An Exploration into the Impact the Use of a Night Shelter Service has on the Health of Asylum Seekers Experiencing Destitution

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Abstract

The rising number of asylum seekers experiencing destitution in the U.K. is a key issue within research. This ‘hidden’ population cannot access mainstream homeless services or welfare support leaving them heavily reliant on friends, family and voluntary organisations. The Glasgow Night Shelter for Destitute Asylum seekers provides emergency shelter accommodation to males who fit this remit. There is a huge gap in research regarding the provision of services to this group and how this impacts on their wellbeing. This study used ethnographic methods (participant observation and interviews), over a 3-week data period, to explore the use of this shelter and how it impacts on the wellbeing of people using it. The findings of the study demonstrate that this service positively influences health of guests through the provision of basic shelter, organisational procedures, informal care structures (for more vulnerable individuals) and as a space for creating social capital. However, the demand for this service is growing and the delivery of these provisions and subsequent impact on health are constrained by structural barriers such as staffing, time and space limitations. This study has implications for the wider exploration into the wellbeing, coping strategies and use of services by this extremely vulnerable population.

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Table of Contents

Glossary of Terms

Term	Definition
Refugee	The 1951 United Nations Refugee Convention defines a refugee as: 'A person who has a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinion.' In addition the person is outside the country of his/her origin and is unable or unwilling to return to it out of fear of persecution (ICAR, 2012).
Asylum Seeker	"When a person lodges an application for asylum under the 1951 Refugee Convention they are described as an asylum seeker. In the UK, a person is not officially described as a refugee until they have been granted asylum (or refugee status) (ICAR, 2012).
Failed (refused) asylum seeker	A person whose claim has been rejected by the Home Office. Individuals have no right to remain in the UK but can appeal. If all rights of appeal have been exhausted, all Home Office support is taken away, and they are asked to return to their country of origin.
Homeless	Refers to individuals living in the streets with no physical shelter of their own including those staying night shelter accommodation (Layton, 2000).
Rough Sleeping	Refers solely to individuals sleeping outside who have no physical shelter (Layton, 2000).
The Shelter	Glasgow Night Shelter for Destitute Asylum Seekers
Guest	Person using the Night Shelter

1. Introduction

In recent years an increase in the number of conflicts and subsequent displacement of people worldwide has resulted in large numbers of people fleeing these countries and claiming asylum in European countries including the U.K. (Murthy and Lakshminarayana, 2006; Blinder, 2015). Concomitantly, a rise in the body of research investigating issues affecting refugees and asylum seekers is evident. This research is highly significant in its contribution to better understanding the experiences of immigrants, especially in the current political climate and public opinion where the issue of immigration and its impact on U.K. services, including the NHS, is being fiercely debated.

The U.K. asylum process is notoriously complex and hard to navigate with recent statistics showing the majority of claims are refused (Wren, 2007; Blinder, 2015). Bloch and Schuster (2005) noted that reforms in legislation have led to welfare support being increasingly difficult for asylum seekers to access; notably, reforms in the Immigration and Asylum Acts 1999 and 2002 which prevent people claiming asylum from accessing mainstream benefits and the right to work. Brown (2008) attributes these reforms to a rise in the number of people within the asylum process experiencing destitution. This population are referred to as the 'hidden population' and are much less widely documented within current literature (Smart and Fullegar, 2008, Lewis, 2009).

Section 95 of the Immigration and Asylum Act 1999 defines destitution as someone in the process of claiming asylum who (1) 'does not have adequate accommodation or any means of obtaining it (whether or not his other essential living needs are met)'; or (2) 'has adequate accommodation or the means of obtaining it, but cannot meet his other essential living needs'. Additionally, this paper employs a broader definition of destitution to include people who have also been refused asylum, are in the process of or have exhausted appeals and people not from the E.U. who are subject to immigration control and have no recourse to public funds (NRPF) - Home Office support, public housing or mainstream benefits (Gillespie, 2012).

Asylum seekers can experience destitution at multiple stages throughout the asylum process and for a variety of reasons (Brown, 2008). However, the group is reported to be predominantly refused asylum seekers who do not want to return home voluntarily believing that there are risks to their safety and wellbeing or that of their family if they return to their country of origin (Red Cross and Boaz Trust, 2013; McIntyre and Mogire,2012). The vast

majority of this group have no access housing or welfare support (British Red Cross and the Refugee Survival Trust, 2009). While there is no centralised demographic data on this group the population in the U.K. is estimated at over 100,000, and to consist of predominantly men, aged 18-49 (Blinder, 2015; Crawley *et al*., 2011). It has been argued that the wide disparity in demographic data and research accounting for the movement and wellbeing of this group is reflective of the government's unwillingness to take responsibility for the welfare of this group (Mutwira, 2012). Of particular relevance to this dissertation is the specific lack of investigation into the support available and subsequent impact this support may have on the health and wellbeing of this group.

Glasgow is one of the dispersal areas where asylum seekers can be housed after their initial claim has been submitted, normally in the South East of England. Figures show that Glasgow receives the highest proportion of asylum seekers compared with the rest of the UK – over 3,000 asylum seekers housed in Glasgow in 2015 (Home Office, 2016). In accordance with this, there are also estimated to be high numbers of asylum seekers experiencing destitution in Glasgow (Wren, 2007; Stewart, 2011). This is reflected in the large number of voluntary organisations working with refugees, asylum seekers and migrants in the city (Piacentini, 2015; Wren, 2007).

The Glasgow Night Shelter for Destitute Asylum Seekers (referred to as 'the Shelter' throughout the paper) is the only service offering shelter accommodation to asylum seekers experiencing destitution in Scotland. The Shelter, with a capacity of 15, describes itself as offering shelter to male-only asylum seekers and non-EU immigrants unable to access mainstream homelessness services (referred to within the service as 'guests') ("About the Night Shelter", 2016). It operates within a church within the Glasgow City area. Informed research highlights that the marginalisation of asylum seekers and the subsequent effects of destitution, poor access to services and living conditions exacerbate health issues, emphasising the significance of this particular research.

There are currently no studies analysing the provisions offered by a shelter service in the U.K. and how they respond to the significant health needs of this group. In this paper health is defined as "a state of complete physical, mental and social wellbeing and not merely the absence of disease" (WHO, 2005), where wellbeing is a dynamic concept regarded as having the psychological, emotional and physical resources required to meet an individual's needs at

any given point (Dodge *et al*., 2012). This paper aims to explore this topic by asking the following research questions:

(a) What are the main health issues facing guests at the Shelter?

(b) What does the Shelter provide for guests?

(c) In what ways do guests use the space and provisions within the Shelter?

(d) How does the shelter respond to and impact upon the health needs of guests?

Through the employment of ethnographic research methods, this study will explore the experiences of Shelter staff and guests. Through offering a unique perspective, this dissertation will contribute meaningfully to the limited research on the growing 'hidden' population of asylum seekers experiencing destitution. Specifically, it seeks to explore research gaps around the provision and use of shelters by this group and in doing so increase the knowledge spectrum regarding the impact of shelters on the health of this specific population.

Initially, the thesis will examine existing literature around the wider context of destitution, health issues within this population, shelter services and the place of social capital within health. A subsequent exploration and justification of the research strategy and methodological approach will be outlined. This is followed by a presentation of the findings of the study presenting key themes which consider how the Shelter impacts on the health of guests, provision of basic needs, organisational structures, social capital and "shared space". Finally the discussion will analyse these findings drawing conclusions on the mechanisms through which these themes impact on the health of guests, reflecting on the constraints placed upon these and the implications of these results in the wider research arena. Concluding remarks will outline the most significant issues in relation to the data findings.

2. Literature Review

This dissertation explores the impacts on health and wellbeing of asylum seekers staying in night shelter accommodation, and so this section reviews relevant literature within this research area in the form of governmental legislation policy, non-governmental organisation's reports, research studies and theory. Knowledge of this group and their experiences is limited due to little data and a constantly changing and complex asylum process.

2.1 Health, Destitution and the Asylum Process

2.1.1 Health as a Direct Result of Destitution

The health needs and outcomes of people that are homeless, in non-migrant specific studies, show huge discrepancies when compared with the housed population. Studies have shown increased rates of substance abuse, trauma-related conditions, tuberculosis and other respiratory infections, and mortality (Riley *et al*., 2003; Cheung *et al*., 2004; Story *et al*., 2007; Bhugra, 2007). While there have been no studies exclusively investigating the health of destitute asylum seekers, several reports investigating aspects concerning the extent and nature of destitution have highlighted health as a significant and complex issue in this group (Crawley *et al*., 2011; British Red Cross, 2010; Lewis, 2009; Gillespie, 2012). Poor living conditions were reported to contribute to ill health due to difficulty acquiring food, or healthy food leading to undernutrition or malnutrition (Lewis, 2009). Studies often refer to physical hardships resulting in poor physical health such as damp housing, lack of heating or facilities for washing clothes leading to skin conditions, colds and flus (Gillespie, 2012; Crawley *et al*., 2011). Additionally, Crawley *et al*. (2011) investigated the survival strategies of asylum seekers experiencing destitution in England and found specific risks to the health of this group to include: social exclusion, isolation, gender-based violence, distress, insecurity and lack of access to primary care services.

Illegal work, carried out in order to obtain resources, is also a cause of poor health due to high amount of physical labour, long hours and the little regard for health and safety (Skrivankova, 2014; Dwyer *et al*., 2011). Lewis *et al*. (2013, 2015) report extensively on the contributions of forced employment to decreased mental wellbeing; the precarity of the

employment; manipulation by bosses including threats of reporting workers to the Home Office; and the demoralisation of financial exploitation especially as skilled workers having to now work in unskilled jobs to survive. Several reports have also documented men and women engaging in transactional sexual relationships and commercial sex work as survival strategies during periods of destitution resulting in consequences for sexual health as well as emotional health (Reeve, 2011; Crawley, 2011; Forro, 2013).

2.1.2 Health Related to the Asylum Process

Substantial evidence shows that being a part of the asylum process has a profound impact on wellbeing, especially psychological. The asylum process within in the U.K., lasting up to years in some cases, has been found to fuel feelings of anxiety and uncertainty of future (Crowley, 2003; Burnett, 2002). For those who are refused, increased feelings of depression at one's circumstances and feelings of injustice have been reported (Lewis, 2009; Gillespie, 2012). Crawley *et al*. (2011) found that the main fear of people experiencing destitution was that of being deported to their country of origin where they suspected they would face imprisonment, torture or death causing huge anxiety towards the authorities and the belief that they would prefer to live in destitution, without adequate food or shelter than chance being detained and deported.

Furthermore, destitution has been reported to lead to feelings of worthlessness among participants as they considered themselves to be in the margins of society, without permanent residence and having to depend on others (Gillespie, 2012; Omata, 2013). Qualitative studies have also remarked on participants feeling dehumanised by the asylum process, being left in a state of limbo between refused asylum in this country but an inability to return home (Pittett, 2013; The Red Cross and Boaz Trust, 2013). These findings all indicate disproportionately high experiences of mental health issues within this group.

2.1.3 Health related to events prior to arrival in the U.K.

Poor health in asylum seeker populations has also been attributed to grief and trauma resulting from the circumstances in which one has left their country of origin. Primary reasons for this include experiences of violence, war, political oppression and persecution against themselves or their families in their countries of origins (Crawley, 2010). Due to these circumstances many asylum seekers may have increased health needs relative to other migrant groups including injuries from torture and large numbers of trauma-related diagnoses

(Burnett, 2002; Crowley, 2003). Their journey to the U.K. can regularly entail enduring many physical hardships, exposure to communicable diseases, water-borne diseases through lack of sanitation and adequate housing and end with the adaptation to difficult living circumstances on arrival. These have all have been reported to contribute to poor physical and mental health status (WHO, 2016).

