HUMAN RIGHTS ABUSE AMONG PEOPLE SEEKING ASYLUM: CLINICAL ASSESSMENT IN A UK PRIMARY CARE SETTING

EVALUATION OF A TORTUREID PROJECT

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EXECUTIVE SUMMARY

It helped me. You took it seriously

I really feel less burden on my heart.

Context

Human rights abuse, including torture and other cruel, inhuman and degrading treatment, is frequent among individuals seeking asylum.

We evaluated a project in a UK general practice where individuals seeking asylum and recently registered with the practice were routinely asked about their experience of human rights abuse. 51 patients who reported human rights abuse had a comprehensive clinical assessment by an experienced TortureID (TID) doctor.

We aimed through the evaluation to understand the impact of this clinical assessment, and the potential for using a similar approach in other settings. We used mixed methods, including analysis of patient records and written and telephone feedback. This reports outlines the evaluation findings and their implications.

Evaluation findings

We found that in a general practice setting it was feasible to introduce a system of routine enquiry[2] about human rights abuse, with follow-up clinical assessment, and that the assessments were valued by patients and staff. We did not identify adverse psychological consequences to patients, or disadvantages other than cost.

All 51 patients assessed confirmed a history of human rights abuse. 42% reported abuse that the doctor categorised as torture, 20% reported rape or other sexual abuse.

In the majority there were clinical findings linked to the abuse:

- 88% had current mental health issues, including post-traumatic stress disorder (PTSD) in 58% and depression in 72%.
- In 60% there were physical findings, predominantly scars, attributed to physical abuse.
- 8% were assessed to be at significant short term risk of suicide and in need of urgent safeguarding referral, and 45% as having indications of increased suicide risk, such as suicidal thoughts or a history of suicide attempts.
- In a majority of patients there were clinical factors that could affect their ability to give an accurate, coherent and consistent account for example in a Home Office interview. These included distress at assessment (50%), cognitive problems (17%), and presentations that might be liable to misinterpretation (29%).

Evidence of the assessments contributing to improvements in patients' health included:

- 33% had medications for mental health initiated or changed.
- 16% were referred for psychological therapy.
- 15% were referred for follow up of physical health issues.
- 74% of patients who gave feedback subsequently said that they felt their health had benefited.

[2] 'Routine enquiry' is a term used to describe a proactive, professional enquiry into past experiences of abuse in order to respond with some tailored support, depending on the outcome of the enquiry. The aim is to move beyond health professionals waiting for spontaneous disclosure of past experiences. In this project, those who disclosed abuse were referred on for specific follow-up, and so the routine enquiry here could also be regarded as a form of screening. 'Routine enquiry' is a familiar term in work around screening for domestic violence and adverse childhood experiences. The GP practice in this study has for many years routinely asked patients seeking asylum about past experiences of abuse in order to make decisions about clinical care needed, but without using the term 'routine enquiry'.

- Patient feedback suggested possible direct benefit from the experience of assessment, for example through emotional relief and validation.

Evidence that the assessments were available to be taken into account in deciding asylum claims included:
- 45% of patients shared their assessment letters with solicitors or the Home Office directly (43% did not have a solicitor).
- In all cases, the reports were made permanently available within GP records. (This is important given the increasing reliance of the Home Office and Courts on primary care records.)

The project identified significant under-identification of human rights abuse within routine NHS care.
- 66% of patients had no previous mention of their abuse history in their GP record.
- Only 27% of patients recalled ever being asked about human rights abuses by healthcare providers previously.

The project developed practical measures for improving efficiency of routine enquiry and follow-up systems, in particular templates to facilitate recording and reporting that are now embedded within general practice IT systems nationally.

Implications

This evaluation provides strong support for two important arguments:

1. When asylum-seeking patients present to primary care a system of routine enquiry is feasible and beneficial, and can lead to needed health interventions and a potential contribution to asylum decision-making.
2. For asylum-seeking patients, current routine NHS care does not adequately identify those who have experienced torture and other cruel, human and degrading treatment, and does not adequately identify or treat the health consequences associated with this abuse.

Based on our findings we have made detailed recommendations for primary care teams, other clinical specialties, health service commissioners, the Home Office and researchers.

To summarise, we recommend that NHS services that see people seeking asylum introduce routine enquiry about human rights abuses, and consider using the templates and training opportunities now available to facilitate this.

INTRODUCTION

Purpose of the project

We use the term 'human rights abuse' to refer collectively to torture and other cruel, inhuman and degrading treatment[3]. A substantial proportion of people seeking asylum in the UK report that they have experienced human rights abuse. A linked prevalence study identified that 60% of a cohort of those having new patient assessments in primary care reported experiencing some form of human rights abuse [Summers & Miller, 2024].

Most people who have experienced human rights abuses do not routinely receive any assessment from a clinician who both asks about their experiences of human rights abuse, and explores the potential clinical consequences or needs arising from this. Without such assessment they are unlikely to receive optimum treatment and rehabilitation. In addition, those making decisions in relation to their asylum claims will lack crucial information for decision making.

The aim of the charity TORTUREID (TID) is to improve access to early clinical assessments for people seeking asylum in the UK who have experienced human rights abuses. At the Whitehouse Centre GP practice in 2023, new patient assessments already included routine enquiry to screen for human rights abuse. In November 2023, TID began a feasibility project of offering TID clinical assessments to patients who disclosed abuse.

The project was enabled by Locala Health and Wellbeing who manage the Whitehouse Centre. The Whitehouse Centre provided room space and some administrative and IT support. Grants from the Network for Social Change and the Mears Foundation funded the TID doctor's time.

This report summarises findings for the first 51 patients who had a TID clinical assessment.

Routine Enquiry and TID clinical assessments in the Whitehouse Centre

The Whitehouse Centre is a specialist primary care service, and is the practice that registers all those who are seeking asylum and accommodated in Huddersfield. Newly registered patients are offered an NHS new patient screen where a healthcare assistant additionally enquires whether they have experienced human rights abuse. We refer to this as 'routine enquiry'. At the time of the project the healthcare assistant conducted new patient screens by telephone, using a telephone interpreter.

Prior to the current study, a referral for further clinical assessment (usually a GP appointment) occurred only when there was an acute or urgent clinical presentation. However the information recorded at the new patient assessment was routinely utilised and found to be invaluable by the practice team whenever a patient became unwell.

Over a six month period, from 1.11.23 to 30.4.24, those patients who reported abuse had the opportunity of automatic referral for a TID assessment.

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[3] **Human rights abuses**. We use the term here to mean 'torture and inhuman or degrading treatment'. This phrase is taken from Article 3 of the European Convention on Human Rights 1950 (ECHR), to which the UK is a signatory : "***No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment***."

Torture is inhuman treatment deliberately causing serious and cruel physical or mental suffering.

Inhuman treatment need not be deliberate, but it must reach a minimum level of severity, causing either actual bodily harm or intense mental suffering.

Degrading treatment need not be deliberate and must involve humiliation and debasement.

Other clinicians in the GP practice were also able to refer for a TID assessments.

All TID assessments were conducted by a TID-employed doctor (JM) who had training and experience in assessment of human rights abuse and who (on separate days) worked in the same practice. The doctor had access to the patients' NHS primary care records.

Those who were considered appropriate for an assessment received a telephone call from the TID doctor, to confirm that they would like to come for the assessment, along with supporting information detailing the purpose of the assessment and what it would entail (sometimes, but not always, in the patient's language - See Appendix 1).

In an appointment of 60 minutes, the doctor enquired about the nature of the abuse experienced, and about physical and mental health, including a mental state examination, focusing on issues relevant to the abuse. Where appropriate she also offered a brief physical examination. In some cases she also photographed lesions attributed to abuse. The doctor initiated treatment or referral as appropriate. The patient was given a leaflet for wellbeing and support (Appendix 2). In several assessments other clinicians were present observing the process for their own learning.

The doctor recorded the outcome of the assessment in the practice's computerised NHS record system (SystmOne)[4]. A copy of the assessment was provided to the patient. The patient was offered an opportunity to be sent an electronic copy of this and/or to collect a paper copy (Appendix 3).

All assessments were completed within six weeks of referral.

EVALUATION

Aims

We aimed to understand the impact of the TID clinical assessments, and the potential for using these approaches in other settings. Specifically we looked at:

- The assessment process
- Assessment findings
    - Demographic information
    - Asylum status
    - Human rights abuses
    - Clinical findings
- Impact of the assessments

This evaluation did not review the routine enquiry process. Aspects of this are considered in a separate linked paper (Summers & Miller, 2024).

[4] SystmOne is a computer system used by over 2,600 GP practices in the UK and a third of acute mental health trusts. (Source TPP website 22.9.2024). It enables accurate data recording and secure communication of patient information.

Methods

We used mixed methods.

(1) **The doctor's assessment records**. The doctor conducting the clinical assessments recorded information about patient characteristics, clinical findings, and actions taken.

For some patients this information was incomplete as clinical needs took priority, and the doctor made judgements about what questions were appropriate depending on clinical circumstances. Some questions were introduced part way through the cohort as themes became apparent. Where information was not obtained for all 51 patients, this is indicated in the text (see Findings).

(2) **Patients' written feedback**. Immediately following the appointment, those patients who understood sufficient English were invited to complete a simple feedback form. This asked for responses to four questions on a Likert scale, and also invited free text comments. Twelve patients completed forms.

(3) **Patient telephone interviews**. At the end of the project, the doctor who conducted the assessments telephoned patients (using an interpreter where needed) to request verbal feedback about the appointment and about any clinical and asylum outcomes.

Of the 51 patients assessed, the doctor spoke with 29, typically for around 15 minutes. In a further seven cases, attempts to contact the patient were unsuccessful despite two telephone calls on different days. Fifteen patients were not telephoned: nine because they were under 18; three because they had been distressed or were receiving pro-active GP follow up and the doctor felt an evaluation phone call would be confusing for them; three because they had not been given a copy of their assessment.

The independent evaluator also conducted telephone interviews with two of seven patients who agreed to be contacted by her.

(4) **Stakeholder interviews**. Following completion of the project, the independent evaluator conducted six remote interviews with stakeholders including: the TID doctor who conducted the assessments; another Whitehouse Centre GP; a GP from a different practice who had observed TID assessments, the Whitehouse Centre Practice Manager; two TID doctors who had observed assessments.

All patients gave consent to use of the anonymised data in the evaluation.

FINDINGS: ASSESSMENT PROCESS

Referral to TID assessment

During the 6 month period (1.11.23 – 30.4.24), the TID doctor assessed 51 patients who had reported human rights abuse.

36/51 (70.6%) patients were referred following a new patient assessment that took place between 1.11.23 and 30.4.24.

11/51 (21.6%) were referred by a GP or nurse within the GP practice; 3/51 were external referrals from social workers or support workers supporting young people. 1/51 was referred by the practice manager.

The initial intent was that the health care assistant doing new patient assessments would be the only practitioner referring for TID assessments. However, as word spread, other practitioners asked to be able to refer patients, and in response to demand the assessments were made available through other routes. By the end of the project, 15 patients were referred through these alternative routes.

