HUMAN RIGHTS ABUSE AMONG PEOPLE SEEKING ASYLUM FREQUENCY BASED ON ROUTINE ENQUIRY IN A UK PRIMARY CARE SETTING

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EXECUTIVE SUMMARY

Background

TortureID (TID) is a UK charity responding to the needs of people who are seeking asylum in the UK and who report torture and other cruel, inhuman and degrading treatment[1], referred to here collectively as 'human rights abuse'.

Clinical experience indicates that people seeking asylum frequently report that they have experienced human rights abuse. However routine NHS clinical practice often does not identify or document these histories, or assess for clinical findings linked to them.

The project

In one UK general practice, we explored the frequency with which routine enquiry[2] and follow-up identifies a history of human rights abuse and clinical findings linked to this.

Over a six month period, 110 asylum-seeking patients were routinely asked during new patient telephone assessments whether they had experienced human rights abuse. Those who reported such a history were referred for further clinical assessment in which a TortureID doctor (a GP) focused on the history of abuse, and clinical issues linked to this. Assessments were completed for 36 patients.

This project is linked to a TortureID service evaluation [1].

Findings

A history of human rights abuse was frequent, and associated with clinical findings related to the abuse.

- 60% of those having a new patient assessment gave a history of having experienced human rights abuse and were referred for a TortureID (TID) assessment.
- Among those who attended the TID assessment, all confirmed a history of mistreatment.
- 75% gave a history of physical violence.
- 25% gave a history of sexual violence.
- In 22% the doctor recorded suspicion of modern slavery.
- In 44% the assessing doctor categorised the abuse as 'torture'.

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[1] **Human rights abuse**. 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.
Many forms of human rights abuse are encountered in general practice, particularly torture, modern slavery, female genital mutilation (FGM) and domestic violence.

[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 disclose abuse were referred on for specific follow-up, and so the routine enquiry here can also be regarded as a form of screening.

- 69% said that the abuse reported had taken place in their country of origin.

Of those with a history of human rights abuse, in the vast majority, there were clinical findings linked to these.

- 97% reported current psychological symptoms.
- 61% had physical findings linked to the reported abuse.
- In 61% the doctor noted clinical findings that could affect the person's ability to give an account of their experiences.
- 8% were found to have indications of imminent suicide risk.

Among those who gave a history of human rights abuse, and for whom a previous GP record was available, in the majority of cases the previous record did not document the abuse adequately.

- In 62% the previous GP records contained no reference at all to a history or possible history of human rights abuse.
- Only 14% of previous GP records contained a clear reference to the patient's history of human rights abuse within the main GP record (i.e. not hidden within correspondence).
- No previous GP records included human rights abuse in the list of major issues in the person's health history.

Implications

The study provides some evidence that in a UK general practice, routine enquiry at new patient assessment reveals that a majority of asylum-seeking patients give a history of human rights abuse that has not been recorded in previous GP records, and that the majority of those reporting such abuse have associated clinical findings and health care needs.

In the majority of those patients reporting human rights abuse there are clinical findings that could have implications within the asylum process including:

- Clinical findings relating to human rights abuses in the country of origin;
- Clinical factors affecting the person's ability to give their account, for example in a Home Office interview or Tribunal hearing;
- Current health and risk issues, for example suicidality.

For the majority of patients, current practice in primary care does not explore the history of human rights abuse or associated health care needs. Thus providing appropriate health care and rehabilitation requires additional measures.

As the majority of GP records do not document human rights abuse, they are of limited utility as a source of information or 'medical evidence' in asylum-decision-making.

The high prevalence of a history of human rights abuse and associated clinical need among asylum-seeking patients adds to the argument that for this patient group there should be routine enquiry about abuse [1].

INTRODUCTION

Published literature suggests that significant numbers of UK asylum applicants are likely to have experienced torture or other cruel, inhuman or degrading treatment, termed in this paper 'human rights abuse' [2].

When someone has experienced human rights abuse, there are a number of reasons to identify and document this trauma, and any impact that it has on the person's health.