The combination of previous trauma from countries of origin, alongside the stress of the enduring asylum process and physical hardship of destitution can result in severely negative effects to people's mental wellbeing (Crawley *et al*., 2011). For example, Freedom from Torture report destitution to have a severely negative impact on victims of torture, having a large impact on their ability to recover from experiences of past trauma and increasing risk of suicide among survivors (Pettitt, 2013). In opposition to this is literature investigating the potential for higher levels of resilience to psychological distress in asylum seekers resulting from their previous traumatic experiences (Papadopoulous, 2007; Folkman, 1997). Papadopolous (2007) reviewed the many examples of refugees experiencing adversity-activated development (AAD) after going through traumatic experiences and how this can strengthen the psychological development in some circumstances however this has not been explored within populations of asylum seekers also experiencing destitution.

2.2 Access and Barriers to Services

2.2.1 Food and Shelter

While experiencing destitution, generally without any welfare support, refused asylum seekers predominantly rely on voluntary sector organisations or the generosity of religious organisations, friends or family to provide essential living resources such as financial grants, food packages and clothing (Refugee Action, 2006; Smart, 2009). However, one report found that a large number of asylum seekers experiencing destitution do not access voluntary organisations as they have found them to have limited resources, or fear them to be connected to the Home Office and would rather seek support from friends, other asylum seekers or faith-based organisations (Crawley *et al*., 2011). This raises issue with the majority of the research carried out by these voluntary organisations on whether they are missing data about barriers to services from an 'invisible' proportion of people experiencing destitution that are not accessing these services.

In terms of accommodation, shelter is given primarily through acquaintances, friends or family as refused asylum seekers cannot access mainstream homeless accommodation (Lewis, 2009). There are a growing number of grassroots schemes which organise 'hosts' for asylum seekers who are homeless for example 'Rooms for Refugees' ("Rooms for Refugees", 2016). Night shelter services, specifically available to people experiencing destitution, are only available in Glasgow and some locations in London. However the Shelter is unique in that it is open 7 days a week and people may stay for an unlimited period. There remains no research exploring the mechanisms behind how people access and use this type of accommodation apart from quotes from service users that are presented in their own websites which are potentially flawed in their bias ("Rooms for Refugees", 2016).

2.2.2 Health and Care Services

All people who have been refused asylum in the UK are allowed to access primary and secondary health care where required however under the NHS (Charges to Overseas Visitors) Regulations (1989) charges may be incurred for people accessing secondary care services if they are deemed to not have 'ordinary residence' within the UK. In England, this has been interpreted and amended to purposefully include refused asylum seekers, including those who are destitute, under this legislation charging for secondary care services. However, in Scotland, the corresponding legislation was amended to ensure clarification in the continuing treatment of failed asylum seekers:

> *'Anyone who has made a formal application for asylum, whether pending or unsuccessful, is entitled to treatment on the same basis as a UK national who is ordinarily resident in Scotland while they remain in the country.'* (NHS (Charges to Overseas Visitors) (Scotland) Regulations 1989 / 364)

Asylum seekers and refused asylum seekers are also generally excluded from community care services under the control of local authorities, which include all non-medical social care services, unless it is seen to be a breach of their human rights under the European Convention on Human Rights Act (2003) or they have a need for care and attention that does not arise solely from their destitution ("Accessing and Supporting Family…", 2011).

However, even in Scotland where primary and secondary health care comes at no cost, destitution has still been shown to go hand in hand with losing access to health care services (Pittett, 2013). Studies have found that many people will refrain from attending a GP surgery

or hospital with health problems due to fears of expensive bills or that their details will be passed to the Home Office and they will risk deportation (Thomas *et al*., 2010). Research has also shown barriers to healthcare to include lack of a permanent address, language barriers, lack of cultural competency of practitioners and racial discrimination (Williams and Mohammed, 2008; Crawley *et al*, 2011). Inevitably loss of access to services can adversely affect health in so many ways including lack of medication, repeat prescriptions, which for some could be catastrophic (Pittett, 2013).

Legislative literature clearly describes the limited access asylum seekers experiencing destitution have to service. Recent qualitative reports cited above have also begun to examine specific barriers this group have in accessing the services available to them however no in depth research has looked at how this population access and use services or the impact they have on wellbeing.

2.3 Shelter Accommodation and Health

Emergency Shelter accommodation arrived as a response to widespread homelessness in the West in the 1970s and 80s offering a place to sleep, a meal and sometimes a shower (Lyon-Callo, 2000). Banham (2007) distinguished shelters from a home in that their fundamental purpose is solely to protect people. However, while some research found that service users viewed homeless shelters as a place of sanctuary several other studies have found people often find them to insecure, inhospitable and degrading (Gilkey, 2009; Whitley,2008; Dordick, 1997; Liebow, 1993). Hoffman and Coffey (2008) even reported many service users opting out of shelter services due to feeling undignified and disrespected as a result of the power relations within the provider-client relationship. Glisson *et al*., (2015) studied the model of care within one shelter and found that nutrition and health were seen as secondary aims after getting clients moved on. In contrast to this, Lyon-Callo's (2000) ethnography in a homeless shelter found that their preference was a medical model, where they would provide in house counselling and referral to external services to get clients treatment for health issues. There is a supporting link between staying in a shelter and increased access to healthcare compared with rough sleepers (De Rosa, 1999). Dejarlais' (2011) extensive research into an American shelter found that although isolation was epidemic among service users due to the stigma and status of homelessness, relief was sometimes found through social connections within the shelter. These were formed through shared feelings of marginalisation and

sometimes led to economic exchanges. However, violence was also found to be a common occurrence. These studies offer insight into some of the experiences and impacts on health of people while staying in shelters. However all available studies took place within mainstream homeless shelter accommodation predominantly in North America leaving a gap in the experiences and knowledge of shelters in the U.K. accommodating male destitute asylum seekers.

2.4 Social Relationships and Health

Social relationships have been described in literature as impacting both positively and negatively on the health of individuals.

Social capital and social support are associated with buffering the effects of risks to psychological wellbeing and independent positive influences on health and health behaviours. Social capital is defined by Lin (2002) as "resources embedded in a social structure that are accessed and/or mobilized in purposive actions" (Lin, 2002, p. 29) where "social structures" refer to formal hierarchical structures (e.g., organisations) and more informal social networks.

Social support is defined as "support accessible to an individual through social ties to other individuals, groups and the larger community" (Lin *et al*., 1979). Social support and health are generally described in literature in relation to quantity - number and frequency of interactions; and quality - amount of emotional and practical support received through social connections. Umberson and Montez (2010) described the quality as a better predictor of good health but found both to be important.

2.4.1 Evidence of Social Factors Affecting Health

A vast amount of literature has linked social capital positively with improved health through mechanisms such as supply of social support, maintenance of healthy norms, promotion of healthy behaviours and enhancement of health services (Song, 2013). Improved health outcomes that have been demonstrated include decreased mortality, increased physical and mental health, health information and life satisfaction (Song *et al*. 2011; Umberson and Montez 2010). Low levels of support have been correlated with heightened stress reactivity including 'elevated' heart rate, elevated blood pressure and cardiovascular and

neuroendocrine responses to stress (Grabe *et al*., 2005; Ozbay *et al*., 2008; Feder *et al*., 2013).

Rutter (1985) first established the presence of social supports providing a protective function in health in the area of adult depression following adverse life events. It has been argued that the protective abilities of social supports only function in the face of adversity, as a buffering influence and not a preventative measure (Henderson *et al*., 1981). More recently social support has been linked increasingly to resilience in mental health (Friedli, 2009). 'High quality' social support can enhance resilience to stress, development of trauma-related psychopathology and functionality after experiences of combat trauma, and reduce morbidity and mortality (Ahern *et al*., 2003; Miller and Rasmussen, 2010).

Social capital has been known to act across diverse populations as a buffer to health inequalities in marginalised groups such as lower socioeconomic groups and ethnic minorities (Uphoff *et al*., 2013; Grundy and Sloggett, 2003; Song, 2011). However, while some papers have argued that social capital acts as a buffer for the deleterious effects of marginalisation on health through better coping mechanisms, it has also been suggested that this is only through active participation in organisations and social inclusiveness solely from neighbourhoods is not proved significantly beneficial to health (Cattell, 2001).

Cohen (2004) and Beery and Kaufer (2015) both identified negative social interactions as one of the primary mechanisms by which social relationships affect wellbeing through their destructive role as an external stressor. August *et al*., (2007) expanded upon this further examining two models by which the presence of adversity can interact with the effect of negative social interactions on health: the stress-exacerbation model demonstrates how external life stress can multiply the distress experienced from negative social interactions; and the second model through which a person may be so emotionally distressed by an initial stressor that a negative social interaction will have little further effect on stress levels.

2.4.2 Social Relationships and Destitution

The family and immediate support networks of people experiencing destitution can be back in countries of origin, in transit, missing or dead making contact with them difficult or impossible (Smart and Fullegar, 2008). Aside from this, physical barriers of cost prevent people from contacting family to be reassured of their wellbeing or for emotional support (British Red Cross, 2010).

Crawley *et al*. (2011) specifically named social contacts as the most important resource in coping with destitution over others such as economic and institutional resources. However, they simultaneously report experiences of loss and dignity, stress and pressure to please their host when relying on social connections for accommodation. Gillespie's (2012) research commented positively on the effects of social connections reducing feelings of isolation among destitute asylum seekers. In other cases social exchanges are not altruistic as people experiencing destitution have engaged in transactional relationships where they have been exploited for sex and work (Reeve, 2011). Therefore social relationships alone may not always be beneficial and may in some cases be detrimental to or result in the disempowerment of individuals.

Studies in refugee communities worldwide have shown that scarcity of material items leads to the establishment of informal support structures where there is a transfer or exchange of resources to those who are facing even more extreme hardship and destitution (Omata, 2013; Williams, 2006; Zetter *et al*., 2008; Simich *et al*., 2003). Williams' (2006) study exemplified this when reporting the use of social contacts within migrant communities for gaining information on health services and as unofficial translators for doctors' appointments.

Decades of research has examined the influence of social relationships on health and more recently how these mechanisms work within the context of refugee and asylum seeker communities. Social support has also been referenced as a key factor when coping with destitution indicating its relevance within this study however the ways in which services can help facilitate this is underexplored.

2.5 Conclusion

Much of the research into destitution examines the extent and nature of destitution, along with its causes however there are no direct studies into the specific health needs of this population or how services respond to these. While some research has reported on the opinions of services and use of social resources, no in depth exploration has been carried out into the impact of services on this population. Additionally, most of the research is carried out by voluntary organisations working with refugee and asylum seekers or with links to organisations who work with them. Therefore, using this literature as a contextual evidence base, this study aims to contribute a unique, impartial perspective on destitution through

exploring how people experiencing destitution use and are impacted by staying at the shelter accommodation provided to them.

3. Methodology

This section describes the methods used to conduct the research, including justification for particular methods, description of fieldwork and analysis and reflections on the process.

3.1 Methodological Approach

In order to answer the overarching research question most effectively, a qualitative methodological approach was used. These methods allowed rich, in depth narrative data to be collected and analysed, inaccessible through quantitative research, in order to gain a greater understanding of the social world experiences of the participants in the Shelter (Desjarlais, 2011). Health and wellbeing are social and cultural constructs and therefore subjective, context-specific concepts that require adequate, inductive methods for exploration (Kleinman, 1980; Al-busaidi, 2008). This is especially relevant in areas concerning refugees, asylum seekers and immigrants where the current quantitative measurements for health are predominantly Western-conceived instruments based on Western concepts of health (Muecke, 1992).

The strength of producing data rich in explanation of the processes in identifiable local context, such as the Shelter, means that this work could be translatable to other similar services working with similar vulnerable groups of refugees and asylum seekers (Miles and Huberman, 1994).

3.2 Research Design

The research questions that are stated in Chapter 1 were designed to be comprehensive, guide the observations and interviews, and evoke discussion about personal perceptions of health of guests and how the provision and use of the night shelter affects this.

In order to best answer these, I chose to interpret flexibly the traditional complete immersion of the ethnographic approach to explore this research, due to time constraints, and employed two ethnographic tools: participant observation and semi-structured interviews (Atkinson and Hammersley, 1994; Spradley, 2016). By employing two different methods, the aim was to triangulate the data as well as allowing an iterative process whereby primary data from

observations could inform later questions asked in interviews creating a more informed research process (Reeves *et al*., 2008; Bryman, 2012).

