

Comparing Approaches to Integrating Refugee and Asylum-Seeking Healthcare Professionals in Canada and the UK

Comparaison des approches d'intégration des professionnels de la santé ayant le statut de réfugiés et de demandeurs d'asile au Canada et au Royaume-Uni



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Abstract

In this paper, we examine barriers to the integration of refugee doctors and nurses in Canada and the United Kingdom. Key obstacles impeding the integration of internationally trained health professionals are well documented, but less attention has been paid to the integration of refugee health professionals, particularly in Canada. Based on documentary analysis and semi-structured interviews with 46 Canadian and 34 UK stakeholders, our research shows

that there are no simple solutions to mitigating the core obstacles that prohibit the professional integration of refugee doctors and nurses into host countries. The targeted approach adopted in parts of the UK does provide some promising practices for Canada, which has yet to develop policies and initiatives specific to health professional refugees. This study is intended to contribute to our understanding of how immigration and health human resources policies have shaped the economic integration of refugee healthcare professionals in the UK and Canada in distinct ways.

Résumé

Dans cet article, nous examinons les obstacles à l'intégration des médecins et infirmières réfugiés au Canada et au Royaume-Uni. Les principaux obstacles à l'intégration de professionnels de la santé formés à l'étranger sont bien documentés, mais il y a peu d'études portant sur l'intégration des professionnels de la santé ayant le statut de réfugiés, en particulier au Canada. À l'aide d'une analyse de documents et d'entrevues semi-structurées menées auprès de 46 personnes concernées au Canada et 34 au Royaume-Uni, notre recherche fait voir qu'il n'existe pas de solution simple pour atténuer les principaux obstacles à l'intégration professionnelle des médecins et infirmières ayant le statut de réfugiés dans leur pays d'accueil. L'approche ciblée adoptée dans certaines régions du Royaume-Uni fournit des éléments de pratiques prometteuses pour le Canada, qui n'a pas encore développé de politiques ou initiatives visant précisément les professionnels de la santé ayant le statut de réfugiés. Cette étude entend contribuer à la compréhension des rôles distincts que jouent, respectivement au Canada et au Royaume-Uni, les politiques en matière d'immigration et de ressources humaines en santé dans l'intégration économique des professionnels ayant le statut de réfugiés.

SIMILAR TO OTHER COUNTRIES, IMMIGRANTS COME TO CANADA AND THE UK FOR both economic and humanitarian reasons (Castles and Miller 2003; Salt and Millar 2006). An economic migrant, one that is attracted to a host country primarily for the purpose of gainful employment (Salt and Millar 2006), differs from a refugee, who is forced from his or her country of origin owing to fear of persecution (UNCHR 2011). What sets refugees apart from other immigrants in host countries is not only their forced migration and associated need for protection, but their ability to “establish economic potential” (Yu et al. 2007).

In this paper, we consider the fundamental challenges to the integration that refugee doctors and nurses in the UK and Canada face as they attempt to pursue careers in their chosen professions. Whereas the UK offers examples of a more targeted approach, relatively little specific attention has been paid in Canada to this group of refugees, even though research shows that when refugees are successfully integrated they become a significant asset to local healthcare systems (NHS Employers 2009). Although we argue that there are no simple solutions to eliminating or mitigating the many barriers that prohibit the integration of health

professional refugees into host countries, a targeted approach seems promising. Through greater awareness, sensitivity and continued commitment, the economic integration of refugee healthcare professionals can be more fully realized. Whether this is likely remains nebulous. This paper contributes to our understanding of how immigration and health human resources (HHR) policies have shaped the economic integration of refugee healthcare professionals in the UK and Canada in distinct ways.

