

RECOGNISING VICTIMS OF TORTURE IN NATIONAL ASYLUM PROCEDURES

A comparative overview of early identification
of victims and their access to medico-legal
reports in asylum-receiving countries



International Rehabilitation
Council for Torture Victims

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The International Rehabilitation Council for Torture Victims (IRCT) is an independent, international health-based human rights organisation, which promotes and supports the rehabilitation of torture victims, promotes access to justice and works for the prevention of torture worldwide. The vision of the IRCT is a world without torture.

For more information please visit www.irct.org



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List of abbreviations

APD	European Union Asylum Procedures Directive
BaFF	German Association of Psychosocial Centres for Refugees and Victims of Torture
BAMF	Bundesamt für Migration und Flüchtlinge – German Federal Office for Migration and Refugees
CEAS	Common European Asylum System
DIAC	Australian Department of Immigration and Citizenship
EASO	European Asylum Support Office
ECHR	European Convention on Human Rights
ECtHR	European Court of Human Rights
EU	European Union
GP	General Practitioner, i.e. a medical practitioner who treats acute or chronic illnesses and provides preventive care and health education to patients; a family doctor
ICCPR	International Covenant on Civil and Political Rights
ICE	United States Immigration and Customs Enforcement
MLR	Medico-Legal Report
NGO	Non-Governmental Organisation
OFPRA	L'Office français de protection des réfugiés et apatrides – French Office for the Protection of Refugees and Stateless Persons
PTSD	Post-Traumatic Stress Disorder
RCD	European Union Reception Conditions Directive
UKBA	United Kingdom Border Agency
UNCAT	United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
UNHCR	United Nations Refugee Agency
UNVFVT	United Nations Voluntary Fund for Victims of Torture
VoTs	Victims of Torture

Foreword

All member centres of the International Rehabilitation Council for Torture Victims (IRCT) work to ensure that victims of torture have access to appropriate health-based torture rehabilitation services. It is not only in countries where torture takes place that the victims need this support. Today we see an increasing number of asylum-seekers and refugees who are victims of torture but struggle to access the appropriate medical, psychological or legal and social assistance that would constitute fair and humane treatment during the asylum procedure.

The IRCT's members in the three regions covered in this report (Europe, North America and Australia and New Zealand) share a main focus on the rehabilitation of asylum-seekers and refugees. This report is based on the work of these experts who work directly with asylum-seekers and refugees to provide them with medical and psychological support, access to medico-legal reports and legal and social assistance during the asylum procedure. In addition, the members provide the rehabilitative treatment necessary to enable asylum-seekers and refugees to integrate and function in the host country where they have sought refuge.

In order to ensure their protection and access to rehabilitation, the early identification of asylum-seekers who have suffered traumatic experiences such as torture is a key issue for all organisations involved in the field of asylum. The wider use and acceptance as evidence of medico-legal reports, which meet the internationally recognised standards outlined by the Istanbul Protocol, also plays an essential role in asylum proceedings involving victims of torture. The introduction of a systematic early identification process of victims is therefore fundamental.

The IRCT has compiled this comparative overview on the early identification of victims of torture and the use and acceptance of medico-legal reports as evidence in asylum proceedings in regions where these issues are particularly relevant to our membership. The report analyses the responses from centres in 18 countries that participated in a survey. From these findings, we make a number of recommendations to stakeholders. In doing so, we hope to encourage them to address the gaps and shortfalls in the protection offered to victims of torture in national asylum procedures.

This report comes at a time when positive developments are taking place. Within the European Union, for example, the legal revisions of the Common European Asylum System (CEAS) were formally adopted in July 2013. These revisions create new obligations for the EU Member States to identify, through individual assessments, whether applicants are vulnerable persons who have special reception and/or procedural needs. In addition, EU institutions and EU Member States have shown a great interest in the application of the PROTECT-ABLE tool (a project supported by the IRCT), which has proven beneficial and cost-efficient for both national governments as well as rehabilitation centres as a way of screening for victims of torture.

However, there remains much to be done. Many of our members struggle financially to provide the best possible services to torture victims, including in the countries covered in this report. This is despite growing national and multilateral recognition of the right to rehabilitation as an absolute obligation within a victim of torture's right to reparation. IRCT members will continue to promote states' accountability for the provision of adequate and holistic rehabilitation to torture victims, including asylum-seekers and refugees. We encourage stakeholders to unite with IRCT members to work towards our global vision of a world without torture.



Victor Madrigal-Borloz,
Secretary General, IRCT

Introduction

The work of the IRCT

The IRCT is an independent, international health-based human rights organisation that promotes and supports the rehabilitation of torture victims, access to justice and the prevention of torture worldwide. The IRCT comprises more than 140 independent organisations in over 70 countries, making it the largest membership-based civil society organisation to work in the field of torture rehabilitation and prevention.

As a membership organisation, the IRCT's members are the focal point for the work of the organisation. Member centres provide expert knowledge and experience of working with victims of torture in diverse environments. The Secretariat works with its membership to develop the organisation's strategy, policy framework and project-led work.

The work of IRCT's member centres

IRCT member centres work within diverse regional, national and local contexts and within varied economic, cultural and political environments. The member centres offer rehabilitation programmes that are oriented towards different target groups and use various methods to address the effects of torture on individuals, families and communities.

The member centres participating in this report are all based in asylum-receiving countries and therefore offer a range of services, many of which target asylum-seekers or refugees. The report focuses on the three regions with a predominance of asylum-receiving countries: Europe, North America and the Pacific. The IRCT has considerable presence in all three of these regions: there are 51 member centres in 26 European countries; 31 of these are based in an EU Member State. The IRCT has 19 members in North America, and 10 members in the Pacific region. The centres offer a range of holistic rehabilitation services, including medical, psychological, legal and social support to asylum-seekers. Holistic support is essential for asylum-seekers in order to help them to address the multi-faceted problems that they may face as a result of past traumatic experiences and the post-migration situation in the host country.

Structure of the report

The report is structured in five parts. Part 1 of the report provides an introduction, outlining the key research objectives and gives an overview of the three regions so as to provide some background information on the asylum procedures in each of the regions (Europe, North America and the Pacific). Part 2 sets out the empirical analysis of the responses to IRCT's questionnaire. The key findings for each section of the questionnaire are laid out at the beginning of each section, followed by general observations and an analysis for each region. The sections relate to: the identification of victims of torture in the national asylum procedure; the access to medico-legal reports (MLRs) in the national asylum procedure; the provision of medical and psychological assistance to victims of torture; and specific aspects of the national asylum procedure.

Part 3 outlines IRCT's key recommendations for change and ways to overcome the shortfalls in protection that have been identified. To illustrate some of the critical gaps in the protection offered to victims of torture, Part 3 also highlights a number of examples where progress is either being made to strengthen the safeguards afforded to victims of torture in national asylum procedures, or where safeguards are lacking.

The concluding remarks in Part 4 of the report summarise the key shortfalls in the early identification of victims of torture and the use and acceptance of MLRs in asylum procedures. Part 5 lays out the IRCT's recommendations to stakeholders working in this field. The key recommendations made in this report will present a useful starting point for developing further advocacy in this area so as to ensure that victims of torture are treated appropriately within national asylum procedures.

Acknowledgements

This report would not have been possible without the valuable input of the member centres who responded to the IRCT's questionnaire. The IRCT is grateful for the responses to the questionnaire, and the additional comments and input to the report given by member centre staff and by Dr Jonathan Benyon.

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INTRODUCTION

Background

A brief overview of the right to asylum and the right to freedom from torture

The right to “seek and to enjoy asylum from persecution” was first enshrined in Article 14 of the Universal Declaration of Human Rights.¹ An asylum-seeker can obtain asylum if (s)he meets the UN Refugee Convention’s definition of a refugee, as someone who has a “well-founded fear of persecution on the grounds of race, religion, nationality, membership of a particular social group, or political opinion”.² The right to freedom from torture is enshrined in many international treaties, most notably the International Covenant on Civil and Political Rights (ICCPR) and the UN Convention against Torture (UNCAT).³ Regional conventions such as the European Convention on Human Rights (ECHR), the Charter of Fundamental Rights of the European Union and the American Convention on Human Rights also recognise it as a prohibited act.⁴ The acceptance that torture is forbidden under any circumstances, including war, public emergency or terrorist threat, indicates that universally it is considered as a fundamental principle of customary international law. This means that even states that have not ratified any of the international treaties explicitly prohibiting torture are banned from using it against anyone, anywhere, under any circumstances.⁵

Both the Refugee Convention and the UNCAT expressly prohibit the return of an asylum-seeker to a country where he/she may be at risk of torture.⁶

The right to rehabilitation for victims of torture who are asylum-seekers

Article 14 of UNCAT obliges a state party to “ensure in its legal system that the victim of an act of torture obtains redress and has an enforceable right to fair and adequate compensation including the means for as full rehabilitation as possible.” The Committee against Torture has provided non-binding interpretative guidance on how the State Parties should implement Article 14. It makes clear that a state has an obligation to ensure that all victims of torture and ill-treatment are able to access remedy and obtain redress, including those that suffered torture outside the state’s territory. Redress includes the means for as full rehabilitation as possible, which has been interpreted by the Committee to be “holistic and include medical and psychological care as well as legal and social services”.⁷ In addition, State Parties should adopt a long-term integrated approach to rehabilitation, ensuring that specialist services are available, accessible and appropriate to victims’ needs. According to the Committee, this should include “a procedure for the assessment and evaluation of individuals’ therapeutic and other needs, based on, *inter alia*, the Istanbul Protocol”.⁸ Thus, asylum-receiving states must be encouraged to recognise that asylum-seekers and refugees who are victims of torture must have early access to holistic rehabilitation services, including legal and social support.

Health problems amongst asylum-seekers and refugees

Research studies looking at the health problems prevalent in asylum-seekers and refugees have widely confirmed that they are at risk of having many, possibly severe, health problems of a varied nature.⁹ Pre-migration experiences, such as suffering torture, ill-treatment or sexual violence, will impact on the physical as well as mental health of an asylum-seeker, particularly where injuries sustained in the country of origin remain untreated. In addition, the journey to the asylum-receiving country may place the physical health of an asylum-seeker at greater risk due to poor sanitation, malnutrition and overcrowding, which are likely to occur on long journeys. In addition, the asylum-seeker may suffer stress and anxiety, and may also be at risk of further abuse such as exploitation, sexual violence or trafficking.

Post-migration factors will also affect the mental well-being of vulnerable asylum-seekers, including torture victims. Asylum-seekers often encounter difficulties with accessing information on asylum procedures or legal assistance, due to cultural or language barriers. This can lead to feelings of disorientation or isolation. The stress of leaving family, friends and community can be further compounded by the associated loss of status, personal identity and employment, which is experienced on arrival in the host country. For asylum-seekers who are detained while their application is outstanding, research shows that detention exacerbates their pre-existing physical and mental health conditions. These post-migration factors all increase the mental anguish and stress that many asylum-seekers may already be suffering and are further exacerbated by delays in the asylum procedure, i.e. long periods of time spent in a situation of uncertainty. The limitations on, and delays in, access to health care during this period can further exacerbate the mental and physical health of the individual. In its guidance on mental health and mental health care for migrants, the World Psychiatric Association notes that:

Refugees are perhaps the most vulnerable of all migrant groups to mental and physical ill health. Lack of preparation, attitudes of the new country, poor living conditions, poor or lack of employment and variable social support all add to this vulnerability. Rates of mental disorders may be high in some refugee groups: those of common mental disorders are twice as high in refugee populations in comparison with economic migrants.¹⁰

Research studies have found that rates of post-traumatic stress disorder (PTSD) can range from 20-40 percent, and anxiety and depression rates can vary from 30-70 percent within this population sector.¹¹ Studies have linked the incidences of depression and PTSD among asylum-seekers to traumatic events that they have suffered pre-migration, including torture.¹² It is generally estimated that between 5 and 35 percent of refugees are torture survivors.¹³

The physical and mental health problems that many asylum-seekers suffer indicates that there is an urgent need for national asylum procedures to identify vulnerable asylum-seekers, including victims of torture and other trauma, so that they are able to access justice, health care and rehabilitation services as early as possible in the asylum procedure. Many of the physical and mental health conditions caused by torture or ill-treatment have severe and long-term debilitating effects on the individual, which are exacerbated if left untreated. The delay in treating symptoms makes it harder for the individual to reintegrate into society and resume life as a normal, functioning individual. The debilitating effects caused by suffering torture or other trauma in the past are heightened in situations where the individual has been through a difficult and stressful journey to escape persecution, and is alone in a foreign culture without family or friends on whom to rely for financial and emotional support.

The Istanbul Protocol – documenting torture in asylum procedures

The Istanbul Protocol,¹⁴ adopted by the United Nations in 1999, sets out international standards for states and health and legal professionals, on the investigation and documentation of allegations of torture and other ill-treatment. Although the principles in the Istanbul Protocol are not legally binding, its adoption by the United Nations gives it global authority as an instrument that should be used to guide standards for the documentation and investigation of torture.¹⁵

By detailing the process of documenting medico-legal evidence, the Istanbul Protocol's key objective is to contribute to achieving justice and to the fight against impunity in cases of alleged torture and other ill-treatment. However, given the principle of non-*refoulement* of asylum-seekers, the proper investigation and documentation of allegations of torture and other forms of ill-treatment is often a key element of an asylum claim. Therefore, in asylum-seekers' cases, the systematic documentation of allegations of torture according to the Istanbul Protocol can also provide a foundation for both the asylum claim itself and for the rehabilitation of the victim.

In the three regions covered by this report — Europe, North America and the Pacific — the Istanbul Protocol is primarily used within asylum proceedings to assess possible victims of torture and to corroborate evidence of alleged torture.

The research objective

The purpose of this research is to gain a comparative overview of two interrelated issues that are critical to the treatment of victims of torture within national asylum procedures. The first is the early identification of victims of torture within the asylum procedure to ensure appropriate treatment. The second issue relates to the ability to effectively present medical evidence in support of the alleged claims of torture or ill-treatment, following the internationally recognised standards outlined in the Istanbul Protocol. The medical documentation can also serve as a part of the assessment of the rehabilitation needs of the victim.

Drawing from 25 years experience, the IRCT conducted this research to further support its advocacy work on the recognition and promotion of the use of medico-legal reports (MLRs) within asylum procedures. The research addresses the importance of identifying victims of torture at an early stage in the asylum procedure and highlights the main gaps in the protection offered to them. In addition, the results obtained from the comparative overview of the three regions covered — Europe, North America and the Pacific — can be used to highlight cross-cutting issues and challenges faced. Through this empirical research, the IRCT is able to identify the key issues that future advocacy activities should focus on.

Why early identification is essential

bzfo, Germany

We had a family from Chechnya. Both parents were victims of torture and the children, having witnessed the violence, also have psychological problems. The family was not granted asylum by BAMF (the German immigration authorities), despite bzfo providing an MLR during the court proceedings. An appeal has been lodged with the court, and bzfo asked that the proceedings be expedited as the mother's mental health has been getting progressively worse. However, there is no final outcome after several years. Costs of intensive treatment for the mother are accumulating, and the children's development is hampered by the protracted uncertainty.

The early identification of asylum-seekers as victims of torture or other traumatic events, and the offer of appropriate support to the applicant allows them to present their asylum application as fully as possible from the initial stage. Early identification allows asylum-seekers to access assistance to enable them to present medical evidence of a standard that meets international guidelines and which supports the alleged traumatic events. In addition, studies have shown that the presence of traumatic experiences and PTSD directly influence refugee-status decision-making as both can severely impact on the asylum applicant's memory and therefore ability to present the claim in what is perceived by decision-makers to be a credible way.¹⁶ The consistency of an asylum-seeker's account is often a central question to determining asylum status, and so an applicant who gives discrepant accounts of their experience at different points in the asylum procedure may be assumed to not be credible.¹⁷ Victims of torture are more likely to suffer from PTSD or other barriers to disclosure, for example, as a result of dissociation, shame, mistrust or avoidance. Therefore, it is paramount that victims of torture are able to access the relevant services to enable them to seek assistance from both medical and legal experts.

Early identification also enables health services to initiate and provide on-going medical support, which may prevent any physical or mental symptoms from becoming chronic. Physical or mental health problems of asylum-seekers, which go unrecognised and untreated because of the barriers to accessing health care, may also place a heavier burden on the state's health system in the immediate and long-term. Lack of early treatment causing the aggravation of symptoms may lead to an increase in the use of emergency services and even the eventual hospitalisation of the person, both of which will be more costly for the health system. Cost implications may also arise from the asylum-seeker (once a refugee) being unable to enter the job market and thus fully contribute to the economy of the host country.

One of the key objectives of this research is therefore to gain an overview of the current status in the main asylum-receiving countries in relation to the early identification of victims of torture within the national asylum procedures.

Why medico-legal reports are an important evidential tool in the asylum procedure

bzfo, Germany

We had a young victim of torture from Iran. On the initiative of both bzfo and the applicant's lawyer, we submitted an MLR (on somatic and psychological sequelae) with his asylum application. He was granted refugee status, and after receiving 25 sessions of trauma-oriented psychotherapy, he hardly has any PTSD symptoms. He is now studying and wants to start his own business.

A medico-legal report (MLR) is a report carried out by a medical expert that includes a physical and/or psychological evaluation of the victim, and the expert's opinion of the probable relationship of the physical and/or psychological findings to possible torture or ill-treatment.¹⁸ In relation to evidence, the use and acceptance of MLRs within the asylum procedure can be critical to a victim of torture's asylum case.

The IRCT believes that medico-legal reporting, according to the internationally recognised standards outlined in the Istanbul Protocol, is beneficial to both the asylum-seeker and the state assessing the asylum application, for the following reasons:

1. It helps to assess the consistency between the medical findings and the account of torture, ill-treatment or trauma made by the asylum-seeker in his/her claim for protection;
2. It decreases the number of procedures and appeals necessary to correct previously incomplete evidence in support of the asylum claim;
3. It improves the quality of the decision-making process by ensuring the information provided in support of the allegations is in conformity with internationally recognised standards.

The use of an MLR as evidence allows an expert opinion to be given on the degree to which medical or psychological findings correlate with the alleged victim's allegation of abuse. The MLR is used as an evidential tool that effectively communicates the clinician's medical or psychological findings and interpretations to the decision-making authorities and the judiciary. It should be used as early as possible in the asylum procedure to ensure that decision-making authorities have the strongest evidence available when reviewing the applicant's case.

The increased use and acceptance of MLRs to support allegations of torture or ill-treatment must be accompanied by training for decision-makers on how to interpret findings in the MLR. Decision-makers need to understand the effects torture can have on an asylum-seeker's ability to recount events.

If decision-makers are sufficiently trained, the quality of decision-making at the early stages of the asylum procedure improves. An improvement in the quality of decision-making leads to less protracted time-scales for the determination of an asylum application, as better decision-making in the early stages decreases the likelihood that the decision will be appealed. Shorter time-scales for determining an asylum claim have a positive impact on the asylum-seeker, as it enables them to commence the necessary steps to fully integrate in the host country once they have been accepted as a refugee. The second key objective of this research is to understand how widely MLRs are already accepted within national law and policy in asylum-receiving countries, and whether there are any limitations on when MLRs are accepted as evidence. An overview of the types of organisations that are accepted as providers of MLRs and how the cost of producing an MLR is funded is essential for IRCT's future advocacy activities.

Scope

An overview of the regions featured in this report

The research is intended to give a comparative overview of the way that victims of torture are identified during the asylum procedure and to what extent MLRs are used and accepted as an evidential tool. The three regions covered by the research are: Europe (EU and non-EU countries), North America (Canada and the USA) and the Pacific (Australia and New Zealand). These regions were chosen on the basis that they all have IRCT member centres present that work directly with asylum-seekers and refugees, which are an invaluable primary source of information. In addition, the participating countries in each region are considered by the UN Refugee Agency (UNHCR) to be industrialised asylum-receiving countries.

According to the UNHCR, the number of asylum applications made in industrialised countries (the regions covered by this research, plus Japan and South Korea) increased by 21 percent (2010/2011) and by a further 8 percent (2011/2012).¹⁹ Overall, around 46 percent of asylum claims in the industrialised countries were submitted by individuals from Asia, around 25 percent from Africa, 17 percent from Europe and 8 percent from the Americas.²⁰

The countries receiving the highest number of asylum applicants in 2012 were the USA, Germany, France, Sweden and the United Kingdom.²¹ In addition, some of the countries in this report — Canada, the USA and Australia — take a large proportion of the world's resettled refugees.²² Resettlement currently amounts to 80,000 places worldwide annually. However, with the adoption of the joint EU resettlement programme, it is expected that more EU countries will introduce resettlement programmes.²³

Europe – Key trends and developments in asylum

Asylum in Europe

- Europe saw a 9 percent increase in asylum applications (2011/2012)²⁴
- The EU saw a 40 percent increase in asylum applications but with contrasting trends in the 'old' and 'new' member states²⁵
- The Nordic countries experienced the highest relative increase in asylum applications compared to 2011 (38 percent)²⁶
- The southern European countries reported a significant drop in new asylum claims (-27 percent) compared to 2011.²⁷

Asylum procedures in the EU

The Common European Asylum System (CEAS)²⁸ includes a number of EU directives aimed at harmonising asylum systems within the EU by laying down minimum standards that EU Member States must transpose into their national asylum legislation. The directives with most relevance to the treatment of victims of torture are the Reception Conditions Directive, the Qualification Directive and the Asylum Procedures Directive.²⁹ In order to prevent asylum applicants making multiple claims within the EU, Member States have also agreed to terms under which an asylum applicant can be returned to the first EU Member State where he made an asylum application (Dublin II Regulation).³⁰

The goal of achieving a harmonised asylum system is far from being attained, evidenced by the numerous reports highlighting breaches of asylum-seekers' fundamental rights and inconsistent standards by which many Member States have implemented the EU directives.³¹ The European Court of Human Rights (ECTHR), in



its judgment in *MSS v Belgium and Greece* considered that there had been a violation of Article 3 ECHR by both Belgium and Greece due to the authorities' treatment of the asylum-seeker. The court attached considerable importance to the applicant's status as an asylum-seeker and, as such, a member of a particularly underprivileged and vulnerable population group in need of special protection.³² As part of the second phase of the CEAS, revisions to the asylum directives have been negotiated in order to iron out the ambiguities that have led to the poor implementation of the directives in many EU Member States and inconsistent standards in national asylum procedures. All directives within the CEAS framework were renegotiated and formally adopted by July 2013. EU Member States need to transpose the amendments into their national law at the earliest by July 2015.

North America – Key trends and asylum procedures

- | | |
|------------------------------|--|
| Asylum trends | <ul style="list-style-type: none"> • Asylum applications in the region increased by only 3 percent compared to 2011. • In Canada, asylum applications decreased by 19 percent. • By contrast, the USA saw a 10 percent increase in asylum applications.³³ |
| Asylum procedures in Canada | <ul style="list-style-type: none"> • Victims of torture or violence may be considered vulnerable or urgent cases within Canada's resettlement programme, in which case their resettlement application is prioritised ahead of regular refugee cases.³⁴ • For in-country applications, an application can be made at a port of entry or at an immigration centre. Claims considered to be eligible are referred to the Refugee Protection Division for a hearing before the Immigration and Refugee Board (IRB). • Some categories of applicant are given priority, including persons who have been identified as vulnerable. According to the IRB's published guidelines, this can include persons who have "experienced or witnessed torture or genocide or other forms of severe mistreatment".³⁵ • Cases may be decided within six months, although more complex cases have a longer processing period. Proposed legislation was reintroduced in 2012 that would penalize asylum-seekers arriving in Canada in an irregular manner, for example when smuggled by sea. The proposals include lengthy mandatory detention without timely review of the grounds of detention and other measures that violate international norms.³⁶ |
| Asylum procedures in the USA | <ul style="list-style-type: none"> • The refugee resettlement programme can grant refugee status to applicants outside of the USA. • Some asylum applicants enter the USA by other methods and seek asylum or other forms of relief, including protection under the UNCAT. There are two procedures for in-country applicants: <ul style="list-style-type: none"> • Affirmative procedure – for individuals who are lawfully present (e.g. on a student or tourist visa) or who have no lawful immigration status but have not been apprehended by immigration authorities. Applications are adjudicated in non-adversarial proceedings at Asylum Offices. The asylum officer will interview the applicant con- |

•••

cerning his eligibility for protection, and the US government makes no submissions against the application.

