minority ethnic background.

White British smokers smoked an average of 14.4 cigarettes a day, significantly more than those from 'other' white ethnic groups (12.1). The only significant difference among ethnic groups in the age of starting smoking was among the 'other' white group where respondents started smoking at an average age of 19.3 years, which is significantly higher than the national average of 17.5.[85]

[83] Scottish Government (2012) The Scottish Health Survey 2008-2011: Topic Report on Equality Groups.
[84] Scottish Government. Ethnicity and Health, Social Care and Sport.
[85] Scottish Government (2012) The Scottish Health Survey 2008-2011: Topic Report on Equality Groups.

Drug Misuse

Ethnicity of new drug misuse patients/clients, Scotland, 2008

	Numbers	Percentage
New Individual patients/clients	**12 560**	
Information available	**12 224**	
White: Scottish	11 711	*95.8*
White: Other British	296	*2.4*
White: Irish	19	*0.2*
White: Any Other Background	110	*0.9*
Mixed: Any Mixed Background	16	*0.1*
Asian: Indian	16	*0.1*
Asian: Pakistani	18	*0.1*
Asian: Bangladeshi	x	*x*
Asian: Chinese	x	*x*
Asian: Any other background	13	*0.1*
Black: Caribbean	6	*0.0*
Black: African	9	*0.1*
Black: Any other black background	x	*x*
Any other ethnic background	x	*x*

0 (>0.0 & < 0.5)
x Information not shown to prevent calculation of entries <5.
Source: ISD Scotland (SMR25 Interim Database). Drug Misuse Statistics Scotland 2008.

Source: Drug Misuse Statistics 2008

The previous table from the NHS Scotland shows ethnicity breakdown among clients entering drug misuse treatment for the first time in 2007-2008.[86] That year, around 1% of new clients reported their ethnicity as something other than white. As the sample size is very small, any analysis on this data would not be robust. More recently published comparable data does not offer a detailed breakdown by ethnicity. For 2012-2013, it was reported that over 95% of new clients described themselves as white Scottish.[87]

Aside from service use data, there is a shortage of national data on levels of drug use relating to ethnicity. A study in Glasgow in 2002 reported that, of the people surveyed, 20-25% of respondents from the Pakistani, Indian and Chinese communities had experienced

[86] NHS Scotland (2008) Drug Misuse Statistics 2008.
[87] ISD Scotland (2014) Scottish Drugs Misuse Database NHS Health Board Overview of Initial Assessments for Specialist Drug Treatment 2012/13

drug use with the majority (21-23%) consuming cannabis.[88] A 3-6% use of crack/cocaine was also reported.[89]

In 2012 CRER investigated the support available for minority ethnic groups who were trying to overcome a drug addiction. It found that the Glasgow South Community Addictions Team was the only addiction service in Scotland that provided non-white minority ethnic specific addiction services, available only to communities in Glasgow with 79 registered service users. The non-white minority ethnic service users and their families reported high levels of satisfaction with the service, however many felt that more could be done to improve the interpretation service to assist with overcoming language barriers.[90]

Anecdotal evidence also suggests that members of minority ethnic groups may be reluctant to seek help for drug and alcohol misuse due to fear of being stigmatised by their family, friends and community.[91]

Diet

The Scottish Health Survey[92] includes a module of questions on fruit and vegetable consumption which was designed to monitor the '5-a-day' policy[93]. To determine the total number of portions that had been consumed in the 24 hours preceding the interview, the fruit and vegetable module asked about the following food types: vegetables (fresh, frozen or canned); salads; pulses; vegetables in composites (e.g. vegetable chilli); fruit (fresh, frozen or canned); dried fruit; and fruit in composites (e.g. apple pie). A portion was defined as the conventional 80g of a fruit or vegetable.

There was a significant association between fruit and vegetable consumption and ethnic group. White British respondents were the least likely to eat 5-a-day (21%, 3.2 mean portions). 'Other' white (40%, 4.6 mean portions), Pakistani (48%, 4.8 mean portions), Chinese (49%, 5.2 mean portions), 'other' Asian (51%, 5.0 mean portions) and other ethnic groups (46%, 5.0 mean portions) were all significantly higher than the national average (22%, 3.2 mean portions).

Physical Activity[94]

Within the Scottish Health Study accumulation report (2008-2011)[95] physical activity recommendations for adults were stated as 30 minutes of moderate physical activity on most

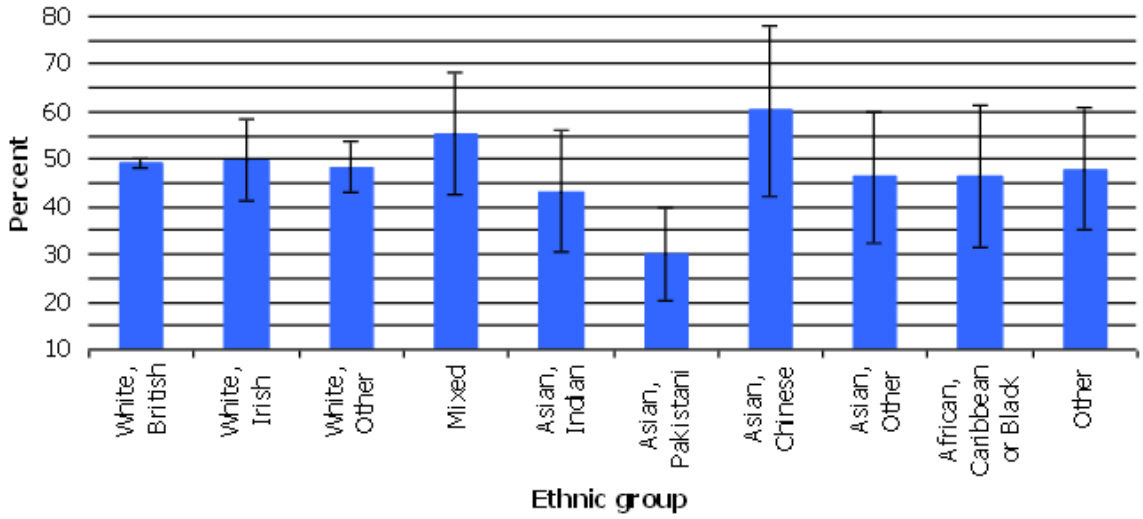
[88] ISD Scotland 2007/2008, as reported in CRER (2012) "My story with Addictions: An insight into the road to recovery"
[89] NHS Greater Glasgow (2002) as reported in CRER (2012) "My story with Addictions: An insight into the road to recovery"
[90] CRER (2012) "My story with Addictions: An insight into the road to recovery"
[91] The Herald Scotland (2015) Call to help addicts from BME communities in Glasgow.
[92] Scottish Government (2012) The Scottish Health Survey 2008-2011: Topic Report on Equality Groups.
[93] The 5-a-day campaign encourages individuals to eat five servings of fruits and vegetables a day.
[94] Please note, additional information about participation in sport can be found in the Participation and Representation Evidence Paper, available at www.crer.org.uk.
[95] Scottish Government (2012) The Scottish Health Survey 2008-2011: Topic Report on Equality Groups.

days which can be accumulated in shorter periods of as little as ten minutes. In order to self-report their levels of physical activity, respondents were asked to report on the time they spent being active, the intensity of the activities undertaken and the frequency at which the activities were performed.

Four main types of physical activity were included: home-based (house work, gardening, building work and DIY), walking, sports and exercise, and activity at work.

The differences in participation by sport and exercise by ethnicity is given below:[96]

Participation in sport by ethnic group, 2008-11 combined



Source: Scottish Health Survey 2008-2011

According to the survey,[97] Pakistani respondents were the least likely to achieve the recommended physical activity levels (27% did so, compared to the national average of 38%) and were also the least likely to participate in sport (30% compared to 49% on average).

This finding corresponds with other research that found that, in Britain, Pakistani individuals and South Asian individuals, generally, are less likely to be sufficiently active. [98]

Other studies highlight the importance of gender differences of physical activity within ethnic groups. Pakistani respondents were found to be less active overall, but also with a gender

[96] Scottish Government (2012) The Scottish Health Survey 2008-2011: Topic Report on Equality Groups.
[97] Ibid.
[98] Fischbacher, C.M., Hunt, S. and Alexander, L. (2004) "How physically active are South Asians in the United Kingdom? A literature review." Journal of Public Health. Vol. 26, No. 3 pp 250-258

difference which was most prominent in the younger age groups, with women less active than men.[99]

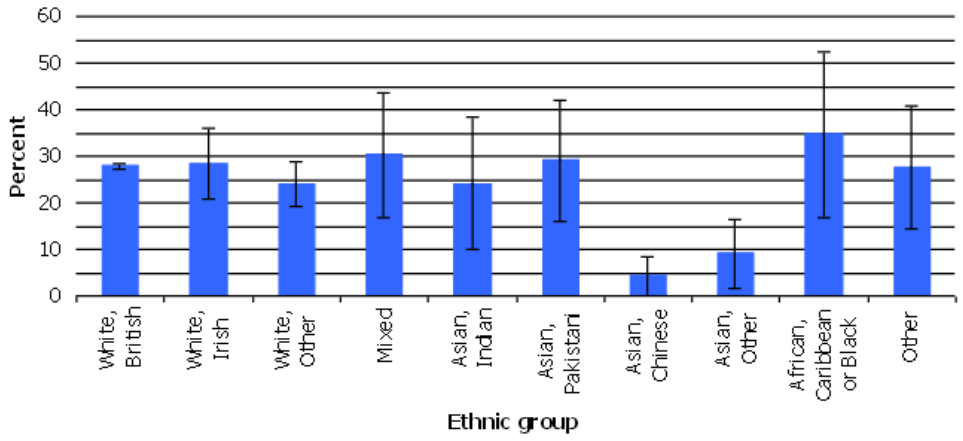
Findings show that ethnic variation in physical activity and sedentary behaviour in the UK are present as early as eleven years of age.[100]

Obesity

In order to calculate levels of obesity and being overweight, respondents to the Scottish Health Survey[101] were asked to submit their height and weight in order to determine their Body Mass Index (BMI). This does not take into consideration the levels of fat, as this measurement does not determine how much of an individual's weight is fat or muscle, but for the purposes of this survey, this information does offer insight into obesity among ethnic groups in Scotland.

