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WORKING TOGETHER TO COMBAT POVERTY

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FROM RIGHTS TO REALISATION

Disabled people and carers navigating the asylum system – A community research report

February 2026

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Finally, we acknowledge Inspiring Scotland and the Scottish Government for their support of the Rights in Action project, and for enabling community-led research that centres the lived experiences of those too often excluded from policymaking. We hope this report helps to amplify these voices and contribute to lasting, rights-based change.

Rights in Action: Rights in Action is a project led by the Poverty Alliance working across Scotland to support communities to use human rights as a tool for change. Rights in Action is funded by the Scottish Government's Equality and Human Rights Fund managed and supported by Inspiring Scotland. The project has three workstreams:

1. 'Know Your Rights' workshops to raise awareness of how human rights can be used as a tool in the fight against poverty.
2. Action Learning Sets to bring together community organisations and community members to identify actions to support rights realisation and combat poverty.
3. Participatory research projects enabling community researchers to generate learning on the overlaps between human rights and intersections of inequality and to undertake action.

Disclaimer: The views in this report are those of the researchers and participants and opinions expressed in this report do not necessarily reflect the views of the Poverty Alliance or our members.

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EXECUTIVE SUMMARY

The following research report presents findings from a participatory action research project led by people with lived experience of the UK asylum system, including disabled people and carers. Conducted as part of the Poverty Alliance's Rights in Action project, the research examines the barriers faced by disabled people and carers who are seeking asylum or have refugee status in accessing their fundamental human rights. Grounded in international human rights frameworks, specifically the UN Convention on the Rights of Persons with Disabilities (UNCRPD) and the International Covenant on Economic, Social and Cultural Rights (ICESCR), the report reveals widespread and systemic failures in upholding these obligations.

Participants consistently reported fragmented services, unmet health needs, and inaccessible housing, as well as a lack of formal carer support, and dehumanising interactions with duty-bearers. The testimonies of participants highlight how inadequate access to accurate, accessible, and targeted information leaves individuals (at some personal cost) to navigate complex systems alone, reinforcing precarity rather than security. Despite being entitled to rights under international law, many described experiences of marginalisation and neglect that undermined their health, dignity, and ability to live independently.

Third sector organisations were often the only sources of support, providing practical help, advocacy, and a sense of connection, but these services are under increasing financial pressure. The report calls for urgent action from duty-bearers to address the gap between human rights commitments and lived experience in both devolved and reserved contexts.

KEY RECOMMENDATIONS

- Ensure access to healthcare, housing, and social care for all, regardless of immigration status, in line with human rights obligations.
- Incorporate the UNCRPD and ICESCR into Scots law through the Human Rights Bill, using a minimum core obligations approach to guarantee realisation of rights, including access to adequate housing, healthcare, and social care for everyone, regardless of immigration status.
- Deliver mandatory, co-designed, rights-based training on the specific needs of asylum seekers and refugees, covering trauma, disability, long-term health conditions, cultural and linguistic barriers, and the impact of immigration status on access to services.
- End the use of unsuitable and inaccessible housing, including contingency hotel accommodation, and ensure accountability so that all placements meet safety, dignity, and accessibility standards.
- Guarantee continuity of care and support during all transitions, including accommodation moves and changes in immigration status.
- Establish a dedicated, rights-based advocacy service for disabled asylum seekers, refugees, and carers, co-designed with people with lived experience.
- Sustain and expand funding for third sector organisations, which provide essential support and advocacy where public services fall short.

INTRODUCTION

Our aim for this research was to explore the experiences of disabled people and carers who are or have navigated the asylum process.

In doing so we aimed to understand the types of support people access, the impact of that support, and identify areas where support is needed but currently unavailable. This report is grounded in the lived experiences of disabled people and carers who are navigating or have navigated the UK's asylum system and interpreted through the lens of international human rights frameworks and standards. It reveals persistent and systemic failures across key areas such as healthcare, housing, social care, and access to information. These failures are not isolated but suggestive of structural barriers and patterns of neglect that compromise individuals' health, dignity, and access to support to live independently. The findings cut across both reserved and devolved contexts, contexts that are notable for a gap in rhetoric and policy direction.

The UK Government has recently published a white paper that signals a 'radical' overhaul of the UK's immigration and asylum system[1]. The white paper's proposals to curtail the use of Article 8 of the European Convention on Human Rights reflect a broader trend of diminishing protections, alongside increasingly hostile political rhetoric, within the UK's asylum and immigration system. Proposed legislation to restrict family and private life claims poses a particular threat to disabled asylum seekers, for whom the presence of family or established support networks is often vital to their care, independence, and well-being (as highlighted in this report). Undermining these protections risks breaching the UK's obligations under the Human Rights Act 1998 and the United Nation's (UN) Convention on the Rights of Persons with Disabilities (UNCRPD). The government's framing of human rights as a means to "frustrate deportation" is particularly concerning, as it both undermines the legitimacy of these rights and casts lawful human rights protections as obstacles to be removed.

Many of the relevant policy areas covered in this report such as health and housing are devolved. Whilst the Scottish Government are notable in comparison for co-producing rights-based, social policy such as the New Scots Refugee Integration Strategy[2], the evidence presented in this report suggests enduring structural barriers that prevent rights realisation. Overall, this research raises serious concerns about the extent to which the UK and Scottish Governments are fulfilling their obligations under treaties such as the UN Convention on the Rights of Persons with Disabilities (CRPD) and the International Covenant on Economic, Social and Cultural Rights (ICESCR), particularly in respect of disabled people and carers seeking asylum.