- Adversarial procedure – for individuals who have been placed in immigration court removal proceedings, i.e. asylum is raised as a defence against removal. The US government is represented in all cases by an attorney. However, the asylum-seeker often has no legal representation, as they are ineligible for free representation.³⁷
- The Department of Homeland Security takes responsibility for the processing of asylum claims. Within the Department there are three agencies likely to come into contact with VoTs: Immigration and Customs Enforcement (ICE), the interior enforcement branch; Citizenship and Immigration Services (CIS), which includes asylum officers and other adjudicators; and Customs and Border Protection (CBP), which handles inspections at land borders and airports.
- The “one-year bar” is a controversial rule whereby an asylum-seeker must prove they applied for asylum within one year of entering the USA or that they fall into one of two limited exceptions.³⁸ This rule does not take into account that many asylum-seekers who arrive in the USA have faced physically and mentally traumatic journeys and may not be able to familiarise themselves with the asylum system or even be aware that they are eligible to claim asylum.
- Applicants who are denied asylum may appeal the decision to the Board of Immigration Appeals, then to a Circuit Court of Appeals and finally to the US Supreme Court.³⁹
- If asylum is denied, but protection is given under the UNCAT, benefits are limited as they do not lead to permanent residence or citizenship, and do not provide derivative protection for dependents. In contrast, an asylee can obtain asylum for the dependent spouse and minor children and may apply after a year for permanent residency, and after five years for US citizenship.⁴⁰

The Pacific – Key asylum trends and procedures

Asylum trends

- The number of asylum applications in the region increased by 36 percent during 2012.
- Australia saw applications increase by 37 percent.
- In New Zealand, the number of asylum applications lodged has remained fairly stable over the past seven years (on average 300 new claims per year).⁴¹
- Australia and New Zealand both provide for an annual quota of resettlement refugees.

Asylum procedures in Australia

- There is a two-tiered refugee determination procedure depending on whether the asylum-seeker arrives on the mainland or at one of the excised offshore places (e.g. Christmas Island):
 - Arrival on the mainland – the Department of Immigration and Citizenship (DIAC) makes a primary assessment as to whether an applicant meets the criteria for refugee status. If the person is not a refugee but is at risk of human rights abuse on return, including torture, they might be eligible for complementary protection. If the



Asylum procedures in New Zealand

- person is assessed to be either a refugee or in need of complementary protection and satisfies health, identity and security requirements, they will be granted a protection visa.
- Decisions to refuse an application can be appealed to the Refugee Review Tribunal (RRT), or in some circumstances the Administrative Appeals Tribunal (AAT). In limited circumstances, the applicant can seek judicial review of negative decisions made by the RRT or the AAT.
 - Arrival at an excised offshore place – third country processing was introduced in 2012 for arrivals to an “excised offshore place” (e.g. Christmas Island), and was extended from May 2013 to apply to all boat arrivals in Australia. Under the system, asylum seekers who arrive by boat are transferred to a third country as soon as is reasonably practicable unless the Minister for Immigration exercises his discretion to exempt them from transfer.⁴²
 - Australia has a policy of mandatory detention for asylum-seekers who arrive in excised offshore places. Since August 2012, over 4,500 asylum-seekers have arrived at Christmas Island. The majority have been transferred to immigration detention facilities in Australia, where their claims for protection are unlikely to be processed for many months.⁴³
 - There is an annual quota of 750 resettled refugees, 600 of which fall under the ‘protection’ category. A further 75 are selected from ‘women at risk’ and the other 75 fall within the category of ‘medical/disabled’.⁴⁴ In 2007-2008, 19.2 percent of newly arriving refugees were found to have a history of torture.⁴⁵
 - New Zealand has incorporated and codified the Refugee Convention and its 1967 Protocol into national legislation through the Immigration Act 2009. A person can also be recognised as a protected person in accordance with either UNCAT or the ICCPR under the 2009 Act.
 - The Immigration Act 2009 contains provisions for the refusal to consider an application that is considered to be manifestly unfounded, clearly abusive or is a repeat of a previous claim. The individual has the right to appeal against this decision to the Immigration and Protection Tribunal. The Immigration Act 2009 established the Immigration and Protection Tribunal (IPT) to consider all grounds for appeal together in a single decision, where possible, including the refusal to grant refugee status, or decisions to remove or deport the asylum applicant.⁴⁶
 - There are current proposals to introduce mandatory detention for groups of asylum-seekers arriving by sea, similar to the policy followed in Australia.

Methodology

The report bases its findings on responses to a standardised questionnaire that was sent to rehabilitation centres (most of which are IRCT members) in Europe, North America and the Pacific region. The questionnaire consisted of 20 questions addressing different stages of the asylum procedure in order to evaluate:

1. The identification of victims of torture in the national asylum procedure;
2. The access to MLRs in the national asylum procedure;
3. The provision of medical and psychological assistance to victims of torture; and
4. Specific aspects of the national asylum procedure.

The questions were a mixture of multiple-choice questions, with an option to provide more detailed answers on specific areas, and open questions. In addition to findings gathered from the IRCT's questionnaire, background scientific research on the participating countries was carried out. Further information from a recent survey carried out by an IRCT member centre was referred to where relevant. The responses to the IRCT questionnaire have been analysed and key findings are presented in Part 2 of this report. Additional information provided by member centres is also referred to where relevant.⁴⁷ The results of the questionnaire and the analysis provide an overview of the current challenges and shortfalls in the treatment of victims of torture within national asylum procedures. A list of recommendations for key stakeholders has been drawn up from the key findings with the objective of shaping further advocacy work in this area.

The participating centres

The questionnaire was sent to a total of 80 centres in 30 countries in Europe, North America and the Pacific region. Out of a total of 80 centres, 24 responded to our questionnaire. This amounted to a response rate of 30 percent. However, two responses from Europe were a nil response, i.e. they did not have the expertise to provide answers as the centres did not work directly with asylum-seekers.⁴⁸ In total, IRCT received a response from at least one member centre in 18 of the 30 countries covered. By region, IRCT received completed questionnaires from all countries in North America and the Pacific regions but only from 14 countries in Europe. Within the latter, ten responses were from EU Member States (including one accession country), and four from non-EU countries (this includes two EU candidate countries).⁴⁹

The following countries and IRCT member centres are represented in the report:

		Country	Centre
EUROPE	EU Member States	Bulgaria	Assistance Centre for Torture Survivors (ACET)
		Croatia	Rehabilitation Centre for Stress and Trauma (RCT)
		Finland	Centre for Torture Survivors in Finland (CTSf) at Helsinki Deaconess Institute
		France	Parcours d'Exil - Accompagnement Thérapeutique des Victimes de Torture
		Germany	Berlin Center for the Treatment of Torture Victims (bzfo)
			Medical Care Service for Refugees Bochum (MFH - Bochum)
		Hungary	Cordelia Foundation for the Rehabilitation of Torture Victims
		Ireland	SPIRASI - The Centre for the Care of Survivors of Torture
		Italy	Hospitality and Care for Victims of Torture, Italian Council for Refugees (VI.TO/CIR)
		Netherlands	Institute for Human Rights and Medical Examination (IMMO)*
	Psychological Centre South Netherlands (RvA NL)		
	Sweden	Swedish Red Cross Centre for Victims of War and Torture, Malmö	
	non-EU states	Armenia	Foundation Against the Violation of Law (FAVL)
		Kosovo	Kosova Rehabilitation Centre for Torture Victims (KRCT)
Moldova		Memoria Medical Rehabilitation Center for Torture Victims (RCTV Memoria)	
Turkey		SOHRAM-CASRA Centre of Social Action, Rehabilitation and Readjustment	
NORTH AMERICA	Canada	Réseau d'intervention auprès des personnes ayant subi la violence organisée (RIVO)	
	USA	Advocates for Survivors of Torture and Trauma (ASTT)	
		Northern Virginia Family Services (NVFS) Program for Survivors of Torture and Severe Trauma (PSTT)	
PA-CIFIC	Australia	The Victorian Foundation for Survivors of Torture Inc.- Foundation House (VFST)	
	New Zealand	Refugees As Survivors New Zealand (RASNZ)	

* IMMO is not an IRCT member centre.

Limitations of the analysis

There are a number of limitations to this analysis, in part due to time and funding constraints. The findings are based on primary sources, i.e. the responses of the member centres; however, only 30 percent of the total number of centres that were sent the IRCT questionnaire completed it. This means that some countries are not represented, particularly in Europe. For example, the IRCT member centres in Central and Eastern Europe, e.g. Albania, Georgia and the Russian Federation did not complete the questionnaire. In addition, some countries in southern Europe are not represented in the report because the IRCT does not have member centres namely Portugal, Spain or Greece. This is a limitation given that in recent years southern Europe, particularly Greece and Italy, have experienced a dramatic increase in asylum-seekers resulting in widespread problems with accessing the national asylum procedure, health care and reception facilities.⁵⁰

Secondly, there are limitations in relation to the resources available to conduct a research project that spans 18 countries with very diverse legal systems. However, this limitation does not detract from the main objective of the research - to provide a broad comparative overview of the current treatment of victims of torture within national asylum systems with reference to the issues focused on in the questionnaire.

2

FINDINGS BASED ON IRCT MEMBER CENTRES' RESPONSES

The identification of victims of torture in the national asylum procedure

The questions in this section sought to elicit whether asylum-seekers are identified as victims of torture (VoTs) in the national asylum legislation, and whether the national legislation sets out who is in charge of their identification. Member centres were also asked whether there is a specific procedure in place for the early identification of VoTs, and, if so, at what stage of the asylum procedure early identification takes place. Finally, member centres were asked whether the authorities in charge of the identification of VoTs receive any training.

Key findings on the identification of victims of torture in the national asylum procedure

- The asylum interview is the most common method for identifying VoTs (83 percent of participants referred to it as a method). Only 50 percent of countries indicate that medical screening is provided in national legislation as a method for identifying VoTs.
- Seventy-seven percent of the participating countries indicate that there is no national legislation to determine who is in charge of identifying VoTs within the national asylum procedure.
- The Pacific region has the most developed system for identifying vulnerable persons within the asylum procedure. However, the means for identifying VoTs is implemented through policy or practice, not through legislation.
- Most of the EU Member States indicate that there are no special procedures for the early identification of vulnerable persons, including VoTs, in the national asylum procedure. With the new provisions to the Reception Conditions Directive, Member States will be obliged to assess vulnerable persons to ensure that they identify those with special reception needs (see Part 3).

QUESTION 1

According to national legislation, how are vulnerable asylum-seekers identified as VoTs by the national immigration authorities?

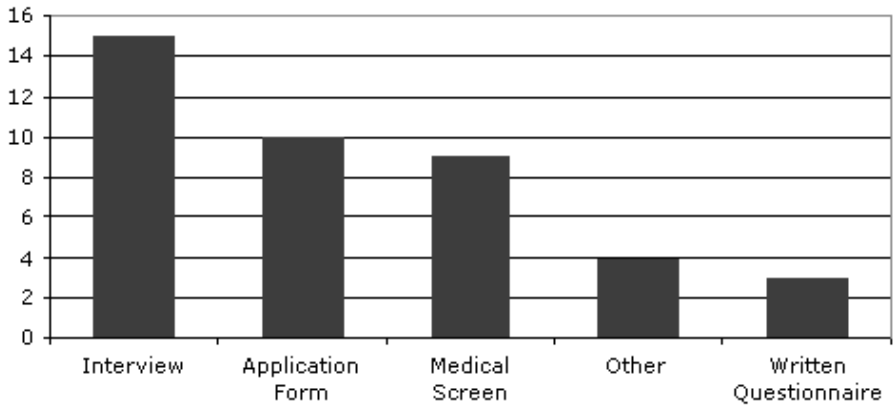
Member centres were asked to indicate whether VoTs were identified (a) by providing background information on the asylum application; (b) by interview(s); (c) by written questionnaire; (d) by medical screening(s); or (e) by another method. Member centres were asked to indicate all methods used.

Swedish Red Cross, Malmö

“Worst practice occurs when an asylum-seeker in the asylum interview has told immigration authorities that he/she has been tortured and is told by the Migration Board that it is the asylum-seeker’s own responsibility to find assistance to submit the necessary evidence.”

General observations

In all three regions covered by the report, the asylum interview is the most common method used by the national immigration authorities for identifying VoTs. Of the 18 countries represented in the questionnaire, organisations in 15 countries (83 percent) indicated that national legislation states that VoTs should be identified at the asylum interview. Centres in ten countries (55 percent) indicated that national legislation expects identification through the asylum application form itself, and centres in nine countries (50 percent) indicated that national legislation states that medical screening can be used to identify VoTs to the immigration authority.



Country	Interview	Application Form	Medical Screen	Other	Written Questionnaire
Armenia	•	•	•	•	•
Australia	•	•	•	•	
Moldova	•	•	•		•
Hungary	•	•	•		
Netherlands	•	•	•		
Kosovo	•	•	•		
USA	•	•		•	
Turkey	•	•			•
Canada	•	•			
Germany	•	•			
Finland	•		•		
New Zealand	•		•		
Bulgaria	•				
Croatia	•				
Sweden	•				
Italy			•		
France				•	
Ireland					

Europe

EU countries:

All the EU Member States participating in the questionnaire use the asylum interview and/or the application form to identify VoTs, apart from Italy and France. The member centres from France and Ireland confirmed that VoTs are not identified at all through national legislation. In Ireland, the measures that are in place to identify VoTs are according to custom and practice and have no basis in law. It is the asylum applicant's own responsibility, via their legal representative, to approach a centre for a medico-legal report to support their claim. Only Finland, Italy, Hungary and the Netherlands currently use medical screening as a method for identifying VoTs.

The changes to the Reception Conditions Directive — formally adopted in July 2013 — place an obligation on Member States to assess whether an asylum applicant has “special reception needs”, which could include a need for appropriate mental health care. It is hoped that the obligation on Member States to identify vulnerable asylum-seekers will encourage more states to use medical screening as a method of identification early on in the asylum process.⁵¹ Some Member States are already piloting schemes in which medical screening is used. For example, one of the member centres in Germany (bzfo) highlighted that asylum-seekers normally fill out a short application form and have an interview in which they are able to raise allegations of torture. In addition, there is a pilot project being conducted in some areas of Germany that introduces medical and psychological screening of vulnerable groups, including VoTs. However, the pilot project is not currently part of the national legislation.

Rest of Europe:

The asylum interview is also the most common method of identifying VoTs in non-EU countries that participated in the survey. Centres in Armenia and Moldova indicated the most possible methods for identification. In Armenia, there is no special procedure set out by the national legislation on who is in charge of the early identification of VoTs. However, there is a general procedure in place for the designating bodies to conduct health checks.⁵² In Kosovo, the reception centre sends all asylum-seekers for the first general medical screening within 24 hours of their arrival. In addition, psychological reports provided by the IRCT member centre (KRCT) are also used to identify VoTs.

North America and the Pacific

All four countries in these regions use the asylum interview to identify VoTs. All, except New Zealand, also use the application form. Only Australia provides in its national legislation for the use of medical screening to identify VoTs. In the USA, medical and psychological evaluations are not part of the standard asylum process. An applicant will only obtain an evaluation if they are able to access a rehabilitation centre that is able to provide one. Asylum-seekers may provide proof (medical and psychological reports, for example) to support their asylum claims.

In Australia, the method used for identifying vulnerable asylum-seekers depends on how they have entered the country. Asylum-seekers who enter the country without a visa are automatically detained and are given an initial health interview as part of the detention screening process, during which any allegations of past torture or ill-treatment should be picked up. For persons making a protection claim after they have entered the country on a valid visa, identification as a VoT will depend on the applicant disclosing the allegations as part of the asylum claim, i.e. in the application form or at the interview.

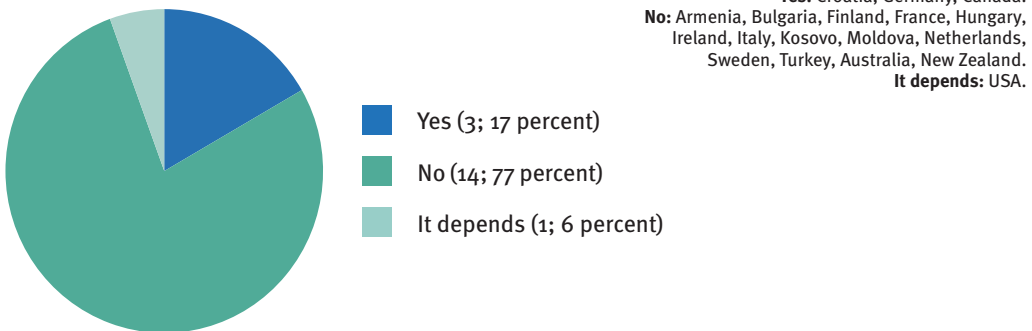
QUESTION 2

Does the national legislation set out who is in charge of identifying VoTs?⁵³

General observations

The majority of respondents across all three regions (77 percent) stated that there is no national legislation laying out who is in charge of identifying VoTs within the national asylum procedure. Only centres in three countries (17 percent) confirmed that there is national legislation setting out who is in charge of identifying VoTs (two countries from Europe and Canada).

Does the national legislation set out who is in charge of identifying VoTs?



Europe

Croatia and Germany are the only two countries in Europe that have national legislation that sets out who is in charge of identifying VoTs. In Croatia, the Ministry of the Interior is in charge of the asylum procedure. This includes determining whether an asylum claim is justified, including on the basis that the individual is a VoT. Therefore, the national asylum legislation gives authority to the Ministry of Interior to identify VoTs, although the legislation does not explicitly mention the identification of VoTs in the asylum procedure or indicate who specifically is in charge of that activity. In Germany, the Federal Office for Migration and Refugees (BAMF) has responsibility for identifying VoTs, and the officials in charge are either legal or administrative staff. The BAMF officials receive training on asylum, interview techniques and country credibility; some officials receive additional training on trauma. Training is mainly provided in-house but also by specialised external experts and NGOs, for example Baff centres.⁵⁴ The training provided by independent experts is not carried out on a regular basis. There is also a lack of training on intercultural communication and communication using interpreters.

North America and Pacific

One centre in the USA and the Canadian centre both confirmed that the relevant immigration authorities are responsible for identifying VoTs. In the USA, division of responsibility is split within the asylum system between the Department of Homeland Security, which has responsibility over immigration officers during the refugee processing stage, and the Department of Justice, which has responsibility over immigration judges during immigration court proceedings. Immigration officers and immigration judges may receive training, some of which is provided by centres working with VoTs, such as ASTT. However, they are not responsible for identifying VoTs, unless the applicant makes a claim under the Convention against Torture. In Canada, the Immigration Refugee Board (IRB) is responsible for iden-

tifying VoTs.⁵⁵ There is no national legislation setting out who is in charge of identifying VoTs in either Australia or New Zealand.

QUESTION 3

Is there a specific procedure for the early identification of VoTs?

QUESTION 4

According to national legislation, when must the procedure for early identification of VoTs take place?

Respondents were asked to confirm the stage at which early identification of VoTs should take place, according to national legislation: (a) when the asylum application is lodged; (b) on arrival at the reception centre; (c) during the qualification process; (d) other.

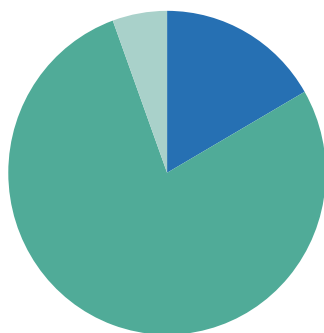
QUESTION 5

Does the national legislation set out who is in charge of the early identification of VoTs?

General observations

The majority of those responding state that their respective country does not have a specific procedure in place for the early identification of VoTs (72 percent). Of the three countries with a specific procedure for early identification, two are in the Pacific (Australia and New Zealand). The member centres in Germany gave differing responses as to whether there is a specific procedure in place for early identification of VoTs.

Is there a specific procedure for the early identification of VoTs?



- Yes (3; 17 percent)
- No (14; 77 percent)
- Not sure (1; 6 percent)

Yes: Moldova, Australia, New Zealand.
No: Armenia, Bulgaria, Croatia, Finland, France, Hungary, Ireland, Italy, Kosovo, Netherlands, Sweden, Turkey, Canada and USA.
Not sure: Germany

Europe

The majority of respondents indicated that their country in Europe (both EU and non-EU) do not have a special procedure in place for the early identification of VoTs. Only RCTV Memoria confirmed that there is a specific procedure for the early identification of VoTs in Moldova, and identification may take place at any step of the asylum process, i.e. when an application is lodged, at an immigration reception centre or during the qualification process. In many cases, VoTs are identified as such during examination and assistance at the member centre.

The situation in Germany depends according to the regional state: in some regions legal advisors and

social workers who work with the doctors carrying out the medical screening of asylum applications (e.g. for tuberculosis) can send persons to special services provided by NGOs to screen them and decide whether they belong to the defined group of vulnerable persons. This practice currently takes place in Bavaria, Berlin and Brandenburg, as part of an on-going pilot project; it does not form part of the national asylum procedure or national asylum legislation.

North America and the Pacific

In the USA, although the immigration system is national and so should not vary by state, the responses to Question 3 were mixed. Generally, an asylum applicant may self-identify as a VoT during the asylum process, but there is no specific procedure for early identification among asylum-seekers. If an applicant is in detention, their being a VoT may be an additional vulnerability. ASTT, the IRCT member centre based in Baltimore, Maryland, confirmed that the early identification of VoTs may take place when the applicant lodges the asylum application, during the qualification process, or when interviewed by border guards at an airport or port entry point. In Canada, there is no special procedure in place for the early identification of VoTs.

Both centres in Australia and New Zealand indicated that there are special procedures in place for the early identification of VoTs within the national asylum system but that these are implemented through policy or practice, not through any specific legislation. In Australia, the early identification of VoTs takes place either when the asylum application is lodged, or on arrival at a reception centre (for those applicants who arrive in Australia with no visa). In New Zealand, early identification of VoTs takes place during the qualification process.

Access to medico-legal reports in the national asylum procedure

This section considers the extent to which asylum-seekers have access to medico-legal reports (MLRs) to support their claim, how these are financed and the estimated costs of producing an MLR. Member centres were also asked about the acceptance of MLRs within the national asylum procedure in order to ascertain how widely MLRs are acknowledged as a relevant evidential tool within the national asylum procedure.

Key findings on access to medico-legal reports (MLRs) in the national asylum procedure

- MLRs are acknowledged in policy or practice in nearly all of the countries (73 percent) in this report. However, only centres in three countries indicated that MLRs are acknowledged by law (11 percent).
- In most countries (72 percent), an MLR can be submitted at any point in the asylum procedure. This will benefit VoTs who are not identified early on in the asylum procedure or who have trouble accessing services to assist them in producing an MLR.
- Public hospitals/health centres and NGOs (in 72 percent of the participating countries) are the main organisations accepted by the national authorities as being able to produce MLRs. Government institutions and private GPs are also accepted but to a lesser extent (in 44 percent of the participating countries).
- Sixty-six percent of the participating countries indicated that the costs of producing MLRs are supported in part by public or private funds. However, in 44 percent of the countries the individual is identified as having to bear the costs of the MLR themselves in certain circumstances. For example, this is likely where the asylum-seeker is not eligible for legal aid. Australia is the only country where the cost of an MLR is entirely publicly funded.
- The estimated cost of producing an MLR fluctuates widely depending on the time it takes to produce and the time spent assessing the patient. The average cost of producing an MLR across all three regions is around 800 Euros (based on responses from 78 percent of the participating organisations). Where an MLR is produced on a voluntary basis by a centre, it is often not possible to estimate the cost.
- There is a lack of training for health experts on the preparation of MLRs in a majority of the represented countries. This is a concern as training is essential to ensure that MLRs meet the standards outlined by the Istanbul Protocol.

