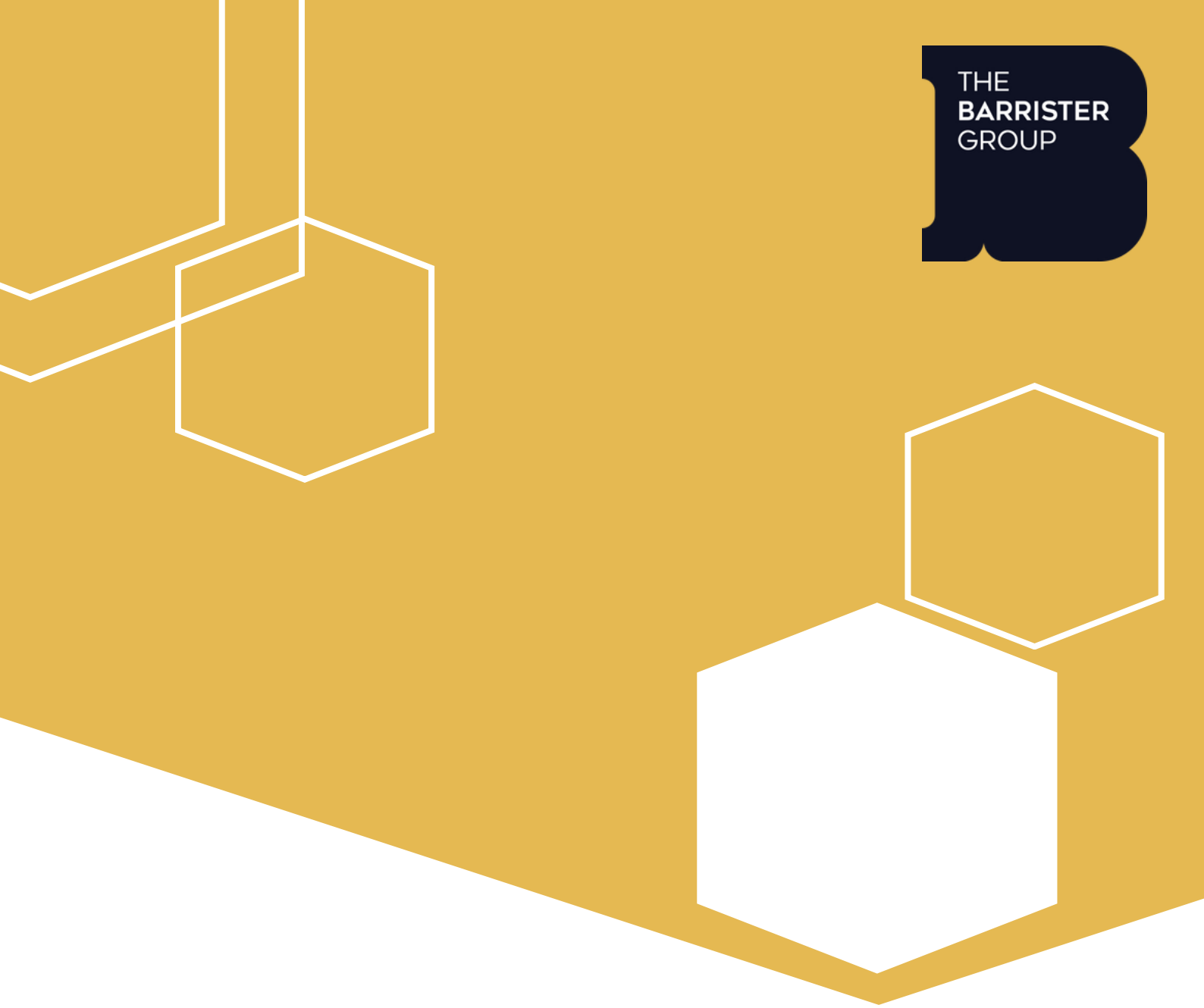

FIGHT OR FLIGHT: THE LONG WALK TO FREEDOM

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THE SPEAKERS

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Fight or Flight: The long walk to freedom

Those of you lucky enough to remember, will know the above passage "Long walk to Freedom" is taken from the 1994 autobiographical book of the same name by Nelson Mandela. For those of you who don't know, you should!

