

## ICAR Briefing 2009

# Disabled refugees and asylum seekers in the UK

## I. Introduction

Apart from in the specific field of mental health, there is a significant lack of research on disabled asylum seekers and refugees in the UK. What little does exist, together with anecdotal evidence, indicates that this is a largely 'hidden' population, unknown in size and need, which faces particular and often multiple disadvantages. In particular, there appears to be a gap in knowledge about asylum seekers and refugees with physical or sensory impairments or learning difficulties.

The two main pieces of work so far on disabilities amongst refugee and asylum-seeking communities were carried out by Ceri Roberts and Jennifer Harris (2001, 2002a) and the Information Centre about Asylum and Refugees (ICAR) (Ward, Amas and Lagnado 2008). The first study examined a number of aspects, including the numbers and social characteristics of disabled refugees and asylum seekers in Britain; their needs and experiences; the experiences of service providers; and the impact of changes in social welfare entitlements (Robert and Harris 2002a)<sup>1</sup>. The more recent work by ICAR focussed specifically on service provision in London for those with physical disabilities.

### Definitions

Definitions of disability tend to vary between organisations and individuals. The 'medical model' for example is seen as emphasising the impairment as , the medical 'condition' which causes the disability, while the 'social model' highlights the social and environmental barriers that prevent disabled people from playing an equal role in society.

<sup>1</sup> The same research also produced Roberts (2000); Roberts and Harris (2001); Harris (2003).

The 'official' definition originates with the 1995 Disability Discrimination Act, which is enforced by the Equality and Human Rights Commission.

The 2005 version of the Act defines disability as when a person has

*"a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities."*

A 2006 revision of the Act broadened the scope of disability in specific ways, and legally obliged local authorities to promote disability equality.<sup>2</sup>

An influential policy document defined disability as:

- 'disadvantage experienced by an individual...resulting from barriers to independent living or educational, employment or other opportunities...that impact on people with impairments and/or ill health.' (PMSU 2005).

This 'social model' definition of disability was largely welcomed by advocacy groups at the time, as it drew out the difference between disability and impairment. Subsequent policy, however, was received much more critically (Ward et al 2008).

<sup>2</sup> Department for Work and Pensions (2006). The new definition also broadened the DDA to cover people with 'progressive conditions' from the point of diagnosis, rather than from the point when the condition has affected their ability to carry out normal day-to-day activities. In addition, it also removed the requirement that a mental illness must be 'clinically well recognised' before it can count as an impairment.



## 2. Statistics

Across all kinds of organisations there is a lack of reliable data on numbers of disabled refugees and asylum seekers, and little consistency in collection methods when recorded (Roberts and Harris 2002; Ward et al 2008).

There are a number of reasons why there is such an incomplete picture.

- The Home Office does not publish official data for the number of disabled asylum seekers in the UK.
- The Department for Work and Pensions does not record how many refugees are claiming Disability Living Allowance.
- Local authorities appear not to record the number of refugees to whom they provide disability support.
- Disability organisations do not tend to collect data on the number of refugees and asylum seekers using their services.
- Refugee organisations and Refugee Community Organisations (RCOs) who support disabled refugees and asylum seekers do not tend to collect data on this group, either because they do not record immigration status or because they do not use a 'disability marker' to record impairments or disabilities.
- Organisations and agencies use different methods and definitions of disability for the purposes of data collection and this makes comparison difficult. Some capture data on the basis of self-definition whilst others use the 1995 Disability Discrimination Act definition.
- Where organisations rely on 'self-definition' for data collection, individuals either do not know they could qualify as disabled, or do not want to be labelled as disabled. In both cases they are not included in the data.