In total, I attended the shelter on 9 evenings (from 8pm) and stayed overnight on 5 of those nights over a one month period. I took observational notes on all of my visits and additionally carried out 4 semi-structured interviews. The 4 nights I chose not to stay was due to trouble I had sleeping at the Shelter. Specifically, on two of these nights there was not enough mattresses for guests, volunteers and myself and while some volunteers slept without these or stayed on sofas in the TV room I chose to leave on these evenings.

3.2.1 Participant Observation

Gottlieb (2006) recommends participation observation as a means to remove a strict outsider status from the researcher enhancing the quality of data offered by participants. Additionally, as a unique service, the described experiences of the participants were thought to be better understood if I utilised this method to gain rich, descriptive data through viewing first-hand the setting, use of space, interactions between guests and staff and organisational procedures within the service (Hughes, 2007).

My time throughout the observations would be spent moving between the kitchen, foyer, TV room and sleeping room (see fig.1). I ended up spending most time in the TV room where most guests and staff congregated and the majority of conversations took place. I generally did not set up my mattress and go to sleep until after the majority of guests, between 11pm-12am, in order to partake in late night conversations. Initially I intended to sleep in the floor area where guests sleep in order reduce the power imbalance between researcher and guest participants however the sleeping space was quite crowded, with many guests sleeping in regular spots, so I chose to sleep on the stage with other volunteers so as to not disrupt the routine of this.

During observations, in order to not disrupt conversations or draw continual attention to my role as an observer, removing my ‘participant’ status, I chose to only write rough field notes and sketches periodically throughout my nights at the shelter and fully expand upon these after leaving (Sharma, 2007). In order to aid my memory for more detailed, comprehensive field notes, I drew detailed sketches and plans of the rooms and layout of the shelter (see figs.1 and 2) (Musante and DeWalt, 2010).

3.2.2 Interviews

Informal interviews during observations and planned semi-structured interviews were both used as methods. Through encouraging detail and anecdotal data, interviews were used to explore specific areas of research raised through the observation sessions (Spradley, 2016). Interviews, compared to other method choices such as focus groups, could also add value through allowing a better space in which the participant can feel comfortable if raising sensitive issues (Silverman, 2011). After completing three nights of observation, I scheduled the interviews with participants on an informal basis. This gave me the chance to get to know the space and build rapport with participants. Each interview varied in length from around 20 minutes to an hour depending on the participants' provision of lengthy or detailed answers.

Topic guides (appendices A and B) specific to whether participants were staff or guest and covering a range of relevant themes, were created by reviewing relevant literature and extrapolating themes based on the research aims. This was useful in facilitating responses as well as consistency between interviews and provided a reference point to ensure the intended themes were visited especially in instances where the discussion may stray off topic (Seidman, 2013).

Semi-structured interviews were recorded, with written consent (appendix C) provided by participants, which allowed my full engagement in the conversation without the pre-occupation of note-taking (Rubin and Rubin, 2010; Groenewald, 2004). Due to the sensitive nature of the asylum process, guests and former guests who were interviewed were also made repeatedly aware that no identifying information would be used and that they were free not to disclose their real names or details while recording.

3.2.3 Sampling

The research took place at the location of the night shelter in order to combine both observational sessions and schedule interviews with the staff and users of the service. Upon arrival at the service, I verbally informed all guests and staff of the observational research and directed them toward participant information sheets (appendix D) which were left out on the table – a visible central point. I sought consent as an ongoing process (Creswell, 1998) and allowed participants the option of not being included formally in observations, but after multiple explanations, no one opted out.

Following observational sessions, participants were approached to be interviewed after a rapport had been established (Spradley, 2016). To obtain a more holistic view of the research topic participants I interviewed included service user providers, in this case a volunteer and service coordinator, as well as a guest and former guest who was on a return visit. I approached participants that I perceived could give a detailed or unique insight to the research for a more holistic view of the Shelter (Agar, 1980).

3.2.4 Analysis

The grounded theory data analysis process (Glaser and Strauss, 2009) included carefully and repeatedly reading field notes and interview transcripts, manually colour coding and deconstructing the data to consider key concepts and ideas that emerged from the data (Charmaz, 2014). These emerging concepts were then coded, further analysed based on theoretical relevance to the research question, and broken down into four key themes, using the qualitative analysis software NVivo. The use of NVivo also facilitated triangulation of data as it provided a more comprehensive view of the themes and data sources (Siccama and Penna, 2008).

3.3 Role of the Researcher

The undertaking of qualitative research should coincide with the acknowledgement and critique of the inherent contamination of the researcher's worldview on data collection and analysis (Silverman, 2011). As a researcher and a white, British female carrying out research in a service for male destitute asylum seekers, I continually reflected on my influence as a researcher, and that this could precipitate less than accurate responces (Milner, 2007).

In order to not be mistaken for a volunteer during observations (as I was on several occasions) I continually reminded participants of this and decided to only partake minimally in volunteer tasks when speaking to volunteers. In doing this, I aimed to minimise risk of over-disclosure by guest participants and reduce the researcher-participant hierarchy (Li, 2008).

Additionally, I found the role of participant and observer difficult to navigate in some circumstances (Rashid *et al*., 2015). For example, on one occasion, where a fight between guests began in front of me, I was torn between immediately separating this, influencing the

outcome and risk being further perceived as a figure of authority by guests, or taking no direct action. As other volunteers rushed to separate the altercation, and I perceived no serious risk to people's safety, I chose alert the service coordinator who was in the Shelter.

As a former volunteer I was aware of dismissing preconceptions I could have of findings. As the period I volunteered was over two years ago, I was able to form new relationships with volunteers and guests as a researcher. However, my familiarity of the building and sleeping area meant I quickly felt at ease in my surroundings which was conducive to navigating the space to take notes and conduct interviews.

3.4 Ethical Issues

I stressed to the service coordinators, volunteer staff and guests that should they feel uncomfortable at any point to let myself or a staff member know and I could pause or omit them from observations (De Haene *et al*., 2010). This was part of the ongoing consent process for observations which was crucial for the ethical approach to data collection within a service for vulnerable individuals (Siriwardhara *et al*., 2013; Pittaway *et al*., 2010).

I was aware of the possibility of evoking distress when raising sensitive information about health and experiences of destitution and continually practised the process of balancing my duty of care toward participants with the value of the data collected. For example, I felt it was unnecessary for my research to enquire about specific sensitive details concerning the asylum status of participants (and risk losing the trust of participants) although such information emerged naturally throughout the data collection.

This research was given full ethical approval by the University of Glasgow Social Sciences Ethics Committee Board (appendix E). I complied with ethics regulations concerning the anonymisation and safe and secure storage of all data.

Figure 1. Floor plan of the church in which the Shelter is situated, drawn during observations. (The pink represents areas exclusive to the Night Shelter, the blue represents areas accessible but with shared use while the orange area is a room that was rarely were used by Shelter.)

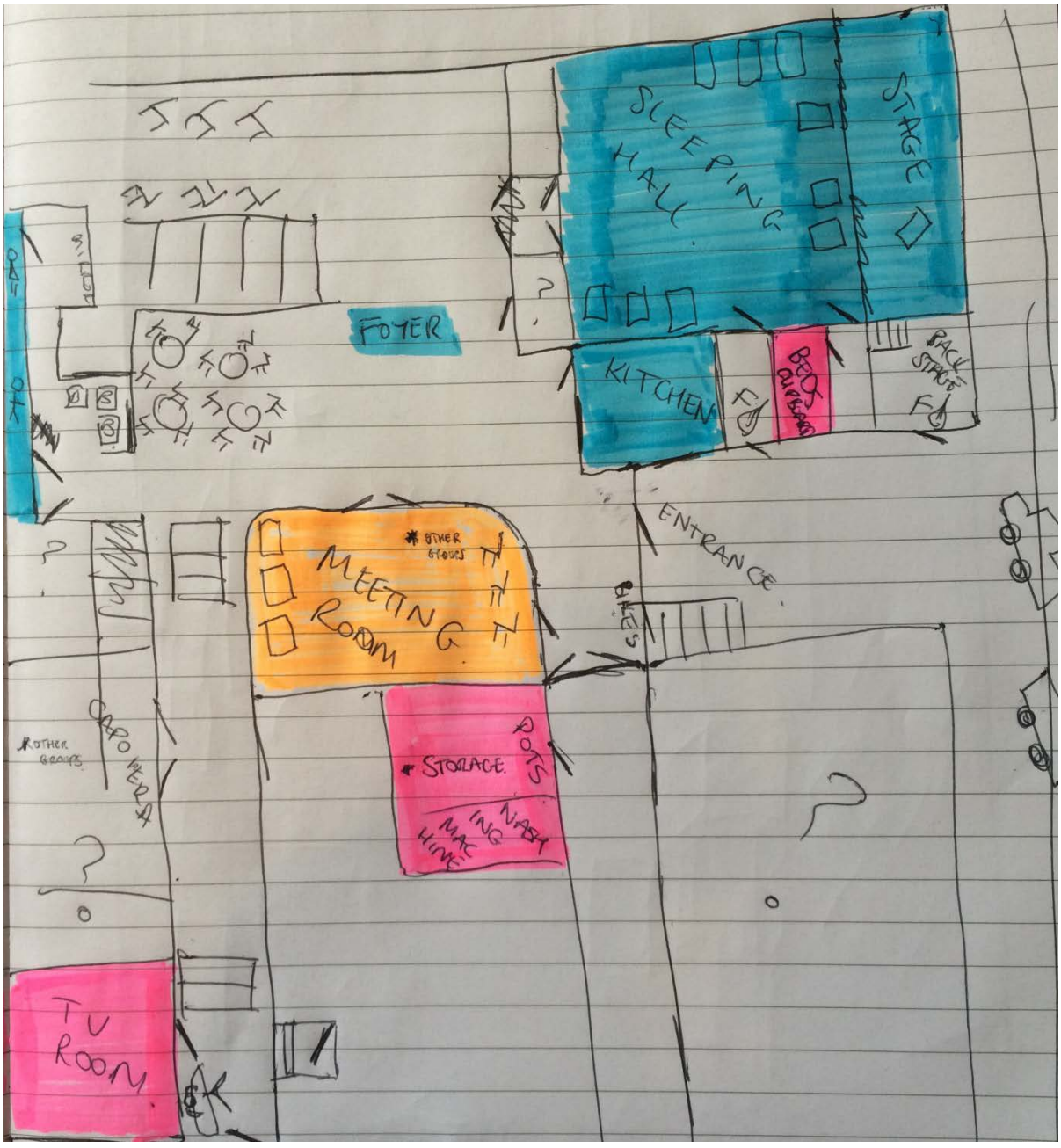
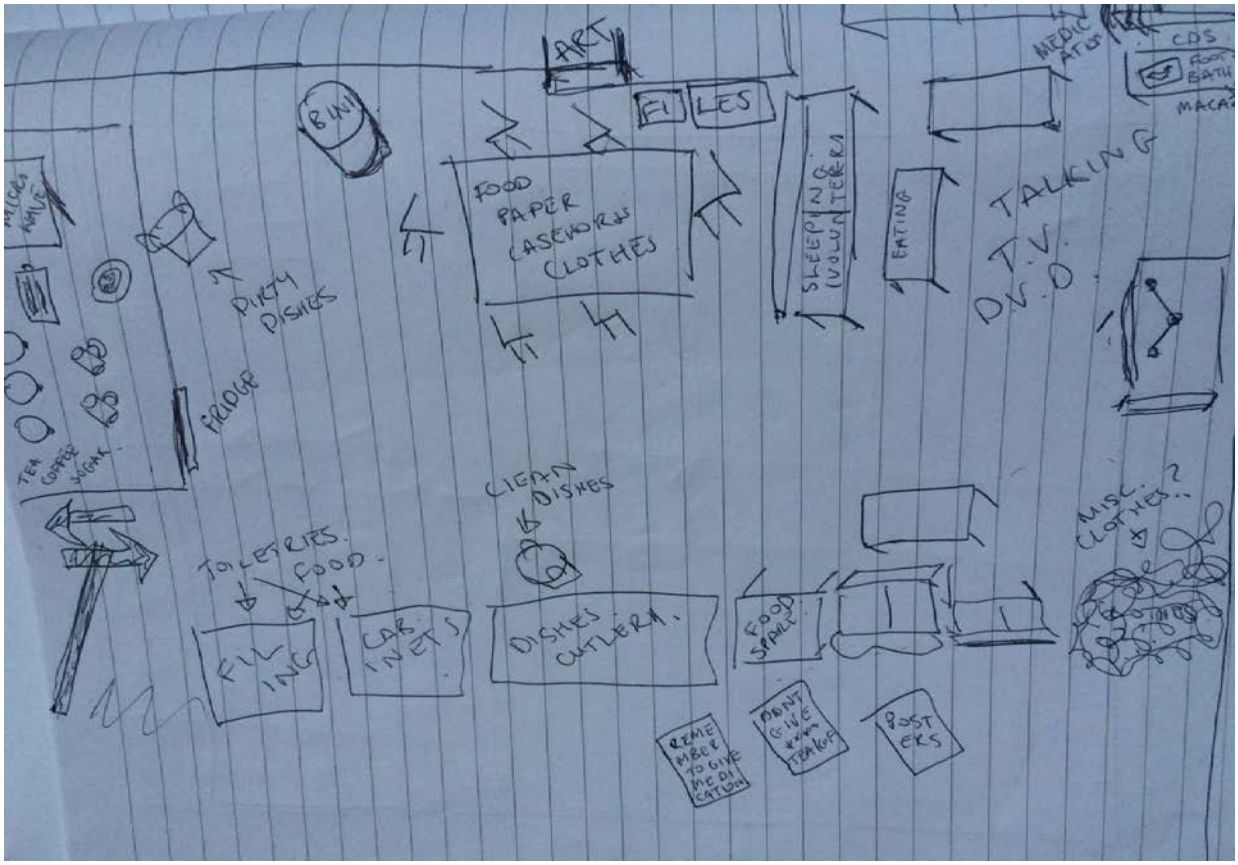