[1] https://www.gov.uk/government/news/immigration-white-paper-to-reduce-migration-and-strengthen-border

[2] https://www.gov.scot/publications/new-scots-refugee-integration-strategy-2024/

THE RIGHTS IN ACTION PROJECT

This research was carried out as part of the Poverty Alliance's Rights in Action project, funded by the Scottish Government's Equality and Human Rights Fund, managed and supported by Inspiring Scotland, which aims to raise awareness of economic, social and cultural rights and support communities to use them to fight against poverty and injustice.

The research team

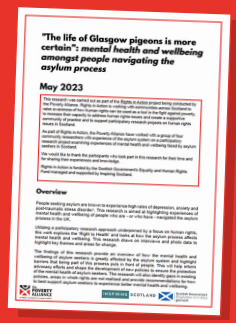
The research was undertaken by a team of seven researchers with lived experience of the asylum system, in collaboration with colleagues from the Poverty Alliance, and included disabled people and people with long-term health conditions.

Previous research

Members of the research team carried out two previous research projects as part of Rights in Action. One project focused on the right to education for people seeking asylum in Scotland, with a specific focus on further and higher education, and is available to access here.[3]


"Education is supposed to be free for all": Asylum seekers' experiences of accessing further and higher education in Scotland

The second project focused on the right to health as experienced by people who have, or are, navigating the asylum system, with a specific focus on mental health and wellbeing, and is available to access here.[4]


"The life of Glasgow pigeons is more certain": mental health and wellbeing amongst people navigating the asylum process

May 2023

Overview

[3] https://www.povertyalliance.org/wp-content/uploads/2023/05/Asylum-Seekers-Right-to-Education-Briefing.pdf

[4] https://www.povertyalliance.org/wp-content/uploads/2023/05/Rights-in-Action-Final-Report-Mental-Health.pdf

METHODOLOGY

Research design and background

Our community-led action research began by us coming together to discuss the issues that are faced by people who are, or have been, navigating the asylum system, and where we thought there was a gap in understanding. From this, the experience of disabled people and carers emerged.

Together, we developed a research framework grounded in human rights principles and informed by our lived experiences. We designed and carried out two focus groups and two semi-structured interviews that aimed to explore the experiences of disabled people and carers who are, or have been, navigating the asylum system, with the aim of better understanding the support they have accessed, its impact, and the additional support that is needed but currently unavailable. The questions were shaped collectively and refined through discussion and pilot sessions. Our research criteria were that participants had lived experience of the asylum system, were adults, and identified as a disabled person or as someone living with a long-term health condition, and/or a carer.

Our approach was also informed by wider activist experience within the group, including previous involvement in campaigning, advocacy, and community organising around asylum rights, disability justice, and social inclusion. This grounding helped us to frame the research in a way that not only documents lived experience but also challenges systemic injustice and seeks to influence change.

Finally, we held a roundtable workshop with practitioners from four third sector organisations to complement the core findings drawn from lived experience. This session was not a primary source of data but offered valuable additional insight into existing services, gaps in provision, and opportunities for advocacy. The research team developed specific questions for practitioners, including: “What support does your organisation provide?”, “How do you reach people?”, and “Who should we engage with?” The workshop also provided an opportunity for us to present our emerging findings, helping to contextualise our analysis within the broader service landscape and informing our dissemination plans to ensure that our recommendations are relevant, actionable, and aligned with existing work across the sector.

METHODOLOGY

How we reached participants

To recruit participants, we reached out to organisations working in relevant areas, such as disability rights, refugee support, and health advocacy. These included both national and community-based organisations. We also drew on our own pre-existing networks and relationships, which helped us reach individuals who may be less likely to be included in research. We aimed to make participation as accessible and flexible as possible, and while focus groups were our primary method, we also arranged one-to-one interviews to accommodate participants who were unable to attend group sessions. In total our research involved 13 participants. This included nine participants who identified as being disabled and or living with a long-term health condition, and four participants who provide care for a disabled person and or a person who is living with a long-term health condition.

Data analysis

We analysed the data using a thematic analysis approach. After collecting the transcripts from the focus groups and interviews, each researcher read through the material in full. We individually coded the transcripts, identifying key issues, patterns, and recurring themes. We then came together to compare our coding, discuss our interpretations, and agree on the final set of themes. These are the themes presented in the findings section of this report.

Note on participant quotes

Unless stated otherwise, all quotes are from participants who identify as disabled and or as living with a long-term health condition. Quotes from carers are clearly attributed.

FINDINGS

The following section details our research findings, grouped into the relevant themes that developed during analysis.

Everyday costs – Barriers to healthcare, food, and dignity

Participants consistently described living in poverty, facing food insecurity, and having to make very difficult choices between essentials such as food, transport, and healthcare. Grossly inadequate levels of financial support, especially during long asylum waits[5], places significant barriers to meeting basic necessities such as proper nutrition and prescription eyewear. This represents a failure of the state to ensure people in the asylum system can realise their right to an adequate standard of living (ICESCR art 11), impacting people's ability to realise their right to the highest attainable standard of physical and mental health (ICESCR art 12). One participant who is seeking asylum shared a deeply personal account of the long-term impact of living on asylum support, highlighting not only the lack of access to adequate healthcare, but also the trade-offs forced by the structurally enforced limited income. Their experience illustrates how systemic restrictions and policy choices create conditions where essentials become unaffordable and interconnected needs are not met:

> **"Because when I wanted to get my eyeglasses, I wasn't seeing right, and when I went to the eye section there was a blue paper, maybe there is a discount or something. Then when they did the eye test for me the glasses that it's supposed to cover, I think maybe £20 or £30 or something, I couldn't still see with the glasses. The eye doctor said to me this is my limit, I can't go beyond £30, and maybe what I could see with is about maybe £100. So, he said you can't do this, I should go with this, I should manage it. How can I manage something that I can't even see because I'm restricted on that because I'm an asylum seeker?"**