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

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

### Relevant research

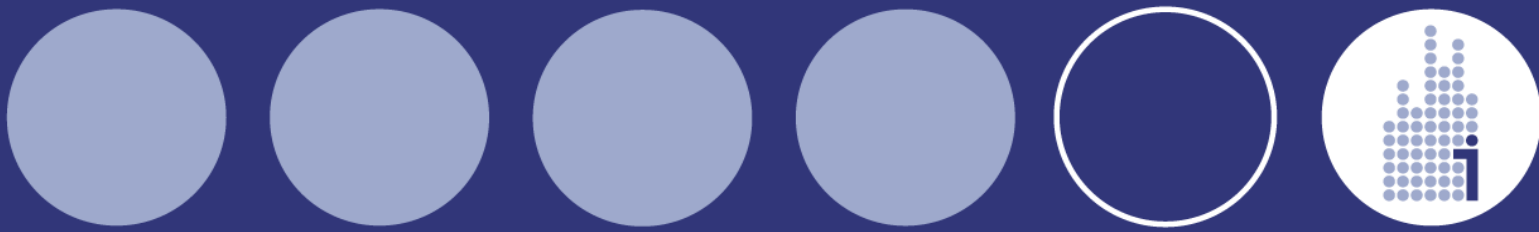
There is a lack of accurate demographic data on disabled refugees and asylum seekers, but preliminary investigations demonstrate that there are thousands resident in the UK and considerable diversity within the population in terms of social characteristics (Robert and Harris 2002a).

Some attempts have been made to estimate the number of disabled refugees and asylum seekers in the UK. Roberts and Harris (2001) produced a 'minimum estimate' of numbers by distributing a 'screening questionnaire' to 300 disability and refugee community groups in the UK. A total of 99 organisations responded; 44 of which reported contact with 5,312 disabled refugees and asylum seekers.

More recently, a 2008 study of 30 organisations in London indicated that they were in contact with a combined total of 11,992 disabled refugees and asylum seekers in London (Ward et al 2008). The larger number is likely to reflect the fact that all of the places contacted are based in London where the number of refugees and asylum seekers has traditionally been much higher.

The study concluded that as data collected from organisations is overwhelmingly based on the guesswork of staff, it could only be taken as a very rough guide to the number of disabled refugees and asylum seekers they work with.

In terms of prevalence of disability among refugees, a 1995 Home Office study found ten



per cent of a sample of 263 individuals with either refugee status or exceptional leave to remain had a disability that impacted on their daily life (Carey-Wood et al 1995).

### Local authority data

Each local authority should be able to access data on the number of asylum seekers they are providing support and services to as a result of a community care assessment. However this data does not appear to be automatically compiled and published. Ward et al (2008) found that of three inner London local authorities contacted, only one was able to provide data for the number of asylum seekers they were supporting. Most of these cases were thought to be asylum seekers that have had their asylum cases refused. The local authority had also been referred two cases by UKBA.

### UKBA / Home Office

From 4 January 2008 to 3 March 2008 the Complex Casework Team (CCT) at the UK Borders Agency referred a total of 203 cases to local authorities around the country. This figure can be broken down into the following types of impairments and medical conditions: HIV (11); TB (12); operations (68 - including anything from heart bypasses to cataracts); mental health (77 – this covers various degrees of severity) and physical mobility (35). Obviously these figures are not just for disabled asylum seekers and what constitutes a disability will depend on individual and organisational definitions (Ward et al 2008).

## 3. Legal and policy

Britain's treatment of disabled refugees and asylum seekers is guided not only by national laws and policies but also European and international agreements relating to protection, and guidance provided by relevant supra-national bodies to help implement such policies.

### International Protection

The Convention on the Rights of Persons with Disabilities articulates the rights of disabled people within an international human rights perspective.<sup>3</sup> Further to that, disabled refugees and asylum seekers may well be survivors of physical and/or mental torture, and still be suffering from this in some way. In such cases they are specifically covered by the 1951 Refugee Convention, under which an asylum seeker must demonstrate a well-founded fear of persecution (of which torture is a form) for one of the five Convention reasons. For asylum applications in the UK, the standard of proof is lower than criminal and civil proceedings and applicants must demonstrate that there is a 'reasonable degree of likelihood' that they have been tortured.