Immigrant Health Professionals

The literature shows that although refugees coming to host countries are relatively well educated, they also tend to have limited employment opportunities (Bloch 2007; Charlaff et al. 2004; Krahn et al. 2000; Yu et al. 2007). Structural and individual constraints impede the integration of refugees and asylum seekers. For example, studies in the UK have highlighted how asylum seekers are economically compromised owing to restrictions on their residential mobility and access to paid employment (Charlaff et al. 2004; Clements 2007; Hubbard 2005; Smith et al. 2007; Wren 2007; Zetter and Pearl 2000). Similarly, in Canada, research indicates that current immigration policies can impede refugee and asylum seekers' eligibility to attend integration programs and to receive services, while tightened security measures delay applications and leave individuals with little or no financial support (Yu et al. 2007). Gender has also been found to affect employment opportunities, with women refugees being more disadvantaged than men (Adams and Kennedy 2006; Bloch 2007; Kofman et al. 2005; Refugee Council 2005). Fuelled by public discourse decrying refugees as a "threat," some resistance towards the settlement of refugees has arisen in various communities in the UK (Lewis 2006). Biography also matters. Difficulties in accessing the labour market are further hindered through experiences of torture, loss of family members, trauma and various health problems (Charlaff et al. 2004).

Over the past decade, the UK has embraced a coordinated, top-down approach to the integration of refugees and asylum seekers, with collaborative efforts at both the local and national levels. The policies shaping the integration of refugees and asylum seekers in the UK are detailed in a number of Home Office documents (see Home Office 2000, 2002, 2005, 2006). HHR policies, concerned with workforce planning, have complemented immigration policies. As a result, a number of mentorship, financial assistance and orientation programs were designed to improve language proficiency and to prepare refugee health professionals to enter and adapt to the UK workforce (Department of Health 2003).

Similarly in Canada, immigrant health professionals are supported through various initiatives. In contrast to the UK, however, current HHR policies – which are, for the most part, provincially or regionally controlled – are not coordinated with immigration policies, which are largely directed federally. Researchers recognize that there is much work to be done to improve integration policies and initiatives so that the diverse circumstances and potentials of "newcomers" to Canada may be more adequately addressed (see Pressé and Thomson 2007; Walsh et al. 2008).

Despite these efforts, there are recognized obstacles that impede and prolong the integration of refugee health professionals. These include lack of information, language proficiency, credential documentation, references, support networks and financial resources, as well as interruptions in training (Adams and Kennedy 2006; Overseas Doctors Sub-Group 2000; Stewart 2003, 2005; Winkelmann-Gleed 2006).

Employability: An Analytical Concept

In this research, we draw on the theorization of integration as a two-way process (Raghuram 2007: 2247) wherein humanitarian rights are provided and individual identity is preserved within the economic, cultural and civic parameters of the host country. We use the term “employability” to capture the barriers discussed by representatives of the various policy communities with respect to health professional refugee and asylum-seeker integration (see Bloch 2007: 21). Employability encompasses those obstacles that deter refugee doctors and nurses from practising in their chosen fields, and is inclusive of pertinent aspects of social and cultural integration that influence the career paths of refugee and asylum-seeking health professionals (adapted from Raghuram 2007). Social integration refers to relational social characteristics, such as gender and ethnicity, and cultural integration includes factors intended to ease or enhance adaptation into the host country, for example, ethnic community support or mentorship programs.

In utilizing “employability” as an analytical concept, we found that initial obstacles to integration include the professional registration process and the career path directions open to refugee and asylum-seeking health professionals. These barriers intersect with refugee status, professional status, gender and ethnic community support, and are further implicated in the policies, initiatives and programs that fluidly enhance or constrain integration. Our analysis demonstrates that refugee integration in the UK has been framed as a “win–win” situation, whereas Canadian policy makers have yet to specifically target the issue of integrating refugee health professionals.

Methodology

We examine the barriers to employment that refugee doctors and nurses face in host countries with data derived from structured interviews with 46 Canadian and 34 UK stakeholders involved in the integration of healthcare professionals. The interviews, conducted in 2007, were completed largely via telephone and included representatives from immigration, health professional regulation, health human resources planning, health professional associations, educational training, and program development policy communities in both countries. Intensive documentary analysis of federal and provincial official websites and reports began in 2006 and continued until 2009. Periodic reviews ensued in 2010, 2011 and 2012.

