

# Vulnerable groups in the asylum determination process

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## Overview

This briefing provides an overview of the legal and social concerns of vulnerable groups in the asylum determination process in the UK. The decision of which groups can be considered to be 'vulnerable' was informed by the European Union Council Directive as well as those groups experiencing structural discrimination within and outside the asylum process. The groups are not mutually exclusive; asylum seekers may be vulnerable for several reasons and these should not necessarily be seen in isolation.

The European Union Council Directive 2003/9/EC of 27 January 2003 laying down minimum standards for the reception of asylum seekers<sup>1</sup> states that the "reception of groups with special needs should be specifically designed to meet [their] needs". Article 17 provides that Member States shall take into account the specific situation of vulnerable persons such as minors, unaccompanied minors, disabled people, elderly people, pregnant women, single parents with minor children and persons who have been subjected to torture, rape or other serious forms of psychological, physical or sexual violence.

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<sup>1</sup> [http://eur-lex.europa.eu/LexUriServ/site/en/oj/2003/l\\_031/l\\_03120030206en00180025.pdf](http://eur-lex.europa.eu/LexUriServ/site/en/oj/2003/l_031/l_03120030206en00180025.pdf)

## Unaccompanied asylum seeking children

Asylum seeking children are afforded additional protection because of their vulnerability by the 1989 United Nations Convention on the Rights of the Child (CRC) and the Children Act 1989, which partly brings the CRC into UK law. The UK has placed a reservation on Article 22 of the CRC concerning the guaranteed protection of refugee children. A recent report by the Joint Committee on Human Rights stated that the reservation of Article 22 leaves asylum seeking children with a lower level of protection in relation to a range of rights that are unrelated to their immigration status, therefore unduly discriminating against this vulnerable group.<sup>2</sup>

The Border and Immigration Agency (BIA) of the Home Office defines an unaccompanied asylum seeking child as a person who, at the time of making the asylum application:

- is, or (in the absence of documentary evidence establishing age) appears to be, under eighteen;
- is applying for asylum in his or her own right;
- is separated from both parents and not being cared for by an adult, who by law or custom has responsibility to do so.

The Home Office does not consider a child to be unaccompanied if he or she is being cared for by an adult prepared to take responsibility for them. It is Home Office policy to involve social services in any case where there is concern about the child's relationship with the 'responsible' adult.<sup>3</sup>

### Statistics

Whilst overall asylum numbers have been notably decreasing over the last couple of years, down to 25,710 in 2005 from 49,405 in 2003<sup>4</sup>, the number of asylum applications from unaccompanied asylum seeking children (UASC) has remained around 3,000 per year for the last three years. The most recent Home Office figures indicate that in 2005, 2,965 unaccompanied children applied for asylum in the UK, which equates to nearly 12% of all applications for asylum during that year. In 2005, the main countries of origin for this group of children were Afghanistan (18%), Iran (15%) and Somalia (8%).<sup>5</sup> In 2007, the Home Office confirmed that around 6,000 UASC were being supported by local authorities across the UK.<sup>6</sup>

Discretionary leave (DL) is the most common outcome of an asylum application made by UASC and is usually granted for three years or until the child reaches 17.5 years<sup>7</sup> (whatever is the shorter period). In 2005, 70% of asylum applications made by UASC were granted discretionary leave; 5% were granted asylum; 1% were awarded humanitarian protection (HP) and the remaining 24% were refused asylum and HP/DL.<sup>8</sup>

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<sup>2</sup> **Joint Committee on Human Rights** (March 2007) *The treatment of asylum seekers, Tenth report of session 2006-7*

<sup>3</sup> **Home Office** (April 2006) *Asylum Policy Instruction - Children*

<sup>4</sup> These figures exclude dependents.

<sup>5</sup> **Heath, T., Jeffries, R. and Pearce, S.** (August 2006) *Asylum statistics United Kingdom 2005*

<sup>6</sup> **Home Office** (February 2007) Consultation paper - *Planning better outcomes and support for unaccompanied asylum seeking children*

<sup>7</sup> **Home Office** (March 2007) *Amendment to Discretionary Leave Policy for asylum seeking children*

<sup>8</sup> **Home Office** (October 2006) *Response to a request under the Freedom of Information Act - Asylum seeking children, FOI 3840*

## Asylum applications and process

When an asylum application is made by an UASC, basic information is noted in a short screening interview. This information includes their name, nationality, date of birth and family details as well as information about how the child travelled to the UK. The child will then be photographed and fingerprinted in the presence of a responsible adult. Children under the age of five are not fingerprinted.<sup>9</sup> UASC are given a statement of evidence form (SEF) to complete and a 'One stop notice', which requires them to detail any human rights that would be breached if they were removed from the UK. They are given 20 working days to return the completed forms (adult asylum seekers have 10 days). When the forms are returned the child will be given an ARC (application registration card). It used to be the case that minors were not required to attend a substantive interview, but since April 2007 the Home Office has begun to interview all minors aged 12 or over, whilst in the company of a responsible adult.<sup>10</sup> For further information on the asylum process for children refer to the diagram at the end of this briefing.

## The New Asylum Model

Under the New Asylum Model (NAM) several changes affecting the asylum process for UASC have been implemented since 1 April 2007. The key amendments include:

- every child is assigned a specially trained case owner who they will meet in person and who will oversee their application from beginning to end;
- all UASC aged 12 or over are now interviewed by a case owner about the substance of their asylum claim;
- UASC are given 20 working days to return their SEF form instead of the previous 28 days;
- instead of granting discretionary leave until a child turns 18, it is now granted until the child is 17 and a half.<sup>11</sup>

Refugee children's advocates are concerned that these changes may negatively impact on children's experiences of the asylum process. The reduction in the number of days allocated to complete a SEF may create added pressure when finding an immigration lawyer prepared to represent a child and may not be sufficient time in which to initiate medical examinations and prepare evidence.<sup>12</sup> Furthermore, commentators have noted that if the asylum process, including the application to extend discretionary leave and the appeal against refusal to extend, is concluded before the UASC turns 18, then their status will be as 'overstayers' and therefore they will be unlawfully in the UK. This could mean they may no longer have access to employment, benefits or a leaving care service from a local authority and will be potentially destitute.<sup>13</sup>

In February 2007 the Home Office published a consultation paper outlining its reform programme for UASC. In addition to the four main changes under the NAM explained above, the Home Office is currently seeking feedback from stakeholders on several proposals including plans to disperse UASC to other areas of the UK to relieve pressure on local authorities dealing with high numbers of UASC in London and the South East; to use x-rays

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<sup>9</sup> Home Office (April 2007) *Processing asylum applications from children - instructions to NAM case owners*

<sup>10</sup> *Ibid.*

<sup>11</sup> Home Office (5 March 2007) *Letter to members of the NAM and UASC Reform Stakeholder Groups on asylum process for minors - accompanied and unaccompanied asylum seeking children*

<sup>12</sup> Children's Legal Centre (2006) *Information note on the New Asylum Model - minors segment*

<sup>13</sup> *Ibid.*

(dental and possibly wrist and collarbone) as an additional age determination method; to extend the use of social workers to assess age at the two Asylum Screening Units; and to develop incentives for the voluntary return of minors by reducing the value of the package the longer the child delays in agreeing to return.<sup>14</sup> According to ILPA, it is expected that some of these proposals will be implemented in spite of feedback from key stakeholders.<sup>15</sup>

### Legal representation

Similarly to adults in the asylum determination process<sup>16</sup>, the provision of adequate legal advice and representation for UASC remains a concern for many refugee and children's organisations.<sup>17</sup> It is recognised in Home Office guidance that case owners need to be aware that UASC may not, for example, always recount events in chronological order and there may be inconsistencies in their evidence.<sup>18</sup> Due to this vulnerability, legal advocates insist that adequate legal advice and representation is imperative if UASC are to be properly supported throughout the asylum process.<sup>19</sup> In evidence submitted to the Joint Committee on Human Rights, the Children's Society reported that they come in to contact with significant numbers of children either with no legal representation or with very poor quality legal representation. They expressed concern that without somebody to advocate on their behalf, UASC may go through the system without being able to put forward a fair asylum claim.<sup>20</sup> In a recent letter to the UASC reform stakeholder groups, the Home Office acknowledged that the provision of legal advice remains a priority and they are currently working with the Legal Services Commission on this issue.<sup>21</sup>

### Decision making and credibility

According to government policy, applications for asylum from UASC should be considered in light of the child's maturity, with more weight being given to objective factors of risk than to the UASC's subjective assessment of the situation, for example the use of country evidence and information from people who know the child.<sup>22</sup> Research into the quality of decision making for UASC indicates that this does not happen in practice. For example decisions do not tend to reflect the fact that the claim is by a child and no difference is made between adult and child refusal letters.<sup>23</sup> In addition, the report notes a lack of Home Office research into the reasons why children seek asylum, which it is argued, may be a reflection of the fact that many immigration officers do not accept the reasons children give for seeking asylum, such as 'forcible recruitment as child soldiers' and 'trafficking', as falling under the Refugee Convention.<sup>24</sup>

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<sup>14</sup> Home Office (February 2007) Consultation paper - *Planning better outcomes and support for unaccompanied asylum seeking children*

<sup>15</sup> ILPA (April 2007) *Information sheet on children's asylum claims*

<sup>16</sup> For more information on legal representation, refer to the first IAC briefing on the asylum determination process

<sup>17</sup> ILPA (February 2006) *Child first, migrant second: Ensuring that every child matters* and **Joint Committee on Human Rights** (8 January 2007) *Uncorrected oral evidence on the treatment of asylum seekers*

<sup>18</sup> Home Office (April 2006) *Asylum Policy Instruction - Children*

<sup>19</sup> ILPA (February 2006) *Child first, migrant second: Ensuring that every child matters*

<sup>20</sup> **Joint Committee on Human Rights** (8 January 2007) *Uncorrected oral evidence on the treatment of asylum seekers*