- Effective clinical treatment and rehabilitation will often depend on this.
- Documentation by a clinician may assist those making decisions in the asylum process, and facilitate appropriate decision making which is often a necessary step to optimum rehabilitation.
- Current UK guidance on post-traumatic stress disorder (National Institute for Health and Care Excellence [3] recommends that refugees and people seeking asylum be routinely screened for PTSD, which necessarily involves asking about their traumatising experiences.
- The importance of routine enquiry into histories of past abuse has been established for some time in work around domestic violence and adverse childhood experiences.
- Clinicians have a humanitarian and ethical duty to identify and document torture, and other cruel, inhuman and degrading treatment and their consequences [4, 5]

Clinical experience in providing health care and writing medico-legal reports for people seeking asylum suggest that, in routine NHS health care, human rights abuse in people seeking asylum is frequently neither identified nor documented. A study in unaccompanied asylum-seeking children [6], provides additional evidence.

TortureID (TID) is a UK charity aiming to improve access to timely clinical assessments for people seeking asylum in the UK who have experienced human rights abuse.

In the UK, general practices may offer an appropriate setting for timely identification of human rights abuse. General practices frequently register new patients who have applied for asylum and are awaiting a decision on their applications. New registrations happen when the Home Office moves asylum applicants from their initial accommodation to dispersal accommodation, and also at other points when the Home Office changes the asylum applicant's accommodation, something which can happen several times before a final decision is made on the asylum claim.
We evaluated a TID project which offered clinical assessments to asylum-seeking patients who were newly registered in primary care[1]. In evaluating this service, we obtained information about the outcomes of routine enquiry, which provided data on prevalence of disclosures of human rights abuse. Through the analysis presented here, we aim to quantify the extent to which routine enquiry identified unrecognised human rights abuse and unmet health needs related to this abuse.

METHODS

We studied human rights abuse and related health issues in newly registered primary care patients in a specialist general practice that registers most asylum applicants who are accommodated in Kirklees, UK. At their new patient telephone assessment, patients were routinely asked (using a telephone interpreter if needed) whether they had experienced human rights abuse. Those who reported that they had, were then offered a clinical assessment with a TID doctor (JM). This offer was

an initial telephone call from the doctor to explain what the assessment would entail, followed by a one hour in-person appointment at the practice.

A linked paper describes the setting, and the process of routine enquiry and follow up . [1].

Participants

All asylum-claiming patients who underwent a GP new patient assessment between 1.11.23 and 30.4.24 were included in the study population. We included data on follow-up TID assessments for all those who were referred for an assessment and for whom an assessment was completed by 31.5.24.

Variables

Data for all asylum-seeking patients undergoing new patient assessment included: age, gender, the patient's response to routine enquiry about a history of human rights abuse, and whether the patient was referred for a TID assessment.

Data for those who were referred for a TID assessment but did not receive one also included the reason for this.

Additional data available for those who had a TID assessment included the doctor's comment on the type of abuse, and their clinical findings and interventions.

For those patients assessed who had previously registered with a general practice in another area, data was also collected on whether the previous primary care record mentioned human rights abuse.

Data was collected primarily for clinical purposes, and in recording findings practitioners relied on their existing understanding of human rights abuse. Appendix 1. provides information about the approach to coding used in analysing the data.

RESULTS

New patient assessments

110 asylum-seeking patients had a new patient telephone assessment during the period studied.

Age. Ages at the time of new patient assessment ranged from 13 to 59, median 25.5, mean 28.0. 10 (9%) were under 18.

Gender. 91 (83%) were male

Country of origin. Participants came from 21 different countries. 20 (18%) were from Iran, 18 (16%) from Iraq, 15 (14%) from Afghanistan, 11 (10%) from Sudan, 8 (7%)from Eritrea, 8 (7%) from Syria, 6 (5%) from Pakistan, 5 (5%) from Vietnam, 4 (4%) from Namibia, 2 (2%) each from Albania, India, Lebanon, 1 (1%) each from Brazil, Chad, Ethiopia, Myanmar, Senegal, Somalia, Sri Lanka, Trinidad and Turkey.

Patients referred for TID assessment. 66 (60%) patients reported that they had experienced human rights abuse and were referred for a TID assessment. Two did not engage in the new patient assessment sufficiently for the healthcare assistant to be able to enquire about human rights abuse.