The interview data were analyzed using the computer-assisted management systems NUD*IST 6 and NVivo 7. The systematic comparative analysis involved a constant iterative

process of going back and forth between documents and interviews. Key segments from the documents were excerpted and organized according to common themes that began to emerge from the data. Relationships between themes and between the responses of different participants were then identified. Integration was a particularly salient theme within the UK data but emerged less frequently in Canada.

Barriers to Employability of Refugee and Asylum-Seeking Health Professionals

The following analysis highlights the response of key stakeholders in the UK and Canada with respect to the integration of health professional refugees. The comments emphasize how language proficiency is measured, how language courses are taught and the dilemma that lack of proof of credentials poses for both refugees and regulators. These conditions are often coupled with uncertainty over residency, legal restrictions that in some instances limit access to paid employment, and financial hardship. These issues have a cumulative impact on one's career path. For many, the quest ends here. Even for those who are able to prove their professional competency, limited options with respect to retraining, difficulty in finding orientation placements, lack of support, underemployment and discrimination further deter refugee health professionals from their chosen professions. The following accounts demonstrate the complexity and cumulative impact of these intersecting barriers.

Stakeholders in the UK and Canada stressed first and foremost that language proficiency is fundamental to moving through the registration process. Notably, passing the exam does not guarantee that one has reached a level of proficiency that satisfies employment requirements. Similarly, in the UK, the barriers associated with becoming linguistically proficient are reflected in the skill level of the individual refugee, the availability of training and mentorship, and the generic design of the assessment tool. In some instances, it was not the program but rather the assessment tool that stakeholders considered unsuitable and in need of redesign. They stressed the importance of tailoring language programs to better meet the needs of those they serve. This is no simple matter, as it may require increased personnel and greater financial investment than more traditionally designed orientation approaches.

We have included language tutors completely within our academic program and ... it's relatively expensive to run. Because we realized we were trying to teach nursing to people who we don't understand how you learn in a different language. If you're learning a subject in a different language, you need to be taught in a different way because you're constantly translating and retranslating. And we needed to look at how we were teaching because our traditional teaching methods weren't working that effectively. (UK Nursing Stakeholder S2)

Both countries have invested only in a limited way in the advanced language training necessary to meet employment requirements or to redesign programs.

Comparing Approaches to Integrating Refugee and Asylum-Seeking Healthcare Professionals in Canada and the UK

While language proficiency influences many aspects of integration, credentialing issues are central obstacles to acquiring professional registration. These encompass program recognition as well as individual proof of credentials:

One of the things that we've had is, in a lot of situations, they're refugees and therefore they've got no documentation and therefore they can't provide a lot of the paraphernalia that we demand, you know, voluntary migrants to provide. They sometimes can't provide, you know, their references from the school of primary medical qualification. They haven't got the sort of portfolios of evidence to demonstrate specialist training. They may have been out of clinical work for a sustained period of time while they've been going through the whole refugee process and therefore ... they do actually have to be treated rather uniquely. (UK Medical Stakeholder 1)

This situation closely resembles that in Canada, where difficulty in gaining recognition for foreign educational credentials and professional experience is common. The variation in training in different countries also poses a challenge for regulators and is summed up in a comment made by a Canadian stakeholder:

So the policy issue is to figure out kind of how do we take a candidate and credentials that seem very foreign to us and how do we plug them into our system in a meaningful way to figure out what they really are. ... [T]o figure out how to measure them is the huge challenge right now. (CA Government Stakeholder 1)

Hence, the refugee's ability to prove his or her professional competence is coupled with the receiving country's way of measuring proficiency. Further barriers to health professional employment may be related but are not limited to the registration process. There are other career path obstacles that may impede a refugee's chances of acquiring employment as a healthcare professional.