For those patients referred from the new patient assessment, initially the healthcare assistant would discuss the option of referral with the patient. Some patients declined, stating that they felt relatively well at that point. Part-way through the project, an automatic referral system was introduced where the healthcare assistant ticked a 'trauma notification' box on the computer assessment form, and this triggered an electronic message to the TID doctor, who then decided whether to offer the patient an assessment [Summers & Miller 2024]. Both the TID doctor and the healthcare assistant felt this system worked well, and the healthcare assistant appreciated no longer having the task of explaining the TID appointment.

Attendance

Initially, some of those invited did not attend. In response, part-way through the project, additional personalised reminder messages were texted to patients and this improved attendance.

Non-attendance for young people was more frequent than for adults. In response, part-way through the project the doctor started to involve the support worker in planning the appointment and this helped to improve attendance.

Appointments

Initially appointments of 45 minutes were offered. Part-way through the project this was increased to one hour.

Clinicians who observed the appointments noted that it was possible to obtain crucial information within this time, and the process did not feel rushed.

Observers also highlighted the TID doctor's skill in conducting the assessments as an important factor in their effectiveness. They reported that she maintained a low-key, relaxed atmosphere whilst asking questions about very difficult experiences, and that although writing for much of the time, she maintained eye contact at critical moments, likely to help the patient feel attended to and listened to. They noted that she conducted a relatively unstructured interview, allowing patients time to talk, but was still able to obtain the key information. They commented on how much patients were willing to disclose during the assessment, and considered this might be due to the doctor's approach. The TID doctor reported that, although training and experience

probably enables eliciting of greater detail of the abusive experiences, many patients are very willing to disclose considerable detail when anyone in healthcare asks, as evidenced by the amount of information provided to a healthcare assistant on routine enquiry.

Observers also noted that the TID assessments involved listening to accounts of extreme violence and abuse and that the conducting assessments may be emotionally challenging for clinicians.

Language

42/51 (82.4%) assessments were conducted with an interpreter, who joined by telephone.

Sometimes telephone interpreting was not acceptable to the patient, or failed, and alternatives had to be found.

Interventions

The TID doctor noted that over the course of the project she had become increasingly aware of the significance of risk and safeguarding aspects of the assessment, and of the potential value of using the systems for reporting safeguarding concerns in people seeking asylum. She began to use the Home Office safeguarding email address to raise concerns, copying in the safeguarding lead for the asylum accommodation provider when the information was pertinent to them.

Documentation

Initially, the TID doctor created each assessment letter as a Word document, accompanied by a brief CV of the doctor. However this was time-consuming, and limited the potential for the system to be used by other GPs and practices in the future. In the later part of the evaluation, the letters were sent out as a pre-formatted letters, created from templated clinical entries.

Much GP assessment work is now based on templates that include questions and prompts for the clinician and provision for recording within the template, using tick-boxes and drop-down menus to simplify the recording process. A company creating these templates (Ardens) responded to a request from the TID doctor by agreeing to develop a template for the TID assessment free of charge. Once this template was available, the data entered by the doctor was used to automatically populate a standard letter that could be printed out and given or sent to the patient. This template was initially developed for SystmOne, the computer system in use in the Whitehouse Practice and which is widely used nationally. Ardens have made the template Open Access, so that any GP using SystmOne can use it. The other computer system used by GPs is EMIS Health, and subsequently Ardens have developed an EMIS-compatible version of the template. Appendices 4-6 provide further information about the templates.

Patients' perceptions of the assessment

Written feedback at the time of the appointment. The 12 patients who completed a feedback form about the appointment all reported that they understood the purpose of the appointment and that they felt safe, respectfully treated and listened to. Their free text comments about the doctor indicated appreciation of her manner, for example 'kindness'. Free text responses to the questions about what patients liked and disliked about the appointment mostly referred to the impact it had on them, predominantly a positive one (Table 1). There were no negative comments about the service, and no suggestions for improving it other than one

person saying that they would have liked more time. Several people stated that there was nothing they disliked and nothing that could be improved,

Table 1 COMMENTS MADE IN WRITTEN FEEDBACK AT THE TIME OF THE APPOINTMENT

Question	Example comment
What did you like?	*I get to say what happened to me* *Talk about the past and what happened* *To be able to express myself* *Getting my thoughts out there clearly* *The question was good and very directive*
What did you dislike?	*I liked everything, but I had a hard time expressing myself* *I wish I had enough time to tell in detail my whole story but I know that will be a lengthy one. I am grateful.* *My past memories remember*
Any more comments about the doctor?	*Doctor is really understanding and so polite. I feel so comfortable with her.* *I like her kindness* *Kind and patient* *Very good doctor* *I like her facial expression and how to treat me* *The doctor was very considerate, compassionate and kind. I saw how she looked at me as I narrated my story*

Patient feedback in telephone calls with the doctor. Questions focused on events since the assessment and no patient made any further comments about the assessment process itself.

Patient feedback by phone to the researcher. Two patients were interviewed by telephone. Both were very positive about the assessment experience and the letter that the TID doctor produced. One said that it felt rather overwhelming to be asked questions about difficult past experiences, but that it was good to talk about them. The other said it was the first time anybody had asked him this type of question. The TID doctor's manner was described as kind, warm, calm and approachable, and as making it easy to address difficult issues. One had submitted their assessment report along with other documents to the Home Office and said that the inclusion of the report gave her some confidence, although she had not yet been interviewed so was unsure to what extent it would influence the process. Both found the practical arrangements for the appointment straightforward, although one noted that the lack of funding to cover transport costs could create difficulties for some. One patient felt it would have been good if the report was sent automatically to the Home Office and other relevant authorities, including local charities.

Observations of the TID doctor about patient responses to the assessments. Some patients were upset when disclosing abuse and a very small number had active flashbacks or dissociative episodes during the assessment. The TID doctor reported that patients tended to say they appreciated the opportunity to talk and seemed to like to see someone who is pleasant with them. They were generally not aware that the assessment documentation might be helpful for them in terms of creating a record of their experiences. She also felt that they tended to under-report how they were feeling and that the fact that they do not return to collect their assessment letters was an indication that they do not see these as documents which may be useful in the future.

FINDINGS: INFORMATION FROM ASSESSMENTS

Demographic information

Age: At the time of the TID assessment 40/51 (78.2%) were recorded as adults, 11/51 (21.3%) as under 18. Ages ranged from 16-48 (mean 26). Over 75% of patients were under 30.

Age disputes: Two patients reported that they had been under 18 when they arrived in the UK but the Home Office had classed them as adults. One said they were still under 18 at the time of the TID assessment. The doctor was not in possession of information about whether this patient had had an adequate (Merton-compliant) age assessment and had to refer to Social Services Children's Safeguarding Team to look into this further.

CASE STUDY 1 Age disputes

A male patient was referred to TID by a health care assistant following his new patient assessment. He had disclosed persecution and harassment by the authorities in his home country, including being struck on the head.

Early on in the TID assessment the doctor noted difficulties obtaining a clear account from him and wondered about his maturity. When asked how old he thought he was, he replied that he was about 17 and a half years old. In his NHS record, his age was recorded as 25. He expressed great surprise at this. There was nothing in his medical record to confirm that he had been age assessed and he himself was unable to describe anything that sounded like an age assessment.

Further questions revealed that he had no schooling and was illiterate in his own language. He described a head injury and a small scar on his head was noted. He had symptoms of low mood.

Concerns were recorded in a TID assessment letter about his maturity, education, possible head injury and mental state impacting on his ability to explain himself well. He did not have a solicitor and was sign-posted to the voluntary sector for legal advice. He was referred to Children's Social Services because of concerns he could be under 18.

As part of the project evaluation, he was interviewed by telephone a few months later. and had not collected the letter explaining his difficulties. He did report that he had recently obtained the services of a solicitor. His letter was resent.

Social Services established that soon after arrival in the UK, he had been age- assessed and thought not to be a child.

Gender and sexuality: 42 (82.4%) were male. 9 (17.6%) were female. No patient reported any other gender identity. Patients were not routinely asked about their sexuality. In three cases patients reported abuse because of their sexuality.

Literacy: Of 25 patients who were asked about their literacy 8 (32%) said they were unable to read in their own language. The question about literacy was added part way through the project when it became apparent that some patients could not read.

Detention in the UK: Although patients were not routinely asked if they had been in immigration detention or prison, one 17 year-old patient volunteered that he had been in prison after being found working on a cannabis farm. He was on bail and wearing an electronic tag at the time of the appointment.

Nationality: Patients came from 15 different countries (Table 2)

Table 2 COUNTRY OF ORIGIN	
Country	**Number (%)[5]**
Afghanistan	13 (25.5)
Sudan	8 (15.7)
Iraq	6 (11.8)
Eritrea	5 (9.8)
Vietnam	4 (7.8)
Iran	3 (5.9)
Namibia	3 (5.9)
Syria	2 (3.9)
Albania	1 (2.0)
Brazil	1 (2.0)
Ethiopia	1 (2.0)
Guinea	1 (2.0)
Pakistan	1 (2.0)
Sri Lanka	1 (2.0)
Uganda	1 (2.0)

Case Study 2: Detention and finding information in the GP record

A 17 year boy was referred from new patient assessment because he disclosed abuse during his childhood and during the journey to the UK.

His previous GP record showed that he had been seen in another practice and given medication for stress and palpitations. A copy of an assessment by the Looked After Children's team (sent to the GP) advised of weight loss, stress and palpitations. It also stated that he had come into Children's Services after he was found in a UK adult prison and discovered to be under 18 and a victim of trafficking (he had been arrested for involvement in cannabis cultivation). None of this information had been coded and highlighted in the GP record and was therefore only retrievable on re-reading all correspondence.

At his TID assessment he talked about abuse by family members in his home country that culminated in him being sent away to make money for the family. He listed exploitative experiences in countries on his journey and in the UK, and witnessing other people being harmed.

Examination revealed symptoms of depression and PTSD and shame about the fact he was having to wear an electronic tag as he was still on bail for cannabis cultivation. He was unable to make any eye contact and had a very limited range of facial expressions. He was carefully risk assessed and reported a suicide attempt whilst he was held captive in the 'cannabis farm' but no thoughts or attempts since. He said that he believed the traffickers would not be able to locate him.

His social worker was given a copy of his assessment.

The Home Office did receive the TID letter, via the social worker, as their safeguarding team wrote to the GP practice about receiving the information.

[5] Where not otherwise stated, the denominator for all percentages is 51.

Asylum information

Length of time in UK: 44/51 (86.3%) patients said they had been in the UK for 15 months or less when seen for their TID assessment (Table 3). One patient had been in the UK for 30 months and two for three years.

Table 3 TIME IN THE UK

Months	Number (%)
0-5	11 (21.6)
6-11	16 (31.4)
12-17	17 (33.3)
18-23	4 (7.8)
24+	3 (5.9)

In many cases, patients were uncertain of the date they claimed asylum and/or arrived in the UK, so this data should be treated as approximate.

Asylum Stage: For two patients the doctor was unable to clarify whether they had claimed asylum. Of the remaining 49, 43 (87.5%) patients had not received a decision on their asylum claim. 3 (6%) had received a refusal, 3 (6%) had Leave to Remain.