QUESTION 6

Are MLRs acknowledged as relevant evidence in the national asylum procedure?

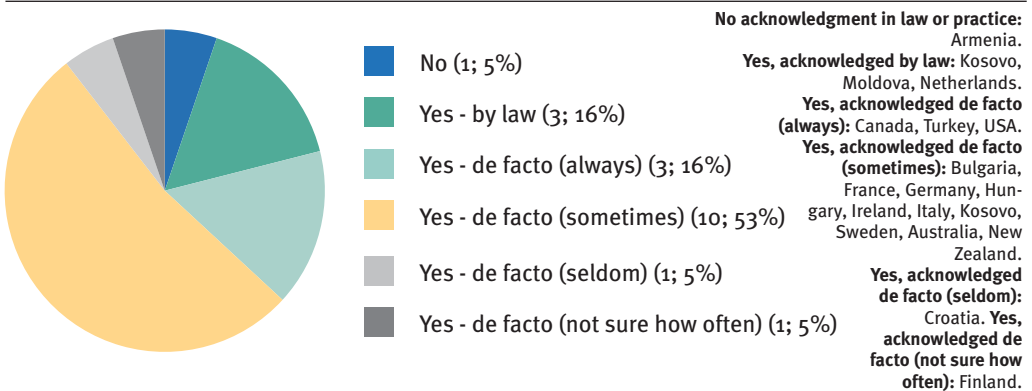
RvA NL,
Netherlands

“National asylum procedures seem completely unpredictable. MLRs appear to be treated in an inconsistent manner by the immigration authorities. The same quality MLR can at times help a victim of torture to obtain status whilst at other times it is ignored by immigration authorities.”

General observations

In most of the represented countries in all three regions, MLRs are not acknowledged in law, but are acknowledged in policy or practice (de facto) to varying degrees. Only centres in three countries (16 percent), all in Europe, confirmed that MLRs are acknowledged by law. MLRs are sometimes acknowledged as relevant evidence, either through policy or practice in over half the participating countries (52 percent). One organisation in a non-EU country indicated that MLRs are not acknowledged at all, which is concerning.

Are MLRs acknowledged as relevant evidence in the national asylum procedure?



CTSf, Finland

“An example of worst practice is when an MLR is provided as evidence but the decision-maker argues that the victim’s injuries could have arisen in any other way as well.”

Europe

EU countries:

Most of the centres in EU states indicated that MLRs are sometimes acknowledged as relevant evidence in policy or practice, but not by law. The Netherlands is the only EU state where MLRs are acknowledged by law to be relevant evidence in the national asylum procedure. The Dutch asylum regu-

lations mention MLRs in the instructions on the Aliens Law (Vreemdelingen­circulaire, Vc).⁵⁶ In Germany, bzfo highlighted a basic court rule introduced by the German Federal Administrative Court (Bundesverwaltungsgericht, BVerwG)⁵⁷ in 2007. The court rule states that if during the court proceedings an MLR is introduced by the asylum-seeker or the legal representative, which meets certain minimum standards, but where the judge does not acknowledge the diagnoses and prognosis, then the court should adjourn the hearing and order that a second full and independent MLR is obtained (funded by public funds). This rule should be applied during any asylum appeal proceedings and in deportation cases where a failed asylum-seeker is appealing a deportation order. This also should apply when an MLR meeting the minimum standards is introduced to BAMF before the first decision. However, BAMF rarely requests an MLR at the early stages of the asylum procedure, and therefore the proper investigation of an asylum-seeker’s allegation of past torture continues to not be realised in many cases.⁵⁸

In Croatia, the member centre indicated that MLRs are seldom acknowledged in practice. MLRs are not mentioned in either legislation or policies regarding the national asylum procedure. As a member of the EU from 1 July 2013, Croatia must ensure that national asylum legislation and policy is harmonised according to the minimum standards laid down by the relevant asylum directives that form part of the Common European Asylum System (CEAS).⁵⁹

Rest of Europe:

The centre in Armenia indicated that MLRs are not acknowledged. This is of concern as Armenia is a party to the European Court of Human Rights (ECHR). Further to the ECHR judgment in *RC v Sweden*, all parties to the ECHR should acknowledge the importance of MLRs as relevant evidence in asylum proceedings and the additional obligations to obtain medical evidence in asylum cases where allegations of torture have been raised.⁶⁰

On a positive note, centres in Kosovo and Moldova both indicated that MLRs are acknowledged by law, and the centre in Turkey indicated that MLRs are always acknowledged as relevant evidence in policy and practice. In Kosovo, the member centre confirmed that MLRs, including psychological reports produced by IRCT member centre KRCT, are used as evidence in practice during the asylum procedure. With the recent amendments to the Law on Asylum, asylum-seekers who have experienced torture or degrading punishment in their country of origin will receive additional protection.

North America

In the USA and Canada, MLRs are always acknowledged in practice or policy as relevant evidence in the national asylum procedure. In the USA, the applicant’s lawyer (if represented in the asylum proceedings) is usually the person who deems whether it is necessary to rely on an MLR as relevant evidence. The relevance of the MLR as evidence also depends on the qualification of the expert; for example, psychological evaluations must be conducted by a licensed mental health evaluator and are submitted as an affidavit in the asylum proceedings.

In Canada, the MLR is considered an important piece of evidence to be submitted to the Immigration and Refugee Board (IRB). Guidelines produced by the IRB note that the early identification of “vulnerable” persons is preferable “at the earliest opportunity”, and that, “Wherever it is reasonably possible, independent credible evidence documenting the vulnerability must be filed with the IRB

Foundation
House,
Australia

“Best practice is when the Tribunal accurately understands the purpose of the MLR and the way it can inform decision-making, and then applies the MLR’s conclusions to assist in the evaluation of the applicant’s credibility, capacity to undertake the hearing and his/her ability to inform the Tribunal of experiences relevant to the claim.”

Registry”.⁶¹ However, the weight given to such evidence will depend on the credibility of underlying facts in support of the allegations.⁶²

Pacific region

Both the centres in Australia and New Zealand confirmed that MLRs are sometimes acknowledged as relevant evidence in practice or policy.

In Australia, there are no explicit legislative guidelines acknowledging MLRs as evidence in the current legislation,⁶³ nor any reference to the use of MLRs in the Department of Immigration and Citizenship’s information on the initial assessment of claims. However, the Migration Review Tribunal and Refugee Review Tribunal have published non-binding guidelines that state that expert evidence, in the form of written reports provided by an applicant, may be submitted during a hearing. Expert evidence is generally submitted in the form of written reports, and the guidelines refer specifically to medical or psychological expertise. The guidelines also confirm that the Tribunal will have due regard to expert opinion and the basis upon which an expert has reached an opinion, including the use of clinical diagnostic criteria, the number and frequency of consultations and relevant experience.⁶⁴

QUESTION 7

When can an MLR be submitted in the national asylum procedure?

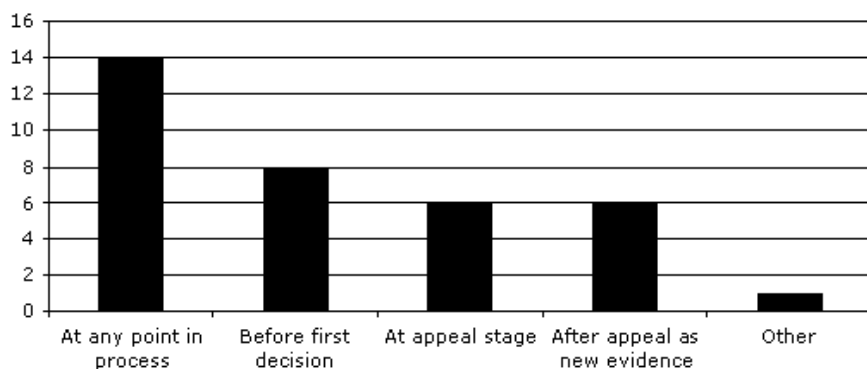
VI.TO/CIR,
Italy

“In a recent case, a woman showing severe psychological *sequelae* of extreme trauma appealed the refusal of her asylum application and submitted an MLR as evidence. The appeal court decided to grant subsidiary protection. In some cases where a severe clinical condition is certified in the MLR, humanitarian protection will be granted instead.”

Member centres were asked to specify at what stage of the asylum procedure an MLR could be submitted: (a) at any point in the asylum procedure; (b) before the first decision has been taken; (c) during the appeal stage; (d) after appeal, as new evidence to reopen the claim; or (e) other. More than one answer was possible and the responses are shown below.

General observations

Centres in 72 percent of countries represented in the survey indicated that an MLR can be submitted at any point in the asylum procedure. This gives a good indication that in the majority of countries participating in the survey an asylum-seeker should be able to submit medical evidence at any stage during the asylum process, and that MLRs can play a significant role in the asylum procedure. However, only 39 percent of represented countries indicated that an MLR is submitted before the first decision is made on the asylum application. The low figure shows that there remains a need to encourage states to acknowledge that the availability of medical evidence as early as possible in the asylum procedure is a benefit to both the applicant and the state. Considering the medical evidence early on in the asylum procedure avoids protracted decision-making and ensures that first decisions take all evidence into account. Early medical evaluation will also help the victim to seek treatment and rehabilitation. It is also important that the decision-maker receives training on how to consider an MLR with all other evidence available.



Country	At any point in process	Before first decision	At appeal stage	After appeal as new evidence	Other
Germany	•	•	•	•	
Sweden	•	•	•	•	
Turkey	•	•	•	•	
Bulgaria	•	•	•		
USA	•	•		•	
France		•	•	•	
Italy		•	•	•	
Netherlands	•				•
Finland	•				
Hungary	•				
Ireland	•				
Kosovo	•				
Moldova	•				
Canada	•				
Australia	•				
New Zealand	•				
Croatia		•			
Armenia	-				

Europe

EU countries:

Almost all centres in EU countries that answered this question indicated that an MLR can be submitted either at any point in the asylum procedure or at all stages, i.e. before a first decision, at appeal or after appeal. Although this is a positive indication that an MLR is accepted at all stages of the asylum procedure, it is important to ensure that an MLR is submitted as early on in the decision-making procedure as possible, for the reasons previously explained. However, the organisation in Croatia indicated that an MLR can only be submitted before the first decision is taken on the asylum application. There is no legislation or policy on this issue. In practice, there have been cases when an MLR is submitted at the appeal stage, but legal practitioners advise that an MLR is submitted as early on in the process as possible, to increase the likelihood that it is considered as relevant evidence.

In some EU countries, such as Germany, an MLR may be sufficient evidence to warrant an appeal of

a previous negative decision. However, the appeal can be processed in the accelerated procedure, which can disadvantage the asylum applicant, particularly as no explicit attention is given to whether applicants assigned to the accelerated procedure are VoTs or traumatised persons.⁶⁵ In most EU countries covered in this survey, there is the further possibility to submit a subsequent asylum application after the initial claim has been rejected.⁶⁶ In these cases, an MLR may be submitted as a new element as long as it meets the conditions to be accepted as a new fact or circumstance.⁶⁷

Rest of Europe:

Centres in the majority of countries in the rest of Europe indicated that an MLR can be submitted at any point in the process (Turkey, Kosovo, Moldova). The Armenian centre did not provide any information for this question.

North America and the Pacific

In Canada and the USA, MLRs can generally be submitted at any point in the asylum procedure. The Immigration and Refugee Board of Canada can suggest that an expert report be submitted, and this includes a medical, psychiatric, psychological or other expert report regarding the vulnerable person. However, the IRB will not order or pay for an expert report.⁶⁸ In the USA, there are no explicit policy rules determining that MLRs must be taken into account, but they can be used as corroborative evidence. Health professionals can submit expert testimony, which provides additional credibility. Both the centres in Australia and New Zealand indicated that an MLR can be submitted at any point in the asylum procedure.⁶⁹

QUESTION 8

What type of organisation is accepted by the national asylum authorities to produce an MLR?



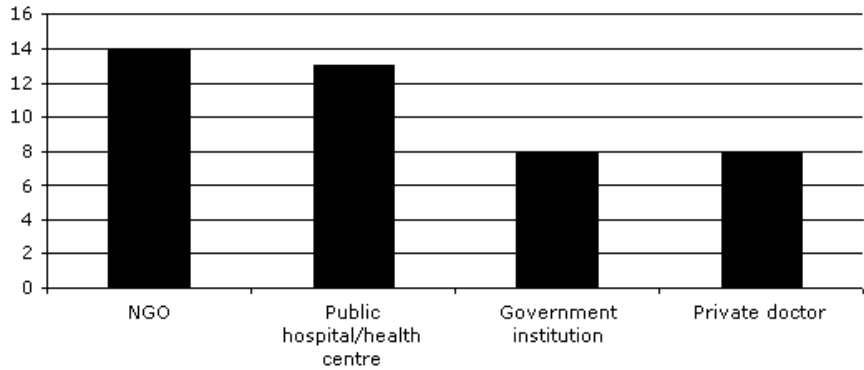
Cordelia
Foundation,
Hungary

“The consideration of MLRs has improved in recent years. Most NGOs now rely on MLRs produced by our centre when representing victims of torture in asylum proceedings.”

Member centres were asked to indicate what type of organisation is accepted by the national asylum authorities to produce an MLR: (a) a government institution; (b) a public hospital or health centre; (c) a non-governmental organisation (NGO); (d) a private general practitioner (GP), either as an individual or as part of a private health centre; (e) another organisation.

General observations

All respondents to this question indicated that at least two types of organisation are accepted to produce MLRs. In 89 percent of the countries that responded to this question reported that the authorities accept either an NGO or public hospital/health centre as being able to produce MLRs for asylum applicants. In 61 percent of countries, centres indicated that both these categories are accepted. Of note is that only 44 percent of the represented countries indicated that an MLR would be accepted if produced by a government institution.



Country	NGO	Public hospital/health centre	Government institution	Private doctor
France	•	•	•	•
Germany	•	•	•	•
Netherlands	•	•	•	•
USA	•	•	•	•
Hungary	•	•	•	
Croatia	•	•	•	
Moldova	•	•	•	
Finland	•	•		•
Italy	•	•		
Sweden	•	•		
Kosovo	•	•		
Ireland	•			•
New Zealand	•			•
Turkey		•	•	
Canada		•		•
Bulgaria	•			
Armenia	-			
Australia	-			

Europe

EU countries:

Centres in the majority of the EU Member States participating in this research reported that three or more types of organisations are accepted to produce MLRs for use in the national asylum procedure. Centres in France, Germany and the Netherlands indicated that all four categories are accepted providers. SPIRASI in Ireland indicated that MLRs are produced by either NGOs or private doctors, which could suggest that it is more likely that VoTs may risk missing out on accessing these services if they are only provided through private avenues. The member centre in Bulgaria confirmed that it is the only organisation that produces MLRs and referrals are usually either from lawyers or the victims themselves.

Rest of Europe:

There was some disparity in the rest of Europe. The centre in Moldova indicated that three types of organisations are able to produce MLRs, whereas centres in Kosovo and Turkey reported only two organisations. In Kosovo, medical reports are issued only by public health institutions, while IRCT member centre KRCT only issues psychological reports. In Turkey, MLRs are produced by either the public hospital/health centre or government institution. This means it is of paramount importance that the Istanbul Protocol guidelines are followed to ensure that the MLR is of a high quality, and that an impartial and independent doctor produces the report.

North America and the Pacific

There is some disparity between the types of organisations accepted to produce MLRs in the USA and Canada. Centres in the USA indicated that all four categories of organisation are accepted, whereas in Canada only the public hospital/health centre or a private doctor is accepted as being able to produce an MLR.

In New Zealand, MLRs are accepted from either NGOs or a private doctor. As with Ireland, this indicates that it is very much up to the VoT to seek this help of his or her own volition. The member centre in Australia reported that there is no specific type of organisation that is accepted by the national asylum authorities as having expertise to produce MLRs. It is up to the Tribunal to determine whether the expertise is accepted and what weight should be given to an MLR in asylum proceedings. This is reflected in the Tribunal's Guidance, which states that, "Experts are persons who are appropriately qualified to provide informed comment and opinions on a relevant matter, whether by formal qualifications or by practical experience in a particular area." In addition, "The tribunal will have due regard to expert opinion and the basis upon which an expert has reached an opinion, including the use of clinical diagnostic criteria, the number and frequency of consultations and relevant experience." Finally, the guidance makes clear that, "It is the tribunal's task, as the decision-maker, to weigh each piece of evidence and make appropriate findings of fact. The tribunal should not substitute its own lay opinion for that of a reliable expert."⁷⁰

In addition, the Tribunal's Guidance on Vulnerable Persons makes it clear that a hearing should be adjourned in order to enable, "the assistance of a medical or other expert report to be obtained", if a member of the Tribunal considers, at the hearing, that it is appropriate that a vulnerable person be given the opportunity to obtain assistance to be medically assessed.⁷¹ This is particularly relevant to ensure that any asylum-seeker who claims to be a VoT, but who has not managed to access proper assistance, is given an opportunity to do so before the Tribunal makes a decision on the asylum application.

QUESTION 9

Who bears the costs of producing an MLR?

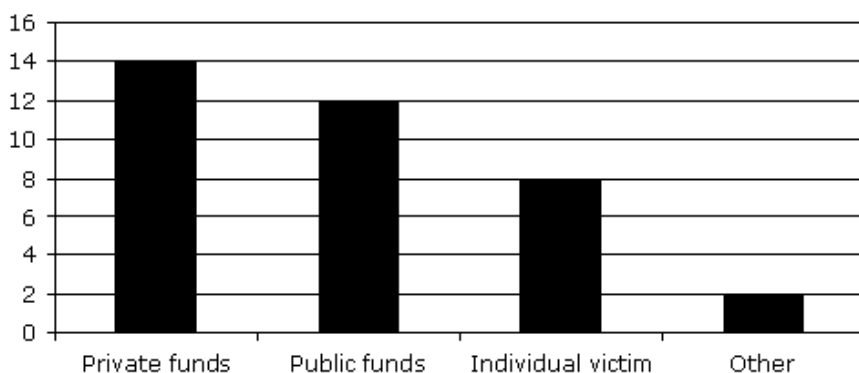
Swedish Red
Cross, Malmö

"Best practice occurs when the Migration Board acknowledges that a person has been subjected to torture, and they ask for and pay for a MLR to be done in the early stage of the asylum proceedings."

Member centres were asked which categories of funding are used to pay for an MLR: (a) public funds, e.g. legal aid, the courts, public health insurance; (b) the individual victim; (c) private funds, including NGOs' core funds; (d) other sources.

General observations

The majority of respondents (72 percent) reported that funding for MLRs was available from at least two different sources. Fifty percent of respondents indicated that the costs of MLRs are borne by private funds (including NGOs' core funds) and public funds (as well as additional categories in some cases). However, a relatively high proportion (44 percent) indicated that the victim could be expected to bear the cost themselves. This is a concern, bearing in mind that most asylum-seekers will have insufficient personal funds to meet the costs of producing an MLR. Centres in 28 percent of the participating countries answered that at least three types of funding could support the cost of an MLR.



Country	Private funds	Public funds	Individual victim	Other
Germany	•	•	•	•
Finland	•	•	•	
Ireland	•	•	•	
USA	•	•	•	
Moldova		•	•	•
Netherlands	•	•		
Sweden	•	•		
Croatia	•	•		
Kosovo	•	•		
New Zealand	•	•		
France	•		•	
Turkey	•		•	
Canada		•	•	
Bulgaria	•			
Hungary	•			
Italy	•			
Australia		•		
Armenia	-			

Europe

EU countries:

There is some disparity within the EU relating to how the cost of producing an MLR is borne. In Croatia, Finland, Germany, Ireland, Netherlands and Sweden both public and private funds can be used towards the cost of MLRs. In Germany, if the court or BAMF requests an MLR during asylum proceedings, it will be paid for from public funds. In addition, the applicant's lawyer may also request funds to pay for an MLR (e.g. through legal aid), but the court will decide whether to grant this support to the applicant. Most MLRs are produced by the rehabilitation centres pro bono, unless it is covered by project funding. In other words, rehabilitation centres often bear the costs of producing an MLR themselves. In France, Bulgaria, Hungary and Italy, it is highly concerning that the national authorities do not offer any direct support to VoTs in relation to bearing the cost of producing an MLR. In France, the cost is borne by either private funds (i.e. the rehabilitation centre producing the report) or the individual VoT. In Bulgaria, Hungary and Italy, only private funds are available. The member centres in Bulgaria (ACET) and Hungary (Cordelia Foundation) both confirmed that the member centre covers the cost of producing an MLR from its core funds.⁷²

Rest of Europe:

The centres outside of the EU that responded to this question said that the costs of producing an MLR are borne by more than one funding source. The costs of producing an MLR can be funded by both public and private sources in Kosovo and Moldova. In Kosovo, as medical reports are issued by public health institutions, they are paid for through public funds. However, IRCT member centre KRCT issues psychological reports, which are paid for by private funds, supported by the UNHCR. In Turkey, the national authorities do not offer any support, and the costs are borne either by private funds or the individual VoT.

North America and the Pacific

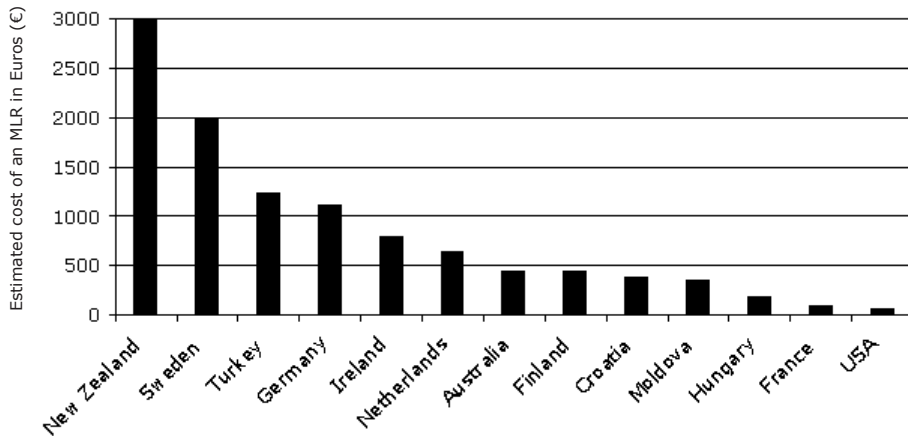
There are differences in the sources of funding for MLRs in the USA and Canada. The cost of producing an MLR in the USA can be borne by public or private funds or the individual VoT. In Canada, there are no private funds available, and costs are borne by either public funds or the individual VoT. In Australia, the cost of producing an MLR is borne entirely by public funds. In New Zealand, both public and private funds are used.

QUESTION 10

What is the estimated cost of producing an MLR?

General observations

The responses to this question indicate that the cost of an MLR will vary, depending on the length of the report or the type of MLR requested. For example, the cost of producing an MLR may differ if it is for private use (i.e. the MLR is requested by the asylum-seeker or his/her lawyer) or if it has been requested by the immigration authorities or the court. The difference in estimated costs also reflects the number of hours of work it takes to produce the MLR, the amount of information and complexity of the report and whether or not interpreters fees have to be factored in. It should also be noted that the cost of an MLR will not necessarily be charged to the VoT. The highest costs were quoted by centres in New Zealand and Sweden. The lowest costs were quoted by centres in France and the USA. The average estimated cost of producing an MLR across all three regions is around 800 Euros.



Note: Where several figures are quoted in the responses from a country, the average cost is shown.