The same participant then discussed having to "reduce the food in the house" for a period before being able to go "back to get the proper lens". This experience is reflected in other research which highlighted the both the lack of access to opticians and lack of support to cover associated fees.[6]

[5] https://migrationobservatory.ox.ac.uk/resources/briefings/the-uks-asylum-backlog/

[6] https://www.doctorsoftheworld.org.uk/wp-content/uploads/2022/04/DOTW-Access-to-healthcare-in-initial-and-contingency-accommodation-report-April-2022.pdf

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Another participant explained, following a cancer diagnosis, the challenge of trying to follow dietary guidance from doctors whilst living on an inadequate income due to the restrictions placed on people seeking asylum:

> **"Well, with £5 per day and you need to pay transportation how could I buy fresh items or herbs or the things that the doctors told me? And whenever I called anywhere that I have no money, I have no food they said to me, okay you can go to the food banks or pantries."**

These accounts highlight systemic flaws in respect to access to healthcare, illustrating how access itself can be inadequate when wider considerations of people's health needs and the circumstances in which they live, structurally enforced by duty-bearers, are not considered. These examples are stories of survival in a system which is inadequate and undignified and reflect the accounts of the "extreme deprivation" forced upon disabled people seeking asylum, that requires systemic change "in order that people are valued for their common humanity, rather than their perceived value to the status quo."[7]

Systemic failures in health and housing: fragmentation, neglect and harm

Healthcare emerged as a key area of systemic failure in the experiences shared by participants. Across interviews and focus groups, individuals described distressing and dehumanising encounters with the healthcare system, including the inadequate or incomplete treatment of serious health conditions such as cancer, trauma, and miscarriage. These experiences were often characterised by what participants perceived as a lack of empathy embedded within bureaucratic systems such as healthcare. This was particularly evident in interactions that required people to repeatedly prove their identity despite having presented valid legal documentation.

[7] https://dgsjournal.org/wp-content/uploads/2012/06/dgs-02-01-07.pdf (p. 545)

> **"I told the cancer staff when they were asking me some questions, he was asking me, okay can you identify yourself. I said, I'm a refugee. He said do you have any ID, where is your passport. I said, maybe you could call the Home Office and ask them about my passport, because I don't have a passport. I've showed you my BRP (Biometric resident permit) card, you are still asking me."**

The interaction took place when the participant was undergoing treatment for cancer and illustrates how such procedural processes are experienced not as administrative hurdles, but as dehumanising and emotionally taxing, particularly for people navigating serious illness and structural disadvantage.

There was a widespread perception, rooted in lived experience, that people navigating the asylum system receive substandard care, due not only to strain on the NHS, but also because of their immigration status.

> **"Because we are asylum seekers for any reason that you go to the NHS, they just give you paracetamol, and that's not fair, someone who has cancer. And they didn't believe me that I had cancer, I had miscarriage."**

Participants also reported a lack of joined-up care and continuity in relation to their medical histories. Fragmented communication between duty-bearers further compounded the risks and frustrations experienced by people managing complex health conditions while navigating the asylum process. One participant described the harrowing consequences of this fragmentation after experiencing a miscarriage and being moved into isolated housing without clear follow-up care or the ability to contact anyone for support.

> **"I had a miscarriage the first night that I arrived here. And when I was at the hospital, I remember that a nurse came to me and she said basically I'd had a miscarriage, I was at the hospital for about ten days, and she came to me every day. After ten days they moved me, [Government contracted housing provider] company moved me from my hotel to my accommodation, without any signal, even I couldn't call the police or ambulance. It was absolutely blind place that I didn't have any signal to make a call. And I was there in accommodation without anybody else. I had bleeding for over ten days. No one came to me. I didn't know that I needed to go to the NHS. Then I didn't know what**

[8] https://www.equalityhumanrights.com/sites/default/files/2022/access-to-healthcare-a-guide-for-organisations-working-with-people-seeking-asylum.pdf

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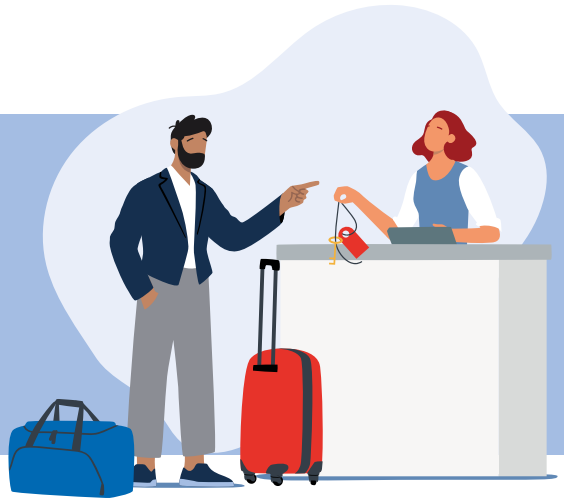

> **should I do. I was just at home, that's it, no one came to me. And after ten days for example I had to go out to the park near my house to be able to call my husband or the other people, I didn't know anyone here, and that was not fair because they just moved me from a hotel to accommodation, that's it, and they didn't tell me anything."**

For people seeking asylum, accommodation providers are required to ensure that a 'supported person' (i.e. a person who is seeking asylum and in receipt of asylum support) is taken to a GP within five working days of arriving at their dispersal accommodation, and that in cases of urgent need this should take place within one working day.[8] The participant's experience would therefore appear to be a breach of the accommodation provider's contractual obligations.

This experience highlights a profound breakdown in the duty of care and coordination between duty bearers, in this case the NHS and the UK Government–commissioned housing provider. The absence of adequate follow-up care, communication, or ensuring the person was able to contact anyone left this person isolated and at risk following a medically serious and emotionally distressing event. It illustrates how institutions can neglect the needs of those they are legally responsible for, raising serious concerns around fragmented responsibilities and a lack of accountability or redress.