Figure 2. A sketch drawn during observations of the layout of the TV room within the Shelter with notes on some of its uses.



4. Results and Analysis

Through the qualitative analysis of the data particular themes emerged which were felt to answer the research question most effectively. These include ‘health and wellbeing of guests’, ‘organisational structures’, ‘social structures’ and ‘sharing space’. In the remainder of this chapter the results will be discussed and analysed under these themes drawing primarily on observation data with supplementary references to interview data. Prior to this discussion it is necessary, in order to enable better understanding of future references in this chapter, to include background details concerning the running of the Shelter.

4.1 Background Details

For the purpose of a comprehensive understanding of the results the following details are provided, clarifying many essential components of the running of the Shelter during the research period:

- While guests were all male, both volunteers and staff were both male and female.
- Countries of origin of the guests were many and varied.
- Most guests were ‘refused’ asylum seekers.
- There were a very small number of EU nationals experiencing homelessness that staff allowed to use the service.
- Length of stay at the Shelter varied from 1 night – over 3 years.
- The Shelter was restricted to certain areas of the church.
- Guests and Shelter staff must vacate the Shelter by 8am.
- The Shelter relies on volunteers (at least 3 per night).

4.1.1 Brief Description of Service Structure

Guests predominantly arrived between 8-8.30pm. Some chose immediately to sit or lie down on seats in the foyer area alone while most went to the “TV room”. Guests would sometimes go to the fridge in this room and eat leftover food or have tea or coffee (from urns filled up by volunteers). Several social and activity groups run in the church until 9pm on certain nights, sharing foyer and kitchen space with the Shelter guests for short periods.

Guests' movements were irregular; more often the TV room was a central point, especially during dinner. This room was the only 'living' space exclusive to the Shelter and as a result had a more domesticated atmosphere with second-hand sofas, crockery, guest dishwashing rota and a T.V.. The bedding storeroom was open around 9pm, some guests went straight to set up beds, and most went to sleep between 10 and 11pm. Dinner (cooked by volunteers) was generally service between 9pm and 10pm, eaten by the majority of guests and volunteers together in the TV room but by some alone in the foyer. The main door was locked around 11.30am-12.30am. In the morning guests generally had to be woken by volunteers repeatedly going into the sleeping hall to advise them of the time. Breakfast was unstructured, with some guests taking food away in their bags, and guests either left voluntarily or were ushered out by volunteers as they tidied and left themselves.

4.2 Health and Wellbeing of Guests

> *'Everyone has something'*
>
> *(Service Coordinator)*

In order to answer the research of question of how the Night Shelter affected people's health and wellbeing while staying there, it is important to first discuss the health issues being faced by the current guests of the shelter. Literature in Chapter 2 describes common health problems afflicting asylum seekers experiencing destitution in other studies. However, while this literature is a key reference in my research, health is a nuanced and complex concept and it is important to record the findings from my data regarding the health of service users in order to analyse the specific contextual impact of the Night Shelter in Glasgow. As health is such a vast topic, it is understandable there were huge variations among participants in describing health and wellbeing. The quote above represents the overarching opinion of how ubiquitous health issues are within the Shelter.

4.2.1 Physical Wellbeing

Overall, physical wellbeing was not as widely spoken about throughout the data collection when questioning the health of participants at the shelter.

While I saw no visible, significant physical health issues among guests, participants stated on a very general note that the health of guests was *'not good'* and that guests tend to be *'run*

down' or *'get ill'* and coughing could be heard on certain evenings throughout the night in the sleeping hall. One volunteer explained that this led to a high prevalence of flus and colds among guests in winter and another volunteer also stated that back and knee pain was a problem for *'the boys who are having to work illegally'* as they endure long hours and bad working conditions.

There were also more specific physical health issues that arose in interviews including allergies to dust and the description of one guest who has ongoing issues with his lower extremities due to injuries sustained as a result of torture. While these issues affected smaller numbers or individuals they remain indicative of the types of health problems facing guests.

4.2.2 Psychological Wellbeing

In accordance with the literature reviewed in the previous section, symptoms and conditions akin to psychological health and mental wellbeing emerged from the data as the more significant issue facing participants who were staying at the shelter. Some of the terms used to describe the guests' mental health included: *'anxiety'*, '*depression'*, '*stressing'*, '*exhaustion'*, '*frustrated'*, '*suicidal thoughts'*, '*thinking too much'* and '*PTSD'*.

One former guest expanded on the feelings of '*frustration'* felt by guests explaining that this derives from being within the asylum process and coping with refused claims:

> *'Most of them, their cases have been declined over and over again and they have exceeded their appeal so they kind've living the life of no hope which can also, you know, if you have no hope then you mentally, basically just dead.'*

This concept of hopelessness was widely acknowledged in the data. As above, the discussion of health and the Shelter with participants was almost synonymous with discussing the impact of being a refused asylum seeker. In one conversation a volunteer told me that the guests' poor mental health is an affliction of the 'bigger picture'; that discriminatory legislation, having no civil identity and nowhere to go all day equates to a lack of freedom and independence.

Trauma-related conditions emerged as a key mental health concern of guests. Interview participants made references to past trauma and the diagnosis of '*PTSD'*. I could hear guests experiencing night terrors (sounds of distress shouting in their sleep) throughout the night –

something which was later raised by several participants as an ongoing issue and explored later in this chapter.

Mental health issues indirectly related to the asylum process were also raised. Participants described three guests as either 'being schizophrenic' or experiencing delusional thoughts and talking to themselves, sometimes erratically, which they interpreted as schizophrenia. I viewed one guest conversing with himself at length, regularly while sitting in the TV room and only engaging with myself or others if he was spoken to directly. Furthermore, there was one guest, who was described, in the context of health, as '*incapacitated'* and required various support. His presence and situation was regularly raised with me by both guests and volunteers in relation to my research topic reflecting the high levels of concern regarding this guest's situation in the Shelter which is discussed further below.

From these results it is clear that there are a myriad of nuanced health issues facing guests at the shelter. What is apparent is that psychological wellbeing, especially in relation to the asylum process and the extreme marginalisation of destitution, was spoken about as a more significant issue and permeated all facets of the guests' existence while at the shelter, mirroring findings in other studies exploring this issue. Furthermore, the Shelter is host to a few guests who have high physical and mental support needs. This sets the scene for the complexities of discussing how staying at the shelter impacts on health which continues below.

4.3 Organisational Structure

The organisational structures in the Shelter have a significant impact on health of guests and their access to health care. These organisational structures and the provision of care within them came across as both structured and unstructured in their practices and impact on the health of participants in a direct and indirect manner depending on the support needs of the guests.

4.3.1 Basic Needs

One of the biggest impacts on the health of guests is the ability of the Shelter to run continuously, every night throughout the year providing immediate shelter and food to those who, in some cases, would otherwise be sleeping rough.

'...they give you a place to stay when you have none so it's perfect.' (Former Guest)

This acknowledgement of the provision of shelter and that most guests have no other options for shelter exemplifies the role of the Shelter in minimising the health risks that would be faced if sleeping rough (Johnson *et al*., 2016). The Shelter manages to provide these needs through the structured recruitment and management of the volunteer rota by service coordinators (including 'emergency call-outs' via texts when there are shortages). This ensures there are staff there every night to cook, stay overnight and overlook guests' departure every morning.

Organisational structures also facilitate access to health care for guests through means of a fixed address and a system for letters to be delivered. Letters are delivered to the church and put in an assigned place in the TV room where I regularly saw guests and former guests checking for mail on arrival. A service coordinator also advised of another basic provision the Shelter offers:

> *'when people first arrive we just give them the letter...our standard letter that just says "this person is staying at the Night shelter and they are not given any financial support. We give them a hot meal", and they can take that to Positive Action to get cash or to the doctors or, em, yeah.'*

This participant further explained that this letter, written by the Shelter, is recognised within other services across Glasgow offering support to asylum seekers or people experiencing homelessness allowing the guests to be eligible for healthcare (at a health centre exclusive to people with no fixed address) or other services such as free meals, showers, money or food vouchers. On the new arrival of one guest, however, I did not see this letter being handed over the volunteer filling out the registration form indicating that this intention is not followed through, at least not immediately or by all staff members.

4.3.2 Cases of Concern

When discussing the health of the guests with participants there was a strong sense of responsibility that some staff feel for guests whose health they have a heightened concern for:

> *'he was sort of, em, having suicidal thoughts and we were seriously concerned about him for a couple of weeks and…yeah, two or three of the volunteers were sort of looking out for him over a sort of couple of weeks and just, sort of, taking him to the Red Cross and taking him to the doctors and we were emailing each other about that*

and texting and yeah…and we were to wait in...to see that he got in cause he used to get here late so either myself or Grant would wait and check and speak to him and see he was alright.' (Service Coordinator)

This story, representative of many that were told and witnessed, simultaneously highlights the awareness and concern felt by staff for guests' wellbeing, use of communication between staff and subsequent actions in these instances – in this case, supporting him to other services during the day and making sure he arrived at the Shelter before he eventually received professional psychiatric help. However, the communication structures and monitoring strategies that were observed appeared predominantly informal and unstructured.

On one morning I observed one volunteer asking a guest whether they were going to a health clinic that day (this guest was receiving ongoing medical treatment and had visible issues walking). When the guest replied he didn't have bus fare the volunteer left briefly to check 'what she could do' and returned handing him some money. I was later told by a service coordinator that this provision of money to facilitate healthcare appointments was not officially from the Shelter and generally from volunteers' own pockets illustrating the generosity of staff but also how circumstantial provision of support could be.

4.3.3 Case of High Support Needs

Finally, there are organisational procedures for responding to the high support needs of one specific guest. While this case is an anomaly in the Shelter, it represents the notion that the health needs of guests fall on a spectrum and when guests appear on the severe end of this spectrum meeting basic health needs goes beyond simply the provision of food and shelter.

This guest was the first to arrive at the service in the evening and one of the last to leave in the morning. He was known by all staff and guests, made sure he knew all staff by name and was the first to engage new volunteers in conversation. He spent most of his time in a specially designated seat in the TV room before sleeping on the same mattress each night due to issues of incontinence and practicalities of cleaning. This guest received medication from volunteers in the evening and mornings from a weekly pill box.