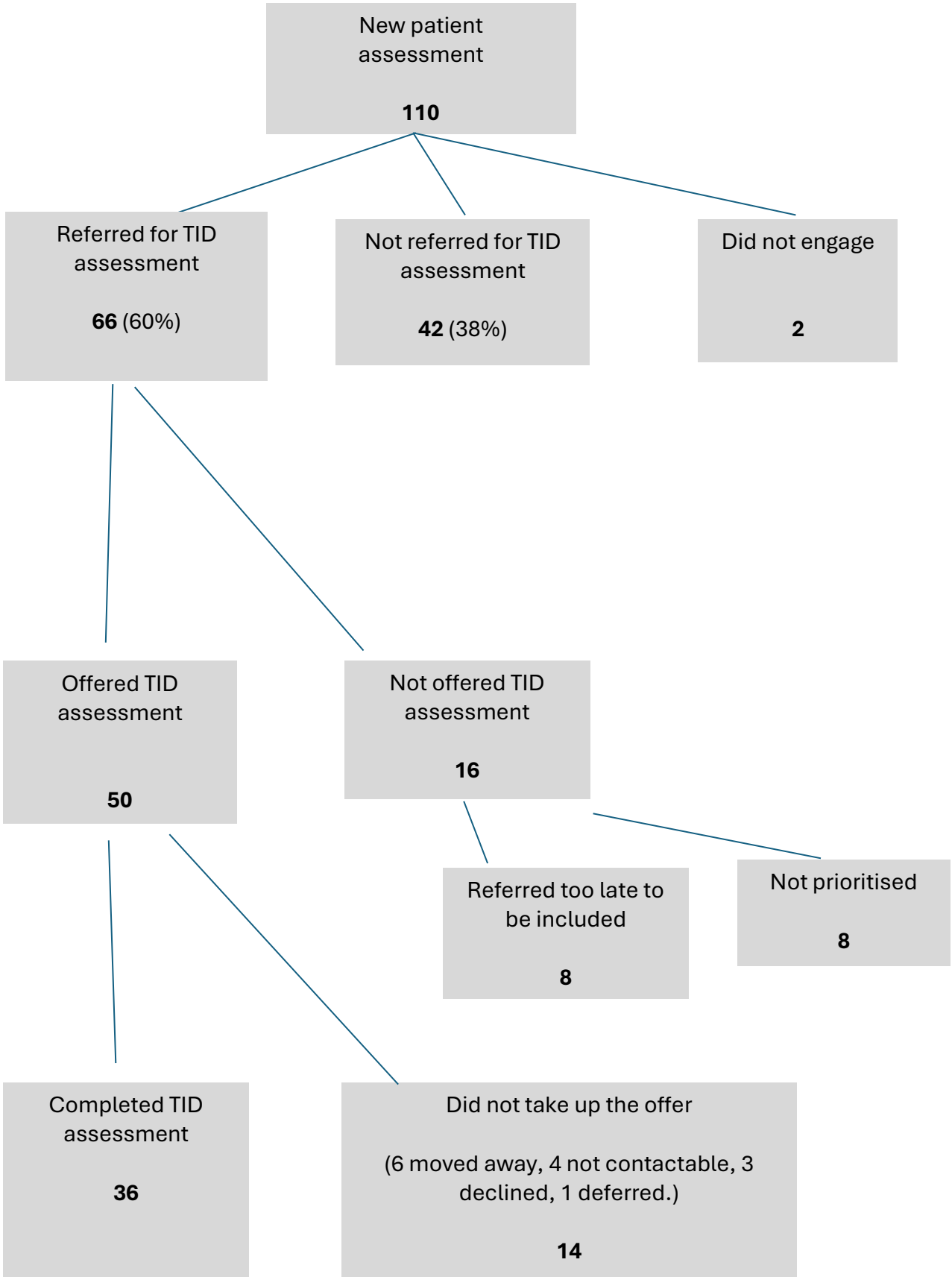
Patients not referred for a TID assessment. This project was not set up to examine the reasons why patients seeking asylum were not referred for a TID assessment following their new patient assessment (44 patients). We did have access to the limited record of the decision made at new patient assessment. Only 8 (7%) of the asylum-seeking patients in this sample of 110 said that they had not been exposed to any harm or threat. Other patients not referred commonly disclosed less specific violence or threat such as living in a conflict zone or problems with community or family.

Take up of TID assessments

Of the 66 patients referred for a TID assessment, 50 were offered an assessment during the period of study. Limited capacity meant that 16 patients referred could not be offered an assessment during this time frame and were still on the waiting list. For 8 patients this was a direct result of having been referred in the latter part of the study. For the remaining 8 patients it was a result of the doctor having given their cases lesser priority because other patients referred later had presented as more unwell or unstable and needing earlier intervention and GP care, or with more likelihood of significant injury.