This talks is about the complex area of mental health in asylum claims and best practice. By virtue of the complexity of the topic it is not a light read (don't run just yet).

In the short time of this talk I have sought to try and bring the important strands together and give the source references for those interested, to enable personal research later.
"Fight or Flight" is a physiological reaction that occurs in response to a perceived harmful event, attack, or threat to survival. It was first so described by American Psychologist Walter Bradford Cannon in 1915.

When you put these two phrases together, I believe they reflect challenges an individual faces when they flee their home country. They are forced through circumstances, often beyond their control, to make difficult decisions to leave their home country and face the arduous geographical and psychological journey to recognition as refugees, as per Nelson Mandela's last chapter in his book, to "Freedom."

Mental health is a complex area.

"The asylum claim system, UK Home Office immigration agencies, the public sector workforce (e.g. those working in health, education, transport, social security, and the police) and all other policies and practices affecting asylum seekers and refugees should become trauma informed. The UK Home Office should work with people with experience of seeking asylum to redesign the asylum system to ensure it does not retraumatise individuals or create new trauma."[1]

Understanding asylum seekers as a cohort of people with some of the greatest need in terms of mental health is the starting point.

Nationality of people seeking asylum in the UK: the top 15 most common in 2023

Country	Asylum seekers in 2023	% of people seeking asylum in 2023	Initial decision grant rate in 2023	% of 2019-21 applicants ultimately granted asylum or other leave	Trend, 2001–2023
Afghanistan	9,307	11%	99%	79%	
Iran	7,397	9%	86%	77%	
Pakistan	5,273	6%	55%	53%	
India	5,253	6%	9%	6%	
Bangladesh	4,258	5%	29%	34%	
Turkey	4,255	5%	88%	83%	
Iraq	3,985	5%	42%	49%	
Eritrea	3,870	5%	99%	91%	
Albania	3,898	5%	13%	32%	
Syria	3,772	4%	99%	91%	
Sudan	3,453	4%	98%	77%	
Vietnam	2,304	3%	54%	78%	
Brazil	1,857	2%	7%	11%	
China	1,378	2%	18%	24%	

[1] Mental Health of Asylum seekers and refugees in UK, Mental Health Foundation, Mental health of asylum seekers - report - February 2024.pdf

The UNCHR reported some 3-4% of a population affected by an emergency suffer persistent (more than 12 months duration) severe mental health disorders like psychosis, severe depression, 15-20% mild to moderate including moderate PTSD, depression and anxiety disorders and the likely large percentage of the entire cohort suffer normal distress and other psychological reactions. The Refugee Council reports 61% of those that manage to get to the UK and claim asylum suffer serious mental health distress and asylum seekers are 5 times more likely to have mental health needs than the UK population[2].

That means over half of those people you deal with in your office have serious mental health needs and most have some mental health needs.

The Royal College of Psychiatrists reported in 2020,

"Common mental illnesses in displaced adults include PTSD (31%), depression (31%), anxiety disorders (11%), and psychosis (1.5%). There are also high rates of distress, grief and PTSD in displaced people under the age of 18, especially in the context of war and trauma."[3]

If we assume most of us dealing with asylum seekers have little or no real expert knowledge regarding identification of mental health needs and yet we are seeking to extract the necessary evidence and represent the individuals' best interests in their asylum claims, then there is a duty on us to do all we competently can do within the remit of our roles.

The immigration Rules at 339K

"The fact that a person has already been subject to persecution or serious harm, or to direct threats of such persecution or such harm, will be regarded as a serious indication of the person's well-founded fear of persecution or real risk of suffering serious harm, unless there are good reasons to consider that such persecution or serious harm will not be repeated."

The Law Society publishes a helpful guide for meeting the needs of potentially vulnerable clients[4] they say,

"It is not always easy to identify vulnerability. Some signs will be easier to spot than others. You should not assume that your client will tell you about any difficulties.

Do not hold back from asking for more information for fear of being intrusive. Many clients will be open about their difficulties if asked and happy to discuss any help they need."