Unaccompanied asylum-seeking children: All 10 patients under the age of 18 at the time of assessment had arrived in the UK as unaccompanied minors. Another young person who had been under 18 on arrival was 18 years old at the time of the appointment.

Home Office interviews: Of the 43 patients who had not received a decision on their asylum claim, 5/42 (12%) had been invited to or had their substantive interview, 37/42 (88%) reported they had had no contact about interviews from the Home Office. One patient was not asked for more information as they were too unwell at the time.

Solicitors: The doctor asked 44 patients whether they had a solicitor: 25/44 (56.8%) said they had and 19/44 (43.2%) that they did not (Table 4). Of the seven patients excluded from analysis, three had leave to remain, two may not have had asylum claims, one did not know if they had a solicitor, one was not asked.

The proportion who had a solicitor was higher for those who had been in the UK over 12 months (15/20; 75%) compared with those who had been here less than 12 months (10/24; 41.7%).

Table 4 LEGAL REPRESENTATION

Time since arrival in UK	Has solicitor	Does not have solicitor
0-12 months (n=24)	10 (41.7%)	14 (51.3%)
More than 12 months (n=20)	15 (75%)	5 (25%)
TOTAL (n=44)	25 (56.8%)	19 (43.2%)

Medical Evidence for asylum claims: At no stage of the project was it apparent that any patient was undergoing any form of medico-legal assessment.

Entry to the UK: Of 44 patients asked about their route of entry to the UK, 35/44 (68.6%) had entered the UK by boat across the English Channel, 5/44 (9.8%), had entered by lorry, 3/44 (5.9%) by plane, 1/44 by ferry (2%).

Human rights abuse

Overall findings. Of the 51 patients seen, 50/51 (98%) were asked about human rights abuse (Table 5). One patient was not asked because he was 16 years old, had just found out that some family members in his home country had been killed, and was acutely distressed at the time of the assessment. No patients were found to have been inappropriately referred for assessment.

Form of abuse. 44/50 (88%) reported physical abuse, and 10/50 (20%) disclosed rape or sexual assault. (16 patients were not asked a direct question about sexual assault.)[6] (Table 5)

Psychological abuse can be considered to be an aspect of all forms of abuse. The doctor recorded 'psychological abuse' as the primary method of ill-treatment in 3/50 (6%) cases where no specific physical or sexual abuse had been disclosed but there was a clear account of mistreatment. An example was a student from Afghanistan who had been threatened with kidnapping by the Taliban and then made a difficult journey witnessing other refugees dying from thirst and starvation.

Context of abuse. In 21/50 (42%) patients there was clinical suspicion of torture. In 9/50 (18%) patients there was clinical suspicion of modern slavery. 3/50 (6%) patients gave a history of intimate partner violence. (Table 5). The doctor recorded a clinical suspicion of 'torture' in all cases where the abuse took place in detention or was inflicted by authorities or organised groups; when particular torture methods were described (e.g. burns and positional torture); or when the abuse was particularly inhumane or degrading. Physical assault, in the form of beatings outside the above scenarios, was not classed as torture.

The doctor recorded 'modern slavery' in cases where the patient was already in the National Referral Mechanism for Modern Slavery or when they described forced labour or servitude

Patients reported other situations of abuse and dangers in their lives, that in some cases were additional to experiences of torture, modern slavery and intimate partner violence. 18/51 (35%) patients reported that they had been exposed to conflict in their country of origin. Others reported abuse by family or community members.

[6] It is widely recognised that many people do not disclose sexual assault and rape unless it asked directly. It was not always possible in a one hour appointment to ask, or was not considered necessary, and 16 patients in this project were not directly asked.

Table 5 HUMAN RIGHTS ABUSE (n=50)						
	Form of abuse			Context of abuse		
	Physical	Sexual	Psycho-logical only	Clinical suspicion torture	Clinical suspicion modern slavery	Intimate partner violence
All locations	45 (90%)	10 (20%)	3 (6%)	21 (42%)	9 (18%)	3 (6%)
Country of origin only	25 (50%)	5 (10%)	2 (4%)	14 (28%)	0	1 (2%)
Country of origin & journey	6 (12%)	1 (2%)	1 (2%)	2 (4%)	0	0
Journey only	13 (26%)	4 (8%)	0	5 (10%)	8 (16%)	0
In UK only	1 (2%)	0	0	0	1 (2%)	2 (4%)

Age at first abuse: Of the 50 patients who reported abuse, 16 (32%) patients reported having experienced human rights abuses while under 18 years of age.

Clinical findings

Clinical findings are considered here for 50/51 cases. One patient was excluded from this analysis because they left the assessment after giving a brief history only. They had been informed that they had been given leave to remain two days before the appointment and did not want to stay and be more comprehensively assessed.

Physical findings. In 30/50 (60%) patients, there were physical findings that the patient attributed to physical abuse. 28/30 had scars or other skin lesions; 2/30 were pain presentations. Most of the skin lesions seen were compatible with the account given but non-specific in appearance. 17/50 (34%) patients did not report any lasting physical injury (they were not examined unless something else in the account given suggested there could be scarring). In three cases the patient was either not asked or not examined.

Psychological symptoms. All of the patients assessed reported that they had experienced psychological symptoms either currently or in the past.

In 44/50 patients (88%) the doctor identified current psychological symptoms. The doctor found 38/50 (76%) to have current sleep disturbance, 36/50 (72%) current symptoms/signs associated with depression and 29/50 (58%) current symptoms/signs associated with PTSD. One patient was too irritable for the doctor to adequately clarify the nature of their symptoms.

In 21 cases, the doctor noted other apparent psychological problems in addition to one of the three above issues. These included; dissociation (4 cases); severe anxiety (3 cases); shame (3 cases); head injury (3 cases); complex PTSD (2 cases); anger / irritability (2 cases); acute grief reaction (1 case).

Five (10%) patient were already being prescribed medication for psychological problems.

6/50 (12%) patients reported that they had experienced psychological symptoms in the past, but not currently.

Patients' difficulties in giving an account of their experiences

Cognitive problems. In 9/51 (17%) patients, the doctor noted an obvious impairment in attention, focus, in understanding of questions, or in memory and recall. This was in addition to anticipated problems with interpretation.

CASE STUDY 3 Difficulty with giving an account

A 45 year old man was referred to TID following his new patient assessment, because he had reported torture in his home country and had some scars.

Early on in his TID assessment he became distressed and began hyperventilating, requiring a clinical intervention to calm him down. He appeared confused at times and was unable to fully answer questions.

A working diagnosis of PTSD and depression was made and he was started on medication with GP follow up arranged.

Several scars were documented in his record.

He did not have a solicitor and concerns were recorded in a TID assessment letter about his ability to give an account in his current psychological state.

His GP follow up did not take place because he was moved by the Home Office to another area of the country. When he was spoken to by phone some time later (for evaluation purposes), he still sounded unwell on the phone. He could not recall his TID assessment or receiving a letter about it. A friend was present with him and an arrangement to resend information was made with advice to approach his new GP and the voluntary sector for legal advice.

Distress. For 26/51 (50.5 %) patients, the doctor noted that they showed acute signs of distress when giving an account of their experiences. This included: agitation in 5 (9.8%), irritability in 5 (9.8%); sadness in 7 (13.7%), shame in 7 (13.7%), panic attack in 2 (3.9%). One who was grieving became acutely distressed during the assessment. In some cases agitation, irritability and panic may have been related to symptoms of reliving traumatic experiences and dissociative episodes.

Presentations liable to misinterpretation. The doctor noted 15/51 (29.4%) patients who, in her view had psychological symptoms affecting their behaviour, and were at risk of this behaviour being wrongly attributed to other causes or their presentation being seen as incongruous with their account. Three patients showed challenging behaviour which could be misunderstood as occurring through choice or personality factors rather than trauma. Nine patients who did not talk at length about their experiences could be misunderstood as coping better than they were.

Similarly, the behaviour of those patients who were distracted and struggling to concentrate, could be misinterpreted if their responses were not understood in the context of their trauma history.

CASE STUDY 4 Misleading presentation

A 17 year old boy was referred by a GP for assessment because of concerns about difficulties understanding his psychological state. He had been noted to be smiling inappropriately, or 'smirking', when talking about his difficult past e.g. when discussing the loss of a parent.

He was seen with his social worker in attendance. He was excluded from college. He had recently been involved in two fights. He had begun self-harming and using alcohol.

There was time in his TID appointment to elucidate a history of an abusive childhood, bereavements and then some very severe repercussions from an adolescent relationship in his country.

He presented as a young man struggling with low mood, shame and anger. He was beginning to develop unhelpful ways of trying to cope with his difficult feelings.

Counselling was suggested to try to help with anger and shame. His TID assessment letter explained his psychological state and advised that the smiling could be misunderstood and was actually a sign of discomfort and distress.

Risk assessments

All patients were assessed for current suicidal thoughts and attempts. The doctor explored other aspects of risk to the extent that she deemed clinically indicated.

Suicide and self-injury. In 23/51 (45%) patients, the doctor found indicators of increased risk of suicide (current or past suicide attempts, suicidal thoughts or self-injury) (Table 6).

In 4/51(7.8%) patients, the doctor considered the current (short term) risk to be significant. Two had made recent suicide attempts and continued to experience suicidal ideation, and a further two reported that they were actively considering suicide. Another patient did not respond when asked about current suicidal thinking. (See below 'Safeguarding Referrals)

Four (7.8%) patients reported past suicide attempts, and 10 (19.6%) reported that in the past they had had active thoughts of suicide.

One patient was engaging in self-injury during the assessment. Three more gave a history of self-injury.

Table 6 PATIENTS ASSESSED TO HAVE HEIGHTENED SUICIDE RISK

Risk factor	Number (% of 51)
Current concerning thoughts of suicide + recent suicide attempt	2 (3.9%)
Current concerning thoughts of suicide	2 (3.9%)
Unwilling to answer questions about suicidality	1 (2%)
Previous suicide attempt	4 (7.8%)
Previous thoughts of suicide	10 (19.6%)
Other previous self-injury	4 (7.8%)

CASE STUDY 5 Suicide risk

A 31 year old woman was referred from new patient assessment after she disclosed she had witnessed the murder of a parent and been sexual assaulted during her journey to the UK.

Her previous GP record mentioned PTSD symptoms and prescriptions for sedatives. Suicidal thoughts had been noted.

The TID assessment revealed that her psychological difficulties were severe with a likely diagnosis of complex PTSD. She made extensive further disclosures of torture and sexual assault. Her ability to recall clearly was impaired. There were episodes of dissociation which required clinical intervention during the assessment.

She described an attempt to strangle herself 2 weeks earlier. On further questioning the timescales and descriptions kept changing. She described impulsive behaviours.

In view of the recent attempt, the severity of her psychological difficulties and her changing levels of recall she was assessed as high risk for suicide.

Active GP monitoring of risk was arranged with medication and counselling. An email was sent to the Home Office safeguarding hub. No reply was received. In this case a direct approach was made to the patient's solicitor (because giving her letters and reports directly could have caused distress). The solicitor did not reply.