Of the 50 patients offered a TID assessment, an assessment was completed for 36 (72%). These assessments were in person, using a telephone interpreter if one was needed. For the other 14 patients, the reasons for not taking up the offer were: 6 had moved away: 4 were not contactable through unscheduled phone calls, without leaving answerphone messages; 3 declined for with no reason given; 1 asked to defer the appointment because of pregnancy. Of those who declined, one sounded distressed on the phone and said he did not want to talk about his experiences with anyone (he did talk about his experiences in a later routine GP appointment).

Figure 1. Outcome of GP new patient assessments



TID assessments

Age. For the 36 patients assessed, ages at the time of assessment ranged from 16-47, median 26, mean 26.5. 5 (14%) patients were under 18.

Gender. 29 (81%) were male.

Country of origin. 7 (19%) were from Afghanistan, 7 (19%) from Sudan, 4 (11%) from Eritrea, 4 (11%) from Vietnam, 3 (8%) from Iraq, 3 (8%) from Namibia, 3 (8%) from Iran, 2 (6%) from Syria and 1 (3%) each from Brazil, Pakistan, and Sri Lanka.

Immigration status. At the time of the TID assessments, 32 patients said they were still awaiting an asylum decision, two had leave to remain (one had been granted this since their new patient assessment), and in two it was unclear that they had applied for asylum.

Reports of human rights abuse among the 36 patients assessed. Of the 36 patients all confirmed a history of human rights abuse.

Context of abuse. 25/36 (69%) reported having experienced human rights abuse in their country of origin. Two reported such abuse only after arrival in the UK (both domestic violence). The remainder reported abuse only during their journey to the UK.

Types of human rights abuse reported. 9/36 patients (25%) gave a history of rape or other sexual violence, 27/36 (75%) gave a history of violence, three gave a history of psychological harm alone[3]. For 16 / 36 (44%) the doctor categorised the abuse as 'torture'. In 8 (22%) the doctor recorded clinical suspicion of modern slavery.

Previous documentation of human rights abuse in GP record. For 21 patients, the GP record was available from a general practice where they had previously been registered. In 13 (62%) of these 21 patients, the previous GP record contained no mention at all of human rights abuse, although in 5 the record did include mention of mental health issues that would raise suspicion of a history of trauma. In a further 5/21 (24%) patients, there was very limited indication of human rights abuse e.g. mention in correspondence from a community paediatrician but not in the main body of the record, mention just of 'trauma', or a mention limited to a tick in a box for 'human trafficking'. In only 3/21 (14%) of cases did the main GP record contain note of human rights abuse. In terms of effective documentation, no GP record cited abuse as a 'problem header' (this is the part of the GP record which serves as the list of major issues in a person's health history). All of the information available on human rights abuse was only retrievable on using key word searches in consultations and re-opening filed correspondence.

Clinical findings in the 36 patients assessed. In 22 (61%) patients the doctor recorded physical findings, predominantly scars or other skin lesions attributed to physical abuse. 34 (97%) patients reported current psychological symptoms, in 22 (61%) the doctor noted clinical factors with a potential impact on their ability to give their account of their history, for example cognitive issues, distress, or potentially misleading presentations. In 3 (8%) the TID doctor assessed there to be a significant current risk of suicide.

[3] Human rights abuse were coded as mutually exclusive categories of: sexual violence; violence without a sexual element; psychological harm only.

DISCUSSION

Summary of main findings

We found that among asylum-seeking patients newly registered in general practice:

1. In their GP new patient telephone assessment with a healthcare assistant, 60% gave a history of having experienced human rights abuse.

2. Among those with such a history who attended an assessment with a TID doctor, 69% reported human rights abuse that took place in their country of origin, 25% gave a history of sexual assault, in 44% the doctor categorised the trauma as 'torture' and in 22% the doctor recorded clinical suspicion of modern slavery.

3. 61% had physical findings that they attributed to human rights abuse. 97% reported current psychological symptoms, In 61% the doctor noted clinical findings that could affect the person's ability to give their account. In 8% the doctor found indications of current suicide risk sufficiently concerning to require immediate action.

4. In 62% of those with a previous GP record, this record contained no mention of a history of human rights abuse. No previous GP records included human rights abuse in the list of major issues in the person's health history.