Career path

Career path obstacles are an extension of the previously described barriers and involve difficulties associated with not being able to pursue one's chosen profession, the inability to attain an entry-level position that reflects former career status and the problems associated with achieving career promotion. These hurdles were more widely and explicitly acknowledged in the UK context. Without proof of qualifications, one of the few options involves retraining within the same profession:

I had a guy who was a plumber and a nurse. And we looked into getting his qualifications from Iraq and were basically told that ... they're not worth anything. He's going to have to requalify. And similarly, I worked with a lady who was a nurse in

Zimbabwe and she's now just about to finish her degree here in nursing. She went back and requalified. And I mean, obviously, I think it would depend on what country you came from, you know, how your qualifications would be accepted. You know, in my experience they tend to be advised to go back and start again. (UK Integration Stakeholder S1)

Stakeholders also recognized that refugee and asylum-seeking health professionals face greater disadvantages due to law-enforced restrictions on their employment, mobility and lack of finances. Such barriers further preclude the integration process for asylum seekers:

But also in terms of whether they are legally permitted to work or get paid work because of the restrictions ... if you're recognized as a refugee it's okay, but if you're seeking work on an asylum-seekers basis, then there are all sorts of problems about both being able to work and accessing benefits which are quite complex, and god knows how they understand them. (UK Nursing Stakeholder 2)

Severe financial hardship is a salient deterrent both to obtaining registration and to retraining:

Indeed, they don't have very much money in the first place. They're really very poor. Some of them may even be on benefits. (UK Nursing Stakeholder 1)

This situation was also acknowledged by some stakeholders in Canada:

It's intensely emotional for some of the people who are involved because you know that people are literally, like, don't have enough money, like, they're making choices because they don't have enough money. You know, they can't get gas in their car to drive to their practicum. (CA Employer Stakeholder 1)

Retraining is additionally problematic because it is time-consuming and places added burden on individuals. Such scenarios contribute to the difficulties of refugees as they try to rebuild their former careers. Many are forced to abandon such hope, and integration workers are obliged to impress upon individuals that it may not be possible to continue in their chosen profession:

The most important thing with people is not necessarily training to pass exams, but career advice and having somebody having a very good relationship with them so they are able to say after a period of assessment okay, here's the situation. You can try for another year or however long to pass this exam but let me tell you, you probably won't get a job at the end of it because you're either too old, have been out of practice

for too long, you're in a field that is highly competitive. ... You're not going to make it as a doctor here. It doesn't mean you're not a good doctor. It just means the system is such that you won't make it through. (UK Nursing Stakeholder 3)

Impressing this "reality" on refugees applies to nurses as well as doctors:

It's about being able to offer some hope in relation to utilizing existing skills and knowledge in an alternative health career, and the same goes for nurses. There are some who won't be able to register and can be supported to develop in a different direction. So alternative health careers are also an issue that we're trying to address in terms of managing expectations. (UK Nursing Stakeholder 1)

Although refugee health professionals face similar obstacles in the UK and Canada, the policy responses are framed in contrasting ways.

Responses to Refugee Health Professional Employability Barriers

There is a striking difference in the way that issues facing refugees and asylum-seekers have been framed in the UK and Canada. In the UK, the reasons provided by stakeholders for increased support for refugees relate to the obvious, "because we have huge numbers of refugees" (UK Academic Stakeholder 2). Perhaps because there is "some kind of tradition or some event [that] occurred in the UK and so people are more aware" (UK Nursing Stakeholder 4). Still others pointed to the mutual benefit, or the "win-win" situation, that accommodating refugees had for the UK during a time when there were workforce shortages:

I think it's partly because we've got such large numbers of refugees per se that there is an awareness that they should be ... that it's better for the UK economy and for integration and all the social reasons if they can be enabled to get back into their professions, whatever those professions are. (UK Medical Stakeholder 1)

"Making use" of refugee health professionals was also seen as a convenient way to provide care for other non-English-speaking refugees:

I think the reason why the NHS or the Department of Health or the UK Home Office is trying to promote the development of the refugee nurses in particular is that they can get employed in different trusts in the long-term future so that if local non-English-speaking refugees come and use the service, then they would tap into that particular knowledge as well. (UK Nursing Stakeholder 6)

Although the benefit is claimed to be reciprocal, if the refugee does not get permanent residential status the local health authority still profits from the volunteer labour provided by the refugee and comes out the "winner" in the situation:

When we have a captivated group of people who have skills, so why are we not using them? ... So they volunteer their time, and in a way they benefit by retaining their skills and eventually, if they do get the status, it would give them the opportunity to access the job market because they would ... know how the system works and, you know, ... the health system would be familiar to them. So we would employ people that we're familiar with. ... So yes, it is a win-win situation if everything adds up at the end of the day. (UK Nursing Stakeholder S1)

Alternatively, in Canada, some stakeholders tended to dismiss the idea that refugee health professionals should be considered separately from internationally educated health professionals in general because of their small numbers: "When I look at the breakdown of what we see with the clients, I think it would be fairly small in comparison to those coming through as independent class" (CA Integration Stakeholder 2). Secondly, a notion of targeted support is not considered because it remains outside the boundaries of specific policy departments:

I won't be able to give you a turn on refugees either, because we have a different refugees group here that deals with that. My focus is more on the labour market integration side generally, and we tend not to think of refugees in the main. (CA Government Stakeholder 1)

Other stakeholders argued that there is no need to treat refugees differently than other migrants because it is unfair to give them an advantage over economic migrants:

Well, I don't even know if you can [differentiate between those two groups of immigrants]. I mean, why would it be fair to make it easier for refugees to become a doctor than someone who has done this through the processes that we have in place? (CA Government Stakeholder P2)

The notion of a "refugee advantage" is one that was also expressed by a stakeholder in Scotland as a result of recent changes in immigration rules affecting overseas doctors in the UK:

There's been a big huge change ... in the permit-free training and regulations in the UK, which has caused huge problems for overseas doctors who want to come and work in the UK or train in the UK. And that really has created a big issue, and probably we're still to feel the full repercussions of that. So you know, obviously for the refugee doctors it's not a problem because if they're refugee status, they have the same rights as a British citizen; so they don't need a work permit, so it's not a problem. But for other overseas qualified doctors it's now much, much more difficult to get in and get a training post in this country. (UK Government Stakeholder S1)

Fairness takes on a different dimension when the situation of refugees is considered:

When we talk to refugee doctors and you ask them “Is it fair?” I mean, that’s one of the questions I actually do ask them. ... And they’ll say, “Of course it’s fair,” and it’s the fundamental reason about why they fled their home countries. You know, “They haven’t been through what we’ve been through,” you know, “They can go home,” you know, “They don’t worry about families they’ve left behind.” ... So basically, it’s a psychosocial element of being a refugee versus being an economic migrant. (UK Government Stakeholder 3)

Undoubtedly, tension and competition occur between and within groups when competing for scarce resources. Nevertheless, this dynamic exacerbates the precarious position of refugees and further fuels resentment and discrimination:

What’s very clear is the whole stigma of being known as a refugee doctor is very high, and so there’s kind of like – again, this decision about when you use the refugee card and when you don’t. You know, sometimes it opens doors and sometimes it doesn’t. (UK Government Stakeholder 3)

The importance of context cannot be overstated. In the UK there have been some unintended consequences despite good intentions. Owing to a variety of circumstances involving changes to medical training, coupled with an underestimation of the number of applicants applying for medical training positions and an overabundance of entry-level doctors in the UK, there has been stiff competition for entry-level jobs. This situation has exacerbated the difficulties facing refugee doctors, undermined the accomplishments of integration initiatives and programs, and culminated in the creation of the “unemployed box” where “a lot of these people got a huge amount of help. But at the end of the day what it didn’t give them was jobs. It made them job-ready.” (UK Medical Stakeholder 3)