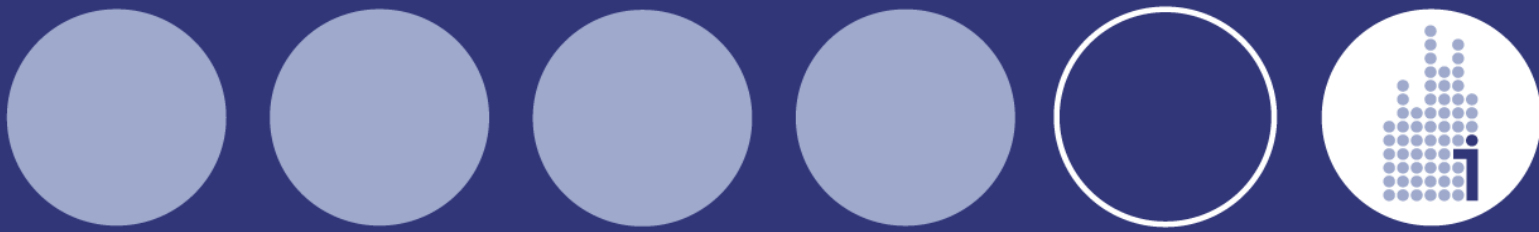
Both the UN Convention Against Torture (CAT) and Article 3 of the European Convention on Human Rights (ECHR) enshrine the absolute prohibition against torture (United Nations 1984). Article 3 states that no one shall be subjected to torture or to inhuman or degrading treatment or punishment, and Article 3 of CAT maintains an absolute bar on the removal of torture survivors where there are substantial grounds for believing that they would be in danger of being subjected to torture on return.

Articles 3 and 8 of the ECHR may provide protection where the Convention does not, by providing the legal basis to argue that removing someone may put their health at risk to such an extent that it amounts to inhuman and degrading treatment (Article 3) or an unjustifiable interference with their private life (Article 8) (Joint Council for the Welfare of Immigrants 2006, pp. 796-7 and 809).

### UK asylum process

The asylum procedure in Britain allows for publicly funded legal representation at the asylum interview where the asylum seeker suffers from Post Traumatic Stress Disorder or mental

<sup>3</sup> See UNHCR/Inter-Agency (2008). The toolkit is aimed principally at advocates of landmine survivors but also contains material of wider application to disabled refugees.



incapacity<sup>4</sup>. There are also specific guidelines for interviewing torture victims, although practice in this area has been controversial (Information Centre about Asylum and Refugees 2007).

Disabled asylum seekers may well fall into the category of 'complex cases'. Legal aid providers have raised concerns that the introduction of a fixed fee structure in 2009 inhibits their ability to provide an adequate service to asylum seekers within this category, and could lead to legal firms not taking complex cases because of the difficulty in securing adequate funding.

Two other areas of the asylum process where special provision is available but has also been the subject of criticism are dispersal and detention.

Dispersal is the means by which UKBA-supported asylum seekers are assigned accommodation throughout the country. Home Office guidelines state that asylum seekers who have been accepted for ongoing specialist treatment with the Medical Foundation for the Care of Victims of Torture should be provided with accommodation where the treatment is provided (usually in London), rather than being subject to compulsory dispersal to other parts of the UK (Home Office (2002)<sup>5</sup>. If dispersal of torture victims does take place it may be in breach of the EU Reception Directive and Home Office policy bulletins numbers 19 and 83 (Medical Foundation for the Care of Victims of Torture 2006). Furthermore, the Home Office acknowledges that torture victims should not be placed in mixed or full board accommodation, as the institutional nature of such accommodation can provoke and exacerbate negative recollections of imprisonment (Home Office 2002).

Where the Home Office believes it can process an asylum claim quickly then the asylum seeker may be detained after the initial screening interview and put through the so-called Fast Track procedure. Disabled applicants 'except the most easily manageable' are included in the categories of those who are exempt from the detained fast track (JCWI 2006, p. 676).

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<sup>4</sup> JCWI (2006), p. 659.

<sup>5</sup> The Medical Foundation is the main specialist organisation in the UK which provides treatment and support to asylum seekers and refugees who have been tortured, and these make up the vast majority of the 2,500-odd clients it sees each year.

