Disabled Asylum Seekers,
the Social Model of Disability
and United Kingdom Government Policy and Legislation

by

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Part A

Chapter One: Introduction

I have volunteered with asylum seekers for several years, teaching English at a conversation class. I also provide occasional emergency accommodation at weekends for homeless asylum seekers. Through these activities I have developed a deep concern for asylum seekers and the treatment they receive in Britain. I began to observe their exclusion from many aspects of British law and policy. In addition to this, as a result of my recent placement in a community organisation led by adults with learning difficulties, I similarly began to consider the oppression experienced by people with disabilities. I have also had contact with groups of disabled asylum seekers through a previous job as a Grants Assistant, which raised my awareness of their concerns. As a result of these experiences, I decided to focus my dissertation on the issues faced by disabled asylum seekers living in Britain, particularly those arising from their experiences of our government's laws and policies. I feel that this topic merits study as it is the duty of social workers to "protect the rights and promote the interests of service users" (GSCC, 2010). This dissertation will investigate whether the statutory services available to disabled asylum seekers and the restrictions placed upon them are disabling or enabling from a social model perspective, and whether they comply with the social work value base and the Human Rights Act (1998). It will also look at what social workers can do to promote best practice in this area in line with National Occupational Standard 21 (TOPSS, 2004).

This dissertation is therefore relevant to social workers working with asylum seekers and also to social workers working with disabled people. Both of these communities experience oppression, and those people who are both asylum seekers and disabled will experience dual oppression. In addition to considering the statutory services and restrictions experienced by disabled asylum seekers, I will consider how social workers should respond (on both an individual and a collective level) in light of their value base and international human rights. The aim of this dissertation is to set out a thorough description of the statutory services and restrictions that disabled asylum seekers experience in the UK as a result of our law and policy, and whether the impact of these services and restrictions is disabling or enabling. I hope that this will be of use to those that work with asylum seekers or disabled people in assisting them to ensure the support they offer meets the needs of the disabled asylum seekers. If appropriate support is not available I hope this dissertation will collate evidence that can be used to campaign for needs to be met. My research question is "**What statutory services and restrictions do disabled asylum seekers experience in the United Kingdom? Is the impact of these services and restrictions disabling or enabling?**". I have broken this down into four main chapters, the first of which will describe the current policy and legislation relating to disabled asylum seekers, examining the system for claiming asylum, their support and restrictions, and the legal basis for this. The second chapter will look at the impact of statutory services and restrictions from the perspective of the social model of disability, commenting on to what extent each service or restriction is disabling or enabling. The next chapter outlines the potential responses to

this: it will consider what action social workers could take, both as individuals and as a collective body. The final chapter will summarise and conclude my findings.

Though this project is a literature review, I see it as a potential pilot for a larger empirical research project, the details of which I will describe in my methodological review. I think that research should be emancipatory wherever possible, and my recent placement in an organisation run by adults with learning difficulties who undertake emancipatory research has confirmed this view. It therefore does not seem right for me to decide which issues are most important to disabled asylum seekers without consulting them. However, due to the time frame and the assignment criteria for this project, it is not possible for me to discuss the dissertation in detail with disabled asylum seekers to allow them to shape the project so that it fits their agenda and is emancipatory (Oliver, 1992). Nevertheless, my experiences with asylum seekers, disabled people and disabled asylum seekers (and the organisations that support them) described earlier in this introduction have naturally highlighted key challenges that they face. I will allow this to influence which particular services and restrictions experienced by disabled asylum seekers are particularly focused on (though I will give a broad overview of all those most commonly mentioned in the literature I have found).

To explain how I found, selected and appraised literature relating to disabled asylum seekers, the next chapter will describe my methodology and approach to the literature review.

Chapter Two: Methodology

This chapter will describe my methodological approach to the literature review, including definitions of terms, inclusion and exclusion criteria, search methods, theoretical underpinnings and values.

To begin with, I defined the terms mentioned in my research question: **What statutory services and restrictions do disabled asylum seekers experience in the United Kingdom? Is the impact of these services and restrictions disabling or enabling?** An 'asylum seeker' is someone who has applied for refugee status and is waiting for the government to make a final decision regarding their claim (Burnett and Peel, 2001a). The disabled asylum seekers referred to in the research question could include individuals who have a range of impairments including those described in section 29 of the National Assistance Act 1948: sensory impairments, physical disability, mental health issues, and chronic illness. However, I am taking a social model definition of disability which is "the failure of physical and social environments to take account of the needs of particular individuals or groups" (Oliver, 1993, p61). An individual is not disabled by their impairment but rather by the barriers created by society not accommodating their needs and thus preventing them from participating fully in the mainstream of society (UPIAS, 1976, cited in Oliver, 2009, p42-3). The focus of this dissertation will therefore not be individual impairment but instead will look at disability in terms of the barriers experienced by individuals. The statutory services and restrictions to which I refer in my research question are specifically the

support or restrictions delivered by statutory services as prescribed in law and policy. It does not refer to any services provided by voluntary or community organisations, as this would not contribute to the discussion as to whether UK law and policy towards disabled asylum seekers is enabling or disabling. It would also be too broad for the time and length constraints of this review.

I will endeavour to produce a balanced, thorough review of the literature regarding disabled asylum seekers. However, I do not think it is possible (or even desirable) to suspend all values and produce an entirely objective review (May, 2001). With this in mind, I will outline my values, approach and theoretical underpinnings, as these have influenced my methodology and interpretation. I support the social model of disability (Oliver, 1996) with the caveat that some symptoms such as pain are, in some circumstances, caused by a medical condition requiring medical treatment, rather than the disabling effect of barriers. My ontological approach is constructionism (Bryman, 2008), as this dissertation will consider the impact that UK government law and policy has on disabled asylum seekers, and to what extent this law and policy has contributed to and constructed their situation as disabled people with no place of refuge. I will take a social production theory approach as I consider the disabling impact of inequalities (Wilkinson, 2005), as much inequality is experienced by asylum seekers. My epistemological standpoint is broadly interpretivist in that I do not think detached, positivist approaches are appropriate when studying people: their actions are complex and demand interpretation (Bryman, 2008). This does not imply that my viewpoint is postmodern: reality is not conditional upon my interpretation.

My values as well as theoretical approach will influence my view of the subject matter. Though I am looking at the treatment of disabled asylum seekers as a whole, they are not a homogenous group and my most recent placement has taught me the importance of a person-centred approach. My Christian world view and my commitment to social work values mean that I believe that everyone should respect human rights, including those of disabled asylum seekers. I hope this dissertation will contribute to the upholding of human rights.

This literature review is intended to be a systematic rather than narrative review. I began the literature search by identifying inclusion and exclusion criteria, as suggested by Aveyard (2007). The inclusion criteria I identified were:

- Literature in the English language, because this is the only language I read fluently.
- Literature written from 1998 onwards. Literature after 1998 will include the situation before the Immigration and Asylum Act 1999, as well as after, without being too out of date.
- Literature that is relevant to the research question, therefore:
    - Literature on the subject of disabled asylum seekers
    - Literature on the subject of asylum seekers that would also apply to disabled asylum seekers
    - Literature on the subject of statutory services that disabled people can expect to receive that would also apply to disabled asylum seekers.

- Both literature published in journals and grey literature, as much relevant literature has been produced by charities and community organisations working directly with asylum seekers.
- Research carried out in the UK, so that it is relevant to the research question and the situation in which I hope to practise social work.

The exclusion criteria I identified were:

- Literature that does not directly relate to the research question.
- Literature regarding immigration in general rather than issues specific to asylum seekers.
- Literature that was written before 1998.
- Literature that is not in English.
- Newspaper articles. These are excluded so as to keep the literature review achievable within the time frame. The media's approach to asylum seekers, disability and disabled asylum seekers is significant to this review but will be covered in other literature.
- Research regarding the statutory services and restrictions experienced by asylum seekers outside the UK. This will also help to keep the review achievable within the time frame.

My next stage was to identify initial key words relevant to the research question: 'disabled' and 'asylum seeker'. I then searched for 'disabled' and 'asylum' and 'seekers' on Google scholar which produced 8680 results. To narrow this down, I limited this to after 1998 and changed it to 'disabled' and 'asylum seekers'. This reduced the search total to 5160. I narrowed the

search further by limiting it to the title only, using the same keywords and excluding citations. This produced the more manageable sum of five results: a chapter of a book (Harris and Roberts, 2004) and four articles: Ward et al (2008), Harris (2003), Roberts (2000) and Roberts and Harris (2002a). All the articles and chapter met my inclusion criteria and were extremely relevant to my research.

To find more results I used the 'cited by' and 'related articles' function on Google Scholar for each article. This produced an additional 326 articles, several of which were repeated, probably because the original articles were on similar topics with similar authors. After excluding all repeated results and reading the remaining abstracts, fifteen were found to be relevant.

I then searched on the University of York's Social Policy Research Unit using the subject keyword 'refugees/asylum seekers' from a list of options, for all publications after 1998, as several of the articles I had found were published there. This produced 16 results, of which one met my criteria and had not already been found. A search using the keyword 'ill/disabled adults' and the parameter 'after 1998' found one additional relevant article.

The next stage of my search was to search in the University Library's online catalogue for books. I searched for anything published between 1998 and 2010 in English, using the keywords 'disability' and 'asylum seeker'. This did not produce any results, so I tried various combinations of similar terms such as 'disabled' and 'refugee' but still did not produce any results. I then did a title

search for ‘asylum seeker’ which produced a number of books, of which nine appeared to be relevant.

My next stage was to search on the Social Care Online database, for the key words ‘asylum’ and ‘disability’ in the topic list of an article. This did not produce any results even after trying combinations of similar terms such as refugee, so I broadened the search to anywhere in the text of an article. This produced 17 results, but all the relevant articles had already been discovered in earlier searches.

Finally, I looked at three specialist websites which I was aware of through my interest in asylum issues: www.refugeecouncil.org.uk, www.centreforsocialjustice.org.uk, and www.icar.org.uk (Information Centre about Asylum and Refugees). On the Refugee Council website I looked for articles in the A-Z under the keywords ‘Mental health’ and ‘Disabilities’, and found the same three articles under each, all of which met my criteria. On the Centre for Social Justice website I selected ‘asylum’ from the list of topics, which led me to the report ‘Asylum Matters – Restoring Trust in the UK Asylum System’ (2008), which met my inclusion criteria. Next, on the Information Centre about Asylum and Refugees, I searched for ‘disability’ and ‘disabled’ and found three new, relevant documents. I also found information about the asylum system on www.ukba.homeoffice.gov.uk.

On reflection I felt that my earlier Google scholar search may have been rather narrow, as it searched for keywords in the title only, and only pulled up

5 articles. With this in mind, I ran the search again but for keywords anywhere in the article. As earlier, this produced 8680 results but as they were in order of relevance, I decided to look through the first 100 articles for any that earlier searches may have missed, and found six articles which met my criteria.

I then decided to search for the key words ‘asylum seeker’ and ‘mental health’ on Google Scholar, as I had noticed several papers in the reference lists of the articles I had found that specifically related to these topics. I once again limited my search to after 1998 and title only, but this proved to be wider as it produced 68 results of which eight met my criteria. Again, to ensure I had not missed any I then changed the limits of the search from title only to anywhere in the text, and checked the 100 most relevant results (of 5270) for any that met my criteria and had not yet been found. This produced an additional six articles.

I decided to try a few additional search approaches to ensure that I had been thorough. Firstly, I searched for key authors on Google Scholar in case they had written any additional relevant papers (Roberts, Harris, and Ward, as they were key authors on the most relevant papers). This produced one additional article: Palmer and Ward (2007). From this paper I realised that ‘forced migrant’ can be considered a synonym for asylum seeker, which I had previously overlooked. I then ran another Google Scholar search combining this with disab* (to include disabled and disability) and then with mental* (to include mental health, illness and distress) but I could not find any results. I

believe this to be because ‘forced migrant’ is a less common term for asylum seekers and can also be applied to human trafficking.

I did not search in any particular journal for additional articles as my results have come from a broad range of sources. Finally, I checked in the reference lists of the most recent and relevant article (Ward et al, 2008). This produced two additional documents which then led to a further three documents. Any additional documents mentioned in this dissertation were discovered in the reference lists of other articles, during the writing process.

Overall I feel my search approach has been effective at identifying the majority of relevant literature, as I took a number of different approaches to reduce the chance that I had missed any key documents. I have used a combination of three search methods, as described by Greenhalgh and Peacock (2005): a protocol driven search, in which I decided my criteria, terms and search strategy beforehand; ‘snowball sampling’, in which the strategy developed throughout the search through checking reference lists and electronic citation tracking; and finally personal knowledge, in which I looked on relevant websites of which I had previous knowledge. I found the ‘snowball’ technique to be the most effective as it ensured I had not missed any relevant articles whose titles did not contain my search terms, and enabled me to discover information from more unusual sources such as websites or community organisations with which I am unfamiliar.

In order to critically appraise the documents I had found, I consulted the Critical Appraisal Skills Programme appraisal tools (available from http://www.sph.nhs.uk/what-we-do/public-health-workforce/resources/ critical-appraisals-skills-programme) and used questions from it to help me to assess the reliability and validity of the qualitative papers and the majority of the quantitative and review papers. For the papers that were based on questionnaire research and did not fit into any of the categories for which a CASP tool was available, I used the suggestions from Boynton and Greenhalgh (2004) as to what good questionnaire research should look like. I then categorised the papers as to which particular areas of statutory services or restrictions they covered in order to structure my review.

This chapter has explained my search strategy in detail as well as my methodological approach. The next chapter will describe the UK asylum system and the statutory services, support and restrictions experienced by disabled asylum seekers.

Chapter Three: Background

This chapter will give a broad overview of both the restrictions and the rights of disabled asylum seekers in the UK. It will serve to put into context later chapters describing the impact of these restrictions and rights. I will start by describing the asylum process in the UK and the legal restrictions placed upon asylum seekers while awaiting a claim. I will then outline the current situation regarding the entitlement of disabled asylum seekers to statutory services of which they may be in need, including housing, health care, financial support and social care.

The asylum process

An asylum seeker is a person who is awaiting the result of a request for refugee status (Burnett and Peel, 2001a). A refugee is defined by the 1951 Refugee Convention as a person who has 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 or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it." (UNHCR, 1951).