At the time of writing, further information was available from the patient's GP record. A second email had been sent to the Home Office safeguarding hub by her GP regarding recent crimes against her committed in the UK. This email advised of likely difficulties with an imminent Home Office interview. Several weeks late there was an urgent request from the voluntary sector to her GP to provide them with information from her medical records. She had attended a Home Office interview and not been able to answer questions. The Home Office sent her a message advising that they felt it was reasonable to expect her to be able to answer questions and they also asked if she could provide any medical evidence. A copy of her TID assessment, subsequent GP consultations and the two safeguarding emails were given to the voluntary sector to forward to the Home Office.

Vulnerability (risk of being harmed) in the UK : Vulnerability was not assessed in detail but, in some cases, the doctor noted possible vulnerability on the basis of the clinical history and observations. One patient was deemed vulnerable because of a suspected learning disability. Six were assessed as possibly vulnerable to harm due to the severity and nature of their psychological illness, for example because of frequent dissociation or risky behaviours triggered by reminders of past experience.

CASE STUDY 6 Vulnerabilities

A 16 year old boy was seen following a referral from his social worker. He had arrived in the UK as an unaccompanied minor and was being looked after by Children's Social Services.

The social worker was concerned about the young man's ability to live independently. The TID doctor summarised reports from multiple sources (verbal and written in his GP record) which expressed concerns about his level of education, his ability to look after himself and higher than usual needs for support. He was reported as displaying repetitive behaviours and following advice very literally.

At his TID assessment there were symptoms of depression and PTSD evident. He was not able to talk about what had happened, alluding to 'bad things' and nightmares. He responded to some questions very literally.

The conclusion of the assessment was that there were possible vulnerabilities in relation to his ability to learn and cope but no obvious evidence of a severe learning disability. As he was well supported by Social Services they were advised to continue to monitor and to request input from the GP should it be needed (for example to consider neurodiversity).

A letter about the vulnerability issues was given to the patient and Social Services to assist them with his immigration matters as he had problems communicating what has happened in his earlier life.

Risk of harm to others: Where there were indicators of possible increased risk of violence in the history or examination (e.g. irritability, psychotic symptoms, poor rapport), the doctor enquired about past history of violence. One patient reported having assaulted someone before coming the UK.

FINDINGS: IMPACT OF ASSESSMENTS

Perceived direct impact of the appointments

Patients' comments made in written feedback at the time of the appointment. Some of the responses to the question about what was liked about the appointment indicated that patients found benefit in the opportunity to talk about what had happened to them (Table 7). Other than one comment in written feedback about 'remembering' painful memories (Table 1), there were no comments suggesting that people felt it was bad for them to have this appointment.

Table 7 DIRECT IMPACT OF THE APPOINTMENT: PATIENTS' WRITTEN FEEDBACK AT THE APPOINTMENT

Question	Examples of comments
What did you like?	*Every time I get to express myself and talk about my story, I feel better and relieved* *They gave me the chance to talk normally about my journey, so that is good for me* *I am feeling happy to talk about the bad things what happened to me* *I get to say what happened to me* *It helps me to talk to somebody. I really feel less burden on my heart. I genuinely feel good*

Patients' subsequent recollection of the assessment. Of the 29 patients who provided telephone feedback to the doctor, 23 (79.3%) recalled the TID appointment. Recall was more frequent when photographs had been taken at the appointment. Of the six who could not recall the TID appointment, five had been seen in the earliest part of the project and one had been seen more recently but was unwell.

Patient feedback in telephone calls with the doctor Several patients' comments indicated that they felt some direct benefit from the appointment (Table 8) .

Table 8 DIRECT IMPACT OF THE APPOINTMENT: PATIENTS' TELEPHONE FEEDBACK TO THE DOCTOR

Question	Examples of comments
Relief through talking	*It helped me to express my feelings. It also helped me reduce some thinking for the day* *Telling people the truth was very good for me* *Talking to someone always helps*
Appreciation of opportunity	*You feel that someone is there to care for you. You feel safer* *It helped me. You took it seriously* *it was quite nice that somebody ask you about your situation* *Definitely* [it is good that] *someone can stay with me and hear me*

Stakeholder comment. One of the clinicians who observed the assessments wondered whether the assessment itself has some therapeutic value, beyond the documentation of difficulties.

Perceived health outcomes

Patient feedback in telephone calls with the doctor (Table 9) Of the 23 who recalled the appointment 17 (73.9%) stated that they believed that the appointment had helped them with their health, four (17.4%) were unsure, two (8.7%) thought it had not helped. Most comments were about the importance of telling their personal story and health interventions made.

Table 9 HEALTH IMPACT OF THE ASSESSMENTS

PATIENTS' TELEPHONE FEEDBACK TO THE DOCTOR

It helped identify those issues [sexual assaults and sexually transmitted infection]*. At that time I was shy and I was not able to talk about things.*
.....It was really helpful for my mental health
The medication also helped me
You gave my injuries attention
It helped me a lot. The way I sleep is better than before
It was beneficial because I got scan for my pain and also I started medication. I am better now. I was reassured
Yes I was referred for surgery
It made a difference, I'm good now
My health is great. I am in a better position. I discovered a lot. It helped me cope

One patient telephoned was still very unwell psychologically, but was no longer registered at the practice, and had not collected his assessment letter. With his permission, the TID assessment letter was sent to a friend for him to take him to his new GP and local voluntary agency.

Clinical interventions documented at assessment

Prescribing for psychological conditions. For 17 (33.3%) patients the doctor either initiated a new psychotropic medication (medication to treat mental health conditions) or increased the dose of the person's current medication (Table 10). In a further three cases a new or changed prescription was offered but not accepted. Those under 18 were not offered medication even if their presentation would have warranted this in an older person.

Table 10 PSYCHOTROPIC MEDICATION FOLLOWING ASSESSMENT

	Number (%)
Medication initiated or increase in dose offered and accepted	15 (29.7%)
Offered but not accepted	3 (5.2%)
No medication offered (includes 11 under 18 years old)	28 (54.5%)
Already on medication, no changes made	5 (9.4%)

Follow-up in primary care: 17/51 (33.3%) patients were felt to need pro-active follow-up from the GP team and appointments were made for them to be reviewed. 34/51 (66.6%) were advised to contact the GP service if they felt more unwell. This 34 included the 11 young people who were under the care of social services (the GP practice would usually be contacted by the social workers to make appointments).

Referrals for psychological therapy. For 8/51 patients (15.7%), the doctor offered a direct referral for psychological therapy.

Other referrals. For 8/51 (15.7%) patients, the doctor made other types of referral. This included referral for:

- Sexual health screening (2 cases)
- HIV services for a new HIV diagnosis
- Colorectal assessment (anal injury)
- CT head scan (head injury)
- Psychiatry (for advice on treatment of agitation)
- Children's Social Services (for age assessment)
- Acute mental health care via the police (for self-harming during the appointment)

Case Study 7 Clinical interventions

A 30 year old woman was referred following repeated GP appointments and A&E attendances with palpitations and insomnia. Several medications to settle her psychological state had been tried. Although there was an entry by a nurse 18 months earlier, that she had been 'brutalised by police' and had injuries and PTSD symptoms, the significance of this was overlooked, with all subsequent efforts concentrating on trying to reduce her symptoms without reference to this history.

When seen she had symptoms of PTSD and had a panic attack during the assessment. She gave a history of sexuality-related discrimination, violence and torture by the authorities in her country (including burns). Her TID assessment resulted in ongoing regular GP follow up, and referrals for psychological support and sexual health care.

Since the TID assessment she has been much more settled. She is engaging with the healthcare and support services she needs and there have been no more attendances at A&E. There has been no progress with her asylum claim.

Information provided. Most patients were given a leaflet about self-care and further sources of advice, as well as what to do in an emergency (Appendix 3). One patient was also sent information about support available for victims of modern slavery.

Safeguarding referrals. For the four patients where the current risk of suicide was assessed to be significant, the doctor shared information about suicide risk with other agencies.

Information about three of these patients' suicide risk was emailed to the Home Office Safeguarding Hub and to the asylum accommodation provider's safeguarding team. (The fourth had Leave to Remain so that the Home Office and accommodation provider were no longer involved in their care).

One patient was referred to Children's Social Services because he was reporting being under 18 and there was no information available to the clinician about whether he had already had an adequate age assessment.

Documenting of human rights abuses in previous GP records

Documenting of human rights abuses in the GP record. For the 30 cases where a previous GP record was available, in only 10 (33%) was the history of human rights abuses documented in the main GP record prior to registration with the Whitehouse Centre.

In a further five (17%) there was information about human rights abuses in correspondence from the Looked After Children's Service (4 cases) or an entry by a TB nurse (1 case), but no information in the main GP record, and no coding to identify the issue.

15 patients (50%) had no reference in their notes to any history of human rights abuses.

Enquiry about human rights abuses. Part-way through the project, a question was added to the assessment protocol, to explore whether patients recalled any health professional asking them about human rights abuse. Of the 26 patients who were asked this question, only 7 (27%) said they had had this opportunity, 18 (69.2%) said they had not, and one was unsure.

In the 15 cases where the GP record had no mention of human rights abuses, none of these records included mention of the patient having been asked if they had experienced such abuse. In eight of these 15 cases, there were indications that there had been a particular reason to ask: seven patients had mental health symptoms including one who had taken an overdose and one who was self-harming; in one case a box had been ticked for 'modern slavery' but no clinical assessment made.

The use made of assessment letters

Provision of letters to patients. 46/51 (90%) patients accepted the offer of a copy of their assessment in a letter. Two did not want a copy because they had Leave to Remain and did not think they needed it. One patient was not offered a letter because although he had reported abuse, he had mild psychological symptoms only. One was not offered a letter because the documentation was used instead to support an emergency referral to mental health services (via the police) and a safeguarding referral. One was too unwell at the time of assessment to receive the paperwork directly (Case Study 5). The doctor made these five patients aware that they could access this information from their GP record in future.

Letters collected Of 29 patients who provided verbal feedback, 20 recalled collecting documentation after their appointment or being sent this. Nine did not recall receiving any documentation (For these nine, the doctor arranged for them to receive a further copy of the report).

Use of letters. Of the 20 patients who recalled obtaining a copy of the documentation, 9 (45 %) said they gave the report to a solicitor. One said they gave the report directly to the Home Office, one to the Council Housing department, one to a voluntary sector organisation. Eight (40%) said they did not share the documentation with anyone (6 of these 8 did not have a solicitor)

Impact of assessment letters in legal and other processes

CASE STUDY 8 Impact of documentation

A 34 year old female was referred by a nurse because she was difficult to assess and had expressed a specific concern that she had 'dementia'.

At the TID assessment she was unable to talk in detail but a sufficient history of torture by police in her home country was obtained. Multiple symptoms and signs of PTSD were observed, including frequent checking for threat behind her and under her chair. She had severe depression with bruising up both arms from self-inflicted pinching, a recent overdose which she could not remember fully and continued suicidal thoughts.