There is a reminder that the SRA Principles require solicitors:

"d. Identifying and taking reasonable steps to meet the particular service needs of all clients including those in vulnerable circumstances.[6] See Statement of Solicitor Competence

For Barristers and clerks, the Bar Standards Board has published in April 2018 the "Vulnerability Good practice guide Immigration clients."[5] It says,

"Regardless of the stage at which the client instructs the barrister, however, the barrister should be aware of vulnerabilities and issues to look out for, as these may not be the same for every stage of the journey i.e., they can change over time. Issues earlier in the journey can also be missed."

[1] https://www.refugeecouncil.org.uk/our-work/mental-health-support-for-refugees-and-people-seeking-asylum/
[2] Mental Health of Asylum seekers and refugees in UK. Mental Health Foundation. Mental health of asylum seekers - report - February 2024.pdf
[4] https://www.lawsociety.org.uk/Topics/Client-care/Guides/Meeting-the-needs-of-vulnerable-clients
[5]https://www.barstandardsboard.org.uk/static/196ca72c-464d-4b59-9d3f95ef4569b233/immigrationvulnerabilityguidance2018.pdf
[6]https://www.barstandardsboard.org.uk/static/a4556161-bd81-448d-874d40f3baaf8fe2/bsbprofessionalstatementandcompetences2016.pdf

"Barristers are expected to have an awareness of the wide range of organisations supporting the administration of justice and their roles, as well as be able to identify and advise clients of alternative sources of advice and funding available to them" BSB (2016) The Professional Statement for Barristers (1.4) [6]

This talk is to hopefully discuss some best practice methodology for practitioners.

Indicators of mental health needs

The Bar Standards board defer to the Legal Services Consumer Panel "LSCP" and British Standard on Inclusive Service Provision (BS18477). The indicators for practitioners include:

• Age (young or old).
• Being a victim of modern-day slavery/trafficking (both those who have escaped and those who are currently Being trafficked);
• Being an offender or ex-offender;
• Being in immigration detention;
• Cultural barriers;
• Family conflict or separation;
• Fear of children being taken out of school;
• Fear of sudden deportation;
• Financial hardship;
• Gender-based persecution /gender identity-based persecution;
• Persecution on the grounds of sexuality;
• Language barriers;
• Mental health issues;
• The underlying reasons for seeking asylum;
• Trauma experience; and
• Unaccompanied minors

The above are affected by other factors such as:

Language/communication barriers: English as a second language or those with little or no understanding of English, health problems and lack of internet access.[7] Further cross-cultural communication may mean people use different tone, style and language in unexpected ways.[8]

"The interpreters just translate what they like, not what you are saying."[9]

The quality of interpreters is variable, and the BSB thematic review highlighted the potentially severe consequence for clients where there is substandard service delivery. This is a well-trodden path for those who work in this area and have seen the damage done. The sex of the interpreter can be important if the client is a victim of sexual exploitation or fears cultural or community disapproval.

The use of family members or "friends" as interpreters. The BSB says "*If this occurs, carefully consider any potential risks, including the possibility of inaccurate translation or undue influence/unequal power dynamics, as well as implications for legal professional privilege. However, if there is limited funding for an interpreter and the client requests and consents to the use of a family member or friend, this may in some cases be the most convenient arrangement, providing it is adequately managed and carefully monitored*."

[7] Legal Services Consumer Panel (2014) Recognising and Responding to Consumer Vulnerability
[8] See footnote 4
[9] See footnote 11

Community: People with mental disorders and psychosocial problems and their families may fear that seeking help for such problems makes them vulnerable to discrimination and rejection in the communities.[10]

And many more!

"I've experienced mental health professionals being desensitised to asylum seekers and refugees and not having knowledge of how to help them."[11]

Identification: stages

(i) On arrival

Very often those of you attending this talk will not have seeN the lay client at this very early stage. Further, it can sometimes coincide with a Screening Interview. The Home office published guidance on asylum screening [12] says,

"Although some categories of special needs (or vulnerability) in the asylum procedure are clear, for example, an unaccompanied asylum-seeking child or someone who is pregnant, others may be hidden, or the individual may not recognise they are vulnerable due to their situation. For example, a claimant may appear to have a mental health disorder but may not have declared that they have one. Their responses may indicate a traumatic event which they feel unable to discuss. You must record on, any known special needs, such as pregnancy, health issues, disability, and any observations or behaviours seen in the claimant, for example withdrawn, agitated, tearful on Atlas (CID if required) and file minutes. Recording such information will assist both the allocation and casework teams in deciding if any adjustments are needed to the asylum procedure or indicate that there are other factors or procedural needs that may need to be explored in future."