<sup>21</sup> Home Office (5 March 2007) *Letter to members of the NAM and UASC Reform Stakeholder Groups on asylum process for minors - accompanied and unaccompanied asylum seeking children*

<sup>22</sup> Home Office (April 2006) *Asylum Policy Instruction - Children*

<sup>23</sup> Bhabha, J. and Finch, N. (November 2006) *Seeking asylum alone - unaccompanied and separated children and refugee protection in the UK*

<sup>24</sup> *Ibid.*

## Support arrangements for UASC

Under the Children Act 1989 local authorities are responsible for unaccompanied asylum seeking children, as opposed to the Border and Immigration Agency of the Home Office which is responsible for the provision of support to all destitute asylum seekers and their dependents. The two relevant sections of the Children Act are section 17 and section 20. Until the 'Hillingdon Judgement' in August 2003, UASC under the age of 16 were supported under section 20 and those over that age were supported under section 17. The Hillingdon judgement means that all UASC should be supported under section 20 of the Act unless a full assessment of their needs indicates otherwise. The range of support available under section 20 is much more extensive and includes a care plan, the allocation of a social worker and sometimes residential care.<sup>25</sup>

It is the responsibility of the Home Office to ensure that all UASC have been referred to the relevant social services department as soon as they make a claim for asylum. If the child gives an address in their application, then they will be referred to that area but if the child has no local connection or address then they will be referred to the local authority in which the application was lodged.<sup>26</sup> The local authority has a 'corporate parenting responsibility' for UASC and the Home Office provides local authorities with grants to cover the costs of the asylum seeking children for which they are responsible.<sup>27</sup> All UASC should receive a full needs assessment by social services in line with the national framework<sup>28</sup> for the assessment of children in need. Details of all UASC are passed to the Children's Panel of the Refugee Council who provide a range of support services including ensuring that all referrals have legal advice and interpreters.<sup>29</sup>

Evidence provided to the Joint Committee on Human Rights' investigation into the treatment of asylum seekers stated that some local authorities were unable to provide all UASC with a social worker and that the quality of support, particularly regarding accommodation arrangements varied significantly between authorities, resulting in a 'lottery of care.'<sup>30</sup>

## Age disputed cases

If an applicant claims to be under the age of 18 but the Home Office believes that they are over 18, then the stated policy is to treat them as adults until credible documentary or medical evidence confirms that the applicant is less than 18 years old. This means that applicants who are age-disputed will be offered the same asylum support as an adult asylum applicant. In borderline cases it is Home Office policy to give the claimant the benefit of the doubt. If a local authority disagrees with the Home Office assessment then the BIA will modify its decision so that it is in line with Social Services.<sup>31</sup>

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<sup>25</sup> Refugee Council (January 2005) *Ringling the changes: The impact of guidance on the use of Sections 17 and 20 of the Children Act 1989 to support unaccompanied asylum seeking children*

<sup>26</sup> Home Office (April 2007) *Processing asylum applications from children - instructions to NAM case owners*

<sup>27</sup> Free, E. (2005) *Local Authority support to unaccompanied asylum-seeking young people - Changes since the Hillingdon Judgement (2003)*, Save the Children

<sup>28</sup> Department of Health (2000) *Framework for the Assessment of Children in Need and their Families*

<sup>29</sup> Joint Council for the Welfare of Immigrants (2006) *Immigration, nationality and refugee Law handbook*

<sup>30</sup> Joint Committee on Human Rights (March 2007) *The treatment of asylum seekers, Tenth report of session 2006-7*

<sup>31</sup> Home Office (April 2007) *Policy instruction for NAM case owners on disputed age cases*

The Home Office indicates that it will accept medical evidence on the age of applicants but also maintains that this is an inexact science and there can be a margin of error of several years either way of the estimate. The 'Merton case', which resulted in a judgement from the High Court, gives guidance on the requirements of a lawful assessment by a local authority of the age of an asylum seeker claiming to be under the age of 18 years. The guidance states that the decision maker should not determine age solely on the basis of the appearance of the applicant, that appropriate information needs to be sought in order to determine age, and that the local authority must give adequate reasons for a decision that someone is not a child.<sup>32</sup>

In recent years there has been a significant increase in the number of age disputed cases in the asylum system. In 2001, 11% of asylum claims made by UASC were age disputed<sup>33</sup> compared to the most recent figures for 2005 of 45% (2,425) resulting in these cases being treated as adults.<sup>34</sup> Data collated at Oakington Immigration Removal Centre during the period November 2003 - January 2006 revealed that 50% of detained age disputed cases were subsequently found to be minors.<sup>35</sup> Refugee agencies are concerned that erroneously determining a child as an adult could place them at unnecessary risk. For example, age disputed UASC are susceptible to detention with adults and may be returned to another country under the Dublin II regulation.<sup>36</sup>

### Turning 18

Until recently, when an UASC who has been awarded discretionary leave (DL) turned 18 it was necessary to apply for an extension of that leave. It is now the case that an extension for DL has to be made when an UASC reaches 17.5 years.<sup>37</sup> The Home Office believe this amendment will provide young people with more clarity about their future in the UK or whether return to their country of origin is more probable.<sup>38</sup> When an UASC whose asylum application is outstanding reaches the age of 18, they are eligible to apply for asylum support from the BIA. Applicants can request not to be dispersed and decisions are made on a case by case basis.

If a child was accommodated by the local authority under the Children Act 1989 and they qualify as 'former relevant children' under section 23c of the Children (Leaving Care) Act 2000 then they could be supported by the local authority up to the age of 24. Until the 'Hillingdon case' local authorities only had an obligation to those accommodated under section 20 of the Children Act and at that time these were only children under 16.<sup>39</sup>

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<sup>32</sup> Children's Legal Centre (2003) *Information note on The Queen on the application of B v London Borough of Merton*, [2003] EWHC 1689 (Admin) (14 July 2003)

<sup>33</sup> Bhabha, J. and Finch, N. (November 2006) *Seeking asylum alone - unaccompanied and separated children and refugee protection in the UK*

<sup>34</sup> Heath, T., Jeffries, R. and Pearce, S. (August 2006) *Asylum statistics United Kingdom 2005*

<sup>35</sup> Refugee Council (November 2006) *Unaccompanied children and the Dublin II Regulation*

<sup>36</sup> Joint Committee on Human Rights (20 November 2006) *Uncorrected oral evidence on the treatment of asylum seekers* NB: The Dublin II Regulation is designed to ensure that asylum seekers can only claim asylum in one EU state and adult asylum seekers may be returned to a country to claim asylum on the basis that they originally passed through that state

<sup>37</sup> Home Office (5 March 2007) *Letter to members of the NAM and UASC Reform Stakeholder Groups on asylum process for minors - accompanied and unaccompanied asylum seeking children*

<sup>38</sup> *Ibid.*

<sup>39</sup> Children's Legal Centre (2007) *Information on transition at 18*

## Access to education, health and employment

Unaccompanied asylum seeking children are entitled to free education until the age of 16. They are also entitled to apply for a place at a sixth-form college or a further education college. However, these places are given at the discretion of the institute and local education authority. Some colleges allow 16-19 year old asylum seekers to study for free and others charge overseas student fees. Nevertheless, according to the Department of Education, all UASC under 19 should be treated as domestic students and be exempt from international fees. Individuals with refugee status, discretionary leave and humanitarian protection can apply to institutes of higher education and are treated as domestic students for the purposes of fees.<sup>40</sup> UASC are entitled to access all NHS services and prescriptions are free to those under 16 and those who are in full-time education under 19.<sup>41</sup> UASC with refugee status, discretionary leave and humanitarian protection automatically have permission to work once they reach the age of 16.<sup>42</sup>

## Children in families

Whilst UASC are recognised to be a particularly vulnerable group in the asylum determination process, children who are dependents of asylum seeking families may also be at risk. For example, Section 9 of the Asylum and Immigration Act 2004 gives the Home Office power to withdraw asylum support from families with dependent children if they fail to take reasonable steps to leave the UK voluntarily when their asylum application has been turned down. If families are deprived of support, the children in these families may be separated from their parents and accommodated by local authorities.<sup>43</sup> Section 9 began as a pilot project in December 2004 in three areas (Central/East London, Greater Manchester and West Yorkshire) and involved 116 families. According to data collated by the Refugee Council, thirty six of the 116 families have gone 'underground' in order to avoid having their children taken into social services.<sup>44</sup> Whilst Section 9 still remains on the statute books, it has not yet been rolled out nationally and both refugee organisations and local authorities alike have called on the government to repeal this piece of legislation.<sup>45</sup>

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<sup>40</sup> Children's Legal Centre (2007) *Information on Education under 16 and Children's Legal Centre (2006) Information on Further and Higher Education*