Persons who have had a request for refugee status rejected are known as 'refused asylum seekers'. This dissertation will discuss both asylum seekers and refused asylum seekers, but will not comment on refugees in any detail, in order to stay focused on the research question: **What statutory services and restrictions do disabled asylum seekers experience in the UK, and what is the impact of these services and restrictions?**

Disabled asylum seekers may be people who were disabled or impaired in their home country prior to their need to claim asylum. Alternatively, they may have become disabled through torture or persecution, directly resulting in their need to claim asylum. Thirdly, they may have become disabled through their journey to the UK, as such journeys are often difficult and dangerous. Finally, they may have become disabled as a result of their experiences in the UK after arrival.

The asylum process in the UK is complex and whole textbooks have been written on the subject. With this in mind, I will summarise the procedure most commonly undertaken by asylum seekers, without exploring all potential deviations.

(Information for diagram from UKBA, 2011).

There are three possible outcomes: the first is that the asylum seeker is granted 'indefinite leave to remain', or refugee status; the second is that the asylum seeker is granted 'humanitarian protection' or 'discretionary leave' (these replace 'exceptional leave to remain') for a limited period, and the final possible outcome is that the claim is refused (Ward, 2003). If the claim is refused, the refused asylum seeker usually has the right to appeal.

To give further context to the situation, in 2009, there were 24,485 new applications for asylum in the UK (excluding dependants, which bring the total to 30,675 for 2009). There were 7,400 cases still waiting for an initial decision at the end of 2009. Of the initial decisions made in 2009, 17% were granted asylum (Home Office, 2009). These statistics were produced by the Home Office Research, Development and Statistics Directorate under the National Statistics Code of Practice, based on data provided directly from UKBA, and may therefore be regarded as extremely credible. However, government statistics are influenced by the government's methodological approach and underpinning values. Oliver (1990) highlighted this in his discussion of interview questions used by the Office of Population Censuses and Surveys in a 1986 survey, which used a medical model approach and could be seen to be contributing to the oppression of disabled people. Government statistics should therefore not be assumed to be entirely objective but could be subject to differing interpretations.

Many of these refused cases will then go to appeal; in 2007 89% of initial decisions were appealed (Centre for Social Justice, 2008). UKBA also

estimate there is a large backlog of older (pre-March 2007) cases which could be up to 450,000, though they anticipate having all these cases resolved by 2011 (UKBA, 2010b). Additionally, once a case has been decided, there is a gap between the decision and the time when the refused asylum seeker returns to his or her own country, if at all. In 2004-5, 1000 asylum seekers were removed or left voluntarily, on average per month. In 2003-4, the average length of time between a final decision and actual removal was 403 days (National Audit Office, 2005, p7). This shows how difficult it is to form a clear picture of the number of asylum seekers and refused asylum seekers currently in the UK; I could not find any definitive statistics on the matter. Jacqui Smith, while Home Secretary, stated that it is "impossible to quantify" the number of failed asylum seekers who remain in the country (House of Commons Hansard, 2008).

In terms of the number of disabled asylum seekers in the UK, this is even more difficult to define. The most recent paper that I found specifically on the subject of disabled asylum seekers (ICAR, 2009) highlighted the lack of reliable demographic data available. A number of reasons were suggested for this, including the following: the Home Office does not include disability in its statistics about asylum, organisations (statutory and voluntary) providing services to people who are disabled do not tend to record the numbers of asylum seekers using their services, and vice versa – organisations (statutory and voluntary) providing services to asylum seekers do not tend to record the numbers that are disabled, and the fact that the definition of disability varies

between organisations and individuals, so even if the data is recorded it is not consistent.

There have been two key investigations into the demographics of disabled asylum seekers in the UK. The first surveyed 300 organisations (a mixture of disability organisations and refugee community groups) of which 101 replied. Of these organisations, 44 'were in contact with' 5312 disabled refugees or asylum seekers (Roberts and Harris, 2001). The second study contacted 51 organisations based in London (a mixture of refugee organisations, disability organisations, citizen's advice bureaux and one solicitor), of which 30 'were in contact with' 11,992 disabled refugees or asylum seekers (Ward et al, 2008). Ward et al also found that the UK Borders Agency referred 203 asylum seekers with disabilities to local authorities between 4 January 2008 and 3 March 2008. Only one of three local authorities surveyed had any data regarding disabled asylum seekers, which was that they had referred 35 asylum seekers for community care or mental health support (Ward et al, 2008). Ward's study is more credible as his team set out their research methodology in more detail than Roberts and Harris (2001), however Roberts and Harris only intended their study to serve as a minimum estimate rather than reliable demographic data. Ward's investigation is more internally consistent as his team set out broad guidelines as to the definition of disability and the impact of impairment on daily life. However, Ward et al made it clear in their research that they felt the guidelines may not have been followed and that much of the data provided by organisations was the result of guesswork so should only be treated as a "very rough guide" (Ward et al, 2008, p25).

Both studies showed a wide variety in the disabled asylum seekers surveyed, in terms of the nature of their impairments and in terms of their country of origin.

Restrictions on asylum seekers

Asylum seekers and refused asylum seekers can be detained for administrative purposes in immigration removal centres at any point during the process, and there is no maximum amount of time for which they can be detained (Nationality, Immigration and Asylum Act 2002, Part 4). Asylum seekers who can show they are suffering from serious medical conditions, serious mental illness, or have serious disabilities that 'cannot be satisfactorily managed within detention', or those who can show independent evidence that they are victims of torture, are considered to be 'suitable for detention only in very exceptional circumstances' (UKBA, 2010a, section 55.10). However, there is evidence to suggest that many asylum seekers in these categories are still being detained (Joint Committee on Human Rights, 2007, section 236). If an asylum seeker is not detained, he/she is granted 'temporary admission', in which case the restrictions and entitlements outlined in the rest of this chapter apply.

Asylum seekers are not usually allowed to work; the exception to this is asylum seekers who have been waiting for over a year for an initial decision who may apply for the right to work, but this is a rare situation, as most receive an initial decision within a year and then can wait indefinitely for an

appeal (ibid). Refused asylum seekers are not allowed to work (Clayton, 2004).

Accommodation

Accommodation may be provided for destitute asylum seekers and their dependants under section 95 of the Immigration and Asylum Act 1999 (or section 98 for emergency 'initial accommodation'). An asylum seeker is defined as destitute if

> *"(a) he does not have adequate accommodation or any means of obtaining it (whether or not his other essential living needs are met); or (b) he has adequate accommodation or the means of obtaining it, but cannot meet his other essential living needs."* (Immigration and Asylum Act, 1999).

They may also be eligible for accommodation by the local authority under section 21 of the National Assistance Act 1948 if they are 'destitute plus' – that is, if they have community care needs as well as being destitute. The accommodation provided to asylum seekers in either case is basic and they do not have a choice about where it is, due to the Government's policy of dispersing asylum seekers around the country. This lack of choice is particularly detrimental to disabled people whose accommodation may be inappropriate for their needs and far from the support of family or friends (RMAG, 2006, and Aspinall and Watters, 2010, p59-60), but this will be discussed in more detail in a later chapter.

Refused asylum seekers are not eligible for accommodation under the above legislation; instead they may be eligible for accommodation under section 4 of the Immigration and Asylum Act 1999. There are strict restrictions on the eligibility for this accommodation, of which the key criteria are that the asylum seeker must be making all possible attempts to leave the country but cannot for reasons outside his or her control (UKBA, 2010c). The Centre for Social Justice (2008) has calculated that only 3% of refused asylum seekers are accessing section 4 support; however this is based on estimates of the number of refused asylum seekers in the UK, which as discussed earlier, cannot be quantified with any confidence.

The accommodation potentially available under sections 4, 95 and 98 of the Immigration and Asylum Act 1999 described above can be denied if the asylum seeker has not made their asylum claim 'as soon as reasonably practicable after the person's arrival in the UK (Nationality, Immigration and Asylum Act 2002, section 55). This is usually within 3 days of arrival, however it can be difficult for asylum seekers to claim asylum within this time frame as there are only two Asylum Screening Units in the UK at which asylum seekers can make their claim: Liverpool and Croydon. It is obviously difficult for new arrivals in the country who may not speak English and have very little money to find out that they need to travel to one of these units and to navigate our transport system. Asylum seekers can claim on arrival in ports, but only if they pass through the official channels which is not always possible due to the nature of the transport they have had to use in order to gain entry to the country.

Additionally, until an asylum seeker is able to make his or her official claim for asylum, there is no support available at all, and he or she will have to rely on charities or friends, or more likely, sleep rough. There are also many reported cases of delays in administration or administrative errors resulting in asylum seekers becoming homeless or destitute (Centre for Social Justice, 2008, p50, Joint Committee on Human Rights, 2007, p28). For the reasons discussed earlier in this dissertation, it is difficult to define the numbers of homeless or destitute asylum seekers, but there have been several small-scale studies that have attempted to quantify the numbers in their local area. I will not attempt to summarise these due to the space constraints of this dissertation, however Aspinall and Watters (2010, p57-63) outline the details of the studies and conclude that destitution and homelessness are widespread throughout the asylum process but most commonly for refused asylum seekers.

Financial support

Asylum seekers and refused asylum seekers are not entitled to any benefits. However, asylum seekers may be entitled to financial support under section 95 of the Immigration and Asylum Act 1999, if they meet the criteria for destitution outlined above. A destitute adult asylum seeker with no dependants is entitled to £35.52 per week, or £42.62 if he or she is a lone parent (UKBA, 2010d). It is assumed that asylum seekers entitled to this support will also have been provided with rent-free accommodation with most bills also covered.

Refused asylum seekers may be eligible for financial support under section 4, subject to the criteria outlined earlier in this dissertation. This financial support consists of £35.59 per week loaded onto an Azure card, which can only be spent on food or toiletries (UKBA, 2010c). The Azure card cannot be used for travel (to shops, doctors, schools), medicines, shoes or clothing, phone cards to contact lawyers or family members, or food from smaller shops selling more familiar or religiously compliant food. It is a recent replacement of the similar voucher system in which the refused asylum seeker received supermarket vouchers each week to the required amount, which was described as an 'inhumane and inefficient' system by the Joint Committee for Human Rights (2007, p38). The new system is even more so, as the asylum seeker must keep their Azure card so cannot even sell the food vouchers to charities at face value, in exchange for cash to be used for travel etc, as used to happen with the old system.

The section 55 restrictions outlined earlier apply to both the section 95 financial support and the section 4 Azure card support. The administrative errors and delays impacting accommodation also impact on financial support. All of this results in the widespread destitution described earlier.
There appears to be no clear process for applying for additional disability-related financial support from UKBA for asylum seekers or refused asylum seekers who have disabilities, though they may be eligible for support or services through community care.

Health care

Asylum seekers are entitled to register with a GP, and GP practices have discretion to register refused asylum seekers. Primary care is free to both asylum seekers and refused asylum seekers, however an HC2 (Health Costs 2) certificate is required for exemption from prescription charges. To get an HC2 certificate, a complicated form must be completed and various documents provided. Additionally, Aspinall (2006) reports that almost all studies he reviewed showed that there were problems for asylum seekers accessing health care, including lack of (or temporary) registration with GPs, commonly due to lack of ID or lack of permanent address, communication difficulties and lack of awareness of entitlements by both GPs and asylum seekers themselves. Aspinall's review is reasonably reliable as he searched a wide range of databases using a variety of search techniques which were clearly explained in an appendix to his review. A smaller study of 36 asylum seekers in Glasgow found that the main issues were in navigating the healthcare system, and once asylum seekers actually saw the GP or other health professional, their experiences were mostly positive (O'Donnell et al, 2007). This study could be considered less reliable as it is small, however the qualitative nature of the results and the rigorous, consistent comparative approach to analysis mean it is worth considering, as a larger study would make the findings difficult to synthesise in this way.

In terms of secondary care, asylum seekers are exempt from paying charges; however refused asylum seekers are not exempt. The main exceptions to this are for treatment for certain infectious diseases for public health reasons (not

including HIV), and treatment in the Accident and Emergency Department (Department of Health, 2007a, p27). There is some evidence to suggest that refused asylum seekers are pursued for payment for treatment (which they have no means of affording due to destitution) or are denied treatment because they cannot pay, including maternity care (which can lead to babies of HIV positive mothers contracting HIV, which could be prevented with treatment) and care for long term manageable conditions such as diabetes, which left untreated can become life threatening (Kelley and Stevenson, 2006). This could be seen as a breach of Article 1 of the Human Rights Act (1998): the right to life.

Community care

Asylum seekers who appear to be in need of community care services are entitled to a community care assessment under section 47 of the NHS and Community Care Act 1990. However, their community care needs cannot be solely due to destitution – they must be 'destitute plus' as described earlier. If they meet these criteria they may be eligible for community care under section 21 of the National Assistance Act 1948. They are also eligible for after care if they have been detained under the Mental Health Act 1983, under section 117. Refused asylum seekers are not entitled to section 21 community care under Schedule 3 of the Nationality, Immigration and Asylum Act 2002, unless they applied for asylum on arrival at a port.

In reality, though an assessment must be carried out, local authorities have the power to provide services rather than the responsibility to, and can also

ignore needs if there are resource limitations (Harris and Roberts, 2004). Community care services to asylum seekers have been described as confusing, unclear and inconsistent (ICAR, 2007b). Harris and Roberts (2004) found that community care services to asylum seekers were fragmented mainly because of conflicts of responsibility between the local authority and the key organisation for supporting asylum seekers (at the time, NASS). It would appear therefore that many asylum seekers are not having their community care needs met.

In summary, there appears to be statutory support available to disabled asylum seekers, however there are problems accessing this support. Whether this support is enabling or disabling is discussed in the next chapter, together with the impact of the restrictions placed upon asylum seekers.