Europe

Some of the European member centres provided an explanation of how the estimated costs of producing an MLR are accrued.⁷³

- Finland: the cost of a medical certificate provided by the centre is estimated at 450 EUR. This includes four to five appointments with the doctor, two to three meetings with a psychiatric nurse, two to three physiotherapy sessions and, if needed, three to five support sessions with other professionals. A certificate provided by a private forensic expert can cost between 60 and 120 EUR.
- Germany: bzfo indicated that the cost charged to the court, or (in rare cases) to BAMF when they request an independent MLR, depends on the length of the examination, including the costs of the interpreter and time to write up the results. A short MLR in response to specific questions that are posed can cost as little as 250 EUR. However, on average, a full MLR, according to Istanbul Protocol and German SBPM standards, costs about 2,000 EUR.⁷⁴ In bzfo an MLR carried out for a client in therapy (i.e. a private MLR) is not charged to the client; it is covered by various sources of funding. Sometimes, if an MLR is submitted during the appeal stages of the asylum procedure, the costs may be reimbursed by legal aid together with the costs of the lawyer. This is dependant on the court's decision. The other member centre, MFH-Bochum, estimated the costs of producing an MLR to range from 250-2,000 EUR with an average cost of 1,200 EUR.
- Hungary: The Cordelia Foundation does not charge any external stakeholder for producing MLRs as this is covered by the organisation's core funds. However, the member centre has estimated the cost of producing an MLR based on the salary of the medical expert and the interpreter's fees.
- Ireland: The actual cost of producing an MLR is c. 800 EUR (as indicated on the chart). However, SPIRASI indicated in its response that it charges a fixed rate of 492 EUR for an MLR. The member centre generally only agrees to prepare an MLR if it is requested by a legal profes-

sional, and therefore the payment for the report is borne by the legal representative. Most reports are requested by the Refugee Legal Service, which is a legal aid mechanism in Ireland for asylum-seekers, and therefore, through a legal aid mechanism, the state is paying for the report. However, approximately 20 percent of SPIRASI's clients who are referred for MLRs opt for private/non-state provided, legal representation. The cost of the report in this instance is usually borne by the client, but through the solicitor.

- Moldova: RCTV Memoria indicated that the cost of producing an MLR, including the costs of all the consultations, tests, diagnostic investigations and the time taken by the team members to produce the final document is around 360 EUR. In more complex cases, the cost can be higher, for example, when additional tests, which can cost up to 100 EUR, are required.
- Netherlands: iMMO indicated in its response that the medical advice relevant to producing an MLR costs c. 150 EUR. MLRs produced by iMMO are done on a voluntary basis, so it is difficult to calculate the average cost of producing them. However, with reference to the amount of time taken on the preparation, examination and writing up of the MLR, the cost of producing an MLR is between 600 and 1,000 EUR. RvA NL indicated in its response that MLRs it prepares cost an estimated 300 EUR.
- Sweden: The Swedish Red Cross, Malmö quoted the highest average costs for producing an MLR in Europe – 2,000 EUR.
- Turkey: SOHRAM-CASRA estimated that the cost of producing an MLR is between 500 to 2,000 EUR, depending on the length and complexity of the report.

Within Europe, there were no responses to this question from Armenia, Bulgaria, Italy and Kosovo.

North America and the Pacific

The centres in North America were unable to give detailed information in response to this question. Canadian centre RIVO gave no response to this question. In the USA, Survivors of Torture, International reported that the cost of producing an MLR could be around 75 EUR. The centre in Virginia, NVFS, said that the cost would vary depending on the type of organisation producing the MLR and whether it received funding from grants and/or donors.

In Australia, the cost of producing MLRs is estimated to be between c. 400-500 EUR. The centre indicated that whilst the Legal Aid Board pays this amount for an MLR, most MLRs are produced on a pro-bono basis. In New Zealand, the estimated cost of producing an MLR is given as 3,000 EUR, which is the highest amount quoted.

QUESTION 11

iMMO,
Netherlands

"There are elements of good practice but also some poor quality in the work carried out by medical advisors."

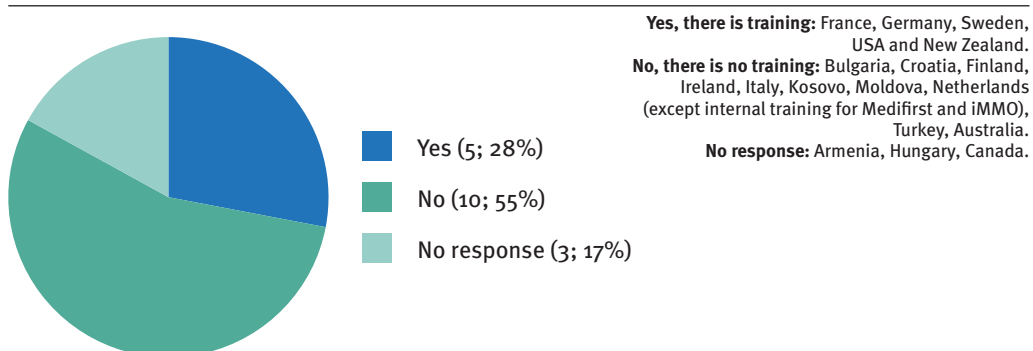
Is there training on the preparation of MLRs for health experts?

Member centres were asked whether there is training provided to health experts on how to prepare MLRs, and if so, who provides the training and who pays for it.

General observations

Centres in over half the participating countries (55 percent) reported that there is no training on the preparation of MLRs for health experts. This is particularly concerning given that a bad quality MLR could significantly disadvantage an asylum applicant's claim. In order that MLRs serve their purpose, it is essential that both legal and health experts receive training to both effectively investigate and document acts of torture, and thereby act in the best interests of the VoT. If MLRs are not produced to a sufficiently high standard, as detailed in the Istanbul Protocol, then there is a danger that they will be considered unfavourably by the decision-making authority or court.

Is there training on the preparation of MLRs for health experts?



Europe

EU countries:

France, Germany and Sweden were the only EU Member States to report that training is provided on the preparation of MLRs for health experts. In France, *Parcours d'Exil* provides training to health experts on the Istanbul Protocol and MLRs. In Germany, the Chamber of Doctors and Psychotherapists has carried out training for health professionals since 2002, in cooperation with IRCT member centre *bzfo* and other experts in the field. However, there is still a lack of trained health experts in Germany.⁷⁵ The Swedish Red Cross, Malmö provides training on the Istanbul Protocol for relevant professionals. One concern is that there are a number of EU Member States that did not report that training is provided to health experts: Bulgaria, Croatia, Finland, Ireland, Italy and Netherlands. The recently negotiated changes to the Asylum Procedures Directive and the Reception Conditions Directive place more obligations on Member States to ensure that personnel involved in asylum decision-making receive adequate training in handling cases involving allegations of torture. This obligation should go hand in hand with ensuring that health experts receive training on the medical documentation of alleged torture victims.

Rest of Europe:

No member centres that participated in the questionnaire from non-EU European countries stated that there is training provided to health experts on preparing MLRs. However, it should be noted that in Turkey, IRCT's member centre Human Rights Foundation of Turkey (TIHV) carries out training on the Istanbul Protocol for medical professionals and judges who work mainly with VoTs of Turkish nationality. Recently, TIHV has also started to offer similar training programmes for health and legal professionals who work with refugees and asylum-seekers.⁷⁶

North America and the Pacific

No information was available about whether training is provided in Canada. In the USA, all three centres reported that training is provided on preparing MLRs for health experts. Generally, NGOs and US torture treatment programmes provide training, which is funded by grants.

In Australia, there is no training on the preparation of MLRs specifically supported by public funds. However, organisations run some internal training. In New Zealand, RASNZ has trained health experts on preparing MLRs, with the help of the IRCT. The training was funded by RASNZ, the IRCT, the EU and UNHCR.



Survivors
of Torture,
International,
USA

“Best practice should be to always include the physician’s CV when submitting an MLR. The physician should explain the connection between the physical findings and claimed means of harm.”

Provision of medical and psychological assistance to VoTs

This section considers who provides medical and psychological assistance to VoTs once they are identified in the asylum procedure and how this assistance is financed. In addition, centres were asked whether there is a legal obligation to provide assistance to VoTs.

Key findings on the provision of medical and psychological assistance to VoTs

- Seventy-eight percent of countries in the report have no provision in the national legislation that places an obligation on the state to provide medical or psychological assistance to VoTs, once they are identified.
- NGOs are the most common type of institution that provides medical and/or psychological assistance to VoTs (in 100 percent of the respondent countries). State institutions provide assistance in 78 percent of the countries responding to the questionnaire. NGOs fill the gap by providing assistance where the state does not.
- Funding for medical and/or psychological assistance to VoTs comes mainly from the United Nations Voluntary Fund for Victims of Torture, public grants, public health insurance or charities. However, centres in 44 percent of responding countries reported that no assistance comes from private funding (charities or foundations).

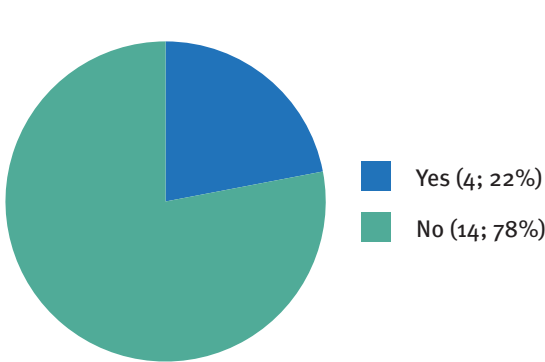
QUESTION 12

Does the national legislation place an obligation on providing medical and/or psychological assistance to VoTs, once identified?

General observations

The majority of respondents (78 percent) indicate that there is no national legislation that places an obligation on providing medical or psychological assistance to VoTs once they have been identified. All centres indicating that there is national legislation were located in Europe.

Does the national legislation place an obligation on providing medical and/or psychological assistance to VoTs, once identified?



Yes, there is national legislation: Hungary, Ireland, Kosovo, Moldova.

No, there is no national legislation: Armenia, Bulgaria, Croatia, Finland, France, Germany, Italy, Netherlands, Sweden, Turkey, Canada, USA, Australia, New Zealand.

Europe

EU countries:

Two EU countries (Hungary and Ireland) have national legislation that places an obligation on providing medical and/or psychological assistance to VoTs, once identified. The centre in Ireland indicated in its response that the state ratified UNCAT in 2001, and therefore Article 14 of the UNCAT is invoked. Ireland passed legislation to give effect to the UNCAT in 2000.⁷⁷

In some EU countries, access to health care is covered by the basic health insurance available. For example, in the Netherlands, although there is no legislation placing an obligation on providing such assistance to VoTs, all asylum-seekers have health insurance and should be able to access health care if required. Similarly, the member centre in Croatia noted that asylum-seekers can access basic health insurance, which covers access to health services, in accordance with the general legislation on health care. However, what is understood as “health care” varies depending on the country’s situation and legislation and may often be limited only to urgent health care and/or will not include, for example, preventive health care or access to psychotherapy.

Rest of Europe:

Kosovo and Moldova were the only other countries to have national legislation that places an obligation on the state to provide medical and/or psychological assistance to VoTs. The member centre in Armenia confirmed that there is no legislation placing an obligation on the state to provide medical or psychological assistance to VoTs. However, asylum-seekers benefit from access to medical care and services in accordance with the general conditions for access to health care applied to citizens of Armenia, as long as they meet the requirements laid down in the legislation.

North America and the Pacific

There is no national legislation placing an obligation on the state to provide medical and/or psychological assistance to VoTs, once identified in the USA, Canada, Australia or New Zealand. It was highlighted that in Australia there is national public funding of services that provides assistance to VoTs and a national policy that outlines how and when these services should assist.

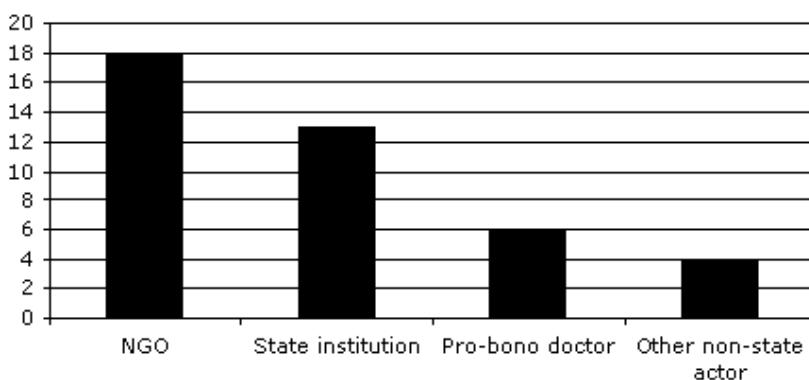
QUESTION 13

Who provides medical or psychological assistance to VoTs once they have been identified?

Member centres were asked to indicate the main providers of medical and/or psychological assistance to VoTs once they have been identified within the asylum procedure: (a) state institutions; (b) NGOs; (c) pro-bono doctors; and (d) other non-state actors. Respondents could indicate as many of these categories as relevant.

General observations

NGOs are the main providers of medical and psychological assistance to VoTs in all countries represented in this survey (100 percent). Centres reported in 78 percent of the represented countries that assistance is also provided by state institutions. In the countries where no state provision is given, NGOs fill the gap (Bulgaria, Hungary, Turkey and New Zealand). Only 22 percent indicate that other non-state actors provide medical or psychological assistance to VoTs.



Country	NGO	State institution	Pro-bono doctor	Other non-state actor
Germany	•	•	•	•
Armenia	•	•	•	•
Canada	•	•	•	•
Australia	•	•	•	•
France	•	•	•	
Finland	•	•		
Ireland	•	•		
Italy	•	•		
Netherlands	•	•		
Sweden	•	•		
Croatia	•	•		
Kosovo	•	•		
Moldova	•	•		
USA	•		•	
Bulgaria	•			
Hungary	•			
Turkey	•			
New Zealand	•			

Europe

EU countries:

Germany and France show the most varied base of providers for medical and/or psychological assistance to VoTs. Centres in the remaining EU Member States, apart from Hungary and Bulgaria, indicated that assistance is provided by either NGOs or state institutions. In Hungary and Bulgaria, the sole providers of assistance to VoTs are NGOs.

In Finland, if a doctor assesses that a VoT needs medical or psychological assistance, the VoT will be referred to the appropriate health care services. In Ireland, the majority of SPIRASI's clients are referred by general practitioners (80 percent) and other medical professionals. About 20 percent are referred by legal professionals. In the Netherlands, clients are referred through the public health system, and in Sweden, they are referred by the immigration authorities, by legal professionals or by self-referral.⁷⁸

Rest of Europe:

The centre in Armenia reported that all four types of institutions can provide medical or psychological assistance to VoTs. In Kosovo and Moldova, either NGOs or state institutions can provide assistance. The member centre in Moldova confirmed that clients are referred by their lawyer, other NGOs, journalists or they approach the centre of their own accord. In Turkey, NGOs are the sole provider of medical or psychological assistance to VoTs.

North America and the Pacific

Both Canada and the USA have a variety of providers of medical and/or psychological assistance to VoTs. In Canada the centre indicated all four categories of providers are relevant. In the USA, the member centres reported that NGOs and pro-bono doctors provide assistance to VoTs.

There is a marked difference in the providers in the Pacific region. The centres in Australia indicated that all four categories of providers are relevant. However, in New Zealand only NGOs provide medical and/or psychological assistance.

QUESTION 14

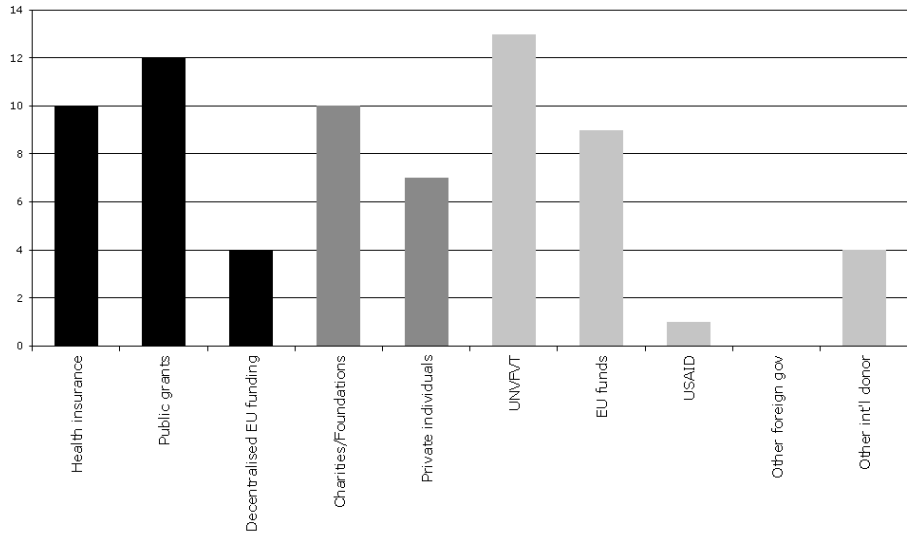
Who finances the medical / psychological assistance provided to VoTs?

Member centres were asked whether assistance was financed by domestic public funds (health insurance; public grants (national/regional/local); or decentralised EU funding); private funds (the centre's core funds; charities or foundations; private individuals); or international donors (UN Voluntary Fund for Victims of Torture; EU funds; USAID; other foreign governments; other international donors).

General observations

The main funding sources for medical and/or psychological assistance to VoTs comes from: the UNVFVT (72 percent), public grants (67 percent), public health insurance (55 percent) or private funds (55 percent). Half of the respondents indicated that funding comes from a combination of all three categories (domestic public, private, international). Just under half (44 percent) indicated that there is no private funding. The majority of respondents (83 percent) reported that they receive some funding from international donors. The Netherlands was the only country that indicated that it only receives funding from one source — health insurance.

The results are shown in the diagram below.



Country	Health insurance	Public grants	Decentralised EU funding	Charities/Foundation	Private individuals	UN/VVT	EU funds	USAID	Other foreign gov	Other int'l donor
Germany	•	•	•	•	•	•	•			•
France	•	•	•	•	•	•	•			
Canada	•	•		•	•	•				
Moldova	•			•	•	•		•		
USA		•		•	•	•				•
Turkey				•	•	•	•			•
Sweden	•	•		•			•			
Hungary		•	•			•	•			
Italy	•		•			•	•			
Ireland		•		•	•	•				
Armenia		•		•		•	•			
Croatia	•					•	•			
New Zealand		•		•		•				
Bulgaria						•	•			
Finland	•	•								
Australia	•	•								
Kosovo		•								•
Netherlands	•									

Europe

EU countries:

There are great disparities between the EU Member States in the way assistance to VoTs is financed. The Netherlands is the only EU Member State in which medical and/or psychological assistance to VoTs is financed wholly by its public health insurance. In most other EU Member States in this report (Germany, France, Ireland, Sweden), assistance is financed through a combination of domestic public funds, private funds (often core funds) and international donors. In Croatia, Hungary and Italy, there

is no assistance provided by private funds. Finland relies on financing entirely from domestic public funds (health insurance and public grants). Assistance in Bulgaria is financed entirely by international donors (UNVFVT and EU donors).

It is worth noting that the centres in the Netherlands, which are funded wholly by the public health insurance, are also the only centres in Europe that show signs of prosperity and development. In other parts of Europe, almost all specialised centres have a lack of funding, and therefore struggle to maintain their activity and meet the increasing demand of VoTs for treatment. In Germany, for example, with the diminishing availability of EU funding from the European Instrument for Democracy and Human Rights (EIDHR), most centres are forced to reduce staff numbers and some centres even face closure.

Rest of Europe:

In the rest of Europe, there are also disparities. In Armenia and Moldova, assistance falls within all three categories (domestic public funds, private funds, international donors). In Kosovo, assistance is financed through either domestic public funds or international donors. In Turkey, there are no domestic public funds to finance assistance, and the centre relies on private funding and international donors (UNVFVT, EU and other international donors).

North America and the Pacific

Centres in both Canada and the USA reported that there are five main sources of financing for medical and/or psychological assistance to VoTs. In both countries, the centres receive at least one source of funding from each category (domestic public funds, private funding and international donors). In the USA, public health insurance is not indicated as a source of financing, but assistance is financed through public grants. Both countries rely heavily on private funding (both charities/foundations and individuals) and financing from international donors, particularly the UNVFVT.

Australia and New Zealand have quite a different overview of financial resources for medical and/or psychological assistance to VoTs, both in comparison to one another, and as compared to the other regions. In Australia, assistance to VoTs is completely financed by domestic public funds, i.e. public health insurance and public grants. In New Zealand, all three categories of funding are relevant as assistance is financed by public grants, charities and the UNVFVT.

Specific aspects of the national asylum procedure affecting VoTs

This final section considers specific aspects of national asylum procedures that are relevant to the treatment of VoTs. Firstly, whether there is a risk that VoTs could be placed in an accelerated procedure, and secondly, whether VoTs are likely to be detained.

Key findings on accelerated procedures and detention

- Accelerated procedures for some asylum applicants are increasingly common in many asylum-receiving countries, particularly those in Europe (50 percent of respondents' countries have an accelerated procedure). This is a situation of concern as there is an additional risk that vulnerable applicants placed within an accelerated procedure will be returned to their country of origin without proper consideration of all the evidence in their claim.
- Detention of asylum-seekers is becoming increasingly common in all asylum-receiving countries, and it is therefore of particular concern that 65 percent of participants indicated that no measures are taken to avoid the detention of VoTs.

QUESTION 15

Is there an accelerated procedure for assessing asylum applications?

If there is an accelerated procedure, participants were asked to clarify whether VoTs can be processed within that procedure.

General observations

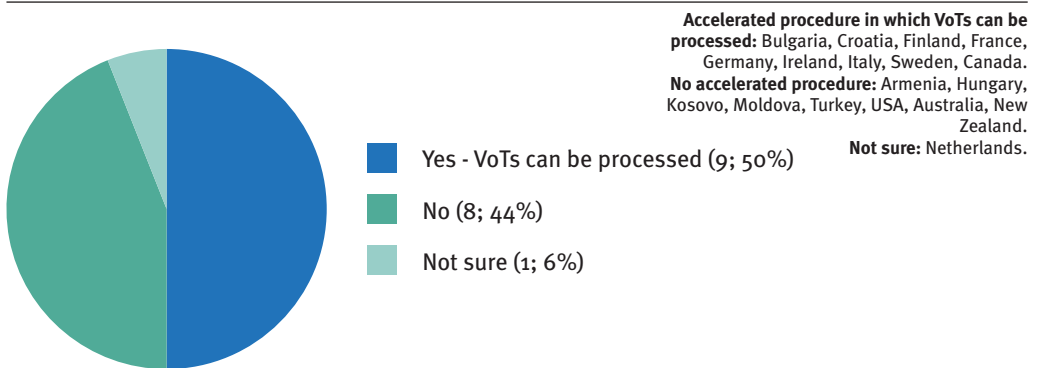
Fifty percent of the countries in which centres responded have an accelerated procedure for processing some asylum applications. Of the nine countries that do have an accelerated procedure, only one does not process VoTs within the accelerated procedure. If VoTs are placed in an accelerated procedure, they risk being unable to access the assistance necessary to present their case fully, including access to an MLR, because of the shortened time-frames. As a result, a VoT placed in the accelerated

bzfo, Germany

“An applicant’s asylum claim was rejected after an interview at the airport in Dusseldorf under the accelerated procedure. Afterwards, the applicant became suicidal. A medical / psychological examination was undertaken, and the asylum-seeker reported he had been tortured for years in his home country. However, he had not been able to disclose that fact in his asylum interview because he had been too nervous and too afraid. The examination by the doctor showed scars caused by torture as well as evidence of serious posttraumatic stress disorder. After the examination, the applicant was found to be credible and was granted asylum.”

procedure is at risk of being sent back to their country of origin without adequate consideration of the evidence pertaining to the allegation of torture. It is arguable that in countries that have an accelerated asylum procedure for certain categories of applicants (for example, those from a designated list of countries perceived to be ‘safe’) there should be a more robust system in place for the early identification of VoTs to ensure that, as vulnerable persons, they are not processed within the shortened time-frames.

Is there an accelerated procedure for assessing asylum applications?