<sup>41</sup> Children's Legal Centre (2007) *Information sheet on health*

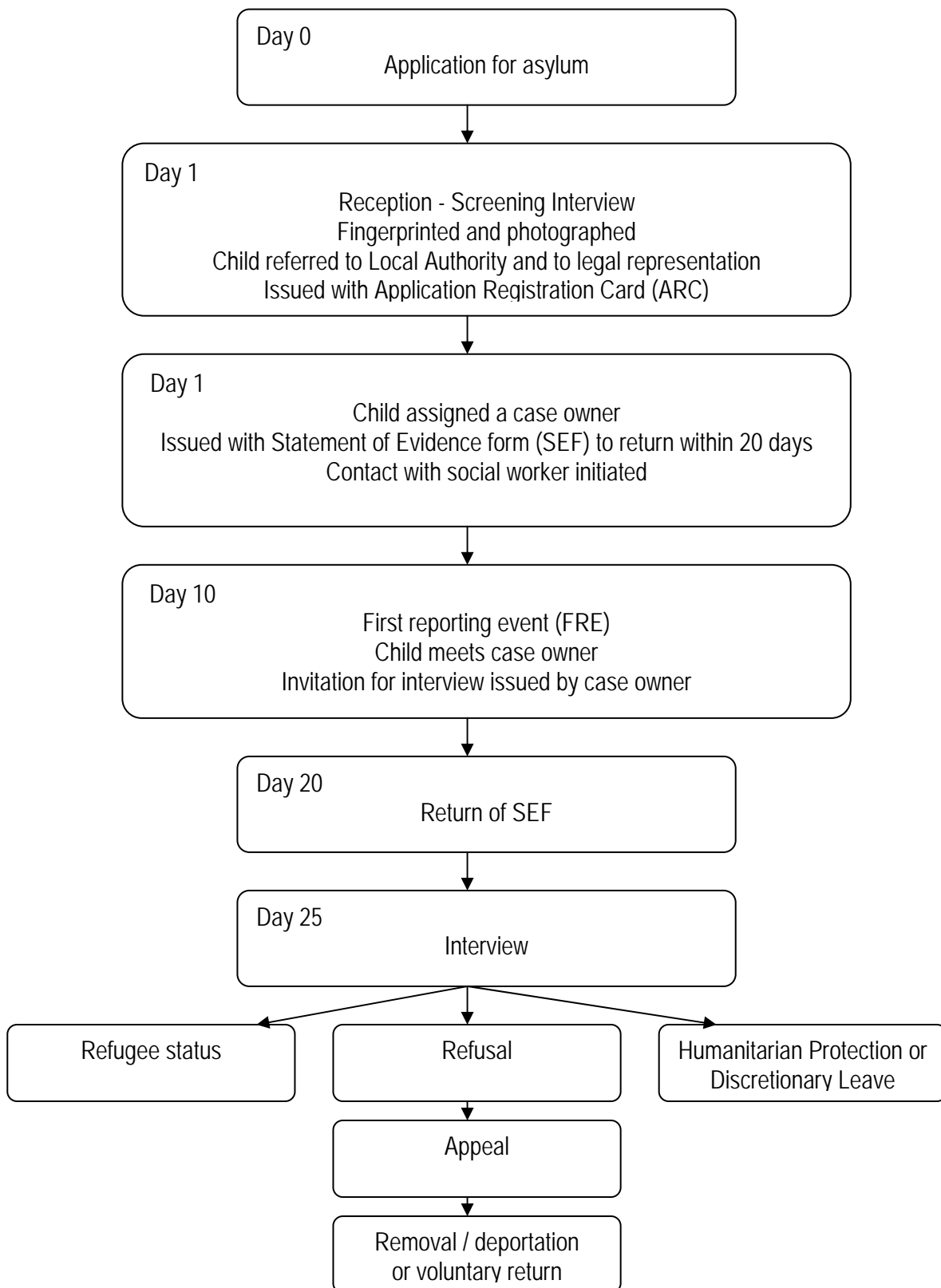
<sup>42</sup> Children's Legal Centre (2007) *Information on work and training*

<sup>43</sup> ILPA (February 2006) *Child first, migrant second: Ensuring that every child matters*

<sup>44</sup> Joint Committee on Human Rights (20 November 2006) *Uncorrected oral evidence on the treatment of asylum seekers*

<sup>45</sup> Refugee Council (January 2006) *Inhumane and Ineffective - Section 9 in Practice: A Joint Refugee Council and Refugee Action report on the Section 9 pilot* and ILPA (February 2006) *Child first, migrant second: Ensuring that every child matters*

Diagram of the asylum determination process for children<sup>46</sup>



<sup>46</sup> Diagram adapted from: Home Office (April 2007) *Processing asylum applications from children - instructions to NAM caseowners*

## Women

The experiences of asylum seekers are gendered in several ways, including forms of persecution in countries of origin, the migration journey, experiences of social services and the legal process itself. It has been argued that women are rendered 'invisible' in the asylum process,<sup>47</sup> from a lack of documentation of gender-specific persecution to failures to provide appropriate social services to asylum seeker women. Male bias, it has been argued, permeates social and legal processes in the asylum system.<sup>48</sup> One explanation for this may be the general perception that the overwhelming majority of asylum seekers in the UK are male (this issue will be addressed further below). It has been suggested that women face significant barriers in reaching industrialised countries, including: lack of funds, responsibilities to family and dependents and restrictions on travelling alone.<sup>49</sup>

Women may apply for asylum for similar reasons as men, but some gender-specific differences have been observed. One commentator notes that women are more likely to apply on the basis of 'low level' political activities and to be targeted by association with male political activists.<sup>50</sup> Another reason has been the refusal to comply with social norms imposed on women in countries of origin, which has on occasion been interpreted as 'political activity'. In many countries, women are seen as the guardians of national or ethnic identity and often face pressures to conform to particular forms of behaviour, which can bring about punishment if disobeyed.<sup>51</sup>

### Statistics

The number of women applying for asylum in industrialised countries is significantly lower than the number of men (approximately 30% compared with 70% for men<sup>52</sup>). This may explain the lack of policy concerns specific to women in receiving industrialised countries. Many women arrive as dependents or through family reunion programmes. The number of male and female asylum seekers and refugees around the world however is roughly equal. 2003 UNHCR figures show that 48% of the world's refugees are women.<sup>53</sup>

The Home Office began recording the gender of principal applicants in the early 1990s but these were not included in their statistical publications until 2001. Since 2002, the gender of dependents has also been detailed in the publications. There remains however no gender-disaggregated data relating to appeals, removals, NASS support and figures of dependents arriving during appeals processes.

Some of the key statistics from 2005 relating to women are as follows:

- 29% (7,365) of principal applications were made by women
- 54% (2,765) of applications as dependents were made by women
- 10% of women were granted asylum compared with 6% for men

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<sup>47</sup> Dumper, H. (2006) *Women Refugees and Asylum Seekers in the UK*, Information Centre about Asylum and Refugees

<sup>48</sup> *Ibid.*

<sup>49</sup> Dumper, H. (2002) *Is it safe here? Refugee women's experiences in the UK*, London: Refugee Action

<sup>50</sup> Crawley, H. (2001) *Refugees and gender: law and process*, London: Jordans and Refugee Women Legal Group

<sup>51</sup> Anthias, F. and Yuval-Davies, N. (1992) *Racialised Boundaries: race, nation, gender, colour, class and the anti-racist struggle*, London: Routledge

<sup>52</sup> Heath, T., Jeffries, R. and Pearce, S. (August 2006) *Asylum statistics United Kingdom 2005*

<sup>53</sup> UNHCR (2005) *Statistical Yearbook 2003: Trends in displacement, protection and solutions*

- 11% of women were granted Humanitarian Protection or Discretionary Leave compared with 10% for men
- 14% (205) of asylum seekers in detention were women, of whom 20 were minors

### Gender bias of refugee law

There is no specific asylum legislation relating to women in the UK. Some commentators have noted a male bias in the Refugee Convention<sup>54</sup> and women have struggled to include gender-specific persecution within the definitions set out by the Convention. Persecution resulting from the refusal to conform to gender norms has however gradually become interpreted as persecution on account of political opinion. One landmark case on this issue was that of *Fathi & Ahmady* (1996), whose refusal to conform to gender norms in Iran was seen as a political act within the definition of the Convention at the appeals stage.<sup>55</sup>

Women have on other occasions been granted asylum on account of gender-specific persecution due to their membership of a social group. The landmark case of *Shah & Islam* (1999) saw the House of Lords consolidating the idea that women, who share an immutable characteristic, can constitute a social group if they face persecution in a country for being a member of that group.<sup>56</sup>

It has been noted that gender-specific persecution is insufficiently documented. This is particularly pertinent in relation to new legislation introduced in the 2002 Immigration and Asylum Act, where asylum applications from a Home Office list of 'safe countries' are presumed to be 'clearly unfounded'. This list includes several countries where women continue to face systematic discrimination, such as the risk of trafficking for sexual exploitation.

### Access to the legal process

The literature highlights several ways in which women can be marginalised in the legal process. Women may not be actively encouraged to submit a separate claim from their husband or partner and many do not know that they have the option to do so. More broadly, women may not realise they have the possibility of claiming asylum. It has been noted that only gender-aware legal advisors will recognise the independent experiences of wives/partners of male applicants and encourage them to make their own application.<sup>57</sup> Further, practical arrangements in court, such as a lack of childcare facilities, can discriminate against women.<sup>58</sup>

### Gender guidelines

The UNHCR developed gender guidelines in 1991 and 2002 to promote a gender-sensitive approach to the Refugee Convention and to address the male bias of its provisions. In 1996, the EU stressed the need for gender guidelines to be established in each EU state, which has only been upheld to date by Sweden. The UK added guidance on gender issues to the Asylum Policy Instructions (APIs) for caseworkers in March 2004. The guidelines aim to provide caseworkers with information about the additional issues they should consider in relation to women's claims, how to take gender into account when looking at instances of persecution

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<sup>54</sup> Ceneda, S. (2003) *Women asylum seekers in the UK – some facts and figures*, London: Asylum Aid; Crawley, H. (2001) *Refugees and gender: law and process*, London: Jordans and Refugee Women Legal Group

<sup>55</sup> Crawley, H. (2001) *Refugees and gender: law and process*, London: Jordans and Refugee Women Legal Group

<sup>56</sup> De Jong, A. (2003) *LGBT Navigation Guide*, ICAR

<sup>57</sup> Dumper, H. (2006) *Women Refugees and Asylum Seekers in the UK*, Information Centre about Asylum and Refugees

<sup>58</sup> Ceneda, S. (2003) *Women asylum seekers in the UK – some facts and figures*, London: Asylum Aid

and whether there has been a failure of state protection in cases involving women. Some commentators have criticised the Home Office for failing to implement the guidelines effectively.<sup>59</sup>

### **Welfare and services**

There has been some concern over the rights of women as dependents. The entitlement of women who apply as dependents for support from NASS rests on the existence of their husband or partner's asylum claim. There are several problems with this if the relationship comes to an end: both applications may have to be made anew, which causes delay; if the woman leaves to make her own asylum claim, this may put the husband/partner's claim in danger; women may have no further right to remain in the UK if they are seen not to be dependent; and if a woman makes a fresh claim the delay may be held against her.<sup>60</sup>

The absence of accurate data on women asylum seekers and refugees presents difficulties for service providers to plan and develop their services effectively. Asylum seeker women have similar issues to all women, but they may face particular difficulty accessing services due to lack of English, cultural restrictions on leaving their home without an escort and caring responsibilities for children.<sup>61</sup>

It has been noted that there is a tendency for services for asylum seekers to be developed without the specific needs of women in mind. For example, pregnant asylum seeker women are often housed in temporary accommodation with men, which many women find difficult, inappropriate and culturally unacceptable. Some refugee organisations have evaluated their own service provision and acknowledged the lack of women-specific services they provide. As a result, they have begun to provide women-only services including legal advice sessions.<sup>62</sup>

### **Women in detention**

There has been some concern expressed by organisations over the detention of women in relation to two main issues. Firstly, detention has been identified as detrimental to the mental and physical health of pregnant women due to inadequate attention to nutrition and provision of medical care at Immigration Removal Centres (IRCs). It has been suggested that alternatives to detention should be considered for pregnant women, such as regular reporting. Further, the Home Office's enforcement manual states that pregnant women should only be detained under 'exceptional circumstances'.