There was a semi-structured system in place whereby this particular guest has been assigned two volunteers (called 'caseworkers' in this role). Their role was to provide additional support or 'general care' as described by a volunteer who was one said 'caseworker'. She advised this includes legal casework, regularly meeting this guest outside the shelter to see

him and escorting him to appointments. This guest's 'caseworkers' and attended to him in a variety of ways: filling up his medicine tray, washing and cutting his finger and toenails, and bringing him in fresh clothes. Other staff also played a key role in the medical and personal care of this individual when his caseworkers did not attend.

Staff used structured forms of communication, like a whiteboard in the TV room and a designated notebook, reminding volunteers to administer his medicine and record this, respectively. However, interview material indicated that extremely vulnerable guests and busy volunteers and staff results in an environment neither appropriate nor conducive to their needs. There was more than one occasion where his medication was not provided. Staff explained that this guest was not currently receiving care from any other organisations and how they were in a complicated process of attempting to link him in with professional support through social services.

I discovered that the 'casework system' was supposed to be part of a wider programme, put on hold because of training limitations, which will work in training volunteers on predominantly legal areas and assign two volunteers to every guest to support them with their asylum cases but also other support needs (although the latter point seemed to be a secondary addition to an initial plan).

Organisational procedures are largely informal within the night shelter and their effect on the wellbeing of the guest is indirect and invisible in some cases and therefore hard to measure. Research finds that general provisions of shelter and food provide more for sustaining guests' health than the alternative of rough sleeping. Staff concern for the deterioration of some guests' mental health has been met in some cases by a system of support coordinated with the aid of an 'unwritten' communication protocol (including emails, texts, and verbal alerts to staff), and included support to seek professional medical help through transport to and advocacy at appointments. However, this informal approach to support and communication could suggest that staff are not always made aware of concerns for guests' health causing some people to 'slip through the net' or receive sporadic support. The shelter is also using its volunteers as care providers for a guest of high support needs, where there is no other external support.

4.4 Social Structures

Social relationships between all participants within the Shelter emerged as a dominant factor in impacting on the health of guests. A basis for this exploration in the analysis was previous literature which highlights direct correlations between social structures and health.

4.4.1 Supportive Social Structures

A wide spectrum of horizontal social structures was visible within the shelter. Participants described these relationships between guests with terms like '*friends'*, '*strong friendships'*, '*family'* and '*camraderie'*.

What exemplified the formation of positive relationships and their potential longevity, was the visits of former guests to the Shelter:

> *'Yea, I come stay here because, eh, it's very convenient (laughs). And you get to meet a lot of good people here too. I made a lot of friends during the process.' (Former Guest)*

This participant, who also chose to stay overnight despite having access to Home Office private flat, stated that he still occasionally sees other former guests who have also left indicating strong social connections potentially preventing feelings of isolation (Ryan *et al*., 2009).

One volunteer reflected that these positive social structures can be beneficial:

> *'It's like a support system and the guys support each other through a lot'*

This shows that in some cases guests' increased social capital from relationships built within the night shelter provide emotional support and possibly contribute to improved wellbeing (Cohen, 2007). Another former guest who returned to the shelter during an observation also appeared to illustrate this point as he spoke about the shelter nostalgically. He stated that he misses it here, gesturing to the other guests in the room and pointing to one in particular saying that they make him feel *'this big'* (he gestured to feeling bigger and taller than his actual size), indicating feeling better or more confident.

It appeared that the more vulnerable guests sometimes benefitted more from the support in horizontal relationships. Some guests appeared to take on a caring role in response to other guests who appeared more vulnerable by approaching and engaging conversationally with a guest who presented as very isolated. Another guest I observed, was described by a volunteer

as having a *'love-hate relationship'* with a guest who had high support needs. I observed him as he enthusiastically offered practical support to this guest while joking and bickering with him.

Vertical relationships, between staff and guests, also appeared to work as supportive structures. One volunteer spoke about guests coming to her for emotional support if they were upset about something. However, this seemed to only reflect relationships with regular volunteers and staff whereas on some nights volunteers were new, or solely took on practical tasks such as cooking. The relationships between regular volunteers and guests were often described as '*friendships'* and aspects of these appeared to transcend the regular hierarchies involved in service-user service provider relationships. For example, on one night one volunteer waited up to '*catch-up'* with a guest arriving back from work, texting him to check when he was going to return.

4.4.2 Weak Social Structures

Some of the guests chose not to describe their relationships within the Shelter so positively, reflecting the complexities of these social structures:

> *'I'm keeping myself away. I don't know if they are good or not and I don't care about whether they are good or not but I'm ok with all the people. If they say 'hello', I say 'hello', if you talk to me, I'll talk to you' (Guest)*

This guest offered a more guarded perspective on his approach to relationships however still suggested that he has weak bonds, with mutual exchanges of formalities and conversations although rejects the possibility of this support continuing beyond their time at the Shelter. Another participant focussed on the transient nature of the Shelter affecting relationships:

> *'if I need soap, they give me soap, but friendship goes deep. I would be happy to create that. Here is not permanent, all the people are on the move. This affects relationships...' (Guest)*

While he felt that the temporary nature of people's stays affected the ability to form 'deep' connections, he also commented that there is an element of reciprocity within the Shelter's horizontal social relationships including the gifting of practical items also supported in observations.

A service coordinator explained guests' willingness to offer practical support to new arrivals including showing them the way to GP health services, showing them around the shelter, or providing translation of information (which I observed first-hand). This portrays the horizontal relationships of these guests not in the form of strong, long-lasting, social support, but as temporary, weak or superficial bonds with immediate benefits to health and wellbeing (Eklund and Hannson, 2007).

4.4.3 Negative Social Interactions

Negative social interactions have been shown to elicit stress responses in individuals leading to decreased wellbeing (Cohen, 2007). Despite observing predominantly positive social structures within the Shelter, participants also spoke about negative, disruptive and mistrustful feelings between guests and incidents of aggression and accusations of theft that have occurred. Participants agreed that there are visible tensions between some of the guests stating that this is because of wider political differences, '*domestic'* disagreements or frustration in their situation causing '*emotions to spike'*.

One guest explained why he thought these tensions exist and resulted in verbal and physical altercations:

> *'I can understand from their own point of view it can be very frustrating and can lead to your emotions to spike. So things could get a little bit heated up.'*

His explanation was that the negative interactions are fuelled by the wider context of guest's frustration at their own situation within the asylum process.

Despite a predominantly positive social atmosphere in the Shelter between most guests, there were two significant incidents of violence and aggression during observations. On one evening, a physical fight broke out between several guests, and was broken up by staff and other guests. While the staff management and use of de-escalation techniques in this instance ensured no serious injuries were incurred, this resulted in one guest being asked to leave the shelter for one night due to his role in initiating violence and directly increased immediate risk to his health while rough sleeping.

The atmosphere in the Shelter changed markedly during and after this altercation to an air of tension and negativity. Several guests remained sitting silently in the TV room away from the incident and some commented about how they disliked like the fighting did not wish to be

involved as it made them feel anxious. This contributes to the suggestion that guests may suffer indirect effects to health as witnesses:

> *'it will affect them in the way that it will make them feel a little uncomfortable. It will make them feel a little bit uncomfortable, you know, like some of them have been through PTSD and things like that. So, if you have people round the corner fighting you're gonna feel a little bit tension inside…but apart from that most of them are grown men here so I guess they can handle it…they've probably seen worse.' (Former Guest, Interview)*

This participant seems to think that the violent incident that took place could elicit stress responses in individuals who have pre-existing conditions relating to trauma – something which is supported within the literature (Cohen, 2003).

There are complex social networks present within the Shelter. There are some clear benefits from positive social relationships formed within the Shelter most apparent in the exchange of emotional and information resources. Vulnerable guests are supported by guests as well as staff in caring roles, however these only partially fill the void left through complete lack of external or familial support normally available to vulnerable populations. Tension and negative social interactions are brought on by living conditions and external stressors of guests' situations. These then have direct consequences in the precarity of guests' position in the Shelter and indirect negative emotional responses in guests' who are more vulnerable, increasing risk to mental wellbeing. It is also noted by a service coordinator that due to the high turnover of guests and increasing numbers of guests, the structures and effects of these relationships are ever-changing.

4.5 Shared Space

The final theme that emerged as having a significant impact on the health of people using the service was the concept of 'sharing space'. This relates to the idea of the Shelter as a public space and how the guests' health is affected by using this space for private means. Although numerous examples of this concept were present within the data, this section will focus on three areas: sleep, maintaining personal hygiene and privacy.

4.5.1 Sleep

The Shelter only has access to the Church from 8pm to 8am. This translates to the guests being woken every morning at around 7am and ushered out of the Church by 8am. One guest described passionately the feeling of being woken by staff on the morning of an observation session:

> *'It's like having my soul ripped off'*

This exemplifies the disdain with which participants repeatedly raised this issue in conversation and emanates the feeling in the sleeping hall in the morning. It was also repeatedly connected to the wellbeing of guests, and was one of the first things that was mentioned when I spoke to one volunteer about health during the first observation; they answered decisively that having to get up at 7.30am every morning for a year would not be good for anyone's health.

Not only is the length of sleep an issue but also the quality of sleep for some guests as one interview participant explained from his own experience:

> *'And sometimes you are not sleeping as it is cause sometimes you are not sleeping early...keep stressing, keep thinking. Sometimes, not always. And you not sleeping good and waking up at seven or half seven. You not sleeping enough…'*

This indicates that the sleep of some guests was already affected by stress or over-thinking and having to wake up early on top of this exacerbated their sleeping further.

The sharing of sleeping space in one big hall, with beds situated only 1-3 meters apart around the outside, regular loud snoring and occasional distressing sounds of night terrors, also resulted in disturbed sleep for most guests. Multiple conversations in the mornings were centred around lack of sleep and accusations of snoring between guests.

Issues around the shared sleeping space could result in heightened tension between the guests creating an inhospitable atmosphere:

> *'On Friday night, for example, one of the boys shouting in his sleep, post-traumatic stress I think there, and one of the boys was shouting at him to be quiet and you can just see it kinda riles them up a wee bit. I think it can create tension because lack of sleep after months, some of them probably years, it's exhausting and, yeah, it does*

create a lot of tension and lack of sleep will obviously lead into the next day and how it affects their activities.' (Volunteer)

This volunteer also acknowledges the 'lack of motivation' after prolonged periods using the shelter and how this affects their ability to carry out tasks during the day. They later attribute this to preventing some of the guests accessing healthcare services as they do not have the energy to walk across town.

4.5.2 Maintenance of Personal Hygiene

An issue that was also repeatedly raised was the lack of ability or control to maintain either one's own personal hygiene directly or through the upkeep of their surroundings.

One guest reflected that the shelter was '*dirty'* and that this directly worsened his allergies. He explained that when he lived in a flat this was not an issue as he had his own space and facilities to wash his bedding more often and keep the space clean. While a service coordinator spoke about the state of cleanliness of the rooms in the church affecting guests on a more psychological level:

'I think sometimes the mess gets to people in certain areas or I can imagine the toilets in the morning might be quite…yes…cause a bit of tension...or just everyone's stuff in the cupboard where we keep the bedding. That can be...eh, drive people a bit mad if somebody takes something from a certain spot'

This encompasses both the guests inability to maintain their surroundings to their own standards as well as not having their own space for their personal bedding is frustrating for guests and can consequently negatively affects social structures as mentioned above.

Participants also referred to the condition of the toilets which affected the guests' maintenance of personal hygiene. As the building is not purpose built to be a Shelter the only washing facilities are one small set of public toilets for males with sinks, a couple of toilet cubicles and urinals as described by the male participants. The lack of showers was overwhelmingly perceived to be an issue by participants. Some guests mentioned that they navigate this issue by going to another mainstream homeless service during the day to shower and wash their clothes. A volunteer stated how they perceived the washing situation to affect guests:

‘There’s nothing nicer than a shower just to make yourself feel better and the boys can’t have that here. But I think, yea I think all they’ve got here is just the sink and, eh, there’s not many of the sinks...I never go into the guys toilets so I don’t know the conditions but I don’t hear they’re great so it can be probably a bit demoralising going in there and I don’t see many of them going in there. There’s one who I know goes in and washes every night and every morning and he has a shave. But he’s probably the only one I know who consistently will do that be kind of a self-care routine so I think better washing facilities would be really nice for them.’