One participant, whose asylum pathway prevents them from returning to their home country, described the lack of medical planning and guidance offered by the Home Office for their ongoing, life-sustaining treatment:

> **"I asked at the Home Office, what I need to do with me because I am waiting on a transplant and nobody knows, it's you need to wait one year, three years. So, what I need to do, and they were in shock, they cannot answer me this question, they said, no we will see you just when you continue, so you just write in your application that you have this problem. What is this, it's a really serious problem, it's about life. I cannot leave this country because I need dialysis every day and to my country, it needs three days to go by transport. No sorry, the next day I will die without dialysis, so how I can leave this country, and they cannot answer that."**

These accounts reveal systemic patterns of disregard, fragmentation, and inadequate access and support across healthcare and asylum systems. Rather than receiving coordinated care and clear guidance, participants were left to navigate these circumstances largely on their own. These accounts are indicative of structural failures that are the responsibility of duty-bearers that compromise the dignity, safety, and rights of people seeking asylum in the UK.

Delays and lack of continuity in care

The lack of timely responses to urgent medical needs was a recurring theme among participants. Many described long waiting periods and delays in care that led to worsening health conditions.

> **"And then they told me that we need to send you to our own, I don't know, sonograph or something like that, and it took 18 months. And after then when they understood everything, it was too late."**

In some cases, participants were advised, despite living on minimal financial resources, to access private healthcare. This once more put the onus on the individual to resource their own healthcare with little regard to the impact on having to do so.

> **"this GP was not ready. So, there was a time when he told me, I'm going to refer you to a private hospital so you can go there and do whatever tests you want to do. So, I save £38 they [the State] were giving us and I saved it to be able to pay the one hundred and something pounds for me to go private or see one doctor for five minutes, for five minutes."**

> **"One of my doctors even told me that if I have money, I should just go private. Where would I get the money from?"**

These accounts show how delays in the public health system, alongside signposting people with little financial resources towards private healthcare, create an inequitable environment, and denies or delays people from receiving the healthcare that they have both a need for, and right to.

Inadequate, inaccessible, housing

In the UK, people seeking asylum are frequently placed in unsuitable temporary housing, such as overcrowded or poorly maintained hotels[9]. Participants in this study described being placed in accommodation that did not meet their basic needs, both while in the asylum system and after receiving refugee status. Inaccessible and unsafe housing was a recurring issue across various stages of their journeys, with significant consequences for health, dignity, and daily life. These failures to fulfil the right to housing for asylum seekers, impact the realisation of right to the highest attainable standard of health, and undermine people's dignity.

Participants discussed being placed in so-called 'hotel accommodation', which was not accessible for them, and of the impact this had on meeting essential, basic needs:

> **"When I came in as an asylum seeker the hotel that I was accommodated in is a second floor that has no lift. And they saw me with crutches, and it takes me time to get to the floor. I kept complaining that they are not getting better, and they keep**

[9] https://justfair.org.uk/wp-content/uploads/2023/09/Families-seeking-asylum-report.pdf

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telling me that they're going to change me. Like, for four months I was in the hotel, some days I don't even come down to eat because of taking the staircase and going up and down... I kept asking to be moved but they kept saying, 'we'll change it' and nothing happened."

The Home Office meets most of its statutory duties in respect to the accommodation of people seeking asylum through the Asylum Accommodation and Support Services Contracts (AASC), which set out how the Home Office works with the companies that provide housing for people seeking asylum – and Advice, Issue Reporting and Eligibility (AIRE) contracts, which sets out the terms of engagement and responsibilities between the Home Office and the contractor responsible for delivering advice and support in understanding the asylum support system.[10,11]

The AASC (awarded to Mears Group in Scotland) and AIRE (awarded to Migrant Help across the UK) contracts require that all staff involved in delivering services receive training that includes, as a minimum, the asylum and support systems, equality and diversity, data protection, and safeguarding. Additionally, staff who have regular face-to-face contact must also be trained in a broader range of areas. These include cultural awareness, diversity, suicide and self-harm prevention, basic first aid, gender-based violence, fire safety, health and safety, unconscious bias, vicarious trauma, counterterrorism, modern slavery, and meeting required housing standards.[12]

However, an inspection report published in 2023 on contingency asylum (hotel) accommodation for families and children in Northern Ireland carried out by the Independent Chief Inspector of Borders, raised serious issues including children losing weight due to the provision of culturally inappropriate food, inconsistent clearances and training for some contractor staff, safeguarding systems 'still in development'.[13]

Furthermore, the report highlighted that "the Home Office's solution to communicating between service users in hotels and the Home Office is not working. Service users, Home Office staff and contractors have no confidence in it, and it needs to be reassessed. This was highlighted in the 2021 inspection of contingency asylum accommodation and has still not been addressed, with the author concluding at the time of the report that "the challenges faced by families and those involved in

[10] https://www.gov.uk/government/publications/asylum-support-contracts-safeguarding-framework/asylum-support-contracts-safeguarding-framework

[11] https://asylummatters.org/app/uploads/2019/11/The-Asylum-Accommodation-and-Support-Contracts-A-Guide.pdf

[12] https://www.gov.uk/government/publications/asylum-support-contracts-safeguarding-framework/asylum-support-contracts-safeguarding-framework

[13] https://assets.publishing.service.gov.uk/media/65e0786f7bc329001ab8c192/An_inspection_of_contingency_asylum_accommodation_for_families_with_children_in_Northern_Ireland__May_to_June_2023.pdf – p.2

supporting them in Northern Ireland are no more problematic than those in any other parts of the UK's contingency asylum accommodation estate."[14] These concerns echo longstanding calls for reform, including from the Scottish Refugee Council to ensure formal accountability, adequate funding to local authorities and charities, and the removal of destitution from the UK asylum system.[15]

Outside of hotel settings, participants described being placed in physically inaccessible housing that was not accessible and in disregarding their needs, dangerous:

> **"I live in floor 11. Many times, the lift doesn't work."**

> **"Bathroom… not for disabled people. Five times I fall down in the bathroom. I said to them, but they said to me, what can we do nothing." [16]**

Other participants spoke of being forced to repeatedly move from one location to another:

> **"we ended up in the hotel. We ended up in [name of location] … then from [location] to [location] to [location], from [location] to [location]." – Carer**

This reflects previous research that highlighted that families in the asylum system are often moved with little notice, sometimes across significant distances, to live in temporary housing conditions that are often inhumane, with issues such as rat infestations and mould.[17] Our data highlights how these relocations impact asylum seekers other human rights, including their right to education, and to healthcare. These disruptions also remove people from their existing support networks compounding the stress and instability many already face.