Secondly, concern has been expressed over access for women to adequate legal representation under the New Asylum Model (NAM). Bail for Immigration Detainees (BID), an organisation that campaigns to increase detainees' access to bail, has documented cases in the fast-track system where women have had insufficient time to prepare their cases and disclose information about rape and sexual violence.<sup>63</sup> An evaluation of the application of the Gender APIs in fast-tracked cases at Yarl's Wood IRC recommends that caseowners receive

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<sup>59</sup> Ceneda, S. and Palmer, C. (March 2006) *'Lip service' or implementation? The Home Office Gender Guidance and women's asylum claims in the UK*, London: Refugee Women's Resource Project at Asylum Aid

<sup>60</sup> Dumper, H. (2006) *Women Refugees and Asylum Seekers in the UK*, Information Centre about Asylum and Refugees

<sup>61</sup> Ceneda, S. (2003) *Women asylum seekers in the UK – some facts and figures*, London: Asylum Aid

<sup>62</sup> Refugee Council (2005) *Making women visible: strategies for a more woman-centred asylum and refugee support system*

<sup>63</sup> Bail for Immigration Detainees (2006) *Memorandum to the Joint Committee on Human Rights - Uncorrected evidence on the treatment of asylum seekers*

improved training on gender issues and that there is a need for a stronger referral mechanism where the basis for an asylum claim is considered prior to deciding its eligibility for fast-tracking.<sup>64</sup>

Further details relating to women in detention can be found in the ICAR briefing for the IAC on detention (March 2007).

### Examples of gender-specific bases for asylum claims

#### **Female Genital Mutilation (FGM)**

FGM is the basis for asylum claims lodged by some women. It is a practice performed primarily in Africa and the Middle East, involving the partial or total removal of the female genitalia. Many African states criminalise the practice, but there has been concern over the effective enforcement of these laws.<sup>65</sup> FGM has increasingly been recognised as a human rights violation and the UNHCR has consequently recognised FGM as a form of persecution.<sup>66</sup>

In the UK the debate has centred around whether women who have been subjected to FGM constitute a 'social group' under the terms of the Refugee Convention. A landmark case in relation to this was that of *Fomah* (2005) whose case was taken to the House of Lords. The latter recognised that women in Sierra Leone constituted a social group because of their perceived inferiority and subjection to male dominance, of which FGM is an expression.

#### **Trafficking**

The UK is a major destination for trafficked women, who come mainly from Eastern Europe, Asia and West Africa.<sup>67</sup> In 2003, the Sexual Offences Act introduced offences for trafficking people to the UK for the purpose of sexual exploitation, with a maximum penalty of 14 years imprisonment. As a response to EU legislation, the Asylum and Immigration Act 2004 expanded the definition of trafficking to include other forms of exploitation such as forced labour and domestic slavery. Trafficked women may have the basis for an asylum claim if their country is unable or unwilling to protect them on return, where they may be vulnerable to re-trafficking and/or face severe discrimination. The Home Office gender guidelines state that trafficked women have a legitimate claim to asylum based on their membership of a particular social group.<sup>68</sup>

The POPPY project, a support organisation for women trafficked to the UK for sexual exploitation, has noted that many of their clients had experienced domestic violence prior to being trafficked, including rape and sexual abuse. They suggest two reasons to explain this. Firstly, trafficking networks target women who are especially vulnerable and who may have been abused already; they may consequently be desperate to escape their situation and become a trafficking victim. Secondly, violence against women may be purposefully perpetrated in order to groom them for trafficking. Further, traffickers may rape women, such that the stigma forces them to leave<sup>69</sup>.

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<sup>64</sup> **NAM Quality Team** (August 2006) *Yarl's Wood detained fast-track compliance with the Gender API*

<sup>65</sup> **US Department of State** (2001) *Laws/Enforcement in countries where FGM is commonly practised*

<sup>66</sup> Letter to the Refugee Legal Centre from UNHCR 1994 cited in **Crawley, H.** (2001) *Refugees and Gender: Law and Process*,

<sup>67</sup> **House of Lords** (October 2006) *House of Commons Joint Committee on Human Rights, Human trafficking*, Twenty-sixth report of session 2005-06, volume 1, p 28

<sup>68</sup> **Home Office** (October 2006) *Asylum Policy Instruction – Gender in the asylum process*

<sup>69</sup> **Women's Commission for Refugee Women and Children** (June 2005) *The struggle between migration control and victim protection: The UK approach to human trafficking*

Some organisations have criticised the government for treating trafficking for sexual exploitation as a migration problem rather than as a human rights violation<sup>70</sup>. In October 2006, The Joint Committee for Human Rights (JCHR) criticised the UK government for the lack of protection given to trafficked women, highlighting in particular instances of arrest, detention and deportation. Following the JCHR report, the Prime Minister announced his intention to sign the Council of Europe Convention on Action against Trafficking in Human Beings 2005. The Convention stipulates that victims of trafficking have rights to help with housing, medical advice and a minimum of 30 days 'reflection period'; it also allows states to grant temporary residence permits to victims of trafficking.

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<sup>70</sup> Women's Commission for Refugee Women and Children (June 2005) *The struggle between migration control and victim protection: The UK approach to human trafficking*

## LGBT

Asylum claims based on sexual orientation and transgender have succeeded in UK courts since the late 1990s. There was considerable disagreement during the 1990s over whether Lesbian Gay Bisexual and Transgender (LGBT)<sup>71</sup> could qualify as a 'social group' under the 1951 Convention on the Status of Refugees and thus as individuals be entitled to protection under the Convention. As the debate has become more or less settled and LGBT cases are more widely included within the groups covered in the Convention, attention has shifted towards *proving* applicants' sexual orientation, arguably due to concerns over applicants 'falsifying' their sexual orientation. There is also an enduring belief held by some decision-makers that sexual orientation can be (or should be) hidden in order to 'avoid persecution'; this is discussed in more detail below.

The literature on LGBT asylum seekers is concerned primarily with the legal issues facing LGBT asylum applicants, however some social issues are covered by the literature and additional information on social issues has also been obtained from the author's research with service providers working with LGBT asylum seekers.<sup>72</sup> It should be noted that the majority of LGBT asylum applicants are gay men. The lack of LBT women applying for asylum may partly be explained by the differential control of women in countries of origin.<sup>73</sup> The Home Office do not keep records of the number of asylum applications based on grounds of sexual orientation.

### Key legal issues

There is no specific legislation relating to LGBT asylum seekers in the UK. Some critics have argued that international refugee law, and its subsidiary UK asylum law, are heterosexist in nature because responses to LGBT issues have been incorporated into existing legislation rather than separate legislation being drafted.<sup>74</sup> It has also been argued that LGBT issues do not appear to be taken into account when countries are included on the 'white lists' introduced in the 2002 Nationality and Immigration Act. These countries are deemed safe by the Home Office, yet LGBT people may still suffer persecution there, for example in Jamaica.<sup>75</sup>

### Social group

The Home Office and Immigration Appellate Authority have generally recognised LGBT as a 'social group' under the 1951 UN Convention on the Status of Refugees since the case of *Shah & Islam* in 1999. In this case the House of Lords decided that groups who share an immutable characteristic "including women and homosexuals or other persons defined by sexual orientation" could constitute a social group if they face persecution in a country for being a member of that group. This judgement came later than in several other industrialised nations who recognised LGBT as a 'social group' under the Convention in the late 1980s and early 1990s, including Australia, Canada, Germany and the USA.<sup>76</sup> The UNHCR has

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<sup>71</sup> A note on terminology: LGBT is the preferred term for what is commonly referred to as 'homosexuals'; the latter term is used here only in contexts where it is widely used by parties in question. Similarly, sexual orientation is the preferred term for what is commonly referred to as 'homosexuality'.

<sup>72</sup> These conversations have taken place as part of ICAR's current Researching Asylum in London project, analysing gaps in the research on refugees and asylum seekers in London.

<sup>73</sup> McGhee, D. (2001) 'Persecution and social group status: homosexual refugees in the 1990s', *Journal of Refugee Studies*, vol. 14, no.1

<sup>74</sup> De Jong, A. (2003) *LGBT Navigation Guide*, ICAR

<sup>75</sup> *Ibid.*

<sup>76</sup> Millbank, J. (2005) 'A preoccupation with perversion: the British response to refugee claims on the basis of sexual orientation 1989-2003', *Social and Legal Studies*, vol. 14, no.1, pp. 115-138

recognised LGBT as constituting a social group under the convention since 1993. Since this shift in policy, the burden upon applicants has been to 'prove' their sexual orientation and to provide evidence that their treatment has amounted to persecution.