Chapter Four: Impact

This chapter draws on the social model of disability to examine possible disabling and enabling impacts of the policies and procedures summarised in the previous chapter. The social model of disability defines disability as social oppression: the "failure of physical and social environments to take account of the needs of particular individuals or groups" (Oliver, 1993, p 61). There are several criticisms of the social model of disability: that it does not take account of the reality of having an impairment, that it does not acknowledge the difficulties associated with having an impairment, that it does not include other types of oppression such as racism, that the main issue is not environmental barriers but instead being treated as something 'other', and that it is not a social theory (Oliver, 2004). However, Oliver counters these by explaining that "the social model is not about the personal experience of impairment but rather the collective experience of disablement" (p8), it can be seen to be based on the experiences of people with impairments, it is open to including other oppressions, 'otherness' is not as big a problem as the poverty experienced by many disabled people in the world, and finally, that the social model never claimed to be a theory (Oliver, 2004). I would argue that despite the criticisms, the social model is a credible framework within which to seek to understand the experiences of disabled asylum seekers. United Kingdom government policy and procedure appears to generally locate the problems of disability in the individual disabled asylum seeker, rather than in the treatment they have received at the hands of the people from whom they are seeking sanctuary, or from a society which fails to take adequate account of their

needs. This chapter will explore ways in which the UK policy response to disabled asylum seekers may have a disabling impact on them. I will start each section by acknowledging the counter-arguments and then discuss examples of potential disabling barriers. A full list of the research that I found that suggest disabling barriers that may be experienced by disabled asylum seekers is available in Appendix 1, as the scope of this dissertation prevents me from detailing all possible disabling barriers at this point.

Detention of adults

The discussion below regarding detention uses the term asylum seeker to include refused asylum seekers as well as asylum seekers awaiting the outcome of their claim, in line with the terminology used in most related research (e.g. Robjant et al, 2009b). There has been a relatively large amount of research into the impact of detention on asylum seekers in general, when compared to the amount of research into disabled asylum seekers in particular. The available studies provide a variety of evidence as to the impact of detention: on children, on adults, and on adults who already have impairments. The majority of the research that I found suggested that detention does have a detrimental impact on asylum seekers; I found little research to suggest that detention is not harmful However, this may be due to the fact that most researchers who are interested in asylum seekers are sympathetic to their situations, or it could be due to the fact that there is little funding available to undertake research into issues of asylum, and most of the research is therefore undertaken by refugee community organisations who are may be more sympathetic to asylum seekers.

The Independent Asylum Commission (IAC) approached UKBA in 2008 regarding a number of concerns; in their response to the IAC's concerns, the UKBA commented that "detention plays an important role in maintaining an effective immigration control" and is a last resort (IAC, 2008c). There are several arguments that detention is necessary: to prevent refused asylum seekers absconding prior to removal, to ensure speedy decision making as detainees are easily available for interview, and to make sure those without right to remain leave the country (Home Office, 2002). However, the findings of the IAC (2008c) and the Joint Committee on Human Rights (2007) suggest that detention is not being used merely as a last resort, and the Centre for Social Justice (2008) suggest that it is for the most part unnecessary. A study by Bruegel and Natamba (2002) cited in ICAR (2007a, p19) found that 90% of detainees released complied with their bail requirements rather than absconding. There are also alternatives to detention available, such as electronic tagging or home detention.

It could also be argued that detention is enabling to the majority of the asylum seeker population in the UK, as it costs less to detain an asylum seeker during the short 'fast-track' period than to provide accommodation and financial support for an asylum seeker living in the community during a lengthier decision-making process (IAC, 2008c), and this could leave more money available to support asylum seekers generally. Detention helps maintain an efficient immigration system (IAC, 2008c) which will be of benefit to successful asylum seekers. UKBA maintain that detention is not harmful as detainees have the right to the same standard of NHS services as the general

public and that they take seriously their duty of care (IAC, 2008c). Additionally, politicians have argued that if asylum seekers are treated too leniently, this can give opportunity for the extremist right to gain support and treat asylum seekers more harshly (Goodman, 2008). Many members of the general public support the detention of asylum seekers, and Lynn and Lea (2003) have highlighted several of their reasons: it is easier to send 'bogus' asylum seekers home if they are detained, which can help to limit terrorism as well as reducing the strain on the UK's resources, and genuine asylum seekers should not object to being temporarily detained as they have nothing to hide (Lynn and Lea, 2003). However, Lynn and Lea conclude that the concept of 'asylum seeker' has been socially constructed as something alien and undeserving, resulting in unfair treatment: for example, the assumption that if an asylum seeker is not happy to be detained, he or she must be a 'bogus' asylum seeker.

I will now summarise evidence I found for detention being a disabling barrier. Robjant et al (2009a) carried out a systematic review of studies looking at the mental health impact of immigration detention on detainees. This review was relatively thorough and reliable as it used a comprehensive search strategy, with clear inclusion and exclusion criteria based on the reliability of evidence. The authors outline the limitations of each study that they use, however despite these limitations they still report that the studies are consistently finding "poor mental health among detained asylum seekers". They also report a growing body of evidence suggesting that "asylum procedures are

increasing the mental health difficulties of traumatised individuals who are seeking asylum in the West." (Robjant et al, 2009a, p311).

Robjant also carried out her own study, comparing the psychological distress levels of detained asylum seekers, detained former prisoners, and asylum seekers living in the community. Though on a small scale (144 participants), the study is explicit about its methodology and uses robust measures of psychological distress (Hospital Anxiety and Depression Scale, Impact of Events Scale - Revised, and the post-traumatic diagnostic scale), and the findings are statistically significant. The study found that detained asylum seekers were suffering from higher levels of depression, anxiety, and post-traumatic stress disorder symptoms than the asylum seekers living in the community (Robjant et al, 2009b). A high rate of self harm in prisoners has also been reported: 12.97% in immigration detainees compared to 5-10% in 'mainstream' prisoners (Cohen, 2008). Cohen's study is based on data provided by immigration removal centres and by prisons, both of which record known incidents of self harm. However UKBA, state that they "do not agree that levels of suicide or self harm in IRCs are significantly higher than those in other custodial establishments" (IAC, 2008c, p16). They also comment that the same NHS services available to the general public are available to detained asylum seekers (IAC, 2008c, p20). However, HM Chief Inspector of Prisons (2006) found that health care in Yarl's Wood Immigration Removal Centre was inadequate, particularly mental health care, and that concerns about negative medical consequences of continuing detention were not routinely addressed. A later report (HM Chief Inspector of Prisons, 2009)

found some improvement in the health care system but no assessment of mental health need or consistent support for those at risk of self harm. It also found that detention had a clear, adverse impact on the welfare of children. These investigations could all suggest that detaining asylum seekers has a disabling impact on them by creating or exacerbating mental health problems.

Detention of children

I will now consider the impact on children in more detail. Lorek et al (2009) investigated 24 children in Yarl's Wood immigration removal centre, who self-selected by accepting clinical assessment offered when they responded to offers of free legal assistance from Medical Justice, a registered charity. Eleven of these children underwent psychological assessment, which found that all of them had "begun to develop symptoms of depression and anxiety" since being detained (p578), and had also developed eating problems. Ten out of 11 had developed problems sleeping. Eighteen out of the 20 children assessed by a paediatrician had new or increased health problems since being detained. The study concluded that detention could be said to be potentially harmful to children's mental and physical health and should therefore be reconsidered.

When interviewed by the BBC, the UKBA maintained that previous studies [namely, Lorek et al, 2009] into the negative impact of child detention were "limited", out of date and that the Yarl's Wood immigration removal centre had been "praised on numerous occasions for its children's facilities" (BBC, 2009). In response to this, Medical Justice undertook a larger, more up-to-date study.

This describes itself as the first large UK study into the damage caused and exacerbated by detaining children. This study is recent, taking into account the stance of the coalition government on child detention and immigration policy, and reviews legislation, policy and academic studies regarding detention of children and its impact. Further to this, the study uses as cases 141 children from Medical Justice records, selected according to set criteria: their availability (i.e. still in the UK), ethical considerations, and meeting the criteria for this study (i.e. children detained with families, not unaccompanied asylum seeking children). The authors are clear that they acknowledge the sample may not be fully representative, however it presents a "window into the ways in which the detention process has harmed, damaged and vilified a particular group of children" (Burnett et al, 2010, p21). The findings of this investigation are that 74 of the 141 children were found to have suffered psychological harm as a result of detention, and 92 of the 141 were found to have developed or exacerbated physical health conditions as a result of detention. All medical findings were from independent expert clinicians. I will first look at the psychological harm in more detail, then the physical harm, and finally the policy approach that has been taken.

The psychological harm experienced by the children was examined by independent experts in more detail in 32 of the cases, who found that detention had a detrimental impact on the wellbeing of all 32 children, and that 78% of the children were afraid (with symptoms including panic attacks), and 94% were suffering from low mood. Fifty-nine percent were displaying symptoms of developmental regression. The Home Office do not record the

suicidal tendencies of children or instances of self harm specifically in children, however this study (and several others that I have read that looked into this, for example, Robjant et al, 2009a) found instances of self harm in detained children. This study also found that three of the children had attempted suicide whilst in detention. It could be therefore be argued that detaining children is a barrier to their positive mental health and therefore has a disabling impact upon them.

With regard to the impact of detention on the physical health of children, 65% of the children in the Burnett et al (2010) study were found to have new or increased physical health problems as a result of detention. These included seizures, weight loss, abdominal pain, coughing blood, asthma attacks, vomiting and diarrhoea, as well as problems resulting from mismanaged medical conditions such as sickle cell anaemia. There were 28 cases of medical mismanagement which were supported by Medical Justice clinicians. As with mental health, it could be argued that this research suggests that detention may be a barrier to physical health in children, and may thus have a disabling impact.

The detention of children could be considered contrary to several aspects of UK policy and legislation: Firstly, the UK Human Rights Act (1998), particularly the right to liberty and security (article 5), though this does have the qualifier that detention pending deportation is legal, and article 8, the right to private and family life. Secondly, the UN Convention on the Rights of the Child (1989), which the UK only recently (September 2008) fully signed up to

without reservations; detention could be considered contrary to several articles including Article 2: freedom from discrimination, Article 3: protection and care as needed for the child's wellbeing, Article 27: a standard of living adequate for mental and physical development, and Article 37: no child shall be denied liberty unlawfully or arbitrarily. Thirdly, Every Child Matters (HM Government, 2003) states that the key outcomes for all children are to be healthy, stay safe, enjoy and achieve, make a positive contribution and achieve economic wellbeing. It would seem, however, that asylum seeking children are excluded from this as despite a growing body of evidence that detention has a detrimental effect on health, enjoyment and achievement, the UK Government continues to allow it to take place at present.

Financial support

I will now consider the impact of the available financial support and the possibility that asylum seekers experience destitution, as mentioned in the previous chapter. There are three main arguments against destitution being a disabling barrier for asylum seekers: the first is that asylum seekers are not destitute. When the IAC broached the issue of destitution with the UKBA, the UKBA did not acknowledge that there is significant destitution among asylum seekers (IAC, 2008c, p32) but instead outlined the available support. The minimum standards for the living conditions of asylum seekers across the EU have been established (Home Office, 2002) and the UK has committed to them and provides several types of support to asylum seekers, as outlined in Chapter 3. However, the prevalence of, and reasons for, destitution have also been outlined in Chapter 3 chapter – namely, the restrictions on working, the

low levels of financial support for asylum seekers and refused asylum seekers, and the Azure card system and tight criteria on financial support and accommodation for refused asylum seekers.

The second argument against destitution being a disabling barrier for asylum seekers is that limited support for asylum seekers is a legitimate form of immigration control, as it encourages refused asylum seekers to leave the UK (IAC, 2008c) and discourages economic migration (Home Office, 1998). The third argument is that limited support can only be provided due to "obligations to the tax payer" (IAC, 2008c, p12): in essence, support to UK citizens would have to be reduced in order to increase support for asylum seekers. Lynn and Lea (2003) observed that the public do not object to genuine asylum seekers receiving support; however the social construction of the asylum seeker (described earlier in this chapter) as threatening and likely to be 'bogus' can result in a perception that the asylum seekers are undeserving and the public are neglected.

The possibility that destitution has a disabling impact will now be considered. In 1998, Cholewinski described the limited support which is provided to asylum seekers (in fact, the level of support was higher in 1998 than it is currently) as 'enforced destitution' and a denial of human rights. Though the situation has changed somewhat since Cholewinski (1998) was writing, there are more recent papers that support this claim, not least the Joint Committee on Human Rights (2007) which produced an extremely thorough report into the treatment of asylum seekers, using evidence from a wide range of

sources (including legislation, case law, academic studies, visits, other agencies, and case studies), which has been published in full. One of their conclusions was that

> *"by refusing permission for asylum seekers to work and operating a system of support which results in widespread destitution, the Government's treatment of asylum seekers in a number of cases reaches the Article 3 ECHR threshold of inhuman and degrading treatment*" (p5).

I would argue that such treatment may also have a disabling impact.

The IAC produced a report in 2008 called 'Deserving Dignity', which is a review into how asylum seekers are treated. This report was not explicit as to how it gathered its evidence, except to say that it was gathered from several hundred organisations and individuals in Britain. However, in its favour, the Commission has submitted each of its concerns or claims to UKBA for a response, and all responses are recorded in the document followed by the Commissioners' further comments on UKBA's responses. This report found that both UKBA and the Commission thought that it was not acceptable for asylum seekers to be destitute. UKBA clearly explained the procedures and legislation which prevent destitution, however the Commissioners found that UKBA did "little to acknowledge the current destitution amongst asylum seekers, or to analyse the reasons for it" (p32, IAC, 2008c). It could therefore be argued that destitution and poverty have a disabling impact on asylum seekers as poverty may act as a barrier to positive physical and mental health (Carswell et al, 2009). This may be due to malnutrition, sleep deprivation,

distress and isolation, infections due to conditions of poverty, and the effects of sleeping rough, to name but a few. Athwal and Bourne (2007), in their study of deaths of asylum seekers in the UK, found several cases in which the deaths were directly as a result of destitution – for example, poverty leading to hypothermia, or mental deterioration as a result of destitution – or indirectly, through poor working conditions due to working illegally.

Other services and support

It could be said that there are barriers to the services and support available to asylum seekers. However, the fact that these services exist could be considered enabling rather than disabling. Under the various sections outlined in Chapter 3, asylum seekers may be eligible for health care, accommodation, community care and mental health services. That asylum seekers with impairments have access to these services could be said to be taking account of their needs so that they are not excluded from full participation in society. Regarding any of the services to which they do not have direct access, it could be argued that this is to encourage asylum seekers to first try to meet their needs themselves or by their family or community (Home Office, 1998). When access to services is reduced when an asylum seeker's claim is rejected (for example, access to health care is reduced to emergency care only), it could be argued that this is to encourage that asylum seeker to leave the UK, as described earlier in this chapter (IAC, 2008c).

