Supporting disabled refugees and asylum seekers: opportunities for new approaches

Full report
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Information Centre about Asylum and Refugees

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Foreword

Barbara Roche
Chair of Metropolitan Support Trust

I have great pleasure introducing the first piece of research for 2008/09 commissioned by the Research and Consultancy Unit (RCU) at Refugee Support / Metropolitan Support Trust. Supporting disabled refugees and asylum seekers: opportunities for new approaches examines the role of refugee community and mainstream disability organisations in supporting disabled refugees and asylum seekers in London.

This research is extremely important as it fills a huge gap in terms of what has been written about the issues facing disabled refugees and asylum seekers. I am grateful to those individuals that took part in the research and know that their experiences will contribute a great deal to our understanding of the issues disabled refugees and asylum seekers face.

I would like to thank the Greater London Authority for its full support throughout this research project.

There have been many people involved with this research project. I would like to thank Neil Amas, Director of the Information Centre about Asylum and Refugees (ICAR) and his researchers, Kim Ward and Jacob Lagnado, for undertaking this research and producing the report and executive summary. Olani Nemera has kindly volunteered his time to assist the Research and Consultancy Unit throughout this research project. I would also like to express my sincere thanks to the research project steering group that included: Paul Birtill, Charlotte Keeble and Sarah Walker from the Refugee Support / Metropolitan Support Trust, Berhanu Kassayie from Praxis, Claire Glasman from WinVisible and Amna Mahmoud from the Greater London Authority.

The full report is available as download and can be accessed from the Refugee Support website at:

www.refugeesupport.org.uk/researchandconsultancy.html

Please refer to the ‘glossary of terms’ for a comprehensive list of all definitions.
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1. Background and introduction

Background to the research
This research was commissioned by the Research and Consultancy Unit (RCU) at Refugee Support / Metropolitan Support Trust (MST). A key aim of the RCU is to undertake and commission research that will benefit refugees, asylum seekers and migrant populations. The RCU identified the issue of disability among refugees and asylum seekers as a major research gap and, more specifically, the barriers faced by this group in accessing support and advice.

In July 2008, the RCU commissioned research into the role of refugee community and mainstream organisations in supporting disabled refugees and asylum seekers in London. The research was commissioned to the Information Centre about Asylum and Refugees (ICAR).

From its inception, the Greater London Authority has endorsed the research project. Deputy Mayor, Richard Barnes stated that "it is important that all disabled Londoners are able to access the services to which they are entitled. If they are disabled refugees, access may often be especially difficult. Ensuring their full integration into the city’s life means getting a better understanding of these refugees’ needs, and of ways of meeting their needs through support services in the community, voluntary and statutory sectors."

The RCU is also working in partnership with Praxis (an advice and support service to migrants and refugees) and WinVisible (an advocacy and support service for women with visible and invisible disabilities), who are both represented on the research project steering group.

Introduction
Increasing numbers of asylum seekers and refugees have been arriving in the UK since the 1980s and particularly since the mid-1990s. The majority settled in London and the South East before the Government’s dispersal programme, (enacted in 2000), redirected new arrivals to urban areas around the country. While asylum applications have declined in recent years, the capital is still estimated to host the majority of the UK’s refugee and asylum seeking population.¹

The sheer range of national and ethnic backgrounds that characterises Britain’s new asylum seeking and refugee populations has led to what some observers have described as ‘super-' or ‘hyper-diversity’ (Vertovec, 2006). This has brought with it a diverse range of support needs which bring new challenges to existing services and has led to the emergence of a large number of equally diverse Refugee Community Organisations (RCOs).

estimated to total some 600 in London alone (Griffiths et al 2005). RCOs are led by refugees, and traditionally organised around a particular identity such as nationality, gender or ethnicity. Despite a tendency to be small and run by volunteers on shoestring budgets, they are seen to provide invaluable support and culturally sensitive services to new arrivals. They are part of a much broader network of larger services and agencies that offer support to asylum seekers and refugees, encompassing larger refugee support charities, such as the Metropolitan Support Trust and Refugee Council; mainstream voluntary sector agencies such as Citizen Advice Bureaux; specialist voluntary sector agencies, such as those that work with Black, Asian and Ethnic Minorities (BAME); statutory services including local councils, schools and health services, and central government offices.

Disabled asylum seekers and refugees present a particular challenge to these organisations, just as the organisations present a particular challenge to them. Experiences of war or torture, cultural and linguistic differences and a system of rights and entitlements for immigrants that is complex and increasingly restrictive mean that this population presents a very specific set of needs and experiences. Some of these are shared with the UK’s existing ethnic minority populations, but others are additional and ‘refugee-specific.’

Apart from in the specific field of mental health, there is a significant lack of research on disabled asylum seekers and refugees in the UK. What little does exist, together with anecdotal evidence drawn from specialists in the field in preparation for this study, indicates that this is a largely ‘hidden’ population, unknown in size and need, which faces particular and often multiple disadvantages. In particular, there appears to be a gap in knowledge about asylum seekers and refugees with physical or sensory impairments or learning difficulties. It is thought that RCOs and specialist disability RCOs, though few and far between, are picking up the strain and attempting with limited resources to meet a range of disabled asylum seeker and refugee needs that are unmet by mainstream providers.

This research aims to get to the heart of this issue. By capturing the perspectives of so-called ‘hard-to-reach’ disabled asylum seekers, refugees and RCOs, it seeks to examine not only the nature and extent of disability amongst this population but also the nature and extent of the support they are receiving from refugee community and mainstream organisations in London. By also interviewing a sample of representatives from the larger network of support services listed above, this study additionally aims to build a picture of the broader support environment and to examine the adequacy of this support.

**Aims and objectives**

The overall aim of the research is to identify how refugee community and mainstream organisations assist and support disabled asylum seekers and refugees in London. The research objectives are to:
- map the work of RCOs and other organisations working with disabled asylum seekers and refugees;
- assess the unmet needs of disabled asylum seekers and refugees in relation to mainstream provision, RCO support and more generally;
- explore ways in which asylum seeking and refugee populations might experience and conceive disability differently, both in relation to each other and to the wider population;
- identify any shortfalls in the provision of mainstream services;
- explore the potential for RCOs to address any shortfall in these services; and
- identify any support and resources that RCOs and other organisations may require if work on disabilities is to be improved and/or expanded.

Report structure
Whilst Chapter One introduces the research and its aims and objectives, Chapter Two provides a policy and legal background to the research followed by a review of existing literature on disability, asylum seekers, refugees and the role of RCOs. Methodology is described in Chapter Three, followed by relevant data collected from the study in Chapter Four. Chapter Five gives a breakdown of the research sample and key findings are presented in Chapter Six. The report closes with Conclusion and Recommendations in Chapters Seven and Eight, followed by a bibliography.
2. Context

2.1 Policy background

Asylum seekers
Asylum seekers arriving in the UK since the 1990s have been faced with a rapidly changing legal and policy environment. Before 1993, newcomers enjoyed the same welfare rights and benefits as the rest of the population. In the years that followed, increasing asylum numbers and government claims concerning pressure on services in London and the South East led to a succession of legal and policy changes which increasingly restricted social support choices and lowered welfare entitlements. These changes culminated in the 1999 Asylum and Immigration Act, which paved the way for a national scheme of asylum seeker dispersal and moved responsibility for housing and support from local authorities to a new Home Office department in the shape of the National Asylum Support Service (NASS). To a large extent this Act still shapes asylum support policy today.

Refugees
At a national level, refugee-specific policy is grounded in the government’s integration strategy, most recently outlined in Integration Matters (Home Office, 2005). This strategy largely focuses on increased access to services and support that will enhance the integration of refugees into society. At a regional level, the Greater London Authority’s 2007 draft Strategy for Refugee Integration in London makes specific reference to disabled asylum seekers and refugees, and highlights the need to pilot employment training programmes targeted at more isolated groups such as refugee women with children, older refugees and disabled refugees. The children’s section of the strategy calls for actions to increase understanding of the specific issues facing disabled children. The strategy further suggests that partnerships and specialisation could not only increase RCOs’ capacity to provide the culturally sensitive services they are set up for, but also reduce the competition between RCOs for limited funds. More specifically, the GLA sees a role for RCOs in developing more appropriate mental health services for refugees, notably by working with mainstream and second-tier organisations on service delivery.

Disabled people
The Disability Discrimination Act (DDA), originally passed in 1995, aims to end the discrimination and prejudice which many disabled people and people with long term health conditions face in their everyday lives. The DDA is currently enforced by the Equality and Human Rights Commission, a non-departmental public body established under the Equality Act 2006. The Commission’s work on disability is led by a Disability Committee which has decision-making powers in relation to those matters which solely concern disability.

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2 NASS no longer exists as such but its functions are carried out by the newly created UK Border Agency.
The 2005 version of the DDA made important changes to the scope of the original legislation, and defines disability as when a person has “a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities.” Changes to the earlier act include:

- creating a legal duty for public authorities to actively promote disability equality;
- broadening the DDA to cover people with ‘progressive conditions’ such as Multiple Sclerosis, HIV or cancer from the point of diagnosis, rather than from the point when the condition has some adverse effect on their ability to carry out normal day-to-day activities;
- removal of the requirement that a mental illness must be ‘clinically well recognised’ before it can count as an impairment, thereby bringing DDA coverage for people with mental illnesses into line with coverage for all other mental and physical impairments.

In March 2008, the Office for Disability Issues released a five-year cross-departmental Independent Living Strategy (ODI 2008). The strategy made concrete proposals to implement the findings of the policy document Improving the Life Chances of Disabled People (PMSU 2005). One such proposal is to promote independent living by offering a personalised choice of services and benefits in the form of cash or direct provision. The initial policy document made the distinction between a disability and impairment or ill health, defining disability as:

‘disadvantage experienced by an individual…resulting from barriers to independent living or educational, employment or other opportunities…that impact on people with impairments and/or ill health’ (ibid).

Advocacy groups largely welcomed the 2005 document and the above ‘social model’ definition of disability, but have been more critical of the latest strategy, with some arguing that it will not lead to the kind of radical reform required due to a lack of necessary legislative change (RADAR 2008). Others have argued strongly that government commitment to independent living and free choice is seriously undermined by the current system of charging for adult social care services. Unless charging policies are reviewed, the strategy will increase the likelihood of disabled people living in poverty (Coalition on Charging 2008).

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5 A cross-governmental office set up on the recommendation of the Prime Minister's Strategy Unit report 'Improving the Life Chances of Disabled People' (PMSU 2005) in order to coordinate work on disabled issues across government departments.
6 Direct payments are local council payments for people who have been assessed as needing help from social services, and who would like to arrange and pay for their own care and support services instead of receiving them directly from the local council.

Direct payment and individual budgets are part of a broader government-led agenda known as ‘personalisation.’ Set out in ‘Putting People First – A shared vision and commitment to the transformation of Adult Social Care’ (HM Government 2007), the strategy calls for joint working between local statutory, voluntary and private sector organisations and greater emphasis on individual and families as experts in decision-making about care. Personalisation is promoted as being the future ‘cornerstone of public services...... every person who receives support... will have choice and control over the shape of that support in all care settings.’ 7

In London, the Disability Equality Scheme, designed by the Greater London Authority (GLA) and sponsored by Department for Work and Pensions, aims to ‘put equality for disabled and Deaf people at the centre of its work when forming a policy or strategy, providing a service, or employing people’ and to ‘remove barriers preventing disabled and Deaf Londoners from being equal citizens.’ (Mayor of London 2006, p.8) An assessment of this scheme noted that although progress in implementing equality strategies and assessments had been made, gaps in knowledge continued to affect appropriate service provision (ibid).

2.2 Legal entitlements

Disabled refugees, disabled asylum seekers with an outstanding claim, and asylum seekers that have been refused (and exhausted all appeal rights) have different entitlements when it comes to welfare benefits and community care services.

Refugees

Individuals who have claimed asylum and have been awarded Indefinite Leave to Remain (ILR) in the UK or five years limited leave to remain as a refugee8 are entitled to the same social and welfare benefits and services as British residents. 9 This includes free primary medical care and medical services provided by the National Health Service (NHS).

Those who are unable to work can claim either Income Support or Incapacity Benefit, although these may be withdrawn over the next few years under new government proposals.10 Other relevant welfare benefits are Disability Living Allowance [DLA] for those aged 65 and under; Attendance Allowance [AA] for

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7 Department of Health website, An Introduction to Personalisation http://www.dh.gov.uk/en/SocialCare/Socialcarereform/Personalisation/DH_080573
8 After September 2005 individuals awarded refugee status were no longer granted indefinite leave to remain in the country. Refugees are now granted a limited period of five years leave to remain (Humanitarian Leave) after which their cases will be reviewed to determine whether or not they are still in need of protection.
9 Individuals with Discretionary Leave are also eligible for welfare benefits and NHS medical care.
10 A new government green paper, ‘No-one written off: reforming welfare to reward responsibility,’ proposes to replace Incapacity Benefit and Income Support for those who have a medical condition which prevents them from working with a new Employment and Support Allowance by 2013 (DWP 2008)
the over-65s, and Carer’s Allowance. Individuals may be awarded DLA or AA if they ‘have a physical or mental disability or both’ and if the disability is severe enough ‘to need help caring for yourself’.  

There are two components to DLA and AA: mobility and personal care. Individuals are assessed on the level of care they require in both these aspects. Carer’s Allowance can be claimed by someone caring for a disabled adult or child for at least 35 hours a week if they have been awarded DLA or AA with the middle or highest rate care component.

Under section 47 of the National Health Service and Community Care Act (1990) refugees are able to request a community care assessment by the social services department of their local authority. The social services department is required to ‘carry out an assessment for anyone who appears to need a community care service because they are, for example, elderly, disabled or suffering from a physical or mental illness’. Services that may be provided as a result of a community care assessment include: a place in a care home, home care services, home helps, adaptations to the home, meals and recreational and occupational activities.

**Asylum seekers**

As a result of the 1999 Immigration and Asylum Act, asylum seekers are not eligible to apply for welfare benefits. They can request a community care assessment from the relevant local authority, but must demonstrate that they have a need for services which is caused by something other than the lack of accommodation and financial support. This is known as being ‘destitute plus’. Under section 21 of the National Assistance Act 1948 asylum seekers are entitled to be accommodated by the local authority if they are found to be destitute and have community care needs. When assessing a case for destitution under section 21 the local authority must ignore any asylum support that may be available from UKBA (United Kingdom Border Agency). As a result, if an asylum seeker is identified as having community care needs, then it is the responsibility of the local authority to accommodate and support them as well.

What constitutes a need for ‘care and attention’ beyond destitution has also been considered by the courts, and the House of Lords has ruled that to be in need of care and attention a person must need someone to look after them and do things for them which they ‘cannot or should not be expected to do’.

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13 [http://www.adviceguide.org.uk/index/family_parent/family/community_care.htm](http://www.adviceguide.org.uk/index/family_parent/family/community_care.htm)
15 [http://www.parliament.the-stationery-office.co.uk/pa/ld200708/ldjudgmt/jd080730/rmfc-1.htm](http://www.parliament.the-stationery-office.co.uk/pa/ld200708/ldjudgmt/jd080730/rmfc-1.htm)
If this is not found to be the case then it is UKBA that is responsible for an asylum seeker and not the local authority.

Asylum seekers with potential care needs can be referred by UKBA to the relevant local authority for an assessment. Many are also referred by solicitors, refugee community organisations, advice services, refugee support organisations and other services. They can also refer themselves. In practice, there are often disputes between the Home Office and local authorities in terms of who is responsible for asylum seekers with community care needs.

As with refugees, asylum seekers are entitled to free primary medical care and medical services provided by the National Health Service (NHS).