Disabled applicants may still be detained at a later stage of the asylum process. In 2007 a high court [ruled](#) that the Home Office and Kalyx Ltd (in charge of services at the centre in question) were bound by 1995 Disability Discrimination Act, thus allowing Peter Gichura, a detained asylum seeker and wheelchair user, to sue over conditions in detention on the basis of discrimination. The Home Office had argued that the Act did not extend to centres of immigration control.

Finally, Britain's resettlement programmes consider disability as a factor in selecting refugees to be resettled. The current programme, known as the Gateway Programme, includes disability within the category of 'refugees with medical needs', who UNHCR is required to refer separately to UKBA for consideration, with a 'limited number' being taken as part of each group accepted for resettlement (UNHCR 2004). This appears to have replaced a small-scale programme known as the Ten or More Programme (literally ten or more cases per year) begun in the 1970s for refugees with disabilities or a serious medical condition, which remains suspended.

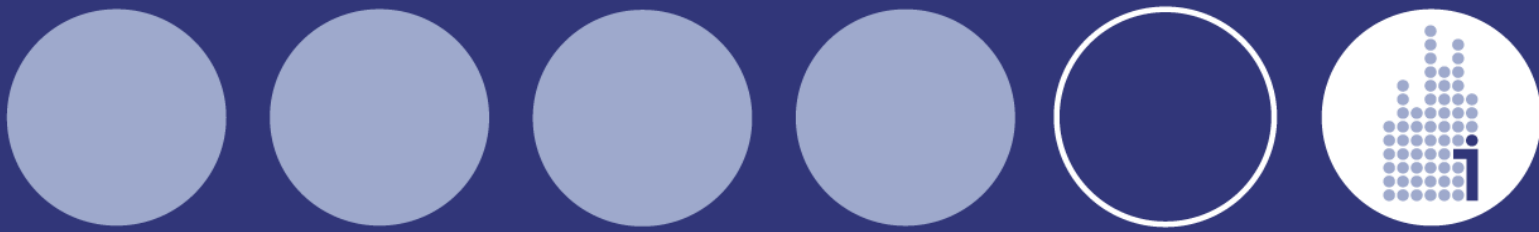
## 4. Rights and entitlements

The 1995 Disability Discrimination Act (DDA) is currently enforced by the Equality and Human Rights Commission, a non-departmental public body established under the Equality Act 2006. The Commission's work on disability is led by a Disability Committee which has decision-making powers in relation to those matters which solely concern disability. Its application to refugees and asylum seekers has not always been clear cut (see below).

Disabled refugees, disabled asylum seekers with an outstanding claim, and asylum seekers that have been refused (and exhausted all appeal rights) are governed by different policies and receive different welfare entitlements and community care services.

### Refugees

Individuals who have claimed asylum and have been awarded Indefinite Leave to Remain (ILR) in the UK or five years limited leave to remain as a refugee, and individuals with Discretionary or



Humanitarian Leave, are entitled to all the same social and welfare benefits and services as British residents.<sup>6</sup>

The government's refugee integration strategy largely focuses on increased access to services and support that will enhance the integration of refugees into society. In London, the Greater London Authority's 2007 draft Strategy for Refugee Integration in London, [London Enriched](#), makes specific reference to disabled asylum seekers and refugees, and highlights the need to pilot employment training programmes targeted at more isolated groups, such as disabled refugees. The GLA also sees a role for RCOs in developing more appropriate mental health services for refugees, notably by working with mainstream and second-tier organisations on service delivery.

## Asylum seekers

Before 1993, newcomers enjoyed the same welfare rights and benefits as the rest of the population. In the years that followed, increasing asylum numbers and government claims concerning pressure on services in London and the South East led to a succession of legal and policy changes which increasingly restricted social support choices and lowered welfare entitlements. These changes culminated in the 1999 Asylum and Immigration Act, which paved the way for a national scheme of asylum seeker dispersal and moved responsibility for housing and support from local authorities to the Home Office. To a large extent this Act still shapes asylum support policy today.