However, there is evidence to suggest that despite the enabling nature of these services, disabling barriers still exist. A number of studies have been

undertaken into the disabling barriers to services and support experienced by asylum seekers. The key studies I found are Ward et al (2008), Harris and Roberts (2004), Harris (2003), Roberts (2000), Roberts and Harris (2002a) and Refugee Council (2005). ICAR (2009) also produced a short briefing on Disabled Asylum Seekers in the UK, which is based mainly on the research by Ward et al and Harris and Roberts.

Community care

Disabled asylum seekers may be eligible for community care under the legislation described in the previous chapter. This could be seen as enabling as those who receive community care services are having their needs accommodated to enable them to participate more fully in society. However, the articles mentioned above highlight several disabling barriers within community care services. One of these is the tendency of agencies to deny responsibility for supporting asylum seekers who have impairments, particularly local authority social services and UKBA. Each agency has a tendency to think that it is the responsibility of the other and therefore does not provide support. One of the earliest articles on the subject of disabled asylum seekers (Roberts, 2000) highlighted the issue that services for asylum seekers take little account of those who are disabled, and that services for disabled people take little account of the additional needs of asylum seekers. Though this article is based only on the author's understanding of the legislation and services related to disabled asylum seekers, further research has been undertaken. Harris and Roberts (2004) interviewed seven representatives from social services and 11 from 'reception assistant

organisations' (usually refugee community organisations) around the country and found that the majority of experiences of the local authority were that workers were confused about the entitlements of refugees and asylum seekers, as well as a general atmosphere of defensiveness and 'buck-passing', and limited access to community care assessments. Though this is a small sample, other research has backed this up. Ward et al (2008) cited evidence from solicitors, disability organisations and asylum seekers to show that conflicts of responsibility can occur between UKBA and the local authority. Other barriers to social services were also found, including the complexity of the law, resulting in both asylum seekers and service providers not understanding what asylum seekers are entitled to (Ward et al, 2008) and dispersal meaning the continuity of services is broken, and linguistic difficulties: usually information being unavailable in the asylum seeker's first language (Harris, 2003).

Accommodation

The provision of accommodation can be described as enabling as it prevents disabled asylum seekers being homeless and therefore meets what is one of their most basic needs (shelter), according to Maslow's hierarchy of needs (Maslow, 1954, cited in Trevithick, 2009, p93). Conversely, accommodation could also be considered a disabling barrier. There are two reasons for this: first is the dispersal system, and second is the nature of the accommodation. The dispersal system means that asylum seekers can be moved to different parts of the country other than where they were previously based. The argument in favour of dispersal is that it shares the burden on services

throughout the country, rather than concentrating it in a particular area. This could be considered enabling as more resources will be available to support disabled asylum seekers. However, dispersal can result in isolation and the loss of support networks, which may be particularly difficult for asylum seekers with impairments or additional needs (Ward et al, 2008, and ICAR, 2009) which were previously met by family or friends. It can also result in a lack of continuity of care which is extremely dangerous for patients with HIV, requiring regular medication, and who may be moved away from specialist services that could support them (Refugee Council, 2005). Dispersal can be very difficult for asylum seekers with mental health needs, however Ani (2005) suggests to clinicians that they should not challenge dispersal (except in very severe cases), as the challenge is unlikely to succeed and will raise false hopes. This is based on the author's personal experiences of working with asylum seekers and discussions with other professionals. As this is not based on any statistics or research into the matter, it can not be considered reliable in contrast to the more robust investigations with clear methodology that are outlined elsewhere in this dissertation.

The nature of the accommodation allocated may not always be suitable for the asylum seeker, especially if they require adaptations to the property to enable mobility and safety. Harris (2003) found that five of the disabled asylum seekers in her study were living in accommodation that had not been adapted to their needs and was therefore unsuitable. Though this is an extremely small study, others have also since found unsuitable

accommodation to be an issue for disabled asylum seekers, including Ward et al (2008), Refugee Council (2005) and Roberts and Harris (2002b).

Health care

Asylum seekers can have a wide variety of health needs for reasons including experiences in their home country (such as exposure to particular diseases), conditions in which they are currently living in the UK (Burnett and Peel, 2001b), or experiences of torture (Burnett and Peel, 2001c). Most asylum seekers are eligible for at least emergency health care, which could be viewed as enabling as it will meet some of their health needs. However, there are difficulties in accessing health care (as outlined in the previous chapter) and this can be detrimental to health. Kelley and Stevenson (2006) highlighted 37 cases known to the Refugee Council in which difficulties accessing health care had a detrimental impact on health.

The samples used in all the research mentioned in this section may not be considered large enough to be representative, however they serve as examples demonstrating the disabling barriers that may be faced by asylum seekers. I suggest that further research with a larger sample is warranted, and that effort to reduce these barriers should be made.

I will now comment on the impact of barriers created by mental health services. The reasons that asylum seekers may have mental health needs have been published by several studies, and include their experiences in their home country (war, torture, persecution), the fact they have left their home

country (loss of family, job, culture) and their experiences in the UK (isolation, poverty, racism, uncertain future) (Tribe, 2002). In the area of mental health of asylum seekers, several investigations and reviews have been undertaken. The most thorough of these appears to Raj and Reading (2002), who reviewed current literature as well as interviewing 38 service providers (NHS and others), including representatives from a range of projects provided by refugee community organisations, particularly in the Somalian and Bosnian communities. Raj and Reading commented on the importance of valuing the capacity of asylum seekers and refugees to cope with very difficult situations. We should not lose sight of their inherent resilience in the midst of the challenges they face and the negative impact these have upon them. They highlighted the work of Summerfield, who in much of his work has argued against "undue pathologisation" (Summerfield, 2001, p162) of refugees and asylum seekers. Crowley (2003), in his interviews with asylum seekers and services in Newcastle, found that though asylum seekers experienced a high level of mental distress, this did not necessarily constitute mental illness. Experiences of war and torture do not automatically result in pathological damage to a person's mental health, and to assume that all asylum seekers are 'traumatised' and treat them as victims rather than survivors does not help them to achieve the active citizenship and new life that they seek in the UK (Summerfield, 2001). It is possible therefore that mental health and other services themselves can be a disabling barrier, through negative assumptions and disempowering attitudes.

Lack of cultural awareness and a 'westernised' approach to mental health is a topic mentioned in almost all papers I found on the subject of mental health and asylum seekers. This issue applies not only to asylum seekers but can also apply to ethnic minority communities in the UK (Li et al, 1999). Different cultures view and express mental health in different ways, and this should be taken into account when deciding which approach to take.

McColl and Johnson (2006) found a significant level of unmet mental health needs in their study of asylum seekers in London. Though they acknowledge that their sample is relatively small (104 asylum seekers who are current cases with the community mental health teams), they use standardised scales to ensure that the data is consistent, and all data is gathered from independent clinicians. The authors believe their research is a snapshot of the current picture in London and will help fill the void of information regarding uptake of mental health services by asylum seekers in the UK. Their findings suggested that mental health services were not meeting the needs of asylum seekers in areas such as psychotic symptoms, as over half the sample had unmet needs in this area. The authors suggest several reasons for this, including the sheer complexity of the needs of asylum seekers, lack of adequate training to respond to this, linguistic and cultural barriers, and lack of evidence-based solutions for their needs. All of these factors could be considered barriers created by mental health services.

This chapter has summarised research that could demonstrate a variety of disabling barriers experienced by asylum seekers. Detention in particular can

be seen to have a disabling impact, especially for children. The existence of financial support, accommodation, health care and community care is not in itself disabling, however several examples were given of how these services do not adequately accommodate the needs of asylum seekers with impairments and these services can therefore be seen to contain disabling barriers. In the next chapter I will suggest the responses that social workers can make, both as individual practitioners and as a body of professionals.

Chapter Five: The Social Work Response

In this chapter I will discuss the responses social workers can make to the disabling barriers and inequalities experienced by asylum seekers. I will first look at the responses that an individual practitioner can make, and then at the responses that social workers as a body of professionals can make.

Individual

There are several responses that individual social workers could make to the possibility that asylum seekers experience disabling barriers. For example, social workers may believe that the policies of the UK government towards disabled asylum seekers result in services and supports that are enabling rather than disabling. Social workers also have a duty to work within the context of the legislation and policy of the UK and to comply with the policies and procedures of their employer. They may therefore wish to comply with any restrictions placed upon disabled asylum seekers or limitations to their support, and be supportive of the approach taken by the government. They may not wish to change anything in the way that asylum seekers are treated.

Another response could be that in their interactions with disabled asylum seekers, social workers may wish to ensure they consider the large power imbalance that exists. Asylum seekers are often reliant on state support, of which the social worker can be viewed as a gatekeeper. They are in an uncertain situation, awaiting the outcome of their claim, with the potential of detention or deportation hanging over them. The social worker may have little

control over this, but the asylum seeker may perceive that the social worker as a professional carries some level of influence over their situation. Additionally, social workers have a professional body and may be employed by a large organisation, whereas the asylum seeker is likely to have left behind most of his or her support networks. Dominelli (2002) would argue that social workers should endeavour to practice as anti-oppressively as possible in this situation.

It could be argued that social workers should avoid stereotyping disabled asylum seekers or their needs, as asylum seekers are a diverse group from a variety of backgrounds and cultures, who have different impairments and may have had very different experiences. Though this dissertation has outlined disabling barriers experienced by many disabled asylum seekers, it is important not to make assumptions about a particular asylum seeker's needs or experiences, as not all barriers will be experienced by all disabled asylum seekers. This is in line with section 1 of the Code of Practice: "treating each person as an individual" (TOPSS, 2004, Code of Practice 1.1). The Code of Practice (TOPSS, 2004, 1.6) encourages social workers to respect the culture and values of the individual and this can be done by being aware of these and ensuring any intervention is culturally appropriate and in line with the individual's values. It could also be considered important for the social worker to ensure his or her practice is not prejudiced or discriminatory, as the prevailing media discourse is that asylum seekers are 'bogus' (Lynn and Lea, 2003). Disabled asylum seekers could be considered at risk of discrimination on a personal, cultural and structural level, and Thompson (1998) would

argue that practitioners should be careful not to contribute to this. Briskman and Cemlyn (2005) encourage social workers to take any opportunities to challenge dehumanising viewpoints of asylum seekers. An additional aspect of labelling is that highlighted by Summerfield (2001), who encourages practitioners not to label asylum seekers as victims but instead to value their resilience and the fact they have overcome so many difficult experiences. It would be easy to focus on the negatives as asylum seekers do have so many needs; however they are also survivors. An intervention could take this into account, by not solely concentrating on helping the individual cope with past traumas, but instead having an empowering, person-centred approach that helps the individual to have a meaningful life in the UK and a positive sense of self (Smith, 2005).

Watters (1998) highlights the value of members of refugee and asylum seeking communities helping one another. By using the skills existing within the asylum seeking community, an intervention is likely to be more culturally appropriate and again identifies the members of that community as survivors and contributors rather than purely recipients and victims.

Within social services departments, Roberts and Harris (2002a) suggest that there should be a lead practitioner for disabled asylum seekers, and that all staff should undertake relevant training to prepare them for working with disabled asylum seekers. Social workers could request this training,

One barrier to services was particularly highlighted in research and may be influenced by an individual social worker: that of being passed between different departments or organisations, none of whom are willing to take responsibility for meeting the needs of the disabled asylum seeker (Harris and Roberts, 2004). An individual social worker may be able to influence this practice by willingly taking on the case.

Together

One response from social workers as a body could be to support the current policies regarding disabled asylum seekers and to highlight the enabling aspects of these, such as access to NHS health care. This could be done through positive campaigns, or simply through complying with the policies as they currently stand. Social workers as a group may wish to do this if they do not consider the current policies to have a disabling impact, or simply to uphold their duty as a profession to work within the law.

This fits with the compliance approach, as described by Oliver and Sapey (2006). Oliver and Sapey describe three service approaches to working with disabled people, which originate from an unpublished service review carried out by Oliver and Bailey in 2002. These are the *humanitarian approach*, the *compliance approach* and the *citizenship approach*. According to this conceptualisation, social workers who take the compliance approach comply with government policy to the letter, doing only what is necessary within the legislation; social workers who take a humanitarian approach to working with disabled asylum seekers assume that the social worker is the expert, and the

disabled asylum seeker should be thankful for the help they receive; and social workers who take the citizenship approach treat disabled asylum seekers as “full citizens, with all the rights and responsibilities that are implied” (Oliver and Sapey 2006, p41). The citizenship approach is described as Oliver and Sapey as the only approach compatible with the social model of disability, and the approach that is supported by legislation and policy related to disabled people (such as the Department of Health’s *Valuing People Now*, 2009, and *Putting People First*, 2007b, and the *Equality Act 2010*). However, Oliver and Sapey were writing about disabled people in general rather than asylum seekers and the citizenship approach is not supported by legislation and policy related to asylum seekers (such as Home Office, 2002). Asylum seekers are inherently not full citizens, and therefore disabled asylum seekers are not treated by policy as full citizens. Social workers who wish to adopt the full citizenship approach to working with disabled asylum seekers may need to challenge policies and legislation.

If social workers as a body believe that asylum seekers are experiencing disabling barriers, there are several responses that could be considered. Oliver (2009) suggests that rather than solely undertaking individual interventions, practitioners should focus on challenging the disabling society. Cemlyn and Briskman (2003) encourage social workers to challenge inequalities, speak out against human rights abuses and campaign for better treatment of disabled asylum seekers. One way of doing this could be through the new national College of Social Work (2011). This is being created at the recommendation of the Social Work Task Force that the profession

needs a clear, independent voice that will be heard in policy development (Social Work Task Force, 2009).

There are several papers which give social workers a clear idea of a system that they can fight for. For example, the Centre for Social Justice (2008) outlines evidence-based, cost-effective recommendations for changes to the asylum system, using ideas from effective processes in other countries such as Canada. The Independent Asylum Commission also make clear recommendations in their papers, (IAC 2008a, 2008b and 2009c), as to how the asylum system should be improved to provide more dignity and humane treatment to asylum seekers. Ward, Amas and Lagnado (2008) specifically recommend that the Home Office should review the support available to disabled asylum seekers, and provide cash rather than vouchers as well as additional support. All of these papers give social workers as a body a place to start when campaigning against injustice, as they clearly set out changes that could be made. There is also room for a social work body to campaign on issues of injustice to individual asylum seekers as well as to them as a group. The Joint Committee on Human Rights (2007) highlighted many examples of breaches of asylum seekers' human rights. Briskman and Cemlyn (2005) would encourage social workers to condemn this bad practice rather than colluding with it.