Refused asylum seekers
The situation for asylum seekers who have care needs but whose case has been refused (including all appeals) is more complicated. Schedule 3 of the Nationality Immigration and Asylum Act 2002 prevents local authorities from providing support under section 21 of the National Assistance Act to failed asylum seekers who refuse to co-operate with removal directions\(^{17}\) or who fail to take reasonable steps to leave the UK.\(^{18}\) However, Schedule 3 only relates to individuals who made their application for asylum in-country, not those who applied ‘at port’ (an airport, train station or ferry terminal on their arrival in the UK). As a result, ‘at port’ asylum seekers whose claim has been refused, but who have been assessed as having care needs, are not excluded from accommodation and support under section 21. In contrast, ‘in-country’ asylum seekers, whose claim has been refused, are considered to be unlawfully in the UK and fall under the restrictions to support detailed by Schedule 3.

The only situation in which ‘in country’ asylum seekers who have been refused asylum can access support under section 21 is when the withholding or withdrawing of support would constitute a breach of the person’s Human Rights. However, the threshold for such a breach is very high, as demonstrated by the case of \(N\) (FC) v SSHD (2005) UKHL 31.\(^{19}\)

Since 2004 asylum seekers whose claims have been turned down have had to pay for certain NHS services which they previously received free of charge. At the same time a number of services remain free of charge to refused asylum seekers, including primary care services; treatment at an accident and emergency or casualty department; treatment of specific communicable diseases; compulsory psychiatric treatment, and treatment of sexually transmitted diseases (although in relation to HIV this only extends to an initial test and any associated counselling). The charging regulations mean that refused asylum seekers are now liable for hospital charges and are no longer entitled to free NHS routine hospital treatment (ICAR 2007).

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18 This category was added by the Asylum and immigration (Treatment of Claimants, etc) Act 2004
19 [http://www.parliament.the-stationery-office.co.uk/pa/ld200405/ldjudgmt/jd050505/home-1.htm](http://www.parliament.the-stationery-office.co.uk/pa/ld200405/ldjudgmt/jd050505/home-1.htm)
However, Department of Health guidance discourages GP surgeries from registering refused asylum seekers - although they have the discretion to accept them if they wish - and the government has recently threatened to withdraw the right to free GP treatment from refused asylum seekers altogether. The plans are based on claims that free primary care encourages asylum seekers and other migrants to come to the UK (so-called 'health tourism'). However, following pressure from GPs arguing that the move would be unethical and potentially illegal, and reports that refute any evidence of health tourism (National Aids Trust 2008), recent commentary suggests the government will scrap these plans.

2.3 Existing research

Only a limited amount of research has been carried out specifically on disabled people who are refugees or seeking asylum in the UK. Consequently, little is known about this population in terms of their experiences, needs and ability to access services. In contrast, a substantial amount of research has been conducted on mental health issues in relation to refugees and asylum seekers and to date more is known about this aspect of disability.

Refugees, asylum seekers and disability

The main piece of work on disabilities amongst refugee and asylum-seeking communities was carried out between 1999 and 2002. It focussed on a number of aspects, including the numbers and social characteristics of disabled refugees and asylum seekers in Britain; their needs and experiences; the experiences of service providers; and the impact of changes in social welfare entitlements (Robert and Harris 2002a). The research used quantitative and qualitative techniques to estimate the size of this population and explore its needs and experiences. Various publications emanated from this work (Roberts 2000; Roberts and Harris 2001; Roberts and Harris 2002b; Harris 2003), the key findings of which can be summarised as:

- disabled and asylum seeker entitlements to social welfare services are complicated, resulting in confusion amongst service providers;
- there is a lack of accurate demographic data on disabled refugees and asylum seekers, but preliminary investigations demonstrate that there are thousands resident in the UK and considerable diversity within the population in terms of social characteristics;
- there are a number of barriers preventing disabled refugees and asylum seekers from accessing services, including linguistic difficulties, mobility issues, cultural issues and lack of knowledge; and

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20 Joint Committee on Human Rights (March 2007) The treatment of asylum seekers, Tenth report of session 2006-7
21 http://www.guardian.co.uk/society/2008/oct/12/nhs-health
• there are high levels of unmet need amongst this population in areas such as social contact, personal care, communication and support with parenting.

A much smaller scale research project took place in 2006 involving interviews with nine disabled refugees in the London borough of Islington in order to explore their experiences of accessing and using primary care services (Disability Action in Islington 2006). This research followed a consultation event in 2005 which looked at the needs of older disabled refugees in relation to health services in Islington (Tansley 2005). One of the main findings of this work was that communication plays a major role in the accessibility of services and that the language and interpreting services in the borough are inconsistent. Other barriers identified by the researchers include knowledge about entitlements to services as well as physical access.

Minority ethnic groups and disability
Research has also been carried out on disabled people from BAME (Black, Asian and Minority Ethnic) groups in the UK, and many of the issues arising from this work have relevance to disabled refugees and asylum seekers. Some of the main themes in the literature are the lack of facilities for non-English speaking clients; the prevalence of the stereotype of ‘caring extended families’ in order to justify limited services; and the use of ‘low numbers’ to justify the ‘marginalisation of need’ (Ahmad 2000). It has also been found that minority ethnic parents with disabled children are likely to be poorer than the general population and hence less able to access service provision (Chamba et al. 1999).

Some work has highlighted the negative and stigmatizing attitudes towards disabilities that can be found in various belief systems and cultures (Croot et al. 2008). However, other authors have also been keen to emphasise the parallels in negative attitudes held by the mainstream population (Ahmad 2000) and the sometimes mistaken assumption that it is always culture that determines negative attitudes towards disability rather than ‘circumstantial or contextual factors such as a relative ignorance of disability and its implications, and a lack of confidence in negotiating their lives in a wider society’ (Ali et al. 2006). One study amongst Pakistani and Bangladeshi families found attitudes towards their children’s impairments to be complex and varied and that low levels of service provision had more to do with institutional racism than with the attitudes of the parents (Bywaters et al. 2003).

Other studies have explored the complex factors behind the higher incidence of certain types of impairments and medical conditions amongst minority ethnic groups by looking at intersecting and compounding issues such as deprivation, low service take-up, knowledge and education, class, genetic predisposition, culture and lifestyle (Johnson and Scase 2000). Emphasis has also been placed on the great diversity that exists within the ‘ethnic minority category’ and the implications that these differences can have for appropriate service delivery in terms of language and culture. It has been observed that there are some instances where the differences between men and women
can be more acute than the differences between ethnic groups. One example of the potential commonalities across gender is the cultural restrictions that some disabled women from minority ethnic groups may face (Chahal 2004).

Finally, another theme in the literature is the inherent difficulty in disentangling different forms of discrimination and disadvantage and whether negative attitudes in any given situation result from racism, disabilism, a complex combination of the two or one disguised as the other (Ali et al. 2006). In addition to the research summarised above there is also a huge amount of literature that focuses on the barriers faced when accessing services by disabled people (Swain et al. 2003), minority ethnic groups (Smaje 1995; Hopkins and Bahl 1993; Arai and Harding 2002), and migrants (Arai 2005). However, the focus of this overview has been on the intersections between disability and refugees or BAME groups.

Refugees, asylum seekers and mental health
Literature on the mental health needs of refugees and asylum seekers highlights the high levels of mental distress amongst this population (Tribe 2002). The potentially negative impact that the different stages of the migratory process can have on mental health are also identified. These stages not only include experiences in the country of origin but also during the migratory journey and after arrival in the UK (Van de Veer 1998). Traumatic experiences such as torture, war and rape can all have a significantly detrimental effect on mental health (Loutan 1998). Forced migrants can also face difficult and long journeys before arriving in the UK and then a plethora of problems once in exile, such as communication and cultural difficulties; a complex asylum process; anxiety about their immigration status; and isolation (Raj and Reading 2002 and Burnett and Peel 2001).

Whilst recognising the psychological difficulties that many refugees and asylum seekers face, it has been observed that there is ‘no such thing as a uniform response to highly stressful events’ (Summerfield 2000). Some authors have observed the general tendency for stress to be over-medicalised and interpreted as trauma when ‘symptoms’ such as the lack of concentration and social withdrawal are normal reactions to traumatic experiences rather than symptoms of psychiatric disorder (Harris and Maxwell 2000). A major theme of the research on refugees and mental health is the potential inappropriateness of Western concepts of mental health when applied to refugee and asylum-seeking populations (Keating et al. 2003). Post-Traumatic Stress Disorder has been highlighted as a particularly controversial diagnosis (Summerfield 2001) and it has been argued that mental health providers need to take into consideration the cultural context of mental health difficulties amongst refugee and asylum-seeking clients.

In common with much of the research already mentioned, literature on mental health provision for asylum seekers and refugees emphasises barriers to accessing services such as the lack of qualified and appropriate interpreters (Raj and Reading 2002); fear of stigma or negative reactions (Li et al. 1999; Gabriel and Ritchie 2000); culturally inappropriate services (Watters 2001) and lack of knowledge (Keating et al. 2003). High levels of unmet need have
been identified amongst refugees and asylum seekers with mental health difficulties in areas such as housing, finances, and social contact (McColl and Jackson 2006). It has also been argued that there are not enough NHS staff equipped to assess and meet these needs (Keating 2003 et al).

Some commentators have argued that mental health providers need to work holistically with asylum seekers and refugees as therapy is unlikely to be effective if their additional needs are not addressed (Watters 2001). Addressing these needs is likely to involve the provision of advice on housing and welfare issues, advocacy work and social activities (Harris and Maxwell 2000; Watters 2001). Finally, it has been observed that because of the particularly sensitive nature of mental health issues there is not only a need for good interpreters but also bicultural therapists who are able to both speak the same language and bring a cultural understanding to their work (Raj and Reading 2002). However, it has also been observed that resources are unlikely to accommodate this need (Raj and Reading 2002) and that the use of bicultural therapists does not necessarily mean that a service is culturally sensitive, because inappropriate interventions may still be used (Watters 2001).

The role of RCOs
RCOs are described in the literature as being fundamental to the refugee integration process, particularly in relation to new arrivals. Historically they have provided not only reception services such as housing and welfare advice, but also a sense of belonging and the space and contacts for individuals and groups to rebuild community life and strengthen their sense of ethnic or national identity (Hopkins, 2006; Griffiths et al, 2005; Zetter and Pearl, 2000).

RCOs are also seen as characterised by organisational precariousness. This insecurity is thought to be due to a number of interrelated factors. One of these factors is a competitive funding environment, in which small RCOs are not only disadvantaged in comparison with larger organisations better equipped to bid for service contracts, but are also in direct competition with many other RCOs who are contending for the same funds. Another factor is a lack of professional staff competent in fundraising, reporting, policy advocacy and understanding UK voluntary sector systems and structures, often compounded by language difficulties. Thirdly, there is a lack of coordination and collaboration in an environment which increasingly rewards clusters and mergers (Harrow and Bogdanova, 2006). A final factor to be considered is the in-fighting and factionalism amongst and between refugee groups (Griffiths, 2000; Griffiths et al, 2005; Zetter and Pearl, 2000).

These shortcomings are put into context by Zetter and Pearl (2000) and Griffiths et al (2005), who argue that institutional and structural determinants, reinforced by a series of recent laws and policies such as the Asylum and Immigration Act of 1999, have led to a fragmented and marginalised RCO sector. The authors argue that RCOs have sprung up due to the inadequacy of existing services to meet potential needs or for psychological benefits derived from populations sharing the same origins or refugee experiences.
The marginalisation of RCOs will continue, they contend, as an increasingly restrictive policy environment and exclusion from benefits and resources reinforces their position as ‘reactive providers of a safety net’ (Zetter and Pearl 2000, p.694).

Examining approaches to strengthening the role of RCOs in local social care services, Cambridge and Williams (2004) emphasise the importance of developing positive links with professional mainstream services, such as social services, health services and local councils. For RCO self-advocacy to occur, however, the authors call for refugee support advocates to hand over power and redirect resources to refugee communities themselves, building on emerging self-help networks and assisting those groups to marshal resources from within. A similar point is made by Hinton (2001) in a study of a health project for refugees and asylum seekers in south London. This found that the ability of RCOs to be proactive on health issues depended on working links with the health authority.
3. Research methodology

The research was split into two stages: a review of relevant policy and legislation and academic literature, followed by a series of stakeholder interviews. In the first stage, the policy and legal review aims to give broad background and context to the study, whilst the literature review scopes existing evidence on asylum seekers, refugee and disability in order to identify themes for the interviews and to guide analysis. The second stage used qualitative research to explore the support given by the full range of service providers, and the lived experiences of disabled refugees and asylum seekers.

Literature was identified from existing resources at the Information Centre about Asylum and Refugees (ICAR), especially its ‘Researching Asylum in London’ database; key social science databases; relevant websites on refugee issues and agencies working with refugees; charitable trust websites; policy documents accessed through the Home Office and Department of Communities and Local Government websites; and the research databases of key academic institutions. While this analysis has sought to give policy, legal and academic overviews, it was beyond the scope of the research to undergo a systematic review of all related literature in the field.

The qualitative research stage was split into three phases.

Phase one
The aim of the first phase was to explore the scale and nature of support provided by various organisations to disabled refugees and asylum seekers in London. Fifty one short telephone interviews were conducted with members of staff responsible for service provision in each organisation. The following types of organisations were interviewed. The number of organisations interviewed are given in brackets:

- Refugee community organisations (RCOs) (15)
- Refugee support organisations (10)
- Mainstream disability organisations (15)
- BAME disability organisations (3)
- Citizens Advice Bureaux (7)
- Solicitors (1).

The specific objectives were to ascertain which organisations provide services to this population, the number of disabled refugee and asylum-seeking clients seen by the organisations and, if relevant, reasons why they do not have disabled refugees and asylum seekers on their caseload.

In large organisations made up of a number of local, semi-autonomous branches, one branch was contacted rather than the head office. Short

22 A list of organisations contacted is given in Chapter Five
telephone interviews were considered the most efficient means of obtaining information from individuals who are likely to be very busy.

**Phase two**
In the second phase of the project, in-depth, semi-structured interviews were carried out with representatives from 19 organisations about their work with refugees and asylum seekers. These organisations were selected from, or based on information from, those participating in the first phase. The breakdown by type and number of these organisations is as follows:

- Refugee community organisations (RCOs) (5)
- Refugee support organisations (4)
- Mainstream disability organisations (3)
- BAME disability organisations (1)
- Solicitors specialising in welfare, asylum support and housing law (2)
- Local authority departments working on adult social care (3)
- Complex Casework Team member at the Home Office.23 (1)

Interviewees were questioned about their work, the needs of disabled refugees and asylum seekers and the role of RCOs in the provision of support for this population.

All interviews were transcribed and analysed using the qualitative software ‘NVivo’.24 Details of data gathered from these phases are given in Chapter Four.

**Phase three**
The last phase of the research consisted of 21 in-depth semi-structured interviews with disabled refugees and asylum seekers. A demographic breakdown is given in Table 2, Chapter Five. Interviewees were recruited from ten different organisations in order to prevent over-reliance on one source. As the interviews were in part designed to critically evaluate interviewee experiences of RCO support, it was important to ensure that not all of the interviewees were recruited through them to avoid a conflict of interest. Accordingly, referrals were obtained from disability organisations and housing organisations as well as RCOs.

In terms of the profile of the sample, researchers aimed to interview refugees, asylum seekers and asylum seekers whose claim had been refused, with a

23 The Complex Casework Team (CCT) is part of the United Kingdom Border Agency at the Home Office and deals with applications for support from asylum seekers that have needs in addition to accommodation and finances because of their disability or medical condition.

24 NVivo is a software programme for analysing qualitative data. The core principle of this sort of software is to select passages of text and then apply conceptual labels called 'codes' to the selection - known as 'coding'
range of physical and sensory impairments. The sample included 11 men and 10 women, ranging between the ages of 25 and 77. The interview questions explored a number of issues including experiences of statutory services, RCOs and other organisations; the impact of their disability on their daily life, and unmet needs. All interviews were transcribed and analysed using the qualitative software ‘NVivo’.