Carers also described the impact of living in homes that were not adapted adequately for disabled family members. One participant described having an adaption made by their housing provider, but discussed how in practice this had been inadequate:

> **"a slight adaptation of the house but still my daughter can't access the kitchen. She can't access her own room using her own wheelchair, we have to leave the wheelchair in the living room… Even the bathroom, she can't access the bathroom in her wheelchair, we have to leave the wheelchair. That's add more work to me as well, so I have to move her." – Carer**

[14] ibid

[15] https://scottishrefugeecouncil.org.uk/working-for-change/policy-campaigns/asylum-accommodation/

[16] A news report by Channel 4 news which interviews people similarly affected can be found here – https://www.channel4.com/news/the-disabled-asylum-seekers-trapped-in-unsuitable-housing

[17] https://justfair.org.uk/wp-content/uploads/2023/09/Families-seeking-asylum-report.pdf

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These testimonies highlight the impacts of a lack of accessible, safe and suitable housing for asylum seekers in Scotland. Furthermore, it raises serious questions as to accountability within the system, which lacking, forces people to live in conditions that are not accessible for them and their families, are dangerous, and ultimately undignified.

Carers' experiences

Our research found that carers lack both formal support and recognition for the vital roles they perform in caring for their loved ones. This lack of support was reported to have direct consequences for carer's own health and was directly linked to their asylum status.

> **"When it comes to me as a carer, that is an issue because it's only me who is taking care of her and I am an asylum seeker, I'm not entitled to public funds, that means I don't get any respite, I'm taking care of that girl 24/7 and I have an issue with my back and I don't get any support. That is my health, I don't get any support." – Carer**

The UNCRPD clearly states that State Parties are required (under Article 28) to ensure that disabled people and their families living in 'situations of poverty' have access to respite care[18]. The participant's testimony highlights how a gap in provision and compliance can have direct consequences for health and wellbeing.

Other participants echoed similar situations where support for care responsibilities were similarly lacking and unacknowledged:

> **"And I didn't got anything [support]. Plus, this situation has affected the mental health of the entire family." – Carer**

> **"The problem is like I was leftover. Without a single support, no one is asking. No one is checking, no one is giving a single value to what I'm suffering. I have to dig down personally." – Carer**

One carer spoke of the long and emotionally draining struggle to access suitable medical care for their adult son, describing the process as a "battle" to obtain the "proper support" for their adult son:

> **"Then after battle, I'm serious about my terminology, after the battle." – Carer**

The descriptions provided illustrate how carers in this research were left to navigate care provision with little evidence of assistance, at great personal cost. The lack of recognition and redistribution raises further questions as to the adequacy of existing support structures for carers who are navigating the asylum system.

[18] https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-persons-disabilities

Inconsistent, unempathetic interactions with duty bearers

Across both focus groups and interviews, participants described their experiences with health and housing services as unreliable, inconsistent, and often lacking empathy. Many conveyed a sense of dehumanisation, describing themselves being treated as case numbers in bureaucratic systems that failed to recognise their individuality and humanity. One participant shared:

> **"We are a counted number. We are just numbers; we are numbers in the system, number one, number two, number three, number four, number five.... We are not numbers; we are human beings, treat us as human beings."**

This reflects a deeply impersonal system, failing short of the General Principles of the UN Convention on the Rights of Persons with Disabilities (UNCRPD), which emphasise 'respect for inherent dignity'.

Several participants noted that that accessing appropriate and empathetic support was often a matter of luck, rather than a systemic norm. The ability to access support, was frequently cited as being dependent on the individual caseworker that people were assigned or came into contact with:

> **"For disabled asylum seekers depending on whoever is handling your case, depending on the institution you may face. If you are lucky, you meet a good handler who has empathy, because that's number one [...] Then you are lucky that that person connects you, signposts you to the authorities that need to look into your case."**

This reliance on individual goodwill or luck – rather than consistent institutional provision – is indicative of a lack of systemic accountability and suggests that current support structures are inadequate. Participants spoke of the role of support organisations (discussed further in 'The role of Third Sector Organisations' section below), but also shared examples of support from individuals, in one case their local MSP in the form of vouchers and gifts for their children:

> **"I was getting support from my local MSP... and she helped me a lot when were on asylum support, their secretary normally gave a voucher or two for my kids every six months and at Christmas also they gave lots of presents and vouchers to my kids." – Carer**

While participants expressed gratitude for such examples of support, it was clear that this still depended on whether someone had the ability and opportunity to engage with the right individual at the right time, and not the product of reliable state provision.