This explains how guests can lose their sense of self-care routine, through obstacles to washing in the Shelter and this can lower some of the guests’ self-esteem or emotional wellbeing.

4.5.3 Privacy

The continuous bustle of activity and people was significant within the context of the research question and emotional wellbeing. The noise of other groups present in the Church, ringtones, phone conversations, the entrance door alert chime, fire alarm, the ‘*madness’* of the TV room and the occasional arrival of people under the influence of drugs or alcohol into the foyer area were all part of the atmosphere of the Shelter during the evenings. The analysis of the data looked at how people staying at the shelter navigated these nearly constant stimuli in the evenings and the lack of private or quiet spaces.

One service coordinator spoke positively about the small, busy spaces within the Shelter being good for encouraging socialising among guests (discussed in the previous section). Another prominent opinion of the space was that guests simply ‘*adapt’*, and can find a quiet spot if they want one. For example, in regard to finding a space to pray; *‘you just find them in the laundry room sometimes*’, a staff member explained.

However, talking with and about former guests, the realities and comparisons of moving into more private accommodation after the Shelter suggested a contradicting opinion. One former guest also advised his health has improved slightly upon leaving the shelter because of better sleep but also just being able to go home and ‘*relax*’. Staff contributed more overarching perspectives:

'one of the boys I mentioned who was here for three years and then left...he's come back and he looks great. I think it's just having that bit of personal space, he can have a shower…' (Volunteer)

'particular where somebody's like living with a family or something and they just get a bit of a break. And they can have their own room and sort of stuff like that. That makes a lot of difference.' (Service Coordinator on guests living with host families)

These statements all suggest that there is an impact on guest's mental wellbeing as they discussed guests who are now in their own accommodation as looking visibly healthier and '*more confident*' and participants attribute this, in part, to amenities provided in these places as well as the concept as having their own private space.

In terms of the guest with higher support needs the reality of sharing space presented different problems. As his caseworkers are both female the informal care and discussions around his health took place in public areas of the Shelter. One of his caseworkers explained that this is due to the fact there are no alternative discrete spaces in which to do this highlighting the lack of privacy and dignity in the provision of care.

On one hand the intense sharing of space that permeates all realms of the Shelter is viewed as facilitating the positive social structures mentioned above. This was represented by eliciting feelings of nostalgia in a former guest who enjoyed being around lots of activity. On the contrary, the overcrowding, especially in the sleeping area led to tensions also discussed above. I regularly observer guests purposefully trying to find quiet or isolated spots for eating, sitting and praying. It was conclusive that most guests suffer in both sleeping and self-care routines while residing at the shelter having negative consequences to feelings of wellbeing. This was reflected most strongly in the perspectives of former guests. This alludes to the idea that some guests in particular are not thriving in a setting where there is no real space to be alone or have control over your surroundings and who is sharing them.

5. Discussion

This research has explored the impact of staying in night shelter accommodation on the health of asylum seekers experiencing destitution. The findings identified the health concerns of the guests and key elements that positively impact on these including provision of shelter, food, social and emotional support, and organisational structures (which support particularly vulnerable guests). However most of these are constrained by limited resources, shared space, informality of procedures, and overcrowding.

5.1 Health Issues Regarding Guests

This research found that one of the most significant obstacles facing guests at the shelter is poor mental health, including widespread feelings of depression, anxiety, fear and worthlessness, as a direct result of experiencing destitution and their situation within the asylum system. This is affirmed by the literature in this area (Gillespie, 2012; Lewis, 2009; Bernhard *et al*., 2007; Ryan *et al*., 2009). A key concept in buffering against these risks to mental health and wellbeing is resilience. Resilience is interpreted to be a multiply determined developmental process that is not fixed or immutable affected by material, psychosocial and biological factors (Cichetti, 2010; Friedli, 2009). In light of this, resilience and how the Shelter influences these factors will be a key theme which will be drawn on throughout the discussion.

Physical health issues emerged in relation to exploitative working hours and also from previous incidents of torture prior to arrival in the U.K.; issues also supported by existing literature (Burnett, 2002; Lewis *et al*., 2015). Prominent physical ailments which affect the rough sleeping population, such as respiratory infections, were not found to be a significant issue (Riley *et al*., 2003; Story *et al*., 2007). The impact the shelter has on the physical health of guests and how they facilitated access to healthcare for these issues is extremely significant especially in respect to physical health as a key factor in stress in adverse circumstances, such as destitution (Friedli, 2009).

The presence and use of the shelter by people who have high support needs in both personal care and mental health unrelated to the asylum process is something which has not been documented before. However, within homelessness research, it is well documented that there

are higher proportions of mental health conditions such as schizophrenia compared with the general population which may also be mirrored in the population of homeless asylum seekers (Bhugra, 2007). This is a highly significant finding which should be accounted for in the wider research concerning this population and also in terms of the Shelter's limited capacity to cope with these cases. These individuals are perceived to be much more vulnerable while experiencing destitution and therefore the findings discussed below would be considered to have a more extreme effect in cases such as these.

5.2 The Shelter as a Provider of Basic Needs in a Public Space

First and foremost the Shelter provides shelter for 12 hours per day to all guests who reside there. This meets some basic needs of those experiencing destitution in the asylum process who have no other means to accommodation and cannot access mainstream homeless services.

In providing this basic shelter the Shelter reduces the disparity in health shown in literature between people accessing shelters or sleeping rough, including higher rates of illness from cold, damp and hunger (Story *et al*., 2007). It is also widely accepted that basic provisions, such as food, water, access to toilets and washing facilities are crucial factors in building up resilience to mental health issues in adverse circumstances (Betancourt *et al*., 2008; Johnson *et al*., 2013; Ungar *et al*., 2007).

However, the limitations of the Shelter being located in a public space and only providing shelter for 12 hours also poses negative impacts on the health of guests. Many of the participants reflected negatively on having nowhere to spend their remaining 12 hours of the day aside from public spaces including parks and libraries. Stewart (2005) found that people experiencing destitution felt vulnerable in public spaces, due to fear of authorities and Gillespie (2012) reported higher feelings of isolation from having nowhere to go. While this highlights a constraint to the impact of basic provision on health through restricted access, it is argued that the Shelter's benefits through providing relief from these risks to emotional wellbeing every night outweigh the limitations.

The Shelter space has also been adapted to the needs of guests in providing a sleeping area, bedding and secure main door. As sleeping is an act which is generally illegitimised in public spaces, these are crucial provision in relation to preserving dignity and wellbeing (Hodgetts *et al*., 2011). However, the results found that structural barriers such as access to the church,

and shared sleeping space results in chronic sleep loss and exhaustion in guests affecting guests' emotional and physical wellbeing and motivation to carry out tasks such as going to health care appointments. This is supported in literature which connects sleep with depressed moods, low levels of concentration, self-reported poor quality of life and cites it as a protective factor against the high risk of mental health conditions in adverse circumstances (Didge *et al*., 2005; Strine and Chapman, 2005; Colten and Altevogt, 2006). Therefore, although the Shelter provides a space where participants felt comfortable in terms of bedding provisions and security, the lack of sleep due to special limitations impacted negatively to overall wellbeing. This was exemplified in the comments and presentation of a former guest who now slept in private accommodation.

While the Shelter provides the basic shared facilities of toilets, sinks and washing machine participants reported the difficulty guests have with navigating personal care and how this physical hardship affected their emotional wellbeing. Specific barriers preventing this access lie within the social organisation of the Shelter such as over-subscription for use of the washing machine, upkeep of the toilets and lack of showers. Participants explicitly commented on how this physical hardship affected emotional wellbeing of guests. This is potentially due to using a public space for private acts such as washing, generally not legitimised and leading to feelings of loss of dignity and self-esteem (Lynch, 2002). These effects could also be exacerbated by the over-subscription of guests currently at the Shelter and the resulting lack of private space.

Although the Shelter is situated within a public space with basic provisions the findings show that the organisation has adapted the environment to be more hospitable with the use of its own homeware, provision of duvets over sleeping bags and use the TV and DVD player. De Certeau (1984) wrote about the development of social mastery over public spaces, through routine and familiarity, which can result in enhanced liveability in these spaces and also social verification in your environment which can be crucial as a buffer against stigma of homelessness. Arguably, this 'social mastery' is seen in the adaptation and use of space in the Shelter e.g. domestication through the dishwashing rota, use of space for praying and routine of dinner. In adverse circumstances such as homelessness, studies show normality and routine can also contribute towards protecting wellbeing (Stolte and Hodgetts, 2015). The findings of this study suggest that the protective aspect of routine exists within the Shelter.

In its provision of basic shelter and food the Shelter meets the nutritional needs of guests and contributes to building basic resilience against the adversity of destitution. These effects are tempered by aggravating factors related to the social organisation within the Shelter, such as overcrowding and shared use of public facilities for private acts which causes loss of sleep and difficulty in navigating personal care. While resilience is an individual and dynamic concept (Friedli, 2009), the Shelter's facilities could still be sufficient for them to temporarily buffer against the severe adversity of their situation.

5.3 Organisational Procedures and Informal Care Structures

While basic needs are met at the Shelter in the form of shelter, nutrition and toilets, results also demonstrate how the organisational procedures and informal care structures present within the Shelter enable the additional provision of support which positively influence the health needs of guests.

The shelter can work to support facilitating access to health care for guests. On a practical level this is done through the provision of an address to receive letters, provision of official letter confirming destitution, information on available health services and transport to and advocacy at healthcare appointments. These are key structures in overcoming barriers to accessing healthcare and other support which were reported by people experiencing destitution in other areas (Crawley *et al*., 2011; Lewis, 2009). As a marginalised group, both as experiencing homelessness and as asylum seekers, with higher prevalence of mental and physical health issues, access to health care is crucial to improving health outcomes through medical treatment (Gill *et al*., 2013). Although basic health information is intended to be given out to all guests on arrival structural barriers, such as the time limitations of volunteers to register guests on arrival, prevent this in some cases.

Emotional support was also given by most staff members on an individual basis and as a staff team when there was concern for a guest's wellbeing. While predominantly unstructured, specific emotional support from staff stands to improve resilience when vulnerable regarding their asylum claim or external stressors such as news from home (Fazel *et al*., 2012). Furthermore, evidence highlights that the ability to speak to someone when isolated from other social contacts, and spending whole days alone, could be imperative to stress reduction (Cattell, 2001).

However, the ability to provide emotional support is constrained by limited staff resources and a subsequent reliance on core staff members. The transience of both staff and guests and the subjective nature of social relationships similarly pose as barriers to the effective development of a supportive relationship (Song, 2013). These constraints can prevent all guests from accessing this beneficial support at any time potentially resulting in increased risk to emotional wellbeing.

The subjectivity and decentralised provision of practical support was also an issue that was raised. While guests received transport costs to a healthcare on some occasions, this is reliant on circumstantial factors such as the staff member's personal choice or ability to provide support. This lack of procedure also presents issues of power imbalances between guest and volunteer. However, the same informal structures, through acting out with the boundaries of mainstream hierarchical care structures are argued to contribute to reducing power imbalances between service users and service providers seen as an issue in other homeless care provision (Hoffman and Coffey, 2008). The blurred service user-service provider relationships within the Shelter, indicated in staff-guest friendships, were effective in reducing power imbalances and providing more dignified care.

Informal care structures and use of communication strategies in cases of concern for individual guests was a regular occurrence in the Shelter and acted to fill the gap in care where no other services were involved. The communication strategies of staff were identified as a key element in the monitoring of the emotional or psychological wellbeing of guests and subsequent support in accessing health services. This use of communication strategies is used formally within social and health care settings to relay concern for vulnerable individuals in order to minimise further risk or deterioration of health and when used effectively within the Shelter it had similar effects (Manser and Foster, 2011). However, communication strategies were unstructured, reactionary and largely employed in relation to guests being informally identified as vulnerable by volunteers or other shelter staff. Therefore high numbers of guests and high turnover of volunteers make the effectiveness of communication and consistency in this provision of care difficult to navigate. Irregular working patterns also prevented the development of effective, supportive relationships in some case (Cohen, 1985).