Interviews were conducted in English or, where required, with the use of trained interpreters. Certified British Sign Language interpreters were provided for individuals with hearing impairments. Research participants were offered a cash payment of £20 to acknowledge the time they gave to the project. Interviews were conducted wherever interviewees felt most comfortable - some in homes, some in the offices of various organisations.

Definitions of disability
During phase one it quickly became apparent that different organisations and individuals have very different understandings of the term ‘disability’. This made it challenging when attempting to collect data on the number of disabled refugees and asylum seekers seen by each organisation.

It was not felt appropriate to give a completely closed definition of disability or to rely too heavily on the ‘medical model’ - which emphasises impairments as the basis of disability – as opposed to the ‘social model’, which highlights the social and environmental barriers that prevent disabled people from playing an equal role in society. Nevertheless, because it is important for the data to be comparable two guidelines were given.

The first guideline was that the researchers understood disability to cover not only physical impairments but other impairments such as mental health, learning difficulties, brain injury, autistic spectrum disorder and sensory impairments. The second guideline related to the impact of impairment on daily life which, for the purposes of data-collection, should be ‘significant’. It could also relate to the negative attitudes of others in relation to disability. Nevertheless, despite these general guidelines it is likely that different organisations and individuals interpreted the term disability in very different ways. This is a very important point since this difference is reflected in their estimates and the way in which disability is recorded on databases.

Research parameters
Individuals with mental health problems or learning difficulties were not included in the sample for the third phase of the research. As this was a small scale research project, clear parameters needed to be made regarding the sample. Preliminary literature searches identified a comparatively large amount of primary research on mental health in relation to refugees and asylum seekers. It was felt important to concentrate on gaps in research by concentrating on issues that have been under-researched such as physical

25 Please see the sample detailed in Chapter 5.
and sensory impairments. However, where issues relating to mental health or learning difficulties were raised by interviewees, they are reflected in the findings. Children and young people under the age of 18 were not included in the study.
4. Relevant data

The lack of available statistics on disabled refugees and asylum seekers has been identified in previous research (Roberts and Harris 2002). There are a number of reasons why there is such an incomplete picture.

1. The Home Office does not publish official data for the number of disabled asylum seekers in the UK.
2. The Department for Work and Pensions does not record how many refugees are claiming Disability Living Allowance.
3. Local authorities appear not to record the number of refugees to whom they provide disability support.
4. Disability organisations do not tend to collect data on the number of refugees and asylum seekers using their services.
5. Refugee organisations and RCOs do not tend to collect data on the number of disabled clients or the nature of their impairments.
6. Organisations and agencies use different methods and definitions of disability for the purposes of data collection and this makes comparison difficult. Some capture data on the basis of self-definition whilst others use a set of criteria such as that set out in the 1995 Disability Discrimination Act.

Available data

There are three types of statistics relating to the number of disabled refugees and asylum seekers in the UK, as discussed below:

1. Research projects that estimate the number of disabled refugees and asylum seekers in the UK.
2. Local authority records on the number of asylum seekers they are supporting.
3. Data held by the Complex Casework Team at the United Kingdom Border Agency (UKBA).

Relevant research on data collection

Some attempts have been made to estimate the number of disabled refugees and asylum seekers in the UK. In 1995 a Home Office study found that ten percent of the 263 refugees (and individuals with Exceptional Leave to Remain) included in the research had a type of disability that impacted on their daily life (Carey-Wood et al. 1995).

One of the aims of the Roberts and Harris research on disabled refugees and asylum seekers in Britain was to investigate the numbers and social characteristics of this population. Part of this work involved producing a ‘minimum estimate’ of numbers by distributing a ‘screening questionnaire’ to 300 disability and refugee community groups in the UK. A total of 99 organisations responded; 44 of which reported contact with 5,312 disabled refugees and asylum seekers (Roberts and Harris 2001).
Other research has looked at the incidence of disability amongst particular populations. A Home Office study focusing on Vietnamese refugees estimated that three per cent were either disabled or ‘chronically sick’ (Duke and Marshall 1995). Research carried out in Camden and Islington found that 10 percent of the respondents from the Horn of Africa had some form of long term illness or disability (Bariso 1997).

Attempts have also been made, using a variety of methods, to estimate the prevalence of mental health problems in various refugee and asylum-seeking populations. Although the focus of this work is not disability per se, there are obvious overlaps. An example of this work is a 2003 study which surveyed 843 Kosovan Albanians in the UK in order to estimate the prevalence of Post Traumatic Stress Disorder (PTSD) and depression. It was found that just under half the group surveyed had a diagnosis of PTSD and less than one-fifth had a major depressive disorder (Turner et al. 2003).

**Local authority data**

Each local authority should be able to access data on the number of asylum seekers they are providing support and services to as a result of a community care assessment. However, this study has found that this data does not appear to be automatically compiled and published. Of three inner London local authorities contacted for this research, only one was able to provide data for the number of asylum seekers they are supporting. In this case the local authority reported 35 cases of asylum seekers across Adult and Social Care and the Community Mental Health Trust (with whom they work in partnership). Most of these cases were thought to be asylum seekers that have had their asylum cases refused. The local authority had also been referred two cases by UKBA.

**UKBA / Home Office**

The Complex Casework Team (CCT) at the UK Borders Agency was also asked for data on their caseload. The CCT liaises with clinicians and local authorities about issues relating to medical conditions and disabilities, and has a nation-wide remit. Asylum seekers with potential needs beyond destitution are referred to the relevant Social Services by the CCT for a community care assessment. If they meet the criteria they are supported by Social Services. If they do not, the in-house clinician (who is a GP) will look at the decision and give a second opinion. If it is decided that they do not meet the criteria then they are given only the standard accommodation and support package provided to all asylum seekers.

The CCT were able to provide figures from 4 January 2008 to 3 March 2008. During this period a total of 203 cases were referred to and accepted by local authorities around the country. This figure can be broken down into the following types of impairments and medical conditions: HIV (11); TB (12); operations (68 - this can include anything from heart bypasses to cataracts); mental health (77 – this covers various degrees of severity) and physical mobility (35). Obviously these figures are not just for disabled asylum seekers and what constitutes a disability will depend on individual and organisational definitions.
This overview of existing knowledge about the size of the disabled refugee and asylum-seeking population has demonstrated that knowledge is patchy and incomplete - something that can only be rectified by remedying the deficiencies detailed above and implementing systematic data collection.

Data obtained from this research
The main focus of this research project is the exploration of experiences and needs of disabled refugees and asylum seekers and the supporting role various service providers play. However, during the mapping stage the research team used the opportunity to gather data on the number of disabled asylum seekers and refugees that access the services of each organisation over a period of 12 months, so that it could add to the limited statistical picture that exists for this population.

It was found that most organisations advising and supporting disabled refugees and asylum seekers do not capture data on this group, either because they do not record immigration status or because they do not record impairments or disabilities. Very few organisations working with refugees and asylum seekers had a ‘disability marker’, and the ones who did used ‘self-definition’ as the criteria. In one case this was applied by caseworkers in a discretionary way. These discrepancies between data systems pose difficulties in analysis as the statistics are compiled using different criteria. Also, reliance on ‘self-definition’ means that individuals who either do not know they could qualify as disabled, or who do not want to be labelled as disabled, are not included in the data.

The data collected from organisations is overwhelmingly based on the guesswork of service managers, project workers and other staff working with disabled refugees and asylum seekers, and should only be taken as a very rough guide to the number of disabled refugees and asylum seekers they work with. In a few instances, the recording process means that numbers are based on ‘client contacts’ rather than individuals and so the same individual may be counted more than once.

Additional caveats need to be considered when looking at the charts which follow. Some of the organisations contacted were aware they had come into contact with refugees and asylum seekers but were not willing to provide an estimate without the accurate data. Organisations that provided a figure of ten or less have not been included in the graphs.
Number of disabled refugee and asylum seekers reported
[Less than 250]

RCO

Disability organisation

Refugee support organisation
Bearing in mind the caveats given, it is possible to report that 30 organisations (RCOs, disability organisations, refugee organisations and Citizens Advice Bureaux) indicated that they were in contact with a combined total of 11,992 disabled refugees and asylum seekers. This number is much higher than the figure of 5,312 previously reported in research which focussed on the whole of the UK (Robert and Harris 2001). The larger number is likely to reflect the fact that all of the places contacted are based in London where the organisations are much bigger and the number of refugees and asylum seekers has traditionally been much higher.
## 5. Sample details

**Table 1**

List of organisations interviewed in Phases One and Two

<table>
<thead>
<tr>
<th>Refugee Community Organisations (RCOs)</th>
<th>Mainstream disability organisations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chinese Information Advice Centre</td>
<td>Autism London</td>
</tr>
<tr>
<td>Indoamerican Refugee and Migrant</td>
<td>DIAL Waltham Forest</td>
</tr>
<tr>
<td>Organisation</td>
<td>Disability Advocacy Network</td>
</tr>
<tr>
<td>Iranian Association</td>
<td>Disability Law Service</td>
</tr>
<tr>
<td>Iranian Community Centre</td>
<td>Elfrida Society</td>
</tr>
<tr>
<td>Iraqi Welfare Association</td>
<td>Headway</td>
</tr>
<tr>
<td>Kurdish Advice Centre</td>
<td>Leonard Cheshire</td>
</tr>
<tr>
<td>Kurdish Association</td>
<td>Mencap</td>
</tr>
<tr>
<td>Latin American Women’s Rights Service</td>
<td>Mind</td>
</tr>
<tr>
<td>South London Tamil Welfare Group</td>
<td>Polio Fellowship</td>
</tr>
<tr>
<td></td>
<td>Royal Association for Deaf People</td>
</tr>
<tr>
<td></td>
<td>Royal National Institute for the Blind</td>
</tr>
<tr>
<td></td>
<td>Royal National Institute for the Deaf</td>
</tr>
<tr>
<td></td>
<td>Scope</td>
</tr>
<tr>
<td></td>
<td>Winvisible</td>
</tr>
</tbody>
</table>

**RCOs providing specialist disability support**

- Derman
- Ethiopian Health Support Association
- Kurdish Disability Organisation
- Latin American Disabled People’s Project
- Somali Refugee Action Group
- Vietnamese Mental Health Service

**Refugee support organisations**

- Refugee Support / Metropolitan Support Trust
- Croydon Refugee Project
- Manor Gardens Advocacy Project
- Medical Foundation for the Care of Victims of Torture
- Medicin du Monde
- Migrant and Refugee Communities Forum
- Oxford House
- Praxis
- Refugee Council
- Southwark Refugee Project
- St Pancras Refugee Centre

**BAME disability organisations**

- Anika Patrice
- Newham Ethnic Minority Disability Alliance
- Organisation of Blind Africans and Caribbeans

**Citizens Advice Bureaux**

- Camden
- Hammersmith and Fulham
- Haringey
- Hillingdon
- Hounslow
- South Kilburn
- Walthamstow

**Solicitors**

- Hammersmith and Fulham Law Centre
- Pierce Glynn

**Statutory Organisations**

- Brent Social Services
- Camden Social Services
- Lambeth Social Services
- UK Border Agency
Table 2
Breakdown of disability, age, gender, nationality and status of interviewees in Phase Three

<table>
<thead>
<tr>
<th></th>
<th>Disability</th>
<th>Age</th>
<th>Gender</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Mobility</td>
<td>37</td>
<td>F</td>
<td>Asylum seeker</td>
</tr>
<tr>
<td>2.</td>
<td>Blind</td>
<td>43</td>
<td>F</td>
<td>Asylum seeker</td>
</tr>
<tr>
<td>3.</td>
<td>Deaf</td>
<td>52</td>
<td>M</td>
<td>Asylum seeker</td>
</tr>
<tr>
<td>4.</td>
<td>Mobility</td>
<td>62</td>
<td>M</td>
<td>Asylum seeker</td>
</tr>
<tr>
<td>5.</td>
<td>Mobility</td>
<td>27</td>
<td>F</td>
<td>Refused asylum seeker</td>
</tr>
<tr>
<td>6.</td>
<td>Mobility</td>
<td>44</td>
<td>M</td>
<td>Refused asylum seeker</td>
</tr>
<tr>
<td>7.</td>
<td>Mobility</td>
<td>47</td>
<td>F</td>
<td>Refused asylum seeker (ILR as a result of 7 year rule)</td>
</tr>
<tr>
<td>8.</td>
<td>Mobility</td>
<td>25</td>
<td>M</td>
<td>Refugee</td>
</tr>
<tr>
<td>9.</td>
<td>Mobility</td>
<td>29</td>
<td>F</td>
<td>Refugee</td>
</tr>
<tr>
<td>10.</td>
<td>Deaf</td>
<td>32</td>
<td>F</td>
<td>Refugee</td>
</tr>
<tr>
<td>11.</td>
<td>Mobility/memory loss</td>
<td>38</td>
<td>M</td>
<td>Refugee</td>
</tr>
<tr>
<td>12.</td>
<td>Blind</td>
<td>38</td>
<td>M</td>
<td>Refugee</td>
</tr>
<tr>
<td>13.</td>
<td>Mobility</td>
<td>42</td>
<td>F</td>
<td>Refugee</td>
</tr>
<tr>
<td>14.</td>
<td>Hard of hearing</td>
<td>42</td>
<td>M</td>
<td>Refugee</td>
</tr>
<tr>
<td>15.</td>
<td>Mobility</td>
<td>43</td>
<td>F</td>
<td>Refugee</td>
</tr>
<tr>
<td>16.</td>
<td>Mobility/visually impaired</td>
<td>46</td>
<td>F</td>
<td>Refugee</td>
</tr>
<tr>
<td>17.</td>
<td>Mobility</td>
<td>51</td>
<td>M</td>
<td>Refugee</td>
</tr>
<tr>
<td>18.</td>
<td>Mobility</td>
<td>52</td>
<td>F</td>
<td>Refugee</td>
</tr>
<tr>
<td>19.</td>
<td>Mobility (polio)</td>
<td>58</td>
<td>M</td>
<td>Refugee</td>
</tr>
<tr>
<td>20.</td>
<td>Mobility</td>
<td>70</td>
<td>M</td>
<td>Refugee</td>
</tr>
<tr>
<td>21.</td>
<td>Mobility</td>
<td>77</td>
<td>M</td>
<td>Refugee</td>
</tr>
</tbody>
</table>

**Nationality:** Interviewees were from Zimbabwe, Iraq, Sri Lanka, Iran, Ecuador, Sudan, Eritrea, Somalia, Ethiopia, the Lebanon, and Palestine. To ensure anonymity of participants nationalities have not been included in the table.
6. Findings

This chapter has been divided into themes which reflect the findings of the research. These look at the nature and extent of work being carried out by the different organisations interviewed; the support role played by RCOs, friends, families and communities; the experiences of accessing disability services and support as reported by disabled asylum seekers and refugees and the people that work with them; and barriers faced by this population when trying to access support.

The seven themes are:
- Organisations supporting disabled asylum seekers and refugees
- The role of refugee community organisations
- The role of family, friends and ‘communities’
- Experiences of statutory services
- Experiences of the asylum process
- Experiences of mainstream disability organisations
- Barriers to access

6.1 Organisations supporting disabled asylum seekers and refugees.
Who is doing what?

The following findings are drawn from the first phase of the research.

Disability organisations

Very few of the mainstream disability organisations contacted work with disabled refugees and asylum seekers. Interviewers spoke to a broad range of organisations, both in terms of the focus of their work and their size. Most of the large national disability organisations that focus on particular impairments were approached by the team, but interviewers also spoke to smaller disabled people’s organisations that work on disability in general, organisations that target Black Asian and Minority Ethnic (BAME) populations and impairment-specific groups that serve the London region or particular boroughs.

Of the 18 organisations approached only one has a project that focuses specifically on disabled refugees and asylum seekers, and this is a user-led organisation using a ‘self-help approach’. Another organisation has a project that trains deaf people from overseas in British Sign Language and provides coaching on life skills. Around 5-10% of the total caseload of 560 seen by this project each year are refugees and asylum seekers. One other disability organisation provides legal advice to disabled refugees and asylum seekers as part of their overall work and has a ‘significant number’ of Somali and Kurdish refugees and asylum seekers on their caseload. The three BAME disability organisations spoken to provide services that can be accessed by refugees and asylum seekers, who make up a small proportion - around 5% - of their caseload.