As a result of the 1999 Immigration and Asylum Act, asylum seekers are not eligible to apply for welfare benefits, but are entitled to free primary medical care and medical services provided by the National Health Service (NHS). They can request a community care assessment from the relevant local authority, but must demonstrate that they have a need for services which is caused by something other than the lack of

6 After September 2005 individuals awarded refugee status were no longer granted indefinite leave to remain in the country. Refugees are now granted a limited period of five years leave to remain (Humanitarian Leave) after which their cases will be reviewed to determine whether or not they are still in need of protection.

accommodation and financial support.<sup>7</sup> This is known as being 'destitute plus'. Under section 21 of the National Assistance Act 1948 asylum seekers are entitled to be accommodated by the local authority if they are found to be destitute and have community care needs. When assessing a case for destitution under section 21 the local authority must ignore any asylum support that may be available from UKBA (United Kingdom Border Agency).<sup>8</sup> As a result, if an asylum seeker is identified as having community care needs, then it is the responsibility of the local authority to accommodate and support them as well.

What constitutes a need for 'care and attention' beyond destitution has also been considered by the courts, and the House of Lords has ruled that to be in need of care and attention a person must need someone to look after them and do things for them which they 'cannot or should not be expected to do'.<sup>9</sup> If this is not found to be the case then it is UKBA that is responsible for an asylum seeker and not the local authority.

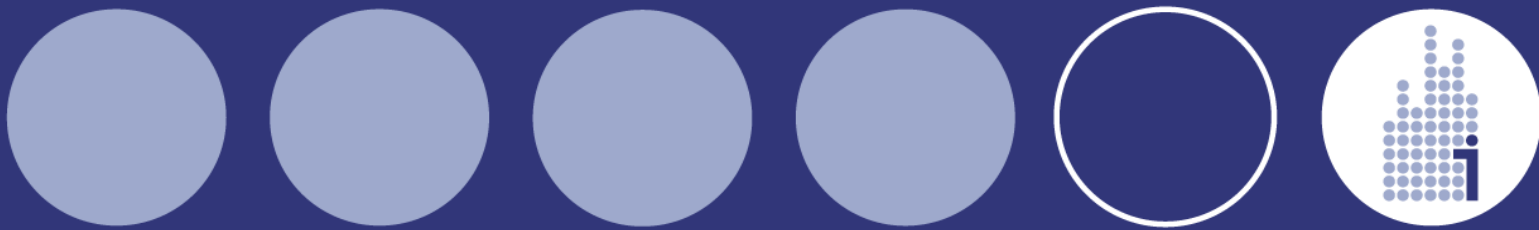
Asylum seekers with potential care needs can be referred by UKBA to the relevant local authority for an assessment. Many are also referred by solicitors, refugee community organisations, advice services, refugee support organisations and other services. They can also refer themselves. In practice, there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

The Complex Casework Team (CCT) at the UK Borders Agency liaises with clinicians and local

7 National Information Forum (2004). Under section 47 of the National Health Service and Community Care Act (1990) social services departments are required to 'carry out an assessment for anyone who appears to need a community care service because they are, for example, elderly, disabled or suffering from a physical or mental illness'. Services that may be provided as a result of a community care assessment include: a place in a care home, home care services, home helps, adaptations to the home, meals and recreational and occupational activities.

8 See the House of Lord's decision in *R (Westminster City Council) v NASS* [2002] 1 WLR 2956.

9 *R (M) v Slough Borough Council* (2008) UKHL 52. <http://www.parliament.the-stationery-office.co.uk/pa/ld200708/ldjudgmt/jd080730/rmfc-1.htm>



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

## Refused asylum seekers

The situation for asylum seekers who have care needs but whose cases have been refused (including all appeals) is more complicated. Schedule 3 of the Nationality Immigration and Asylum Act 2002 prevents local authorities from providing support under section 21 of the National Assistance Act to failed asylum seekers who refuse to co-operate with removal directions<sup>10</sup> or who fail to take reasonable steps to leave the UK.<sup>11</sup>

However, Schedule 3 only relates to individuals who made their application for asylum in-country, not those who applied 'at port' (an airport, train station or ferry terminal on their arrival in the UK). As a result, 'at port' asylum seekers whose claim has been refused, but who have been assessed as having care needs, are not excluded from accommodation and support under section 21. In contrast, 'in-country' asylum seekers, whose claim has been refused, are considered to be unlawfully in the UK and fall under the restrictions to support detailed by Schedule 3.