The shelter was unable to always provide adequate support to individuals with high support needs due to limited staff numbers, training, resources and time. It was acknowledged by staff that the wellbeing of these individuals suffers as a result of this and ideally they should

be accessing care from professional health and social care services. In these instances, the Shelter attempts to provide essential support such as distribution of medicine, personal care and advocacy with health and social services in attempts to gain external, mainstream professional help for individuals. The limited means of the service means that this essential but informal delivery of care relies heavily on a group of core volunteers and staff members. In a wider context, the implications of this responsibility on the staff as carers in the crucial management of individual's health could affect their own psychological wellbeing, and in turn the longevity of the support they can offer (Ducharme *et al*., 2007). While this was never a planned issue within the observations or interviews this remains a relevant point and worthy of future exploration.

The most beneficial health improvement to guests is considered to be stability through housing and status as a refugee, and removal from the extreme marginalisation of destitution (Ryan *et al*., 2009). Therefore, the use of the Shelter as a space for support with legal casework for claiming asylum is integral to improving mental wellbeing of guests. However, the sporadic nature of the casework that took place is a limitation on this provision. Staffing and training issues has delayed the proposed casework system from allowing all guests that require legal support to access it effectively and on a consistent basis. While there are other services in Glasgow offering legal advice to asylum seekers, the Shelter offers a potentially unique space in which to do this as it will act to centralise provision of services. This has proven to be effective within other social care outcomes through overcoming transport and economical barriers to support (Wren, 2007; Pleace, 2010). Further research would be valuable to fully explore of the exact effect and role of the service on the progression of people's claims for asylum and welfare support.

5.4 The Shelter as a Social Space

The positive health effects of social support and social integration through networks was discussed in the literature review with evidence showing that people within refugee communities use social support and exchange of resources for positive gains. This research found that the shelter provided a space for meeting people, creating friendships and increasing social networks - all visible in the extensive spectrum of social relationships observed. Participants' relationships in the Shelter were beneficial to their emotional wellbeing, buffering their stress response to external family issues, aggravations within the Shelter and their situation within the asylum process. This is supported by other studies

within refugee communities which use social support for positive gains however what is notable here is that these studies mainly show this within homogenous groups whereas in the context of the Shelter these transgressed the boundaries of similar backgrounds (Williams, 2006).

Cohen (2004) spoke about the two social constructs beneficial to health and wellbeing as social integration, a feeling of community, and social support. However the transience of people's stays at the Shelter meant that some found difficulty in developing deep bonds with other guests. This therefore would be expected to reduce the health benefits of social support. However, the results also display that in the immediate term, relationships produced short-term practical benefits in the form of reciprocity between guests. This is supported by research showing that superficial or 'weak' social connections can be equally important in forming social capital and decreasing feelings of isolation or enable the exchange of information resources (Eklund and Hannson, 2007; Cohen, 2003). As other studies have shown, these cooperative relationships can offset the health undermining consequences of hostile or adverse environments in homelessness (Stolte and Hodgetts, 2015; Johnson *et al*., 2016).

The inclusive open-door policy meant that service providers would not turn anyone away despite the fact that there were limited resources for the increasing numbers of guests. The continual reference to 'over-crowdedness' emulated feelings of uncomfortableness and was directly attributed to negative tensions within the Shelter. Negative social stressors are evidenced to have deleterious effects on people's ability to cope with adversity (Cohen, 2004). Furthermore, exposure to violence can be a trigger for symptoms of trauma-related conditions prominent within asylum seeker populations (Crumlish *et al*., 2010). While staff management of these situations contributed to damage limitation, some incidents at the Shelter, such as accusations of theft and physical altercations, were seen to create a potentially harmful environment and limited the benefit to wellbeing in terms of the Shelter as a social space.

In the wider social and health care arena, social inclusion has been focussed on as a key concept to incorporate into services aimed at increasing wellbeing in marginalised communities (Marmot *et al*., 2007). The fact that these connections have naturally formed within the Shelter, and have contributed to increased social capital of guests, is significant in relation to similar services, especially as social support is a key contributor to the building of

resilience within individuals (Schweitzer *et al*., 2007). However there is a question of the inclusive open door policy practised by the Shelter, including over and above their official remit, and how this can increase negative social interactions. While the service coordinators acknowledged this as an issue they spoke about it in terms of having to find more space rather than having to turn people away. This is indicates that the benefits of providing shelter to many override the cost of overcrowding creating a stressful atmosphere at times however this is a fine balance.

5.5 Strength and Limitations

The qualitative methods facilitated a close rapport with my study subject and led to richness within the data collected. In addition to this, I formed good relationships with Shelter staff permitting me access to staff and guests.

Resource limitations meant that sampling for interviews was restricted to guests who were able to speak a certain level of English. This could have created bias as Crawley *et al*. (2011) found that people with good English skills were coping better with destitution in comparison with those with more limited English. They found this was due to being able to better navigate services and support therefore my results may shed a favourable light on state of people's health and impact of the service. However, wider observational data may have minimised this risk.

As a small and unique study set in Glasgow, these results are not generalisable to all asylum seekers coping with destitution however many findings are transferable to other services working with similar populations.

6. Conclusion

Asylum seekers experiencing destitution are widely considered to be one of the most marginalised and under researched populations within the U.K. as they are unable to access any welfare support. They face significant health issues concerning homelessness and their place within the complex and enduring asylum process. This study set out to determine how a shelter accommodation service in Glasgow for male destitute asylum seekers impacts on the health needs of this group. This research, using ethnographic methods, looked specifically at what the main health issues of this group were, how they used the Shelter, and how the Shelter influenced issues around their wellbeing.

A significant finding within this research was that while shelter services meet the basic needs of food and shelter for this group, it goes above and beyond this to impact positively on wellbeing. The Shelter use organisational procedures such as informal care structures and communication strategies to provide emotional and practical support to guests of this shelter. As these structures are out with the regular confines of a mainstream bureaucratic social care services, they allow for a less hierarchical structure between guest and staff member which contributes to more effective support system. However, resource limitations were a key issue in the delivery of support within this organisational structure especially in response to guests who require high support and whose reliance on the shelter for accommodation was detrimental to wellbeing.

The Shelter as a space for the formation of social relationships was also imperative to its impact on health. The Shelter enabled both long-term relationships and weak social bonds to be created between guests which led to emotional support and immediate provision of resources. However, tensions leading to negative effects on psychological wellbeing are being fuelled by the over-subscription and limited resources of the service.

While the service has adapted the basic shelter model to make a positive impact on immediate health concerns, the complex mental health issues facing the guests as asylum seekers experiencing destitution is only thought to be most effectively resolved through casework and the granting of refugee status. Although this research found the Shelter to be attempting to address these needs there are plans to implement a more uniformed structured approach to this which would warrant further exploration in respect to health outcomes.

This research emphasises the wide spectrum of health issues facing a shelter service for asylum seekers experiencing destitution. It also highlights the significant gap in resources and support required to meet the needs of this growing and extremely vulnerable population which can impact on the wellbeing of guests at the Shelter. These findings can therefore be used in a wider context of the research into the “hidden” population of asylum seekers experiencing destitution and services which cater to this group.

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Appendix A – Topic Guide for Staff

University of Glasgow

College of Social Sciences

Interview Topic Guide (staff)

This topic guide outlines the themes that will be explored, and indicates the types of questions that will be asked during the interview. Given that the research is designed to be flexible and iterative, the topic guide may be revised and altered during the course of data collection. Any major changes will be submitted to the college ethics committee for approval.

Introduction –

Researcher introduces themselves and explains:

- Purpose of the interview and timing
- Ensures that the participant has seen and read the plain language statement.
- Ensures that participants to sign the consent forms
- Makes it clear to the participant that they do not need to answer questions which make them feel uncomfortable and can stop the interview at any time.
- Offers a chance to ask any relevant questions or air concerns.

Researcher then asks introductory questions:

- Approximate age
- What is your role/position at the night shelter?

Questions regarding how they began working at the Night Shelter and what services it offers?

Issues covered/explored will include:

- How did you get involved with the Night Shelter?
- How long have you worked at the night shelter?
- How often do you take on shifts here?
    - For non-residential, organisational staff: How often do you visit the shelter?
- What is involved in your role at the night shelter?
    - Probes/follow-on questions: What tasks do you carry out on a typical shift? Describe a typical shift/visit to the shelter? If always varied: describe the last time you were at the night shelter and what you did while here.
- What does the night shelter service provide for service users?
    - Probes/follow-on questions: How does it provide this? Does it only serve one purpose? What else does it provide? Is it only a place for sleeping/eating?

Questions regarding specific use of space and facilities in the Night Shelter by service users

Issues covered/explored will include:

- How do the service users use the night shelter facilities? Alternative: Can you give me an example of how they use the facilities? What is your role in supporting this use? Example areas of exploration include:
    - What is the typical routine of the service users at the night shelter?
        - Do they all arrive at the same time? Where do they go after arrival?

      When do service users go to bed? Where do they sleep? What bedding is offered? What is the atmosphere in the sleeping area? Do service users advised how they sleep while at the shelter? What do they say? Can you give an example?
    - Do service users eat at the shelter?
        - If yes: what is the food like? What meals are offered? Where is the food provided from? Where do service users eat? With other staff/service users? Do offer food to take away? Do you feel the food is good quality/provides enough nutrition? What do service users say about the food? Can you give an example?
    - What rooms do service users use in the shelter before sleeping if any? (kitchen/tv room/reception)
        - What are those rooms used for? Are some rooms used more than others? If yes: Why is this? What is the atmosphere in these rooms?
          Do you spend time speaking with service users? If yes: What do you speak about?
        - Do you feel like the shelter is a sociable place?

    - Toilet facilities
        - How is the bathroom space used by service users? what are the washing facilities available?
    - Do service users use facilities outside the service for food/washing? Have they spoken to you about these? If yes: where/what are these facilities/services?

- Do you service users feel safe at the shelter? What makes you think this? Have service users spoken to you about this? If yes: can you give examples?

Questions regarding wellbeing and health services

Issues covered/explored (if not already) will include:

- How would you describe service user's health (physical and psychological/mental)?
    - Probes/follow-on questions: Where do you get this information? What do you think are the causes of these health issues? Are there similarities between the health of service users? If yes: what are these? Can you give me an example of some of these health needs?
- What do you feel your role is in supporting service users' health needs in the Night Shelter?
- What is your knowledge of organisations which offer health service to the service users?
    - Are there certain services they can't/do not want to use? Why is this? Do they get support to use health services? If yes: Who provides this? Do they have to use different services since they started staying at the night shelter? If yes: why is this?

In regards to the facilities and use of facilities at the Night Shelter by service users, what is the specific impact of staying at the shelter on health and wellbeing of service users?

Issues covered/explored (if not already) will include:

- What is your experience of how physical or mental health/wellbeing of service users is affected while staying at the night shelter? (Refer to answers in previous section if appropriate). If there have been changes, what do you think has caused these changes?
- Is information available to service users about health or accessing health services while residing in the night shelter? Is this information useful to service users? What makes you think this? Can you give an example? In what form is this information available?
- Do you offer any support in relation to service users' health or accessing health services? Can you give examples of this? In what way do you offer support?
- How do you feel the facilities mentioned affect service users' health (physical/psychological/mental)? For example: sleeping conditions/washing space/general atmosphere?
- Aside from the facilities already mentioned, are any other services/structures in place while staying at the night shelter which could affect service users' health? (such as visiting health professionals).
    - If yes: What are these? How do think these affect health/wellbeing of service users? Can the same services be accessed by service users outside of the night shelter? If no: why is this?

- In your opinion, is there anything further the night shelter service could provide in order to help improve your health and wellbeing while staying here?

    - If yes: what are these? Have service users approached you about these? Can you give an example if so?