Prior to this, there was considerable disagreement as to whether LGBT individuals could claim asylum under the Convention. Most of the debate focused on a few key areas: whether association with the group of 'homosexuals' was voluntary; whether homosexuals could demonstrate the characteristics necessary to constitute a social group e.g. common historical and cultural ties; and whether homosexuality can be (or should be) conducted in the private sphere and thus be 'free' from state persecution.

### Identity versus activity

It has been argued that much of the confusion surrounding LGBT asylum cases in UK courts is owing to misunderstanding of the nature of sexual orientation itself, particularly cross-culturally.<sup>77</sup> Perhaps the most crucial contention is whether homosexuality is seen as an identity or an activity; this relates closely to how sexuality is played out in the public and private sphere and this varies between cultures. Some commentators have argued that like heterosexuals, LGBT people should be free to form normal relationships as a universal right.<sup>78</sup> Some decision makers believe however that in certain cases sexual orientation can be regulated by states according to their perceived sense of morality. According to the latter view therefore a certain degree of prosecution is justifiable and does not amount to persecution under the terms of the Refugee Convention. This relationship between prosecution and persecution has been altered somewhat by the incorporation of international human rights law into domestic law; this will be discussed further below.

It has been observed that the stereotyping of LGBT people has impacted upon the experiences of LGBT asylum seekers in court. In the Golchin case for example, the appellant was told that he did not 'look gay' so he therefore would not face execution in Iran. There have been instances where courts have resorted to medical reports in order to prove applicants' sexual orientation (Vraciu (1994), Krasmiqi (2001)). For example, in the case of *Krasmiqi v SSHD* (2001) a mental health report that made no mention of the appellant's homosexuality was used as sufficient evidence to disprove his case.<sup>79</sup> Some commentators have argued that this method of validating sexuality reinforces the outdated idea that homosexuality is a medical infliction.<sup>80</sup> Further, it has been argued that such methods are not useful (except for in some cases of transgender individuals) because a patient's homosexuality is not necessarily intrinsic to mental or physical illness.

There has been a widespread belief in UK courts that sexual orientation can be shielded from the public sphere. This has been used as a justification to return asylum seekers to their countries of origin based on the idea that they will be safe as long as they do not 'promote' their sexual orientation in public and thus render themselves vulnerable to persecution. Cultural arguments have been employed to validate such decisions i.e. that in non-Western

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<sup>77</sup> De Jong, A. (2003) *LGBT Navigation Guide*, ICAR; McGhee, D. (2003) 'Queer strangers: Lesbian and gay refugees', *Feminist Review*, vol. 73, pp.145-148, Johnson, T. (April 2007) 'Flamers, flaunting and permissible persecution', *Feminist Legal Studies*, vol. 15, no.1, pp. 99-111

<sup>78</sup> De Jong, A. (2003) *LGBT Navigation Guide*, ICAR

<sup>79</sup> *Ibid.*

<sup>80</sup> De Jong, A. (2003) *LGBT Navigation Guide*, ICAR; McGhee, D. (2000) 'Accessing homosexuality: truth, evidence and the legal practices for determining refugee status – the case of Ioan Vraciu', *Body and Society*, vol.6, no.1, pp.29-50

societies, homosexuality is not expressed in public, but rather discreetly. It has been argued that such a position reduces the identity of LGBT people to 'people who have sex with people of the same sex' and ignores the reality that many people across the world want to live a normal life with their same-sex partner.<sup>81</sup>

The solution in the case of *Vraciu v. SSHD* was seen in the adjustment of his behaviour rather than the recognition of his unjust treatment by the Romanian state. Again, in the case of *R.G. (Colombia) v Secretary of State for the Home Department (2006)*, arguments for the use of discretion, or more specifically the adjustment of behaviour to become discreet, was made in the UK court to justify safe return. The excessive modification of behaviour itself has however been recognised as persecutory e.g. in the case of *Z v SSHD (2004)* and *Darian V SSHD (1999)*. In order for behaviour modification to be viewed as intolerable, it must be proved that the modification required places the appellant in a situation of persecution.<sup>82</sup>

### Issues of evidence

It has been argued that legal evidence of homosexuality is problematised by the social realities of LGBT people.<sup>83</sup> The burden of evidence is on the applicant as opposed to the secretary of state. The credibility of LGBT asylum claims is hindered by several factors:

a) *The conduct of the appellant* – Delaying the claim or disclosing new information late in the procedure can have a negative impact on their application. Many asylum seekers are unaware of their right to apply for asylum on the basis of their sexual orientation and this leads to many claiming on false grounds.<sup>84</sup> Many LGBT asylum seekers find it difficult to 'come out' to their legal representative or interpreter, particularly if they are from the same community, thus rendering the credibility of their sexual orientation questionable in the eyes of the courts.<sup>85</sup>

b) *The conduct of courts/legal representatives/decision makers* – Decision makers may see former heterosexual relationships or having children as evidence of a false claim by LGBT asylum seekers. This position ignores the fact that many LGBT people have heterosexual relationships in order to hide their sexuality or because they have no other option, particularly in countries where homosexuality is not sanctioned. An example of this is when Muslim women marry and give birth at very young ages and realise that they are LBT later on in life.<sup>86</sup> Sexual orientation is not easy to prove in court. Self-definition is not considered sufficient, but finding evidence can be difficult, as illustrated in the case where mental health reports were used above. Appellants must prove their sexual orientation by inviting sexual partners to make statements in court, or by demonstrating their participation in LGBT organisations for example.

c) *The lack of country information* – There is insufficient specific, detailed country information on the persecution of LGBT people for legal representatives to represent clients. Moreover, many human rights groups consider the subject taboo, consider LGBT rights a 'western

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<sup>81</sup> De Jong, A. (2003) *LGBT Navigation Guide*, ICAR

<sup>82</sup> Johnson, T. (April 2007) 'Flamers, flaunting and permissible persecution', *Feminist Legal Studies*, vol. 15, no.1, pp. 99-111

<sup>83</sup> McGhee, D. (2000) 'Accessing homosexuality: truth, evidence and the legal practices for determining refugee status – the case of Ioan Vraciu', *Body and Society*, vol.6, no.1, pp.29-50

<sup>84</sup> *Researching Asylum in London (2006) Interview with immigration lawyer working with LGBT asylum seekers, 20/12/06*

<sup>85</sup> Jivraj, S., De Jong, A. and Tauqir, T. (2002) *Identifying the difficulties experienced by Muslim lesbian, bisexual and transgender women in accessing social and legal services*

<sup>86</sup> *Ibid.*

concept' or risk funding for pursuing such work and therefore refrain from documenting human rights abuses based on sexual orientation.<sup>87</sup> Furthermore, LGBT issues often get lost in a sea of other human rights abuses in certain countries and go under-reported. This is particularly true for LBT women, who are doubly 'invisible'.<sup>88</sup>

d) *The nature of persecution* – Persecution of LGBT people particularly women is often experienced as prolonged harassment in the private sphere, making it difficult to provide tangible evidence for the courts. Further, such persecution is often exercised by non-state agents and asylum seekers need to prove that their state is not willing to protect them and that it was reasonable for them not to have sought protection in their own country first.<sup>89</sup>

### **International human rights law**

It has been noted that determination procedures for LGBT asylum seekers have increasingly taken into consideration the treatment of the group by states in question and focused less on applicants' identities, resulting from increasing relations between international human rights law and domestic immigration laws.<sup>90</sup> More specifically, the incorporation of the European Convention on Human Rights (ECHR) into UK law has increased provisions for protection, or at least barriers to refoulement. The ECHR obliges European states to secure the rights and freedoms within the Convention for everyone within their jurisdiction; this encompasses the duty to avoid contributing to human rights violations that may occur outside their jurisdiction.<sup>91</sup>

Article 3 of ECHR can be used to prevent asylum seekers being returned if it can be proved that they would face a real risk of torture and/or inhumane or degrading treatment or punishment on being sent home. Article 8 of ECHR enshrines the right to respect for family and private life. This is relevant if LGBT refugees and asylum seekers if they seek family reunification. It has been argued that Article 8 has not been applied equally to LGBT people; occasionally LGBT cases are defined as 'private life' rather than 'family life' and this limits protection.<sup>92</sup> Further, it has been noted that the use of Article 8 in LGBT (amongst many other) cases virtually closed in 2002 and that human rights considerations have subsequently been limited to very serious breaches of Article 3.<sup>93</sup>

### **Sexual orientation guidelines**

The UK Lesbian & Gay Immigration Group (UKLGIG) and the Immigration Law Practitioners Association (ILPA) are launching sexual orientation guidelines in July 2007 with the purpose of enabling "practitioners and decision-makers to apply the Refugee Convention in a way which embraces the totality of human experiences", raising awareness of LGBT experiences of

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<sup>87</sup> De Jong, A. (2003) *LGBT Navigation Guide*, ICAR; Amnesty International (2001) *Crimes of hate, conspiracy of silence: Torture and ill-treatment based on sexual identity*

<sup>88</sup> Jivraj, S., De Jong, A. and Tauqir, T. (2002) *Identifying the difficulties experienced by Muslim lesbian, bisexual and transgender women in accessing social and legal services*

<sup>89</sup> *Ibid.*

<sup>90</sup> McGhee, D. (2001) 'Persecution and social group status: homosexual refugees in the 1990s', *Journal of Refugee Studies*, vol. 14, no.1

<sup>91</sup> Graupner, H. (2001) *A little bit safe? Asylum on the basis of sexual orientation persecution in Europe* presented at the Business Law International Conference of the International Bar Association (IBA) (Cancun October 28th – November 2nd 2001)

<sup>92</sup> De Jong, A. (2003) *LGBT Navigation Guide*, ICAR

<sup>93</sup> Millbank, J. (2005) 'A preoccupation with perversion: the British response to refugee claims on the basis of sexual orientation 1989-2003', *Social and Legal Studies*, vol. 14, no.1, pp. 115-138

persecution and to assert and affirm the rights of LGBT individuals to international protection. For more information on the guidelines, see: <http://www.uklqig.org.uk/Guidelines.htm>