BMI was calculated for all those participants for whom a valid height and weight measurement was recorded and were classified into the following ethnic groups: [102]

Prevalence of obesity, by ethnic group, 2008-11 combined



Source: Scottish Health Survey 2008-2011

The survey[103] found that the highest prevalence of obesity was among African, Caribbean or Black respondents (35%), but this was not significantly different from the average (27%).

[99] Higgins, V., Dale, A. (2010) "Ethnic Differences in Physical Activity and Obesity' in Ethnicity and Integration: Understanding Population Trends and Processes." Stillwell, J. and van Ham, M. (ed). Springer Netherlands.
[100] Henning Brodersen, N., Steptoe, A. Boniface, D.R. and Wardle, J. (2007) "Trends in physical activity and sedentary behaviour in adolescence: ethnicity and socioeconomic differences." British Journal of Sports Medicine. Vol 41: 140-144.
[101] Scottish Government (2012) The Scottish Health Survey 2008-2011: Topic Report on Equality Groups.
[102] Ibid.
[103] Ibid.

Chinese and 'other' Asian respondents had the lowest prevalence of obesity (4% and 9% respectively) and this was significantly lower than the national average.

The Scottish Government further reports[104] that Chinese and 'other' Asian respondents had the lowest prevalence of being overweight (41% and 45% respectively) compared to the national average of 65% overweight.

Previous research has found that Asians in Britain were almost four times as likely to be obese than white ethnic groups.[105] Another study found that South Asian children born in Britain between 1991 and 1999 were more likely to be overweight and obese than white children.[106] These findings have not been replicated in the Scottish Health Survey results, as they show no significant difference between white British and Indian and Pakistani ethnic groups.

Diabetes

The 2014 Scottish Diabetes Survey[107] complied information from all local authorities in Scotland to give a detailed picture of the prevalence of both Type 1 and Type 2 diabetes in Scotland. This information has been broken down by ethnicity, however in 19% of recordings, ethnicity was not known. Due to this, analysis would not be robust.

Diabetes types by ethnicity, numbers and percentages, 2014

	Type 1		Type 2		Type 1 and 2	
Ethnic group	Number	Percent	Number	Percent	Number	Percent
A - White	24,178	81.1%	180,919	74.1%	205,097	74.9%
B - Mixed or multiple ethnic groups	566	1.9%	6,065	2.5%	6,631	2.4%
C - Asian, Asian Scottish or Asian British	333	1.1%	7,783	3.2%	8,116	3.0%
D - African, Caribbean or Black	100	0.3%	820	0.3%	920	0.3%
E - Other ethnic group	119	0.4%	1,158	0.5%	1,277	0.5%
Not recorded / Not known	4,506	15.1%	47,305	19.4%	51,811	18.9%

Source: Scottish Diabetes Survey 2014

The survey also reported that Type 2 diabetes is much more common in South Asian than white ethnic groups, and tends to be present at an earlier age.

[104] Scottish Government. Ethnicity and Health, Social Care and Sport.
[105] Jebb, S.A., Rennir, K.L. and Cole, T.J. (2003) "Prevalence of overweight and obesity among young people in Great Britain." Public Health Nutrition. 7 (3): 461-165
[106] Balakrishnan, R., Webster, P. and Sinclair, D. (2008) "Trends in overweight and obesity among 5-7- year-old White and South Asian children born between 1991 and 1999." Journal of Public Health. Vol. 30, No.2: 139-144
[107] NHS Scotland "Scottish Diabetes Survey 2014: Scottish Diabetes Survey Monitoring Group" (2014) P.31

Maternity and Ante-Natal Care

Across the UK, non-white minority ethnic women and children have increased risk of poor health outcomes, such as: [108]

- *Stillbirth and infant death* – Babies of mothers born in India, Bangladesh and East Africa have an increased risk, whereas mothers born in the Caribbean and the rest of Africa and Pakistan have double the risk of babies of mothers born in the UK.
- *Low birthweight* – Babies of mothers born in the Caribbean, East Africa, India and Pakistan have an increased risk, and mothers born in Bangladesh have double the risk of babies of mothers born in the UK.
- *Preterm birth* – Babies of mothers of African-Caribbean and African origin have an increased risk compared to babies of mothers of other ethnic origins.
- *Congenital abnormalities* – Babies of mothers born in India and Bangladesh are at an increased risk and babies of mothers born in Pakistan are three times as likely to have this as babies of mothers born in the UK.
- *Severe maternal morbidity* – Non-white minority ethnic women are 50% more likely than white women to suffer severe maternal morbidity, and the risk is double for women of African and African-Caribbean origin.
- *Maternal death* – Mothers of Black Caribbean and Black African origin are more than three times as likely to die in pregnancy or in the year after birth as white women.
- *Late booking for antenatal care* – Women of South Asian origin are likely to initiate care later and have fewer antenatal visits than white women; women from some non-white minority ethnic groups are more likely than white women to book for maternity care later than 22 weeks of pregnancy, to miss more than four antenatal visits or to receive no antenatal care at all; and women who are asylum seekers or refugees are disproportionally represented within un-booked births.

Another study found that UK-wide, women from non-white minority ethnic communities are seven times more likely to die in childbirth than other groups.[109]

Evidence reported by the Scottish Government notes that migrant, asylum seeking and refugee women are at more risk of mental health problems in pregnancy. Post-natal depression may affect up to four times as many migrant women as non-migrant women in developed country settings due to risk factors such as lack of social support, stressful life events and previous history of depression. [110]

In general, according to the Scottish Government, minority ethnic women (both migrants and non-migrants) are more likely to suffer perinatal depression (depression during and after pregnancy) than white women.[111]

[108] Best beginnings. Black and Minority Ethnic families.
[109] Healthier Scotland (2011). Reducing Antenatal Health Inequalities.
[110] Scottish Government (2013) Equality Outcomes: Pregnancy and Maternity Evidence.
[111] Ibid.

In Scotland specifically, women and babies from non-white minority ethnic communities tend to experience poorer health outcomes when compared to other population groups.[112]

The NHS Scotland also gathered data[113] on the ethnicity of the mother in instances of foetal and infant death and total births. The evidence details that British[114] mothers and other European mothers account for a higher proportion of total births, whereas South Asian and other ethnicities account for a higher percentage of foetal and infant deaths.

The Scottish Government reports that 87% of women overall had their booking appointment at or before 12 weeks pregnancy according to the Scottish Government.[115] Ethnicity data for this is not available.

Ethnicity of the mother in foetal and infant deaths and total births, 2012

Ethnicity of the mother		**All foetal and infant deaths (%)**		**Total births (%)**	
		2011 (592)	2012 (597)	2010/2011 (31188)	2011/2012 (37051)
British[116]		85.5	83.6	84.4	85.3
Other European		5.6	5.7	8.5	7.4
South Asian (India / Pakistan)		4.1	4.9	2.1	3.6
Others		4.9	5.9	4.9	3.6

Source: Scottish Perinatal and Infant Mortality and Morbidity Report 2012

A study[117] comparing maternity care for women born in Poland who were delivering in Scotland and women born in Scotland found that Polish women are less likely than Scottish women to have a Caesarean section and more likely to have a spontaneous vaginal or instrumental delivery. The study suggests this could be due to Polish mothers being younger and more likely to exhibit healthy behaviours, such as lower smoking rates and lower mean BMI. However, the Caesarean section rate in Poland is significantly higher and instrumental delivery rate is lower than for either group of women in Scotland. This difference, the study notes, warrants further exploration.

Research also suggest that more Gypsy/Traveller women experienced one or more miscarriages, Caesarean sections or the death of a child than majority ethnic women.[118]

A report from the Scottish Health and Ethnicity Linkage Study (SHELS) found that: [119]

[112] The Scottish Government (2011). A Refreshed Framework for Maternity Care in Scotland. The Maternity Services Action Group.
[113] NHS Scotland (2012). Scottish Perinatal and Infant Mortality and Morbidity Report.
[114] Please note, this report does not specify whether they mean white British mothers in particular.
[115] The Scottish Government (2014). Having a baby in Scotland 2013: Women's experiences of maternity care.
[116] Ibid.
[117] Gorman, D.R., Katikireddi, S.V., Morris, C., Chalmers, J.W.T., Sim, J., Szamotulska, K., Mierzejewska, E., and Hughes, R.G. (2014). Ethnic variation in maternity care: a comparison of Polish and Scottish women delivering in Scotland 2004-2009.
[118] The Scottish Government. Equality Outcomes: Ethnicity Evidence Review.
[119] Bansal, N., Chalmers, J.W.T., Fischbacher, C.M., Steiner, M.F.C., and Bhopal, R.S. Scottish Health and Ethnicity Linkage Study (2014). Ethnicity and first birth: age, smoking, delivery, gestation, weight and feeding.

- Pakistani women had the youngest average age of first birth, followed by white Scottish women. White Irish, Chinese and the 'other' ethnic women were the oldest.
- Far fewer women from South Asian, Chinese and the 'other' ethnic groups smoked during pregnancy (4-8%) than did the white Scottish and mixed ethnic groups (26%).
- Preterm first birth was most common for Pakistani and the combined grouping of African, Caribbean, Black Scottish and 'other' Black ethnic groups, and the least common for those from mixed and white Irish groups.
- Birthweights were lower among white Scottish babies compared with 'other' white groups, and lower in all non-white minority groups compared with white Scottish.
- White Scottish women had lower rates than all other ethnic groups for breastfeeding and the non-white minority ethnic groups tended to have higher breastfeeding rates than the white groups.
- Overall, although non-white minority ethnic groups have the healthiest maternal behaviours, they tend to have lower birthweights than other groups.

Health conditions affecting specific minority ethnic groups

Research suggests that some health conditions disproportionately affect people from specific minority ethnic groups. This includes, for example, conditions such as diabetes and coronary heart disease which particularly affect people from South Asian backgrounds.[120]

The Scottish Health Survey[121] found that Chinese respondents were the least likely to have a diagnosed cardiovascular disease condition (4%) compared to the national average (15%). African, Caribbean and Black ethnic groups were found to have lower risks of cardio-vascular disease compared to European groups, with 8%.

SHELS has identified key findings on ethnicity and health conditions in Scotland including:[122]

- Pakistani men have a significantly higher risk of heart attack and of admission to hospital with asthma compared to white Scottish men.
- South Asians and Black individuals in the UK are substantially more likely to be admitted to hospital as a result of asthma.
- Men and women from nearly all minority ethnic groups are less likely to develop cancer than the white Scottish population.
- Chinese people have particularly good health outcomes in many areas, including lower risk of hospital admission or death from conditions such as heart disease, cancer, psychiatric disorders, alcohol related diseases, asthma and chronic obstructive pulmonary diseases.
- There are unequal patterns of psychiatric hospitalisations by ethnic group in Scotland, with South Asian and Chinese groups in particular accessing mental health services late or not at all.
- There are substantial ethnic differences in breast screening attendance with South Asian women having lower rates of attendance.