Europe

EU countries:

The majority of the participants that report an accelerated asylum procedure are in EU Member States (Bulgaria, Croatia, Finland, France, Germany, Ireland, Italy and Sweden). Hungary was the only EU Member State in which a centre reported that it has no accelerated procedure. The large number of EU Member States with accelerated procedures is concerning as it indicates that VoTs are at risk of having their asylum applications looked at quickly, without the necessary detail and care to ensure that all evidence is presented clearly and fully at the earliest possible stage of the procedure. For example, in France, the accelerated procedure is processed by L’Office français de protection des réfugiés et apatrides (OFPRA) with a decision taken within 15 days. Claims submitted by asylum-seekers from “safe” countries are examined under an accelerated procedure, and the asylum applicant could be forcibly returned before his/her appeal has been examined. The asylum applicant is not entitled to any residence permit, financial or social assistance, and the appeal has no suspensive effect.⁷⁹

Germany has a so-called “airport procedure”, whereby VoTs can have their asylum application processed in a very short time-frame, and there is risk that, in most cases, the fact that the person is a torture victim will not have been recognised at this stage.⁸⁰ In addition, an appeal of a negative decision for an asylum application handled in the accelerated procedure does not have a suspensive effect in Germany, meaning there is a high risk that the person will be deported back to their home country before the court has made a decision on the appeal.⁸¹

In Croatia, an accelerated procedure can be applied if the Ministry of Interior can make a positive decision on the basis of available evidence, or if the claim is clearly unfounded. There is no obligation not to apply accelerated procedure to VoTs; it can be applied if it is assessed that the asylum-seeker meets one of the two requirements outlined in the legislation.

The centres in the Netherlands gave different responses to this question, so the Netherlands is recorded as “not sure”.⁸² However, background research on the Netherlands indicates that in June 2010, the

Dutch government proposed amendments to the Aliens Act, which included the processing of asylum claims in some instances within eight days, including in complex cases. In 2009, the UN Human Rights Committee expressed its concern that existing “accelerated procedures”, allowing determination of asylum applications within 48 working hours, and the proposed eight-day procedure, might not allow asylum-seekers to substantiate their claims adequately, putting them at risk of forcible return.⁸³ In its most recent Annual Report on the Netherlands, Amnesty International also voiced its concern that the eight-day asylum procedure impedes asylum-seekers from substantiating their claims and will result in the rejection of well-founded claims. In addition, it believes that most asylum claims are processed using the new eight-day asylum procedure, and that of these, over 50 percent receive a determination of the claim within the eight days.⁸⁴

Rest of Europe:

All other European countries reported that there is no accelerated procedure for assessing asylum claims (Armenia, Kosovo, Moldova and Turkey).

North America and the Pacific

In Canada, there is an accelerated procedure for assessing asylum applications, and VoTs can be processed within it.⁸⁵ In the USA, there is no accelerated procedure for assessing asylum applications, and the IRCT member centres reported that the US Immigration Authorities have a huge backlog in cases.⁸⁶ Neither Australia nor New Zealand has an accelerated procedure for assessing asylum applications. However, in Australia, the asylum procedure is accelerated for persons in detention, regardless of the specific circumstances of their case (i.e. not necessarily on the basis that they are a VoT), but there are no clear time-frames.

QUESTION 16

Are measures taken to avoid the detention of VoTs?

The detention of asylum-seekers is a worrying trend in many asylum-receiving countries. It is even more concerning where those detained may have previously suffered torture and ill-treatment in their home country. Detention is likely to exacerbate any physical or mental health problems suffered as a result of past torture, particularly if asylum-seekers are detained for long periods of time. The issue of detention is considered in more detail in Part 3 of the report.

General observations

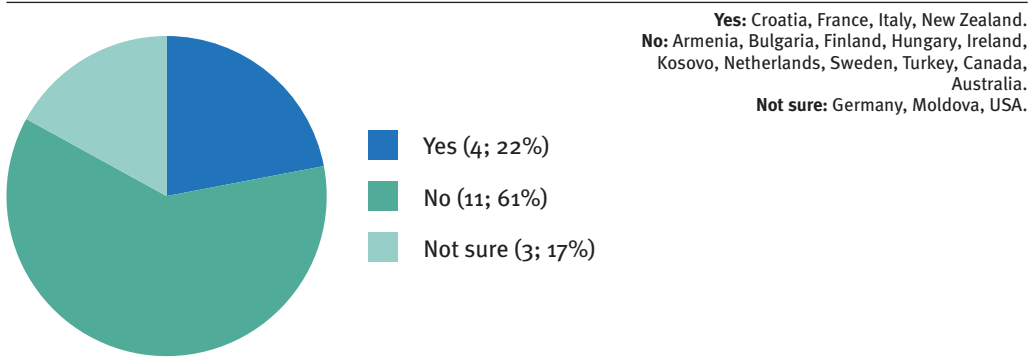
Centres in the majority of the countries participating in the survey reported that there are no measures taken to avoid the detention of VoTs (61 percent). This is particularly concerning for two reasons. First, once in detention, there is substantial research showing that both the physical and mental health of any individual is highly likely to deteriorate.⁸⁷ This deterioration is likely to be even more severe for someone, such as a VoT, who has pre-existing health conditions. Secondly, detention is likely to re-traumatise an individual, particularly if their previous experience of torture or ill-treatment took place in a detention environment in their home country. In addition, once in detention, if there is no effective system in place to monitor the health of individuals, then health problems that require treatment may go undetected for some time as there is likely to be less support (both medical and legal) made readily available to detainees.

Europe

EU countries:

The majority of the EU Member States represented have no measures in place to avoid the detention of

Are measures taken to avoid the detention of VoTs?



VoTs. Only centres in Croatia, France and Italy indicated that there are such measures in place.

In Croatia, measures are taken to avoid the detention of VoTs. The Ministry of Interior will move an asylum-seeker from detention to alternative accommodation if it is indicated by a medical expert or psychologist that the person is possibly a VoT. In Italy, NGOs can help to identify and provide assistance to vulnerable persons in detention centres. They are able to make direct requests to the immigration authorities for the person's release. However, there are no measures taken by the immigration authorities themselves to identify VoTs, who may have been placed in immigration detention.

In Hungary, Cordelia Foundation reported that there are no official measures in place to avoid detaining VoTs. In practice, there has been no detention of asylum-seekers since the beginning of 2013; however, this is likely to change with new proposed legislation. In the Netherlands, the government recorded 3,220 irregular migrants and asylum-seekers taken into detention between January and June 2012. Many of those apprehended are held in detention centres more akin to remand facilities, and alternatives to detention are rarely used.⁸⁸ In cases where a VoT is in detention, organisations such as Amnesty International may address the authorities alerting them to the person's particular situation. However, there is no guarantee that the person will be released from detention.

The member centres in Germany provided different responses to the question. The IRCT member centre bzfo reported that NGOs and lawyers representing the asylum applicant take measures to avoid the detention of VoTs. However, the other German member centre, MFH Bochum, indicated that no measures are taken, perhaps referring only to measures taken by the immigration authorities themselves. According to Amnesty International, asylum-seekers entering Germany via an airport, who went through an accelerated asylum procedure, were routinely detained in the airport transit area.⁸⁹

Rest of Europe:

Armenia, Kosovo and Turkey reported that no measures are taken to avoid detention of VoTs. In Armenia, border guards may detain asylum-seekers entering Armenia for up to 72 hours.⁹⁰ The centre in Moldova stated that it had no information for this question. All individuals that enter Kosovan borders and claim asylum are immediately sheltered in an Asylum-Seekers Reception Centre. The IRCT member centre KRCT visits each of these asylum-seekers and provides information about their psychological situation upon their consent. None of those asylum-seekers found to be VoTs are placed in a detention centre.

North America and the Pacific

There are differing responses in North America and in the Pacific. In Canada, no measures are taken

to ensure that VoTs are not detained. In Canada, immigration officials of the Canada Border Services Agency (CBSA) makes the decision to detain if there are reasonable grounds to believe the person falls within a pre-defined category, such as a risk of absconding or a risk to the public. After someone is detained, the CBSA must bring the person before the Immigration Division of the Immigration Refugee Board within 48 hours (or as soon as possible afterwards) for a review of the reasons for detention.⁹¹ This would be a point at which the individual could raise that they are a VoT.

In the USA, initial detention is mandatory for certain asylum-seekers apprehended upon entering the USA.⁹² These asylum applicants can be released from immigration detention and paroled on a case-by-case basis for “urgent humanitarian reasons” or “significant public benefit”, provided they do not pose a security risk or absconding risk. This includes asylum applicants who have serious medical conditions where detention would not be appropriate.⁹³ However, the policy does not indicate clearly whether any measures are in place to ensure that those with serious medical conditions are identified once they are in immigration detention. This concern was raised by the IRCT member centre in Northern Virginia, NVFS. It reported in its response that the Department of Homeland Security is supposed to screen detainees for torture, but, in practice, still detains many VoTs.

In the Pacific, Australia and New Zealand have contrasting policies in relation to detaining asylum-seekers. In Australia, under the Migration Act 1958 asylum-seekers who arrive on the Australian mainland without a valid visa must be held in immigration detention until they are granted a visa or removed from Australia. In addition, asylum-seekers arriving in excised offshore places, for example, those arriving by boat, are also subject to mandatory detention. Immigration detention in Australia is indefinite – there is no limit in law or policy to the length of time for which a person may be detained, and many asylum-seekers are detained for long periods. As of 31 August 2013, there were 8,732 people in immigration detention facilities and alternative places of detention. According to government sources, the average period of time for people held in immigration detention (not including alternative places of detention) is around 90 days.⁹⁴

In New Zealand measures are taken to avoid the detention of VoTs. However, current proposals are being discussed in Parliament to introduce mandatory detention for groups of asylum-seekers arriving by sea, similar to the policy followed in Australia. The Commission for Human Rights is concerned that the bill and associated policy changes unduly penalise asylum-seekers for irregular entry to New Zealand in clear breach of Article 31 of the Refugee Convention. In addition, they are concerned that the proposed provisions will result in arbitrary detention in breach of both New Zealand’s obligations under the ICCPR and Section 22 of the New Zealand Bill of Rights Act. The Commission has also voiced its concerns about the proposed blanket suspension of applications from nationals of specific countries, without considering whether they should be provided international protection. This proposal is discriminatory and violates the right to seek asylum as guaranteed by international law.⁹⁵ The proposal to move towards a similar detention policy as followed by Australia is concerning, as it fails to take into account the harmful health and social implications of long-term detention.⁹⁶

3

RECOMMENDATIONS AND WAYS TO OVERCOME SHORTFALLS IN PROTECTION

The findings in Part 2 to this report highlight key areas of change that are imperative in order to guarantee the early identification of VoTs within asylum procedures. In addition, there is a need to ensure that MLRs are more widely used and accepted as an important evidential tool in the asylum process. This chapter of the report outlines the IRCT's recommendations for change, based on the key findings from the empirical research, and taking into account the participating centres' own recommendations for change in the specific national context (see Annex 1). In addition, the findings and recommendations underline the obvious shortfalls in the current status with regard to the early identification and treatment of VoTs within national asylum procedures. Therefore, this chapter also considers in more detail some of the critical gaps in the protection offered to VoTs and highlights positive examples where progress is being made to strengthen the safeguards afforded to VoTs in national asylum procedures.

Early identification of victims of torture

The IRCT's recommendations to ensure the early identification of VoTs within national asylum procedures are the following:

- Define clearly the obligation for the early identification of VoTs in national asylum legislation;
- Provide mechanisms for the identification of VoTs as soon as the asylum application is received;
- Provide training to immigration officials in particular, but in general to any stakeholder involved in the asylum process, to be able to identify VoTs and recognise the symptoms and signs exhibited by victims of past torture or trauma so that a VoT can be referred to an independent health expert for an MLR, where required.

Is anything being done to improve the early identification and treatment of VoTs within national asylum procedures?

As discussed in the introduction to this report, the early identification of VoTs or other traumatic events within national asylum procedures is critical to enable the individual to access the appropriate support, which will allow them to present their asylum application as fully as possible from the initial stage. However, the findings in Part 2 of the report demonstrate that there is a general lack of national legislation to clearly define a state's obligations to identify VoTs early on in the asylum procedure, and enable access to the assistance required to be able to present medical evidence of a standard that meets international guidelines and which supports the alleged traumatic events.

In addition, the Committee against Torture's General Comment No.3 on Article 14 emphasises that state parties to UNCAT have obligations to provide asylum-seekers and refugees as full a rehabilitation as possible when they enter the territory of a state, even if the harm suffered is not attributable to that state. States have clear obligations to provide asylum-seekers and refugees with access to holistic rehabilitation, which includes not only medical and psychological care, but also legal and social services. State parties to the UNCAT should, according to the Committee, "adopt a long-term, integrated approach and ensure that specialist services for victims of torture or ill-treatment are available, appropriate and readily accessible. These should include a procedure for the assessment and evaluation of individuals' therapeutic and other needs, based on, inter alia, the Istanbul Protocol".⁹⁷

Do the changes in the EU Reception Conditions Directive (RCD) go far enough in ensuring VoTs are identified early on in asylum procedures?

Changes in the EU: the recast EU Reception Conditions Directive (RCD)

In the EU, as part of the second phase of the Common European Asylum System (CEAS), the EU Council, the European Commission and European Parliament negotiated amendments to improve standards in the Reception Conditions Directive (RCD).⁹⁸ The renegotiated RCD was formally adopted in June 2013, after which EU Member States have two years to transpose the new provisions into national law.⁹⁹

...

The new provisions include:

- A list of vulnerable persons, who may have special reception needs, to include “persons who have been subjected to torture, rape, or other forms of psychological, physical or sexual violence, such as victims of female genital mutilation” (Article 21).
- An obligation is placed on Member States to assess whether a vulnerable person has special reception needs¹⁰⁰. The assessment mechanism needs to be initiated within “a reasonable period of time” after the application for international protection has been made (Article 22).
- An obligation is placed on officials working with victims of torture, rape or other serious acts of violence to have had, and continue to receive, “appropriate training concerning their needs” and to be bound by the confidentiality rules in their national legislation (Article 25(2)).
- An obligation to provide necessary health care, including at least “emergency care and essential treatment of illnesses and of serious mental disorders”. Member States are obliged to “provide necessary medical or other assistance to applicants who have special reception needs, including appropriate mental health care” (Article 19). In the specific case of victims of torture and violence, “Member States shall ensure that persons who have been subjected to torture [...] receive the necessary treatment for the damage caused by such acts, in particular access to appropriate medical and psychological treatment or care” (Article 25(1)).

The amended RCD is clearly an improvement on the 2003 version of the directive as its provisions now explicitly consider the situation of vulnerable asylum-seekers with special needs, including VoTs. The IRCT welcomes the obligation that the recast RCD places on EU Member States to identify VoTs within the asylum procedure and then to assess whether they have special reception needs, including the need to access “appropriate medical and psychological treatment or care”.¹⁰¹ Training is also identified as a requirement for staff working with VoTs, another positive addition. It should be noted too, that the recast RCD places an obligation on Member States to finance training.¹⁰²

However, the IRCT considers that the improvements to the renegotiated RCD are weak and some provisions remain ambiguous, leaving much room for interpretation by Member States, which could potentially endanger the rights of VoTs. For example, too much discretion is allowed to Member States to decide “the reasonable period of time” within which the assessment of vulnerable persons should be carried out. This fails to recognise that it is essential that vulnerable persons’ special needs are identified as early as possible in the asylum procedure, not only to ensure that any physical or mental health problems do not deteriorate, but also to ensure that the authorities are made aware of any issues that may affect the applicant’s ability to present their case consistently and coherently. In addition, Member States are left with a large discretion to interpret the provision on access to health care, in particular what is “appropriate medical and psychological treatment or care”. This discretion is potentially harmful to VoTs as symptoms, such as PTSD or depression, which can have a negative impact on a person’s memory and ability to recount events, may be left untreated. It is also disappointing that the reference to “appropriate medical and psychological treatment” fails to clearly refer to rehabilitation services. This fails to consider that EU Member States’ obligations under the UNCAT are to provide for as full rehabilitation as possible, by ensuring that specialist services are available, appropriate and readily accessible and that rehabilitation services should be provided to VoTs “as soon as possible following an assessment by qualified independent medical professionals”¹⁰³.

How can mechanisms be provided to support the early identification of victims of torture?

As the findings in Part 2 highlight, centres in the majority of countries participating in this report (72 percent) do not have a procedure in place to identify VoTs within the national asylum procedure.

In some regions, alternatives to state-led initiatives are in place. For example, in the EU, experts in asylum and rehabilitation of torture victims have developed a mechanism to identify VoTs because the EU law provisions have not been properly transposed in most Member States, and therefore it has become increasingly necessary to address the gaps in the protection afforded to VoTs. The PROTECT project is an example of an initiative started by experts providing rehabilitation services to VoTs to develop a basic screening tool to overcome the problems currently faced in many countries where medical screening of asylum applicants is not common practice. There has been growing interest shown by EU institutions, and by the EU Member States, to apply the PROTECT screening tool. For example, in Bulgaria, the State Agency for Refugees (SAR) adopted the PROTECT questionnaire as an official tool in October 2012. The adoption of the tool has seen some improvement in the early identification of VoTs in Bulgaria, but it should be noted that it needs to be fully implemented as part of the national asylum legislation to avoid the risk that the state authorities may stop using it at any time. However, as is seen by the increased use of the PROTECT tool, it is proven to be both beneficial and cost-efficient for national governments, as well as the rehabilitation centres. A further expansion of the PROTECT project is expected, as well as the possible inclusion of the tool in the European Asylum Curriculum, the training component of the European Asylum Support Office (EASO).

Addressing gaps in the early identification of VoTs in the EU: The PROTECT tool¹⁰⁴

PROTECT was started by the IRCT member centre *Parcours d'exil*, in France, along with five other EU-based NGOs providing asylum and rehabilitation services. Key objectives were to increase, by proposing practical tools, the number of VoTs identified early in the asylum process and to raise awareness of the need for processes to be put in place for the recognition of torture victims in order to facilitate their access to immediate health care and treatment. The initiative recognised the need to harmonise assessment across EU Member States and to ensure compliance with the Reception Conditions Directive (RCD) and the Asylum Procedures Directive (APD), recognising that at present the procedures vary widely between Member States.

The tool promotes an easy process to be adapted by governments for use before or during the interview phase of the asylum procedure. A screening checklist has been devised that immigration authorities, civil servants, border guards or other stakeholders accessing asylum-seekers can use in the early stages. The checklist assists the identification of vulnerable persons who have suffered severe traumatic experiences or who are suffering from other severe psychological distress in order to provide them with: (i) adapted material reception conditions, (ii) appropriate physical and mental health care, and (iii) adequate support through their asylum application. The questions are designed to check for the signs and symptoms of the most common health problems, such as PTSD and depression, in order to identify psychologically vulnerable asylum-seekers who may have suffered traumatic experiences. The questionnaire, designed to be used by non-medical personnel, is a tool for identifying vulnerable asylum-seekers quickly and in a cost-effective way. As a second step of early identification, that person should have access to a full psychiatric or psychological diagnosis, according to the Istanbul Protocol standards.

The second phase of the project (PROTECT-ABLE) started in September 2012. The project has been extended to 11 NGOs from nine countries.¹⁰⁵ The partners of the project benefit from the support of experts from IRCT, the Odysseus Network and PHAROS (Netherlands). The first goal of the PROTECT-ABLE project is to train 500 persons (volunteers, social workers, etc.) in nine European countries to use the PROTECT questionnaire and screening process. The selected groups are public and/or private partners and the trainings are provided free of charge by the partners. The project will begin by screening around 2,500 asylum-seekers using the PROTECT questionnaire and hopes to reach a target of 10,000 asylum-seekers per year.

Use and acceptance of MLRs in the national asylum procedure

The IRCT's recommendations to ensure that the use and acceptance of MLRs is promoted in national asylum procedures are the following:

- Advocate for national legislation to place an obligation on the state to systematically request that MLRs to be submitted in asylum procedures where allegations of torture are raised;
- Ensure that asylum-seekers have access to independent medical and psychological staff, competent in producing MLRs according to the Istanbul Protocol principles.
- Ensure that health professionals who are tasked with providing MLRs receive training on the Istanbul Protocol;
- Ensure that MLRs are taken appropriately into account in order to improve the quality of decision-making in relation to VoTs' asylum claims;
- Ensure a more consistent approach to the use and application of MLRs across services and across countries;
- Introduce official evaluation and monitoring of use of MLRs;
- Provide training to immigration authority staff and judges on signs and symptoms of torture and trauma and on the interpretation of MLRs.

As discussed in the introduction to this report, the use and acceptance of MLRs within the asylum procedure can be critical to a VoT's asylum case. The IRCT believes that using MLRs that meet the international standards laid out in the Istanbul Protocol assists both the asylum-seeker and the state by providing an accepted standard that medical evidence should satisfy, ensuring the evidence is considered as part of the initial decision-making on the application and avoiding protracted and costly appeals due to the late submission of medical evidence during the asylum procedure.

The findings show that, although MLRs can be submitted at any stage of the asylum procedure in the majority of the participating countries (72 percent), there are still substantial barriers to accessing MLRs. For example, 44 percent of the countries indicated that the VoT may have to bear the costs of an MLR themselves in some circumstances. In addition, there are often difficulties finding trained health professionals who can prepare MLRs to the required standards recognised in the Istanbul Protocol.

The importance of MLRs in asylum proceedings is becoming increasingly recognised at all stages of the asylum procedure, as the example below demonstrates.

The European Court of Human Rights endorses the importance of MLRs in asylum proceedings

The findings of the ECtHR in *RC v Sweden* clearly advocate that a state party to the ECHR should be

obliged in asylum cases involving allegations of torture to provide for its own MLR if it disputes the medical evidence relied on by the applicant.

RC v Sweden – the ECtHR recognises that a state has a duty to ascertain relevant facts, particularly in asylum cases involving allegations of torture

In *RC v Sweden*¹⁰⁶ the European Court of Human Rights judged that the state has a duty to ascertain all relevant facts, particularly in circumstances where there is a strong indication that an applicant's injuries may have been caused by torture."¹⁰⁷ An asylum applicant alleging that he had suffered torture in Iran submitted a medical certificate, confirming that injuries on his body were likely to have originated from torture. The Swedish authorities refused to accept the medical report as proof of torture, and the asylum application was rejected. At the request of the ECtHR, the applicant submitted a further forensic medical report; its findings strongly indicated that the applicant had been tortured. The Court considered that if the state had any doubts about the applicant's medical evidence, it should have arranged for an expert report on its own initiative. The Court considered that, "while the burden of proof, in principle, rests on the applicant, the Court disagrees with the Government's view that it was incumbent upon him to produce such expert opinion. In cases such as the present one, the state has a duty to ascertain all relevant facts, particularly in circumstances where there is a strong indication that an applicant's injuries may have been caused by torture."¹⁰⁸

The recognition of MLRs within the second phase of the EU Common European Asylum System (CEAS)

The decision in *RC v Sweden* was positive in endorsing the significance of MLRs in asylum proceedings. However, the IRCT considers that further safeguards are needed to ensure that VoTs can access MLRs early on in the asylum proceedings. National legislation should place an obligation on the state to systematically request MLRs to be submitted in asylum procedures where allegations of torture are raised. However, as the findings in Part 2 demonstrate, only three countries represented in this report currently acknowledged MLRs in the national legislation.

The changes to the Asylum Procedures Directive recognise to some extent the importance of medical examinations in asylum proceedings, and that personnel involved in decision-making must be trained to recognise symptoms that VoTs may display. However, the renegotiated APD only recognises that national measures dealing with identification and documentation of symptoms and signs of torture may be based on the Istanbul Protocol guidelines. It is regrettable that the changes do not recognise that states must have an obligation to include the Istanbul Protocol in all training involving the treatment of VoTs in asylum procedures.

How will the changes to the EU Asylum Procedures Directive (APD) affect the use and acceptance of MLRs in EU Member States?