A safeguarding alert was emailed to the Home Office and a response received which requested information about her being safely followed up. This individual required two weekly follow up for 10 weeks to monitor effectiveness of anti-depressant medication started and to engage with a partner who could report from home about her safety.

A copy of the TID assessment (explaining the likely diagnoses and risks and impact on her ability to give evidence because of impaired recall) and the safeguarding alert were given to her. At her last follow up appointment she brought a copy of a refusal letter from the Home Office which mentioned medical information was available to them but did not refer to the content. She was refused on the grounds of not giving a credible account of her experiences. She reported her mental state as much improved with medication and was pursuing an appeal.

Patients' telephone feedback on progress in their asylum claims. Of the 29 patients who provided feedback, 16 had had no updates about their asylum status since the appointment.

Four had been given Leave to Remain by the Home Office. Three of these had submitted their TID assessment, one had not.

One had been given Leave to Remain at Tribunal. He reported that the TID documentation was used in that decision.

Five had been refused by the Home Office. Three of these said they had not provided the report to the Home Office, and two were unsure whether their solicitors had submitted it. One refusal letter was seen and it acknowledged that medical information was available but did not discuss the content and went on to find the client not 'credible'.

One did not know what was happening in their asylum claim. One was not asked due to a truncated phone call.

Patients' telephone feedback on perceived impact of their letter in their asylum claim. Several patients said that they believed that the letter had been helpful (Table 11)

Table 11 Patients' comments about impact of their letter in the asylum process

The report helped me because I didn't have to explain and talk about the difficult things again
I am very grateful, it was really good for me …I was able to show I was treated unjustly.' 'The report really helped….they did not believe me before.'
I have not needed it yet but I am hoping that I will use it my interview to explain about the problem with my leg

Patients' telephone feedback re modern slavery. One had entered the NRM for modern slavery. They said they had not used the TID assessment letter.

Patients' telephone feedback about other impact. One patient said that the report helped her to get more housing priority with the Local Council.

DISCUSSION

Summary of findings

1. **Feasibility**. We have demonstrated the feasibility of establishing in a general practice a system for routine enquiry and follow up of patients newly registered with the practice who are seeking asylum and who report that they have experienced human rights abuses. Practice staff appeared to value the opportunity to refer to a clinician able to focus on the reported human rights abuses.

2. **Characteristics of patients assessed**. We have described the characteristics of a cohort of 51 patients who had further assessment and intervention with a specialist doctor following screening,

    - **Reported human rights abuses** All the patients assessed had been appropriately referred and experienced human rights abuses. 42% reported abuse that the doctor categorised as torture, 20% reported sexual abuse. Many people reported being young at the time of first abuse and having undergone cumulative trauma. These factors are likely to increase the impact of the trauma they experienced.
    - **Clinical consequences of abuse**. In 88% the doctor identified current mental health issues, particularly sleep, PTSD and depression symptoms. 60% had physical findings attributed to ill treatment, mostly scars and other skin lesions. The majority required clinical intervention, including a small number with urgent safeguarding concerns.
    - **Safeguarding**. In 45% the assessment recorded indication of increased suicide risk and 8% were assessed to be at significant risk of suicide in the short term.
    - **Limited understanding of asylum process**. Patients often lacked understanding of the progress of their asylum claim, and the potential relevance of health information to asylum decision-making. This finding is supported by the fact that there was an initial period of poor attendance for appointments and that many patients did not collect their assessment letters or give them to their solicitors. This is at odds with a widespread belief that people seeking asylum may understand and abuse the healthcare system by seeking documentation of fabricated medical evidence.
    - **Patients' difficulties giving their account**. The doctor recorded cognitive problems in 17%, evidence of distress at the time of the appointment in 50%, and presentations that may appear incongruous or liable to misinterpretation in 29%. In addition, 20% of patients could not recall the assessment, and the failure to recall a one hour interview where they spoke to a doctor about difficult issues is possibly further indication of impairments of recall.
    - In other words in the majority of patients there were clinical factors that would affect their ability to give an accurate, coherent, and consistent account at interview.

3. **Positive impact of screening and follow up**. We have shown a number of ways in which such a system may impact patients' health and wellbeing

    - **Identification of patients with a history of human rights abuse**. 66% of those with a GP record from a previous practice had not had their mistreatment documented in the main GP record. 69% of those asked said they had never previously been asked by a health professional whether they had experienced abuse.
    - **Health benefits**. 74% patients felt that their health benefitted through having had the assessment. 33% received a medication intervention, 16% a referral for psychological therapy, 16% a referral for a physical health issue, 33% were offered pro-active follow-up in primary care. Over a third of patients with psychological problems had been receiving inadequate treatment for these.

- **Safeguarding**. For 8% the doctor made a safeguarding referral. We also found one instance where the Home Office had acted on a TID assessment by sharing the findings with the GP practice (not realising they had originated there). In one case the Home Office made an enquiry about ongoing support.
- **Direct benefit of assessment appointments**. Patient feedback suggested a possible positive impact simply from the experience of the assessment, and opportunity to talk about their experience within an empathetic and clinically supportive setting.
- **Legal impact.** Although this was a clinical project, clinical information is relevant to asylum claims, and it is evident that legal processes and outcomes (positive and negative) affect people's health. 45% said they gave their report to their solicitor. However 43% did not have a solicitor and it is likely that asylum decision makers would only see the report if GP records were requested. In all cases the assessment report was available within the GP record, and thus available if requested in relation to asylum decision-making. This is important as the Home Office and Courts are increasingly giving weight to what is written in GP records. None of the patients in this study described being offered medico-legal documentation arranged by solicitors.

4. **Limitations to the impact of routine enquiry and follow-up**. We have also identified some limitations to this impact.

- **Age disputes**. Where patients reported that they were younger than their recorded age, it was difficult for the doctor to clarify the situation or take effective action. There is no clear pathway for primary care teams to share this information, and unclear whether referral to Social Service or a Home Office safeguarding alert is the most effective channel. Although the Home Office and accommodation provider are likely to have information about age assessments, it is not routinely shared.
- **Timeliness of the assessments**. Assessing people who are new to a primary care team did not necessarily mean reaching patients new to the UK. Some patients had been in the UK a considerable time and were only new to the practice because they had been moved into the area by the Home Office.
- **Accommodation moves**. Some patients were referred but then moved away before assessment. Some who had an assessment were moved before follow-up, or before receiving their report.
- **Psychological therapy referrals**. The number of referrals for psychological therapies was affected by the doctor's view that availability of suitable psychological therapy options was very limited. It was her view that, had appropriate services been available, it would have been appropriate to offer psychological therapy to the majority of patients, in some cases instead of or as an adjunct to medication.
- **Collection of reports**. The usefulness of the reports will have been limited by the fact that many were not collected. This in turn may be linked to the frequency of limited literacy, limited understanding of English, limited understanding of the asylum process and how to present a claim, and lack of solicitors. However, uncollected reports would still be available in the GP record and, with patient consent, could be accessed here at a later date by patients or solicitors.
- **Young people.** For those young people supported by Social Services, the practice did not hold details of the social worker involved, hence it was not possible to send a copy of the report or involve them in follow up. However social workers do contact the primary care team when they are worried, so there is a safety net.
- **Legal Impact.** There was some evidence that patients do not understand the asylum process and the helping role that medical information can play. Assessment letters were often not collected. During the project and immediate aftermath, there was evidence of unwell patients, with medically documented conditions, attending asylum interviews without the Home Office having access to this information.

5. **Perceptions of assessments**. We have explored the perceptions of the assessments among patients and staff, and found a positive response. Concerns about possible re-traumatisation were not substantiated.

- Practice staff wanted more access to TID assessments. Initially assessments were offered only to patients screened positive at their new patient assessment, but demand from other staff led to additional referral routes being offered also.
- Patients did not always know if they had had a TID appointment. Some were confused about the difference between the TID appointments and other primary care appointments, and about the source of communications by text and letter, and several did not recall their TID appointment. This seems likely to be linked to the TID appointments being held at the same location as other primary care appointments, and being conducted by a TID doctor who was also a GP in the practice and saw some of the patients in other contexts. The lack of information in languages other than English may also have been a factor.

6. **Efficiency and effectiveness of the process**. We identified several features that appeared to affect the impact of the screening and assessment.

- **Automatic referral.** The numbers declining assessments decreased when those screened at new patient assessments were automatically referred to the doctor, who then contacted those invited for assessment by telephone and was able herself to explain the appointment.
- **Measures to increase uptake of assessments**. Attendance appeared to be helped by additional personalised text reminders, and for young people by contact with their social work team. One person mentioned transport costs as a barrier to attendance.
- **The doctor's empathic manner** was perceived as a crucial element by patients and by observers, who also commented that her unstructured interview style seemed helpful.
- **Telephone interpreting** was problematic in some interviews, but retained because of cost efficiency.
- **Templates**. The TID doctor designed a template to facilitate information gathering at assessments and allow assessment letters and safeguarding emails to be generated automatically at the end of the consultation. This template was developed by Ardens and is now available for both of the main primary care computer systems, SystmOne and EMIS Health.
- **Safeguarding reporting**. During the project, the doctor began to make use of the Home Office Safeguarding email address. There was no process around this. In two cases, where safeguarding alerts were sent to the Home Office, it was not apparent that the Home Office had these documents in the client file when interviewing the client for the asylum claim. One case was refused with no reference to the safeguarding work and one case was asked to provide 'medical evidence' when this had already been shared.

Discussion of evaluation methods

This was a clinical project not a research project, which had implications for data collected.
- Data collection was secondary to clinical priorities, and in some cases items were omitted for clinical reasons.
- Data collection evolved during the course of the project in response to emerging findings.
- Categories, e.g. of torture and modern slavery, were based on individual clinicians' decisions rather than tightly defined criteria.

Additional methodological limitations included
- **Patients' psychological difficulties** may have limited the history they provided in the screening or assessments.
- **Sexual abuse**. Using self-report in a telephone interview is likely to miss some cases of abuse due to under-reporting, particular of sexual abuse.
- **Suicide risk.** The figures presented will underestimate the numbers of patients in whom the suicide risk is raised as there are many other factors besides those presented that are associated with increased suicide risk. For example risk is higher in single males, in people with past or current mental health problems and

in people who are likely to experience future significant stressors. Such factors apply to many patients in this population, in addition to those who report current or past suicidal thoughts or actions.

- **Feedback from patients** was based mainly on brief questionnaires (only used by English speaking patients) and on telephone calls from the doctor, followed up in two cases by an independent researcher. It is possible that some patients have experienced negative impacts which they did not disclose. We tried requesting written feedback (survey monkey) but did not continue as the response was poor and it caused confusion. We decided against an interview survey by an independent researcher because we believed this likely to be confusing to patients, and also because of interview costs.
- **Impact on asylum decisions.** There is limited feedback on legal outcomes due to the short time-scale of the project and the longer timescale for decision making at this period.

Discussion and conclusions

Impact of routine enquiry and follow-up

This evaluation provides strong support for the view that when asylum-seeking patients present to primary care a system of routine enquiry and follow-up is both feasible and potentially beneficial.