FINDINGS

Cultural awareness

A recurring theme was a lack of cultural awareness among duty-bearers in the healthcare system. Participants described how duty-bearers often lacked understanding of the backgrounds, culture, and lived experience of disabled people and carers navigating the asylum system:

> **"They don't understand the background of the people who are coming from abroad. They need training. I always ask for that." – Carer**

> **"Back home, we don't have this culture, so it's a cultural barrier that people were expecting to invite immigrants or refugees, but they don't know nothing about their culture and ethnic backgrounds. They don't understand nothing about us." – Carer**

Such calls are not novel, but historic, as shown by the recommendations of a report from 2002 on disabled people who from refugee and asylum seeker communities, that urged the need for "Disability and race equality training for those working with refugees and asylum seeking communities, and with disabled people."[19] Another participant described the positive impact of being treated by a doctor (whilst undergoing treatment for a serious health condition which they reported being incorrectly treated for initially) who they felt had a shared or increased cultural understanding their background. This example highlights the potential of increased cultural awareness in improving access and limiting possible miscommunication. The importance of cultural awareness has informed one of our reports recommendations (see recommendations section): that duty-bearers at all levels receive cultural training. Such training would improve access to services, support the realisation of rights - including the right to health - and better equip frontline staff to meet the needs of people seeking asylum and refugees (in addition to other people who have migrated to the UK).

Status and a reduction in care

Participants – both carers and disabled individuals – consistently reported that their asylum status acted as a barrier to access essential support. The denial of access to public funds was reported as being a barrier to accessing services.

[19] Roberts, K and Harris, J. (2002) *Disabled people in refugee and asylum-seeking communities in Britain*. Joseph Rowntree Foundation, York. Available from: https://citeseerx.ist.psu.edu/document?repid=rep1&type=pdf&doi=e41e45b2180dcbb94c5c439b89e3e5e5e91ddb20 (p. 5) A more recent scoping review (from 2021) that focused on mental health care for people seeking asylum and refugees similarly concluded the need for "Time sensitive and culturally appropriate approaches are needed, with greater funding and resource support from the UK Government." – Pollard, T. and Howard, N. (2021) Mental healthcare for asylum-seekers and refugees residing in the United Kingdom: a scoping review of policies, barriers, and enablers. *International journal of mental health systems*, 15(1), p. 60. Available from: https://ijmhs.biomedcentral.com/articles/10.1186/s13033-021-00473-z

> **"I'm in the asylum process, sorry. It means like you have no access to public fund, which prevents you from a lot of services that are prevention at that time." – Carer**

One parent described the challenge of trying to access a needs assessment for their daughter, who was preparing to start college:

> **"My status is a big, big barrier, it's a big barrier in this sense, for example, when my daughter was about to start college, there is a very special procedure which was supposed to be taken, is a needs assessment. A needs assessment is very important in a disabled person when they're going to start college or wherever and I asked the social worker to do the needs assessment for my daughter, but she couldn't do it, and she didn't get any needs assessment. Why? Because we are asylum seekers." – Carer**

As a result of not receiving this support and provision, the participant was forced to provide full-time care in order for her daughter to access further education:

> **"My daughter is at college, she needs support. I'm taking her to college every time, even now, I'm from college and I'm going to back to college. I have to stay there with my daughter all day as a support, as a carer supporter which I can say I don't have my life." – Carer**

The same parent reflected on how this situation marked a reduction in support compared to when their daughter was a child:

> **"I can say I'm not getting that much support at the moment, when my daughter was a child, she was getting support from different organisations, and she managed to go to school. She was getting transport; she was getting escort which helped her to go to high school and finish, and it helped me as well to have time to go college and accomplish my studies by that time. But at the moment, now she is an adult, so everything has changed, the support she was getting before, she is not getting anymore." – Carer**

In the vacuum left due to the lack of proactive, accessible state-support, carers described to take on the responsibility to gather information and navigate systems as best they could, due to a lack of formal guidance and support:

> **"I suffered personally to gather the information and to grab the advice needed and to do the work that's supposed to be done by either the work or health sector. I've been doing this work myself." – Carer**

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These experiences point to a broader structural gap in the provision of clear, accountable pathways for carers and their loved ones who they support to access appropriate services. This evidence mirrors concerns highlighted by the United Nations Committee on the Rights of Disabled People in a report to the UK, which highlighted the committee's deep concern of "reports that disabled refugees, asylum seekers and those in refugee-like situations do not receive adequate benefits and support to live in the community, and are experiencing challenges in obtaining personal assistants, assistive devices, accessible housing and essential disability supports."

Transition from Asylum Seeker to Refugee status

While the granting of refugee status is a significant milestone, it did not resolve many of the issues and barriers that many participants faced. In some cases, it even led to a reduction in support. Several participants described feeling abandoned after finally receiving their status.

There was a common experience of a lack of support in managing the transition from asylum seeker to refugee status, leaving people without adequate support and assistance, and adequate housing, compromising people's ability to live independent lives. The transition phase was marked by systemic gaps, gaps that duty-bearers have both the power and legal responsibility to address.

Participants described a lack of support in the transition from asylum to refugee status, leaving people without continuity of care, unable to realise their right to adequate housing, and lacking support. The transition process has many gaps, gaps which duty-bearers can choose to close.

One participant, who had been granted refugee status and access to social security, described the continued lack of social care provision beyond what was provided by their immediate family:

> **"Now I get money, but money doesn't mean anything because I need care. My wife and my children they help me, but also, they have something to do; my children go to school and my wife she has to work in the house and also, she studies in college, so they have no time."**

Article 19 of the UNCRPD requires State Parties to ensure that disabled people have access to "a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community."[20] The participant's experience highlights the gap between the rights set out in Article 19 and the lived reality faced when

[20] https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/article-19-living-independently-and-being-included-in-the-community.html

people's human rights are unrealised. The same participant reflected on the difference in support before being granted refugee status, with their experience being one of increased social security, but a reduction in access to healthcare and personal support. This sentiment was echoed in a powerful summary from the same participant:

> **"When I became a refugee, I lost everything, nobody cared for me. I want people to understand that the transition between asylum seeker and refugee is massive and dangerous."**

Whilst the research did not ask participants how long they had been in the asylum system, it is important to acknowledge that, for some, this process can span many years, often without adequate support. One participant highlighted just how long this uncertain process can endure for, sharing that they had been *"in the asylum system for nineteen years now… no practical help… just threats from the Home Office"*. Research has highlighted that spending prolonged periods awaiting an asylum decision is strongly associated with deteriorating mental health, including increased risk of depression, anxiety, PTSD, and suicidal ideation, largely due to uncertainty, isolation, and lack of meaningful activity[21] – conditions often built into the asylum system itself.