### **Social issues**

LGBT asylum seekers may feel isolated in the UK. It has been noted that there is a lack of awareness and sensitivity amongst service providers such as legal representatives, interpreters and social services providers, of the issues facing them. This may result from misunderstanding, ignorance, or from prejudice towards LGBT people. Consequently, LGBT clients may find it difficult to come out to service providers.<sup>94</sup>

They may have been rejected by their community, family and/or friends and lack personal support. Further, the 'gay scene' can be intimidating and expensive, and LGBT asylum seekers may not feel comfortable or able to participate.<sup>95</sup>

In relation to detention, it has been noted that male to female transgender asylum seekers have been placed in male accommodation (and vice versa) and have been discriminated against violently. If detainees are placed in country groups, LGBT asylum seekers may face discrimination from their own community members. Detention centres have no guidelines regarding the treatment of LGBT detainees.<sup>96</sup>

In relation to dispersal, LGBT asylum seekers may not find suitable places to socialise in smaller towns and cities across the UK.<sup>97</sup>

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<sup>94</sup> Jivraj, S., De Jong, A. and Tauqir, T. (2002) *Identifying the difficulties experienced by Muslim lesbian, bisexual and transgender women in accessing social and legal services*

<sup>95</sup> **Researching Asylum in London** (2006) *Interview with representative of human rights organisation working with LGBT asylum seekers, 6/7/06*

<sup>96</sup> *Ibid.*

<sup>97</sup> *Ibid.*

## Asylum seekers with health care needs

### Physical health needs

Policy and legislation concerning the provision of healthcare for asylum seekers is the responsibility of the Department of Health.<sup>98</sup> Asylum applicants and people granted refugee status, Humanitarian Protection and Discretionary Leave are entitled to free primary medical care and medical services provided by the National Health Service (NHS) on the same basis as other residents.<sup>99</sup> It is estimated that 20% of asylum seekers and refugees in the UK have severe physical health problems.<sup>100</sup>

### Access to healthcare

Entitlement to healthcare is governed by the NHS Act 1977 and is amended by subsequent regulations. The Act establishes that charges may be levied for NHS services provided to people who are not 'normally resident' in the UK. The NHS (Charges to Overseas Visitors) Regulations 1989 – Statutory Instrument 1989 no. 306 came into force on 1 April 1989 and provided that refugees and those seeking asylum would be exempt from any charges for health services.

Statutory Instrument 2004, No. 614 – The NHS (Charges to Overseas Visitors) (Amendment) Regulations 2004 came into force on 1 April 2004 and amended the 1989 regulations such that asylum seekers whose claims have been determined and are not successful are no longer exempt from NHS charges for certain services. A number of services remain free of charge to failed asylum seekers, these include: primary care services, treatment at an accident and emergency or casualty department, treatment of specific communicable diseases, compulsory psychiatric treatment and treatment of sexually transmitted diseases (although in relation to HIV this only extends to an initial test and any associated counselling).

### Primary healthcare

Asylum seekers are entitled to register with a GP; however Department of Health guidance discourages GP surgeries from registering failed asylum seekers.<sup>101</sup> Evidence suggests that even asylum seekers can find it very difficult to register with a GP<sup>102</sup>, especially due to a lack of suitable documentation to prove their address and identity. This can lead to increased pressures on Accident and Emergency (A&E) departments, as asylum seekers may present themselves with routine conditions that are not usually dealt with at A&E.<sup>103</sup> A recent report into the gaps and needs within health services for asylum seekers found that some services are struggling with the range of complex issues that are presented to them by asylum seekers. Furthermore, there was concern that some asylum seekers were avoiding using health

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<sup>98</sup> Joint Committee on Human Rights (March 2007) *The treatment of asylum seekers, Tenth report of session 2006-7*

<sup>99</sup> Joint Council for the Welfare of Immigrants (2006) *Immigration, nationality and refugee Law handbook*

<sup>100</sup> Refugee Council (June 2006) *First do no harm: denying healthcare to people whose asylum claims have failed*

<sup>101</sup> Joint Committee on Human Rights (March 2007) *The treatment of asylum seekers, Tenth report of session 2006-7*

<sup>102</sup> Peel, M. and Burnett, A. (2001) 'Asylum seekers and refugees in Britain: What brings asylum seekers to the United Kingdom?' *BMJ*, vol. 322, pp 485-488

<sup>103</sup> Joint Committee on Human Rights (March 2007) *The treatment of asylum seekers, Tenth report of session 2006-7*

services because of fear that using the service might negatively impact on the outcome of their asylum application.<sup>104</sup>

### Secondary healthcare

The charging regulations mean that refused asylum seekers are now liable for hospital charges and are no longer entitled to free NHS routine hospital treatment. The Joint Committee on Human Rights' recent investigation into the treatment of asylum seekers heard testimony that asylum seeking patients with life threatening conditions and people with HIV/AIDS had been refused hospital treatment in the UK. The report documents cases of hospitals wrongly charging asylum seekers who were entitled to free treatment or refusing to treat asylum seekers if they could not pay the charges.<sup>105</sup>

### Charging for healthcare

There has been criticism of the change in the eligibility criteria for free access to the NHS. The main objections include:

- There are moral reasons why anyone who approaches the NHS for assistance should be provided with help. This is especially the case when limited medical intervention is needed when it may not be 'immediately necessary', in order to prevent a serious threat to health in the future.<sup>106</sup>
- There is an economic benefit to treating medical conditions before they become an emergency.<sup>107</sup>
- Asylum seekers that have not been successful in their claim are not necessarily removed from the country straight away. They may remain in limbo for an extended period because it is not safe enough to return them home, or because there is just not the capacity to carry out their removal at that time. Whilst they are waiting to be removed unsuccessful asylum applicants will only be eligible for free access to emergency care or treatment that is 'immediately necessary'. All other forms of treatment will be charged for but they will not be entitled to benefits or able to work.
- Doctors will have an increased workload as a result of having to administer the new system.<sup>108</sup>
- Asylum seekers will be further stigmatised.<sup>109</sup>

### HIV/AIDS

HIV tests and related counselling is provided free to all asylum seekers, however HIV treatment and medication is chargeable for failed asylum seekers. Notably, treatment for other sexually transmitted infections for failed asylum seekers is free.<sup>110</sup> According to the World

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<sup>104</sup> Kanani, A., Webster, A., Ndegwa, D., Murphy, D. and Stevens, R. (2001) *Report on the gaps and needs within health services for refugees and asylum seekers*

<sup>105</sup> Joint Committee on Human Rights (March 2007) *The treatment of asylum seekers, Tenth report of session 2006-7*

<sup>106</sup> Migrant & Refugee Communities Forum (2004) *Proposals to exclude overseas visitors from eligibility to free NHS Primary Medical Services: A consultation response* and

Pollard, A. (7 August 2004) *Eligibility of overseas visitors and people of uncertain residential status for NHS treatment*

<sup>107</sup> Pollard, A. (7 August 2004) *Eligibility of overseas visitors and people of uncertain residential status for NHS treatment*

<sup>108</sup> Refugee Council (March 2004) *Changes to healthcare charges for asylum seekers*

<sup>109</sup> Migrant & Refugee Communities Forum (2004) *Proposals to exclude overseas visitors from eligibility to free NHS Primary Medical Services: A consultation response*

<sup>110</sup> Joint Committee on Human Rights (March 2007) *The treatment of asylum seekers, Tenth report of session 2006-7*

Health Organisation, the UK has not complied with the principles of universal access to HIV treatment, by refusing it to certain groups of people. Moreover, organisations have argued that denying HIV treatment to unsuccessful asylum applicants will deter them from taking HIV tests and will lead to an increase in undiagnosed cases and harm public health.<sup>111</sup>

### **Impact of dispersal**

Home Office policy states that dispersal will be delayed if an asylum applicant has HIV/AIDS, TB or severe mental health problems. However, the policy emphasises that dispersal may still happen if the dispersal location can offer the same level of treatment that the asylum applicant is currently receiving in the area from which they are to be dispersed.<sup>112</sup>

Refugee organisations have voiced concern about the possible dispersal of asylum seekers with serious medical conditions.<sup>113</sup> HIV patients are particularly at risk: inappropriate dispersal of an HIV infected patient could lead to onward transmission of HIV infection, and avoidable mortality for the asylum seeker. A lack of continuity of care has been reported due to temporary registration at GPs and little notice being given before dispersal, therefore leaving insufficient time to arrange referrals. In some cases healthcare professionals are not informed that their clients are being dispersed.<sup>114</sup>

### **Mental health needs**

All asylum seekers are eligible to access mental health services at the primary care level and, following a GP referral, at the level of secondary care.<sup>115</sup> Literature on mental health provision for asylum seekers refers to the need for cultural consideration and understanding when working with this client group. For example, different refugee communities may experience and express mental illness in different ways to the host population; and it has been argued that mental health professionals should be aware that there are other models of mental health intervention beyond commonly practiced 'Western' methods.<sup>116</sup>

### **Mental health service provision**

Some practitioners would like to see a culturally sensitive assessment of mental health needs built into the asylum process, applicable to all asylum seekers on arrival in the UK, which if necessary, should be conducted using properly trained interpreters.<sup>117</sup> Furthermore, it is recognised that mental health services should respond to the different stages of the asylum process and should be sensitive to periods where clients may be particularly vulnerable, for example on receipt of a negative asylum decision.<sup>118</sup>

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<sup>111</sup> **Joint Committee on Human Rights** (March 2007) *The treatment of asylum seekers, Tenth report of session 2006-7*

<sup>112</sup> **Home Office** (December 2005) *Policy bulletin no. 85 – Dispersing asylum seekers with health care needs*

<sup>113</sup> **Refugee Council** (August 2005) *Response to the final draft NASS policy bulletin on dispersing asylum seekers with healthcare needs*

<sup>114</sup> **Creighton, S., Sethi, G., Edwards, S. and Miller, R.** (2004) *Dispersal of HIV positive asylum seekers: national survey of UK healthcare providers*