[120] ScotPHO (2010) Dimensions of Diversity: Population differences and health improvement opportunities
[121] Scottish Government (2012) The Scottish Health Survey 2008-2011: Topic Report on Equality Groups.
[122] Centre for Population Health Studies, University of Edinburgh - SHELS webpage

A Minority Ethnic Carers of Older People Project (MECOPP) briefing exploring health and ethnicity gathered together a range of Scottish and other UK data. Its findings included: [123]

- Higher risks of stroke for African Caribbean and Irish men.
- Higher levels of severe learning disability within children and young people (5-32) in South Asian communities.
- Different and sometimes higher rates of cervical, mouth and liver cancer in South Asian communities with differences by age group (with higher cervical cancer rates also for women identifying as Black).
- Concerns around high rates of self-harm, suicide and eating disorders amongst South Asian women.
- Higher rates of vascular dementia among East Asian and African and Caribbean communities.

Research in other parts of the UK and internationally has established that:

- African and Caribbean groups are more likely to experience psychotic disorders.[124]
- The prevalence of HIV in some African nations makes this condition a particular risk for refugees in Scotland who have fled these regions.[125]
- People whose family originates from Poland, the Mediterranean, Africa, the Caribbean, the Middle East, India, Pakistan, South America, South Asia or South-East Asia are more likely to be genetically affected by sickle cell and thalassemia disorder.[126]
- Lupus is more common in African and Caribbean communities, and to a lesser extent also in Chinese and Polynesian communities.[127]

A review by ScotPHN of migrant workers' health evidence[128] found that a high proportion of migrant workers assessed their physical health and psychological wellbeing as less than good. Roma people, in particular, had issues with tuberculosis.

Although Scottish data disaggregated by ethnicity does exist for some specific conditions, overall there is a poor availability of such information. Concerns have been raised in the past about the quality of data on health and ethnicity in Scotland, with activity being undertaken to address this by the Scottish Migrant and Ethnic Health Research Strategy Group (SMEHRS)[129] and through SHELS.[130]

[123] MECOPP (undated) The Health of Scotland's Black and Minority Ethnic Communities
[124] Tolmac, J. and Hodes, M. The British Journal of Psychiatry. Ethnic variation among adolescent psychiatric in-patients with psychotic disorders.
[125] Palattiyil, G. and Sidhva, D. (2011) 'They Call Me, You Are Aids' - A Report on HIV, Human Rights and Asylum Seekers in Scotland
[126] Scottish Government – Screening during pregnancy: Sickle cell and thalassaemia disorders
[127] Lupus UK (2014) Lupus: Incidence within the Community.
[128] Millard, A. ScotPHN (2009). Migrant Workers' Health: Scottish Evidence in Perspective.
[129] NHS Scotland – SMEHRS webpage
[130] Centre for Population Health Studies, University of Edinburgh - SHELS webpage

Mortality

Information on death rates by ethnicity has recently begun to be published for Scotland by the National Records of Scotland.[131]

Deaths by ethnic group, Scotland 2014

Ethnic group	No. of recorded deaths
White - all	**51,368**
Scottish	45,126
Other British	5,094
Irish	427
Gypsy/Traveller	10
Polish	128
Other white	583
Mixed or multiple ethnicity	**11**
Asian – all*	**216**
Pakistani	96
Indian	59
Bangladeshi	1
Chinese	35
Other Asian	25
African – all*	**22**
African	18
Other African	4
Caribbean or Black – all*	**14**
Caribbean	8
Black	2
Other Caribbean / Black	4
Other ethnic group – all*	**13**
Arab	5
Other ethnic group	8

Source: National Records of Scotland Vital Events Reference Tables, 2014

* Each of these categories includes people who self-identify with a) the named ethnicity, b) both the named ethnicity and Scottish ethnicity or c) with the named ethnicity and British ethnicity.

The numbers for many minority ethnic groups are small and, as such, difficult to interpret. Over time, however, this data can be amalgamated and studied longitudinally to provide more robust information about ethnicity and mortality in Scotland.

However, the Scottish Health Survey[132] reports that people from a minority ethnic group generally have lower mortality than the general population of Scotland.

[131] National Records of Scotland (2014) Vital Events Reference Tables 2014
[132] Whybrow, P., Ramsay, J., and MacNee, K. The Scottish Health Survey: Equality Groups.

Culturally Sensitive Healthcare

ScotPHN[133] suggests incorporating cultural capacity into Scottish health services in order to treat and care for people from minority ethnic groups more effectively. Language training, screening new migrants in primary care, information initiatives and languages systems in place at the point of care delivery have been found useful.

In recent years, research has been conducted on cultural competence and its approach to improving healthcare quality for individuals, communities and populations. One study defined cultural competence as:[134]

> "the ability of individuals to establish effective interpersonal and working relationships that supersede cultural differences by recognising the importance of social and cultural influences on patients, considering how these factors interact and devising interventions that take these factors into account."

The primary aim of the cultural competence movement is to balance quality, improve equality and reduce disparities in healthcare by specifically improving care for minority ethnic groups. Consideration has also been given to the relationship between the cultural competence approach and the patient centeredness approach (with its focus on the individual), with a study suggesting that both of these are needed.[135]

Academics have also highlighted that, while culture does matter in healthcare and while cultural factors can be crucial to diagnosis, treatment and care, more evidence is needed to assess the effectiveness of the approach and identify best practice. It has been highlighted in studies that culture cannot be reduced to a technical skill and that this could lead to stereotyping ethnic groups. Furthermore, cultural factors are not always central to a case.[136]

However, research has found that cultural competence training for health professionals impacts immediate outcomes, such as the knowledge, attitudes and skills of health professionals and patient satisfaction.[137]

Different health boards adopt different models to address health inequalities. The Integrated Impact Assessment Model is used by some health boards.[138] This model seeks to address broader inequalities and asks those involved to consider equality in healthcare decisions.

In relation to ethnicity, it emphasises that those from minority ethnic groups may: [139]

- Require communication support such as interpreters and translated materials, both written and oral.

---

[133] Millard, A. Scot PHN (2009). Migrant Workers' Health: Scottish Evidence in Perspective.
[134] Beach, M.C. et al. (2005). Cultural competence: A systematic review of health care provider educational interventions. Medical Care.
[135] Saha, S., Beach, M.C., and Cooper, L.A. (2008). Patient centeredness, cultural competence and healthcare quality. Journal of the National Medical Association.
[136] Kleinman, A. and Benson, P. (2006). Anthropology in the clinic: The problem of cultural competency and how to fix it. PLOS Medicine.
[137] Beach, M.C. et al. (2005). Cultural competence: A systematic review of health care provider educational interventions. Medical Care.
[138] NHS Lothian (2015). Integrated Impact Assessment Guidance.
[139] NHS Lothian (2015). Integrated Impact Assessment Guidance.

- Have difference experiences and expectations of health services and may not be familiar with primary care services.
- Have difference experiences of, expressions of and ways of dealing with mental health problems that may not be picked up by mainstream services.
- Have cultural needs in relation to diet, modesty, bathing and personal care, organ and tissue donation, blood sharing, certain drugs and treatments, and burial and death rites.
- Have health issues or concerns particular to their ethnic group.

Social Care

The Scottish Government reports that in the year to 31 March 2014, 99% of the people who received home care where their ethnicity was known were of 'white' ethnicity. This is slightly higher than the latest Scottish census figure in 2011 that reported that 96% of the Scottish population were white.[140]

According to the Scottish Government, in the year to 31 March 2014, 96% of the people who received direct payments where their ethnicity was known were of 'white' ethnicity. Data about those from a minority ethnic ethnicity were not provided.[141] It is worth noting that both of these figures are for the total population and are not differentiated by age or type of support, and so the older age profile of the overall white population will have an effect.

Self-directed Support

In November 2010 the Scottish Government published its ten year strategy to enhance self-directed support, with the Social Care (Self-directed Support) (Scotland) Act receiving Royal Assent in 2013. Both the Act and the strategy aim to enable those who require support to build their own package of care using the services available to them locally, or by paying a family member for their care.

In order for those requiring support to access care local authorities have a legal duty to ensure that there is sufficient information to enable individuals to make an informed choice.[142] MECOPP[143] has already reported that mainstream services have failed to meet the care and support needs of Scotland's non-white minority ethnic communities, with access and a lack of appropriate care being identified as key barriers.

[140] Scottish Government (2014) "Social Care Services, Scotland, 2014"
[141] Scottish Government. Ethnicity and Health, Social Care and Sport.
[142] Scottish Government. "Self-directed Support Act"
[143] MECOPP, "Self-directed Support and Scotland's Black and Minority Ethnic Communities" Briefing Sheet 05

Ethnicity of clients receiving Self-directed Support (Direct Payments) packages, 2012

Ethnicity	Number of clients
White	4,001
Mixed or multiple ethnic groups	14
Asian	50
African, Caribbean or Black	12
Other ethnic background	28
Not disclosed	85
Not known	859
All	5,049

Source: Self-directed Support (Direct Payments) Survey 2012

There is not yet sufficient data on the uptake of Self-directed Support by minority ethnic groups to provide sufficient scrutiny. However the Scottish Government figures for 2010-2012 do show that compared with the white ethnic group, the number of non-white minority ethnic recipients remains small, with 97% of uptake from white ethnic individuals where ethnicity was known.[144] However from the data that is currently available, MECOPP has reported a 31.6% increase in the number of non-white minority ethnic recipients compared to an 11.5% increase for white ethnic recipients.[145]

Elder Care

At present, there is no breakdown of elder care service uptake by ethnicity. As mentioned, the minority ethnic population in Scotland is younger than that of the white majority Scottish population in Scotland and therefore a lower uptake rate would be expected.

Qualitative research carried out by the Joseph Rowntree Foundation[146] suggested non-white minority ethnic groups would like services to be more culturally sensitive. They appreciated the specialist day centres for non-white minority ethnic older people, but felt that other services were not sensitive to their needs. They mentioned that, as an alternative, they felt pushed into paying for services.