Within the EU, the Asylum Procedures Directive (APD)¹⁰⁹ lays down minimum standards on procedures that Member States should implement for granting and withdrawing refugee status. As part of the second phase of the CEAS, changes to the APD have been agreed between the European Parliament and the Council, based on the European Commission's proposal. The revision of the APD¹¹⁰ – now formally approved – promotes the strengthening of procedural safeguards for VoTs, for example:

- It recognises that some asylum applicants may be in need of "special procedural guarantees", if their ability to benefit from the rights or comply with the obligations in the APD is "limited" due to "individual circumstances". The categories of vulnerable persons to which this article refers to are listed in Article 21 and includes VoTs (Recital 30, Article 2(d)).

...

- It makes reference to the Istanbul Protocol as a set of guidelines on which national measures dealing with identification and documentation of symptoms and signs of torture, or other serious acts of physical or mental violence, etc., may be based (Recital 31).
- It obliges a Member State, when it “deems it relevant”, to arrange for a medical examination of an asylum applicant “concerning signs that might result from past persecution or serious harm”. In such cases, the Member State is required to pay for the medical examination (Article 18(1)).
- It places an obligation on Member States to ensure that officials interviewing applicants receive training to raise awareness of symptoms of torture and of medical problems that could adversely affect the applicant’s ability to be interviewed (Article 4(3)).
- Member States are obliged to ensure that personnel examining asylum applications are able to seek advice from medical experts, whenever necessary (Article 10(3)(d)).

In the IRCT’s opinion, the renegotiated APD remains unclear in terms of the procedural safeguards it proposes in relation to VoTs. In particular, it is regrettable that the state authorities are given a wide discretion to decide when it is “deemed relevant” to arrange for a medical examination of an asylum applicant. Although the obligation for the state to fund such examinations is welcomed, the provision does not impose a strict obligation on Member States to provide for an examination, and nor does it make it clear that the applicant should be free to choose an independent and impartial medical examiner. This provision therefore falls far short of the guidelines in the Istanbul Protocol on the medical examination of VoTs. The provision further limits the scope of the MLR, insofar that it is intended to support the applicant’s claim in relation to past persecution or serious harm. In addition, although Member States are required to share the burden by placing a duty on authorities to request a medical examination, in cases where the state does not request a medical examination, applicants must arrange to cover the costs themselves. This places an unreasonably heavy burden on the applicant. Overall, there is a lack of clarity in the new provisions, and it is questionable whether the renegotiated APD will lead to significant improvements in the treatment of VoTs at all. Member States will have until 2015 to make relevant changes to national legislation.

The importance of good quality decision-making in asylum proceedings involving victims of torture

The IRCT’s recommendations include the need to improve the quality of the decision-making in relation to MLRs, particularly as good quality decision-making at the early stages of the asylum process avoids the need for protracted appeals and benefits both the applicant and the state authorities. United Kingdom is not a country addressed in Part 2 of this report, however, it provides an example of promising practice where the immigration authorities have engaged with recommendations made by IRCT member centre Freedom from Torture, with a view to improving the quality of initial decision-making in cases involving torture in which medical evidence is relied upon.

United Kingdom
— Engaging with government authorities to improve decision-making in cases involving victims of torture

The UK has had a policy in place (since 2006) to address the handling of claims where torture is raised. Research conducted by Freedom from Torture, *Body of Evidence: Treatment of Medico-Legal Reports for Survivors of Torture in the UK Asylum Tribunal* in May 2011¹¹¹ examining the treatment of medical evidence by Immigration Judges in appeals against refusal of asylum and assessing their compliance with good practice standards, identified the need for the Home Office to improve the standard of initial decision-making, reflected in the high appeal overturn rate documented in the report. The Home Office accepted the recommendations made by the report and has subsequently developed and piloted new guidance¹¹² with input from Freedom from Torture and the Helen Bamber Foundation, a UK-based human rights organisation working with survivors of torture and other human rights violations.

The pilot scheme highlighted a number of best practice guidelines for immigration authorities when considering claims that involve allegations of torture, for example:

- Engagement with civil society organisations with expertise in the medical documentation of torture in the development of policy guidance;
- Recognition that referral of an applicant to an organisation for an MLR to be produced can take time and placing a hold on consideration of the asylum application until the MLR is submitted, whilst granting asylum in those cases where there is sufficient evidence to make a positive decision, irrespective of whether an MLR is submitted.
- Recognition of specialist expertise irrespective of clinical background (for example whether the writer qualified as a GP, consultant or other health care professional) where the report has been compiled using the standards and terms employed by the Istanbul Protocol, *the Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment of Punishment* and where details of the clinician's qualifications, training and experience are provided.
- Provision of guidance to decision-makers to prevent their purporting to make clinical judgments of their own, for example, as to the causation of physical or psychological injuries, or the accuracy of a diagnosis or to late disclosure or discrepancies in the testimony when a clinical explanation has been provided in the report.
- Provision of guidance to decision-makers on the correct approach to assessing the evidence, specifically the need to consider all evidence in the round including the expert medical evidence, and ensuring that a conclusion on the overall credibility of a claim is not reached without careful consideration of the medico-legal report.
- The importance of facilitated training for the correct application and implementation of guidance, providing a practical understanding of the Istanbul Protocol and appropriate case law and involving the input of experts in the field, including health and legal professionals from organisations providing MLRs.

The pilot scheme has now come to an end, with updated guidance incorporating the learning from the pilot due to be published by the end of 2013. The roll out of policy guidance alongside facilitated training to decision-makers nationwide would represent an important step towards addressing the problems identified in the treatment of medico-legal evidence by decision-makers at the initial stage of the UK asylum system and provide an example of promising practice for other asylum-receiving countries to refer to.

Specific concerns regarding the treatment of victims of torture within national asylum procedures

The final part to this chapter highlights key findings and recommendations on specific aspects of some national asylum procedures that the IRCT also considers as essential parts to improving the safeguards for VoTs.

- Abolish the practice of detaining vulnerable asylum-seekers, particularly VoTs;
- Ensure that VoTs are not processed within an accelerated asylum procedure;
- Ensure access to independent legal and medical advice early on in the asylum procedure for all vulnerable asylum-seekers, which should be covered by public funds.
- Provide training on the signs and symptoms of torture and on the identification of VoTs and the use of MLRs to state authorities and legal professionals;
- Encourage collaboration between all stakeholders (lawyers, judges, state authorities, civil society, etc.) on the treatment of VoTs within asylum procedures;
- Promote academic research and assessment of the consequences of torture in the asylum procedure;
- Ensure the recognition of health professionals as experts in the asylum process;
- Encourage states to recognise and meet their commitments under Article 14 UNCAT in relation to providing access to an initial medical assessment (including an MLR) and rehabilitative treatment to asylum-seekers and refugees.

Why detention of vulnerable asylum-seekers must be abolished

Part 2 highlights the concerning trend of detaining asylum-seekers, including vulnerable persons. Most of the centres in the represented countries reported no measures in place in the national asylum procedure to avoid the detention of VoTs. This is particularly concerning given the extent to which detention is known to exacerbate physical or mental health conditions and the re-traumatisation of the victim.

A report published by Jesuit Refugee Services (JRS) Europe in 2010, based on more than 650 interviews with detainees, showed that detention is used in a mostly indiscriminate way, and, in almost every case, detention had “a distinctively deteriorative effect upon the individual person”, whether that person had pre-existing special needs or had been in good health.²¹³

The Council of Europe Commissioner for Human Rights has highlighted the abolition of migrant detention and promotion of alternatives as one of his key priorities, noting: “The detention of migrants, including asylum seekers, upon arrival or when subject to removal in Council of Europe member states

has increased substantially in recent years.”¹¹⁴ The Parliamentary Assembly of the Council of Europe stated in its resolution on the issue that the conditions and safeguards afforded to immigration detainees are often worse than those of criminal detainees, and the provision for the needs of vulnerable persons is often insufficient. It observed that, “This all has a negative impact on the mental and physical well-being of persons detained both during and after detention.”¹¹⁵

The UNHCR advises that the propensity for psychological problems needs to be taken into account when assessing the necessity to detain victims of torture or trauma, i.e. before a decision to detain has been taken. It emphasises that victims of torture and other serious physical, psychological or sexual violence also need special attention and should generally not be detained.¹¹⁶ The UNHCR Detention Guidelines recognise that detention can cause, as well as aggravate, psychological illnesses and symptoms, and that this can happen even if individuals present no symptoms at the time of detention.¹¹⁷

The examples below illustrate why the detention of vulnerable asylum-seekers, including VoTs, must be abolished. These examples demonstrate that policies aimed at identifying VoTs within detention, for treatment and possible release, are not implemented properly. Therefore, the VoT’s ability to access treatment is seriously undermined.

Australia – the Immigration Detention Torture and Trauma Policy

The Australian government introduced a policy in 2009 aimed at identifying and supporting victims of torture and trauma who are in immigration detention. The policy introduces processes for the early identification of victims of torture and trauma so as to enable them to access appropriate services for medical assistance and, if possible, to release them from immigration detention and place them in community detention.¹¹⁸ On paper, the policy has many good intentions, for example:

- It aims to implement different levels of screening, according to whether the asylum-seeker comes from an area known to be high risk for torture and trauma. In these cases the individual would be offered specialised screening and assessment automatically.
- All groups of asylum-seekers entering immigration detention undergo universal health screening designed to detect signs of psychological distress that may be compatible with a history of torture and trauma.
- All personnel who work in detention facilities receive a minimum level of training, which includes recognising the signs and symptoms of torture and trauma, cultural issues relating to the expression of trauma and routes and processes for referral to health services.

Although Australia has a policy in place to identify and support VoTs within immigration detention, a number of NGOs¹¹⁹ and the Australian Human Rights Commission¹²⁰ have questioned how effectively this policy is implemented on the ground. In particular, very few VoTs are transferred into community detention, and there are insufficient numbers of health professionals compared to the number of detainees found to be victims of torture or trauma. These factors hamper the early identification of victims of torture and trauma and their ability to access medical assistance whilst in immigration detention.

United Kingdom – the gap between policy and practice

The UK has a policy in place designed to safeguard vulnerable individuals by setting out requirements that health care staff must follow in order that detained persons who have a special illness, health condition or are a VoT are identified.¹²¹ The principal purpose of the policy is to ensure that particularly vulnerable detainees are brought to the attention of those with direct responsibility for authorising, maintaining and reviewing detention so that a decision can be taken quickly as to whether the person's detention remains appropriate.¹²² Both UK law and policy make clear that people who have been tortured should only be detained in "very exceptional circumstances".¹²³ However, recent reports indicate that there are serious failings in the implementation of the policy:

- In 2011, the Chief Inspector of Prisons found that reports submitted on behalf of detainees who may have been VoTs were often insufficient or formulaic, indicating that the needs of individuals had not been fully considered.¹²⁴ In particular, where there was medical evidence of previous torture or that a detainee's health was likely to be injuriously affected by detention, the reports written by health care staff were of very poor quality, often failing to include any diagnostic findings or judgments about the consistency of the allegations.¹²⁵
- Medical Justice, an NGO advocating for asylum-seekers' rights, reached a similar conclusion in its 2012 report on the policy.¹²⁶ It noted: a lack of knowledge and training in the assessment and management of VoTs; failure to provide relevant clinical information or to conduct proper medical examinations; the existence of a culture of disbelief and cynicism amongst officials, which impacted negatively on the quality of the decision-making.¹²⁷ The health care was of poor quality, with background health information on detainees rarely available, often leading to a failure to prescribe medication and poor doctor/patient relationships.¹²⁸ Detainees were not adequately screened and thorough mental state examinations were not completed, meaning that those with mental health conditions were not diagnosed early on. The report outlined systemic failures on the part of the immigration authorities and private service providers to follow statutory law and provisions put in place to safeguard vulnerable persons, including VoTs. It reported that although monitoring does exist, "accountability remains sketchy and transparency levels are weak... it is often unclear where responsibility or culpability falls".¹²⁹

Germany – poor implementation of the EU Reception Conditions Directive (RCD)

A Parallel Report submitted by NGOs in Germany in accordance with the UNCAT¹³⁰ noted that many regional states still lack a procedure for identification of vulnerable asylum-seekers, despite the obligation on EU Member States to take into account the situation of vulnerable persons in the RCD.¹³¹ In particular, medical checks carried out are designed to detect severe illnesses, but not mental health issues, which many VoTs and vulnerable asylum-seekers may suffer from. A failure to detect vulnerable asylum-seekers, including victims of torture and traumatised persons, increases the likelihood that their health condition will deteriorate. The report highlights that although state-employed psychiatrists are not available for consultation in detention centres on a regular basis, an independent psychiatric or psychological evaluation is usually not granted by the authorities. The report further highlights that traumatised refugees claiming asylum at an air-



port are likely to be placed in refugee accommodation at a closed facility at the airport and automatically placed in the accelerated asylum procedure.¹³² Therefore, they are often not identified as being traumatised, nor given sufficient time to present their case clearly. This places them at a higher risk of being returned to their home country without a proper and rigorous examination of the asylum application. The report further noted that there is a risk that failed asylum-seekers who have suffered torture or trauma might be detained pending deportation when there has been a failure to identify them as a VoT during the earlier stages of the asylum process.

The policies highlighted above are failing to fulfil their key objectives: (i) to identify vulnerable asylum-seekers, including VoTs within detention facilities; (ii) to ensure that detention does not have a debilitating effect on the individual's health; and (iii) to immediately remove the individual from detention if their health is being negatively impacted.

The IRCT considers that these examples of policies that fail to protect vulnerable persons where safeguards are most needed strengthens the argument for the complete abolition of the detention of vulnerable persons. As many VoTs may have experienced torture in a detention environment in their home country, being detained during the asylum process is highly likely to re-traumatise the victim, which has a severe and long-term impact on the victim's physical and mental health.

Detention provisions in the recast Reception Conditions Directive (RCD)

In the EU, the recast RCD lays down provisions for the detention of vulnerable persons, including VoTs, on the basis that: "The health, including mental health, of applicants in detention who are vulnerable persons shall be of primary concern to national authorities. Where vulnerable persons are detained, Member States shall ensure regular monitoring and adequate support taking into account their particular situation, including health."¹³³ There are a number of concerns with this provision (Article 11):

- The wording of "primary concern" and "adequate support" are too vague and allow Member States to interpret this provision widely.
- The obligation to "ensure regular monitoring" does not indicate a specific time-frame, leaving room for interpretation.
- There is no requirement for a full medical evaluation to be carried out by a qualified expert.¹³⁴
- There is no exception made for detaining unaccompanied minors. This is of particular concern given that their age and the fact they have travelled alone makes it likely that they are highly traumatised even before entering the asylum process.
- Member States may derogate from some obligations in Article 11 when detention takes place at a border post or in a transit zone if "duly justified".¹³⁵ There is a concern that this leaves a wide margin of interpretation open to Member States to decide when to derogate, thereby undermining the protection of vulnerable persons in border and transit zones.

Have safeguards improved in the new provisions to the EU asylum directives?

The IRCT is extremely concerned that the recast RCD does little to improve the obligations on Member States to conduct full medical evaluations of vulnerable persons in detention, in order to assess whether the detention is negatively impacting on the individual's health. This is particularly regrettable given the likelihood that detention will trigger re-traumatisation for VoTs.

Why are accelerated procedures a risk to victims of torture?

The findings in Part 2 demonstrate that VoTs are at risk of being processed within an accelerated procedure in most EU countries and in Canada. The IRCT finds this concerning as it places VoTs at a greater risk of being returned to their country without a proper and rigorous consideration of all of the evidence in support of their claim. The short time-frames involved in an accelerated procedure fail to take into account the difficulties that a VoT often faces when disclosing the fact that they have experienced torture. The disclosure of past torture is particularly difficult when state authorities are involved in the screening process. The shortened time-limits in an accelerated procedure make it harder for the applicant to obtain an MLR in time to be submitted as evidence, so that it can be considered by the state authorities at the beginning of the determination process. The short time-frames leave little opportunity for an asylum-seeker to seek legal advice, and therefore many asylum-seekers will simply not be aware of what steps they need to take in order to present their claim supported by all relevant evidence. The absence of any clear safeguards to ensure that applicants who have suffered torture or ill treatment are not at risk of return to their country without a rigorous examination of their application is very concerning. The discretion allowed to Member States to include VoTs within an accelerated procedure, if the state authorities decide that “adequate support” can be provided, renders any procedural safeguards for vulnerable persons virtually obsolete. The IRCT believes that the screening of VoTs is in practice often inadequate, and accelerated procedures simply heighten this inadequacy.

Do changes to the EU Asylum Procedures Directive (APD) improve safeguards to prevent vulnerable persons from being considered in an accelerated procedure?

In the EU, the negotiated changes to recast the APD presented an opportunity to ensure that additional safeguards are in place so that vulnerable persons are not considered within an accelerated procedure. During negotiations, a proposal was put forward to ensure that applicants who are considered to have suffered torture or other forms of ill-treatment and sexual violence are not eligible to have their application considered under an accelerated procedure. However, the safeguard was rejected by the Council and not included in the final version of the recast APD. Instead, “applicants in need of special procedural guarantees”¹³⁶ should be provided with “adequate support” in order to allow them to benefit from the rights and comply with the obligations of the Directive. The Member States have the discretion to decide whether the accelerated procedure or procedure at the border allows “such adequate support” to be provided. If it cannot be provided, then the applicant should be placed in the normal asylum procedure.¹³⁷

Canada – changes to the asylum system shorten time-limits

In Canada, the Protecting Canada’s Immigration System Act 2012¹³⁸ introduced shorter time-lines for processing asylum claims, including time-lines for submitting the initial asylum application and for scheduling hearings before the Immigration Refugee Board. In addition, asylum claims from “Designated Countries of Origin” (DCOs) will be fast-tracked.

The time period for submitting an asylum application (“Basis of Claim” form) is now 15 days, significantly reducing the time available for an applicant to seek legal advice and prepare any documentation in support of the claim. In addition, claims submitted by people from DCOs will be fast-tracked (accelerated) and hearings on these cases are expected to be held no later than 30-45 days after referral of the claim, compared to the 60-day time-frame for other asylum applicants.

Failed applicants from DCOs will not be able to appeal the decision to the Refugee Appeal Division, although they will still be able to bring a judicial review claim before the Federal Court. However, even if a judicial review claim is submitted, this will not necessarily prevent the removal of a failed asylum-seeker back to their home country from proceeding.¹³⁹

The changes in Canada are concerning as they remove safeguards that are needed to ensure that vulnerable applicants, including VoTs, are not at a greater risk of being returned to their country of origin without a proper and full examination of their case. The shorter time-frames will make it difficult for VoTs to obtain an MLR to submit as evidence. If the refugee hearing is held before there has been time for the MLR to be prepared, decision-makers will be without an important piece of evidence that can help them make the right determination. The VoT is more likely to be re-traumatised by the hearing process as a result. In addition, the 15-day time limit for an appeal to be submitted does not allow enough time for new evidence to be prepared. This evidence may include an MLR. The shorter time-limits for applicants from “Designated Countries of Origin” are problematic as they allow even less time to prepare their claims. It is also discriminatory to impose a different process for some people, based on their country of origin. In addition, according to the Canadian Council for Refugees, these applicants are likely to face an inbuilt bias against their claim by virtue of the fact that their country is officially deemed not to produce refugees, and therefore are likely to need to obtain more evidence in support of the claim.¹⁴⁰

Why public funding is essential to enable vulnerable asylum-seekers to access independent legal and medical assistance early on in the asylum procedure

The findings in Part 2 show that, in the majority of countries participating in the report, funding for medical and/or psychological assistance to VoTs comes mainly from the UNRVFT, public grants, public health insurance and private funds from NGOs and charities. On the one hand, the results show a good spread of funding sources in most countries, with half of the respondents indicating that funding comes from a combination of all three categories (domestic public funds, private funds and international donors). However, there is a lack of national legislation placing obligations on the state to provide medical or psychological assistance to VoTs, once they are identified. Therefore, there remains a risk that public funding could be withdrawn by a state according to changes in its economic, health and social policy.

The two contrasting examples below illustrate this issue.

Canada – cuts to funding hinders access to healthcare for vulnerable asylum-seekers

The Canadian federal government recently passed legislation that substantially reduces health-care coverage offered to refugees and protected persons within Canada, including asylum applicants awaiting the outcome of their application.¹⁴¹ Prior to these changes, all refugee claimants received uniform health-care coverage, including prescriptions, access to doctors and emergency facilities and other supplementary benefits (including psychotherapeutic services). In addition, failed refugee claimants also received coverage until their removal order came into effect.

Critics of these reforms argue that the changes create a two-tiered health-care system amongst asylum-seekers. Resettled refugees receive more extensive coverage, including supplemental health-care benefits, which include prescribed medication, psychological counselling provided by a registered clinical psychologist and post-arrival health assessments (in addition to hospital and other medical services).¹⁴² However, vulnerable asylum applicants who claim asylum inland, including those who have suffered torture, etc. will receive substantially reduced health-care coverage, as a result of the reforms.

Health-care coverage offered by the state has now been substantially reduced so that refugee claimants now receive preventative care (i.e. medication) only if their condition is a public health risk. They can only access hospital or medical services in emergency situations. Refugee claimants from a designated “safe country” or failed refugee claimants receive no preventative care and no hospital or medical services, except when public health or safety is at risk.¹⁴³ According to the Depart-

...

ment of Psychiatry at the University of Toronto, “The changes will deprive refugees of basic physical and mental health care... Refugees who have suffered inhumane treatment and trauma in their own countries... will now also encounter systemic barriers to care.”¹⁴⁴

As part of the cuts to health care, psychological services provided to VoTs are no longer available for refugees, including the services provided by some of the IRCT member centres in Canada. The coverage of psychotherapy for VoTs has been eliminated, for anything other than public safety concerns. As the Canadian Council for Refugees points out, “This leaves deeply traumatised refugees without specialised support as they struggle to get back on their feet. The rationale for cutting these services was that refugees should not get health services that are not provided to citizens. But most Canadians (thankfully) have not been subjected to torture, nor had traumatising experiences of war.” It is noted that cutting support to traumatised refugees in Canada is inconsistent with the Canadian government’s support of psychosocial services for traumatised persons overseas, through funding from the Canadian International Development Agency (CIDA).¹⁴⁵

The USA – Torture Victims Relief Act provides some funding opportunities

The Torture Victims Relief Act of 1998 (TVRA) is an example of national legislation introduced to provide funding through a competitive grant process to rehabilitation centres to offer a comprehensive programme of support for VoTs. The legislation recognises that a significant number of refugees and asylum-seekers entering the USA have suffered torture and are in need of rehabilitation services in order to become fully integrated and productive members of the community. The funding provides grants to a range of services, including rehabilitative treatment for the physical and psychological effects of torture, social and legal services, research and training for health-care providers outside of treatment centres. Clients are determined as eligible for the Services for Survivors of Torture Program based on the definition of torture in accordance with the TVRA authorising legislation.¹⁴⁶ Despite this legislation, rehabilitation centres have to seek diversified funding to cover the costs of providing comprehensive services to VoTs. Many of IRCT’s member centres in the USA face inadequate sources of funding, and there is some inconsistency with which centres receive funding via the legislation. In addition, member centres report that the government agency that has oversight of the TVRA does not have experience working with asylum-seekers and, as such, is limited in its expertise with regard to clients’ forensic needs.

The funding of rehabilitation services for VoTs poses a continuous challenge to IRCT and its member centres. The Committee against Torture’s General Comment on Article 14 UNCAT makes clear that states have an obligation to provide for “as full rehabilitation as possible”. This includes to asylum-seekers and refugees and the obligation does not relate to the available resources and may not be postponed. In addition, the General Comment indicates that the obligation to provide rehabilitative services should either be directly by the state, or through the funding of private medical, legal and other facilities, including those administered by NGOs.¹⁴⁷ Unfortunately, very few states yet comply with these obligations, thus leaving NGOs to struggle to obtain sufficient funding to provide the necessary rehabilitation to VoTs.