Three of the interviewees, from organisations differing significantly in size and focus, were aware they had come across ‘a few’ refugees and asylum
seekers, but indicated that this was incidental rather than a conscious focus of their work. Elsewhere, one local branch of a national organisation has around 10 refugees accessing their services every year. In these instances the proportion of refugees and asylum seekers was less than half a percent of overall caseloads. The remaining eight representatives of mainstream disability organisations had not knowingly come across any refugees and asylum seekers in their work.

When exploring the reasons why they did not work with more (or any) disabled refugees and asylum seekers, the most common response was that they simply did not receive many or any referrals. However, given that the organisations interviewed tend to collect data on the ethnicity of their clients rather than immigration status, it is possible that they are unknowingly working with at least some refugees and asylum seekers. This point was confirmed in later interviews with local authorities who indicated that they do not distinguish between refugees and other service users when referring individuals to disability organisations.

Interestingly, two representatives from disability organisations were under the impression that refugees and asylum seekers are not able to access their services. They reported that their services are funded by local authorities who are not legally entitled to assist refugees and asylum seekers. This is not the case for refugees (and not always the case for asylum seekers) but demonstrates a certain level of misunderstanding of the entitlements of this group. 26

For three mainstream disability organisations and one BAME disability organisation, immigration status was a criteria for accessing some services. This was due to the funding restrictions applied by the local authority or relevant Primary Care Trust (PCT). In these cases asylum seekers would not be able to access assistance from the organisation or a particular project unless the organisation had some unrestricted funding available.

Three organisations stated that refugees and asylum seekers did not constitute a ‘priority area of work’ - it had not been raised as an issue at policy level or their focus was on minority ethnic groups more generally. Two of them explained that they wanted to improve their accessibility with regards to ‘hard to reach groups’ such as asylum seekers and refugees and were currently looking at prioritising this area of work. Indeed there have been some notable initiatives by large, mainstream disability organisations to engage disabled refugees, such as the seminar organised by Royal National Institute for the Blind in 2000 (in conjunction with other organisations)27.

Another reason given by interviewees for the low levels of service take-up by refugees and asylum seekers was the other eligibility criteria in place. For example, one organisation requires clients to have been assessed by a

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26 For a discussion on entitlements see policy and legal chapter.
psychologist and given a ‘Personal Care Plan’. Another organisation requires individuals to have a diagnosis of polio from a doctor. In both cases the interviewees felt that asylum seekers and refugees may be less able than other groups to meet these criteria in the first place.

Finally, a representative of an organisation specialising in brain injury speculated that the low number of refugees and asylum seekers accessing their services may be due to a general lack of understanding about this condition, resulting in individuals being either misdiagnosed or left undiagnosed. He also felt that awareness about brain injury in the UK is low and is likely to be even lower in other cultures and countries. Consequently the types of organisations that refugees and asylum seekers come into contact with do not pick up on brain injury as an issue.

Refugee Community Organisations
A total of 15 Refugee Community Organisations were identified and interviewed during the first phase of the research. Six of them either provided a specialist service, such as counselling, or had a specific (mental) health and/or disability focus to their work, whilst the remaining nine provided more general services. Only one of the sample, a Chinese organisation, did not have any users or members that were disabled (including individuals with mental health issues).

The services provided include advocacy and interpreting (including accompaniment to appointments); advice and assistance with asylum support issues; applications for welfare benefits; representation at Department of Work and Pensions (DWP) tribunals, and referrals to social services for community care assessments. Some of the RCOs which provide specialist services also offer educational workshops to the different refugee communities on issues such as mental health or wellbeing. Others translated health information into community languages and one had an on-site counsellor. One RCO was commissioned by the local authority to provide homecare to physically disabled clients.

The nine RCOs that provided more general services ranged from those fulfilling a signposting and support role to others offering the kind of casework and advice described above. In addition, many organisations provided a social space where members of the same community could meet.

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28 See glossary for definition of Personal Care Plan.
Case study 1
The Kurdish Disability Organisation, founded in 1992 and based in north London, provides advice and support with immigration, health, housing, and educational issues to a client base of refugees and asylum seekers, the majority of whom are Iraqi Kurds. A high proportion of service users suffer with war-related disabilities, both physical and mental. One of the more unique services they provide is representing disabled clients at DWP tribunals. They have also published their own self-help manuals, such as a Kurdish-English dictionary with sample model letters to UK authorities. They are currently funded by the Community Fund, European Social Fund, and Work for All. The organisation currently has one paid member of staff. http://www.manorgardenscentre.org//projects/p_health

Defining disability
When contacting RCOs not specialising in health or disability, the research team noted that three such organisations initially understood the term ‘disability’ or ‘disabled’ as meaning individuals who had a physical impairment, and assumed that researchers wanted to talk about issues relating to physical access. One refugee organisation providing general advice and support, which declined to be interviewed due to time constraints, also indicated that the issue was not relevant to them because the building they operate from does not have wheelchair access and so ‘we do not see any disabled refugees or asylum seekers’. This example again illustrates a degree of confusion about the scope of the term ‘disability’ on the part of some RCOs.

Refugee support organisations
Ten organisations providing support and advice to refugees and asylum seekers were also identified and interviewed. Half of the groups provide specialist advice or services in relation to mental health, or health more generally. The other half provide general advice and support to refugees and asylum seekers. There was only one project with a specific focus on disabled users: a learning disabilities project working with ‘ethnic minorities’ which can only be accessed by refugees due to local authority funding restrictions. Nevertheless, work with disabled refugees and asylum seekers formed a substantial part of the services offered by the different refugee support organisations interviewed.

The range of services offered by refugee organisations is similar to the RCOs interviewed and included counselling and therapy; advocacy work and interpreting services; GP referrals, and casework and advice on welfare benefits, asylum support and housing. One organisation had a health screening service and another provided education workshops on all aspects of health for local RCOs. Another project was developing workshops for RCOs in order to educate them about learning disabilities.
Case study 2

The Manor Gardens Advocacy Project in north London aims to help refugees and newly arrived communities, largely from Africa and the Middle East, that face language barriers to access health services. It does so by training members of these communities as interpreters and bilingual health advocates. The Project sees approximately 150 disabled refugees and asylum seekers a year - around 40% of service users - and one of its chief aims is to provide bilingual advocacy to help deal with the complex health needs and difficulty accessing relevant services that they may face.

The Project also organises health workshops and other activities, based on the needs which different communities say they have e.g. stress management for Somali women. They also try and tackle some of the more taboo and difficult issues. The project has been operating since 1998 and currently has three paid staff and over thirty volunteers. Funding comes from Volunteering England, the City Parochial Foundation, and local PCTs.

Manor Gardens Centre, 6 - 9 Manor Gardens, London N7 6LA
http://www.manorgardenscentre.org/projects/p_health

Citizens Advice Bureaux

Seven Citizens Advice Bureaux were identified and interviewed. The services provided by the bureaux included immigration, housing and welfare benefits advice (particularly in relation to Disability Living Allowance). The bureaux that we spoke to were dealing with a surprisingly high number of disabled refugees and asylum seekers, although only one was able to give an estimate for the number of disabled refugees and asylum seekers they have seen in the last year (approximately 350). Of the rest, two estimated that disabled refugees and asylum seekers made up approximately 5 and 30% of their caseloads respectively; and one bureau had only one client that was either a refugee or asylum seeker. 29 The other three bureaux all indicated that they saw disabled refugees and asylum seekers but were unable to provide numbers or estimates for the proportion of their caseloads.

Referral routes

Of the 15 RCOs interviewed in phase one, only two indicated they had referred disabled clients to mainstream disability organisations. The examples given were the Royal National Institute for the Blind, MIND and MENCAP. When asked why they did not refer clients to disability organisations many responded that they had not heard of them. Others had not thought it was an option or indicated that language may be a problem. One organisation felt that mainstream organisations would not work with their asylum-seeking clients.

Mainstream disability organisations are not going to deal with asylum seekers because they don’t have immigration status.
They refer them to Social Services or to NASS (UKBA)
[RCO specialising in disability]

29 In contrast to the other Bureaux that provided more general advice, this Citizens Advice Bureau provides specific advice on debt for individuals who are blind, deaf, have learning disabilities, or care for a disabled child.
The RCOs interviewed are much more likely to refer their disabled clients to refugee support organisations, social services, solicitors or Citizen’s Advice Bureaux. This was confirmed by three of the Citizens Advice Bureaux interviewed, which had all received referrals of disabled refugees or asylum seekers from local RCOs.

**Type of impairments**
Mental health was the most common impairment by both RCOs and refugee organisations. The second most common impairment reported by both RCOs and refugee organisations were physical mobility problems as a result of illness or injury. Three RCOs reported individuals with physical impairments as making up the majority of their disabled refugee or asylum-seeking clients. All organisations reported a much lower incidence of sensory impairments, especially refugees and asylum seekers who are deaf or have hearing difficulties. Only one of the interviewees had come across refugees or asylum seekers with learning disabilities and none had encountered any with autistic spectrum disorders.

Citizens Advice Bureaux interviewees reported dealing with a mixture of physical impairments and mental health issues. Two bureaux felt the proportions were roughly evenly split; one felt that mental health issues were more prevalent amongst their users, and another bureau highlighted physical impairments.

**Key findings**

- Few of the disability organisations interviewed reported that they work with disabled refugees and asylum seekers. The main reasons were that they do not receive referrals; that they do not record immigration status (suggesting that they may encounter this population but be unaware of it); that asylum seekers and refugees were not seen as a priority area by themselves or their funders; and that these groups are not entitled to support.

- In some disability organisations, there is a misunderstanding about the rights and entitlements of disabled asylum seekers and refugees.

- Refugee support organisations are providing considerable specialist support to these groups.

- Local branches of the Citizen’s Advice Bureau were found to be providing significant levels of support.

- RCOs provide a wide range of practical support to disabled asylum seekers and refugees, as well as offering a means of engaging with social activities and networks.
• Amongst some of the RCOs interviewed there is misunderstanding over the definition of the term disability and what kinds of impairments it covers under the law.

• RCOs are largely unaware of mainstream disability organisations and their services, and are generally not referring their disabled clients there. Those that are aware of them indicated that language was a barrier to referral.

• There is a complete lack of reliable data on the number of disabled refugees and asylum seekers. Mainstream disability organisations were found to monitor ethnicity but not immigration status. Where data was found to be collected, there was little commonality between organisations in terms of how and what data is recorded.

• The most common impairments reported by RCOs and refugee support organisations were mental health, followed by physical mobility and, to a much lesser extent, sensory impairments.
6.2 The role of Refugee Community Organisations

Refugee Community Organisations play a key role in helping refugees and asylum seekers to access statutory services. Those interviewed estimated that in total they see 6-7,000 individuals per year. RCOs generally provide a range of support, from social activities through to more traditional advice and representation.

A social space
The ‘social’ aspect was highlighted as an important function by some of the interviewees who depended on these groups for social interaction. This is particularly important for refugees and asylum seekers experiencing isolation through their disability.

One Sudanese lady occasionally visited a Women’s Association but this was mainly for social reasons and so her daughters could ‘meet some children from the community’. A Zimbabwean woman had received vital social support, also from a RCO for women:

> Having that sense of belonging from group with the same nationality is helpful. Through them I’ve been able to network. They’ve put me in touch with other groups, for volunteering and things like that. They’ve been pivotal in that they are like a group of aunties, giving me advice on how to look after the baby, how to wash her when she was tiny. They filled in the missing gaps from what the midwife told me.

> Have they supported you because of your condition?
> No I go there for social reasons…

[Female asylum seeker, 27 – genetic condition]

A blind Somali woman had made contact with an RCO working specifically with women and was grateful for the practical help she received in reading letters and translating them into English.

> If I need to deal with something I go straight to them. They understand me. I don’t have one word of English (…) When I first arrived in this house letters were coming all the time. I don’t where to go, I don’t what to and I was confused by this. But then the lady (a neighbour) told me to go to the Somali community organisation. She said they would help. I was really glad of that of advice.

[Female refugee, 42 - blind]

One significant issue is that four out of the six female interviewees had all made contact with women’s RCOs rather than other groups, suggesting that women prefer getting support from other women and organisations that are sympathetic and sensitive to cultural and religious groups. The issue of
gender and the role that it plays in accessing services will be returned to in the final section of the findings.

The interviewees not in contact with RCOs either did not know that such groups existed, (one woman asked for contact information at the end of the interview), or had found alternative sources of help.

Q. Do you have any contact with other Eritrean people or Eritrean organisations?
No. I didn’t know that there are Eritrean organisations. I would like to socialise with other people from my country but I only meet interpreters.

[Female refugee, 46 – visual and mobility impairment]

Case study 3
The Latin American Disabled People’s Project (LADPP) was founded in 1990 “by and for disabled Spanish and Portuguese speaking people living in London.” The majority of its service users are refugees and asylum seekers, and it sees around 250 disabled refugees and asylum seekers a year. Based in south London, it provides not only advice on disability issues but has sought to develop its users’ capabilities and well-being through two projects in particular: a Health Project which includes liaising with GPs, massage and aromatherapy, on-site health checks with a visiting nurse, and health promotion workshops. Meanwhile the User Development Project aims to build service users’ self-esteem through ESOL, IT, arts, gardening, outings, mental health workshops and volunteering opportunities. The project has four paid staff and is currently funded by the Big Lottery Fund, City Parochial Foundation, The City Bridge Trust, London Council and Lloyds TSB Foundation.
Unit 7, Kennington Workshops 42 Braganza Street, Kennington, London SE17 3RJ
www.ladpp.org.uk/

Practical assistance and outreach
In addition to the social role they fulfill, RCOs provide a number of other key services including help with filling in forms, drafting letters and referrals to GPs, social services, solicitors and UKBA. The organisations appeared to be actively involved in their cases and, on the whole, the interviewees who approached RCOs for practical help were very happy with the service they received. For example, one Iranian woman had received help finding a solicitor and assistance with mental health issues from another women’s RCO.

They also provide help with welfare benefits applications such as Disability Living Allowance and Incapacity Benefit and also obtaining Freedom
Passes, discounted leisure centre cards and reduced taxi fares. A lot of this work seems to be carried out by unpaid volunteers or paid workers who then also work unpaid in their spare time.

**Q. What help or advice did they give you?** They did my application for housing and disability living allowance and disability for work forms. Also activities, we have a support group, there’s always something to do, like English lessons and gardening. I sometimes go to English classes but I sometimes I don’t go because of my leg. These activities are good because I am in contact with other people, disabled of different sorts, but we get to see each other.

[Female refugee, 47 – Mobility impairment]

Another key function identified by the disabled refugees and asylum seekers interviewed was the interpreting and advocacy role RCOs play when accompanying their clients to the GP, hospital, Job Centre and social service appointments. They give language and physical assistance but also ‘moral support’ as described by one RCO interviewee. In some instances, especially where they do not speak English, disabled refugees or asylum seekers are completely dependent on the RCOs for accessing any statutory services:

**Q: Can you tell me about the help that this organisation gives you?**
A lot. If I have a form they help me fill it. They help me make appointments. They go with me to appointments to the hospital.

**What would it be like if you didn’t have them to help you?**
[Laughs] I would be dead. They help me a lot.

[Male refugee, 77- Mobility impairment]

Four of the RCOs interviewed could visit the homes of disabled refugees and asylum seekers if they were unable to come to the organisation. However, restrictions on time and resources meant that they could not regularly offer this service, even though they recognised a need for more outreach work with disabled clients.