Palliative and End of Life Care

[144] The Scottish Government. Self-Directed Support (Direct Payments) Scotland, 2012.
[145] MECOPP, "Self-directed Support and Scotland's Black and Minority Ethnic Communities" Briefing Sheet 05
[146] Bell, D. and Bowes, A. (2006) "Financial Care Models in Scotland and the UK: A review of the introduction of free personal care for older people in Scotland" Joseph Rowntree Foundation

Research carried out by Marie Curie has identified that palliative care for minority ethnic groups is patchy across the country with poor uptake rates and awareness of services.[147]

In partnership with Marie Curie, the London School of Economics reported that there is evidence that people from BAME (Black, Asian and minority ethnic) backgrounds are less likely to experience high quality care in the last three months of life, both overall and particularly from care homes.[148]

In its report, Marie Curie highlighted that there is a significant lack of data in this area with more research needed. However it does make some recommendations for improvement in palliative care for minority ethnic groups:

- Collective effort to ensure that palliative care for non-cancer patients is offered to everyone and particularly BAME communities.
- Raise awareness of the services on offer and understanding around palliative and end of life care services.
- Appropriate training for nurses and health professionals especially regarding 'cultural competency' in hospices and hospitals.
- Responsive and flexible translation and communication services should be offered where suitable.
- Avoid stereotypes; sensitivity and non-judgemental conversations are essential.
- Involve and engage BAME communities.
- Raise awareness of services on offer through outreach events.

Additional Health Resources

Several organisations across Scotland continue to add to the pool of research and data on minority ethnic communities and health in Scotland.

The Edinburgh Migration, Ethnicity and Health Research Group[149] produces quantitative and qualitative research on the nature of inequalities in healthcare and health outcomes for migrant and minority ethnic communities. Recent topics investigated include cardiovascular research, diabetes research and utilising data to improve migrant and minority ethnic health.

SHELS[150] examines the relationship between ethnicity and important health issues. Issues considered include cardiovascular disease, cancer, mental health, maternal and child health, respiratory disease, infectious and parasitic diseases, and uptake of breast and bowel cancer screening.

SMEHRS[151] is a group with membership from the Scottish Government, the NHS, academia and third sector organisations. The group promotes research to help improve the health and wellbeing of all ethnic groups in Scotland and includes summaries of studies, reports and projects in its annual reports and strategies.

Some of these studies have been referenced in this evidence paper.

---

[147] Marie Curie (2015) "Palliative and end of life care for Black, Asian and Minority Ethnic Groups in Scotland: Exploring the Barriers"
[148] Dixon J, King D, Matosevic T et al. (2015). Equity in Provision of Palliative Care in the UK. LSE, PSSRU, Marie Curie.
[149] The University of Edinburgh. Centre for Population Health Studies. Ethnicity and Health.
[150] The University of Edinburgh. Usher Institute. Scottish Health and Ethnicity Linkage Study.
[151] NHS Health Scotland. Scottish Migrant and Ethnic Health Research Strategy group.

Home

Demographics

The demographics of white ethnic groups and non-white minority ethnic groups in Scotland are important to consider in regards to housing. Overall, the non-white minority ethnic population is younger than the white ethnic population. The 2011 Scottish Census found that, with 96% of the population reporting a white ethnic background and 4% reporting a non-white minority ethnic background: [152]

- 5.8% of those aged 0-15 are from non-white minority ethnic groups;
- 6.2% of those aged 16-24 are from non-white minority ethnic groups;
- 7.5% of those aged 25-34 are from non-white minority ethnic groups;
- 3.8% of those aged 35-49 are from non-white minority ethnic groups;
- 1.7% of those aged 50-64 are from non-white minority ethnic groups; and,
- 0.8% of those aged over 65 are from non-white minority ethnic groups.

According to the 2011 Scottish Census:[153]

Household composition by ethnicity category, 2011

	Total	White	Non-white
All households	2,372,777	97.0%	3.0%
One person household: Total	823,314	97.3%	2.7%
One person household: Aged 65 and over	311,867	99.4%	0.6%
One person household: Aged under 65	511,447	96.0%	4.0%
One family household: Total	1,418,008	97.3%	2.7%
One family household: All aged 65 and over	178,972	99.5%	0.5%
One family household: Married couple: Total	756,223	96.5%	3.5%
One family household: Married couple: No children	295,385	97.9%	2.1%
One family household: Married couple: Dependent children	321,722	94.5%	5.5%
One family household: Married couple: All children non-dependent	139,116	98.1%	1.9%
One family household: Married couple: Same-sex civil partnership couple	2,232	97.9%	2.1%
One family household: Cohabitating: Total	217,221	98.3%	1.7%
One family household: Cohabiting couple: No children	117,637	98.1%	1.9%
One family household: Cohabitating couple: With dependent children	87,647	98.4%	1.6%
One family household: Cohabitating couple: All children non-dependent	11,937	99.4%	0.6%
One family household: Lone parent: Total	263.360	97.6%	2.4%
One family household: Lone parent: With dependent children	170,002	97.1%	2.9%
One family household: All children non-dependent	93,358	98.4%	1.6%
Other household types: Total	131,455	90.7%	9.3%
Other household types: With dependent children	36,954	90.9%	9.1%
Other household types: All full-time students	20,928	79.0%	21.0%
Other household types: All aged 65 and over	5,598	99.3%	0.7%
Other household types: Other	67,975	93.4%	6.6%

Source: Scotland's Census 2011

[152] Scotland's Census 2011. Ethnic group by age.
[153] Scotland's Census 2011. Household composition by ethnic group.

According to this data, non-white minority ethnic groups are over-represented in married households with dependent children, other households with dependent children, households with all full-time students and other not-listed household types.

The Joseph Rowntree Foundation[154] reports a significant variance in the demographic structures of households for white ethnic groups and non-white minority ethnic groups. While 32% of white households were from the older age group, only 6% of non-white household were at the time of publication. Additionally, while only 5% of white households had five or more members, 17.5% of non-white households did.

Types of Housing

Studies have shown that non-white minority ethnic communities have disadvantaged housing circumstances compared to the white ethnic population. According to the 2014 Scottish Household Survey, non-white minority ethnic groups are over-represented in private renting, but under-represented in home ownership and social housing.[155]

Housing type by ethnicity category, 2014

	Total	White	Non-white
Owner occupied	62%	98%	2%
Private rent	12%	90%	10%
Social rent	24%	98%	2%
Other	2%	94%	6%

Source: Scottish Household Survey 2014

The 2014 survey[156] also reported 87% of people in social housing recording their ethnicities as white Scottish, compared with 78% for Scotland as a whole. In the private rented sector, only 55% recorded their ethnicity as white Scottish, which is lower than in other tenures.

[154] Joseph Rowntree Foundation (2012). Poverty and ethnicity in Scotland.
[155] The Scottish Government (2015) Scotland's People Annual Report: Results from the 2014 Scottish Household Survey.
[156] Ibid

Data Scottish Survey Core Questions 2013 also reported housing tenue by ethnic group. The results are as follows: [157]

Detailed housing tenure by ethnic category, 2013

	White Scottish	White Other British	White Polish	White Other*	Asian**	All Other Ethnic Groups***
Outright Tenure	82.2%	14.2%	0.0%	1.8%	1.2%	0.5%
Mortgaged	81.2%	12.1%	0.7%	2.8%	2.4%	0.7%
Social rented	87.2%	6.3%	2.1%	1.9%	0.9%	1.5%
Private rented	57.4%	16.7%	4.2%	11.9%	6.4%	3.3%
Unknown rented	77.4%	12.2%	-	2.5%	5.0%	2.9%

Source: Scottish Survey Core Questions 2013

**White: Other includes White: Irish, White: Gypsy/Traveller and White: Other White Ethnic Group*
*** Asian includes the categories Asian, Asian Scottish or Asian British*
**** All other ethnic groups includes categories within the Mixed or Multiple Ethnic Group, African, Caribbean or Black, and Other Ethnic Group sections*

According to the Joseph Rowntree Foundation, non-white minority ethnic households are likely to be in socially rented housing at only two-thirds the rate of white households, and are much more likely to be in private rented housing, with a rate four-and-a-half times greater than that of white households (25% vs 5.6%). While students account for a portion of this, the issue of access to social housing is of significant concern. Private renting could be an indicator of potential deprivation and vulnerability, as housing problems are more likely in this tenure and many private tenancies are short-term and do not offer long-term security. Additionally, private rent is typically twice the level of social rent, and may not be fully covered by local housing allowances.[158]

Among Gypsy/Travellers in particular, there are higher rents and electricity charges on sites compared to costs in social housing, contributing to a significantly disadvantaged socio-economic status.[159] A study by the EHRC[160] found that Scotland is not as advanced as England and Wales in preparing for additional site provision for Gypsy/Traveller communities, both locally and nationally, with a majority of local authorities lacking formal planning policies on Gypsy/Traveller site provision.

The Joseph Rowntree report[161] also suggested that approaches to facilitating greater access to the social rented sector for minority ethnic groups should include increasing the supply of housing, bettering communication between social housing providers and minority

[157] The Scottish Government. Scottish Survey Core Questions 2013.
[158] Joseph Rowntree Foundation (2012). Poverty and ethnicity in Scotland.
[159] Ibid.
[160] The Scottish Government. Equality Outcomes: Ethnicity Evidence Review.
[161] Ibid.

ethnic communities, and actively engaging voluntary organisations that work specifically with these communities.

The Scottish Continuous Recording System (SCORE) annual summary[162] report noted that in 2013-2014, 84.3% of new housing association lets were to white Scottish tenants, 5.1% to white British tenants, 3.7% to white Polish tenants and 1.5% to white tenants of another ethnicity, for a total of 94.6% of lets. As such, 5.6% of lets went to non-white minority ethnic households, which indicates that new housing association lets are roughly representative of Scotland's population. This does, however, contradict previous quantitative findings and perceptions detailed within qualitative studies.