The guidance also says,

"Where a claimant faces any illnesses, conditions, disabilities, or other medical conditions, or there appears to be physical, sensory or psychological impairment or mental distress which may affect reporting or their ability to access the asylum process, CID notes, and where applicable Special Conditions on CID, should be updated with this information."

Therefore, if the interviewer has failed to record indicators of mental health or has recorded them and not taken this into account in the final decision, this seems to me to be a point worth exploring. I would cover the same in any response to the interview record and request the notes if there is an issue with what is recorded in the Screening interview, and you believe it was impacted by the client's mental health. The failure to have made appropriate adjustments at this stage may undermine any adverse use of the Screening record in the final decision

(ii) In detention

"Furthermore, a Home Office response to a Freedom of Information request revealed that there were 159 suicide attempts in detention centres between April and June 2018, which is an average of more than 50 per month during this three-month period."[13]

[10] https://www.unhcr.org/media/operational-guidance-mental-health-psychosocial-support-programming-refugee-operations
[11] See Footnote 1
[12]Screening and routing (publishing.service.gov.uk)
[13] The Guardian. (2018). Revealed: two suicide attempts every day in UK deportation centres. Retrieved December 22, 2023, from https://www.theguardian.com/uk-news/2018/ oct/11/revealed-two-suicide-attempts-everyday-uk-deportation-detention-centre

The period in detention may also be a significant feature of a case that has not been evidence for the final hearing. The Respondent's guidance says [14]

"An individual may be suffering from a mental health condition or impairment (this includes psychiatric illness, or clinical depression, post-traumatic stress disorder and more serious learning difficulties depending on the nature and severity of the condition). Such conditions may inhibit their ability to cope within a detention environment and should be factored into any consideration of detention and, indeed, into consideration of their general management through the immigration process."

The definition of torture for the purposes of the adults at risk in immigration detention policy is set out in rule 35(6)[15] of the DCR,

"any act by which a perpetrator intentionally inflicts severe pain or suffering on a victim in a situation in which-

(a) the perpetrator has control (whether mental or physical) over the victim, and

(b) as a result of that control, the victim is powerless to resist."

For the avoidance of doubt, note the following: There is no difference between 'powerless to resist' and 'powerlessness'. The proper approach is to consider whether the individual was in a situation of powerlessness."

I think most practitioners would recognise this as applicable to at least half of asylum seekers' histories. Not forgetting such acts can also occur during the journey to the United Kingdom.

Nb.

A declaration from an individual or their legal representative to the effect that they have been tortured should be accepted at face value and they should be regarded as falling within Level 1 of the adults at risk policy.

Further, this often leads to the creation of a Rule 35 report (immigration removal centres) or a Rule 32 report (short-term holding facilities.)

I very rarely see any of the detention evidence regarding mental health difficulties faced by the individual in a bundle in Tribunal proceedings and yet this is potentially important evidence of longstanding mental health and may help weigh in to credibility of the events before arrival.

(iii) In the community

Once moved into accommodation, an individual will try and locate a recognised community. Community centre or hub where they can speak to others who share some common background or language. Community sources are sometimes able to signpost to other sources and I have always found them an underutilised resource for practitioners.

[1]Adults at risk in immigration detention.docx (publishing.service.gov.uk)

[1] Detention Centre Rules 2001 (as inserted by the Detention Centre (Amendment) Rules 2018) and rule 32(6) of the Short-term Holding Facility Rules 2018

(iv)At the office (privacy and language appropriate guidance)

See above for the duties and responsibilities of practitioners and language concerns. Clearly the right interpreter, setting and sensitivity to those who may be unable or unwilling to disclose past abuse and mental health concerns. Language appropriate documents can be a non-intrusive way of giving the individual a way of disclosing information they would otherwise not disclose. Assessing and constantly reviewing signals of mental health and not only keeping notes but knowing what to do about it.