I know of a 78 year old Iranian refugee doctor who has been here 50 years and worked as a GP. A few years ago he had a stroke. He lives on the eighth floor in a tower block and has many problems just going out to get a haircut, or to walk the 50 metres to the lift. He can’t even make a cup of tea because his hands are shaking. He gets no support from the community even though he has a wide circle and is well known, having been here 50 years. It’s heartbreaking. I went and gave him a haircut with my clippers and he was very pleased. “When are you coming back?” he asked. Otherwise

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30 See Glossary of Terms for the Freedom Pass definition.
he has to spend £5 on a taxi, then £8-10 on the haircut... He needs company and there is limited support from social services. His wife and her children don’t even live with him now.

[Refugee Community Organisation]

Some of the disabled interviewees also corroborated this by indicating that they would benefit from more home help, particularly from people who spoke the same language.

When questioned about the role RCOs play in the support of deaf refugees and asylum seekers an interviewee with a disability organisation revealed that RCOs were not necessarily accessible to deaf people:

They are for hearing people. It’s like Sri Lankan refugees – there are groups but they have no awareness about deaf issues. It is impossible to access. How could it be done?

[Disability organisation]

Some of the interviewees indicated that they did not feel their community organisations were in a position to help them with practical issues because they did not have the necessary resources. For example, a Somali woman felt let down after approaching a Somali RCO for practical assistance, although she recognised the ‘social’ support they offered:

We are Somalian, we are from the same country, sometimes they say they will help me but they don’t help me...I want to speak to someone, see my people and speak my language so for that reason I go there but for the other reason [help with disability issues] I come here [refugee organisation] because the things I get here I don’t get there (...) they say, no problem, go and we will help you and solve everything, come back tomorrow, and the day after you go back and she’s not in the office.

[Female refugee, 29 – mobility impairment]

On a similar note, an interviewee from a disability organisation also questioned the knowledge of RCOs in relation to the legal entitlements that disabled refugees and asylum seekers have. There is clearly a huge range of RCOs working in this area and some have more specialist knowledge about disability issues than others. However, during the interviews with non-specialist RCOs it was noticed that not all organisations were completely up-to-date with the rights and entitlements of disabled refugees and asylum seekers and two organisations were not aware that asylum seekers could approach social services for a community care assessment.

There is a lack of knowledge within small organisations about what services other organisations have available. What they need to know is what is out there. They need the knowledge
and skills to do that but they are too busy fire fighting to upskill themselves. Groups are looking for funding and just surviving. That impacts on mainstream organisations too because RCOs who are referring to mainstream organisations have the necessary language skills, so if they are not here there is no access to those languages… Some are unlikely to have specialist knowledge if someone wants to pursue a case through the courts. They need to be aware of rights and to be able to provide a basic level of advocacy and to know where specialist support is available.

[Disability organisation]

Clearly there is a real need and opportunity for RCOs and disability organisations to work together, combining the skill set of both organisations to provide a service that is fully tailored to the needs of disabled refugees and asylum seekers.

Another interviewee also highlighted the lack of disability awareness in some RCOs:

**What role do RCOs play in the support of disabled refugees and asylum seekers?**

They provide an incredible amount of practical support to disabled refugees and asylum seekers. However, the disability movement hasn’t infiltrated RCOs. Disability can be stigmatising in some cultures and people don’t want to be labelled disabled. On the whole the disability issue is not put forward by RCOs but they provide a lot of care by providing meals, driving people around, going to appointments, interpreting. RCOs do a huge amount for no money. The funding situation at the moment means that money is being channelled away from RCOs.

[Solicitor]

The benefits of a culturally-sensitive service were not only underlined by RCOs but also other organisations. It was noted by many interviewees that the move away from funding single ethnic or national groups has had a major impact on RCOs and their ability to sustain their services.

I think that instead of putting more effort into community-specific services what we see happening is that funding is being cut for community-specific services and mainstreaming services as if everyone can be fitted in the same model and they can’t.

[Refugee support organisation]

We are short of staff. For over a decade I’ve been going to hospitals or GPs with asylum seekers as an unpaid volunteer. But let’s say I wasn’t there, who would do this job? So funding
could improve disabled peoples services a lot. It’s true there are a lot of organisations but those organisations don’t specialise in, and understand disability or cultural issues as we do. For example, we have clients who hide disability and don’t want to say ‘I’m disabled’. Without our encouragement they don’t want to be ‘part of it’.

[Refugee Community Organisation]

Two RCOs had responded to this change in the current funding climate by exploring the possibility of partnership-working with other RCOs or expanding their services to include other ethnic or national groups.

A notable observation on the work of RCOs was that quite often individuals who are heavily reliant on RCOs for practical help were often unaware of which services they had accessed, what support they had managed to obtain and who provided it. This is not surprising when linguistic and cultural barriers are taken into consideration. However, it also suggests that there could be room to build on the empowerment of RCO clients and to involve them more proactively in the process of accessing services and support, rather than remain passive recipients of assistance.

Finally, when asked about accessing services from RCOs, many interviewees found that RCO premises had stairs, making it difficult for individuals with mobility impairments. As one person observed, this situation can be put down to the quality of premises RCOs have traditionally occupied, implying that funding has a part to play here as well:

I think with the voluntary sector we’ve always been in back rooms and up stairs and places that are just difficult to get to.

[Refugee support organisation]

Case study 4
Through its Carers and Special Needs Project, the Somali Refugee Action Group (SORAG) has since 1996 provided culturally suitable personal and home care to a client base mainly made up of elderly, housebound settled refugees with physical impairments, often aggravated during their passage through refugee camps. Based in south-east London, the project works with social services in drawing up care plans, and with 250-odd carers is the largest East African employer in the UK. Since 2003, SORAG has also run a Community Mental Health Initiative in recognition of the links Somalis in the UK maintain with relatives in Somaliland, and the trauma-related problems that the latter face. Its partner organisation in Somaliland is the only organisation there geared exclusively to mentally impaired people and their carers. SORAG was founded in 1990 and is self-funded through its work with the social services departments of London boroughs.

SORAG Carers and Special Needs Project, 3rd Floor, Royal Sovereign House, 40 Beresford Street, Woolwich, London SE18 6BF
http://www.somalicareagency.org.uk/
Key findings

• RCOS are hugely significant providers of support for disabled asylum seekers and refugees in London, both through the direct provision of specialised assistance and additional provision of social networks, cultural exchanges and other forms of psycho-social support.

• Direct disability support commonly comprises: assistance with applications and paperwork generally; translating/interpreting; basic advocacy at health services, Job Centres and social services; and liaison with GPs and solicitors. There is a significant need for home help, which few RCOs have the capacity to provide.

• RCOs lack funding, space and human resources. They can be difficult to access for people with mobility problems. RCO staff are seen by some to lack up-to-date knowledge on disability issues, rights and entitlements.

• The precarious nature of RCOs is further threatened by the current trend away from ‘single issue’ funding.

• An opportunity exists for RCOs and mainstream disability organisations to work in partnership. This may help increase the sustainability for some RCOs.
6.3 The role of family, friends and ‘communities’

There is an overlap between the role RCOs play in supporting disabled refugees and asylum seekers and the community in general as there are not necessarily clear distinctions between friends, ‘the community’ and RCOs. However, interviewees were also asked about the help they received from friends, family and community members that were not offered in the form of assistance from a specific organisation.

In general, ‘refugee communities’, especially families, seem to be playing a huge role in supporting disabled refugees and asylum seekers. This mainly takes the form of personal care, cooking, shopping and cleaning, but also involves interpreting and accompanying them to appointments.

In general terms… I think most people (are) coming from countries where the issue of the extended family exists. Even if it is diminishing the traditions are still there and people have a strong sense of responsibility towards people in this area and look after them. I know lots of people didn’t know they could claim care allowance because for them it’s a normal social or family duty to look after someone who is disabled, and you even feel ashamed to be paid for that.

[Refugee support organisation]

At least three of the interviewees were concerned about the impact of their care on other family members because of the time it takes out of their own lives. An example of this was given by an Eritrean man who is concerned about the strain of lifting him out of wheelchair on his two sons.

Children were also identified as playing a key role in helping their disabled parents. This is particularly the case when it comes to interpreting. Two service providers expressed concern that because of the lack of appropriate services, children of disabled parents have been put in a position where they needed to interpret delicate information about a disabled parent.

Despite the role played by family and friends, one of the key findings from both the literature review and interviews is that refugees and asylum seekers differ from other BAME groups and migrants in that they are less likely to have the same social networks in place in this country. Half of the disabled interviewees said they lived alone and most did not have any family in the UK.

Where refugees and asylum seekers may differ to BAME here though is that they may have a lack of support systems. Other newly arrived BAME individuals may equally not understand the system and language, but are likely to be joining a spouse, family and existing social networks.

[Disability organisation]

Some of the disabled refugees and asylum seekers interviewed were also reluctant to approach community members because they were
aware that they had their own problems to deal with in terms of the asylum process and also limited resources.

The community starts to be more stressed out about these things because it’s like you’re having other people living at your expense – we have a financial situation where people cannot cope with helping others any more, as it is so expensive. In some ways it takes strength from the communities because people just want to ignore things, not get involved, or are scared.

[Refugee Community Organisation]

Key findings

- Alongside RCOs, families and friends/community play a huge role in supporting disabled asylum seekers and refugees. In many cases they are seen as indistinguishable from one other.

- Despite the role friends and family play in many cases, disabled asylum seekers and refugees do not benefit from the support of wider existing social networks, as experienced by their British BAME counterparts.
6.4 Experiences of statutory services

The interviews addressed the experiences of statutory services of both disabled refugees and asylum seekers and the different bodies and professionals providing services to them. Here we look in turn at the findings relating to general practitioners; hospitals; social services; welfare benefits and job centres, and housing.

A strong theme running through many of the interviews was just how complicated and difficult the processes and systems are for accessing services and benefits, particularly for disabled asylum seekers but also refugees. Most of the interviews carried out with RCOs, disability organisations and refugee organisations were characterised by a sense of frustration with systems that put barriers in the way of accessing services rather than making them accessible.

I think statutory services should be a lot more proactive rather than being entirely reactive. It always seems like they doing nothing unless you batter their door down and tell them that there is a really urgent problem.

[Refugee support organisation]

General Practitioners

Disabled refugees and asylum seekers had very mixed reports about their experiences of GPs. About a third of interviewees stated they were not happy with the services provided by their GPs. Some felt that their problems had not been listened to properly, or that surgery staff had been impolite.

The GP is ok but he wasn’t co-operating enough until they had a letter from the Helen Bamber Foundation. They don’t take into (account) my situation, like the fact I have a carer and try to arrange my appointments around this. There is a nurse at the GP’s surgery (…) once I had to go down the stairs to the nurse’s room with her and she even didn’t hold my hand. And she was telling me rude things: ‘because you sleep with your scarf at night time that is why you get a cold’. Things that aren’t nice.

[Female Muslim asylum seeker, 43 – blind]

Other interviewees were not able to communicate because of language difficulties and lack of interpreters, including sign language interpreters, even though GP surgeries are supposed to use interpreters where required.31

31 Although not a legal obligation strictly speaking, the right to an interpreter is increasingly seen as falling under equality law and is present in NHS guidelines. See for example Citizens Advice Bureau Advice Guide: Hhttp://www.adviceguide.org.uk/index/family_parent/health/nhs_patients_rights.htm (accessed 4/11/08)
It’s not easy to book an interpreter because there is always a delay in getting one and if I am ill, obviously I can’t get any notice on that and there is not an interpreter. I have to go anyway and we have to communicate using written word. And it is made more difficult because English isn’t my first language.

[Male asylum seeker, 52 - deaf]

Another third of refugees and asylum seekers were positive about their experience. They felt that their GP had been polite and helpful and that when needed they had been able to access interpreters. One interviewee receives a phone call from his doctor when he does not go for a while to make sure that he is alright, and another interviewee is sometimes seen in her home.

The service is good but I don’t know about other surgeries…Sometimes I have panic attacks and sometimes it is too difficult and sometimes I need to go out to speak with someone. I feel like I am going to die. The doctor gave me some help because I can’t speak with people in the night and so she gave me a number where I can call to speak to someone. They are good with me. Sometimes they come to my home if I need an appointment at home. It’s not far by wheelchair but if I need it they come here. The GPs have been helpful and they helped me to get my wheelchair. They have helped me apply for an electric one.

[Female asylum seeker, 37 - wheelchair user]

The remaining third of interviewees had mixed reports about their experiences of GPs, identifying some that had been helpful and others who had been less so. They also talked about occasions when interpreters had not been available and they had struggled to be understood. A deaf refugee indicated that she needs to make complaints about the inadequacy of the sign language interpreting before anything is done to address her needs. Another two disabled refugees stated that they could get by in English but found it difficult when it came to medical terminology which they did not understand.

Three interviewees indicated that they were expected to bring a family member or friend with them to the doctors. Another issue highlighted by two of the interviewees was the difficulty they had accessing the building because they were either in a wheelchair and there was no ramp available, or they found it difficult to walk and the lift was often out of order. One indicated that they could not afford to pay prescription charges. Some respondents found it hard to obtain the appropriate letters or reports from GPs:
Recently I had to apply for Disability Living Allowance\(^{32}\) and asked the GP to write me a report and the DWP (Department for Work and Pensions) rejected my application because the report said nothing about my disability. If I showed you the report you would think I could write better than this myself. I could easily have written so much about myself… now I have to re-apply and it’s such a long process. He’s not helpful at all.

**[Female asylum seeker, 27 – genetic condition]**

One interviewee found herself travelling long distance across London to be seen by a GP near her previous address and who she felt treated her well. She had not been able to register with a new GP because of the language problems and lack of support in her new neighbourhood.

Service providers also gave a mixed picture of the service given by GPs to disabled refugees and asylum seekers:

Q: *In your experience how well are GPs meeting the needs of disabled refugees and asylum seekers?*

It varies greatly. There are obviously GPs who have training and there are GPs who don’t know how to deal with post traumatic stress for example. There are GPs who are sensitive and others where you only get your five minutes… There is a huge need for training for GPs in understanding community needs, particularly in the area of mental health but also specific health needs like Female Genital Mutilation (FGM) or tuberculosis (TB) and needs specific to communities in general. And also there is a need to train them in working with interpreters and health advocates as well… it is also about educating GPs about culturally related problems and disabilities which are particularly prevalent amongst particular communities, and also about culturally sensitive issues.

**[Refugee support organisation]**

Lack of appropriate interpreters was the most common complaint, with one organisation speculating that the reason GP surgeries were reluctant to provide interpreters is because of financial cost. Two of the RCOs described the difficulties that some asylum seekers experienced when trying to access services from their GP:

\[(...) some asylum seekers have even been refused registration… some of them have been asked for their passports to be registered with their GPs and that is not right. People are afraid to ask things of their GPs through lack of\]

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\(^{32}\) See glossary of terms.
confidence. For example, those with mental health problems just don’t have the motivation.

[Refugee Community Organisation]

We have a young lad who has kidney problems and they were so bad he was in hospital and he had a letter to go to the GP but the GP said no, I am not treating you because you are an asylum seeker.

[Refugee support organisation]

Hospitals
There were mixed experiences regarding hospital treatment by the refugees and asylum seekers interviewed. Some were very happy with the way they had been treated.

It was easy really. I went to the GP and he referred me to the specialist. I had an operation and I stayed for one night. It was easy. It was simple. Everyone was kind and helpful to me. I could understand everything; they brought an interpreter. I didn’t have to wait long at all. It was fine.

[Female refugee, 42 – blind]

Others expressed frustration with the lack of interpreters or transportation to the hospital.

Since I changed my GP they discharged her from that hospital and now I have to go to different places and that’s what happens. So yesterday I called this new clinic and they asked me to change the date and that they had no transportation but I had all these facilities in the other hospital. It was easier for me to use the other hospital. It was a better facility and there was always transportation. Regular arrangements that I had with the diabetic nurses and interpreters were in order.

[Female asylum seeker, 43 – blind]

One asylum seeker was admitted to hospital after a fall. Through the work of a hospital physiotherapist and social worker she was able to access the care that was unavailable when approaching her local authority directly.