Campaigners argue that greater transparency is needed surrounding the distribution and quality of social housing, and that policies should be developed and implemented to change the low proportion of non-white minority ethnic households in social housing.[163]

While overall home ownership is higher in certain non-white minority ethnic groups than the overall population, this is not necessarily an indicator of financial success; in fact, according to the Joseph Rowntree Foundation, some individuals feel forced to buy their own homes due to a lack of viable alternatives in other tenures. The report further notes 39% of the white population was estimated as being financially able to buy a home using income and local housing princes, compared to 37% of the minority ethnic population.[164]

Research commissioned by Communities Scotland found that higher levels of home ownership among Indian, Pakistani and Chinese communities were driven by the inability of social rented housing to adequately meet their housing needs.[165] Another study suggested that issues such as a shortage of affordable housing, a lack of larger accommodation and long waiting times for the social rented sector were in-line with the experiences of non-white minority ethnic communities and white ethnic communities.[166]

Many individuals in Scotland also live in communal establishments, such as medical or care establishments, education establishments, defence establishments, prison service establishments and hostels and temporary shelters. This chart below details the breakdown of the 99,017 people in communal establishments, according to the 2011 Scottish Census.[167]

[162] The Scottish Government. Summary: Ethnicity.
[163] The Poverty Alliance and the Joseph Rowntree Foundation. Understanding Poverty: Exploring Critical issues in poverty in Scotland. Seminar 1: Poverty and Ethnicity in Scotland.
[164] Joseph Rowntree Foundation (2012). Poverty and ethnicity in Scotland.
[165] The Scottish Government. Equality Outcomes: Ethnicity Evidence Review.
[166] Ibid.
[167] Scotland's Census 2011. Communal establishments by ethnic group.

Residence in communal establishments by ethnicity category, 2011

	Number	White	Non-white
Communal establishments (total)	**99,017**	**89.6%**	**10.4%**
Hospitals	3,700	97.1%	2.9%
Adult care homes	37,549	99.5%	0.5%
Children's homes	830	95.7%	4.3%
Student accommodation	33,609	74.8%	25.2%
Schools and other education establishments	4,061	86.8%	13.2%
Defence establishments	2,613	97.2%	2.8%
Prison service establishments	5,908	96.4%	3.6%
Hotels and holiday accommodation	6,144	95.8%	4.2%
Hostels for homeless or temporary shelter	2,027	93.5%	6.5%
Other, including sleeping rough	2,576	89.4%	10.6%

Source: Scotland's Census 2011

The non-white minority ethnic population had a greater rate of individuals in student accommodation, schools and other educational establishments, other communal establishments and hostels for homeless or temporary shelter, while being least represented in adult care homes and defence establishments.[168]

Overcrowding[169]

9% of the approximately 2.4 million households in Scotland are overcrowded[170]. Previous research has found that minority ethnic households are more likely to suffer overcrowding.[171] This is a common issue among certain minority ethnic groups. White Scottish and white British households were the least likely to be overcrowded (8% and 6% respectively), with white Polish (30%), Bangladeshi (28%) and African (28%) households the most likely to be overcrowded, according to Scottish Government statistics.[172]

Of those who live in overcrowded households, 90.8% are from a white ethnic group and 9.2% are from a non-white ethnic group.[173](According to the 2011 Scottish Census 97% of households are white ethnic and 3% are non-white minority ethnic).

[168] Scotland's Census 2011. Communal establishments by ethnic group.
[169] In Scotland, according to the Scottish Census 2011, the total room requirements for a multi-person household are: 1) one room per couple or lone parent; 2) one room per person aged 16 and above who is not a lone parent or in a couple; 3) one room for every two males aged 10-15, rounded down; 4) one room for every pair of males of whom one is aged 10-15 and one is aged 0-9, if there are an odd number of males aged 10-15; 5) one room for a remaining unpaired male of there are no males aged 0-9 to pair him with; 6) repeat points 3-5 for females; 7) one room for every two remaining children aged 0-9 (regardless of gender), rounded up; 8) add two rooms to this total.
[170] Scotland's Census 2011. Detailed characteristics of housing and accommodation in Scotland.
[171] Scottish Ethnic Minorities Research Unit and Heriot Watt University (2004) Black and Minority Ethnic Communities and Homelessness in Scotland.
[172] The Scottish Government. Equalities Summary: Housing and Regeneration.
[173] Scotland's Census 2011. Central heating type and occupancy rating by ethnicity.

Household occupancy rating[174] by ethnicity of people in households, 2011

	Total people in households	White	Non-white
Occupancy rating -1 or less	574,352	90.8%	9.2%
Occupancy rating 0	1,307,585	95.6%	4.4%
Occupancy rating +1	1,307,518	97.0%	3.0%
Occupancy rating +2 or more	2,006,931	97.5%	2.5%

Source: Scotland's Census 2011

Some ethnic groups, including the Asian, Asian Scottish or Asian British ethnic group, are particularly over-represented in overcrowded occupancy rating, as detailed in the chart below: [175]

Overcrowded occupancy rating by non-white minority ethnic group, 2011

	Homes with occupancy rating of -1 or less	All homes
Mixed or multiple ethnicity	0.48%	0.37%
Asian, Asian Scottish or Asian British	6.27%	2.57%
African, African Scottish or African British	1.58%	0.54%
Caribbean or Black, Caribbean or Black Scottish or Caribbean or Black British	0.22%	0.12%
Other ethnicity	0.65%	0.26%

Source: Scotland's Census 2011

[174] An occupancy rating of -1 indicates that there is one less room than needed in the household, whereas +1 indicates there is one additional room.
[175] Scotland's Census 2011. Central heating type and occupancy rating by ethnicity.

The 2011 Scottish Census also allows comparison of the ethnic group of a Household Reference Person by the occupancy rating of a household. For households with an occupancy rating of -1 or less (overcrowded), the results are as follows:[176]

Ethnic group of Household Reference Person by occupancy rating (rooms), 2011

	All HRPs	Occupancy Rating -1 or less	% of All HRPs	% of All Occupancy Rating -1 or less
All Household Reference Persons	2,372,777	214,345	-	-
White Scottish	2,001,047	168,181	84.33	78.46
White Other British	205,040	12,485	8.64	5.82
White Irish	28,594	2,633	1.21	1.23
White Gypsy/Traveller	1,792	433	0.08	0.20
White Polish	22,588	6,681	1.00	3.12
White Other	41,520	7,211	1.75	3.37
Mixed	4,802	679	0.20	0.32
Pakistani, Pakistani Scottish or Pakistani British	13,878	3,451	0.58	1.61
Indian, Indian Scottish or Indian British	11,990	2,362	0.51	1.10
Bangladeshi, Bangladeshi Scottish or Bangladeshi British	1,248	346	0.05	0.16
Chinese, Chinese Scottish or Chinese British	12,096	2,753	0.51	1.28
Other Asian	7,258	1,884	0.31	0.88
African, African Scottish or African British	12,183	3,383	0.51	1.58
Other African	222	45	0.01	0.02
Caribbean, Caribbean Scottish or Caribbean British	1,611	246	0.07	0.11
Black, Black Scottish or Black British	1,094	221	0.05	0.10
Other Caribbean or Black	319	68	0.01	0.03
Arab, Arab Scottish or Arab British	3,404	872	0.14	0.41
Other ethnic groups	2,091	411	0.09	0.20

Scotland's Census 2011

Overall, the ethnic groups most over-represented in an occupancy rating of -1 or less were the Polish, other white, other African and Pakistani, Pakistani Scottish or Pakistani British groups.

According to the Joseph Rowntree Foundation, inequalities are partially due to the difference in demographics, with non-white minority ethnic groups tending to have more large households with younger age compositions and fewer elderly households.[177]

Overcrowded housing can impact the quality of life of residents, including opportunities to participate in social and leisure activities. A Joseph Rowntree Foundation study also identified overcrowding as a contributing factor in relationship breakdowns, causing some residents to leave their homes. Furthermore, overcrowding may create challenges in securing routes out of poverty through education by limiting children and young people's opportunity for quiet study.[178]

[176] Scotland's Census 2011. Data Warehouse. Table AT_122_2001
[177] Joseph Rowntree Foundation. Poverty and ethnicity in Scotland.
[178] Ibid.

Research into homelessness found overcrowding to be significant among minority ethnic households, particularly among A8 migrants,[179] refugees and Pakistani and Bangladeshi households, which may indicate hidden homelessness, material and social deprivation, and poor living conditions.[180]

Research has explored the experience of migrants coping with overcrowding. The Joseph Rowntree Foundation[181] reported that, while single migrants could manage with overcrowded accommodation, it was more difficult for families. While often linked to poverty, in some situations, overcrowding is a choice made by migrants to save money. However, high rents and council tax also contribute to overcrowding conditions.

This report[182] also found that, for asylum-seekers and refugees, overcrowding is often due to a lack of adequately sized accommodation, especially in the social rented sector where the size of accommodation is often inadequate.

Among non-refugee minority ethnic communities the Joseph Rowntree Foundation[183] further found that Pakistani and Bangladeshi households have the highest incidence of overcrowding (31%), with African households following (30%). Responses to overcrowding identified in the report included accepting accommodation which was too small rather than moving or using double-purpose rooms (e.g. lounges for bedrooms).

Quality of housing

The poor quality of housing and surrounding neighbourhoods is another significant issue faced by minority ethnic individuals, including access to key facilities. Research on migrant communities in particular found evidence of substandard accommodation, including unsafe living conditions, poor furnishings and inadequate heating. Many participants who were interviewed in the research indicated they were willing to sacrifice a good standard of accommodation for lower rents, or that there was simply limited or no access to adequate accommodation.[184]

Poor living conditions were also found among asylum-seekers and refugees, with high-rise flats identified in research as inappropriate for families with young children and those with disabilities or long-term health conditions. Studies have also reported difficulties with dampness, faulty plumbing systems, lack of electricity, broken windows, the absence of furniture and inadequate heating systems.[185]

There is a lack of recent information detailing how housing quality affects minority ethnic groups who are not recent migrants or refugees.

The chart below details the difference in the percentage of white households and non-white households who do not have central heating, as measured against the occupancy rating of the dwelling. According to the 2011 Scottish Census, of all homes (with or without heating),

[179] A8 migrants are migrants from eight of the ten countries that joined the European Union in the 2004 enlargement (excluding Cyprus and Malta). These are the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia.
[180] Joseph Rowntree Foundation (2012). Poverty and ethnicity in Scotland.
[181] Ibid.
[182] Ibid.
[183] Ibid.
[184] Ibid.
[185] Ibid.