The only situation in which 'in country' asylum seekers who have been refused asylum can access support under section 21 is when the withholding or withdrawing of support would constitute a breach of the person's Human Rights. However, the threshold for such a breach is very high, as

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[http://www.opsi.gov.uk/Acts/acts2002/ukpga\\_20020041\\_en\\_16#sch3](http://www.opsi.gov.uk/Acts/acts2002/ukpga_20020041_en_16#sch3)

<sup>11</sup> This category was added by the Asylum and immigration (Treatment of Claimants, etc) Act 2004

demonstrated by the case of *N (FC) v SSHD* (2005) UKHL 31.12

Since 2004 asylum seekers whose claims have been turned down have had to pay for certain NHS services which they previously received free of charge. This excludes primary care services; treatment at an accident and emergency or casualty department; treatment of specific communicable diseases; compulsory psychiatric treatment, and treatment of sexually transmitted diseases (although in relation to HIV this only extends to an initial test and any associated counselling). The charging regulations mean that refused asylum seekers are liable for hospital charges and are not entitled to free NHS routine hospital treatment.

In 2009 the Court of Appeal [ruled](#) that refused asylum seekers have no legal entitlement to free healthcare, but that hospitals should use their discretion when deciding whether to treat someone who is unable to pay for their treatment or return home. Likewise, Department of Health guidance discourages GP surgeries from registering refused asylum seekers - although they have the discretion to accept them if they wish (Joint Committee on Human Rights 2007).

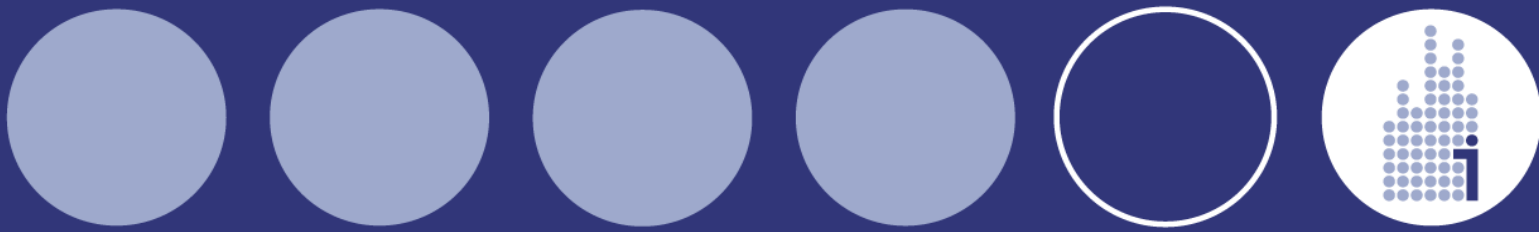
## 5. Access to services and support

Issues of support and access can be divided into:

- General barriers to services
- Statutory services and the asylum process
- Refugee Community Organisations (RCOs) and the voluntary sector

There are high levels of unmet need amongst disabled refugees and asylum seekers in areas such as social contact, personal care, communication and support with parenting (Robert and Harris 2002a). It has also been found this population face a number of barriers preventing access to services which are also faced by the wider disabled BAME (black, Asian and

<sup>12</sup> <http://www.parliament.the-stationery-office.co.uk/pa/ld200405/ldjudgmt/jd050505/ho-me-1.htm>



minority ethnic) population. These include language difficulties, greater levels of poverty, cultural stereotypes of 'caring extended families' among service providers, amongst others (Ward et al 2008).