When I fell down and went to hospital I got a social worker at the hospital and they helped me. Before I was only getting a carer once every two weeks for an hour and a half but I needed one more often because I couldn’t take the rubbish out and it had to sit in my flat and I couldn’t clean. When the physiotherapist called Social Services she was told that they were waiting for my status to be resolved before the home care issue could be resolved. After the hospital social worker assessment a carer comes every day to help me wash and I get help once every week for 45 minutes for the cleaning.
Social Services
The individual experiences of social services differed significantly depending on the status of the interviewee. For this reason, refugees and asylum seekers experiences will be discussed separately.

Refugees and social services
One refugee interviewee was unhappy with the standard of interpreting available at her local social services department, and an RCO claimed that “often social services call us because they cannot understand a client.” The latter also observed that cultural and language barriers affected the provision of ‘home help’ and that as an RCO they were limited in their capacity to meet social services’ requests for support with this:

The home helps have difficulties working with our clients and are rejected by them [the clients] for cultural reasons. For example they might wash a mop in the sink where dishes are washed. Once a home help emptied a bucket onto the kitchen sink and the client asked for them never to go back. Also because of language the home help and client cannot communicate. Social services have asked us for home helps but that’s very hard for us. We have sent interpreters and a volunteer to help a blind client.

[Refugee Community Organisation]

On the whole however, those refugees accessing support from social services were reasonably satisfied with the assistance received. They had only limited difficulty accessing this support largely because they had done so after being awarded status. Three refugees were very happy with the support their social worker had given them and found them to be empathetic and helpful.

I have had a social worker before. I didn’t really get on well with the first one but then they changed it and that was great. She was very understanding but then she retired and then I just gave up. When I became pregnant the hospital informed social services and they gave me lots of equipment for my baby and that has been great like a vibrating baby alarm and a monitor.

[Female refugee, 32 – deaf]

All of the refugees assessed by social services had achieved this with the assistance of an RCO, another voluntary organisation or a hospital.
Asylum seekers and social services
The experiences of asylum seekers stood in stark contrast to those of refugees. All of the asylum seekers in the sample who approached social services for an assessment had experienced great difficulty in accessing the care they needed. Undoubtedly one of the reasons for this is because the law is complicated and contested when it comes to the provision of accommodation and support for disabled asylum seekers. As a solicitor commented:

They often do not understand the immigration aspect of cases and make unlawful decisions. …It is difficult for the ordinary social worker to keep up with the law as it is very complex and hard for them to implement when carrying out assessments.

[Solicitor]

However, it is not just the complexity of the law that was identified by respondents as a reason why it is so difficult for asylum seekers to get assistance from social services. The perception amongst some of the service providers is that social services are deliberately ‘gate-keeping.’

Q: So, what you are saying is that there is lots of confusion around who is responsible for supporting asylum seekers; whether it is the local authority or the Home Office (UKBA)?

Disabled asylum seekers are barred by legislation from claiming disability benefits, which causes huge deprivation and creates a climate where Councils won’t assume responsibility either. It’s not confusion but a deliberate policy, as Councils don’t set out to meet the needs of vulnerable people generally. It happens all the time which is why people need legal representation to enforce their entitlement to social services. But it’s hard to get a knowledgeable and committed solicitor, so most people are deprived of their entitlements.

[Disability organisation]

We have to threaten legal action to get an assessment carried out in the first place or to get services offered. Even when we have threatened Judicial Review on a number of occasions with a particular social services it’s still needed to get an assessment carried out and that’s when the disability is quite obvious - where there is clear medical evidence for example.

[Solicitor]

Three of the asylum seekers interviewed had approached social services for support and found it very difficult, if not impossible, to access the support they needed.

I tried contacting the social services, but they were not that helpful. They told me ‘oh you don’t have status.’ And I would say to them what does status mean when you have a person
who is in need and wants to use their services? They came up with all sorts of answers until I just gave up.

[Female asylum seeker, 27 – genetic condition]

The same individual later on had contact with social services after she had a baby, which resulted in an incredibly difficult experience for her.

Social Services came into the picture when I had a child. They suddenly thought ‘whoops, she is disabled, she does need help.’ I thought, you were not there when I really needed you, so why are you here now? They took away my baby. They thought that because of the nature of my disability I wouldn’t be able to care for her…my child was in foster care for five solid months. I was forced to give up breast feeding, so between me and the baby there was not that bond… Then they acknowledged that taking the child away from me was the wrong move and shouldn’t have happened.

[Female asylum seeker, 27 – genetic condition]

A blind asylum seeker described how she had to ‘fight with them for four months’ before a solicitor helped her secure support from social services. Another asylum seeker also described the difficulties she had accessing support:

Social services are very difficult. They don’t have heart; they talk to you like a table. Every time I call I get a different response to my questions from different people. They don’t give a receipt or proof of their decisions so if I want to go to a solicitor for help and they want evidence there is nothing to show them. Like when I asked for a freedom pass and was refused.

[Female asylum seeker, 37 - wheelchair user]

Welfare benefits and Job Centres
Interviewees were not directly prompted for their experiences of Job Centres, but when they were mentioned their responses were uniformly negative. Barriers included the lack of interpreters, including sign language interpreters, lack of knowledge among DWP staff about disability issues and long waiting times.

I had no money, no money at all, they told me to go the Job Centre, when I go there, 9am at 5pm they gave me £30, and said come back tomorrow, you know 2 children…me disabled, They are tired from being there all day, and when they cry they say “Please! Control your children!” They make you stress, It was very, very bad…now I’m ok, because now I don’t go there I get it from them so I stay home but when you go there you apply for something they treat you very bad, they wait, wait, wait, for many hours, they send you letter, they told you bring it, the next day they tell you no, we didn’t get any
letter, and still you do the same thing and you apply again, I don’t really like it, the last place I like to go is the Job Centre.

(Female, 29 - mobility impairment)

The inappropriateness of applications for Disability Living Allowance was also mentioned by two of the respondents. One highlighted the information lost or misunderstood when applications are made in writing and not in person:

… they give you the form and it has many, many questions you maybe don’t understand…. when you fill a form on paper you don’t see the person. If you see them it makes a difference. If someone is sitting with you and filling it they’re not just listening to the answer but they know what the answer means.

[Male Refugee, 58 – wheelchair user]

Finally, the same respondent expressed frustration at the dependency that he felt the welfare benefits system encouraged:

When they ask a question. ‘can you make tea?’;- I can make it with difficulty. They know that if I say ‘I can make it’ then I don’t need help; but if I say ‘I can’t make it’ then they accept you need help… in this system you feel like it makes you useless - if you describe your self as useless then you get every benefit, but not if you don’t want to say.

[Male refugee, 58 – wheelchair user]

Housing

Housing was not raised as an issue by the interviewers either, but three interviewees highlighted the need for more appropriate accommodation because of their mobility problems:

I use a walking stick or crutches and I can’t go down the stairs of my house, when it’s raining I can’t even leave the house.

[Female refugee, 37 – mobility impairment]

Even when a specific housing need was identified, acquiring suitable accommodation could be a lengthy process: Two out of three interviewees had been waiting three and five years respectively, and the other a month.

Key findings

• Two-thirds of the disabled asylum seekers and refugees interviewed reported negative or mixed experiences of GPs.

• Language barriers were a common problem when seeking help from GPs. In some cases interpreters were not made available and patients were asked to bring family members or RCOs to interpret.
Some disabled asylum seekers and refugees reported feeling uncomfortable discussing their condition to their GP. It was suggested that GPs could benefit from training on community needs and cultural awareness to ensure sensitivity towards the diverse needs of this population.

There is a stark contrast between the experiences of asylum seekers and refugees seeking assistance from social services. While the refugees interviewed had mainly positive views, asylum seekers had experienced great difficulties due to the complexity of the law around asylum seeker entitlements; confusion and lack of knowledge about entitlements amongst social workers; contested responsibility for asylum seekers with care needs; and a reported wilful reluctance by some social services departments to assume responsibility.
6.5 Experience of the asylum process

The policy of dispersal is one of the ways in which the asylum process can negatively impact upon disabled asylum seekers and refugees. An interviewee from an RCO observed that disabled refugees and asylum seekers have much greater access to help and support from their community if based in London. If they are dispersed away from London there are far fewer networks and organisations that they are able to approach.33

When an individual is awarded refugee status the transferral from UKBA to the local authority, or from one accommodation provider to another, can also interrupt support networks that have been built up by an individual. A refugee with a mobility and visual impairment disability described how she had lost all of the day-to-day support from other people living in her hostel when she was moved into more permanent accommodation in another part of London. She recounted how she had gone from a relatively strong support network where people helped her with her shopping and cleaning to a situation where she does not know anyone in her local area and has limited support.

Interviewees also commented on the inaccessibility of the asylum process for both disabled asylum seekers and refugees. The process was identified as lacking disability awareness by a solicitor, who observed that the impact of memory problems or a lack of mental capacity is not taken into account by decision-makers when assessing claims made by disabled asylum seekers:

One client I had couldn’t remember who he had been to see and who had said what. He couldn’t answer questions and concentrate properly. In the appeal courts the adjudicator thinks that they are lying but it is a mental health issue.

[Solicitor]

A representative from a disability organisation also felt that the asylum process was inaccessible for different reasons:

The Home Office is not accessible. The asylum process and the interviews are impossible for deaf people as they don’t provide interpreters or a ‘deaf relay service’. They don’t make provisions. How do we know whether deaf people are expressing themselves in their applications and explain why they have come to this country? You can’t make an appointment at the Home Office. You have to go there in person to claim asylum but how can they do this when they

33 Bloch and Schuster (2005)
don’t have an interpreter and they don’t know how to access them.

[Disability organisation]

Another example of the inaccessibility of the immigration system for disabled applicants was given by a refugee organisation whose client is incontinent and unable to leave their house because of this problem:

She applied to be British and the Home Office said she should go to classes to learn English. But this isn’t possible, so we wrote letter and the doctor wrote letters. And then, when she applied for her passport, this poor woman had to go up to the Elephant and Castle and then she had an interview with a Somali, with an interpreter, and they doubted the authenticity of her being Somali so she then had to have another interview and they set this interview for Peterborough and her daughter said that she couldn’t possible travel there by public transport. So her family, who are all on income support, gave her £120 to travel there by taxi. So that’s a horrible example of bureaucracy not being at all enlightened about the situation.

[Refugee support organisation]

Key findings

- The dispersal programme means that some disabled asylum seekers are moved away from appropriate services and support in London.

- UKBA decision makers are seen to be insensitive to the needs of disabled asylum seekers, particularly with regards to appropriate accommodation and provision of support.
6.6 Experiences of mainstream disability organisations

First and foremost it should be noted that only three of the disabled refugees and asylum seekers interviewed had been in contact with mainstream disability organisations. This contact had led to mixed experiences.

The most frustrating was that of a blind female asylum seeker, with limited financial means common to people with her status. Thus despite being in contact with a major national blind person’s organisation, she was prevented from making full use of the telephone club and other phone-based services because of the cost associated with relying on a mobile phone. This reliance was in turn a result of not being able to get a landline because as an asylum seeker she had not managed to open a bank account.

All three found language to be a problem when it came to taking full advantage of the services offered by mainstream disability organisations. For example, an Iranian asylum seeker had attended a knitting club but was unable to make meaningful social contact because of language limitations. (The issue of language and communication is further examined in a separate section).

A male Palestinian refugee found that a local disability organisation tended to lack a more proactive approach to their advice and support work, compared to his own past experiences giving advice as a trade union activist:

“These advisors are different, they don’t tell you what you can get, they (just) tell you what you get.” (Emphasis added)

(male refugee, 58 – mobility impairment)

The two refugees who were in contact with mainstream disability organisations both had positive experiences to recount regarding the benefits advice they had been given and occasional financial contributions they had received towards costs incurred by their disabilities, such as the upkeep of a wheelchair. The asylum seeker on the other hand whilst recognising the potential worth of the services on offer could simply not afford to access them, again confirming the importance of status in determining experiences.

When RCOs were asked about their experiences and relationships they had with mainstream disability organisations, two out of the fifteen interviewed said they had virtually no contact or knowledge about them. Others explained that disabled refugees and asylum seekers had problems accessing their services because they tended not to work with asylum seekers and because their work was geared towards British disabled users with their superior “knowledge of the language and system”. The representative of one small disability organisation linked this to a failure to implement anti-racist policies, thus giving engagement with disabled refugees and asylum seekers and migrants a low priority.
Key findings

- Disabled refugees and asylum seekers were found to have very little contact with mainstream disability organisations. Contact depended to a large extent on status and financial means, and so asylum seekers are at a considerable disadvantage compared to refugees.

6.7 Barriers to access

A number of the barriers to accessing services have already been identified in the previous sections, such as the lack of appropriate interpreting; immigration status; poor physical access; lack of finances for disabled refugees and asylum seekers; and knowledge about services available. This section will expand upon some of these issues and highlight other barriers identified by interviewees.

Negative attitudes

The issue of stigma around disability can be a major barrier to refugees and asylum seekers accessing services from both the voluntary and statutory sector. A number of service providers commented on the particularly negative attitudes that some communities and cultures have towards certain types of disabilities. Mental health issues were a common example, as were HIV and AIDS and learning difficulties.

There is a tendency in the cultures that I work with – African, Turkish and Asian - to see that it is a punishment from God when they have a child with a learning disability.

[BAME disability organisation]

We have got 10 to 20 clients suffering from these illnesses which they are hiding. If they arrange an appointment it has to be as an individual with no one else here. They sometimes want to come on Saturdays so no one else sees them or their application form and their kind of difficulties. Let’s say I fill the DLA application form I have to ask about their disabilities. Regarding confidentiality they ask a lot ‘who is accessing and looking at my file’. They try to hide everything. Sometimes it’s not about HIV but mental health. I think people with physical disabilities they can’t hide it even if they try, but those with mental disabilities, psychological problems; they try to hide them.

[ Refugee Community Organisation]

Individuals can try to hide their difficulties because they are afraid of negative reactions due to stigma associated with the disability, or because of the stigma associated with the circumstances that caused the disability. The mental health problems associated with rape and torture are good examples.

In terms of stigma and HIV/ AIDS, it can be worse for women. There are also some mental health issues that arise as a
result of rape and sexual assault that are very, very difficult to unpack, so a woman will often go on and on with this trauma and these problems and she will be unable to share them and get any real help to deal with them.

[Refugee support organisation]

Gender
There are other issues relating to gender that make it more difficult for disabled refugee and asylum seeking women to access appropriate services. A common point made by both service providers and disabled refugees and asylum seekers was that some women only feel comfortable being seen by another woman.

We have Muslim ladies who have their own way of life according to the religion so most of them wouldn’t let a male doctor or person look after them. So they always ask for a woman carer, but sometimes it is difficult to find a woman. More carers from the same religion and culture need to be employed by social services.

[Refugee Community Organisation]

Some of the respondents highlighted the issue of children and the difficulty that women have attending appointments because they have childcare responsibilities. Three of the women interviewed are single mothers, and they all talked of the extra difficulties they faced caring for their children and the need for more support in this area.

Another issue raised in the interviews was domestic violence. One interviewee had observed evidence of domestic violence by husbands against some of her clients who are also the mothers of children with learning disabilities.

The wives quite often suffer domestic violence at home and some are made to go out and earn money because the asylum case has been refused and they don’t have any other source of income. I have seen mothers leave their son or daughter with learning disabilities at home by themselves when they shouldn’t have been because the mother has had to go and earn money from working illegally in a factory or something.

[Disability organisation]

The interviewee observed that because of their precarious immigration status, such women are too afraid to approach social services for the help that they need with their children.

In another interview a disabled refugee described how she had been completely dependent upon her husband when she first arrived in the country because he could speak English and she could not. Hence it was her husband who was the main applicant in the asylum application and he handled all of the appointments.
My husband spoke English and he made the applications and managed everything when we arrived. We suffered with my husband. My daughter was in school and one day she told a teacher that my husband beat her and me and the police came to the school. And then the social worker came here and my husband had to go. Then she helped me with the benefits… It is difficult for a woman. A woman accepts her situation and waits.