<sup>115</sup> **Home Office** (December 2005) *Policy bulletin no. 85 – Dispersing asylum seekers with health care needs*

<sup>116</sup> **CVS consultants and Migrant and Refugee Communities Forum** (1999) *A shattered world: The mental health needs of refugees and newly arrived communities*

<sup>117</sup> **Watters, C. and Ingelby, D.** (November 2004) *Mental health and social care for asylum seekers and refugees*

<sup>118</sup> *Ibid.*

Much mental ill health amongst asylum seekers is directly related to the asylum process and isolation as a result of living in an unfamiliar environment and culture.<sup>119</sup> Research has shown that in many cases, if social factors are properly addressed, such as poor housing or social isolation, then the mental health of asylum seekers can improve significantly.<sup>120</sup>

### **Post Traumatic Stress Disorder**

Traumatic events, such as imprisonment; lack of shelter, food or water and torture, can be associated with a high prevalence of mental health issues such as: anxiety; concentration problems; sadness; nightmares; and recurrent memories of past events. Many of these symptoms fit the profile of Post Traumatic Stress Disorder (PTSD).<sup>121</sup> The Department of Health have identified PTSD as the most common problem amongst asylum seekers and refugees and has also observed that because of these mental health issues the risk of suicide amongst asylum seekers and refugees is raised in the long term.<sup>122</sup>

There has been much debate surrounding PTSD. Some practitioners believe that the symptoms which have come to be identified as PTSD are actually a natural human response to any experience of trauma and are concerned that it may be inappropriately used to pigeonhole asylum seekers' mental health conditions and is overly used as a 'catch-all' diagnosis.<sup>123</sup>

### **Refugee Community Organisations**

Refugee community organisations (RCOs) can play a significant part in reducing isolation amongst asylum seekers and are considered to be a valuable alternative form of support.<sup>124</sup> Members of RCOs often have skills in healthcare, including professional qualifications in mental health from their country of origin. In this respect it can be useful for members of RCOs to develop counselling skills to provide additional support to asylum seekers with mental health needs.<sup>125</sup>

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<sup>119</sup> Misra, T., Connolly, A. and Majeed, A. (July 2001) *Addressing mental health needs of asylum seekers and refugees in a London Borough: epidemiological and user perspectives*

<sup>120</sup> Summerfield, D. (2001) 'Asylum seekers, refugees and mental health services in the UK', *British Journal of Psychiatry*, vol. 25, pp.161-163

<sup>121</sup> Watters, C. and LeTouze, D. (undated) *Good practice in mental health and social care for refugees and asylum seekers*

<sup>122</sup> Department of Health (2007) *National service framework for mental health: modern standards and service models*

<sup>123</sup> Summerfield, D. (2001) 'Asylum seekers, refugees and mental health services in the UK', *British Journal of Psychiatry*, vol. 25, pp.161-163

<sup>124</sup> Peel, M. and Burnett, A. (March 2001) 'Asylum seekers and refugees in Britain: Health needs of asylum seekers and refugees', *BMJ*, vol. 322 pp 544-547

<sup>125</sup> *Ibid.*

## Disabilities

Disabilities amongst asylum seekers may result from their experiences in their country of origin and connected to the reason they are seeking asylum or they may be independent of it. Their specific needs have particular implications for service provision, which is the principal subject of discussion in the literature on disabled asylum seekers. The Disabilities Discrimination Act (2005) defines disabilities as when a person has “a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities”.<sup>126</sup>

### Key issues

Asylum seekers are not entitled to disability-related benefits. They can request a community care assessment from social services and the relevant local authority decides whether they are eligible to receive services and whether they will charge for these services.

It has been argued that entitlements to services for disabled asylum seekers are confusing and unclear. Lack of awareness of entitlements exists amongst service providers as well as asylum seekers themselves.<sup>127</sup> Loopholes persist in the law which leads to inactivity or disputes between NASS and social services departments in relation to the responsibility for asylum seekers with community care needs. In the *Westminster vs NASS* case in 2002, the court ruled that local authorities' responsibilities took precedence over NASS in terms of provision of support, support services and accommodation to asylum seekers with community care needs.<sup>128</sup>

There is inconsistency of practice between local authorities, with some categorising community care assessments as urgent whilst others give them no priority. Social services are divided into asylum seeker teams and disabilities teams, which creates confusion; asylum seekers are often passed between the two and can go without support for some time.<sup>129</sup>

Some concern has been articulated regarding the accommodation support provided for disabled asylum seekers. Temporary accommodation is often an unsuitable arrangement, because it takes time for disabled asylum seekers to become accustomed to their housing. Disabled asylum seekers may risk getting stuck in emergency accommodation if they resist dispersal, and this accommodation may not be appropriate to their needs.<sup>130</sup> Further, disabled asylum seekers may experience isolation, particularly if they live in unsuitable accommodation. An additional concern is the difficulties deaf asylum seekers may experience learning British sign language.<sup>131</sup>

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<sup>126</sup> Department for Work and Pensions (2006) *Provision of the Disability Discrimination Act 2006 – The definition of disability*

<sup>127</sup> Harris, J. (2003) *All doors are closed to us: a social model analysis of experiences of disabled asylum seekers and refugees in Britain*

<sup>128</sup> Roberts, K. and Harris, J. (2004) *'Not our problem': the provision of services to disabled refugees and asylum seekers*

<sup>129</sup> *Ibid.*

<sup>130</sup> Roberts, K. and Harris, J. (2002) *Working with disabled refugees and asylum seekers - Information workshop for refugee and social care practitioners*

<sup>131</sup> *Ibid.*

## Statistics

Some commentators have noted that finding data about refugees and asylum seekers with disabilities is difficult. The Home Office, NASS and most local authorities do not collect data on impairments experienced by refugees and asylum seekers. A 2001 study by Harris and Roberts estimates that there is a minimum of 5,312 disabled refugees and asylum seekers in Britain and that a maximum of 10% of refugees and asylum seekers are disabled. The same study identified a range of impairments amongst its respondents, the most common being physical disabilities (52%); 20% had mental health problems. The authors argue that accurate demographic data on asylum seekers with disabilities should be collected in order that disability-aware services and policies can be developed.<sup>132</sup>

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<sup>132</sup> Roberts, K. and Harris, J. (2001) *Disabled refugees and asylum seekers in Britain: numbers and social characteristics*

## Elderly

Available information on elderly refugees and asylum seekers is limited. Much of the literature addresses the long-term settlement and integration concerns of elderly refugees and there is little in relation to elderly asylum seekers. Although most refugees will remain in exile and therefore age here, few arrive as asylum seekers at an older age. In 2004, 3% of asylum applicants were aged 50 or over. It was more common for women asylum seekers to be elderly than men: 4% of women were 50 or over compared with 2% for men. As dependents, 2% of applicants were 50 or over; twice as many dependents were women than men.<sup>133</sup> The presence of women in the elderly category is notable, given that women account for less overall applications.

There are different definitions of what constitutes the elderly. A common conceptualisation in the UK is related to employment trends, where 60 for women and 65 for men is a conventional age of retirement. Refugee agencies have suggested a lower age when considering refugees and asylum seekers: 50/55+, because they may become physically and/or mentally frail due to their experiences of flight.<sup>134</sup> Others have suggested that the only practical option is to use self-definition for age.<sup>135</sup> Some elderly asylum seekers may not know their date of birth or they may have lost any record of it; this may prove problematic when applying for services that require date of birth for receipt of benefits.<sup>136</sup>

There is no specific legislation relating to elderly asylum seekers. Furthermore, there are no guidelines or policies on this subject included in the APIs for caseworkers.

Some concerns have been expressed regarding restrictions in healthcare services for asylum seekers, which may affect elderly asylum seekers more acutely.<sup>137</sup> Additional barriers to healthcare have been identified as language difficulties, lack of awareness of the health system<sup>138</sup> and of free treatments such as pharmacies and eye care.<sup>139</sup> Further concern has been articulated regarding the isolation of elderly asylum seekers. A UNHCR paper asserts that the needs of elderly refugees and asylum seekers are met most effectively within the community and family.<sup>140</sup> It has however been argued that the importance of these networks cannot be generalised; further, there is a stereotype that black and minority ethnic communities 'look after their own', and this may hide the isolation of elderly members of these communities further.<sup>141</sup>

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<sup>133</sup> Heath, T. and Jeffries, R. (August 2005) *Asylum statistics United Kingdom 2004*

<sup>134</sup> Refugee Council (2006) *Older refugees in the UK: A literature review*

<sup>135</sup> Coombes, N., Hutton, C. and Lukes, S. (1999) *Older but wiser: a report on the needs of older refugees for Refugee Council* (unpublished); Refugee Women's Association (2004) 'Older refugee women' in *Refugee Women's News*, issue 26

<sup>136</sup> Refugee Council (2006) *Older refugees in the UK: A literature review*

<sup>137</sup> *Ibid.*

<sup>138</sup> BME Health Forum and the Migrant & Refugee Communities Forum (2003) *Asylum pulse: Are we feeling it right? Health needs of refugees and asylum seekers in the boroughs of Kensington & Chelsea and Westminster*

<sup>139</sup> SLWF (Sierra Leone Women's Forum UK) (2003) *Report on the needs and gaps within services for asylum seekers and refugees within the Sierra Leone community in London*, London, Sierra Leone Women's Forum UK

<sup>140</sup> UNHCR (2002) *No safety net for older migrants and refugees* <http://www.un.org/ageing/prkit/oldermigrants.htm>

<sup>141</sup> Refugee Council (2006) *Older refugees in the UK: A literature review*

## Victims of torture

Torture is still prevalent in many countries throughout the world. Some asylum seekers have been tortured in their home countries and require specialist help in the UK. Torture is defined in various international instruments, including the UN Convention against Torture (CAT) and is considered to:

- cause severe pain or suffering, either physical or mental;
- be intentionally inflicted to obtain a confession or information, or to intimidate or coerce; and
- be inflicted by a public official.<sup>142</sup>