4

CONCLUDING REMARKS

The report considers two key elements relating to the treatment of VoTs within asylum procedures. The first element considers whether there are systems in place (either through law or policy) to identify VoTs early on in the asylum procedure, to enable them to access appropriate medical, psychological, legal and social services. The second element addresses the extent to which MLRs are used and accepted as evidence within asylum procedures. The experiences of the member centres participating in the empirical research form the basis for providing a comparative overview of the three regions in the report. From the findings, the IRCT has identified current challenges and gaps in the national asylum procedures. The research does not attempt to draw direct comparisons between countries given that the context in each country will vary greatly in many aspects, including the procedures in place, numbers of asylum-seekers, main countries of origin, etc. By way of summary, the key shortfalls underlined by the research are listed in this section.

Key shortfalls: early identification of victims of torture

- There remains significant gaps both in law and policy in most countries covered by the report concerning the early identification of VoTs. The case studies in Part 3 show that even where there is a policy in place, it is often poorly implemented, therefore failing to provide the necessary protection to VoTs.
- Where there is a specific policy in place for identifying VoTs, this is often part of a policy to detain asylum-seekers, e.g. in Australia and the UK. The identification of VoTs within detention settings is only of benefit to VoTs if it leads to their immediate release, given the debilitating effect that detention is recognised as having on the physical and mental health of an individual.
- In the EU, the standards and extent of implementation of procedures to identify vulnerable persons varies widely between Member States. However, the new provisions to the Reception Conditions Directive place a legal obligation on Member States to introduce mechanisms for screening asylum-seekers to identify those who are vulnerable and have special reception needs.

Key shortfalls: use and acceptance of MLRs in national asylum procedures

- There are concerns that the quality of MLRs does not always meet the standards outlined in the Istanbul Protocol. Some countries have indicated there is a lack of suitably trained medical professionals to produce MLRs to the standards outlined in the Istanbul Protocol.
- Concerns have been raised about the independence of medical staff carrying out MLRs, particularly in cases where the asylum-seeker is in detention. In cases where state institutions provide MLRs, it is paramount that the medical staff is independent and impartial, as reflected in the Istanbul Protocol.
- Immigration officials acceptance of MLRs continues to be varied. MLRs are often rejected due to a lack of understanding of how the evidence should be considered.
- Access to and financing of an MLR in most cases is difficult, particularly when immigration authorities and judges rarely order an independent MLR to be financed within the procedural costs of an asylum case.

Key shortfalls: specific areas of concern

- Accelerated procedures are increasingly used by asylum-receiving countries to attempt to process certain types of claims more quickly. Accelerated procedures hinder the full and proper examination of an asylum claim, and fail to take into account that extended time may be required to obtain medical and/or psychological evidence in support of a past torture claim.
- The detention of asylum-seekers, but particularly those who are vulnerable, is a major concern and occurs in the majority of the countries covered by this report. No asylum applicant should have to be detained during the asylum procedure, and where detention is needed to effect removal of failed asylum-seekers, it should only ever be used as a measure of last resort and in exceptional circumstances.
- The detention of VoTs is of particular concern to the IRCT given that immigration detention is highly likely to cause re-traumatisation. Research from various countries indicates that detention exacerbates health problems, both in the short and long-term.¹⁴⁸
- The shortage of public funding and other financial resources are key issues of concern for IRCT's member centres when providing services to asylum-seekers. States must recognise that

their obligations to provide funding for services directed at the medical and psychological treatment and social support of VoTs includes asylum-seekers and refugees.¹⁴⁹ It is concerning that many governments are cutting the public funding available for the most vulnerable sectors of the population.

The IRCT encourages the readers of this report to influence the different stakeholders involved in national asylum procedures and the provision of rehabilitation services to address the current gaps and shortfalls in the protection offered to victims of torture at the national, regional and global level. The final part of this report lists our recommendations.

5

RECOMMENDATIONS

The IRCT makes the following key recommendations to stakeholders. In addition, the participating member centres have made specific recommendations, relevant to their particular country context, which are outlined in Annex I.

To state authorities:

- Introduce national legislation that makes reference to the early identification of victims of torture and the use of MLRs as an evidential tool in asylum proceedings.
- Introduce mechanisms for the early identification of victims of torture, for example, through medical and psychological screening at the national or regional level. The planned inclusion of the PROTECT tool in the European Asylum Curriculum (the training component) of the European Asylum Support Office (EASO) is an example of a regional initiative to improve mechanisms.
- Introduce training programmes for:
 - State officials who interview asylum applicants. Training is essential to recognise signs and symptoms of torture or trauma.
 - State officials who issue the initial asylum decision. Training is essential on how to consider medical evidence alongside all other evidence in an asylum application. In addition, awareness must be raised of the guidelines set out in the Istanbul Protocol, as well as of intercultural communication and communication with the support of interpreters.¹⁵⁰
- Improve collaboration with:
 - Health professionals who examine and treat VoTs. Health professionals who treat VoTs should be consulted to ensure that the standard of training meets the accepted guidelines, including the Istanbul Protocol.
 - Rehabilitation centres that treat VoTs. Input from rehabilitation centres will lead to a better understanding and acceptance of the medical issues that concern victims of torture and which impact on an asylum-seeker's ability to communicate with state authorities and present their case coherently and effectively.
- Increase the capacity and financing for medical and psychosocial treatment in all asylum-receiving countries in recognition of states' obligations under Article 14 UNCAT.
- Abolish the detention of all asylum-seekers and victims of torture under all circumstances. Policies to identify VoTs within detention centres are not sufficient protection as they are often poorly implemented due to a lack of resources and poor training of staff. Therefore, the complete abolition of detention of vulnerable asylum-seekers will be the only satisfactory conclusion.

To civil society:

- Develop tools to advocate for changes to national asylum policy. NGOs and rehabilitation centres must play an active role by advocating that states implement tools and mechanisms to ensure that state officials involved in asylum proceedings are able to recognise signs and symptoms of torture or trauma. The PROTECT tool, discussed in Part 3, provides an example of this type of initiative.
- Improve data collection, for example, on the numbers of asylum-seekers who are VoTs and the cost/benefits of early access to healthcare. Data is essential to support the sector's understanding of the issues and to support advocacy. For example, data on the cost/benefits of early treatment can be used to advocate the benefits that states would experience by increasing the funding provided to support vulnerable asylum-seekers, including victims of torture.

To medical and health professionals:

- Provide training to all medical and health professionals to improve the quality of MLRs so that they meet the standards outlined in the Istanbul Protocol. For example, the examination and documentation of torture should be included in the national university curriculum, and peer-to-peer training support should be encouraged amongst medical and health professionals. In addition, general practitioners must be trained to recognise symptoms and signs of torture and trauma, so that they are able to make a referral to a relevant medical or psychological expert for an MLR if required.
- Encourage collaboration with state authorities, to develop training programmes to be provided to state officials to aid the early identification of VoTs and improve the quality of decision-making where MLRs are relied on. Barriers in communication and a lack of trust towards state authorities also need to be broken down if collaboration on training programmes is to be successful.¹⁵¹
- Research is essential to build on the current understanding of the health effects that the asylum process has on VoTs. Additional research on the cost/benefits to states that provide for the early identification of VoTs is also needed to demonstrate that early identification not only benefits the individual but also the state.

To legal professionals:

- Clarify the relevant guidelines to the use of MLRs in procedures, including when payment should be covered by the state.
- Provide training to legal professionals involved in asylum proceedings:
 - Immigration judges involved in asylum tribunal and court proceedings must receive training on the recognition of the signs and symptoms of torture and trauma and on the standards and guidelines in the Istanbul Protocol. Research shows that the treatment of MLRs by tribunal and court judges can be varied, suggesting that more training is required. This can be the case even where there are specific guidelines in place on procedures with respect to vulnerable persons appearing before the immigration tribunal or court.¹⁵²
 - Legal representatives who advise asylum applicants must receive training from medical professionals on recognising the signs and symptoms of torture or trauma, so that they are able to make referrals to relevant medical and/or psychological experts if they think that a client may have suffered past torture or trauma, or that an MLR should be submitted as evidence. This is particularly important as many VoTs will first come into contact with a legal representative.
- Improve collaboration between legal and medical professionals to provide good quality training on the recognition of signs and symptoms of torture or trauma and the use of MLRs as an evidential tool, in compliance with the Istanbul Protocol standards.

ANNEX 1
KEY RECOMMENDATIONS
TO STAKEHOLDERS FROM
IRCT MEMBER CENTRES

To state authorities:

National asylum legislation should make reference to the early identification of victims of torture and use of MLRs

Key recommendations	Member centre, Country
<ul style="list-style-type: none">The identification of VoTs on arrival is important. At present, if a person claims to be a VoT, he/she can apply for a medical examination and present the examination results during the asylum procedure. However, the role of MLRs needs to be outlined in the asylum procedure.	FAVL, Armenia
<ul style="list-style-type: none">A provision in the national asylum law should be included about identification, care and treatment of VoTs.	ACET, Bulgaria
<ul style="list-style-type: none">Legislation is needed that places a clear obligation on the state to provide access to MLRs.	Swedish Red Cross, Malmö, Sweden

Introduce mechanisms for the early identification of victims of torture

Key recommendations	Member centre, Country
<ul style="list-style-type: none">Capacity development for all actors in reception and asylum procedures is needed, especially regarding the early identification and documenting of torture, e.g. by border police, detention staff, asylum decision-makers and organisations providing psychosocial support.	RCT, Croatia
<ul style="list-style-type: none">Mechanisms for the early identification of VoTs at the beginning of the asylum procedure should be introduced. Medical and psychological screening and access to MLRs is required and should be introduced in all federal states.	MFH Bochum, Germany
<ul style="list-style-type: none">Early identification will facilitate early access to legal advice for VoTs.	SPIRASI, Ireland
<ul style="list-style-type: none">Early identification will facilitate the referral of VoTs for further examination and medical documentation through MLRs. More recognition of the special position of VoTs, including early detection, legal assistance and, if necessary, medico-psychological treatment and rehabilitation is needed.	RvA NL, the Netherlands

Introduce training programmes on the signs and symptoms of torture, early identification of VoTs and consideration of MLRs as evidence

Key recommendations	Member centre, Country
<ul style="list-style-type: none"> The MLR should be taken into account more effectively in the decision-making process. 	CTSf, Finland
<ul style="list-style-type: none"> More training for immigration authority staff (BAMF) is needed, as well as more consideration of MLRs. 	bzfo, Germany
<ul style="list-style-type: none"> Training of immigration officials on the consideration of MLRs is needed. Immigration officials do not consider the majority of MLRs produced by the centre correctly, and as a result these MLRs are not accepted. 	SPIRASI, Ireland
<ul style="list-style-type: none"> Provision of training to immigration officials (referred to as Eligibility Commissions) is required. There is a high staff turnover, and lack of training means that staff are often unaware of the particular clinical signs shown by VoTs. Higher uniformity in decision-making procedures of Eligibility Commissions is necessary to ensure the equal treatment of asylum applications throughout Italy. 	Vi.TO/CIR, Italy
<ul style="list-style-type: none"> Provision of training to staff at the Migration Board should include how to question applicants about torture. 	Swedish Red Cross, Malmö, Sweden
<ul style="list-style-type: none"> The consideration of MLRs varies greatly throughout the USA suggesting that more training should be provided to judges and immigration officials. 	ASTT, USA
<ul style="list-style-type: none"> Decision-makers need to understand the purpose and use of an MLR and the way in which it can assist fair decision-making. They need to be better informed about how to evaluate whether evidence is expert and accurate. 	Foundation House, Australia

Improve collaboration with health professionals who are trained in producing MLRs

Key recommendations	Member centre, Country
<ul style="list-style-type: none"> Where there are signs of torture or trauma, access to a specially trained independent health professional should be given. Costs of the MLR should be paid by the state. Many clients find it very difficult to find a doctor or psychologist who can produce MLRs. 	bzfo and MFH Bochum, Germany
<ul style="list-style-type: none"> There is need for a more systematic way by which decision-makers can draw on appropriate expertise. More medical and psychological expertise needs to be made available to the Tribunal. 	Foundation House, Australia
<ul style="list-style-type: none"> Health professionals should be more widely recognised as experts in the asylum application process by immigration authorities. 	NVFS, USA

Funding in order to access MLRs and to provide training is required, which should be provided by the state

Key recommendations	Member centre, Country
<ul style="list-style-type: none">• More funding is required from the state in order to access MLRs.	Foundation House, Australia
<ul style="list-style-type: none">• There is a need for more resources and processes dedicated to MLRs. The state needs to provide more resources to use for training on the production and use of MLRs. There are private practitioners who RASNZ assisted with training and materials. However, practitioners are not adequately resourced by the government to carry out their work.	RASNZ, New Zealand

To medical and health professionals:

Provide training to all medical and health professionals on producing MLRs that comply with the Istanbul Protocol standards

Key recommendations	Member centre, Country
<ul style="list-style-type: none">• Training for medical staff is required.	FAVL, Armenia
<ul style="list-style-type: none">• Raise awareness that an assessment of psychological consequences of torture and ill treatment is needed, not only the physical consequences.	RCTV Memoria, Moldova

To legal professionals:

Clarify procedural guidelines on the use and application of MLRs in asylum proceedings

Key recommendations	Member centre, Country
<ul style="list-style-type: none">The applicant should be able to lodge a judicial review challenge when there has been the unwarranted dismissal of a probative and relevant expert report.	Foundation House, Australia
<ul style="list-style-type: none">Introduce MLRs as legal documents and ensure they follow Istanbul Protocol guidelines, i.e. are standardised.	RCT Zagreb, Croatia
<ul style="list-style-type: none">There is a need for official evaluation and recommendations on best practices with regards to the use of MLRs in asylum procedures at the international and regional (e.g. EU) level.	Cordelia Foundation, Hungary
<ul style="list-style-type: none">Guidelines have been introduced that place an obligation on the Migration Board to request an MLR if torture is raised. However, these do not go far enough, as the applicant first needs to raise torture in the asylum interview.¹⁵³	Swedish Red Cross, Malmö, Sweden
<ul style="list-style-type: none">More consistent use and application of MLRs in the asylum procedure is needed.	Survivors of Torture, International, USA

Provide training to raise awareness of the importance of medical evidence (and MLRs) in asylum procedures

Key recommendations	Member centre, Country
<ul style="list-style-type: none">The Ombudsman needs to be made aware of the needs of VoTs among asylum-seekers and of the important role that MLRs play in the asylum procedure. With Croatia's accession to the EU, it is expected that the numbers of asylum-seekers will rise significantly so the need is urgent. This urgency is even more necessary given the very low numbers of asylum requests that have been received to date, the low acceptance rate and the lack of integration of asylum-seekers and other immigrants.¹⁵⁴	RCT Zagreb, Croatia
<ul style="list-style-type: none">Medical evidence should be more widely requested by tribunals and courts.	SPIRASI, Ireland

Improve collaboration between legal professionals and other stakeholders

Key recommendations	Member centre, Country
<ul style="list-style-type: none">The verification and certification of medical evidence through MLRs needs to be more widely used. Roundtable discussions with lawyers, judges and immigration authorities to raise awareness of victims' needs must continue.	bzfo, Germany

Notes and references

1. The Universal Declaration of Human Rights (UDHR). Adopted by UN General Assembly Resolution 217A (III) of 10 December 1948, Article 14.
2. United Nations Convention relating to the Status of Refugees. Adopted by the UN General Assembly on 28 July 1951. Available at: <http://www.unhcr.org/>.
3. Article 7 of the International Covenant on Civil and Political Rights (ICCPR), entered into force 23 March 1976; Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UNCAT), entered into force 26 June 1987; Article 5 of the Universal Declaration of Human Rights (UDHR).
4. Article 3 of the European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR), entered into force 3 September 1953; Article 4 of the EU Charter of Fundamental Rights, entered into force 18 December 2000; Article 5 of the American Convention on Human Rights (ACHR), entered into force 18 July 1978.
5. Article 5 of the UDHR reads, "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment." This Article is widely regarded as expressing customary international law. See for example: Association for the Prevention of Torture (APT) and Center for Justice and International Law (CEJIL), *Torture in International Law: A guide to jurisprudence*, 2008, p.6.
6. Article 33 of the UN Refugee Convention: Prohibition of expulsion or return ("Refoulement"); Article 3 of the UNCAT: "No State Party shall expel, return ("refouler") or extradite a person to another State where there are substantial grounds for believing that he would be in danger of being subjected to torture."
7. UN Committee against Torture. General Comment No. 3: Implementation of Article 14 by State parties. 13 December 2012. Paragraphs 11 and 22. Available at: <http://www2.ohchr.org/english/bodies/cat/GC3.htm>.
8. Ibid. Paragraph 13.
9. Norredam M. Access to health-care for asylum seekers. *European Journal of Public Health*. 2005; 16 (3):285-289.
10. World Psychiatry Association guidance on mental health and mental health care in migrants. *World Psychiatry*. 2011; 10 (1):2-10.
11. Heeren M., Mueller J., et al. Mental health of asylum-seekers: a cross-sectional study of psychiatric disorders. *BMC Psychiatry*. 2012; 12:114.
12. In a study carried out in 2005 on the mental health of Cambodian refugees who had resettled in the USA, 54% of the respondents reported torture. See Marshall G N. Schell T.L. etc., cited in Carswell K., Blackburn P., Barker C. The relationship between trauma, post-migration problems and the psychological well-being of refugees and asylum seekers. *International Journal of Social Psychiatry*. 2011 Mar; 57(2):107-19.
13. Jaranson J. et al. Somali and Oromo refugees: Correlates of torture and trauma history. *American Journal of Public Health* 2004; 94(4): 591-598; Kinzie J D. et al. Prospective one-year treatment outcomes of tortured refugees: a psychiatric approach. *Torture*. 2012; 22 (1): 1-10.
14. Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (the Istanbul Protocol). 2004. HR/P/PT/8/Rev.1.
15. Battjes H. in *Care Full: Medico-legal reports and the Istanbul Protocol in asylum procedures*. 2006. p.27.
16. Mueller J., Schmidt M., Staeheli A., Maier T. Mental health of failed asylum seekers as compared with pending and temporarily accepted asylum seekers. *European Journal of Public Health*. 2010; 21 (2): 184-189.
17. Herlihy J., Turner S. Should discrepant accounts given by asylum seekers be taken as proof of deceit? *Torture* 2006; 16(2): 81-92.
18. As a minimum, the MLR should include the circumstances of the interview, history, physical and/or psychological examination, opinion and authorship. See Principles on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, in Annex I to the Istanbul Protocol, para. 6(b).
19. UNHCR. *Asylum Trends 2012: Levels and Trends in Industrialized Countries*. March 2013. p.7.
20. Ibid. p.3. The main source countries for asylum-seekers in the industrialised asylum-receiving countries are Afghanistan, the Syrian Arab Republic, Serbia (and Kosovo), China and Pakistan.
21. Ibid. p.3.
22. UNHCR Research Paper No. 253. *Refugee resettlement: 2012 and beyond*. February 2013. p.20. Resettlement involves the selection and transfer of refugees from one state in which they have sought protection to a third state which has agreed to admit them, as refugees, with permanent residence status. In 2012 the UNHCR reported that 90% of resettlement places for refugees are provided by the USA, Canada and Australia. By contrast, only 11 EU countries have national annual resettlement programmes, and they contributed to only 6.6% of the global total number of resettlement places in 2011. Available at: <http://www.unhcr.org/510bd3979.html> (last accessed on 23 September 2013).
23. UNHCR. Executive Committee of the High Commissioner's Programme. Progress report on resettlement. June 2012. p.2. Report No: EC/63/SC/CRP.12. Available at: <http://www.unhcr.org/5006a6aa9.html> (last accessed on 23 September 2013). The EU resettlement programme intends to increase the number of resettlement places made available in the European Union, harmonise and coordinate resettlement priorities among EU Member States, and contribute to

- greater funding opportunities for resettlement. Since 2010, four EU countries have started to establish resettlement programmes - Bulgaria, Germany, Hungary and Spain.
24. UNHCR. *Asylum Trends 2012: Levels and Trends in Industrialized Countries*. March 2013. p.7. This compares to the 19% increase that Europe experienced in 2010/2011 (reference: UNHCR. *Asylum Levels and Trends in Industrialized Countries*. 2011. p.7).
 25. *Ibid.* p.7. The 15 pre-2004 ('old') EU Member States accounted for 93% of all asylum claims in the EU.
 26. *Ibid.* The Nordic countries comprise: Denmark, Finland, Iceland, Norway and Sweden. Sweden received 70% of all asylum claims in the Nordic region.
 27. *Ibid.* p.8. Southern European countries comprise: Albania, Cyprus, Greece, Italy, Malta, Portugal, Spain and Turkey. The drop is due to a fewer number of boat arrivals in Italy than occurred in 2011. In contrast, Turkey continued to see an increase (+8%) in new asylum claims for the third consecutive year (this figure excludes Syrians registered in refugee camps).
 28. The Common European Asylum System (CEAS) was created to address the disparities in asylum systems and practices among EU Member States through the harmonisation of asylum systems within the EU. The first phase of the CEAS, completed in 2006 under the Hague Programme (2004-2009), included three directives and one regulation. These instruments were reviewed as part of the current second phase of the CEAS (2010-2014). The European Commission proposed improvements and modifications in four "recast proposals", which were negotiated with the European Parliament and European Council (made up of relevant ministers from all EU Member States). The amendments were formally adopted in June 2013.
 29. Council Directive 2003/9/EC of 27 January 2003 laying down minimum standards for the reception of asylum seekers (Reception Conditions Directive). OJ L 31/18; Council Directive 2004/83/EC of 29 April 2004 on minimum standards for the qualification and status of third country nationals or stateless persons as refugees or as persons who otherwise need international protection and the content of the protection granted (Qualification Directive), [2004] OJ L 304/12; Council Directive 2005/85/EC of 1 December 2005 on minimum standards on procedures in Member States for granting and withdrawing refugee status (Asylum Procedures Directive). OJ L 326/13.
 30. Commission Regulation (EC) No 1560/2003 of 2 September 2003 laying down detailed rules for the application of Council Regulation (EC) No 343/2003 establishing the criteria and mechanisms for determining the Member State responsible for examining an asylum application lodged in one of the Member States by a third-country national. OJ L 222/3 ("Dublin II Regulation"). The Regulation outlines the arrangements under which an asylum applicant may be returned to another EU Member State and aims to prevent the secondary movement of asylum-seekers within the EU, whilst ensuring they have effective access to procedures for determining refugee status as quickly and efficiently as possible. The amendments to the Dublin II Regulation were negotiated as part of the second phase of the CEAS and were formally adopted in the Dublin III Regulation in July 2013.
 31. In November 2007 the European Commission presented an Evaluation Report on the Reception Conditions Directive in which it concluded that poor implementation of the provisions meant that asylum-seekers were not provided with an adequate standard of living in many EU Member States. Asylum-seekers also faced significant legal and practical obstacles to access employment, education and health care.
 32. *M.S.S. v. Belgium and Greece* (Application no. 30696/09), judgment of 21 January 2011. The court found that Greece was in violation of Article 3 ECHR due to the inhuman and degrading detention and living conditions that an asylum applicant had been placed in whilst awaiting his asylum determination in Greece. In addition, the court considered that by transferring the applicant to Greece, under the Dublin II Regulation, the Belgian authorities knowingly exposed him to conditions of detention and living conditions that amounted to degrading treatment, and therefore Belgium was also found to have violated Article 3 ECHR.
 33. UNHCR. *Asylum Trends 2012: Levels and Trends in Industrialized Countries*. March 2013. p.8.
 34. UNHCR *Resettlement Handbook*, Country Chapters – Canada, July 2011, section 8.2.
 35. Canada. Immigration and Refugee Board of Canada. *Guideline on Procedures with Respect to Vulnerable Persons Appearing Before the IRB*. Paragraph 1.5.
 36. Amnesty International. *Annual Report 2012 on Canada*. Available at: <http://www.amnesty.org/en/region/canada/report-2012#section-24-5> (accessed on 14 May 2013).
 37. Meffert S., Musalo K., McNeil D. and Binder R. *The Role of Mental Health Professionals in Political Asylum Processing*. *Journal of American Psychiatry Law*. 2010; 38: 479-89.
 38. Physicians for Human Rights. *Factsheet on One-Year Bar to Asylum*. Available at: https://s3.amazonaws.com/PHR_other/factsheets/One-Year-Bar.pdf (last accessed on 23 September 2013). The one-year deadline will only be waived on the basis of changed or extraordinary circumstances, but it is often difficult to satisfy asylum officers, immigration judges and board of immigration appeals (BIA) personnel reviewing asylum claims filed after one year that an application meets one of these broad exceptions.
 39. Physicians for Human Rights. *Factsheet on Asylum and Other Relief for Immigrant Victims of Violence and Persecution*. Available at: https://s3.amazonaws.com/PHR_other/factsheets/asylum-and-other-relief.pdf (last accessed on 23 September 2013). Note, however, that the Supreme Court has only accepted review of a handful of asylum cases since the Refugee Act was authorised in 1980.
 40. Ramji-Nogales J. et al. *Refugee Roulette: Disparities in Asylum Adjudication*. *Stanford Law Review*. 2007; 60(2): 309. For an overview of the US