(i) Interview with Home office (screening and substantive) Firstly what type of questions were being asked:

"An assessment of asylum casework by the Independent Chief Inspector of Borders and Immigration (ICIBI) was published in 2021. It identified that although there was evidence of some good practice, caseworkers in the asylum system often used confrontational or insensitive questioning, were openly sceptical of claimants in interviews, and did not respond appropriately to disclosures of sensitive personal information."[16]

Leading questions (a question containing the answer being steered towards)

Loaded questions (Contain assumptions the individual may not realise they are agreeing to)

- "Why would you have stayed where you could be arrested if you feared the police?"

Compound questions (asking multiple questions at once)

Open questions (Giving the claimant the opportunity to give a full and open answer, and generally begin with "what" "why" or "how")

Closed questions (To draw out a statement of fact, for example:

- "When did the demonstration take place?"
- "Did you take part in that demonstration?")

Tag questions (Statements followed by a question)

- "Your lying, aren't you?
- "He didn't leave, did he?"

This allows you to target the questions when explaining why the answer was given and if the question was inappropriate given the vulnerability of the individual.

When looking at the interview record it is worth considering what the guidance says to see if this guidance has been followed and to allow you to raise this when seeking to amend what was recorded or add further information,

- ***signpost sensitive topics before questioning***
- ***ask for active consent to probe further where further questioning may cause distress***
- ***if follow up questions are needed, explain/reiterate the purpose of the questions***
- ***acknowledge sensitive disclosures as relevant, even if they do not directly answer the question you have asked***
- ***avoid interruption when a claimant is making a sensitive disclosure***

[16] See Footnote 11

So, for example, bringing to the decision maker's attention a failure of the interviewing officer to have picked up on the signs of mental health, the failure to signpost the sensitive topic before asking about it and the impact this had on the clients answer. This then explains why a more detailed answer is being provided after the substantive interview.

Screening above, turning to the substantive interview the home office guidance says,[17]

"In line with earlier guidance in this document, claimants may find it difficult to give some of this detail, especially dates and locations, and may not know the identity of their torturers, or may use words such as police and army interchangeably. This is particularly important, since claimants are not required to 'prove' that they were tortured, but simply to establish it to the correct standard as set out in the Assessing Credibility and Refugee Status guidance. This means that evidence at interview may be sufficient to accept a claim to have been tortured without the need for specific medical evidence."

The Guidance also provides some guidance on the way an interviewing officer might seek the relevant evidence in questions,

- the method of torture used
- any equipment employed
- the place where the torture took place
- the duration of the ill-treatment
- the frequency of abuse
- the purpose of the torture or abuse, if known
- the number and sex of the individuals involved
- which agency of the state, if known, carried out the torture
- the immediate effects of the torture on the individual
- what physical scars there are, if any, see 'claimants with scars'
- any ongoing physical or mental effects of torture

"In cases involving victims of gender-based persecution, for example, rape and other forms of sexual violence, domestic violence, crimes in the name of honour, female genital mutilation (FGM), forced abortion and sterilisation, it would be inappropriate for you to obtain details of the act itself. However, it is important that you obtain information regarding the events leading up to, and after, the act, together with the surrounding circumstances at the time it took place, as well as the motivation of the perpetrator, if known. Refer to the guidance on gender issues in asylum claims for more information."

As a practitioner you can ask the home office to make adjustments to the substantive interview, the guidance says,

"Claimants are advised to tell us as soon as possible about any special needs or requirements for an interview so that we can factor these into the interview process. These may include but are not limited to; physical issues that may require reasonable adjustments, needs arising from mental ill health, needs arising from hidden disability or difficulty. Examples of reasonable adjustments may include enabling the claimant to bring a friend, companion or supporter to the interview for emotional, medical or spiritual support, arranging a female interviewing officer and interpreter on request, offering additional breaks in the interview to those that require it, signposting to appropriate support services, and considering the circumstances of each case before deciding whether to invite for VC or face to face interview."