Our data shows that a significant proportion of patients had not received documentation of their abuse or appropriate treatment for symptoms relating to this, even when they had been in the UK for many months, in some cases years. In other words, routine NHS care does not seem lead to early identification of people with a history of human rights abuse. Delayed identification of a history of human rights abuse means that psychological and physical symptoms are likely to be inadequately treated, with likely poorer health outcomes, increased costs, and increase suffering for those involved. Failure to document physical and psychological findings that are linked to abuse will also mean that asylum decision-makers in the Home Office and Courts will lack evidence that might enable them to avoid inappropriate decisions, and the health, wellbeing and economic consequences of these.

Routine enquiry and follow-up increases the likelihood that patients will receive needed clinical interventions and that asylum system decision makers will have access to relevant information. . Although our data does not allow quantitative estimation of benefits, it is likely that early appropriate intervention will reduce overall health costs, for example through leading to fewer appointments, less extensive treatment, or fewer referrals to secondary care. Similarly, if access to clinical information improves accuracy of asylum decisions, then there will be additional reduction in costs to the Home Office and Courts, and additional health benefits.

There was suggestion that the assessment itself had therapeutic value.

We did not identify disadvantages to routine enquiry and follow-up, other than the cost of the follow-up assessments.

We found no indication of adverse psychological consequences for patients caused by asking about their traumatic experiences. Although some patients became upset or dissociated when disclosing abuse, these reactions were manageable in the appointment time. Possible reasons that more extensive problems were not identified include the fact that traumatic experiences were not explored in great depth and the supportive approach taken by the doctor. It is also possible that there were adverse consequences undetected because of methodological limitations.

Published literature

Published literature supports many of our findings. Other studies have found high levels of mental health problems among people seeking asylum, particularly PTSD and depression (Doctors of the World, 2024, Clark, 2022 [1]). The Doctors of the World Study (2024) also found high levels of suicidal ideation confusion about legal status, and unclear safeguarding pathways. Sensitive brief interviews have been found in other contexts

also to give relief rather than re-traumatise (Pérez-Sales,P. & de la Fuente,P. (2023) Difficulties accessing health care among people seeking asylum have been well documented (Summers, McKinnon and Miller, 2022). Health needs have been found to be frequently unmet (Clark, 2022 [1]) and the attitudes of clinicians have found to be a crucial factor in people accessing healthcare and disclosing human rights abuses (Clark, 2022[2]).

International guidance (Istanbul Protocol, 2022), and a recent commentary (Pérez-Sales, P. & de la Fuente, P., 2023) offer the view that health professionals encountering people seeking asylum and reporting abuse should offer assessment and documentation of this. This is argued to be an ethical responsibility. Guidance on PTSD recommends that all people seeking asylum are screened for PTSD, which necessarily includes asking about potentially traumatising experiences (National Institute of Health and Care Excellence, 2018).[7]

Implications for NHS care

There is evidence, including from this evaluation, that in current routine NHS care many asylum seeking patients do not disclose the abuse they have experienced. This may be for multiple reasons: they may think it irrelevant; they may believe that clinicians will not have time to listen to them or will not be interested in the issue, of that if they listen, that they will not respond adequately; or they do not see the link between their symptoms and their experiences (Pérez-Sales & de la Fuente, 2023).

The pressures on primary care resources are well known and many clinicians express fear that asking about mistreatment will be time consuming, require skills they do not have, and cause further traumatisation. In addition, many clinicians are unaware that for this client group, the interventions with the most clinical benefit may not be prescribing or referral, but documentation, reporting and advocacy. More education is needed to explain how dealing with the cause of the patient's distress often leads to less time spent on appointments for issues such as chronic pain.

We have demonstrated that one possible approach is routine enquiry during a new patient assessment conducted by a health care assistant, following up where appropriate with assessment by an experienced doctor. However there are other possible approaches to routine enquiry and follow up.

Providing routine enquiry and assessment following registration in primary care has several advantages compared with offering it in other settings. It means that it is offered relatively early in the asylum process. This in turn means that findings can inform substantive interviews and asylum decision-making. Locating screening and follow-up in primary care also increases the likelihood that all practice staff will have access to relevant history, contributing to continuity of care following assessment.

This evaluation does leave important questions unanswered. We do not know whether a one hour follow-up assessment with a doctor with special training has benefits over and above merely offering an appointment with the patient's own GP. We cannot assume that similar results will be obtained in other settings as the routine enquiry was conducted by a single experienced health care assistant confident asking about human rights abuses, and the assessments by a single specialised doctor, and the context was a specialist practice that has prioritised providing screening for human rights abuses. We do not know to what extent clinicians' empathy and non-directive approaches may have influenced patients' willingness to disclose difficult material, and thus to what extent merely introducing questioning and following a template would replicate the results. There may be both benefits and adverse consequences for patients that we have not been able to identify, particularly in relation to long term impact.

Making assessments more widely available will depend on more primary care teams, as well as clinicians in other settings (such as mental health teams), developing a way of introducing systems of routine enquiry about human rights abuses, with more detailed assessment and documentation where needed.

Routine enquiry may be more readily introduced if steps are taken to address barriers such as uncertainty over what to ask and when, fears of re-traumatising patients and fears of unduly raising expectations or creating further tasks for primary care professionals. It may help to recognise that there are precedents for this kind of

[7] **Recommendations | Post-traumatic stress disorder | Guidance | NICE**: 1.1.8 For refugees and asylum seekers at high risk of PTSD, think about the routine use of a validated, brief screening instrument for PTSD as part of any comprehensive physical and mental health screen. **[2005, amended 2018]**

enquiry in established practice, for example in routine enquiry about childhood abuse and domestic violence, and that the benefits of these have been clearly demonstrated.

Whilst it may not be possible, without additional funding, to offer one hour assessments to all patients reporting human rights abuses, using templates and reporting tools may make it easier to document key findings (such as a scar seen when listening for a chest infection, a collection of PTSD symptoms, a vulnerability concern). GPs and practice nurses are used to collating histories, examination and running tests across multiple follow up appointments. The template developed by TID can be populated cumulatively over time in different consultations, even those initiated for other issues. The template enables multiple consultations to be exported into a structured letter which can be given to outside agencies and kept in the medical record. This is particularly important given the increasing reliance on and requesting of NHS medical records in asylum claims rather than commissioning comprehensive specialist reports.

Introducing routine enquiry about human rights abuse might also feel more achievable if services were commissioned to offer follow-up when concerns about human rights are disclosed.

In response to findings emerging from the project, TID has begun developing links with other GP practices where there is interest in introducing screening and follow up, and has begun to publicise the templates, and to deliver different training approaches.[8]

Recommendations

For all clinicians, health service managers and commissioners

- Recognise that with routine NHS care, the majority of asylum-seeking patients with a history of human rights abuse are likely to go months or years without this abuse and its health consequences being identified and documented in clinical records.

For primary care teams

- Ensure that a system is in place for people seeking asylum to be routinely asked about experiences of abuse and offered further appointments or assessment if needed.
- Consider using the Ardens templates to document relevant findings and to issue letters from the template for the patient.
- Consider using the Ardens templates to produce letters on risks for the Home Office safeguarding reporting system.
- Where information is available about human rights abuse (either from primary care or in letters from other specialities), consider coding the information and creating problem headers so the information is prominent in the past medical history.
- Consider strengthening capacity in this area using resources such as on-line training or bespoke training, and website materials (see TID website for information)

For other clinical specialties

Where there is regular contact with people seeking asylum, (particularly likely for mental health, A&E and paediatric services)

- Consider developing systems for documenting relevant findings and reporting safeguarding concerns to the Home Office.

[8] www.tortuteid.org

- Consider incorporating the TID templates within existing IT systems, or if using SystmOne (one third of mental health trusts) consider using the templated materials already available.
- Consider accessing training.

For NHS commissioners

- Consider how commissioning can support primary care teams and other services to implement systems of routine enquiry and follow-up, recognising that adequate follow-up is likely to require additional resources.

For the Home Office

- When commissioning health provision for people seeking asylum, consider requiring this to include routine enquiry about a history of human rights abuses, with appropriate follow up. This will need additional funding.
- Ensure asylum decision makers are aware that where a person's primary care record does not contain information about human rights abuses or health impact of these, this is not indication that such abuse has not happened, or had significant health consequences. Currently, it is more likely that the individual has not been asked. Similarly it is important that decision makers are aware that where health records do identify a history of human rights abuse, that the absence of clinical findings is not evidence that abuse has not taken place.
- Provide a route for checking whether age has been formally assessed to enable the clinician to know whether a referral to child protection needed to be made when young people report they are under 18 but being treated as adults.
- Acknowledge safeguarding alerts and provide those making them with information about any action taken. Ensure that the safeguarding alert is available and referenced when planning a Home Office interview and/or making a decision on a claim.
- Consider training to enable decision-makers to recognise and manage signs of distress when people are giving their interviews, to understand some of the ways in which psychological factors can impair ability to give a coherent, consistent and comprehensive account and to appreciate how frequently such impairments may affect asylum applicants with a history of trauma.

For researchers

Useful questions to address include:

- What length of assessment is required? Could similar results be obtained in shorter or partial assessments?
- Do focused assessments, such as those used here, provide long term benefits, for example reduced use of health service?
- What would be the impact of having set questions for use in routine enquiry?
- Are similar results obtained with different clinicians doing the initial enquiry and assessments, with screening in different contexts (e.g. when attending for blood tests), and in other GP practices?
- Would more independent and detailed exploration of the impact that assessment has on patients reveal more information about adverse consequences such as re-traumatisation?
- For reporting safeguarding concerns, is there value in reporting to Migrant Help and Accommodation Provider in addition to the Home Office's own Safeguarding system?
- What is the emotional impact for primary care clinicians of conducting assessments of people who have experienced human rights abuses, and are there forms of support that can mitigate or manage this?

For TID

- Continue to explore how TID can best contribute to development of routine enquiry and follow-up in other GP practices, including through training and research.
- Consider exploring feasibility of variations to this model. E.g. Briefer or partial assessments (such as documentation of an injury, or a self-harm event linked to past trauma), assessments by clinicians without specialist training or experience,
- Explore the possibilities for embedding TID assessments and support materials into SystmOne and EMIS in order to maximise potential for sharing materials and improving secure communication and feedback from patients.
- Explore how the same ideas could be utilised in mental health services, A&E and Paediatrics. Even though mental health services may offer lengthy assessments and ask about trauma histories, this information remains in secondary care records and often is not even shared with the GP.
- Disseminate findings from this study, including continuing to work with key partners in the voluntary sector to increase awareness of the benefits to patients of routine enquiry and assessment for human rights abuses.
- Develop training tools that are accessible widely e.g. written training on the website and training videos and role plays that can be accessed as CPD or in practice development meetings. Ensure that training covers not just the tools needed but the likely importance of an open and empathic manner.

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Appendices

Appendix 1: TID Assessment Information

TID Medical Assessments

What is TID ?