97% are white ethnic and 3% are minority ethnic. However, according to the chart below, non-white minority ethnic individuals are over-represented in living in homes without central heating, with 7.2 vs 3.0%.[186]

Absence of central heating in households by ethnicity category, 2011

	Total people in household	White	Non-white
Total	93,692	92.8%	7.2%
Occupancy rating -1 or less	21,238	86.5%	13.5%
Occupancy rating 0	31,161	92.2%	7.8
Occupancy rating +1	22,427	95.7%	2.7%
Occupancy rating +2 or more	18,866	97.3%	7.2%

Source: Scotland's Census 2011

The below chart compares the percentage of homes with no central heating to overall homes, with a breakdown of non-white minority ethnic groups.[187]

Absence of central heating in households by ethnic group, 2011

	Homes with no central heating	All homes
Mixed or multiple ethnicity	0.53%	0.37%
Asian, Asian Scottish or Asian British	4.70%	2.57%
African, African Scottish or African British	1.33%	0.54%
Caribbean or Black, Caribbean or Black Scottish or Caribbean or Black British	0.25%	0.12%
Other ethnicity	0.39%	0.26%

Source: Scotland's Census 2011

According to the data above, homes without central heating are over-represented against all homes for non-white minority ethnic groups. As with the previous chart, this suggests that non-white minority ethnic individuals are more likely than white ethnic individuals to live in a home without central heating.

Little information is available about ethnicity and fuel poverty. A national survey of children and young people in 2008 revealed that 10% of children in families with a Black mother were likely to experience present inadequate heating, compared to 4% overall. Minority ethnic households are included within the list households which are likely to be vulnerable to fuel poverty.[188]

According to the Joseph Rowntree Foundation, [189] Gypsy/Travellers have also recorded poor living conditions related to the location of their sites, with some located under large

[186] Scotland's Census 2011. Central heating type and occupancy rating by ethnicity.
[187] Scotland's Census 2011. Central heating type and occupancy rating by ethnicity.
[188] Scottish House Condition Survey (2012). Fuel poverty evidence review.
[189] Joseph Rowntree Foundation (2012). Poverty and ethnicity in Scotland.

pylons, near major electricity substations or near quarries. Many sites lack adequate heating and access to amenity units with toilet and washing facilities. The EHRC cites the Scottish Government in reporting that 14% of Gypsy/Travellers in 2011 lived in caravans or in mobile or temporary structures, and that Gypsy/Travellers were half as likely to own their homes and twice as likely to live in rented accommodation as the overall population.[190]

Homelessness

Data provided by the Scottish Government[191] looks at the homelessness of minority ethnic individuals with UK or EU nationality and asylum-seekers or refugees separately. In 2013-2014, there were 24,000 assessed cases of homelessness for those with UK or EU nationality. The proportion of white homeless is about 93%, compared to 96% of the overall population. There are some differences within the white population, with the proportion of cases from white Scottish backgrounds higher than that of the population as a whole (84% compared to 80% for Scotland) and with the proportion of white other British less than the wider population (6% compared to 12% in Scotland). The proportion of Asian homelessness is slightly less than the wider population, with 0.9% compared to 2% of Scotland as a whole.

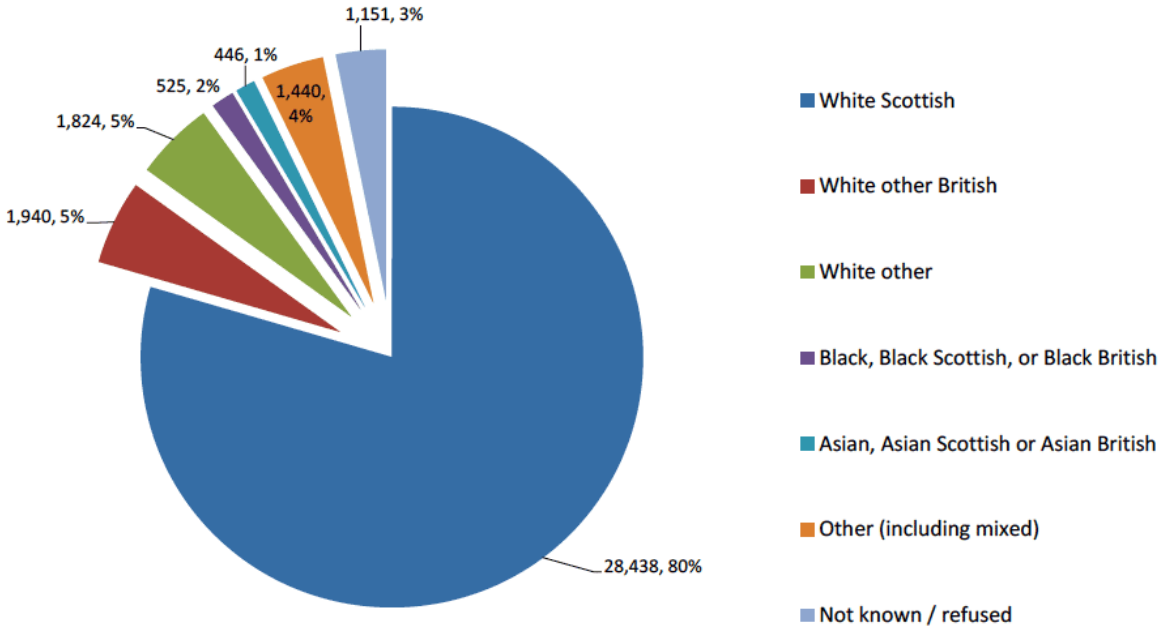
The same data[192] reports that there were around 1,100 cases assess as homeless during 2013-2014 who were entitled to apply after being granted leave to remain or refugee status. Of these, 11% described themselves as 'other' white (and outside of the EU), 14% as Asian, 21% as Black, and 47% as 'other.'

The "Operation of the Homeless Persons Legislation in Scotland: 2014-2015" reports that in 2014-2015, in 90% of applications the main applicant was recorded was white, while 1.5% were recorded as Black, Black Scottish or Black British, 1.2% were recorded as Asian, Asian Scottish or Asian British, and 4.0% were recorded as other ethnic groups. 3.2% of applicants did not record an ethnicity.[193]

It is difficult to make additional comparisons for other ethnic groups, as the ethnic categories given in this report are different than those of the Census. However, it appears that Black, Black Scottish or Black British and 'other' (including mixed) ethnic groups are over-represented in homelessness applications compared to the population as a whole.

[190] Equality and Human Rights Commission Scotland (2016) Is Scotland Fairer?
[191] The Scottish Government. Equalities Summary: Ethnicity, Housing and Regeneration.
[192] The Scottish Government. Equalities Summary: Ethnicity, Housing and Regeneration..
[193] The Scottish Government. Operation of the Homeless Persons Legislation in Scotland: 2014-2015.

Number of applications in 2014-15 by ethnic group of main applicant



Source: Operation of the Homeless Persons Legislation in Scotland: 2014-2015

Utilising the categories of the 2011 Scottish Census, the lowest proportion of homeless applications is from the Asian, Asian Scottish or Asian British category (32 per 10,000) and the highest proportion is from the Caribbean or Black category (246 per 10,000). It was noted that higher rates of homelessness from some non-white minority ethnic groups may be due to the way the asylum system operates, as once granted leave to remain, households may proceed to make a homelessness application as the route to obtain housing.[194]

A 2004 report[195] on minority ethnic communities and homelessness researched those at risk of homelessness, homeless applicants, households accepted as homeless and groups such as rough sleepers. It noted that perceptions of homelessness may differ within communities, with new arrivals to Scotland who are living with relatives in overcrowded accommodation being less likely to perceive themselves to be homeless compared to UK-born minority ethnic individuals forced to live with relatives due to restricted access to housing. It recommended that efforts to make homelessness services more accessible to minority ethnic communities should take these varying perceptions into account.

Analysis of local authority homeless monitoring data in 2004 found that the incidence of recorded homelessness affecting non-white minority ethnic households was 75% higher than the population as the whole, though there was significant variance between specific ethnic groups, with Black African / Caribbean ethnicities over represented and the Chinese ethnic

[194] The Scottish Government. Operation of the Homeless Persons Legislation in Scotland: 2014-2015.
[195] Scottish Ethnic Minorities Research Unit and Heriot Watt University (2004) Black and Minority Ethnic Communities and Homelessness in Scotland.

group under-represented. Edinburgh and Glasgow together accounted for two-thirds of homeless applications. Evidence also demonstrated hidden homelessness with overcrowding and over-representation in poor quality housing.[196]

The 2004 report noted several common housing problems that contribute to homelessness, including: [197]

- Lack of information about housing options and homelessness procedures;
- Lack of sensitivity on the part of housing officers and the potential for racial harassment;
- Unaffordability of mortgages and accommodation in the private sector;
- Difficulties in getting information due to language differences, literacy issues, lack of familiarity with the system and institutional discrimination; and,
- Difficulty in getting specialised legal advice and getting complaints addressed.

Groups identified as particularly vulnerable to homelessness included refugees, Gypsies/Travellers and minority ethnic women escaping violence within the home.[198]

Refugees experienced issues with official asylum-seeking procedures, a lack of appropriate temporary accommodation (apart from hostel accommodation, which leaves them vulnerable to racial abuse), lack of appropriate permanent accommodation in perceived safe areas and a lack of ongoing support and gaps in the provision of services.[199]

Gypsy/Travellers experienced particular difficulty with restricted access to local authority sites due to shortage of appropriate and suitable sites, the poor management and quality of sites and the high costs of rents and amenities. Furthermore, there are issues surrounding low levels of awareness of their needs and discrimination from local authority staff.[200]

The Joseph Rowntree Foundation reviewed research on homelessness in Scotland and found that in 2002/2003 (before to the removal of the priority need test in the Homelessness (Scotland) Act 2003), the proportions of black and minority ethnic and white households assessed as unintentionally homeless and in priority need were similar. However, white applicants were more likely to be judged as “intentionally homeless” while minority ethnic applicants were more likely to be assessed as “non-priority homeless.” [201]

Having to vacate the home of a friend or relative was a particularly common reason for homelessness among minority ethnic households. Changes in household formation due to relationship breakdown, marital problems, violence within the home, inter-generational conflict and financial difficulties were major contributing factors to homelessness. A majority of homeless individuals are unemployed, but those who are employed also experienced difficulties in gaining access to affordable accommodation, with many reporting that their low-incomes made accessing affordable accommodation very difficult.[202]

---

[196] Scottish Ethnic Minorities Research Unit and Heriot Watt University (2004) Black and Minority Ethnic Communities and Homelessness in Scotland.
[197] Ibid.
[198] Ibid.
[199] Ibid.
[200] Ibid.
[201] Joseph Rowntree Foundation (2012). Poverty and ethnicity in Scotland.
[202] Ibid.