The Independent Asylum Commission (IAC, 2008a) suggest that social workers, the media and the government, and refugee and community organisations, should try to gain public support for the concept of seeking asylum. This could help to reduce several disabling barriers on an individual

level (as people are more likely to help) as well as on a national level if public pressure results in changes to government policy. If asylum seekers have a higher profile, this could also result in more information about them being gathered. This information is vital for ensuring successful integration of asylum seekers and refugees into UK society, as it will inform planning about policies, services and dispersal (Robinson, 1998).

Jones (2001) has many concerns about the situation for asylum seeking children in the UK. She strongly encourages the social work profession to "reclaim the children's rights agenda" and to make their voice heard, challenging the increasing inequalities experienced by asylum seeking children. Jones argues that an asylum seeking child is not always fully treated as a child, in that they are not assumed to have the same level of innocence and vulnerability – they are something 'other', of which people may be suspicious. For example, asylum seeking children can be detained. The damaging impact of detention has been discussed in previous chapters, but this is just one example of the ways in which child asylum seekers are not fully accepted as children with all the rights of a child. Jones would argue that social workers should challenge the inequalities faced by asylum seeking children, and campaign for policies that treat asylum seeking children as children before anything else – in practice as well as in theory.

A further social work response is suggested by Steve Cohen (2002): non compliance. He suggests that workers should refuse to carry out immigration checks before providing services. Cohen acknowledges that this is a "high-risk option for workers" (p229) and advises that it should only be carried out

with union support. With union support, individual workers become less vulnerable and the action is also more effective as it is wider spread. However, Cohen also highlights the fact that though widespread non-compliance may be difficult to imagine, in some circumstances it is already occurring. For example, several hospitals have not charged refused asylum seekers for treatment despite the expectation that they would do so (Cohen, p229). Cohen also suggests an additional method of non-compliance: that of not passing on information to the Home Office regarding illegal status of immigrants or illegal working activities. However, he comments that unions have been unwilling to support even this level of non-cooperation.

This chapter has outlined a number of potential responses that social workers could make to the possibility that disabled asylum seekers experience disabling barriers. The following chapter will summarise the findings of this dissertation and draw conclusions and recommendations.

Chapter Six: Conclusion

This dissertation sought to review the subject of disabled asylum seekers from a social model perspective, particularly focusing on whether the policies of the UK government have a disabling or enabling impact upon disabled asylum seekers. My methodology was outlined in chapter 2, followed by an explanation of the legislation and policy related to disabled asylum seekers in chapter 3. The asylum process together with the key restrictions, statutory services and statutory support available to disabled asylum seekers and refused asylum seekers in the UK have been described. Of particular focus were detention, financial support, accommodation, health care and community care. Chapter 4 then considered the possibility that these policies and may have a disabling impact on asylum seekers, particularly in relation to detention, financial support and finally other services including health care and accommodation. Each of these has been examined, looking firstly at arguments against that particular service being disabling, and then looking at examples of and evidence for disabling barriers.

I would conclude that the existence of certain types of support for disabled asylum seekers is enabling, such as the potential for access to community care, NHS health care, accommodation and some financial support. These statutory services could be described as enabling as they seek to meet the needs of asylum seekers who have impairments, so that they can fully participate in society (UPIAS, 1976, cited in Oliver, 2009). Were these services not in place, disabled asylum seekers would find themselves even

more socially excluded and oppressed on the most basic level – they would be at high risk of homelessness, and would have no statutory financial support to buy food and other necessities. They would have no free health care or statutory community care to meet their health or social care needs.

However, there are barriers to the services themselves which could be considered disabling. As described in chapters 3 and 4, not all asylum seekers have access to these statutory services, or have access to different levels of service. This could be for legislative reasons, for example refused asylum seekers are not entitled to section 21 (National Assistance Act 1948) community care, unless they arrived at a port and immediately applied for asylum, under Schedule 3 of the Nationality, Immigration and Asylum Act 2002. Chapter 4 has outlined some of the arguments for limiting support to refused asylum seekers, such as encouraging them to return home. However, withholding necessary services from asylum seekers (or refused asylum seekers) who have impairments could still be seen as disabling, regardless of the political intention behind it. A lack of community care services for an asylum seeker with any impairment requiring social care support will mean that asylum seeker cannot participate fully in society. This may be a political tool, however lack of community care services are unlikely to affect asylum seekers who do not have impairments, and therefore their participation in society will be greater than that of the disabled asylum seeker. This could be viewed as social oppression and an example of a disabling barrier. For this reason I would argue that refused asylum seekers in need of

community care should be provided with this support whilst they are in the UK.

Another reason why asylum seekers may have difficulty accessing these services (or accessing different levels of service regardless of need) could be not as a direct result of the legislation, but instead for practical reasons. Chapter 3 mentions several examples of this, including asylum seekers finding difficulty in registering with a GP, despite their entitlement to do so, as they may not have a permanent address or appropriate identification, or understand their entitlement because of language differences (Aspinall, 2006). These practical reasons could all be considered disabling barriers; while not necessarily created directly by the legislation, if the legislation were to take account of these barriers to statutory services experienced by disabled asylum seekers, it is possible that they could be removed.

Sometimes the services themselves can involve or create disabling barriers. Though being provided with accommodation could be described as enabling, if the accommodation is not adapted to the needs of the disabled asylum seeker it could have a disabling effect (Harris, 2003). Similarly, the policy of dispersal can also have a disabling impact (Ward et al, 2008), as discussed in Chapter 4.

Finally, I would argue that some policies are intrinsically disabling barriers. Into this category I would put detention and restrictions on employment. Chapter 4 outlines a variety of examples of the disabling and detrimental

impact that detention can have on both physical and mental health (for example, Robjant et al, 2009b), particularly in children (for example, Burnett et al, 2010). More obviously, it prevents full participation in society physically by indefinite imprisonment, which could also be considered social oppression. I would therefore recommend that the detention of asylum seekers be stopped, and that the current Government fulfils its promise (HM Government, 2010) as soon as possible to stop the detention of child asylum seekers.

Restrictions on employment prevent full participation in society for two reasons: firstly, it contributes to destitution, and secondly, it prevents asylum seekers from full involvement in society economically and socially. This is even more the case for asylum seekers who have impairments, who may experience the dual oppression of being disabled and an asylum seeker. I would therefore argue that asylum seekers should be given the temporary right to work.

In conclusion, I believe that though the policies of the UK government may be to some extent enabling, disabled asylum seekers can experience numerous disabling barriers which changes to legislation and practice could attempt to overcome. Centre for Social Justice (2008) suggest improvements to the asylum system that are both cost effective and also reduce disabling impacts such as detention and destitution. I would recommend that the policy makers consider their suggestions, as they are evidence-based and well-researched.

Several responses to the findings were outlined in Chapter 5, ranging from social workers supporting the existing policies to refusing to comply with them and campaigning for change. The social work values outlined in the National Occupational Standards (TOPSS, 2004, p20) state that social workers should "challenge discrimination, disadvantage and other forms of inequality and injustice". There are many misconceptions by the public and misrepresentations by the media regarding asylum seekers, resulting in negative stereotypes and limited support for asylum seekers, to the extent that has been described as "a new apartheid" (Lynn and Lea, 2003, p1). I would suggest that it is important for social workers as a body to try to raise awareness of the challenges faced by disabled asylum seekers, and the facts surrounding immigration. Our human rights value base also means that social workers have a responsibility to uphold human rights and to challenge situations and structures in which human rights are not upheld. Contrary to the opinions of the Home Office (1998, 2002) that the current arrangements are acceptable, I would argue that this dissertation has highlighted several disabling barriers experienced by asylum seekers, which result in disadvantage and inequality. It has also highlighted issues of human rights and structural inequalities. Hayes (2005, p191) comments that:

> "*In attempting to improve service delivery [by social workers] to asylum seekers and others subject to immigration control, the context of hostility, racism and grinding poverty has to be acknowledged*".

I believe that social workers, as a body of professionals committed to human rights and equality, should actively challenge the policy and legislative frameworks that disadvantage and disable asylum seekers. Cemlyn and Briskman (2003) feel that social workers are in the ideal position to undertake this, as their value base encourages them to have a holistic approach and embrace new, creative ways of working that do not collude with existing structural inequalities. In order to challenge injustice on a societal level, the social work role must become more politicised than its current job description. Several research papers (Cemlyn and Briskman, 2003, Jones, 2001, Briskman and Cemlyn, 2005) comment on the "resounding silence of social work" (Jones, 2001, p265) in response to the inequalities experienced by asylum seekers. In order to be true to the profession's values, a public voice speaking out against injustice must demand to be heard.

In terms of my personal response to the injustices and disabling barriers experienced by disabled asylum seekers, I believe that I have a responsibility (as a social worker, a Christian and a human being) to uphold human rights and reduce social inequalities as far as I am able. This leads me to campaign against those policies and aspects of statutory services which may be disabling, particularly detention. I have informed fellow social work students of what I have found using social networking, and I have contacted my local MP and local newspapers on the subject. I also intend to contact relevant local campaigning organisations and the Centre for Disability Studies at Leeds University with this literature review, in case my findings are of use to them. I hope to submit a summary of my dissertation to Community Care magazine

and to the new College of Social Work in order to raise the awareness of other social workers and encourage them to have a voice on the subject. The "resounding silence" (Jones, 2001, p265) of social workers regarding these injustices should end.

Part B: A quantitative study of disabled asylum seekers in Sheffield together with a case study of one asylum seeker's experiences of statutory services

Background to the study

There is limited demographic information available regarding the numbers of disabled asylum seekers in the UK (ICAR, 2009). The Home Office does not routinely collect this data with its statistics about asylum seekers, and the of the two largest and most thorough surveys that have taken place, the most recent (Ward et al, 2008) was solely in London and the other took place ten years ago (Roberts and Harris, 2001). Both of these also collected qualitative information through interviews and focus groups with the disabled asylum seekers. The study by Roberts and Harris (2001) looked solely at the barriers experienced by the disabled asylum seekers, and though the study by Ward et al (2008) was broader, the first part of the proposed study will add to the available data by providing a minimum estimate of the number of disabled asylum seekers in Sheffield, with relevant demographic information. The second part of the study will be a case study of one asylum seeker's experiences of statutory services in Sheffield. In order for suitable services to be put in place, it is vital for the statutory services to have as close an estimate as possible as to the number of disabled asylum seekers residing in Sheffield. The case study will add to their understanding of the impact of statutory services, and whether they are disabling or enabling. By contributing to the existing research picture of disabled asylum seekers in the

UK, this study can inform public policy so that it meets the needs of the population.

Research aims, objectives and questions

The aim of my research is to contribute to the limited body of information about disabled asylum seekers in the UK, as the more information there is, the more services can ensure they are appropriate for the needs of disabled asylum seekers. My objectives are to find out demographic information about disabled asylum seekers in Sheffield and to find out about their experiences of statutory services. My research questions are:

- How many disabled asylum seekers are there in Sheffield? What are their ages, first language, country of origin and needs?
- What are the experiences of statutory services and restrictions of one asylum seeker in Sheffield? Are they disabling or enabling? How do they feel the services could become more enabling?

Methodology and methods

My epistemological standpoint is interpretivist, as I think the participants will attach their own meanings to their contributions, and I should seek to understand them in context (Bryman, 2008). This applies to both the qualitative section of my study, and to the quantitative section of my study, as the concept of disability is not absolute. The survey regarding the number of disabled asylum seekers in Sheffield will be based on self-definition rather than a positivist, scientific approach. This also fits within the social model of

disability, as the focus will not be on their particular impairment, but rather on whether they see themselves as being disabled by society (Oliver, 2009).

Though this is my suggested study, I believe in the value of emancipatory research and intend to meet with a focus group of disabled asylum seekers from the organisations with which I am already in touch, to find out what they think is important to research. I will amend my research questions and methods accordingly. I have chosen the current research questions as they will add to the body of existing research as well as highlighting issues that I am already aware are of importance to disabled asylum seekers, through my personal contact with them; for example the need to make services more enabling. I will now outline my proposed methods as they stand, though as with the research questions they could be subject to change as they will be influenced by the focus group of disabled asylum seekers.

My method for the focus group will be to go to a local conversation club where I volunteer, and ask the disabled asylum seekers that attend what they think would be important to research, and the best ways of undertaking the research. As I volunteer regularly I will keep them informed of the progress of the project. They have enough English skills to be able to understand and discuss this.

My method to gather the demographic information about disabled asylum seekers in Sheffield will be to produce a brief questionnaire (see Appendix 2) and send it to:

- Local refugee community organisations, which I will find through personal contacts and through the Help Yourself website

(http://www.sheffieldhelpyourself.org.uk/) which lists contact details for community groups.

- Local disability organisations which I will find through the Help Yourself website.
- Sheffield City Council (Children's Services and Adults' Services)

I will then collate the data into a table. The limitations of this method are the fact that there could be double counting, and that the each organisation may interpret the phrase 'disabled asylum seeker' differently. I will try to reduce this by including definitions with the questionnaire. I will analyse the data, looking at the demographics of the disabled asylum seeker population in Sheffield and any implications of this for services.

For the final part of the study, my method will be to interview a disabled asylum seeker and ask open questions about their experiences of different services. I would prefer to interview a number of disabled asylum seekers, to reduce the risk of bias and generalisation, however financial constraints prevent this. I will contact the disabled asylum seeker by asking for a volunteer from one of the local organisations I am in contact with already, and will use an interpreter to ensure the qualitative information I receive is as accurate and detailed as possible. I will use a guided interview framework (see Appendix 2) to ensure the interview covers the asylum seeker's experiences of each of the various statutory services, support and restrictions that I am interested in (accommodation, financial support, the National Health

Service, social care, and experiences of detention if applicable). I will then analyse the information in light of the research questions.

I piloted my questionnaire and interview questions on a volunteer from the local conversation class, and as a result made changes which can be seen in Appendix 3. He also suggested interviewing more than one disabled asylum seeker so that the results are broader, and using English-speaking asylum seekers so that this did not add to the cost. I would therefore interview three disabled asylum seekers, and provide an interpreter for one of the interviews.

Ethical issues

I will seek formal ethical consent for the research, through the University of Sheffield's ethics review procedures. I will do this several months before the project starts in order to have time to gain the approval.