Discussion

Overall, the central barriers to integration are illustrative of those identified by other scholars who have examined the employability of refugees (Ager and Strang 2008; Beiser and Johnson 2003; Bloch 2007; Charlaff et al. 2004; Krahn et al. 2000; Lamba 2003) and, more specifically, refugee and asylum-seeking internationally educated health professionals (Baumann et al. 2006; Blythe and Baumann 2009; Jeans et al. 2005; Krahn et al. 2000). Unlike previous studies, this comparative analysis emphasizes how two destination countries confront and manage the economic integration of refugees in distinctly different ways. Economic integration is not only fundamental to successful overall integration; it is the first step in the initial phase of integration, as employment influences “economic independence, future plans, socialization, language skill development, self-esteem and self-reliance” (Ager and Strang 2008: 166).

Also crucial to integration is language proficiency, but it remains one of the most formidable barriers to employability (Bloch 2007; Henin and Bennet 2002; Hyndman and Walton-Roberts 2000; Krahn et al. 2000). Although language proficiency ultimately rests with the individual, how proficiency is attained and to what degree, and how such competence is determined is more complex. This study supports research indicating that professionals often need to improve profession-specific language competency (Bloch 2007; Krahn et al. 2000; Blythe and Baumann 2009) and that although some refugee doctors and nurses may have completed their training in the host country's official language (Stewart 2003) this instruction may not make them proficient (Blythe and Baumann 2009; Smith et al. 2007).

Recognition and proof of credentials are essential to moving through the registration process, and for refugees, this is where the process is particularly challenging. Stakeholders in both countries recognize the barriers facing refugee doctors and nurses, the limitations of existing initiatives and programs, and ways to assess competencies. There is a stark contrast in the way that the UK has politicized and explicitly confronted the integration of refugee and asylum-seeking health professionals (Athwal and Bourne 2007; Hubbard 2005) and Canada's relatively silent response (see Blythe and Baumann 2009).

In the UK, government investment in health and immigration infrastructure through a nationally directed effort contributed to the notion of a "win-win" situation, although there is less evidence to support the notion of "win" on the part of the refugees. Alternatively, Canada has lagged behind in explicitly acknowledging the potential of refugee health professionals apart from other internationally educated health professionals. Unlike the UK trajectory, there are no infrastructure changes on the horizon and no injection of federal or provincial funds in this regard in the foreseeable future.

These conditions are coupled with signs of insensitivity or neglect on the part of some policy communities with respect to the unique circumstances facing refugees. Internationally, the humanitarian responsibilities of both countries are undermined through increasingly restrictive immigration policies. At the national and local levels such policy serves to isolate rather than integrate refugee health professionals. Certainly there is more work to be done in this area, but broader contingencies – such as the current global recession and continued political unrest – further jeopardize what has already been achieved.

Overall, this paper contributes to our substantive understanding of how immigration and HHR policies do or do not intersect to shape the economic integration of refugee healthcare professionals in the UK and Canada in distinct ways. Such cross-national comparisons are lacking in the current literature. Conceptually, broadening the analytical concept of "employability" contributes to a more comprehensive understanding of not merely the initial but rather the fundamental and complex challenges impeding the successful economic integration of refugee healthcare professionals and, indeed, immigrant refugees more generally.

In conclusion, recognizing that refugees have unique issues and may need different and additional forms of support poses further challenges to policy developers and service providers. As a number of stakeholders have pointed out, reforming and implementing innovative

Comparing Approaches to Integrating Refugee and Asylum-Seeking Healthcare Professionals in Canada and the UK

initiatives may require program redesign, increased personnel, greater financial investment and a move away from traditional ways of teaching and testing skills and knowledge toward more refugee-tailored approaches. “Managing” the expectations of refugees and streaming those who are unable to meet system requirements towards a “realistic” career path translates into directing refugee health professionals into underemployment. Greater sensitivity regarding refugees, as well as commitment with respect to improving how early integration is handled, is necessary. Early intervention, along with sustained effort, can improve refugees’ chances of economic integration.

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