In minority ethnic groups, homelessness due to alcohol addiction, substance abuse and stays in mental health institutions were rare, as was repeat homelessness; this is in direct contrast to the majority ethnic population.[203]

A 2007 study of A8 migrants in Glasgow found that 55% of respondents had experienced some form of homelessness, whether living temporarily with friends and family (38%), living in bed and breakfasts (16%) or sleeping rough (1%). Another study noted that one of the main causes of homelessness among migrants was the attachment of accommodation to a particular job; if the job ends, a migrant can become homeless without much warning and with little funds to find alternative housing.[204]

Minority ethnic people affected by homelessness appear to have little informal support from families and friends, apart from the provision of accommodation, relying instead on a number of organisations who provide targeted services accessible to minority ethnic individuals. Minority ethnic services were more likely to provide specialised services than mainstream agencies, including translation and advocacy services. Because specialised services address the particular needs of minority ethnic communities, these are favoured greatly over mainstream services. However, large portions of Scotland, including rural areas, have few or none of these services. Furthermore, widespread awareness of these services is lacking.[205]

Measures which the Joseph Rowntree Foundation suggest to reduce homelessness in minority ethnic communities include: [206]

- Provision of high quality advice and information;
- Increased recognition of the existence of hidden homelessness and the particular accommodation needs of minority ethnic families; and,
- Ethnic monitoring of service provision and regular review of services.

A study found that safety from racial harassment continues to be a source of concern for minority ethnic communities, particularly surrounding accommodation. In some instances, a belief that inappropriate temporary accommodation will be offered may deter people affected by homeless from seeking support. Furthermore, minority ethnic individuals may wish to live near to religious or cultural centres. The need for accommodation near to this, and in areas with less fear of harassment, is not often understood by service providers. Limited specialist provision for older minority ethnic people and for women escaping violence in the home was also noted.[207]

Discrimination and housing[208]

According to the Joseph Rowntree Foundation[209], fear of racial harassment among minority ethnic communities hinders the integration of these communities and impacts on the quality of life experienced within the home and neighbourhood. Fear and experience of racial harassment have a great impact on the housing decisions of asylum-seekers and refugees

[203] Joseph Rowntree Foundation (2012). Poverty and ethnicity in Scotland.
[204] Ibid
[205] Ibid.
[206] Ibid.
[207] Joseph Rowntree Foundation (2012). Poverty and ethnicity in Scotland.
[208] Please note, further information on racial discrimination and harassment can be found in the Community Cohesion and Safety evidence paper, which can be found at www.crer.org.uk.
[209] Ibid.

and other minority ethnic communities. In some cases, harassment drives individuals and families to other (often poorer quality) accommodation. Racist incidents in social housing remain under-reported due to unfamiliarity with the local authority and housing association's policies and procedures dealing with racial harassment.

Family Life

Looked after children

The overwhelming majority of children in care are from white ethnic groups. According to Scottish Government statistics for 2013-2014 there were 1,146 children whose ethnicity was unknown, which was a larger sum than all minority ethnicities combined, and therefore makes it difficult to draw effective analysis. The table below shows the total number of children looked after in July 2014.[210]

Children looked after at 31 July 2014 by ethnic group

Ethnic Group		%	Scotland %
White	13,950	89.5%	94.5%
Mixed Ethnicity	235	1.5%	0.9%
Asian, Asian Scottish or Asian British	81	0.5%	3.3%
Black, Black Scottish or Black British	95	0.6%	0.9%
Other Ethnic Background	73	0.5%	0.4%
Not known	1,146	7.4%	0.0%
Total looked after children	**15,580**	**100.0%**	**100.0%**

Source: Children's Social Work Statistics 2013-2014: Additional Tables

Please note that for the above table, the last column presents the data with the 'not known' data removed.

[210] Scottish Government (2015) "Children's Social Work Statistics 2013-2014: Additional Tables"

Child Protection

As with much of the data on children and families separated by ethnicity, the sample size in the Scottish Government data[211] is too small to make any effective comparisons.

Number of children on the child protection register, 2007-2014 - by ethnic group

	at 31 March				at 31 July				% of total	% change
	2007	2008	2009	2010	2011	2012	2013	2014	2014	2013-2014
Ethnic Group										
White	-	-	-	-	2,097	2,142	2,016	2,124	74%	5%
Mixed or Multiple Ethnicity	-	-	-	-	36	45	48	51	2%	6%
Asian, Asian Scottish or Asian British	-	-	-	-	35	24	48	47	2%	-2%
African, Caribbean or Black	-	-	-	-	11	23	17	51	2%	200%
Other Ethnic Background	-	-	-	-	22	21	21	24	1%	14%
Not known	-	-	-	-	370	437	495	585	20%	18%

Source: Children's Social Work Statistics 2013-2014: Additional Tables

Each year the National Society for the Prevention of Cruelty to Children (NSPCC) [212] gathers information on child abuse and neglect and while it did not have enough data to draw analysis on minority ethnic children in particular, it did report that through its UK public survey 61% of respondents thought that disabled and minority ethnic children were more vulnerable to abuse than others.

The report[213] also revealed that an estimated 602 children were victims of child trafficking in the UK in 2013. 160 children were referred to the NSPCC Child Trafficking Advice Centre between November 2013 and October 2014. Of these referrals 38% of children were of Asian ethnicity and 30% of African ethnicity.

The UK-wide Safer Network reported that minority ethnic children are more likely to be subject to child protection plans or end up in the care system than white children, with the reasons for this unclear. It sites cultural differences in raising children and disparity in what is seen as acceptable as a reason agencies may question parents or investigations by the police or children's service may occur. It is also possible that some minority ethnic families may lack awareness of or access to appropriate services which could help address issues such as poverty. [214]

A study on the perceptions of child abuse within Scotland's Black and minority ethnic (BME) communities found that overall, 16% of participants stated that if they knew a child or young person was being abused they would not report it. Those who said they would report it admitted that if child abuse did occur, it would be more likely to be dealt with in the home rather than by the proper authorities. Barriers to reporting child abuse noted included wanting to protect a child from 'further grief via the backlash,' denial of child abuse in communities, the role of shame and honour in some cultures and challenges presented by a

[211] Scottish Government (2015) "Children's Social Work Statistics 2013-2014: Additional Tables"
[212] NSPCC (2015) "How safe are our children? The most comprehensive overview of child protection in the UK"
[213] Ibid
[214] The Safer Network. Supporting your work with children from black and minority ethnic communities.

lack of English language skills and needing a translator. Individuals also believed service providers were not aware of one's cultural or religious needs, which limited their access to such services. [215]

Violence against women

There is no data available to suggest that women from non-white minority ethnic groups suffer a greater threat from domestic violence than white ethnic women.[216] However, there are some issues such as forced marriage, human trafficking or female genital mutilation that women from minority ethnic groups are more exposed to than the majority ethnic population in Scotland.

Additionally, minority ethnic women escaping violence within the home may face particular issues due to their ethnicity, including the acceptance of violence against women in some parts of their communities, the lack of appropriate refuge space for refugees or migrants who did not have permission to stay in Scotland, and lack of recourse to public funds.[217]

Among other groups, women from minority ethnic communities, including those who are worried about their immigration status, may face significant barriers to reporting violence, particularly rape and sexual assault. Research also suggests that minority ethnic women tend to suffer domestic abuse for longer before reporting it, with estimates that on average, it may take minority ethnic women ten years to leave a violent partner.[218] Evidence gathered by ScotPHN[219] found a lack of support for migrant women suffering domestic abuse in Scotland.

A report published by Scottish Borders Council[220] suggested that women from Black, Asian, Minority Ethnic and Refugee (BAMER) communities may also be more isolated. They may have to overcome religious and cultural pressures, or be afraid of rejection from their own community if they disclose the abuse and ask for help. Their experiences may also be made worse due to racism, and for that reason they may be unwilling to seek help from statutory agencies.

This report also found that women whose immigration status is insecure or who are dependent on remaining with their husbands may feel trapped and unable to seek help in case they are deported. They are also likely to have no access to public funds, which means they cannot claim most state benefits. For that reason many refuge organisations will not be able to provide accommodation.[221]

---

[215] Roshni. The perceptions of child abuse within Scotland's Black and Ethnic Minority Communities.
[216] Scottish Borders Council "Issues facing women from Black, Asian, Minority and Ethnic and refugee communities"
[217] Ibid.
[218] Safer Scotland (2009). Safer Lives: Changed Lives. A shared approach to tackling violence against women in Scotland.
[219] Millard, A. ScotPHN (2009). Migrant Workers' Health: Scottish Evidence in Perspective.
[220] Scottish Borders Council. Issues facing women from Black, Asian, Minority, Ethnic and refugee Communities.
[221] Ibid.

As referenced previously in this paper, domestic violence also contributes to homelessness, and there is little specialist support available to minority ethnic women facing this.

Female Genital Mutilation (FGM)

Female Genital Mutilation has been unlawful in Scotland since 1985 by virtue of the Prohibition of Female Circumcision Act 1985. [222] The FGM (Scotland) Act 2005 extended protection by giving those offences extra-territorial effect in order to protect those being sent abroad to have FGM carried out. [223] An amendment to close a loophole in the Prohibition of Female Genital Mutilation (Scotland) Act 2005 to extend the reach of the extra-territorial offences to habitual (as well as permanent) UK residents in that Act was achieved by means of a legislative consent motion in the Serious Crime Act 2015.[224]

Female Genital Mutilation has been illegal in the UK since 1985 and in 2005 the Prohibition of Female Genital Mutilation (Scotland) Act 2005 came into force, also making it an offence to aid or abet FGM abroad.

Data from the Scottish Refugee Council[225] shows that there were 23,979 men, women and children born in one of the 29 countries identified by the United Nations Children's Emergency Fund (UNICEF) (2013) as a 'FGM-practising country' living in Scotland in 2011. The largest community potentially affected by FGM living in Scotland are Nigerians, with 9,458 people resident in Scotland born in Nigeria. When weighted by the national prevalence rate in their country of birth (which varies dramatically from 27% in Nigeria and Kenya, to 98% in Somalia) Nigerians are still the largest community, followed by people born in Somalia, Egypt, Kenya, Sudan and Eritrea.