There are several ethical issues connected to research with disabled asylum seekers. The first is accessibility. I will ensure that the interview is as accessible as possible, for example by taking account of any mobility or support needs. This could mean paying a support worker to attend, or ensuring the room has wheelchair access. I will also take account of needs related to asylum seeker status, like limited money and transportation: I will pay expenses for attending (see Appendix 4 for the budget), together with a £20 contribution for time (as this is the standard amount granted by Ward et al, 2008, for an interview).

The second issue is language and translation: I will pay a qualified interpreter to attend and translate the interview. A qualified interpreter is particularly important to ensure accurate, good quality interpretation (Spencer-Oatey and Xing, 2009) and reduce misunderstandings (Karliner et al, 2007).

Other ethical issues are confidentiality, anonymity and consent. I will ensure that any relevant stored data is kept according to the Data Protection Act (1998). I will inform participants (both of the survey and the interview) of what the information will be used for, how it will be stored and request their informed consent. I will also ensure any interpreters or supporters that are present sign a confidentiality agreement. This is especially important when working with disabled asylum seekers, some of whom may fear stigmatisation within their own community if their personal experiences become known, or who may fear that the information could affect their immigration status (Palmer, 2008). It is important to take advice from disabled asylum seekers themselves as to how best to undertake the research in an ethical way, and this can be done by discussing it with the focus group mentioned earlier.

Finally, I will consider the risk that participation could be emotionally distressing to the participant. To mitigate this risk I will use a guided interview framework focusing on services in the UK rather than experiences that may have led to the participant seeking asylum.

Research impact

I anticipate that my findings will produce a reasonable estimated description of the population of disabled asylum seekers in Sheffield. My research will also

produce a detailed case study of a disabled asylum seeker's experience of statutory services in Sheffield. As this is only one individual, it should not be used to generalise, however it can add to the information provided through other case studies that have been undertaken, particularly the recent study in London (Ward et al, 2008). I will contact Sheffield City Council with the results, in the hope that they will be better able to shape their services appropriately. I will also send the information to local refugee community organisations such as Assist, to contribute data to their campaigns. I will send a summary to Community Care magazine to inform readers of the experiences of the participant so that they can use the information to improve their own practice. Finally, I will of course share my findings with the focus group of disabled asylum seekers who shaped the original project.

Timetable

	July	August	September	October	November
Meet with focus group to discuss research questions, methods and progress	xx	xx	xx	xx	
Prepare and post questionnaires	xx				
Collect and collate data		xx			
Analyse data		xx	xx		
Recruit and interview disabled asylum seeker			xx		
Transcribe interview			xx		
Analyse findings			xx	xx	
Write first draft of report		xx	xx	xx	
Write final draft of report				xx	xx
Send to relevant organisations and publications					xx

References

Ani, C. (2007) 'Working with asylum seekers with mental illness distressed by the Home Office dispersal programme', *Psychiatric Bulletin,* 31, p307-309.

Aspinall, P. (2006) *A review of the literature on the health beliefs, health status, health needs, and use of services in the refugee and asylum seeker population and of appropriate health and social care interventions,* Cardiff, Health ASERT Programme Wales, available from http://kar.kent.ac.uk/9168/1/Aspinall_HealthNeeds_ASERT.pdf [accessed 08/09/10].

Aspinall, P. and Watters, C. (2010) *Refugees and asylum seekers: a review from an equality and human rights perspective*, Manchester, Equality and Human Rights Commission, available from http://kar.kent.ac.uk/24337/1/refugees_and_asylum_seekers_research_report.pdf [accessed 08/09/10].

Athwal, H. and Bourne, J. (2007) 'Driven to despair: asylum deaths in the UK', *Race & Class,* 48(4), p106-114.

Aveyard, H. (2007) *Doing a Literature Review in Health and Social Care: a Practical Guide*, Maidenhead, Open University Press.

BBC (2009) *Asylum children health concerns, 13 October 2009,* BBC News Online, available from http://news.bbc.co.uk/1/hi/england/beds/bucks/herts/8304137.stm [accessed 27/10/10].

Boynton, P. and Greenhalgh, T. (2004) 'Hands on guide to questionnaire research: selecting, designing and developing your questionnaire', *British Medical Journal,* 328, p1312-1315.

Briskman, L. and Cemlyn, S. (2005) 'Reclaiming humanity for asylum seekers: a social work response', *International Social Work,* 48(6), p714-724.

Bruegel, I. and Natamba, E. (June 2002) *Maintaining contact: What happens after detained asylum-seekers get bail?* Social Centre Science Research Papers 16, South Bank University.

Bryman, A. (2008) *Social Research Methods: Third Edition,* Oxford, Oxford University Press.

Burnett, A. and Peel, M. (2001a) 'Asylum seekers and refugees in Britain: What brings asylum seekers to the United Kingdom?', *British Medical Journal,* 322, p485-488.

Burnett, A. and Peel, M. (2001b) 'Asylum seekers and refugees in Britain: Health needs of asylum seekers and refugees', *British Medical Journal,* 322, p544-547.

Burnett, A. and Peel, M. (2001c) 'Asylum seekers and refugees in Britain: The health of survivors of torture and organised violence', *British Medical Journal,* 322, p606-609.

Burnett, J., Carter, J., Evershed, J., Kohli, M.B., Powell, C. and de Wilde, G. (2010) '*State Sponsored Cruelty': Children in Immigration Detention,* London, Medical Justice, available from http://www.medicaljustice.org.uk/images/stories/reports/sscfullreport.pdf [accessed 27/10/10].

Carswell, K., Blackburn, P. and Barker, C. (2009) 'The relationship between trauma, post-migration problems and the psychological well-being of refugees and asylum seekers', *International Journal of Social Psychiatry,* available from http://isp.sagepub.com/content/early/2009/11/19/0020764009105699.full.pdf+html [accessed 09/09/10].

Cemlyn, S. and Briskman, L. (2003) 'Asylum, children's rights and social work', *Children and Family Social Work,* 8(3), p163-178.

Centre for Social Justice (2008) *Asylum matters – restoring trust in the UK asylum system*, London, Centre for Social Justice, available from

http://www.centreforsocialjustice.org.uk/client/downloads/Asylum%20Matters%20Full%20Report%20_Web%20New_.pdf [accessed 08/09/10].

Children's Commissioner for England (2009) *The arrest and detention of children subject to immigration control: a report following the Children's Commissioner for England's visit to Yarl's Wood Immigration Removal Centre*, London, 11 Million, available from http://www.childrenscommissioner.gov.uk/content/publications/content_361 [accessed 27/10/10].

Children's Commissioner for England (2010) *The Children's Commissioner for England's follow up report to: The arrest and detention of children subject to immigration control,* London, 11 Million, available from http://www.childrens commissioner.gov.uk/content/publications/content_393 [accessed 27/10/10].

Cholewinski, R. (1998) 'Enforced destitution of asylum seekers in the United Kingdom: the denial of fundamental human rights', *International Journal of Refugee Law,* 10 (3), p462-498.

Clayton, G. (2004) *Textbook on Immigration and Asylum Law,* Oxford, Oxford University Press.

Cohen, J. (2008) 'Safe in our hands?: A study of suicide and self-harm in asylum seekers', *Journal of Forensic and Legal Medicine,* 15, p235-244.

Cohen, S. (2002) 'In and against the state of immigration controls', in Cohen, S., Humphries, B. and Mynott, E. (Eds) *From Immigration Controls to Welfare Controls,* London, Routledge, p220-234.

College of Social Work (2011) *The College of Social Work: About Us*, London, The College of Social Work, http://www.collegeofsocialwork.org/aboutus.asp [accessed 31/01/11].

Crowley, P. (2003) *An exploration of the mental health needs of asylum seekers in Newcastle,* Newcastle, Newcastle Health Partnership, available from http://www.nnt.nhs.uk/asylum/newsletter/haz.pdf [accessed 09/09/10].

Data Protection Act (1998), available from http://www.legislation.gov.uk/ukpga/1998/29/contents [accessed 07/01/11].

Department of Health (2007a) *Implementing the Overseas Visitors Hospital Charging Regulations: Guidance for NHS Trust Hospitals in England,* London, Department of Health, available from http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_081516.pdf [accessed 15/10/10].

Department of Health (2007b) *Putting People First: a shared vision and commitment to the transformation of adult social care,* London, The Stationery Office.

Department of Health (2009) *Valuing People Now: a new three year strategy for people with learning disabilities,* London, The Stationery Office.

Dominelli, L. (2002) 'Anti-oppressive practice in context', in Adams, R., Dominelli, L. and Payne, M. (Eds) *Social Work Themes, Issues and Critical Debates,* Basingstoke, Palgrave, p3-19.

Equality Act (2010), available from http://www.legislation.gov.uk/ukpga/2010/15/contents [accessed 08/01/11].

Goodman, S. (2008) 'Justifying harsh treatment of asylum seekers through the support of social cohesion', *Annual Review of Critical Psychology,* 6, p110-124.

GSCC (2010) *Codes of Practice for Social Care Workers*, London, General Social Care Council, available from http://www.gscc.org.uk/codes/Get+copies+of+our+codes/ [accessed 16/07/10].

Greenhalgh, T. and Peacock, R. (2005) 'Effectiveness and efficiency of search methods in systematic reviews of complex evidence: audit of primary sources', *British Medical Journal,* 331, p1064-1065.

Harris, J. (2003) ' 'All doors are closed to us': a social model analysis of the experiences of disabled refugees and asylum seekers in Britain', *Disability & Society,* 18(4), p395-410.

Harris, J. and Roberts, K. (2004) "'Not our problem': the provision of services to disabled refugees and asylum seekers", in Hayes, D. and Humphries, B. (Ed.) *Social Work, Immigration and Asylum,* London, Jessica Kingsley Publishers, p151-161.

Hayes, D. (2005) 'Social work with asylum seekers and others subject to immigration control', in Adams, R., Dominelli, L. and Payne, M (Eds.) *Social Work Futures: Crossing Boundaries, Transforming Practice*, Basingstoke, Palgrave Macmillan, p182-194.

HM Chief Inspector of Prisons (2006) *Inquiry into the quality of healthcare at Yarl's Wood Immigration Removal Centre,* London, HM Inspectorate of Prisons, available from http://www.justice.gov.uk/inspectorates/hmi-prisons/docs/yarls_wood_inquiry_final-rps.pdf [accessed 22/10/10].

HM Chief Inspector of Prisons (2009) *Report of unannounced full follow up inspection of Yarl's Wood Immigration Removal Centre,* London, HM Inspectorate of Prisons, available from http://www.statewatch.org/news/2010/mar/uk-yarls-wood-ci-prisons.pdf [accessed 22/10/10].

HM Government (2003) *Every Child Matters,* London, The Stationery Office, available from http://www.dcsf.gov.uk/everychildmatters/about/background/background/ [accessed 27/10/10].

HM Government (2010) *The Coalition: Our Programme for Government,* London, Cabinet Office, available from http://www.cabinetoffice.gov.uk /media/409088/pfg_coalition.pdf [accessed 27/10/10].

Home Office (1998) *Fairer, Faster, and Firmer: A Modern Approach to Immigration and Asylum,* London, The Stationery Office, available from http://www.archive.official-documents.co.uk/document/cm40/4018/4018.htm [accessed 03/01/11].

Home Office (2002) *Secure Borders, Safe Haven: Integration with Diversity in Modern Britain,* London, The Stationery Office, available from http://www. archive2.official-documents.co.uk/document/cm53/5387/cm5387.pdf [accessed 03/01/11].

Home Office (2009) *Control of Immigration: Statistics United Kingdom 2009,* London, Home Office Research, Development and Statistics, available from http://rds.homeoffice.gov.uk/rds/pdfs10/hosb1510.pdf [accessed 13/10/10].

House of Commons Hansard (2008) *Daily Hansard - Written Answers, 29 April 2008, Column 327,* London, House of Commons Hansard, available from

http://www.publications.parliament.uk/pa/cm200708/cmhansrd/cm080429/text/80429w0016.htm [accessed 13/10/10].

Human Rights Act (1998) available from http://www.opsi.gov.uk/acts/acts1998/ukpga_19980042_en_1 [accessed 15/07/10].

Immigration and Asylum Act (1999) available from http://www.opsi.gov.uk/acts/acts1999/ukpga_19990033_en_1 [accessed 21/08/10].

IAC (2008a) *Saving Sanctuary,* London, Independent Asylum Commission, available from http://www.independentasylumcommission.org.uk/ [accessed 17/11/10].

IAC (2008b) *Safe Return,* London, Independent Asylum Commission, available from http://www.independentasylumcommission.org.uk/ [accessed 17/11/10].

IAC (2008c) *Deserving Dignity,* London, Independent Asylum Commission, available from http://www.independentasylumcommission.org.uk/ [accessed 17/11/10].

ICAR (2007a) *Detention of asylum seekers in the UK – Thematic briefing prepared for the Independent Asylum Commission,* London, ICAR, available

from http://www.icar.org.uk/11797/briefings/detention-of-asylum-seekers.html [accessed 03/01/11].

ICAR (2007b) *Vulnerable groups in the asylum determination process – Thematic briefing prepared for the Independent Asylum Commission,* London, ICAR, available from http://www.icar.org.uk/11787/briefings/vulnerable-groups.html [accessed 08/09/10].

ICAR (2009) *Disabled refugees and asylum seekers in the UK,* London, ICAR, available from http://www.icar.org.uk/11202/briefings/disabled-refugees.html [accessed 08/09/10].

Intercollegiate Briefing Paper (2009) *Significant harm – the effects of administrative detention on the health of children, young people and their families,* available from http://www.rcpsych.ac.uk/pdf/Significant%20Harm%20intercollegiate%20statement%20Dec09.pdf [accessed 27/10/10].

Joint Committee on Human Rights (2007) *The Treatment of Asylum Seekers, Tenth Report of Session 2006-07,* London, The Stationery Office, available from http://www.publications.parliament.uk/pa/jt200607/jtselect/jtrights/81/81i.pdf [accessed 08/09/10].

Jones, A. (2001) 'Child asylum seekers and refugees: rights and responsibilities', *Journal of Social Work,* 1(3), p253-271.

Karliner, L., Jacobs, A., Chen, A. and Mutha, S. (2007) 'Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature', *Health Services Research,* 42(2), p727-754.

Kelley, N. and Stevenson, J. (2006) *First do no harm: denying healthcare to people whose asylum claims have failed,* London, Refugee Council, available from http://www.refugeecouncil.org.uk/policy/position/2006/healthcare [accessed 08/09/10].