Access to information

Participants frequently spoke about the lack of accessible and relevant information. Many described being unable to find guidance about their rights, eligibility for services, or the appropriate organisations to turn to for support and advocacy. This lack of information created additional barriers to independence, inclusion, and justice.

> **"I think here, not enough information for foreign disabled people, which they have the right in country, for example, if I am a refugee, I want to find information how I can continue my visa et cetera. But it said, working visa, the right visa, it's for a healthy person, I am disabled but I cannot work, it's forbidden for me. I cannot find information about my rights as I'm foreign and disabled. I cannot find some organisations, I don't know, who would advocate for foreign disabled people, it's very difficult."**

Such experiences point to a failure of the State to meet its obligations set out in Article 9 of the UNCRPD, which requires States Parties to take appropriate measures to ensure disabled people have equal access to information and communications[22].

[21] https://pubmed.ncbi.nlm.nih.gov/40493425/, see also our previous Right in Action report – https://www.povertyalliance.org/wp-content/uploads/2023/05/Rights-in-Action-Final-Report-Mental-Health.pdf

[22] https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/article-9-%20accessibility.html

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Several participants also pointed to the confusion caused by the division of powers between devolved and reserved matters. This overlap in jurisdiction created further uncertainty about where to turn for support, and who is accountable. One participant described raising issues that they faced in a meeting with a senior elected official:

> **"Again, immigration is a reserved matter, there's not much we can do... okay, immigration is a reserved matter but what about my disability, what about that?"**

Ambiguity in responsibility is a barrier to accountability and access to justice, and contravenes Article 13 of the UNCRPD, which affirms the right to effective access to justice for disabled people. as to who is responsible and when, is a clear barrier to accountability through which access to redress is hindered, and where access to justice (article 13) is compromised.

These testimonies highlight how inadequate access to accurate, accessible, and targeted information leaves individuals (at some personal cost) to navigate complex systems alone, and undermines rights realisation, and reinforces precarity rather than security.

The role of third sector organisations

Participants consistently highlighted the vital role of third sector organisations in providing support. Organisations were described as filling critical gaps left by the State, offering practical assistance and social contact that directly contributed to individuals' independence, wellbeing and dignity.

Third sector organisations were praised for the wide range of services, including digital inclusion, social connectivity, health related support, and advocacy. Their contributions were seen as essential, particularly in supporting people to live more independently, support that participants described as being inadequate or absent in respect of State provision.

One carer explained how physiotherapy and occupational therapy services provided by a third sector organisation were crucial to their daughter's life:

> **"I'm grateful with Cerebral Palsy Scotland, they are doing very, very well with us. She's having physiotherapists and occupational therapist from Cerebral Palsy Scotland, who is coming to visit us. So, those are the ones who are supporting, we get activities to do at home to help her to be independent and manage it. Cerebral Palsy affects muscles, so as she grew up, the muscles become tighter but with her cerebral palsy, they're supporting a lot." – Carer**

Another participant spoke about the role of the Glasgow Disability Alliance (GDA) and other organisations in providing social connectivity and learning opportunities:

> **"So, she's getting support. learning support from the GDA, she joined some sessions with the GDA, and she attends some activities, I can say she's getting more social support from different organisations." – Carer**

Another participant similarly highlighted the work carried out by GDA in supporting digital inclusion by providing them with a computer, with another reflecting that 'Charities are doing a massive job'. These examples underline the wide-ranging support offered by third sector organisations, from advice, learning opportunities, social connectivity to digital inclusion and health interventions, support that particularly in the absence of adequate state support, helps people to navigate daily life and live independently.

However, this vital support is provided by organisations operating in increasingly challenging environments. Recent research published by the Scottish Council for Voluntary Organisations highlighted a sector under growing strain, with financial pressures, funding shortfalls, and staffing challenges threatening the sustainability of many organisations. While short-term confidence remains, long-term viability is at risk, underscoring the urgent need for continued investment and support to sustain vital services for communities across Scotland.[23]

[23] https://scvo.scot/research/scottish-third-sector-tracker/the-scottish-third-sector-tracker-wave-10-spring-2025

CONCLUSION

The evidence presented in this report reveals a system that fails to consistently uphold the rights of disabled people and careers who are, or have, navigated the asylum system. Across healthcare, housing, social care, and access to information, participants described a fragmented and dehumanising system in which essential support is frequently unavailable, inaccessible, or conditional. These failures have profound implications for individuals' health, dignity, and ability to live independently.

The UK is a State Party to both the UN Convention on the Rights of Persons with Disabilities (CRPD) and the International Covenant on Economic, Social and Cultural Rights (ICESCR). These treaties affirm a wide range of rights, including the right to the highest attainable standard of physical and mental health (CRPD Article 25; ICESCR Article 12), the right to an adequate standard of living, including housing, food, and social protection (CRPD Article 28; ICESCR Article 11), the right to live independently and be included in the community (CRPD Article 19), and the right to access information and justice without discrimination (CRPD Articles 21 and 13). These rights apply to everyone under the UK's jurisdiction, regardless of immigration status. Yet, as neither treaty has been incorporated into domestic law, these rights are not directly enforceable in UK courts and restrict routes to redress when people's rights are denied.