- asylum process, refer to Part I.
41. UNHCR. *Asylum Trends 2012: Levels and Trends in Industrialized Countries*. March 2013. p.8. One third of asylum-seekers in Australia originate from Afghanistan or Sri Lanka.
 42. Australia. *Australia Human Rights Commission*. Available at: www.humanrights.gov.au/publication/asylum-seekers-and-refugees (last accessed on 23 September 2013).
 43. Professor Triggs G., President of the Australian Human Rights Commission. Speech delivered to the United Nations Association of Australia (WA Division): *Current issues Australia faces in relation to its treatment of refugees*. 24 October 2012. Available at: http://www.humanrights.gov.au/about/media/speeches/speeches_president/2012/20121024_refugees.html (last accessed on 23 September 2013).
 44. New Zealand Human Rights Commission. Available at: <http://www.hrc.co.nz/report/chapters/chapter12/asylum2.html> (last accessed on 23 September 2013).
 45. Poole G.E. and Galpin G. *Prevalence of victims of torture in the health screening of quota refugees in New Zealand during 2007-2008 and implications for follow-up care*. *New Zealand Medical Journal*. July 2011; 124.
 46. New Zealand. *Immigration New Zealand. Immigration Act 2009: Refugee and protection status determinations*. Available at: <http://www.immigration.govt.nz/migrant/general/generalinformation/immigrationact/factsheets/refugees.htm> (last accessed on 23 September 2013).
 47. The ICAR Foundation (Romania) carried out a survey on Medical Certification on Torture in April 2012. Some of the questions in the survey, which are relevant to the issues raised in this report, are referred to in the analysis in Part 2.
 48. Denmark, The Danish Institute Against Torture – DIGNITY; and Serbia, International Aid Network – Center for Rehabilitation of Torture Victims (IAN-CRTV).
 49. Croatia became the 28th EU Member State on 1 July 2013. Turkey is a candidate country to the EU. Kosovo is a potential candidate country.
 50. See for example: Swiss Refugee Council. *Asylum procedure and reception conditions in Italy: Report on the situation of asylum seekers, refugees, and persons under subsidiary or humanitarian protection, with focus on Dublin returnees*. May 2011. Available at: <http://www.refworld.org/docid/4e2699b92.html>; and UNHCR. *Observations on Greece as a country of asylum*. December 2009. Available at: <http://www.unhcr.org/refworld/docid/4b4b3fc82.html> (last accessed on 23 September 2013).
 51. See Part 3 for more detailed discussion on the changes to the EU Reception Conditions Directive.
 52. It is interesting to note that from 1998 to 2008 asylum-seekers were given a mandatory medical screening which was funded by the Armenian state. However, the law was amended in 2008 and medical screening, was removed as a standard requirement. However, a medical examination can be conducted on a voluntary basis.
 53. If the answer to this question was affirmative, centres were asked to specify the institution that those responsible for identifying VoTs belong to, what profession they have, what training they receive and who provides the training.
 54. Baff (German Association of Psychosocial Centres for Refugees and Victims of Torture) is the umbrella organisation of NGOs providing counselling and treatment to VoTs and refugees in Germany. See: <http://www.baff-zentren.org/>. See also: www.sbp.de.
 55. Canada. The Immigration and Refugee Protection Act (IRPA), S.C. 2001, c. 27. grants the Immigration and Refugee Board (IRB) jurisdiction with respect to claims for refugee protection, which includes those applicants in danger of torture, who are considered by the IRB to be a person in need of protection. See: <http://www.irb-cisr.gc.ca/> (accessed on 21 May 2013).
 56. The Netherlands. Medical advice is outlined in *Vreemdelingencirculaire, Vc C 11/6* and the working instruction for lawyers and immigration officers (WI 2010/13). MLRs as medical evidence are mentioned in *Vc C 14/3.5.2*. Available at: <http://wetten.overheid.nl/> (accessed on 29 April 2013).
 57. Bundesverwaltungsgericht (Federal Administrative Court, BVerwG), U. v. 11.9.2007, 10 C 8.07.
 58. For further explanation see: *Deutscher Anwalt Verein Arbeitsgemeinschaft Ausländer- und Asylrecht (2008). Traumatisierung: Wann muss aufgeklärt werden?* In: ANA-ZAR 1. 2008: 6. Kleinhans M., Bell R., Zeiger H. *Amtsermittlungspflicht bei einer geltend gemachten PTBS- Erkrankung (2008) Bundesamt für Migration und Flüchtlinge. Entscheidungen Asyl*.
 59. See Part 3 for further discussion on changes to the asylum directives in the CEAS.
 60. See Part 3 for further discussion on *RC v Sweden* (application no. 41827/07), March 2010.
 61. Canada. *Immigration and Refugee Board. Guideline on procedures with respect to vulnerable persons appearing before the IRB*. December 2006. Paragraph 1.5 states: “A person’s vulnerability may be due to having experienced or witnessed torture or genocide or other forms of severe mistreatment”. Paragraph 7 refers to early identification, 7.1 states: “A person can be identified as vulnerable at any stage of the proceedings. It is preferable to identify vulnerable persons at the earliest opportunity”. Paragraph 7.3 states: “Counsel for a person who may be considered vulnerable is best placed to bring the vulnerability to the attention of the IRB, and is expected to do so as soon as possible.”
 62. *Ibid.* paragraph 8.5.
 63. Australia. *Migration Act 1958 and Migration Regulations (SR 1994, No. 268)*. Available at: <http://www.comlaw.gov.au/> (accessed on 21 May 2013).
 64. Australia. *Migration Review Tribunal and Refugee Review Tribunal. Guidance on the Assessment of Credibility*. See 2.1, 8.2 and 8.4.
 65. *Care Full: Medico-legal reports and the Istanbul Protocol in asylum procedures*. 2005. p.151. See also Part 3 for discussion on accelerated procedures.
 66. The terminology differs, e.g. in Germany this is referred to as a subsequent procedure; in France

- and Italy a re-examination; in Sweden a review.
67. Care Full report. 2005. p.153-4.
 68. Canada. Immigration and Refugee Board. Guideline on procedures with respect to vulnerable persons appearing before the IRB. 8.4.
 69. The member centre in Australia further noted that this does not include a judicial review stage of national asylum proceedings (i.e. a challenge brought by a failed asylum seeker against the state in relation to a decision to refuse asylum on one or more public law grounds).
 70. Australia. Migration Review Tribunal and Refugee Review Tribunal. Guidance on the Assessment of Credibility. 8.2, 8.4 and 8.5.
 71. Ibid. paragraph 44.
 72. Hungary. Cordelia Foundation confirmed that funding for MLRs is from the European Refugee Fund (ERF) and UNVFT. The government matches the ERF's contribution, so it indirectly contributes to funding the costs of MLRs.
 73. Some of the additional information on costs of MLRs was provided by centres in Finland, Ireland, Moldova and Sweden in response to the ICAR Foundation survey: Medical certification on Torture. April 2012.
 74. SBPM is a Working Group in Germany that has produced 'Standards on the assessment of reactive mental trauma episodes'. See <http://sbpm.de>.
 75. See for example: Haenel F. and Wenk-Ansohn M. (Ed.). Begutachtung psychisch reaktiver Traumafolgen in aufenthaltsrechtlichen Verfahren. Weinheim: Beltz. 2004; Wenk-Ansohn M., Scheef-Maier G., Gierlichs H.W. Zur Begutachtung psychisch reaktiver Traumafolgen in aufenthaltsrechtlichen Verfahren – ein Update. In: Jr. Feldmann, G.H. Seidler (Ed.). Traum(a) und Migration. Psychosozial Verlag. 2013: p.283.
 76. Human Rights Foundation of Turkey (TIHV) did not participate in the IRCT questionnaire. However, more information on the training it offers and its work with asylum-seekers and refugees is available at: <http://www.tihv.org.tr/> (accessed on 20 May 2013).
 77. Ireland. Criminal Justice (United Nations Convention against Torture) Act 2000. Available at: http://emn.ie/cat_search_detail.jsp?clog=4&itemID=36&item_name (accessed on 8 May 2013).
 78. This additional information on referrals was provided by member centres in response to the ICAR Foundation survey, April 2012.
 79. Amnesty International. Annual Report on France, 2012. Available at: <http://www.unhcr.org/refworld/country,COI,,FRA,,4fbc393cc,o.html> (last accessed on 23 September 2013).
 80. The "airport procedure" was highlighted to the UN Committee against Torture in a Parallel Report, Complementing the 5th Periodic Report of the Federal German Government (CAT/C/DEU/5) in accordance with the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. Submitted in 2011 by: Behandlungszentrum für Folteropfer (Berlin Center for the Treatment of Torture Victims (bzfo)), Internationale Ärzte für die Verhütung des Atomkrieges, Ärzte in sozialer Verantwortung, (IPPNW; International Physicians for the Prevention of Nuclear War, German Section: Physicians in Social Responsibility), Refugio München (Counseling and Treatment Center for Refugees and Victims of Torture, Munich) & Jesuiten-Flüchtlingsdienst Deutschland (Jesuit Refugee Service Germany, (JRS)). The shortfalls highlighted in the Parallel Report are referred to in more detail in Part 3 of this report.
 81. For more information see: <http://www.bamf.de/EN/Migration/AsylFluechtlinge/Asylverfahren/BesondereVerfahren/besondereverfahren-node.html> and <http://www.proasyl.de/en/topics/basics/asylum-from-a-to-z/> (accessed on 21 May 2013).
 82. iMMO indicated that there is an accelerated procedure in which VoTs can be processed. RvA NL indicated that there is no accelerated procedure.
 83. UN Human Rights Committee. Concluding observations of the Netherlands. 25 August 2009. CCPR/C/NLD/CO/4. Paragraph 9.
 84. Amnesty International. Amnesty International Annual Report 2012 – Netherlands. May 2012. Available at: <http://www.refworld.org/docid/4fbc3920c.html> (accessed on 24 April 2013).
 85. Canada. Citizenship and Immigration Canada website: <http://www.cic.gc.ca/> (accessed on 21 May 2013).
 86. The member centre in Baltimore – ASTT – confirmed that some asylum hearings are expedited, for example, if the applicant has a sound claim but did not meet the one-year deadline for filing the asylum application, they may be automatically sent for a court hearing.
 87. Jesuit Refugee Service. Becoming Vulnerable in Detention (The DEVAS Project). June 2010. Available at: www.jrseurope.org (accessed on 21 May 2013).
 88. Amnesty International. Annual Report 2012 - the Netherlands. May 2012. Available at: www.amnesty.org/en/region/netherlands/report-2012 (last accessed on 23 September 2013).
 89. Amnesty International. Amnesty International Annual Report 2012 – Germany. May 2012. Available at: <http://www.unhcr.org/refworld/docid/4fbc393a6e.html> (accessed 21 May 2013).
 90. The response from FAVL refers to Article 37 of the law on foreign citizens of the Republic of Armenia. Article 47 of the same law states: "In case Police temporary detains the asylum seeker, the Designated Body shall have unhindered access to the asylum seeker and his/her family members, in order to continue with the asylum procedure, as well as to facilitate the regularization of their residential status."
 91. Canada. Immigration and Refugee Board. Frequently Asked Questions - Immigration Division. Available at: <http://www.irb-cisr.gc.ca/eng/FindRech/Pages/faq.aspx#id> (last accessed on 23 September 2013).
 92. USA. Immigration and Nationality Act 1997, 235(b) (1)(B)(ii). Available at <http://www.uscis.gov/> (accessed on 24 April 2013).

93. USA. US Immigration and Customs Enforcement. Parole of Arriving Aliens Found to Have a Credible Fear of Persecution or Torture. Paragraphs 4.1 to 4.3. Available at: <http://www.ice.gov/> (accessed on 24 April 2013).
94. Australian Government. Department of Immigration and Citizenship. Immigration Detention and Community Statistics Summary. 31 August 2013. p. 10. Available at: www.immi.gov.au (last accessed on 23 September 2013).
95. New Zealand Human Rights Commission. Select Committee report on Immigration Amendment Bill 2012 fails human rights test. 28 August 2012. Available at: <http://www.hrc.co.nz/2012/select-committee-report-on-immigration-amendment-bill-2012-fails-human-rights-test> (accessed on 3 May 2013).
96. For further discussion on this issue see: Poole G.E. and Dr Saeid A. Boat People, Public Policy and Humanitarian Alternatives to Detention, a Policy Paper from the Refugee Council of New Zealand. September 2011. Available at: <http://www.rc.org.nz/news.html> (accessed on 21 May 2013).
97. UN Committee against Torture. General Comment No. 3. Paragraph 13.
98. Directive 2003/9/EC of 27 January 2003 of the European Parliament and of the Council laying down minimum standards for the reception of asylum seekers. The Directive aims to ensure a dignified standard of living for asylum seekers and comparable living conditions within the EU, as well as to strengthen the legal framework of national reception practices. It contains a number of important rights concerning the entitlement to adequate material reception conditions, including accommodation, food, clothing and financial allowances, access to healthcare, the labour market and freedom of movement within the EU. Specific provisions are laid down which deal with vulnerable persons, including minors, unaccompanied children, pregnant women and victims of torture and violence. Denmark, Ireland and the United Kingdom negotiated an opt-out so are not bound by the directive. The IRCT provided its comments to the Commission's proposal to recast the RCD in December 2011.
99. Directive 2013/33/EU of the European Parliament and of the Council of 26 June 2013 laying down standards for the reception of applicants for international protection. OJ L180/96.
100. "Vulnerable person" is defined in accordance with Article 21 and with reference to Article 2(k).
101. Directive 2013/33/EU. Article 25(1).
102. Ibid. Article 29 states: "Member States shall take appropriate measures to ensure that authorities and other organisations implementing this Directive have received the necessary basic training" and "shall allocate the necessary resources in connection with the national law implementing this Directive".
103. UN Committee against Torture. General Comment No. 3. Paragraph 15.
104. PROTECT Project: Process of Recognition and Orientation of Torture Victims in European Countries to Facilitate Care and Treatment, available at: www.protect-able.eu. Lead by France, the PROTECT project gathered six organisations from Bulgaria, France, Germany, Hungary and the Netherlands, with IRCT as an international partner.
105. Bulgaria, France, Germany, Hungary, Italy, Poland, Spain, Sweden, and the United Kingdom.
106. RC v Sweden (Application no. 41827/07), Judgment of 9 March 2010 [Section III].
107. Ibid. Paragraph 53.
108. Ibid. Paragraph 53.
109. Council Directive 2005/85/EC of 1 December 2005 on minimum standards on procedures in Member States for granting and withdrawing refugee status. The Directive is binding for all EU Member States except the UK, Ireland and Denmark. The UK and Ireland are still bound by the first-phase Asylum Procedures Directive.
110. Directive 2013/32/EU of the European Parliament and of the Council of 26 June 2013 on common procedures for granting and withdrawing international protection. OJ L180/60.
111. Freedom from Torture. Body of Evidence: Treatment of Medico-Legal Reports for Survivors of Torture in the UK Asylum Tribunal. May 2011. The report focuses on how MLRs produced by the organisation are considered by immigration judges in the Tribunal, assessing judges' compliance with good practice standards and guidelines. Although the report focuses on the Tribunal stage of the asylum procedure, it makes some important recommendations to the UK Border Agency (UKBA) on the need to improve the quality of initial decision-making, reflected in the high appeal overturn rate which is documented in the report.
112. UKBA, Handling claims involving allegations of torture or serious harm: Interim Casework Instruction (Non Detained Pilot), July 2011. This pilot scheme has now ended and updated guidance is due to be published by the end of 2013. For further information, contact Zoe Harper, Law and Policy Officer at Freedom from Torture: zharper@freedomfromtorture.org
113. Jesuit Refugee Service. Becoming Vulnerable in Detention (The DEVAS Project). June 2010. p.104. Available at: www.jrseurope.org (accessed on 21 May 2013).
114. Council of Europe Commissioner for Human Rights. Speech to the ECRE Annual General Conference: Asylum and Human Rights: Trends and priorities for Action. 17 October 2012. Available at: <https://wcd.coe.int/com.instranet.InstraServlet?command=com.instranet.CmdBlobGet&InstranetImage=2178517&SecMode=1&DocId=1950030&Usage=2> (accessed on 21 May 2013).
115. Council of Europe Parliamentary Assembly. Resolution 1707 (2010) on the Detention of asylum seekers and irregular migrants in Europe. Adopted by the Assembly on 28 January 2010. Paragraph 4. Available at: <http://assembly.coe.int/Mainf.asp?link=/Documents/AdoptedText/tA10/eRES1707.htm> (accessed on 17 May 2013). It also reiterated that the grounds for immigration detention are limited by Article 5.1(f) of the ECHR, meaning that detention should be used only as a last resort, and only if less intrusive measures have been tried but found to be insufficient.
116. UNHCR. Detention Guidelines - Guidelines on the

- Applicable Criteria and Standards relating to the Detention of Asylum-Seekers and Alternatives to Detention. 2012. Guideline 9.1, paragraph 49. Available at: <http://www.unhcr.org/refworld/docid/503489533b8.html> (last accessed on 23 September 2013).
117. Ibid. Guideline 9.1, paragraph 50.
 118. Australia. Department of Immigration and Citizenship. Immigration Detention Torture and Trauma Policy. Published 3 April 2009. Available at: <http://www.asrc.org.au/> (accessed on 24 April 24, 2013). See p.3 in particular.
 119. The IRCT member centre in Australia – VFST – noted in its response to question 16 that, “There is a policy of minimising the time victims spend in detention, but it is not implemented”.
 120. Australian Human Rights Commission. 2011 Immigration detention at Curtin, Observations from visit to Curtin Immigration Detention Centre and key concerns across the detention network. Available at: <http://www.humanrights.gov.au/publications/2011-immigration-detention-curtin> (last accessed on 23 September 2013). The report highlights that only one person had been referred from immigration detention into community detention since June 2010, despite there being over 100 torture victims at the time of the Commission’s visit. There was concern that due to the remoteness of the detention centre, it was difficult to provide access to off-site counselling and as there were only two counsellors working onsite, there was a waiting list of approximately 25 clients.
 121. United Kingdom. The Detention Centre Rules 2001 is the statutory instrument outlining the special regulations for the management of Immigration Removal Centres. It includes a provision (“Rule 35”), designed to safeguard victims of torture and other vulnerable persons within detention.
 122. UK Border Agency. Detention Rule 35 Process. Available at: <http://www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/asylumprocessguidance/detention/guidance/rule35reports.pdf?view=Binary> (accessed on 17 May 2013).
 123. UK Border Agency. Enforcement Instructions and Guidance, Detention and Removals. Chapter 55; section 55.10. Available at: <http://www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/enforcement/detentionandremovals/chapter55.pdf?view=Binary> (accessed on 17 May 2013).
 124. United Kingdom. HM Chief Inspector of Prisons. Report on an unannounced full follow-up inspection of Harmondsworth Immigration Removal Centre. 14-25 November 2011. p.5. Available at: <http://www.justice.gov.uk/downloads/publications/inspectorate-reports/hmipris/immigration-removal-centre-inspections/harmondsworth/harmondsworth-2011.pdf> (accessed on 17 May 2013).
 125. Ibid. Section 3.22, p.37.
 126. Medical Justice. The Second Torture: The immigration detention of torture survivors. 2012. p.87. Available at: <http://www.medicaljustice.org.uk/> (accessed on 17 May 2013).
 127. Ibid. pp.88-89.
 128. Ibid. pp.92-93.
 129. Ibid. p96.
 130. Germany. Parallel Report complementing the 5th Periodic Report of the Federal German Government (CAT/C/DEU/5). 13 October 2011. Available at: <http://www.bzfo.de/homeen.html> (accessed on 24 April 2013).
 131. Council Directive 2003/9/EC of 27 January 2003 (Reception Conditions Directive), Article 17.
 132. This so-called “airport procedure” was discussed in Part 2, in relation to question 15 on accelerated procedures.
 133. Directive 2013/33/EU of the European Parliament and of the Council of 26 June 2013 laying down standards for the reception of applicants for international protection. Article 11(1).
 134. The lack of a requirement to carry out a full medical evaluation, to ensure that detention does not have a detrimental effect on the health of the applicant, ignores the UNHCR’s Detention Guidelines - Guidelines on the Applicable Criteria and Standards relating to the Detention of Asylum-Seekers and Alternatives to Detention, 2012, available at <http://www.unhcr.org/refworld/docid/503489533b8.html>. Guideline 8, paragraph 48(vi) states: “A medical and mental health examination should be offered to detainees as promptly as possible after arrival, and conducted by competent medical professionals...Where medical or mental health concerns are presented or develop in detention, those affected need to be provided with appropriate care and treatment, including consideration for release.”
 135. Directive 2013/33/EU. Article 11(6).
 136. Directive 2013/32/EU. Article 24. The assessment of applicants in need of special procedural guarantees is meant to be carried out “within a reasonable period of time”, in line with Article 22 of the renegotiated Reception Conditions Directive (2013/33/EU).
 137. Ibid. Article 24(2).
 138. Canada. Protecting Canada’s Immigration System Act (S.C. 2012, c. 17). Available at: <http://laws-lois.justice.gc.ca/> (accessed on 24 April 2013).
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146. USA. The definition of torture is found in section 2340(1) of title 18, United States code. For more information, see the Office of Refugee Resettlement (ORR). Available at: <http://www.acf.hhs.gov/programs/orr/resource/services-for-survivors-of-torture-o> (accessed 24 April 2013).
147. UN Committee against Torture. General Comment No. 3 (2012). Paragraphs 12 and 15.
148. See for example: Green J. et al. The health of people in Australian immigration detention centres; Coffey G. et al. The meaning and mental health consequences of long-term immigration detention for people seeking asylum; Medical Justice. The Second Torture – The immigration detention of torture survivors.
149. See UN Committee against Torture's General Comment No. 3 on Article 14. Paragraph 15.
150. The issue of interpreters is not a focus of this report, but is an important requirement, both in asylum interviews and court hearings to enable the victim to present the case accurately and ensure that a fair decision is reached.
151. For example, the IRCT was involved, in both 2011 and 2012, in the training of staff of the Swedish Migration Board (SMB) regarding the vulnerabilities of VoTs during the asylum application. Relevant materials and experiences from the PROTECT project were used.
152. See for example: Freedom from Torture. Body of Evidence report; the Stanford Law Review. Refugee Roulette: Disparities in Asylum Adjudication.
153. Sweden. Rättsligt ställningstagande angående medicinska utredningar av åberopade skador (in English: Legal position of medical investigations of alleged injuries). Published July 2012. These guidelines were introduced further to the European Court of Human Rights judgment in RC v Sweden.
154. The Croatian member centre – RCT-Zagreb – reports that from 1997 to mid-2011 over 2,000 asylum requests were submitted, of which only 42 were granted.



The **International Rehabilitation Council for Torture Victims (IRCT)** is an independent, international health-based human rights organisation, which promotes and supports the rehabilitation of torture victims, promotes access to justice and works for the prevention of torture worldwide. The vision of the IRCT is a world without torture.

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