Li, P., Logan, S., Yee, L. and Ng, S. (1999) 'Barriers to meeting the mental health needs of the Chinese community', *Journal of Public Health Medicine,* 21(1), p74-80.

Lorek, A., Ehntholt, K., Nesbitt, A., Wey, E., Githinji, C., Rossor, E. and Wickramasinghe, R. (2009) 'The mental and physical health difficulties of children held within a British immigration detention center: a pilot study', *Child Abuse & Neglect,* 33, p573-585.

Lynn, N. and Lea, S. (2003) 'A phantom menace and the new Apartheid: the social construction of asylum-seekers in the United Kingdom', *Discourse & Society,* 14(4), p425-452.

Maslow, A. (1954) *Motivation and Personality,* New York, Harper and Row.

May, T. (2001) *Social Research: Issues, methods and process – third edition*, Buckingham, Open University Press.

McColl, H. and Johnson, S. (2006) 'Characteristics and needs of asylum seekers and refugees in contact with London community mental health teams', *Social Psychiatry and Psychiatric Epidemiology,* 41, p789-795.

Mental Health Act (1983) available from http://www.statutelaw.gov.uk/legResults.aspx?LegType=All+Legislation&title=mental+health+act&searchEnacted=0&extentMatchOnly=0&confersPower=0&blanketAmendment=0&sortAlpha=0&TYPE=QS&PageNumber=1&NavFrom=0&activeTextDocId=1729080 [accessed 14/10/10].

National Assistance Act (1948), available from http://www.opsi.gov.uk/revisedstatutes/acts/ukpga/1948/cukpga_19480029_en_1 [accessed 02/09/10].

National Audit Office (2005) *Returning Failed Asylum Applicants,* London, The Stationery Office, available from http://www.nao.org.uk/idoc.ashx?docId=98b248e8-070b-499d-9c2e-8f68c602fa2c&version=-1 [accessed 13/10/10].

NHS and Community Care Act (1990), available from http://www.legislation.gov.uk/ukpga/1990/19 [accessed 14/10/10].

Nationality, Immigration and Asylum Act (2002), available from http://www.legislation.gov.uk/ukpga/2002/41/contents [accessed 08/10/10].

O'Donnell, C., Higgins, M., Chauhan, R. and Mullen, K. (2007) ' "They think we're OK and we know we're not". A qualitative study of asylum seekers' access, knowledge and views to health care in the UK.' *BMC Health Services Research,* 7(75), p1-11.

Oliver, M. (1990) *The Politics of Disablement,* Basingstoke, MacMillan Education Ltd.

Oliver, M. (1992) 'Changing the Social Relations of Research Production?', *Disability & Society*, 7(2), p101-114.

Oliver, M. (1993) 'Re-defining disability: a challenge to research', in Swain, J., Finkelstein, V., French, S. and Oliver, M. (Eds) *Disabling Barriers – Enabling Environments*, London, Sage Publications Ltd, p61 – 67.

Oliver, M. (1996) *Understanding Disability: from Theory to Practice*, London, Macmillan Press Ltd.

Oliver, M. (2004) 'If I had a hammer: the social model in action', in Swain, J., French, S., Barnes, C. and Thomas, C. (Eds.) *Disabling Barriers – Enabling Environments, Second Edition,* London, Sage Publications Ltd, p7-12.

Oliver, M. (2009) *Understanding Disability: from Theory to Practice – Second Edition*, Basingstoke, Palgrave Macmillan.

Oliver, M. and Sapey, B. (2006) *Social Work with Disabled People – Third Edition,* Basingstoke, Palgrave MacMillan.

Palmer, D. (2008) 'Ethical issues and their practical application in researching mental health and social care needs with forced migrants', *Research Ethics Review*, 4(1), p20-25.

Palmer, D. and Ward, K. (2007) ' 'Lost': listening to the voices and mental health needs of forced migrants in London', *Medicine, Conflict and Survival,* 23(3), p198-212.

Procter, N. (2005) ' 'They first killed his heart (then) he took his own life': Part 1A: a review of the context and literature on mental health issues for refugees and asylum seekers', *International Journal of Nursing Practice,* 11, p286-291.

Raj, M. and Reading, J. (2002) *A shattered world: the mental health needs of refugees and newly arrived communities,* London, Migrant Refugee Communities Forum and CVS consultants, available from http://www.harpweb.org.uk/downloads/pdf/rep1%28ref%29.pdf [accessed 10/09/10].

Refugee Council (2005) *A study of asylum seekers with special needs*, London, Refugee Council, available from http://www.refugeecouncil.org.uk/policy/position/2005/specialneeds [accessed 08/09/10].

RMAG (2006) *Seeking asylum: a report on the living conditions of asylum seekers in London,* London, Migrants Resource Centre, available from http://www.researchasylum.org.uk/?lid=132 [accessed 13/10/10].

Roberts, K. (2000) 'Lost in the system? Disabled refugees and asylum seekers in Britain', *Disability & Society,* 15(6), p943-948.

Roberts, K. and Harris, J. (2001) *Disabled Refugees and Asylum Seekers in Britain: Numbers and Social Characteristics,* York, University of York Social Policy Research Unit, available from http://www.york.ac.uk/inst/spru/research/pdf/nlcb1816.pdf [accessed 06/09/10].

Roberts, K. and Harris, J. (2002a) *Disabled People in Refugee and Asylum Seeking Communities,* Bristol, Policy Press, available from http://www.jrf.org.uk/publications/disabled-people-refugee-and-asylum-seeking-communities-britain [accessed 08/09/10].

Roberts, K. and Harris, J. (2002b) *Working with Disabled Refugees and Asylum Seekers: Information workshop for refugee and social care*

practitioners, York, University of York Social Policy Research Unit, available from http://www.york.ac.uk/inst/spru/research/pdf/nl-jrf1867.pdf [accessed 08/09/10].

Robinson, V. (1998) 'The importance of information in the resettlement of refugees in the UK', *Journal of Refugee Studies*, 11(2), p146-160.

Robjant, K., Hassan, R., Katona, C. (2009a) 'Mental health implication of detaining asylum seekers: systematic review', *British Journal of Psychiatry,* 194, p306-312.

Robjant, K., Robbins, I., and Senior, V. (2009b) 'Psychological distress amongst immigration detainees: a cross sectional questionnaire study', *British Journal of Clinical Psychology,* 48, p275-286.

Smith, H. (2005) ' 'Feel the fear and do it anyway': Meeting the occupational needs of refugees and people seeking asylum', *British Journal of Occupational Therapy,* 68(10), p474-476.

Social Work Task Force (2009) *Building a safe, confident future: The final report of the Social Work Task Force*, London, Department of Children, Schools and Families, available from http://publications.education.gov.uk/eOrderingDownload/01114-2009DOM-EN.pdf [accessed 25/11/10].

Spencer-Oatey, H. and Xing, J. (2009) 'The impact of culture on interpreter behaviour', in Kottkhoff, H. and Spencer-Oatey, H. (Eds.), *Handbook of Intercultural Communication,* Berlin, Mouton de Gruyter, p219–236.

Summerfield, D. (2001) 'Asylum seekers, refugees and mental health services in the UK', *Psychiatric Bulletin,* 25, p161-163.

Thompson, N. (1998) *Promoting Equality: Challenging Discrimination and Oppression in the Human Services,* Basingstoke, MacMillan Press Ltd.

TOPSS (2004) *National Occupational Standards for Social Work,* Leeds, TOPSS England, available from http://www.skillsforcare.org.uk/developing_skills/National_Occupational_Standards/social_work_NOS.aspx [accessed 16/07/10].

Trevithick, P. (2009) *Social Work Skills: A Practice Handbook,* Berkshire, Open University Press.

Tribe, R. (2002) 'Mental health of refugees and asylum seekers', *Advances in Psychiatric Treatment,* 8, p240-248.

UKBA (2010a) *Enforcement Instructions and Guidance,* London, UKBA, available from

http://www.ukba.homeoffice.gov.uk/policyandlaw/guidance/enforcement/ [accessed 08/10/10].

UKBA (2010b) *Applications Made Before March 2007,* London, UKBA, available from http://www.bia.homeoffice.gov.uk/asylum/oldercases/ [accessed 13/10/10].

UKBA (2010c) *Section 4 Support,* London, UKBA, available from http://www.ukba.homeoffice.gov.uk/asylum/support/ apply/section4/ [accessed 14/10/10].

UKBA (2010d) *Current Support Amounts,* London, UKBA, available from http://www.ukba.homeoffice.gov.uk/asylum/support/ cashsupport/currentsupportamounts/ [accessed 14/10/10].

UKBA (2011) *The Asylum Process,* London, UKBA, available from http://www.ukba.homeoffice.gov.uk/asylum/process/ [accessed 27/01/11].

UN Convention on the Rights of the Child (1989) available from http://www.cirp.org/library/ethics/UN-convention/ [accessed 27/10/10].

UNHCR (1951) *Text of the 1951 Convention Relating to the Status of Refugees*, Geneva, UNHCR Media Relations and Public Information Service, available from http://www.unhcr.org/3b66c2aa10.html [accessed 07/10/10].

UPIAS (1976) *Fundamental Principles of Disability,* London, Union of the Physically Impaired Against Segregation.

Ward, K. (2003) *Key issues – UK asylum law and process,* London, ICAR, available from http://www.icar.org.uk/download.php?id=83 [accessed 08/09/10].

Ward, K., Amas, N., and Lagnado, J. (2008) *Supporting disabled refugees and asylum seekers: opportunities for new approaches,* London, Metropolitan Support Trust, available from http://www.mst-online.org.uk/documents/Research/MST_RCU_DisabilityFullReport_1108.pdf [accessed 06/09/10].

Watters, C. (1998) 'The Mental Health Needs of Refugees and Asylum Seekers: Key Issues in Research and Service Development', in Nicholson, F. and Twomey, P. (Eds) *Current Issues of UK Asylum Law and Policy,* Aldershot, Ashgate Publishing Ltd, p282-297.

Wilkinson, R. (2005) *The Impact of Inequality: Making Sick Societies Healthier*, London, Routledge, Taylor & Francis Group.

Appendix 1

A summary of disabling barriers that are experienced by disabled asylum seekers, which are mentioned in the research found by the author of this dissertation. Much of this is used in the text of the dissertation, but not all, as the limited word count prevented all the barriers from being included.

Detention of adults

Study	Relevant results/conclusions
Robjant et al (2009a): a systematic review of studies looking at the mental health impact of immigration detention on detainees. Thorough review with comprehensive search and clear inclusion/exclusion criteria based on reliability of evidence.	Studies consistently found "poor mental health among detained asylum seekers" Growing body of evidence suggesting "asylum procedures are increasing the mental health difficulties of traumatised individuals" (p311).
Robjant et al (2009b): Small study comparing psychological distress levels of detained asylum seekers with asylum seekers living in the community and detained former prisoners. Study uses robust measures of psychological distress and findings are statistically significant.	Detained asylum seekers suffering from higher levels of depression, anxiety and post-traumatic stress disorder symptoms than asylum seekers living in the community.
Cohen (2008): study based on data provided by immigration removal centres and by prisoners.	Higher rate of self harm in immigration detainees than in 'mainstream' prisoners.

HM Chief Inspector of Prisons (2006): report of inspection of Yarl's Wood Immigration Removal Centre.	Health care in Yarl's Wood is inadequate, particularly mental health care. Concerns about negative medical consequences of continuing detention not routinely addresses.
HM Chief Inspector of Prisons (2009): report of inspection of Yarl's Wood Immigration Removal Centre.	Improvement in health care systems, but no assessment of mental health need and no consistent support for those at risk of self harm. Detention has a clear, adverse impact on the welfare of children.

Detention of children

Study	**Relevant results/conclusions**
Lorek et al (2009): investigated twenty-four children in Yarl's Wood Immigration Removal Centre. This study is limited due to its size and that the data was collected several years ago, but all assessments were undertaken by professionals and were in depth.	All eleven children that were psychologically assessed had "begun to develop symptoms of depression and anxiety" since being detained (p578) and had developed eating problems. Ten out of eleven had developed problems sleeping, and eighteen out of twenty had new or increased health problems since being detained.
Burnett et al (2010): a large, up to date study, using 141 case studies from Medical Justice records, chosen using clear criteria.	74 of the 141 children were found to have suffered psychological harm as a result of detention. Three children had attempted

All medical findings were from independent expert clinicians.	suicide. 92 of the 141 were found to have developed or exacerbated physical conditions as a result of detention.
Children's Commissioner for England (2009 and 2010): reports of a visit and follow-up visits to Yarl's Wood Immigration Removal Centre, using a variety of methodologies: interviews with detainees, participation sessions with child detainees, meetings with staff, and information gathering by health and social care professionals.	Many improvements were found between the first and second visits. One cause for concern that remained was the treatment of children during arrest, as 10 out of 16 children said the arresting officers were not friendly or helpful. They also reported sometimes being separated from their parents during transport.
Intercollegiate briefing paper (2009) 'Significant harm': a statement from the Royal College of General Practitioners, Royal College of Psychiatrists, Royal College of Paediatrics and Child Health and the UK Faculty of Public Health. This statement is based on expert opinion.	This states that the colleges "believe that the administrative immigration detention of children, young people and their families is harmful and unacceptable, and call on Government to address this issue as a matter of priority and stop detaining children without delay" (p4).

Financial Support

Study	**Particular points of interest**
Cholewinski (1998): an examination of the impact of changes to financial support available to asylum seekers, including case law contesting the changes and their	The level of support was described as 'enforced destitution' and a denial of the human rights of the asylum seekers.

compatibility with human rights law.	
Joint Committee on Human Rights (2007): a report on the treatment of asylum seekers, with findings from a variety of sources including case law, academic studies, legislation, policy, and visits).	The restrictions on employment to which asylum seekers are subject, together with 'a system of support which results in widespread destitution' (p5) result in breaches of human rights.
Carswell et al (2009): A study of 47 refugees/asylum seekers examining if there is a relationship between their psychological wellbeing, trauma, and post-migration problems. Limited sample size and range of post-migration problems.	Strong relationship found between post-migration problems and mental health. 68% of the sample described poverty as a serious or very serious problem for them.
Procter (2005): a literature review of mental health and asylum seekers/refugees. Mostly relevant to Australia except for the account of the death of an asylum seeker in Scotland.	The asylum seeker committed suicide after finding out his accommodation and financial support were both to be removed. However, it cannot be confirmed that this is the reason why he committed suicide.
Athwal and Bourne (2007): an examination of the deaths of 228 asylum seekers and illegal immigrants as recorded by the Institute of Race Relations. Mostly case studies.	Includes examples of death as a result of hypothermia due to destitution and suicide as a result of mental health issue related to poverty, and a variety of others including deaths in detention and suicides because of fear of deportation.