Article 3 of both the European Convention on Human Rights (ECHR) and CAT refer to torture and are considered absolute rights.<sup>143</sup> Article 3 of the ECHR states that no one shall be subjected to torture or to inhuman or degrading treatment or punishment, and Article 3 of CAT maintains an absolute bar on the removal of torture survivors where there are substantial grounds for believing that they would be in danger of being subjected to torture on return.<sup>144</sup> Under the 1951 Refugee Convention, an asylum seeker must demonstrate a well-founded fear of persecution (of which torture is a form) for one of the five Convention reasons.<sup>145</sup> For asylum applications in the UK the standard of proof is lower than criminal and civil proceedings and applicants must demonstrate that there is a 'reasonable degree of likelihood' that they have been tortured.<sup>146</sup>

### Support for victims of torture<sup>147</sup>

The Medical Foundation for the Care of Victims of Torture is the main specialist organisation in the UK which provides treatment and support to asylum seekers and refugees who have been tortured. Although not all the organisation's clients are refugees and asylum seekers, they make up most of its new clients. In 2006, 2,145 asylum seekers were referred to the Medical Foundation. They came from 86 countries, foremost among which were Iran, Democratic Republic of Congo and Eritrea. The largest client group were males, making up 56% of new referrals, followed by women (35%) and children (9%). Most clients were aged between 25 and 34.<sup>148</sup> According to one study, estimates of the proportion of asylum seekers who have been tortured vary from 5 - 30%, depending on the definition of torture used and their country of origin.<sup>149</sup> However, because of the nature of disclosure no reliable study of the numbers of asylum seekers who have been tortured exists.

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<sup>142</sup> **United Nations** (1984) *Convention against torture and other cruel, inhuman or degrading treatment or punishment*

<sup>143</sup> An absolute right is a fundamental right which cannot be limited in any way and is applicable in times of war or public emergency.

<sup>144</sup> **United Nations** (1984) *Convention against torture and other cruel, inhuman or degrading treatment or punishment*

<sup>145</sup> **United Nations** (1951) *Convention relating to the Status of Refugees*

<sup>146</sup> **Peel, M., Hinshelwood, G. and Forrest, D.** (2000) *The physical and psychological findings following the late examination of victims of torture*, Medical Foundation for the Care of Victims of Torture

<sup>147</sup> Note on terminology: Both the terms 'victims of torture' and 'survivors of torture' are used in the UK. Some argue that 'victim' is a Western concept and ignores the fact that these people are 'survivors' who live with the long-term effects of torture. See **CVS consultants and Migrant and Refugee Communities Forum** (1999) *A shattered world: The mental health needs of refugees and newly arrived communities*.

<sup>148</sup> **Medical Foundation for the Care of Victims of Torture** (2007) *Torture: Dispelling the myths - Annual Review 2006-7*

<sup>149</sup> **Burnett, A.** (2002) *Guide to health workers providing care for asylum seekers and refugees*

## Torture victims in the asylum process

The UK government has recognised that asylum seekers who have been tortured have particular needs and has made provision for this in several ways. For example, it is Home Office policy not to disperse asylum seekers who are receiving specialist treatment from the Medical Foundation and to consider covering the travel costs for asylum seekers who have to attend an appointment with the organisation.<sup>150</sup>

UNHCR believes that mechanisms to identify survivors of torture and violence are required at the earliest possible stage of an asylum procedure and that treatment of such persons should be granted to specialist medical staff and organisations.<sup>151</sup> However, the Home Office states that it is not for the Border and Immigration Agency (BIA) to judge whether a referral to the Medical Foundation would be in the best interests of the claimant and only where appropriate will the BIA advise the claimant of the existence of such help. Legal representatives, GPs, social workers and refugee agencies are best placed to help with referrals according to the Home Office.<sup>152</sup>

Under current government policy, in cases where independent evidence of torture exists, asylum seekers will only be detained in exceptional circumstances.<sup>153</sup> However, research has shown that victims of torture are detained even in cases where the Home Office has prior information obtained during an asylum interview of an applicant's past torture.<sup>154</sup> The Home Office also implements a three-tiered frequency of reporting policy, whereby asylum seekers who are certified as Medical Foundation cases are placed on a more relaxed reporting regime.<sup>155</sup>

The Medical Foundation is opposed to any asylum procedures taking place until a thorough medical assessment has been carried out and the asylum seeker has been allocated a GP.<sup>156</sup> Under the New Asylum Model, organisations have called for a degree of flexibility relating to the treatment of torture victims. There are concerns that substantive asylum interviews may take place before a detailed health assessment and therefore potential identification of a torture victim has occurred.<sup>157</sup>

## Dispersal

Home Office guidelines state that asylum seekers who have been accepted for ongoing specialist treatment with the Medical Foundation should be provided with accommodation where the treatment is provided (usually in London), rather than being subject to compulsory dispersal to other parts of the UK.<sup>158</sup> If dispersal does take place it may be in breach of the EU Reception Directive and Home Office policy bulletins numbers 19 and 83.<sup>159</sup> Furthermore, the

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<sup>150</sup> Home Office (January 2002) *Policy Bulletin 19 - The Medical Foundation for the Care of Victims of Torture*

<sup>151</sup> Medical Foundation for the Care of Victims of Torture (2004) *Response to the Implementation of Reception Directive*

<sup>152</sup> House of Lords (16 April 2007) *Written answers Immigration: Victims of Torture*

<sup>153</sup> Home Office (2006) *Operational Enforcement Manual, Chapter 38 - Detention and temporary release*

<sup>154</sup> Bail for Immigration Detainees (May 2005) *Fit to be detained? Challenging the detention of asylum seekers and migrants with mental health needs*

<sup>155</sup> Home Office (June 2005) *Contact management policy, process and implementation (CMPPI), Version 4*

<sup>156</sup> Medical Foundation for the Care of Victims of Torture (May 2006) *Response to NAM quality team proposition paper: Improving asylum decisions through early and interactive advice and representation*

<sup>157</sup> *Ibid.*

<sup>158</sup> Home Office (January 2002) *Policy Bulletin 19 - The Medical Foundation for the Care of Victims of Torture*

<sup>159</sup> Medical Foundation for the Care of Victims of Torture (May 2006) *Response to NAM quality team proposition paper: Improving asylum decisions through early and interactive advice and representation*

Home Office acknowledges that torture victims should not be placed in mixed or full board accommodation, as the institutional nature of such accommodation can provoke and exacerbate negative recollections of imprisonment.<sup>160</sup>

### Obtaining evidence

Torture survivors frequently do not disclose their torture early on in the asylum process. This may be through shame, distress, embarrassment, mistrust of officialdom, humiliation or unwillingness to disclose sensitive information of, for example, sexual violence to an immigration officer of the opposite sex.<sup>161</sup> Difficulties in disclosing information on torture may lead to some asylum seekers being inappropriately processed in the fast-track system. The Medical Foundation believes that to avoid such mistakes all asylum seekers must be treated as potential torture survivors first and foremost.<sup>162</sup> In the case of allegations of torture, it is Home Office policy for claims to be deferred or put on hold whilst medical evidence is sought, but only if the person has received an appointment with the Medical Foundation in writing.<sup>163</sup>

Agencies working with torture survivors have called on case owners and interpreters to be especially sensitive when interviewing potential victims of torture.<sup>164</sup> Regular breaks must be given during interviews and case owners and interpreters should take into account the overall well being of the interviewee at all times.<sup>165</sup>

Analysis of the ability of caseworkers to assess evidence of torture (both medical and applicant testimony) found an overuse of standard paragraphs in the 'reason for refusal' letters issued to failed asylum seekers. The study also found poor analysis of torture testimony by case owners and instances where medical evidence was downplayed, ignored or disputed.<sup>166</sup> In addition, a study conducted by the Medical Foundation recorded cases whereby evidence of torture had been documented, but failed asylum seekers were still being returned to their countries of origin.<sup>167</sup>

Asylum seekers may have been tortured years before they are examined in the UK and it is very rare for a doctor in the UK to examine asylum seekers less than six months after they were tortured. This can cause difficulties in documenting evidence and distinguishing between scars caused by torture and those caused by accidents or illness. Nevertheless, it is still possible for a doctor to provide a medical report.<sup>168</sup> Case owners are advised that an absence of conclusive physical signs does not disprove an allegation of torture.<sup>169</sup>

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<sup>160</sup> Home Office (January 2002) *Policy Bulletin 19 - The Medical Foundation for the Care of Victims of Torture*

<sup>161</sup> Burnett, A. (2002) *Guide to health workers providing care for asylum seekers and refugees*

<sup>162</sup> Medical Foundation for the Care of Victims of Torture (May 2006) *Response to NAM quality team proposition paper: Improving asylum decisions through early and interactive advice and representation*

<sup>163</sup> Home Office (undated) *Asylum Policy Instruction - The Medical Foundation for the Care of Victims of Torture*

<sup>164</sup> Gander, J. and Fox, A. (2004) 'Supporting victims of torture', *The Linguist*, vo.43, no.1 and

Medical Foundation for the Care of Victims of Torture (May 2006) *Response to NAM quality team proposition paper: Improving asylum decisions through early and interactive advice and representation*

<sup>165</sup> Medical Foundation for the Care of Victims of Torture (May 2006) *Response to NAM quality team proposition paper: Improving asylum decisions through early and interactive advice and representation*

<sup>166</sup> Smith, E. (February 2004) *Right first time?* Medical Foundation for the Care of Victims of Torture

<sup>167</sup> Peel, M. and Salinsky, M. (2000) *Caught in the middle: a study of Tamil torture survivors coming to the UK from Sri Lanka*, Medical Foundation for the Care of Victims of Torture

<sup>168</sup> Peel, M., Hinshelwood, G. and Forrest, D. (2000) *The physical and psychological findings following the late examination of victims of torture*, Medical Foundation for the Care of Victims of Torture

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