5. In those few cases where there was information available in the previous GP record, this was not recorded in an easily retrievable format.

Consideration of bias

This data were collected during evaluation of a clinical service, not as part of a research project. Specific data collecting questions and tools were not used. There is a possibility of biases due to misclassification, unmeasured confounding, and missing data.

- Both the health care assistant and the doctor were relying on their own usual clinical practice rather than using standardised measures. It is entirely possible that other practitioners would classify variables differently (e.g. 'human rights abuse', 'torture' 'sexual violence' 'current psychological problems'). Differences in definition will have a significant effect on the frequency with which these issues are identified.
- The method of approaching patients may have affected their willingness to disclose abuse. Both the new patient assessment and initial invitations to a TID assessment were conducted by telephone (reflecting the realities of busy general practice). It is not known whether being asked by telephone makes it more or less difficult for patients to disclose abuse, or whether the lack of visual clues sometimes leads to clinicians being unaware of patients' distress, and hence not picking up when disclosure has been incomplete. There is thus a possibility that the prevalence of abuse is under-estimated because of the approach used during the initial assessment.
- We do not know the impact of the use of telephone interpreters in the initial TID telephone contact and the TID assessment.

- Immigration status, and human rights abuse are based largely on self-report. This may have led to either under-estimation or over-estimation of the prevalence of abuse.
- In some cases the health care assistant recorded a non-specific history of violence or psychological threat but did not refer the patient for a TID assessment; this may have led to underestimation of the frequency of human rights abuse.
- Eight of the 66 referred for a TID assessment were not offered an assessment in the study period on the basis of others being prioritised ahead of them; this may have led to minor overestimation of the frequency of health needs.
- It is possible that psychological distress and patients' preferred coping strategies (such as not talking about experiences) could lead to under-estimation of the prevalence of health needs. Among the 14 patients who were offered an assessment but did not have one, one patient clearly stated that being asked about his experiences was distressing and two others turned down the invitation to the TID assessment without giving a reason.
- We considered whether there might be over-estimation of prevalence due to patients exaggerating health issues to support their asylum case but found no evidence of this, and in a linked study [1] we found that many patients seemed unaware that primary care documentation of the health consequences of abuse might be relevant to their asylum claim.

In summary, biases such as these are a possibility but we are not aware of any reason to assume an overall bias in a particular direction i.e. towards underestimation or overestimation of the frequency of human rights abuse history and related health needs.

Interpretation

We conclude that in this general practice, routine enquiry of newly registered asylum-seeking patients frequently identifies human rights abuse that were previously unrecorded, and follow up frequently identifies unmet health needs related to these.

Our findings are in line with the published literature that suggests that human rights abuse and related health issues are a frequent finding in refugees and people seeking asylum [2].

Generalising to other settings

This was a small study resulting from an evaluation of a clinical project, and care needs to be taken in making generalisations from the findings.

- **Other clinicians.** In this study all new patient assessments were conducted by a single health care assistant, and all clinical assessments by a single TID clinician (a GP). Both clinicians were experienced in the work and the GP had a specific interest and training in clinical work with people seeking asylum. We do not know to what extent their findings would be replicated by different clinicians in different settings.

- **Other primary care settings**. The proportion of asylum-seeking patients in other GP practices may differ from that in the study practice, The GP practice studied registers most asylum-seeking patients in one dispersal area. It has a large number of patients who are seeking asylum and thus the staff are familiar with asylum related health problems and presentations. In practices with smaller numbers of people seeking asylum, it may be more

difficult to identify them, or to identify their asylum status before asking about human rights abuse.

- **Generalising to all asylum applicants**. Having a history of human rights abuse or health conditions related to this may affect in unknown ways the likelihood of being moved to a new area, of registering with a general practice, and of taking up the offer of a new patient assessment.

Implications

If health care needs are not identified, they are unlikely to be met. The study provides some evidence that in a UK general practice, routine enquiry at new patient assessment reveals that a majority of asylum-seeking patients give a history of human rights abuse that has not been recorded in previous GP records, and that the majority of those reporting such abuse have associated clinical findings and health care needs.

In the majority of those patients reporting abuse there are clinical findings that could have implications within the asylum process including:

- Clinical findings relating to human rights abuse in the country of origin;
- Clinical factors affecting the person's ability to give their account, for example in a Home Office interview or Tribunal hearing;
- Current health and risk issues, for example suicidality.