What emerges from this research is not simply a collection of policy failures, but evidence of a structural disregard for the rights of disabled asylum seekers and refugees

In Scotland, many of the domains where these rights should be realised – such as health, housing, and social care – are devolved. The Scottish Government and public bodies therefore have significant responsibilities in ensuring these rights are upheld in practice. Policy frameworks such as the New Scots Refugee Integration Strategy, developed in partnership with the Scottish Refugee Council, and shaped by the input of over 2,000 refugees in Scotland, represent a much-needed rights-based commitment to support people seeking asylum and refugees from the day they arrive. This framework signals a markedly different approach to the increasingly hostile policy proposals and rhetoric of the UK Government, recognising integration as a two-way, rights-based process involving both individuals and communities. However, the lived experiences presented in this report reveal the gap that persists between policy ambition and implementation, particularly in relation to disabled people and carers.

What emerges from this research is not simply a collection of policy failures, but evidence of a structural disregard for the rights of disabled asylum seekers and refugees. Instead of being treated as rights-holders, individuals are often dependent on the discretion of local actors, voluntary organisations, or good fortune. Across the research, participants consistently highlighted the essential role of third sector organisations in providing support where statutory services failed to respond. These organisations often offered the only practical assistance available – whether in the form of advocacy, health support, or accessible information. However, this work is taking place under increasing funding pressure, raising serious concerns about its sustainability and the accountability gap created by the state shifting responsibility onto third sector organisations to compensate for systemic failures in public provision.

Although the Scottish Government has previously made welcome commitments to incorporate international human rights – such as the CRPD and ICESCR – into Scots law through a Human Rights Bill, the future of that legislation is now uncertain. To give effect to these commitments, at both at the UK and devolved levels, government must act urgently to ensure that the minimum core of economic, social, and cultural rights is protected and realised for all. A truly rights-based approach requires not just good policy intentions, but mechanisms for accountability, redress, and enforcement.

Such an approach also recognises the individual, as opposed to the homogenous label of 'asylum seeker' or 'refugee', which the UK Government increasingly uses negatively, with disregard for the intersecting identities and barriers evidenced in this report. Without structural change, the gap between rights frameworks and lived reality will likely persist, captured starkly by one participant's reflection:

> **"WHAT'S THE ASYLUM SEEKERS' RIGHTS?**
>
> **THEY DON'T HAVE ANY RIGHTS."**

RECOMMENDATIONS

All public bodies (including NHS, local authorities, housing providers, and contractors)

- Deliver mandatory, rights-based training on the specific needs of asylum seekers and refugees, covering trauma, disability, long-term health conditions, cultural and linguistic barriers, and the impact of immigration status on access to services.
- Training should be co-designed with people with lived experience and embedded into induction, ongoing development, and service design processes.

UK Government / Home Office

- End the use of unsuitable and inaccessible housing, including contingency hotel accommodation, and ensure accountability so that all placements meet safety, dignity, and accessibility standards.
- Guarantee continuity of care and support during all transitions, including accommodation moves and changes in immigration status.
- Ensure equal access to healthcare for all asylum seekers, including those with refused claims, in line with human rights and non-discrimination duties.
- Withdraw proposals that undermine Article 8 European Convention on Human Rights and end the use of hostile or dehumanising rhetoric that stigmatises people who have or are navigating the asylum system and disabled people.

Scottish Government

- Deliver on commitments made in the previous Human Rights Bill consultation to incorporate the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the UN Convention on the Rights of Persons with Disabilities (CRPD) into Scots law, using a minimum core obligations approach to guarantee realisation of rights, including access to adequate housing, healthcare, and social care-for everyone, regardless of immigration status.
- Establish a dedicated, rights-based advocacy service for disabled asylum seekers, refugees, and carers, co-designed with people with lived experience.
- Ensure that policies on carer support and nutrition explicitly include asylum seekers and refugees, and that local delivery of health and social care integration reflects these responsibilities.
- Fund Local Authorities to ensure access to adequate and culturally appropriate nutrition for everyone who needs it through inclusive referral pathways and emergency provision.

NHS Scotland

- Establish clear, person-centred protocols to ensure adequate and continuous access to healthcare for asylum seekers and refugees, particularly during initial arrival or placement, and throughout any accommodation moves or changes in immigration status. This should begin with ensuring that health information collected at initial screening or arrival is accurate, comprehensive, and accessible to relevant professionals.
- Improve clinical responses to the health needs of asylum seekers and refugees, ensuring staff are supported to respond with empathy, cultural sensitivity, and an understanding of the impact of displacement, trauma, and disability.
- Ensure that all health information is provided in accessible, translated formats, including Easy Read, audio, and in-community languages, and that patients know their rights to interpretation and how to raise concerns.
- Ensure that nutritional advice given by clinicians is matched with access to appropriate food, by coordinating with local authorities and community food providers to support carers and people with specific health-related dietary needs.

Local authorities

- Provide timely, inclusive assessments for social care and housing, removing barriers linked to immigration status.
- Improve coordination between housing, health, and social care services, especially during initial phases, transitions or changes in need.
- Disseminate rights-based information in accessible formats and languages, ensuring people know what support is available and how to access it.
- Ensure access to social care assessments for all who need them, regardless of immigration status.

Mears Group

- Cease the use of inaccessible or unsafe accommodation and ensure housing placements are based on individual access and support needs.
- Implement robust, independently monitored training for all staff and subcontractors on safeguarding, disability, and trauma.
- Implement a transparent, accountable complaints systems.
- Coordinate proactively and transparently with local services to ensure disabled people and carers receive joined-up care and support from day one.

Third sector organisations

- Continue to provide vital support and advocacy where statutory services fall short, particularly for disabled people and carers in the asylum system.
- Continue to work collaboratively with people with lived experience to shape policy, services, and public understanding through rights-based practice.

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