Accommodation

Study	Relevant results/conclusions
Ward et al (2008): a detailed study on the topic of ways to support disabled asylum seekers, including a literature review, 19 interviews with organisations working with disabled asylum seekers and 21 interviews with disabled asylum seekers. Clear methodology.	Dispersal can result in disabled asylum seekers being moved away from appropriate support networks. The nature of the accommodation does not always meet their needs.
ICAR (2009): a briefing on the subject of disabled asylum seekers.	Dispersal can cause isolation, which reduces the support accessible by disabled asylum seekers.
Refugee Council (2005): a qualitative study of the health and other needs of asylum seekers with special needs. 50 asylum seekers with special needs were interviewed, with a clear methodology.	Dispersal can create a break in health care which can have an adverse impact on health, particularly with diseases such as AIDS. Emergency accommodation is often unsuitable, with 56% of those interviewed reporting a state of 'general disrepair' (p11)
Ani (2007): Expert opinion on working with asylum seekers who have mental health needs who have been distressed as a result of dispersal.	Challenges to dispersal are unlikely to succeed therefore Ani does not recommend raising false hope.
Harris (2003): A qualitative study of the disabling barriers experienced by 38 disabled refugees/asylum seekers in their countries of	5 of those interviewed were living in "unadapted and unsuitable properties" (p405).

origin and the UK, with a clear methodology that considered issues of access and communication.	
Roberts and Harris (2002b): Handout from a workshop on the topic of working with disabled refugees/asylum seekers. Based on research carried out in Roberts and Harris (2002a) which has a clear methodology and includes a questionnaire sent to refugee community organisations, interviews with refugee community organisations and interviews with disabled asylum seekers.	Disabled asylum seekers sometimes live in unsuitable accommodation, which can contribute to isolation. Dispersal can make it harder to access community care or other welfare services.
Palmer and Ward (2007): a qualitative study of asylum seekers/refugees and mental health in London. Includes a literature review and 21 interviews. Clear methodology set out with attempts to include a range of participants.	Housing was found to be a high cause of mental health problems in ten of the interviewees: either lack of, or unsuitable accommodation with overcrowding.

Community care

Study	**Relevant results/conclusions**
Roberts (2000): a paper on disabled asylum seekers in the UK, calling for more consideration of then. Expert opinion.	Refugee/asylum seeker community organisations, the disability movement and policy makers do not adequately take account of disabled asylum seekers.

Harris and Roberts (2004): 18 interviews with social services and organisations that assist with reception of asylum seekers. Small sample.	Workers are often confused about the entitlements of disabled asylum seekers, passed them onto other departments and did not always offer community care assessments when appropriate.
Ward et al (2008): a detailed study on the topic of ways to support disabled asylum seekers, including a literature review, 19 interviews with organisations working with disabled asylum seekers and 21 interviews with disabled asylum seekers. Clear methodology.	Conflicts of responsibility occur between social services and UKBA; workers are often confused about the entitlements of disabled asylum seekers;
Harris (2003): A qualitative study of the disabling barriers experienced by 38 disabled refugees/asylum seekers in their countries of origin and the UK, with a clear methodology that considered issues of access and communication.	Barriers include linguistic barriers and the fact that dispersal may mean community care arrangements have to be re-organised from scratch.

Health care

Study	**Relevant results/conclusions**
Kelley and Stevenson (2006): A report on the Government policy of denying refused asylum seekers access to secondary health care. Expert opinion and case studies from	The experiences of 37 refused asylum seekers known to the Refugee Council in which denying secondary healthcare was detrimental to their health.

the Refugee Council.	
Raj and Reading (2002): a report on refugees/asylum seekers and mental health, including a literature review and 38 interviews with service providers. This report looks at the issues from the perspective of the service user where possible. Clear methodology in terms of the interviews.	Highlights many issues with mental health services and suggestions for improvements, such as the fact that counselling should be in mother tongue if possible. Also promotes developing the refugee/asylum seeker's own resources and their ability to cope.
Summerfield (2001): An editorial on the subject of refugees/asylum seekers and mental health. Expert opinion.	Summerfield recommends against the "undue pathologisation" (p162) of refugees/asylum seekers but instead, viewing them as survivors. This also helps integration.
Crowley (2003): a study of mental health services for and mental health needs of asylum seekers in Newcastle. Mixed methodology, including literature review, interviews with mental health service providers and focus groups of asylum seekers with mental health needs. Clear details of methodology included in report.	Asylum seekers experience a high level of post-migration stress in the UK. Many experienced mental distress but not necessarily mental illness. Services were thought to not be adequately meeting the needs of torture victims or asylum seekers in need of psychological therapy.
Li et al (1999): a report on the barriers hindering the Chinese community from accessing NHS mental health services. 401 people recruited from Chinese community	Barriers include language, lack of culturally appropriate mental health services, insensitivity of staff, lack of information about local services.

centres completed a 12 item Chinese Health Questionnaire, and 86% were found to have a high probability of a mental health problem. 71% of these were interviewed. Method of analysis included in the paper. However this report applies to the Chinese community in general, not just asylum seekers.	
McColl and Johnson (2006): a study of 104 asylum seekers/refugees who are registered with Community Mental Health Teams (CMHTs) in London. Quantitative analysis based on data provided by the CMHTs. Relatively small sample however authors see it as a snapshot of the situation.	A mean average of 6.8 unmet needs per asylum seeker, using the Camberwell Assessment of Needs Short Appraisal Schedule. This is high compared to other groups of mental health service users in the community.

Social contact

Study	**Results**
Harris (2003): A qualitative study of the disabling barriers experienced by 38 disabled refugees/asylum seekers in their countries of origin and the UK, with a clear methodology that considered issues of access and communication.	Barriers to social contact include: difficulties accessing buildings for those with mobility impairments, language barriers, restrictions on working and lack of awareness of services.
Roberts and Harris (2002a): a report on the demographics of disabled asylum seekers	Barriers to social contact include: unsuitable accommodation meaning it is

and their experiences in the UK. A clear methodology and includes a questionnaire sent to refugee community organisations, 18 interviews with reception organisations and 38 interviews with disabled asylum seekers. Limited sample size, however the authors acknowledge that this is just a starting point.	difficult for people to go out; forced dependency on others (because of lack of community care) can lead to social isolation, if help is needed to leave the house; lack of social network as new to the country or area.
Lynn and Lea (2003): An analysis of letters written to the British media on the subject of asylum seekers, and how the concept of 'asylum seeker' is being socially constructed.	The social construction of asylum seekers as something 'other', resulting in disregard of their rights is described by Lynn and Lea as "a new Apartheid" (p425).
Burnett and Peel (2001b): an article about how health and social care professionals can approach meeting the needs of refugees/asylum seekers. Expert opinion.	Asylum seekers are a diverse group with diverse needs and experiences. Ensuring the person is not isolated, reducing poverty, ensuring accommodation is adequate and providing work can contribute to alleviating depression.
Palmer and Ward (2007): a qualitative study of asylum seekers/refugees and mental health in London. Includes a literature review and 21 interviews. Clear methodology set out with attempts to include a range of participants.	Leaving the home country reduces social support leading to isolation, together with difficulties within communities (for example because of civil war in the home country). This can result in less social inclusion and reduced access to support.
Raj and Reading (2002): a report on refugees/asylum seekers and mental health,	Reduced access to the refugee or asylum seeker's culture can lead to them feeling a

including a literature review and 38 interviews with service providers. This report looks at the issues from the perspective of the service user where possible. Clear methodology in terms of the interviews.	sense of “cultural bereavement” (p13-14) and creating feelings of loss and depression.

Appendix 2: Tools for Data Collection

Interview Schedule

1. What country are you from?

2. Do you have any dependants in the UK?

3. How old are you? (16-25, 26-34, 35-45, 46-55, 56-64, 65-74, 75+).

4. What are your experiences of your accommodation in the Sheffield?
   How well does it meet your needs? How can it be improved?

5. What are your experiences of the health service in the Sheffield? How well does it meet your needs? How can it be improved?

6. What are your experiences of the support from social services in Sheffield? How well does it meet your needs? How can it be improved?

7. What are your experiences of the financial support you receive? How well does it meet your needs? How can it be improved?

8. Have you been detained? How did it affect you? How well were your needs met in detention? How can it be improved?

Questionnaire

This questionnaire is about disabled asylum seekers that are registered with your organisation. The study aims to find out how many disabled asylum seekers are living in Sheffield in the hope that services for them can be improved. This research has been through the University of Sheffield Ethics Procedure; if you have any questions please contact Val Roberts via the Department of Sociological Studies on 0114 2226400.

For this study, asylum seeker means anyone who is seeking asylum and either has not yet received a decision on their claim, or has received a negative decision but has not yet been deported.
This study is from the perspective of the social model of disability. This means that we think society disables people by not meeting their needs: the problem is not their impairment. Please answer any questions about disabled asylum seekers by defining them as 'asylum seekers who feel that society does not meet their needs or make appropriate changes to accommodate their impairments'.

Name of organisation:

How many disabled asylum seekers are registered with your organisation in Sheffield?

What are the ages of these disabled asylum seekers?

Age	**Number of disabled asylum seekers**
0-15	
16-25	
26-34	
35-44	
45-55	
56-64	
65-74	
75 and over	

What services would be most useful to them?

Service	Number of disabled asylum seekers
Mental health services	
Learning disability services	
Sensory impairment services	
Physical disability services	
Other (please write)	

What are the countries of origin of these disabled asylum seekers?

Country of origin	Number of disabled asylum seekers
Iraq	
Zimbabwe	
Afghanistan	
Somalia	
China	
Iran	
Eritrea	
Sri Lanka	
Pakistan	
Nigeria	
Other (please write)	
Other (please write)	
Other (please write)	
Other (please write)	
Other (please write)	
Other (please write)	
Other (please write)	
Other (please write)	
Other (please write)	

What are the first languages of these disabled asylum seekers?

First language	Number of disabled asylum seekers
French	
English	
Somali	
Punjabi	
Kurdish	
Arabic	
Urdu	
Other (please write)	
Other (please write)	
Other (please write)	

Is there any reason why the information you have provided may not be accurate?

If you would like a copy of the results of the study, please provide a contact email address.

Thank you for your time.

Appendix 3: Revised Tools for Data Collection

Interview Schedule

1. What country are you from?

2. Do you have any dependants (children or adults you care for) in the UK?

3. How old are you? (16-25, 26-34, 35-45, 46-55, 56-64, 65-74, 75+).

4. What do you think of your housing in Sheffield?~~are your experiences of your accommodation in the Sheffield?~~
   How well does it meet your needs? How can it be improved?

~~5.~~What are your experiences of the doctors and hospitals~~health service~~ in the Sheffield?

~~6.~~5. How well do they~~es it~~ meet your needs? How can they~~it~~ be improved?

~~7.~~6. What are your experiences of the support from social services in Sheffield? How well does it meet your needs? How can it be improved?

~~8.~~7. What are your experiences of the money or vouchers~~financial support~~ you receive from UKBA? How well does it meet your needs? How can it be improved?

~~9.~~8. Have you been detained? How did it affect you? How well were your needs met in detention? How can it be improved?

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Questionnaire

This questionnaire is about disabled asylum seekers that are registered with your organisation. The study aims to find out how many disabled asylum seekers are living in Sheffield in the hope that services for them can be improved. This research has been through the University of Sheffield Ethics Procedure; if you have any questions please contact Val Roberts via the Department of Sociological Studies on 0114 2226400.

For this study, asylum seeker means anyone who is seeking asylum and either has not yet received a decision on their claim, or has received a negative decision but has not yet been deported. This study is from the perspective of the social model of disability. This means that we think society disables people with impairments by not meeting their needs or not making changes to accommodate their impairments: the problem is society, not their impairment. ~~Please answer any questions about disabled asylum seekers by defining them as 'asylum seekers who feel that society does not meet their needs or make appropriate changes to accommodate their impairments'.~~ For this study, 'disabled' means anyone who would describe themselves as disabled.

Name of organisation:

How many disabled asylum seekers are registered with your organisation in Sheffield?

What are the ages of these disabled asylum seekers?

Age	Number of disabled asylum seekers
0-15	
16-25	
26-34	
35-44	

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45-55	
56-64	
65-74	
75 and over	

What services would be most useful to them?

Service	**Number of disabled asylum seekers**
Mental health services	
Learning disability services	
Sensory impairment services	
Physical disability services	
Other (please write)	

What are the countries of origin of these disabled asylum seekers?

Country of origin	**Number of disabled asylum seekers**
Iraq	
Zimbabwe	
Afghanistan	
Somalia	
China	
Iran	
Eritrea	
Sri Lanka	
Pakistan	
Nigeria	
Other (please write)	
Other (please write)	
Other (please write)	
Other (please write)	
Other (please write)	
Other (please write)	
Other (please write)	
Other (please write)	
Other (please write)	

What are the first languages of these disabled asylum seekers?

First language	Number of disabled asylum seekers
French	
English	
Somali	
Punjabi	
Kurdish	
Arabic	
Urdu	
Other (please write)	
Other (please write)	
Other (please write)	

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If you would like a copy of the results of the study, please provide a contact email address.

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Thank you for your time.

Appendix 4: Estimated Budget for Research Proposal

Item	**Cost details**	**Total cost**
Printing questionnaires	10p per questionnaire (University rate for 3 double sided sheets). 100 questionnaires (estimation from a quick search on Help Yourself)	£10
Stamps for questionnaires	32p per questionnaire.	£32
Printing interview schedule	1 sheet: notes will be made separately on notepaper which is already owned.	10p
Interpreter for interview	2 hours (to include briefing). Estimated cost £25/hour (from personal experience).	£50
Additional support worker for interview	Estimated cost £12/hour to an agency (from personal experience). 2 hour session including travel. Estimate one interviewee may need a paid support worker.	£24
Expenses for interviews	Estimate £10 per person.	£30
Contribution for time for interviews	£20 per person	£60
Room hire	In kind from the Conversation Class	£0
Total		£206.50.