[17] Asylum interviews (accessible) - GOV.UK (www.gov.uk)

Best practice would be early input in the necessary adjustments. All too often practitioners only think about adjustments at the hearing stage. If this is because those instructed were not legal representatives at the relevant time, then I would suggest medical opinion is sought on the impact of the home office failing to recognise the need for adjustments on the ability of the individual to give their best account. I have almost never seen this done!

vi) Preparation of evidence (for interviews and for Tribunal proceedings)

See above. Turning to the Tribunal proceedings. The most important document is the witness statement/s.

(vii) Attending Tribunal proceedings

I have set out below links to the key sources of material for the purposes of addressing adjustments and questioning on Tribunal proceedings. These are useful for preparing witness statements, requesting and identifying a failure to make reasonable adjustments and for submissions.

Pet hates which indicate the witness statement may not be reliable.

- References in the witness statements to the law (case law, statutory provisions).
- Failure to explain the whole story in chronological order and instead simply responding to the refusal letter which often only contains a brief summary of the story and which is at times inaccurate, misrepresents the evidence or is incomplete. This leaves the Judge trying to piece together the story or worse, taking the story in the refusal letter as the accepted history.
- Use of legalistic terms such as "Article 8" "family life", "very significant obstacles"
- Use of complex language which does not accurately represent the educational or grammatical meaning of the witnesses' words.
- Failure to attach a statement of truth (required by the Rules)
- Failure to reference the evidence in the bundle by page number and explain the relevance.
- Failure to use paragraph and page numbers
- Repetition of paragraphs in identical terms in witness statements for different witnesses.

Best practice in the securing of evidence from vulnerable witnesses:

The Tribunal Procedure (First Tier Tribunal)(Immigration and Asylum Chamber) Rules 2014

14.—(1) Without restriction on the general powers in rule 4 (case management powers), the Tribunal may give directions as to—

(d) any limit on the number of witnesses whose evidence a party may put forward, whether in relation to a particular issue or generally;

(e) the manner in which any evidence or submissions are to be provided, which may include a direction for them to be given—

(i) orally at a hearing; or

(ii) by witness statement or written submissions; and (f) the time at which any evidence or submissions are to be provided.

(2) The Tribunal may admit evidence whether or not— (a) the evidence would be admissible in a civil trial in the United Kingdom; or (b) subject to section 85A(4) of the 2002 Act, the evidence was available to the decision maker.

Practice Direction of the IAC of the FTT

5.1 A witness statement should be capable of standing as the totality of the evidence in chief of the person giving that statement.

5.2 A witness statement may be added to by the provision of a supplementary statement provided that the supplementary statement isfiled and served in accordance with any directions given in the appeal.

5.3 Only in exceptional circumstances and with the leave of the Tribunal, will a witness be permitted to provide additional evidence in chief

Microsoft Word - FtT IAC Practice Direction 2022 FINAL for sub.docx (judiciary.uk)

SI/SR Template (publishing.service.gov.uk)

Practice Direction for the First Tier and Upper Tribunal IAC-Child, Vulnerable Adult and Sensitive witnesses, https://www.judiciary.uk/wpcontent/uploads/2022/08/FTTPracticeDirectionChildVulnerableAdultandSensitiveWitnesses281008.pdf

Joint Presidential Guidance Note No.2 of 2010

4. In so far as it is possible potential issues and solutions should be identified at a CMRH or pre hearing review and the casepapers noted so that the substantive hearing can proceed with minimal exposure to trauma or further trauma of vulnerable witnesses or appellants. It is important not to assume that an individual will want specific or particular arrangements made.

5. Where there has not been a prehearing review or CMHR or the parties were inadequately prepared these matters should in any event be considered at the commencement of the substantive hearing.

Microsoft Word - Child Witness Guidance published final version.doc (judiciary.uk)

Other sources

Equal Treatment bench book 2024, Chpt 2: Children, young people and vulnerable adults.

"It is now generally accepted that if justice is to be done to the vulnerable witness and also to the accused, a radical departure from the traditional style of advocacy will be necessary. Advocates must adapt to the witness, not the other way around." ***R v Lubemba; R v JP [2014] EWCA 2064, para. 45.***

Judges are fully entitled to impose reasonable time limits on cross-examination.