TID is a small human rights charity.
We work with people seeking asylum.
We believe that everyone who has experienced abuses of their human rights should be offered an assessment with a specialist doctor, as soon as possible after arriving in the UK.
TID doctors have specialist training and lots of experience.
We are independent, unconnected to the Home Office.
TID stands for TortureID. You can read more on our website: https://tortureid.org

Can we help ?

Are you seeking asylum because you have been hurt, mistreated or frightened?
Do you have health problems because of what happened to you?
Do you have psychological difficulties?

What we CAN offer

- **A confidential appointment with a TID specialist doctor, for 45 minutes.**
- **Information about health needs that the doctor identifies, including about recommendations for treatment and where to get this.**
- **A record of scars or symptoms perhaps caused by human rights abuses.**
- **A letter that you can show to a GP/nurse and/or solicitor.**

How can this help?

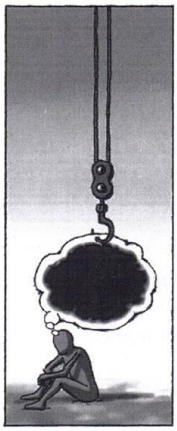
You may have health problems, psychological difficulties or scars because of what has happened to you. These issues can be painful and difficult to talk about. An assessment by a specialised doctor can make it easier. Identifying problems is an important first step to treatment and feeling better. This assessment may also identify issues relevant to your asylum case.

What we CANNOT offer

We are sorry but

- **We cannot help general health problems (you need to see your own GP or nurse)**
- **We cannot provide medication or other treatment.**
- **We cannot provide letters about problems with accommodation, moving out or food.**
- **We cannot offer more than one appointment.**

Appendix 2: Patient Care Leaflet



Many people seeking asylum feel very stressed.

You may feel angry, upset, anxious, ashamed, sad, confused or disturbed by memories.

It can be hard to sleep, and hard to feel calm after you have talked about your situation.

Most people can feel better in time.

Dealing with stress

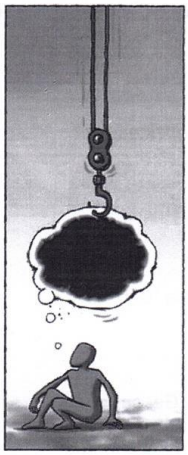
Here are some simple things that can help. If you are feeling bad, you may not feel like doing them. But they are still important for your wellbeing. These things will help most if you keep on doing them.

1. **Stay physically active**. Going for a walk and being outside in nature can really help. Try to do some kind of exercise every day.

2. **Connect with other people**. Try to spend time with other people when you can, perhaps watching TV, eating, or going out together.

3. **Find support**. Get to know at least one refugee organisation that can help you

4. **Look after your body**. Eat and drink water regularly, even if you do not feel you want to. Keep active. See a doctor if you are concerned about your health.



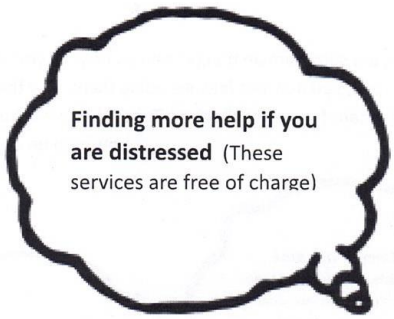
6. **Sleep well**. You may find sleep very difficult but it can help a lot to learn good sleep habits: getting up at the same time every day; avoiding sleeping in the day time; avoiding caffeine. There is more information on our website: https://tortureid.org

5. **Learn calming exercises** such as breathing exercises, relaxation, mindfulness exercises or butterfly hugs. Many people find these useful. You can find exercises on YouTube or you could use the mindfulness app *Headspace*.

8. **Distract yourself** from thinking too much. Spending time with friends and being physically active can help take your mind off memories and worries

7. **Talk to someone** about how you feel. Find someone you trust to confide in. This might be a friend, a health professional, or someone at a local support group. Sharing your worries with someone can be hard but it also often helps.

If you don't feel you can speak to anyone you know, there are services that can help. Your GP will know what is available in your local area. If you are in touch with a refugee support group, they may also be able to help. You can also speak to your GP about how you are feeling. This can be hard, but your GP will be used to hearing from people who are distressed.



•**A GP** will know what is available in your local area.

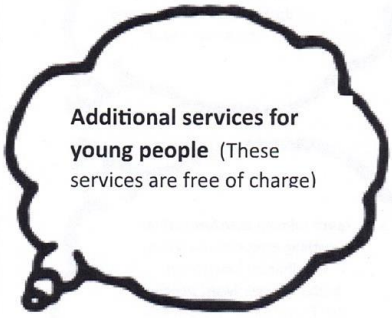
•**Samaritans** Phone **116 123** to speak to a trained volunteer. You can ask for an interpreter.

•**Boloh helpline** Phone **0800 151 2605** for free online advice, emotional support and therapeutic support. Advisers and therapists speak a range of different languages and have access to interpreters. For more information or to use webchat - https://helpline.barnardos.org.uk/boloh-helpline.

- **Refugee Council Infoline** can tell you if there are other services near you. Phone **0808 1962 7272** on Mondays or Thursdays 9.30-12.30 for information about other services near you, and how to access them. https://www.refugeecouncil.org.uk/get-support/services/infoline/

If you are under 25, there are other services that can help:

- **Young Minds** Text YM to **85258.** A trained volunteer will text you back
- **Childline** www.childline.org.uk. Try the 'Get support' tab. Or phone **0800 1111**
- **The Mix** www.themix.org.uk Try the 'Get support' tab. Or phone **0808 808 4994**



If you feel really unhappy or agitated, are experiencing very disturbed sleep or many more nightmares, then it is especially important to ask for help.

If you are thinking about dying, do not keep these thoughts secret.

In an emergency, you or someone helping you can ring your GP or ring **111** for advice on getting help urgently.

If you can't get help anywhere else, you can go to the Emergency department of the hospital.

Appendix 3: TID Sample Letter (fictional)

For enquiries about this report contact: admin@tortureid.org

c/o GP Practice House

GP Practice Town

GP1 XXX

Date: 5.4.2024

Dear Mr Sample Case

Name: Mr Sample Case

DOB: 1.1.2009

Address:

NHS number:

TID Reference:

CLINICAL ASSESSMENT OF REPORTED ABUSES OF HUMAN RIGHTS (1)

This letter contains information from your clinical records.

Although this information will be retained in your GP record, it may not be easy for you to retrieve. Keeping your own copy may be useful in the future if you need to approach health-care providers about any health problems you may have.

The primary purpose of this assessment was clinical, but I am aware that people may have difficulties with explaining what has happened to them for many different reasons. If you use this letter in relation to an asylum claim or other legal proceedings, there is some information for people reading it at the end of this document.

Extract from Clinical Record (Anonymised and any identifiable history changed):

Date 5/4/2024

Suspected Human Rights Abuses

Seen by: Seen by general practitioner

Appointment duration (mins): 60 mins

Very stressed about not having a solicitor. He has a friend who has just had a negative decision and he had no solicitor.

Details: Unaccompanied child asylum seeker

History: Seen in an extended TortureID session. Identified by social worker as needing extra input.

From GP records he did tell a health professional on 2.2.2024 about ill treatment in Afghanistan and on the journey. Imprisoned in Turkey for 3 months. He reported poor conditions and occasionally physical abuse which he thinks has not left any lasting scarring. At new patient assessment here, we recorded beatings on the journey. The account of ill treatment came out in piece-meal fashion. Scars of self-harm also seen.

Reports family life was good until the Taliban took over.

No schooling.

Was shot by the Taliban when trying to escape them taking him. Has some pictures of the fresh injuries on his phone.

Beaten up in Iran, Turkey and Bulgaria.

Denied sexual assault when asked.

Was in a hotel when first came to the UK. He was later found to be under 18.

Physical assessment: Photo of scarring upper left arm attributed to gun- shot injury.

Some further scars attributed to self-harm on lower arms and on face attributed to accidents in childhood. Unrelated surgical scars on abdomen.

Psychological assessment: Support worker had been concerned about some self-isolating behaviour. Seems to have improved. Currently variable mood, tiredness and restlessness, feeling lonely. From his account he was very low in mood when he first arrived in the UK, but he is feeling safe and positive at the moment. Has started college and made some friends.

Not screened for PTSD in depth. Did have some intrusive symptoms when first came to the UK but now settled.

Main worries are missing family and the future of his asylum claim.

If can stay in the UK, hopeful he can set up a business.

If has to return to Afghanistan 'I would prefer to go dead'.

Self-harm - cut on his left forearm was a couple of months ago in the UK when he was feeling stressed and lonely. The scars on the right arm are from when he was in jail in Turkey.

States no further thoughts of self-harm.

Denies drug/alcohol use.

Never tried to kill himself or had thoughts of this.

No report of violence towards others or violent thoughts.

He was smartly dressed today with no sign of lack of self-care. Eye contact, no smiles or lightness. Yawned at times and had to resist picking his phone up. Otherwise, he engaged fairly well. Better rapport than first meeting when he was wary and difficult to engage. He reported feeling worried about trusting people for reasons he could not explain.

Support network & protective factors: Has support worker and social worker.

Plan: No need for any medical input at the moment. Psychological state and risks could change with stress. Previous self-harming and low mood. Any change in situation, especially around asylum claim, could increase risk of suicide and would need clinical assessment.

Copy of this consultation for the social worker for records and to assist with finding a solicitor and to advise of need to build trust in any interviews/assessments when he has to discuss his past.

Yours sincerely,

Dr .....(2)

Signature

1. **TortureID in General Practice**

This service, offered to patients at the ..... GP practice, is provided by TortureID (TID). The funding for extra time needed for an extended assessment into suspected human rights abuses has been provided by TID, using ..... premises and administrative systems. TID is a medical charity (www.tortureid.org) which is piloting offering assessments in general practice, utilising the GP record and NHS IT systems. Any questions about the report should be directed to admin@tortureid.org. There is further information on the TortureID website about this project. If this letter is used in an asylum claim, there are some support materials on the website to help with understanding the impact of trauma on interviews, disclosure, recall and memory.

Obligations

Health Professionals have ethical obligations to evaluate allegations of human rights abuses. These obligations are explained in The Istanbul Protocol: PROFESSIONAL TRAINING SERIES No. 8/Rev. 2 Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment: The United Nations (2022). '*When alleged victims provide their informed consent to health professionals for a clinical evaluation and report torture and ill-treatment, the clinician has an unequivocal duty to document and report the torture or ill-treatment, if substantiated – failing to do so would, according to WMA (World Medical Association), constitute a form of complicity in torture and ill-treatment.' Para 604.*

Nature of clinical assessments

A clinician will target their questions and examination in response to the history obtained and their initial observations of the individual and the circumstances of the encounter. It is rarely possible in short appointments to conduct comprehensive physical and psychological examinations. Problems with distress, trust, focus, rapport and with the sheer extent of ill-treatment may limit the information that can be elicited. If an interpreter is needed, or the individual is speaking in English as a second language, this can further limit assessment. In this pilot project only telephone interpretation is available. Any examinations recorded are likely to be only part of what there is to record and medico-legal documentation in the future may reveal more findings. Psychological presentations can improve or deteriorate with time and in response to external events. It is essential to note that risk assessments can also change significantly and that a reassuring historical risk assessment would need repeating if there is a change in psychological state and personal circumstances. It is rarely possible, in a time-pressured environment, to double check that all information given has been recorded correctly.