There are particular issues relating to access to statutory services. Disabled and asylum seeker entitlements to social welfare services are complicated, resulting in confusion amongst service providers (Robert and Harris 2002a).

There is a notable contrast between the experiences of disabled refugees and disabled asylum seekers in accessing statutory services for health, housing and benefits. Ward et al (2008) found that for refugees the experience is generally positive, whilst asylum seekers encounter numerous barriers, especially in dealing with social services departments. They also found that the most common difficulty at doctors' surgeries concerned the lack of provision of interpreting. Finally, the study found that the asylum process itself separates disabled asylum seekers from support networks through dispersal and UKBA staff were seen as making inappropriate decisions concerning accommodation and support provision (Ward et al 2008).

Ward et al (2008) found that few of the mainstream and BAME disability organisations contacted worked with disabled refugees and asylum seekers, and a number were unclear about the rights and entitlements of this group. Significant levels and breadth of support were found to be given by both well-funded refugee support charities and - in particular - the RCOs interviewed. However the latter had very limited contact with mainstream disability organisations.

As a result it appears that RCOs and specialist disability RCOs, though few and far between, are picking up the strain and attempting with limited resources to meet a range of disabled asylum seeker and refugee needs that are unmet by mainstream providers (Ward et al 2008).

RCOs have been found to provide very significant levels and scope of direct support to disabled refugees and asylum seekers. They are however hampered by a lack of resources which impact on this support in a number of ways, from inability to support housebound clients in their own homes to office premises without adequate access for

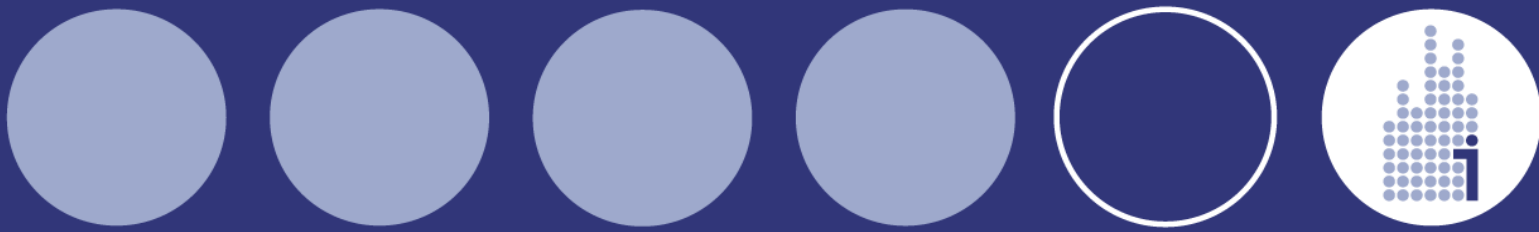
disabled people with mobility problems. In some cases RCOs are also seen to lack expertise on disability issues. Their lack of resources is further threatened by reductions in 'single issue' funding.

The support from family, friends and 'communities' is a vital complement to that of RCOs in the lives of many, but disabled refugees and asylum seekers do not benefit from the same social networks as their BAME counterparts (Ward et al 2008).

## 6. Key issues: Mental health

Both refugee support organisations and RCOs report that mental health impairments are by far the most common kind of disability among their refugee and asylum seeking clientele, and in general the literature on this group's mental health needs highlights high levels of mental distress (Ward et al 2008; Tribe 2002). The different stages of the migratory process can have a negative impact on mental health. These stages not only include traumatic experiences in the country of origin, including torture, war and rape; but also during the migratory journey and after arrival in the UK (Van de Veer 1998; Loutan 1998). Problems once in exile may include communication and cultural difficulties; a complex asylum process; anxiety about immigration status; and social isolation (Raj and Reading 2002 and Burnett and Peel 2001).

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



Research has also highlighted the importance of mental health professionals influencing reception and resettlement policies in a context where immigration controls has become a main priority for governments in Britain and Western Europe. Various studies have concurred that otherwise “migration management will govern provision of mental health promotion and care to such an extent that mental health and lives are threatened and underlying medical ethics and the human right to health are compromised” (Blight et al 2009).