There are potentially affected communities living in every local authority area in Scotland, with the largest in Glasgow, Aberdeen, Edinburgh and Dundee respectively. The number of children born into potentially affected communities in Scotland has increased significantly over the last decade, with 363 girls born in Scotland to mothers born in an FGM-practising country in 2012, representing a fivefold increase over the last decade.[226]

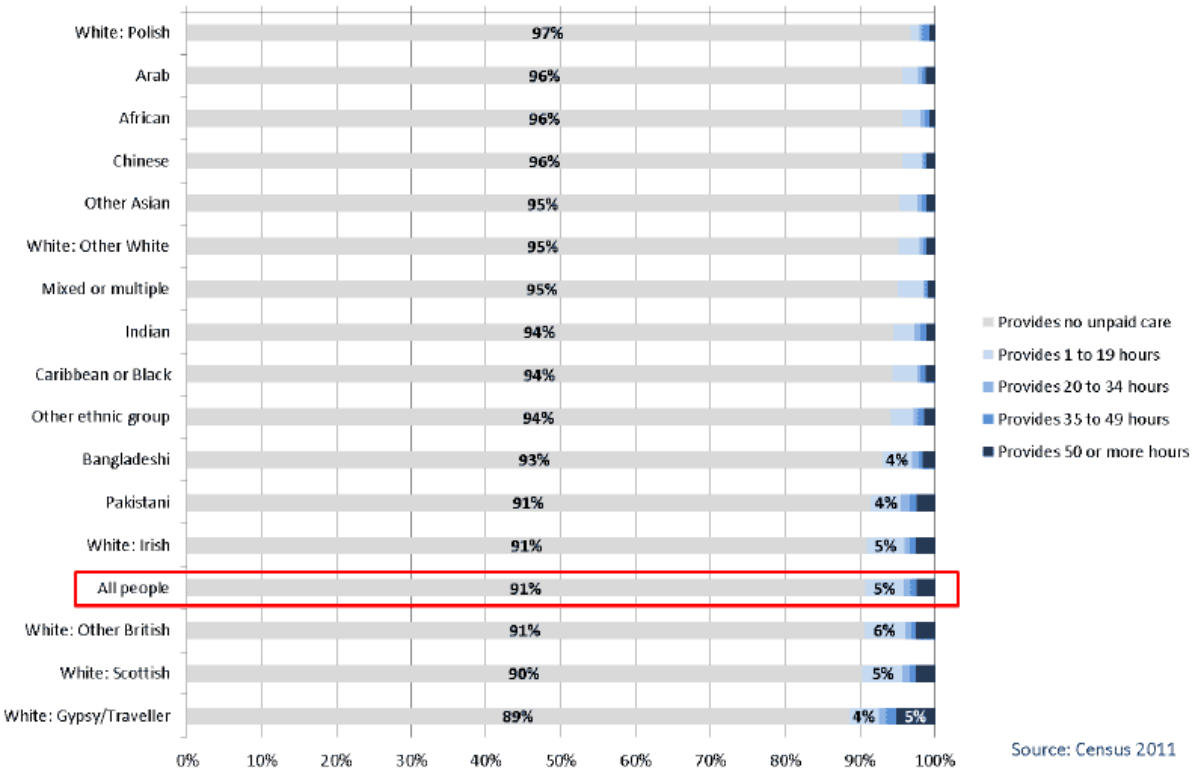
The Scottish Government National FGM Action Plan[227] aims to tackle FGM by engaging with potentially affected communities; working with key statutory and third sector partners to increase access to all relevant health services for survivors of FGM; asking relevant agencies to review violence against women strategies to include specific actions regarding FGM; asking all social work offices, NHS boards and other agencies to have at least one professional with expertise on FGM; and providing information and training on FGM to healthcare workers, teachers and other professionals.

[222] Prohibition of Female Circumcision Act 1985
[223] Prohibition of Female Genital Mutilation (Scotland) Act 2005
[224] Serious Crime Act 2015.
[225] Helen Baillot, Nina Murray, Elaine Connelly and Dr Natasha Howard Scottish Refugee Council (2014) "Tackling Female Genital Mutilation in Scotland: A Scottish model of intervention"
[226] Ibid.
[227] The Scottish Government. Tackling Female Genital Mutilation.

Informal caring

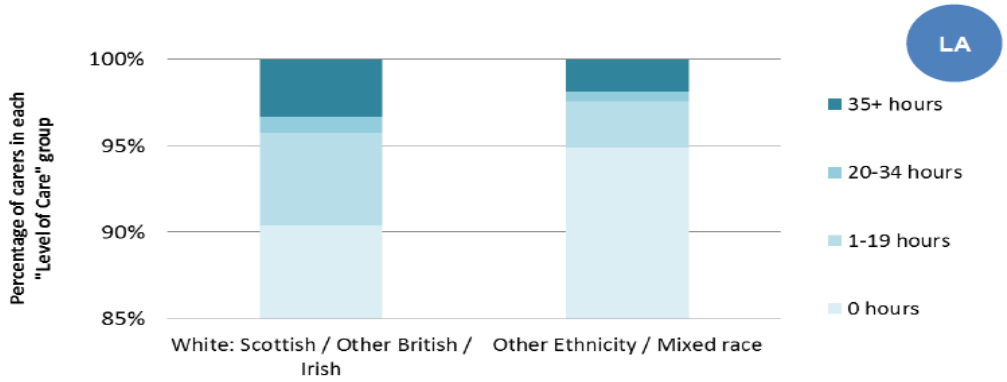
The 2011 Scottish Census found that 96% of carers in Scotland are of a white ethnic background, with 4% from a minority ethnic background.[228]

Ethnic group by provision of unpaid weekly care, all people, 2011[229]



Source: Scotland's Census 2011

Ethnic group and level of care per week provided by carers, 2011[230]



Source: Scotland's Census 2011

[228] Scotland's Carers (2015). An Official Statistics Publication for Scotland.
[229] The Scottish Government. Analysis of Equality Results from the 2011 Census.
[230] Scotland's Carers (2015). An Official Statistics Publication for Scotland.

However, Scottish Government reports that overall, white ethnic groups are more likely to be caring (9.6%) than other ethnicities (5.1%), which may be due, in part, to a difference in age structures for these populations, with 38% of white ethnic individuals aged 50 and over and 13% in 'other' ethnic groups aged 50 and over.[231] [232]

The Pakistani community is the largest non-white minority ethnic group, followed by the Chinese community and the Indian community. 8.7% of the Pakistani community provide some form of unpaid caring, along with 4.3% of the Chinese community and 5.5% of the Indian community.[233]

However in common with informal carers within the majority population, self-identification as a carer can be problematic. Individuals may prefer to think of themselves as spouses, sons or daughters, parents, relatives or good neighbours where the caring role is subsumed within the preferred identity. However, for minority ethnic carers, additional difficulties arise due to the lack of a conceptual framework and the accompanying language of 'informal caring'. Many studies suggest that this may lead to significant amounts of under-reporting within minority ethnic communities.[234]

Data gaps in home policy areas focused on family life

Failure to disaggregate data by ethnicity is common in the main official statistical publications for many areas of home and family policy. These include adoptions, births and stillbirths, fertility rates, marriages and civil partnerships, divorces and dissolutions. Some of these datasets include information on country of birth, however this is not a useful proxy for ethnicity as large numbers of Scotland's minority ethnic population are born in Scotland or other parts of the UK.

[231] Scotland's Carers (2015). An Official Statistics Publication for Scotland.
[232] The Scottish Government (2015). Carers (Scotland) Bill: Impact Assessment.
[233] Ibid.
[234] MECOPP (2012) "Informal Caring Within Scotland's Black and Minority Ethnic Communities: Briefing Sheet 3"

Appendix: Key underpinning threads and questions

The concepts outlined throughout this evidence paper provided perspective and additional scope when discussing these issues in the related action forums, which had the same themes as the evidence papers.

These action forums were organised by CRER and the Scottish Government and brought practitioners, policy makers and other stakeholders together to identify priorities and solutions for each theme.

The key underpinning threads and questions for discussion listed below were used to frame and drive forward these workshops. Complete write-ups from these action forums can be found at www.crer.org.uk.

Key underpinning threads for the purposes of discussion were grouped in the following way:

Health

- Physical and mental health conditions
- Health awareness and preventative work
- Behaviours which impact health, including diet, exercise, smoking, alcohol consumption and drug use
- Health services and treatment
- Social care for older people and disabled people
- Supported living and independent living

Home

- Social housing
- Home ownership
- Private rental
- Temporary accommodation
- Homelessness
- Housing conditions, including overcrowding
- Social work
- Adoption, fostering and looked after children
- Support for families
- Child protection
- Violence against women in the home / family context

Throughout the police development process, the following questions were raised for further exploration and discussion.

Health

- How can we ensure that health policy takes account of the disproportionate effect of certain health conditions (for example diabetes, coronary heart disease, lupus and sickle cell disorders) on particular minority ethnic groups?
- What improvements can be made to data collection and use so that we can better understand health inequalities for minority ethnic communities?
- To what extent do culturally specific perceptions and attitudes affect self-reporting about health and wellbeing what does this mean for interpretation of data?
- What are the impacts of cultural norms and values around care within the family in terms of access to, and take up of, social care provision?
- How can we better understand the relationship between ethnicity, socio-economic deprivation and health outcomes?
- How can we address the data gaps in health, wellbeing and social care research?

Home

- Why do minority ethnic households disproportionately rent housing privately, and what impact does the higher expenditure on rent have on household wealth?
- How can 'hidden homelessness', overcrowding and housing quality issues be tackled for minority ethnic communities?
- Why are minority ethnic individuals disproportionately represented in the figures for temporary accommodation?
- How can we measure destitution due to asylum and immigration status (which is not captured in official homelessness statistics, as those refused leave to remain are ineligible for support)?
- What can be learned from existing practice within housing associations about providing quality services and support for minority ethnic tenants?
- How can we make better use of population projections and distribution trends for minority ethnic communities to help develop effective housing policy?
- How can the availability of data disaggregated by ethnicity in many areas of home and family policy be improved?
- Do minority ethnic families' and children's experience of social work services and the local authority care system differ from those in the majority ethnic community?
- How can violence against women policy best reflect the differing experiences and needs of minority ethnic women experiencing violence in the home or family context?

Overarching issues

- How can the many issues with lack of disaggregation by ethnicity be tackled in data collection and use throughout these policy areas?
- What further qualitative information could be gathered to better understand the needs and experiences of minority ethnic individuals and communities in these policy areas?

Please note, the key underpinning issues and questions identified here are not exhaustive.