Equal Treatment Bench Book (July 2024) (judiciary.uk)

The Inns of Court College Advocacy for Vulnerable people and children (Criminal course)

The 20 Principles of Questioning

Principles for Questioning:

- Signpost a new topic
- Tell the vulnerable person or child that you are going to ask them questions
- Think about the order in which you will take the evidence - chronologically or in a structured way
- Avoid repetition
- Avoid statements posed as questions
- Use places, names, objects and subjects – avoid pronouns
- Avoid 'do you remember' (DYR) questions
- Take special care when asking about telling someone else
- Exercise care when asking about duration, weight, height, age and sensory impact
- Avoid 'Why' questions
- No 'tag' or leading questions
- No compound questions
- Ask concise/direct questions

20-Principles-of-Questioning.pdf (icca.ac.uk)

Access to appropriate services

(i) GP register: Signpost and explain the right of the asylum seeker to register with a GP.

"For asylum seekers, refugees, and undocumented migrants, being asked to provide proof of identification can discourage them from accessing NHS care, including registering with a GP, for fear of being removed from the UK." [18]

"Difficulties reported include accessing GP services, such as not knowing where to find a practice, how to make an appointment, or how to register."[ibid]

(ii) Counselling and support services

Provide Counselling, health and wellbeing workshops, psychosocial groups, intensive casework and crisis intervention for adults, children and families

https://www.refugeecouncil.org.uk/service-category/mental-health/

(iii) Other Specialist services

(iv) Community/charity services

The NHS primary care is available to asylum seekers. GP and other primary care services. National Health Service (Charges to Overseas Visitors) Regulations 2015 do not apply to those seeking asylum so services for treating a physical or mental condition caused by torture, female genital mutilation, domestic violence or sexual violence are free to asylum seekers. See,

https://www.gov.uk/guidance/nhs-entitlements-migrant-health-guide

[18] See Footnote 11

(i) Post the hearing (it does not end at the decision)

(ii) Fresh claims: it is beyond this talk to go into the details here but don't forget the individual.

Pet hates:

- Failure to review whether the individual has been able to access the mental health treatment recommended in earlier reports and if not why not!
- Failure to secure historic evidence.

"The asylum process is not easy, it's a very bad experience. After my first interview, I was refused. I felt like I should kill myself. The second time I applied, the Home Office took me to court, and they refused me again. The third time, I made a fresh claim which dragged on. I had a lot of things on my mind, I wanted to kill myself."[19]

1. Evidencing mental health

(i) GP records

HA (expert evidence; mental health) Sri Lanka [2022] UKUT 00111 (IAC) [20]

This is an important case that should be at least sent to any medical practitioner prepared a MLR, There are 7 headnotes of great importance.

"Accordingly, as a general matter, GP records are likely to be regarded by the Tribunal as directly relevant to the assessment of the individual's mental health and should be engaged with by the expert in their report."

"Where an expert report concerns the mental health of an individual, the Tribunal will be particularly reliant upon the author fully complying with their obligations as an expert, as well as upon their adherence to the standards and principles of the expert's professional regulator. When doctors are acting as witnesses in legal proceedings they should adhere to the relevant GMC Guidance."

"In all cases in which expert evidence is adduced, the Tribunal should be scrupulous in ensuring that the expert has not merely recited their obligations, at the beginning or end of their report, but has actually complied with them in substance."

Note what is expected of the Home office,

"the filing of an expert report by the appellant in good time before a hearing means that the **Secretary of State will be expected to decide, in each case, whether the contents of the report are agreed. This will require the respondent to examine the report in detail, making any investigation that she may think necessary concerning the author of the report**, such as by interrogating the GMC's website for matters pertaining to registration."

[19] See Footnote 11
[20]Tribunal decisions (tribunalsdecisions.service.gov.uk)

(ii) NHS referrals/ specialists

(iii) Ambulance records

(iv) Hospital records

(v) Counselling records

(vi) Therapy records

Such services can be accessed through Freedom from Torture if not readily available through the NHS.