In common with much of the research already mentioned, literature on mental health provision for asylum seekers and refugees emphasises barriers to accessing services such as the lack of suitable interpreters (Raj and Reading 2002); fear of stigma or negative reactions (Li et al 1999; Gabriel and Ritchie 2000); culturally inappropriate services (Watters, 2001) and lack of knowledge and suitably prepared NHS staff (Keating et al 2003). High levels of unmet needs have been identified amongst refugees and asylum seekers with mental health difficulties in areas such as housing, finances, and social contact (McColl and Jackson 2006). A Royal College of Psychiatrists position statement makes a number of relevant policy recommendations based on these and other concerns raised by researchers (Royal College of Psychiatrists 2007, quoted in McColl et al 2008).

Some commentators have argued that mental health providers need to work holistically with asylum seekers and refugees as therapy is unlikely to be effective if their additional needs are not addressed (Blight et al 2009). Addressing these needs is likely to involve the provision of advice, advocacy and social activities (Harris and Maxwell 2000; Watters 2001), as well as regular evaluation of treatment and interventions offered.

Finally, it has been observed that because of the particularly sensitive nature of mental health issues there is not only a need for good interpreters but also bicultural therapists who are able to both speak the same language and bring a cultural understanding to their work (Raj and Reading 2002). However, it has also been observed that resources are unlikely to accommodate this need (ibid) and that the use of bicultural therapists does not necessarily mean that a service is culturally sensitive, because inappropriate interventions may still be used (Watters 2001).

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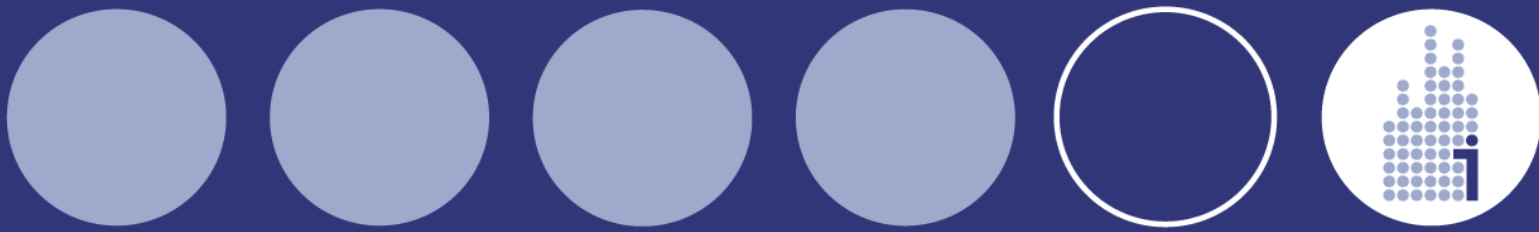
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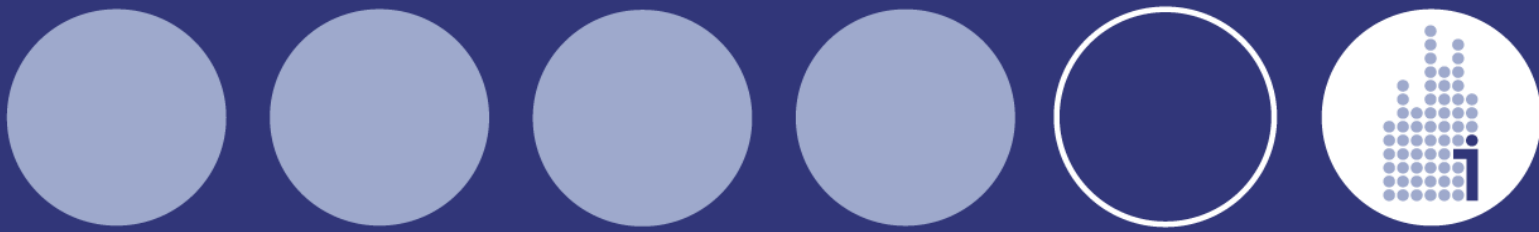
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By Jacob Lagnado