[Female refugee, 43 – mobility impairment]

An interviewee from a refugee organisation commented that she had observed fewer women speaking English than men, which makes it much harder for women to access services. Cultural issues were also highlighted as some cultures tend to encourage women to interact less in public life than men:

We do meet deaf refugees from small villages and it can be that the attitudes mean that sons are more valued and daughters more restricted.

[Disability organisation]

Men are more likely to have contacts with their community than women are. Many Muslim men make contacts through the mosque. It is easier for men to approach RCOs than it is for women as RCOs are mainly run by men. It can be harder for women to talk about their health needs than men and it is particularly difficult when there is an issue such as rape that needs to be discussed. Also, many of the interpreters are male which can make it difficult.

[Solicitor]

Despite these barriers, the picture of women given by the interviews was not one of complete dependence. Many examples were given of women dealing with incredibly adverse situations but still managing to build and continue their lives. For example, the woman quoted above has now learnt English and the disabled asylum seeker (mentioned earlier) whose baby was taken into care by social services, is now managing to look after her baby herself.

Gender issues are also not confined to women as the following example demonstrates:

There is a huge amount of caring that goes on in the community and without that they wouldn’t survive. The friends of the man who has been shot in the spine his friends come and cook for him. They help him shave and dress and I have to say when he first came the local authority were offering him a care package but he resisted it because, for a start, he didn’t want a woman coming along because of the personal
care and another thing was a language problem and so he refused and his friends looked after him for years.

[Refugee support organisation]

Cultural
There are many cultural barriers to accessing appropriate services for disabled refugees and asylum seekers, and these can intersect with other barriers such as gender and attitudes to disability. Certain types of gender interaction are not appropriate for cultural reasons.

The need for culturally specific services have already been highlighted by service providers and is also echoed by some of the disabled refugees and asylum seekers who do not feel comfortable talking about their difficulties with people from a different cultural background.

So they need you to say ‘I need the toilet, I need help to take my trousers up and down’ But I’m not used to saying this, I’m shy to say it so I keep doing with difficulty what I do, rather than ask. I think social services should have people who understand refugees, people from the same countries as the refugees. I know maybe it’s difficult to find qualified people from some countries, but someone from one country will know how someone from a nearby country feels.

[Male refugee, 58 – wheelchair user]

Culturally sensitive care and support from individuals is therefore essential if the needs of disabled asylum seekers and refugees are to be met. Another example relates to mental health:

There is also educating GPs about culturally related problems and (how) disabilities are particularly prevalent amongst particular communities and also about culturally sensitive issues. About what language to use as well. Again about mental health issues. I don’t think that mental health is a good term to use because however much you educate a community there is still going to be stigma about the term and that is something that we have done with the advocacy service we have asked them to come up with terms that are acceptable in their communities so that we can translate the literature. It is also educating the GPs about working with interpreters and bilingual advocates.

[Refugee support organisation]

Language and communication
Much has already been mentioned in relation to the need for appropriate interpreters in order to access services. The majority of the disabled refugees and asylum seekers interviewed indicated that language was the biggest barrier they faced as without this means of communication they were unable to obtain the knowledge they needed to access services. The language barrier also means they are more isolated because their social interaction was
limited. This has a disproportionate impact on disabled refugees and asylum seekers because of their likely need for good support networks, especially if they are far from friends and family.

Deaf refugees and asylum seekers can have a particularly difficult time communicating because it is even harder to access sign language interpreters than it is interpreters for refugee community languages.

Most countries have a separate sign language but many use some bits of ASL. Some deaf people do not have a language as such but use ‘home signs’. Most clients use ‘home signs’ that they have developed with their family, because they haven’t been able to learn a language. In Asia and Africa, deaf people don’t mix that much in mainstream society so some deaf children don’t learn a language to communicate with.

[Disability organisation]

Deaf asylum seekers and refugees are therefore unlikely to understand British Sign Language when they first arrive and may not have used a formal sign language in their country of origin.

One client from Somalia was an asylum seeker and her sister supported her a lot but she didn’t know about deaf issues. She [the asylum seeker] didn’t have any language. Her and her sister had ‘home signs’ but not a proper language. I had to rely on the sister to communicate with her and they communicated well together. Now she [the asylum seeker] can use BSL and has done really well once she engaged with deaf culture. Before she came here she thought that she was the only deaf person in Somalia.

[Disability organisation]
Case study 5

The Royal Association for Deaf People (RAD) currently employs approximately 20 members of staff in London and provides services in legal advice, advocacy, British Sign Language (BSL) training, life skills and employment. These services can be accessed by deaf refugees and asylum seekers, where they can discuss immigration matters and the asylum process. Legal advice is funded by the Big Lottery, European Integration Fund, various London boroughs, and the Legal Services Commission. The London Development Agency has provided funding for RAD’s Deaf Skills into Employment project since April 2007, where they provide BSL training for Deaf people from overseas so they can have access to BSL English Interpreters and therefore have access to information. Advocacy and employment projects are funded by London councils and the European Integration Fund.

Head office: 18 Westside Centre, London Road, Colchester, CO3 8PH
http://www.royaldeaf.org.uk/

Another example of how barriers intersect with each other is the way in which deaf people have to travel further to access services. Deaf asylum seekers, with limited income, are put at a further disadvantage because of their immigration status and the financial barrier they face.

The biggest issue for the deaf is that you have to travel further to access services. Asylum seekers are restricted in terms of the money that they receive and NASS (UKBA) don’t give them the extra support that they need. Deaf people need to learn about deaf culture and to access deaf services. Hearing people develop their own networks, but it is more difficult for deaf people and they need to be able to communicate to be able to access their community.

[Disability organisation]

Similar barriers exist for blind asylum seekers and refugees. An example was given by a blind asylum seeker who did not speak English but could not afford to buy the talking dictionary she needed and the expensive phone calls to the support service she had accessed:

I have just received the books from the library: Braille and talking books. They send me books. That’s it. I chose the books and they send them. I do this on the telephone. The main problem is the telephone number because it is very expensive because I only have a mobile. Sometimes I have to wait a long time and then leave a message. Sometimes they never get back to me. There are language problems often. I have to have prepared what I want to say…The only good service they have is a telephone club. It is for blind people so they can find and talk to friends on the phone but because I
only have a mobile I cannot use this service as it is too expensive. Because I do not have a bank account I can’t have a landline. Most of my money goes to paying my mobile bills. I have no other choice. I have to contact people and it is lots of money… If you have status you get more financial support and the carer spends more time with you. I wouldn’t have such problems with the bank and I could have a landline or a mobile contract.

[Female asylum seeker, 43- blind]

Another blind interviewee from Iraq expressed frustration because he cannot read in Braille until he first learns to speak English. He has been studying English at college among students without visual impairments as a pre-requisite to being trained in reading Braille.

Key findings

- Disabled asylum seekers and refugees face multiple barriers to accessing disability services. These include difficulties with language and appropriate interpreting services; immigration status-linked restrictions on support; lack of knowledge about rights and entitlements amongst both themselves and service providers; and the stigmatising of disability among certain cultures.

- Disabled women face additional disadvantages, such as childcare difficulties compounded by the need to work illegally; dependence on a husband who is the main asylum applicant, or the inaccessibility of male-dominated RCOs.

- Cultural misunderstanding and different attitudes to disability and capability between refugee and host populations creates extra difficulties for disabled individuals.

- Language problems particularly compound disadvantage. The main issues that arose were inappropriate or inadequate interpreting; the combination of isolation with the inability to communicate; the inability to understand services, rights and entitlements, and additional barriers faced by deaf people using sign language and blind people wishing to learn Braille.
7. Conclusions

This study has found that RCOs are disproportionately taking the strain for disability support of London’s asylum seekers and refugees. Estimates indicate that these small and under-resourced organisations are assisting a large number of disabled people backed by little more than a room, a coordinator, a handful of volunteers and a considerable amount of goodwill. They often balance disability support with an array of other services, such as interpreting, counselling, welfare benefits advice and advocacy. RCOs have become part of an informal network of friends, family and community that strives to meet the diverse array of care needs of this population, many of which remain unmet or only partially addressed. Refugee support organisations also provide significant advocacy and assistance and form an additional indispensable resource. Local branches of the Citizens Advice Bureau were also found to be playing a key support role, however these were the only large mainstream voluntary sector organisation found to be engaged significantly with this population, despite the fact that most of the mainstream organisations interviewed specialised in disability support. Statutory providers, in particular UKBA, local borough Social Services departments and GPs were found to be applying the law inconsistently or on occasion inappropriately when dealing with disabled asylum seekers in particular.

This suggests that there remains a considerable support gap between the specialist refugee sector and mainstream disability sector. While RCOs play a huge role, resources are over-stretched and they were found to be falling short of comprehensively meeting the needs of disabled asylum seekers and refugees. This is often due to lack of staff, lack of expertise about disability law and policy and insufficient funding. Most mainstream disability organisations are also failing to meet the needs of these groups, either because RCOs are not referring there, because their services are seen as inaccessable or because they are confused about eligibility. Hence it would appear that that many disabled asylum seekers and refugees are falling through net in terms of overall support. With mainstream providers doing little to reach them and current funding trends threatening to further weaken RCOs, these gaps are likely to widen.

Anecdotal data and estimates collected in this study suggest that mental health issues are by far the most significant cause of disability among this population, followed to a much lesser extent by physical impairment. However, data on this population remains absent, inconsistent and based largely on estimates. In common with other sectors, immigration status is not monitored by mainstream disability organisations and different conceptions of disability among those that do record status contribute to an inconsistency in diagnosis and categorisation. Unless reliable data is collected, it will remain difficult to comprehensively assess the needs of this group and to provide concrete evidence from which to target services and leverage funding.

Confusion and ignorance about entitlements was found at every level of service, from RCOs to hospitals and, perhaps unsurprisingly, amongst asylum seekers and refugees themselves. This has led to misapplications of the law
and the refusal of services by statutory service providers and (in some cases) the voluntary sector, and contested responsibility for care and support between UKBA and Social Services. Asylum seekers and refused asylum seekers have been disproportionately disadvantaged by this, having been reportedly turned down for community care assessments despite eligibility and therefore denied appropriate support. Many of the testaments in this study indicate strongly that it is these groups - asylum seekers and refused asylum seekers – that are especially vulnerable to poverty, hardship and associated mental health problems. And yet it is they who face particular exclusion from the benefits and support.

Many of the barriers to care and support reported by interviewees are shared with the UK’s established disabled ethnic minority populations. These include: language; stigma and culturally-determined attitudes towards disability and the treatment of disability; extra hardship experienced by women; isolation and lack of understanding about rights and entitlements.

However, disabled asylum seekers and refugees face a number of additional disadvantages for a number of reasons: firstly, the vast array of languages spoken by this population adds to difficulty in finding appropriate interpreters. Identifying sign language interpreters is particularly difficult. Secondly, asylum seekers and refugees are less likely to have existing social networks to rely on for informal support, many having arrived alone and some, for a time at least, resettled away from available community support through the dispersal programme. Single women and single mothers are particularly vulnerable to the isolating effects of this. Thirdly, restricted income experienced by carers who are asylum seekers and refused asylum seekers was found to encourage illegal work at the expense of disabled children left at home. Fourthly, the forced migration experience, which in many cases caused the impairment in question, can present a range of symptoms that are unfamiliar to service providers. This might include the physical and mental impacts of war, torture, sexual violence or bereavement and the asylum process itself. In many cases, these intersect and result in multiple and compounding symptoms within one individual. Lastly, and perhaps most significantly, immigration status and the real and perceived impact this has on a disabled person’s benefits and entitlements, remains a significant barrier to equal treatment of London’s disabled asylum seekers and refugees.

Significantly, the findings from this study suggest strongly that little progress has been made in the lives of disabled asylum seekers and refugees since the last significant piece of research into this area in 2002 (Roberts and Harris, 2002). The researchers found then, as this study finds now, that the law around this group is complex and often misunderstood by both voluntary and statutory service providers; that data is not collected on the extent and nature of impairments and that this population experience isolation, unmet personal care needs, communication difficulties and face barriers trying to access social services and benefits. Their recommendations, which centred on addressing these findings, have largely not been acted upon.
By examining the support structures for this population, and in particular the role played by RCOs, and focussing on physical and sensory impairment as a previously under researched topic, this study adds considerably to Roberts and Harris’ original work. It also reinforces a number of their findings from six years ago and reminds us that significant work remains to be done by researchers, policy makers, service providers and advocates if the pressing needs of disabled asylum seekers and refugees are to be addressed.
8. Policy and practise recommendations

The following section identifies four key policy recommendations and a number of supplementary recommendations. These are categorised by relevance for voluntary sector disability organisations, the statutory sector, the UK Border Agency, refugee support organisations and RCOs, joint working and end with suggestions for further research.

**Key recommendations**

1) Mainstream disability and BAME organisations should review existing practises and policies in relation to the accessibility of disability services for refugees and asylum seekers, taking a more proactive approach towards these groups including consulting them on service development.

2) Regular training for mainstream disability organisations, statutory services, UKBA and RCOs on some or all of the following: asylum seeker, refugee, migrant worker and other immigrants’ rights and entitlements; on disability law and definitions; on cultural and gender issues and identifying and dealing with ‘unfamiliar’ and multiple disabilities such as those caused by war, violence and bereavement; and on the use and provision of interpreters.

3) The Home Office should review, in consultation with disability experts, disability support for asylum seekers and refused asylum seekers. This should include cash payment which causes less hardship than the use of vouchers and the need for specialist and additional subsistence support.

4) Review of existing client data collection systems by disability organisations, statutory providers, refugee support organisations and RCOs to enable better recording of information on the needs of disabled asylum seekers and refugees whilst ensuring choice and confidentiality in regards to self-identification of immigration status.

**Recommendations for disability organisations**

Regular training on asylum seeker, refugee, migrant worker and other immigrants’ rights and entitlements, on cultural and gender issues and ‘unfamiliar’ and multiple disabilities such as those caused by war and on the use and provision of interpreters.

Review existing practises and policies in relation to the accessibility of disability services for refugees and asylum seekers, taking a more proactive approach towards these groups including consulting them on service development.

Review of existing client data collection systems by mainstream disability services to enable better recording of information on the needs of disabled
asylum seekers and refugees whilst ensuring choice and confidentiality in regards to self-identification of immigration status.

Organisations with training capacity to provide free, customised training, for disability RCOs on entitlements, benefits and disability law and on using voluntary and statutory sector health and social care services on diagnosing brain injury, learning disability and sensory impairment. RCOs should be consulted as to preferred location and times, which may be evenings or weekends.

Supported participation of disability RCO representative(s) at key regional voluntary sector policy bodies, such as the Race On The Agenda equalities (disability) policy forum, backed by support and training on policy work and compensation for time away from normal RCO activities.

Capacity building organisations such as Councils for Voluntary Service should review existing fundraising support for disability RCOs with the aim of customising capacity building support.

Recommendations for statutory sector organisations

Standardisation of statutory sector equalities training for social services departments and primary care services (including GP surgeries and hospitals) to include asylum seeker, refused asylum seeker, refugee, migrant worker and other immigrants’ rights and entitlements, on cultural issues and ‘unfamiliar’ and multiple disabilities such as those caused by war and on the use and provision of interpreters.

Disabled refugees to be given particular consideration in development of employment integration strategies at both regional and national level.

The provision of culturally/linguistically appropriate outreach support targeting isolated disabled refugees and asylum seekers. Local authorities to look at commissioning RCOs to undertake culturally specific home help and personal care, based on the example of Greenwich Council, which funds the Somali Refugee Action Group to provide home-based care and support for local refugee residents.

Recommendations for UKBA/Home Office

The Home Office should review initial asylum and asylum support procedures to improve early and appropriate support and referral of disabled asylum seekers and assess procedures for identifying mental health conditions. All case owners should receive full training on disability issues.