Appendix B - Topic Guide for Service User

University of Glasgow
College of Social Sciences

Interview Topic Guide (service user)

This topic guide outlines the themes that will be explored, and indicates the types of questions that will be asked during the interview. Given that the research is designed to be flexible and iterative, the topic guide may be revised and altered during the course of data collection. Any major changes will be submitted to the college ethics committee for approval.

Introduction –

Researcher introduces themselves and explains:

- Purpose of the interview and timing
- Ensures that the participant has seen, understood and read the plain language statement.
- Ensures that participant understands and signs the consent forms
- Makes it clear to the participant that they do not need to answer questions which make them feel uncomfortable and can stop the interview at any time.
- Offers a chance to ask any relevant questions or air concerns.

Researcher then asks **introductory questions**:

- Name
- Approximate age
- Approximate region of origin
- How did you come to be in Glasgow?
- Length of time in the U.K./Scotland

Questions regarding how they found the Night Shelter and nature of use of the Shelter?

Issues covered/explored will include:

- How did you hear about the Night Shelter?
    - Probes/Follow-on questions: If through another organisation: what does that organisation do? Why did they recommend it?
- How long have you been using the night shelter?
- How often do you stay?
    - If not every night: Are you staying anywhere else?
    - Where were you staying before?
- What does the Night Shelter service provide to you?
    - Probe/Follow-on questions: Do you just use the shelter for sleeping? If not: what are the other services it provides to you?

Questions regarding specific use of space and facilities in the Night Shelter

Issues covered/explored will include:

- How do you use the night shelter facilities?
    - Alternative: Can you give me an example of how you use the facilities? What is your typical routine while at the shelter?
- What do you think about the facilities offered at the night shelter? Can you give me an example? Example areas of exploration include:
    - Are you happy with the sleeping area/What do you like about this sleeping area?/ Is there anything you do you not like about the sleeping area? Why is that?
        - Do you used the bedding provided? Is it warm/comfy enough? How do you feel about sharing the sleeping area? Do you always sleep in the same space?
        - Do you sleep better at the shelter than other places you stay/have stayed? Why do you think that is?
    - Do you eat at the shelter? Can you tell me about that?
        - If yes: what is the food like? Do you help cook? Do you eat both meals at the service? Where do you eat? With other staff/service users? Do you take food away? Do you feel it gives you energy for the day?
        - If no: Why? Is there a reason? Do you eat elsewhere? Where else do you eat?
        - Do you use the kitchen space? What do you do there?
    - What rooms do you use in the shelter before sleeping if any? (kitchen/tv room/reception)
        - Do you feel comfortable in those rooms? What do you use those rooms for? Do you spend time with staff/service users? If yes: What do you speak about? If no: Why not? How else do you spend your time?
        - Do you feel like the shelter is a sociable place?
        - If not using a room: Why do you not use that room?
    - Toilet/Washing facilities
        - How do you use the bathroom space? Is there enough space for your use? Do you find them clean? Is there washing facilities? Is there a place to brush your teeth?
        - Do you use facilities outside of the service during the day? If yes: where are these? How did you find out about them? How are they different from the facilities in the Night Shelter?
        -
- Do you feel safe at the shelter? What makes you feel safe/unsafe about it? Example follow up questions include:
        - Do you feel comfortable speaking with staff? Do you feel like your conversations are confidential?
        - Do you feel comfortable speaking with other service users? Why is that?
        - Do you feel like the building is secure? What makes you think this?
        - Do you feel like your belongings are safe here? What makes you think this?
        - Do you feel like the information you give on arrival is kept confidential? What makes you think this?
        - How safe are the other places you stay/have stayed in comparison?

Questions regarding wellbeing and health services

Issues covered/explored (if not already) will include:

- How would you describe your current health (physical and psychological/mental)?
    - Probes/follow-on questions: Do you feel healthy? If answer with specific pain/symptom: How often do you experience those symptoms? How long have you experienced them for?
- Are you currently seeking/waiting for/wanting treatment for any health conditions?
    - If yes: What organisations are offering these services? Are there certain services you can't/do not want to use? Why is this? Do you get support to use health services? If yes: Who provides this? Do you use different services since you started staying at the night shelter? If yes: why is this?

Questions regarding specific impact of staying at the shelter on health and wellbeing
Issues covered/explored (if not already) will include:

- Has your physical or mental health/wellbeing changed in any way since you have started staying at the night shelter? (Refer to answers in previous section if appropriate). What do you think has caused these changes?
- Is information available to you about health or accessing health services while residing in the night shelter? Is this information useful to you?
    - In what form is this information available? Do staff at the night shelter offer any support in relation to your health or accessing health services? Can you talk to staff/other services users about issues related to health/personal issues? How does this make you feel?
- How do you feel the facilities you use at the Night Shelter affect your health (physical/psychological/mental)?
    - Example areas of exploration: If not feeling secure: how does this make you feel?
- Aside from the facilities already mentioned, are any other services/structures in place while staying at the night shelter which affect your health? (such as visiting health professionals).
    - If yes: What are these? How do you find these affect your health/wellbeing? Can you access these same services outside of the shelter? If no: why is this?

- In your opinion, is there anything further the night shelter service could provide in order to help improve your health and wellbeing while staying here?
    - If yes: what are these? Have you spoken to staff about this?

Appendix C – Interview Consent Form

University of Glasgow

College of Social Sciences

Interview Participant Consent Form

Title of Project: In what ways does a night shelter service meet the health needs of destitute asylum seekers?

Name of Researcher: Fiona Girvan
Name of Supervisor: Dr Ingrid Young

Please read, tick each of the boxes and sign at the bottom.

1. I confirm that I have read and understood the Plain Language Statement for the research study being carried out in the Glasgow Night shelter on how the service meets the health needs of destitute asylum seekers ☐
2. I have had the opportunity to think about the information, ask questions and have had these answered satisfactorily. ☐
3. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. ☐
4. I agree to the audio recording of the interview. ☐
5. I understand that the information I give will be recorded and stored securely on University of Glasgow computers. ☐
6. I understand that what I say may be used in future reports, articles or presentations by the researchers, but that no identifying information will appear in any way. ☐
7. I understand that the information I give will be treated in confidence. ☐

I hereby consent to take part in this study and agree that my participation has been fully explained to me.

_____	_____	_____
Name of Participant	Signature	Date
_____	_____	_____
Name of Researcher	Signature	Date

Appendix D – Participant Information Sheet

University of Glasgow

College of Social Sciences

Participant Information Sheet

Title of Project: In what ways does a night shelter service meet the health needs of destitute asylum seekers?

Name of Researcher: Fiona Girvan

You are being invited to take part in a research study. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve.

Please take time to read the following information carefully and discuss it with others if you wish. If there is anything that is not clear, or if you would like more information, please ask me.

Please take your time in deciding whether or not you wish to take part.

Thank you.

What is the purpose of the study?

This study is looking at how the Glasgow Night shelter meets the need of asylum seekers coping with destitution. Results from the research will tell us about how the service affects the health of people that use it.

Do I have to take part?

No. It is up to you to decide whether or not to take part.

If you choose to take part, everything you say will be kept confidential and your participation will be anonymous. I will be the only person to listen to the recording and only myself and my supervisor will see the transcript of the interview in its entirety. No personal information will be shared with ANY third parties.

What will taking part in the research mean for me?

I will be attending the shelter in the capacity of a researcher however I will participate in some volunteer duties where appropriate while there making observations. I will be present at the service 1-3 nights per week while carrying out research. While in the service I will observe what happens and make record notes on paper or digitally, so I can write up a full description of what happens in the service later. The Night Shelter has given full permission to carry out this research. I will only be there to look at if and how the shelter helps with your health, including how the facilities are used and any interactions between service user and staff regarding health. I will keep speaking to you throughout my research to check for your permission to observe and take notes. If you are not comfortable with the information gathered during observations I do while at the shelter I will abstain from including it in field notes or if you have any questions about my observations please feel free to ask.

I will also ask some guests of the service and staff if they would like to take part in an interview. If you agree, you will be interviewed by me during the duration of the night shelter, in a separate space from the tv/dinner room or sleeping hall, where we will not be disturbed. The interview will last for around 30-60 minutes, and will be carried out at a time that suits you. During the interview, I will ask you about the night shelter service and what impact it has had on your health (or the health of service users if you are a staff member). With your permission, the interview will be audio-recorded and everything you say will be written out so that I can make sure that I remember what you have said. During the interview I will be there solely as a researcher and will not partake in volunteer duties but there will be other volunteer staff in the building should you need them.

Will my taking part in this study be kept confidential?

Yes. Apart from me, no one will know you have taken part in the study and you do not need to give your real name while taking part. Your information will be held securely in a locked office at the University of Glasgow or on password-protected computer, under the supervision of University of Glasgow staff member, Dr Ingrid Young, and will be destroyed 10 years after the study has ended. Your information will be made anonymous by removing your name and the names of anyone else you may mention in your interview or in the observed sessions, including your children, partner, other family members, service users or providers. All details that could identify you will be removed; you will only be identifiable by a pseudonym (a false name to protect you from being identified).

Please note that your confidentiality will be maintained except under exceptional circumstances where I perceive a person's life to be in danger. In that case I may have to alert other volunteers or agencies.

Can I change my mind about taking part in the research?

Yes. You are free to withdraw from the observation or interview at any time, and you do not have to give a reason.

What will happen to the results of the research study?

The results will be written up in a dissertation that will be submitted as part of the coursework for the MSc in Global Health programme at the University of Glasgow. They may also be used in conference presentations and to write an article for an academic journal.

A summary of the main findings will be given to Glasgow Night Shelter staff. If you would like me to send you a copy of this summary, please let me know.

You will never be able to be identified from the findings we share with others.

Who has reviewed the study?

The study has been reviewed by the College of Social Science Ethics Committee at the University of Glasgow.

For further Information

If you have any questions about the research please don't hesitate to contact me (email: 0707610G@student.gla.ac.uk).

If you have any concerns regarding the conduct of this research project, you can contact the Social Science Ethics Officer, Dr Muir Houston (phone: 0141-330-4699; email: Muir.Houston@glasgow.ac.uk) or the study supervisor, Dr Ingrid Young (phone: 0141-353-7533; email: Ingrid.Young@glasgow.ac.uk).

Appendix E - Ethical Approval

University of Glasgow | College of Social Sciences

Ethics Committee for Non Clinical Research Involving Human Subjects

NOTIFICATION OF ETHICS APPLICATION OUTCOME – UG and PGT Applications

Application Type: **New** **Date Application Reviewed:** 03.05.2016

Application Number: SPS/2016/624/SOCIAL SCIENCE
Applicant's Name: Fiona Girvan
Project Title: In what ways does a night shelter service meet the health needs of destitute asylum seekers?

APPLICATION OUTCOME

(A) Fully Approved ☒ ***Start Date of Approval: 20.5.2016*** ***End Date of Approval: 02.09.2016***

(*B*) Approved subject to amendments
If the applicant has been given approval subject to amendments this means they can proceed with their data collection with effect from the date of approval, however they should note the following applies to their application:

Approved Subject to Amendments without the need to submit amendments to the Supervisor ☐

Approved Subject to Amendments made to the satisfaction of the applicant's Supervisor ☐

The College Ethics Committee expects the applicant to act responsibly in addressing the recommended amendments.

(C) Application is Not Approved at this Time

Subject to Amendments made to the satisfaction of the School Ethics Forum (SEF) ☐

Complete resubmission required. Discuss the application with supervisor before resubmitting. ☐

Please note the comments in the section below and provide further information where requested.

If you have been asked to resubmit your application in full, send it to your supervisor who will forward it to your local School Ethics Forum admin support staff.

Where resubmissions only need to be submitted to an applicant's supervisor.
This will apply to essential items that an applicant must address prior to ethics approval being granted. As the associated research ethics risks are considered to be low, the applicant's response need only be reviewed and cleared by the applicant's supervisor before the research can properly begin. For any application processed under this outcome, it is the Supervisor's responsibility to email socpol-pgt-ethics@glagow.ac.uk with confirmation of their approval of the re-submitted application.

APPLICATION COMMENTS

Major Recommendations:

Minor Recommendations:

Please retain this notification for future reference. If you have any queries please do not hesitate to contact your School Ethics forum admin support staff.