The high prevalence of a history of human rights abuse and associated clinical needs among asylum-seeking patients adds to the arguments for introducing routine enquiry about human rights abuse for asylum-seeking patients in primary care [1].

For the majority of patients, current practice in primary care does not explore the history of human rights abuse or associated health care needs. Thus providing appropriate health care and rehabilitation requires additional measures.

The increasing reliance in asylum claims on copies of GP records for 'medical evidence' to support people's accounts is fundamentally flawed if the majority of GP records do not contain reference to human rights abuse as a result of clinicians not giving patients opportunity to explain what has happened to them.

In a linked paper we offer recommendations based on this prevalence study and other findings from the overall service evaluation [1]

Further study is needed to allow better understanding of the prevalence and severity of abuse that is not disclosed in routine enquiry of the kind described here, and of the prevalence and severity of less specific abusive experiences, which may be dismissed as not requiring further attention.

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Appendix 1. Variables used

New patient assessments (NPA)	
Asylum-seeking	Recorded as asylum seeker at registration OR patient reported this on direct enquiry at new patient assessment (NPA).
Age	As recorded in GP record, at the time of the NPA.
Gender	As recorded in GP record and observed.
Country of origin	As recorded in GP record.
History of human rights abuse requiring referral for TID assessment	Defined by health care assistant according to her existing practice. Patients appear to have been referred if they were unaccompanied children or if their histories suggested a possibility of torture, modern slavery, domestic violence, sexual violence, personal or physical assault in countries of origin or on journeys to the UK. Psychological trauma alone, abuse within families and communities, and experience of war were seen as greyer areas with less consistency in the decisions made to refer.
Decisions on invitation for assessment	
Lesser priority for TID assessment	Defined by the doctor based on information provided by health care assistant. i.e. the doctor judged that there were others on the waiting list at the time who appeared more likely to have health problems that would benefit from earlier assessment. Those prioritised included for example those reported as psychologically unstable, those who were harmed in their country of origin, those who were detained in Libya on their journey, those from Vietnam who are high risk for abuse during long journeys to the UK. Those seen as lesser priority were people presenting as stable and reporting mostly physical assault during journeys to the UK in European countries.
TID assessments	
Age	As recorded in GP record at time of the assessment (In two cases this differed from their stated age).
Gender	As recorded in GP record and observed.
Country of origin	As recorded in GP record and confirmed at assessment.
Asylum seeking	At the assessment the patient stated that they had claimed asylum. .
Leave to remain	At the assessment, the patient stated that they had been granted refugee status or another form of protection.
Unclear if asylum seeking	At the assessment, the doctor was unable to clarify if the patient had claimed asylum.
Human rights abuse	Defined by the doctor according to her existing practice.
Physical violence	Defined by the doctor according to her existing practice.

	She recorded 'physical violence' in cases where the patient reported that they had sustained any physical assault (i.e. not simply witnessed violence).
Rape or other sexual violence	Defined by the doctor according to her existing practice, based on information reported by the patient. She recorded 'rape or other sexual violence' in cases where the patient reported this, and there was physical contact.
Psychological harm only	Defined by the doctor according to her existing practice, based on information reported by the patient. She recorded 'psychological harm only' when the patient reported a deliberate attempt to cause fear or distress, for example threats to kill.
Torture	Defined by the doctor according to her existing practice, based on information reported by the patient. She recorded a clinical suspicion of 'torture' in all cases where the abuse (physical, psychological and/or sexual) 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 deliberate and particularly inhumane or degrading. Physical assault, in the form of beatings alone, was not included, unless in a detention setting.
Suspicion of modern slavery	Defined by the doctor according to her existing practice, based on information reported by the patient. 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.
Physical findings attributed to human rights abuse	Defined by the doctor according to her existing practice. The doctor recorded this when there was scarring or other skin markings attributed to human rights abuse or when there was a pain presentation highly suggestive of the method of human rights abuse described.
Current psychological symptoms	Defined by the doctor according to her existing practice. The doctor recorded this when patients reported symptoms or impaired function due to psychological factors or where she observed these during the interview.
Current risk of suicide	Defined by the doctor according to her existing practice. The doctor recorded current risk of suicide where the patient reported current active thoughts of killing themselves and/or a recent attempt.