Clarification of the responsibilities for providing care and accommodation to disabled asylum seekers and refused asylum seekers between UKBA and local authority social services departments to avoid delays and resulting hardship.
Recommendations for refugee support organisations

Booklet detailing main entitlements for disabled refugees and asylum seekers and services provided by mainstream organisations, including contact details, eligibility criteria, specialist provision and a list of accessible premises.

Service leaflets should be designed and made available in the main refugee languages and placed in places likely to reach these groups, such as churches, mosques, day shelters and GP surgeries.

Training for RCO staff on advocacy and interpreting for disabled refugees and asylum seekers.

Recommendation for RCOs

Improved data collection on numbers of disabled asylum seekers and refugee clients and the nature of their disabilities.

Actively pursue joint working opportunities with mainstream disability organisations and local health and social care services, as detailed below.

Joint working
Formal outreach advice agreements through which disability legal specialists (such as Disability Law Service) provide a free legal advice service at RCO premises on a regular basis.

Assess the feasibility of creating consortium of disability RCOs providing stronger base for commissioning of services, joint working and funding bids, stronger policy voice and enabling better spread and reach of knowledge and information.

Mainstream voluntary sector disability providers and networks should actively pursue genuine, funded partnership work with disability RCOs, building in exchanges of skills and knowledge, enabling mainstream organisations to access isolated groups and building capacity of RCOs to deliver and improve existing services.

Relevant existing training of interpreters should be strengthened to include specific components related to the needs of disabled asylum seekers and refugees.

Understanding the issues in more depth: further research
There remain considerable gaps in knowledge about disabled asylum seekers and refugees. Particular areas identified though the course of this research include the following:
Formal scoping of issue by collection of data on disabled asylum seekers and refugees: numbers, categories, and demographic profile.

Collection of good practise case studies from across the UK: working with disabled people from overseas leading to publication of Good Practise Guide for statutory and voluntary sector disability service providers.

Map existing policy advocacy and information sharing structures and identify entry points for RCOs.

Research into the extent, nature and support needs of the following disabled asylum seeking and refugee groups: those with ‘invisible’ disabilities such as HIV and epilepsy; with learning disabilities; carers; asylum seekers who have had their asylum claim refused; and children.
Glossary of terms

**Attendance Allowance (AA)** is a tax-free benefit for people aged 65 or over who need help with personal care because they are physically or mentally disabled.

**Asylum Process** is the legal process asylum seekers must go through as the UK Border Agency (see below) assesses their application for asylum and includes asylum screening, Home Office asylum interviews and appeals.

An **Asylum seeker** is a person who has left their country of origin to make an application for protection in another country and is awaiting a decision on their claim.

**Asylum support**, also referred to as ‘UKBA support’, is a form of support provided by the UK Border Agency (see below) to asylum seekers and consists of accommodation and/or subsistence support. If they have additional care needs, due to chronic illness or disability, asylum seekers may also be eligible for support from their local authority.

**Autistic spectrum disorder (ASD)** is a lifelong condition that affects how a person communicates with, and relates to, other people. It also affects how they make sense of the world around them.

**BAME (Black, Asian and minority ethnic)** refers to those in black, Asian or minority ethnic groups. BME refers to Black Minority Ethnic groups and is the language often used within the equalities field. The London Development Agency and all related bodies use the acronym BAME.

**BAME disability organisations** are organisations that provide services to black, Asian and minority ethnic disabled people.

**Carers Allowance** is a taxable benefit to help people who look after someone who is disabled. Carers do not have to be related to, or live with, the person that they care for.

**Citizens Advice Bureau (CAB)** The Citizens Advice service helps people resolve their money, legal and other problems by providing free advice and information, and by influencing policymakers. Each Citizens Advice Bureau is an independent registered charity.

**Community Care Law** relates to the provision of services to children and adults in the community by the local authority, which is governed by law. It is a complicated field with overlapping legislation, guidance and an ever-expanding body of case-law: for every general rule, there is at least one exception. However, the overarching duty on local authorities is set out in the NHS and Community Care Act 1990. Under this Act, local authorities have a duty to carry out an assessment of need for community care services with people who appear to them to need such services (known as a community care assessment) and then, having regard to that assessment, decide
whether those needs call for the provision by them (local authorities) of services.

**Disability Living Allowance (DLA)** is a tax-free benefit for children and adults who need help with personal care or have walking difficulties because they are physically or mentally disabled.

**Department for Work and Pensions (DWP)** is the government department responsible for the government's welfare reform agenda; delivering support and advice to people of working age, employers, disabled people, pensioners, families and children.

**Dispersal** is an asylum policy which came into force when the *Immigration and Asylum Act 1999* introduced new measures to transfer newly arrived asylum seekers from London and the South East to other parts of the country. Since April 2000, unless there are exceptional circumstances, asylum seekers who qualify for asylum support and who need both subsistence and accommodation are offered accommodation outside London and the Southeast.

**Discretionary leave** is a form of immigration status granted outside the immigration rules in very limited circumstances to people who have been refused refugee status but who do not fulfil the criteria for humanitarian protection.

The **Equality and Human Rights Commission (EHRC)** is an Independent statutory body established to help eliminate discrimination, reduce inequality, protect human rights and to build good relations. The Equality and Human Rights Commission has a *disability committee* to lead the commission's work on disability.

**Freedom Pass** Since April 2008 everyone who is resident in England and who is over 60 or 'eligible disabled' has been entitled to a free annual bus pass giving free off-peak travel on local buses anywhere in England. The Freedom Pass is paid for by the Local authority.

The **Greater London Authority (GLA)** is the city-wide governing body for London. It is made up of a directly elected Mayor - the Mayor of London - and a separately elected Assembly - the London Assembly - which has scrutiny powers.

**HIV and AIDS** The Human Immunodeficiency Virus (HIV) is a virus transmitted through the blood that attacks the body's immune system, which provides a natural defence system against disease and infection. Acquired Immune Deficiency Syndrome (AIDS) is a term that is used to describe the latter stages of HIV, when the immune system has stopped working and the person develops a life-threatening condition, such as pneumonia (infection of the lungs).
Humanitarian protection (HP) is a form of immigration status granted for up to five years to people who do not meet the criteria for refugee status (see below), but who cannot be returned to their country of origin as they face a serious risk to life or person for one or more specific reason. These are: death penalty, unlawful killing, torture, inhuman or degrading treatment or punishment.

Incapacity Benefit is a weekly payment for people who become incapable of work while under State Pension age. From 27 October 2008, this will be replaced by Employment and Support Allowance (ESA) for new claimants only. It is intended that current recipients of Incapacity Benefit move to ESA between 2009 and 2013.

Indefinite leave to remain (ILR) If after the five year qualifying period a refugee is granted continuing status (s)he is given ‘indefinite leave to remain’. This is a form of immigration status given by the Home Office. Indefinite leave to remain (ILR) is also called ‘permanent residence’ or ‘settled status’ as it gives permission to stay in the UK on a permanent basis.

Mainstream disability organisations are organisations that provide services to disabled people. The term includes organisations led by disabled people but does not include Refugee Community Organisations (RCOs) or refugee support organisations that focus on disability as they are covered by the terms RCO and RSO respectively.

Mapping exercise is a term used in research to mean a systematic study of existing information about a particular subject matter

The Office for Disability Issues (ODI) is a cross-government office which aims to coordinate the way government services are developed and delivered for disabled people. The ODI works with disabled people and disability groups and organisations to move towards full equality for disabled people.

Post Traumatic Stress Disorder (PTSD) is a medical term to describe a range of psychological symptoms people may experience following a traumatic event, which is outside the normal human experience. Symptoms are characterised by distressing recall, nightmares, flashbacks, avoidance behaviour, sleep disorder, irritability, hyper-arousal and social withdrawal.

Physical impairment means a musculoskeletal (involving the joints, limbs and associated muscles) and/or neurological (involving the central nervous system i.e. brain, spinal cord or peripheral nerves) condition which affects the ability to move or to coordinate the control of movement.

Personal Care Plan This system of paying for personal care is for those people who prefer to manage their own care. After an assessment of needs is carried out by Social Services, a Personal Care Plan is agreed. The individual may then elect to receive the funding for these recognized care needs, and then to undertake the recruitment, interviewing, employment and payment of the personnel required. This gives the individual autonomy over their own
support requirements and is thus a more user-led, independent arrangement. An alternative is a ready made package which is put together and entirely managed by a third party. Many people prefer to leave it to Social Services to manage and finance the provision and this is an alternative method of care management. This is part of the personalisation reforms.

**Personalisation** The Government is currently reforming how social care in the UK works and is aiming towards the greater personalisation of services. Personalisation is the concept of individuals having choice and control over their own services. This means that every person who receives support, whether provided by statutory services or self-funded, will have choice and control over the shape of that support in all care settings. The Government has attempted to put personalisation into practice with a series of pilots of individual budgets around the country. The expectation is that by 2010/11 councils will have made significant steps towards redesign and reshaping their adult social care services, with the majority having most of the core components of a personalised system in place.

This holistic approach is set out in ‘Putting people first: a shared vision and commitment to the transformation of adult social care’, the ministerial concordat launched on 10 December 2007 which establishes the collaboration between central and local government, the sector's professional leadership, providers and the regulator.

**Refugee** The term ‘refugee’ has a strict legal definition set out in the Refugee Convention (see below) meaning a person who ‘owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country…’.

However, for the purposes of this report, the term refugee will be understood in its most general sense as referring to all migrants who were forced to leave their country of origin and have been granted some form of leave to remain in the UK.

**Refugee Community Organisations (RCOs)** are ‘organisations rooted within, and supported by, the ethnic or national refugee/asylum seeker communities they serve…these RCOs are established by the refugees and asylum seekers themselves’.

**Refugee Convention** means the 1951 United Nations Convention Relating to the Status of Refugees and its 1967 Protocol, and is the key legal document in defining who is a refugee, their rights and the legal obligations of states. Originally drafted as a temporary way of dealing with the large number of displaced persons in Europe after the Second World War, the 1967 Protocol

expanded the Convention to non-Europeans and removed the temporal limitation.

**Refugee status** is a form of immigration status awarded to someone the Home Office recognises as a refugee as described in the Refugee Convention. Since September 2005 individuals awarded refugee status are no longer granted indefinite leave to remain in the country, as they were prior to this date. Instead, refugees are now granted a limited period of five years leave to remain after which their cases will be reviewed to determine whether or not they are still in need of protection, and thus able to remain in the UK.

A **Refused asylum seeker** is a person whose application for asylum has not been accepted by the Home Office and who has exhausted all rights of appeal against this decision.

**Refugee support organisations (RSOs)** are organisations that provide advice, support, and sometimes specialist services (on issues such as mental health and disability) to refugees and asylum seekers. They may employ refugees or asylum seekers but were not set up by particular ethnic or national refugee and asylum-seeking communities.

**Sensory impairment** means an impairment of any of the five main senses and includes Deafness, Deafblindness and other visual impairments.

**Social Services** is the body run by a local authority or council which provides a number of services for adults, children and families who require advice, support or care because of their particular need.

**Statutory service** is a service that is required to exist by law, e.g. social services and the National Health Service.

**Tribunals** The Social Security and Child Support Appeals (SSCSA) Tribunal is part of the Tribunals Service, an executive agency of the Ministry of Justice. It deals with disputes about welfare benefits. At an appeal hearing a tribunal of three people will look at the facts and evidence about the case and then come to their own decision about the benefit claim.

**United Kingdom Border Agency (UKBA)** is part of the Home Office and is responsible for securing the United Kingdom borders and controlling migration in the United Kingdom. UKBA also considers applications for permission to enter or stay in the United Kingdom, citizenship and asylum, and is also responsible for managing accommodation and support for asylum seekers. UKBA was formed in April 2008 from a merger of the **Border and Immigration Agency (BIA)**, Customs and UK Visas. Prior to that date, the BIA was the agency responsible for overseeing asylum support, and before that asylum support was overseen by the **National Asylum Support Service (NASS)**.
**UKBA Complex Casework Team (CCT)** is part of the United Kingdom Border Agency and deals with applications for support from asylum seekers that have needs in addition to accommodation and financial support because of their disability or medical condition.
Refugee Support / Metropolitan Support Trust

Refugee Support is one of the country’s leading providers of housing and support for refugees and asylum seekers, and is the brand name of Metropolitan Support Trust’s (MST) refugee services.

Refugee Support was established in 1957, as the British Council for Aid to Refugees (BCAR) Housing Society. Its first challenge was to house some of the Hungarian refugees who came to the UK after the 1956 uprising. In 1994 BCAR Housing merged with the Refugee Council’s Housing Division, to become Refugee Housing Association. In 1997, Refugee Housing Association became an independent subsidiary of Metropolitan Housing Partnership (MHP) – a family of social businesses that support and complement each other’s work. Refugee Housing Association changed its name to Refugee Support in 2007 when it became part of Metropolitan Support Trust.

Metropolitan Support Trust (MST) was created in April 2007 from four organisations (Refugee Housing Association, StepForward, Threshold Support and Walbrook Support) coming together to provide a wide range of specialist services to vulnerable people. MST is a registered social landlord and a registered charity. It operates across London, the East and West Midlands, and Yorkshire and Humberside, and works with refugees, people with mental health needs and learning disabilities, older people and other client groups. MST also advocates for progressive social policy. MST is part of Metropolitan Housing Partnership and is the specialist care and support provider.

One of the exciting initiatives within Refugee Support is the new programmes made possible by the Ashmore Fund. The Ashmore Fund is restricted within MST and was created from the free reserves of the former Refugee Housing Association. It is named after the former Chair, Gillian Ashmore. The purpose of the fund is to support innovative initiatives for the benefit of refugees, asylum seekers and migrants, and the Research and Consultancy Unit has received funding for its set up costs from it. While housing continues to be the anchor of all MST’s work, as it remains a priority element of refugees’ integration, MST organises its services around the individual and aims to assist every service user to make a positive contribution to the UK.

Metropolitan Housing Partnership is one of the fastest growing registered social landlords in the UK, responsible for over 34,000 homes in London, the Midlands and East Anglia. It also builds shared ownership properties and is involved in housing regeneration projects and community development.

Email: mst@mst-online.org.uk
www.mst-online.org.uk
Information Centre about Asylum and Refugees (ICAR)

The Information Centre about Asylum and Refugees (ICAR) is an independent information and research organisation based in the School of Social Science at City University, London.

ICAR encourages understanding, public debate and policy-making about asylum and refugees in the UK, grounded in accurate and academically sourced information. Established in 2001, ICAR aims to:

- collect and make available independent information on asylum in the UK;
- undertake research on asylum and refugee issues;
- generate new thinking on asylum and raise the level of public debate;
- provide consultancy expertise to government, practitioners, funders and community organisations.

ICAR does not have a Centre view. The views and opinions expressed in this report are those of the authors.

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MAYOR OF LONDON

The Greater London Authority (GLA) is a unique form of strategic citywide government for London. It is made up of a directly elected Mayor – the Mayor of London – and a separately elected Assembly – the London Assembly. There are around 600 staff to help the Mayor and Assembly in their duties.

www.London.gov.uk

Praxis is a busy centre in East London visited by over 10,000 people each year. It provides a wealth of advice and support services to migrants and refugees from all over the world, as well as a welcoming meeting place for displaced communities.

www.praxis.org.uk/

WinVisible brings together asylum-seeking, refugee and UK-born women with visible as well as invisible disabilities such as polio, Sickle Cell Anaemia and cancer. Since 1984, WinVisible’s grassroots group has been an independent voice for women of all ages and situations. It provides self-help information and advocacy on various issues including homecare, welfare benefits, employment, transport, and against violence, sexism, racism and other discrimination.

www.allwomencount.net/EWC%20WwDisabilities/WVindex.htm
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Please note the identities of all the interviewees in this document have been withheld and all images of people are generic.

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If you would like more information about the report please contact the Research and Consultancy Unit on 020 7501 2234 or email mst@mst-online.org.uk