2. **Curriculum Vitae: Dr Y**

I am a General Practitioner (GP) who qualified from the University of ..... in ..... I completed GP training in ..... This included time spent working in General Medicine, Surgery, Infectious Diseases, Obstetrics and Gynaecology, Psychiatry and Public Health specialities.

My main experience has been in the field of refugee health care. I have worked for 20 years in a practice in ..... which registers all newly arrived asylum seekers to the town. The practice currently registers about six hundred asylum seekers per annum. I am particularly experienced in diagnosing and managing mental health problems.

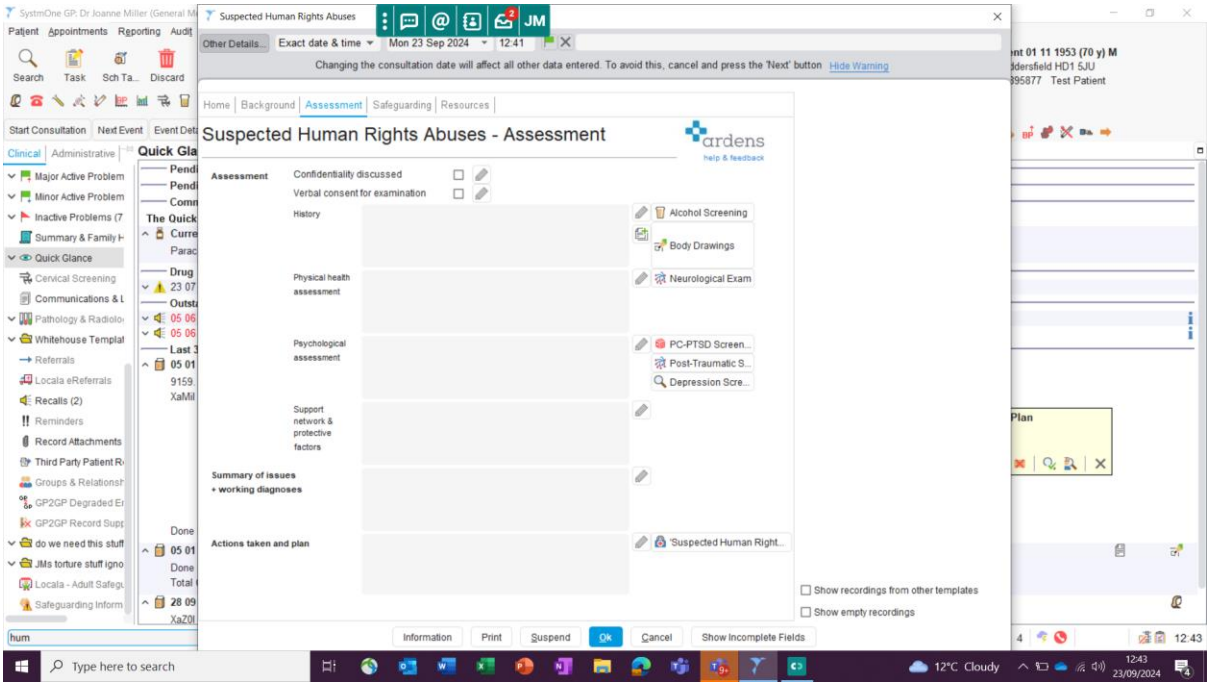
I also have experience in care of the homeless and participate in services for people with serious drug and alcohol problems.

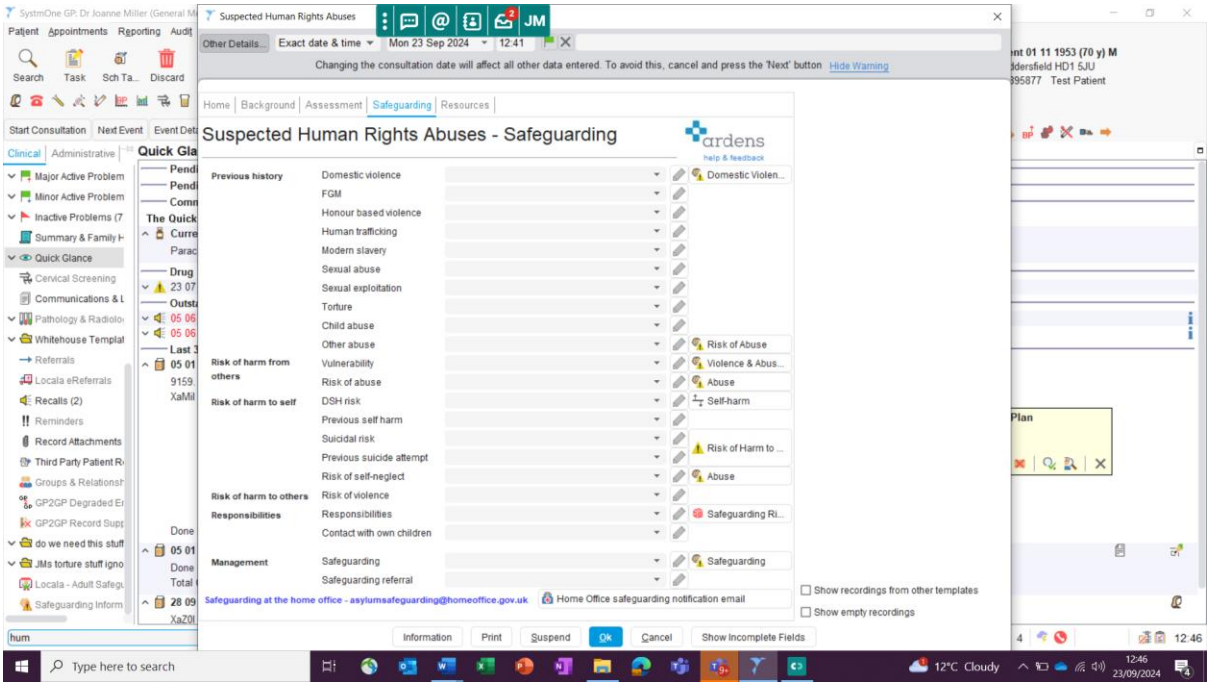
I am currently involved in TortureID. This is a newly established medical charity founded by a group of clinicians and lawyers with the aim of increasing opportunities for survivors of human rights abuses to be identified, by giving them early access to specialist health assessments, conducted by an experienced doctor in accordance with the principles of the Istanbul Protocol. Please see our website for more information.

I understand and know how to work using the guidance contained in "The Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment" as set out in the United Nation's Istanbul Protocol. I am experienced in the examination and interpretation of scars and psychological evidence of torture.

Appendix 4: Screenshots from Ardens template

Screenshots of Ardens 'Suspected Human Rights Abuses Template' plus self-populating letters (SystmOne)





Appendix 5: Pre-formatted letter template 'Suspected Human Rights Abuses'

GP PRACTICE LOGO AND ADDRESS

Patient Details (All self-populates from GP record):

Name	**NHS No.**
Address	**Date of Birth**
	Gender
	Home Tel.
Postcode	**Mobile Tel.**
Ethnicity	**Nationality**
Main Language	**Interpreter Reqd.** ☐ **Yes** ☐ **No**

Assessor Details (All self-populates from GP record):

Name	**Date of assessment**
Base	**Designation**
Address	**Practice Code/ID**
Email	**Telephone**

CLINICAL ASSESSMENT OF REPORTED ABUSES OF HUMAN RIGHT (i)

Dear <name of patient>

This letter contains information from your GP record about your healthcare. This information will remain in your GP record, but it may not be easy for you to retrieve.

For many reasons people may find it difficult to explain what has happened to them. Having your own copy of this letter may be useful if you need health care in the future.

The main purpose of your recent assessment was clinical. However, you may decide to use the letter for alternative reasons. There are notes at the end of this letter for people who read the letter in relation to an asylum claim.

Extract from Clinical Record:

Copies of relevant consultation(s) copied to here

Yours sincerely,

Name: .....

Position: .....

(i) This letter template has been adopted by our GP practice and is based on a suggested template created by Freedom for Torture (FFT) and TortureID (TID) who are both medical charities working with people who have experienced human rights abuses. For more information about the identification and documentation of suspected human rights abuses, please refer to their websites for updates.

1. **Ethical Obligations**
   Health Professionals have ethical obligations to evaluate allegations of human rights abuses. These obligations are explained in The Istanbul Protocol: PROFESSIONAL TRAINING SERIES No. 8/Rev. 2 Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment: The United Nations (2022). 'When alleged victims provide their informed consent to health professionals for a clinical evaluation and report torture and ill-treatment, the clinician has an unequivocal duty to document and report the torture or ill-treatment, if substantiated – failing to do so would, according to WMA (World Medical Association), constitute a form of complicity in torture and ill-treatment.' Para 604.

2. **Nature of the assessment**
   This letter may contain information from one, or more, assessments. A clinician will target their questions and examinations in response to the history obtained and their initial observations of the individual and the circumstances of the encounter. It is rarely possible in short appointments to conduct comprehensive physical and psychological examinations. Problems with distress, trust, focus, rapport and with the sheer extent of ill-treatment may limit the information that can be elicited. If an interpreter is needed or the individual is speaking in English as a second language, this can further limit assessment. Any examinations recorded are likely to be only part of what there is to record and medico-legal documentation in the future may reveal more findings. Psychological presentations and risks can improve or deteriorate with time and in response to external events. Suicide and self-harm risk can change significantly and rapidly and this requires regular reassessment. It is rarely possible, in time-pressured environments, to check that information given has been recorded correctly.

Appendix 6: Pre-formatted letter template 'Safeguarding Concerns'

GP PRACTICE LOGO AND ADDRESS

Patient Details (All self-populates from GP record):

Name	**NHS No.**
Address	**Date of Birth**
	Gender
	Home Tel.
Postcode	**Mobile Tel.**
Ethnicity	**Nationality**
Main Language	**Interpreter Reqd.** ☐ **Yes** ☐ **No**

Assessor Details (All self-populates from GP record):

Name	**Date of assessment**
Base	**Designation**
Address	**Practice Code/ID**
Email	**Telephone**

Email sent on ..... to:

Asylum Safeguarding Hub

Cc Add/delete as appropriate patient, solicitor, accommodation safeguarding lead

Dear Home Office,

SAFEGUARDING INFORMATION FOR HOME OFFICE (i)

This individual is registered at our GP practice. I am writing to alert you to some safeguarding concerns which have come to our attention. The patient has consented to the sharing of this information unless we indicate otherwise. Unnecessary detail has been avoided because of difficulties with sending secure emails. We can be approached for more detail if the patient consents or there are major concerns.

(Enter relevant information below or copy and paste consultation note)

Please could you make sure that this information is forwarded to the relevant case owner or safeguarding lead and kept on their file?

Yours faithfully,

Name: .....

Position:.....

i. This letter template has been designed by TortureID to assist clinicians with reporting safeguarding concerns, relating to people who are seeking asylum, to the Home Office.