Torture Therapy and Support | Freedom from Torture

For the purposes of this talk I focus on:

(vii) Medico-legal reports

All practitioners should understand the need to check the report for accuracy and not simply act as '*a postal service via which [expert evidence] reaches the Secretary of State*': ***R (on the application of Hoxha and Others) v Secretary of State for the Home Department (representatives: professional duties) [2019] UKUT 00124 (IAC)***

See the links before for referrals for medico-legal reports:

Medico-legal reports for torture survivors | Freedom from Torture

Medico-Legal Reports | Helen Bamber

For guidance on what to put in the Instructions see the excellent guidance from Free movement here,

Medico-legal reports: how to instruct and common mistakes to avoid - Free Movement

The home office time limits for the consideration of medical evidence can be found in their Guidance on the same.[21]

It is trite the home office officially recognises Freedom from Torture and the Helen Bamber Foundation as reputable medico-legal report providers[22].

"As with caseworkers, it is not the role of presenting officers to dispute clinical findings in a medical report or make clinic judgements and such reports should be approached in the same way as any expert report and in accordance with the principles set out in this guidance, see Considering medical evidence section."[23]

The home office assessment of credibility commonly follows the approach in Karanakaran [2000] EWCA Civ which addresses the weight to be given to evidence.

http://www.bailii.org/cgi-bin/markup.cgi?doc=/ew/cases/EWCA/Civ/2000/11.html&query=kaja&method=boolean

[21]Medical evidence in asylum claims.docx (publishing.service.gov.uk)
[22] See footnote 11
[23]]Medical evidence in asylum claims.docx (publishing.service.gov.uk)

The starting point for any MLR is the Istanbul Protocol published by the UN Office of the High Commissioner for Human Rights.[24] I would ensure any medical professional being asked to prepare a MLR is referred as a minimum to the Protocol. It would be a serious error to have failed to have taken this guidance into account in the report and the report should refer to having read it.

The most commonly known protocol is paragraph 187 dealing with the evaluation of lesions and how that evidence should be approached. I assume those participating in this talk are familiar with the provisions. **See KV (scarring – medical evidence) Sri Lanka [2019] UKSC 10** which addresses the application of the protocol in MLR's

https://www.supremecourt.uk/cases/docs/uksc-2017-0124-judgment.pdf

Some of the less well known parts of the Protocol,

- In all cases where doctors are acting for another party, they have an obligation to ensure that this is under-stood by the patient. Doctors must identify themselves to patients and explain the purpose of any examination or treatment. Even when doctors are appointed and paid by a third party, they retain a clear duty of care to any patient whom they examine or treat. They must refuse to comply with any procedures that may harm patients or leave them physically or psychologically vulnerable to harm. They must ensure that their contractual terms allow them professional independence to make clinical judgements."

- Torture survivors may have difficulty recounting the specific details of the torture for several important reasons, including:

(a) Factors during torture itself, such as blindfolding, drugging, lapses of consciousness, etc.;
(b) Fear of placing themselves or others at risk;
(c) A lack of trust in the examining clinician or interpreter;
(d) The psychological impact of torture and trauma, such as high emotional arousal and impaired memory, secondary to trauma-related mental illnesses, such as depression and post-traumatic stress disorder (PTSD);
(e) Neuropsychiatric memory impairment from beatings to the head, suffocation, near drowning or starvation;
(f) Protective coping mechanisms, such as denial and avoidance;
(g) Culturally prescribed sanctions that allow traumatic experiences to be revealed only in highly confidential settings.

- 261. Psychological evaluations provide useful evidence for medico-legal examinations, political asylum applications, establishing conditions under which false confessions may have been obtained, understanding regional practices of torture, identifying the therapeutic needs of victims and as testimony in human rights investigations. **The overall goal of a psychological evaluation is to assess the degree of consistency between an individual's account of torture and the psychological findings observed during the course of the evaluation. To this end, the evaluation should provide a detailed description of the individual's history, a mental status examination, an assessment of social functioning and the formulation of clinical impressions (see chapters III, sect. C, and IV, sect. E). A psychiatric diagnosis should be made, if appropriate. Because psychological symptoms are so prevalent among survivors of torture, it is highly advisable for any evaluation of torture to include a psychological assessment**

[24] Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment ("Istanbul Protocol") | Refworld

- k) Clinical impression

287. In formulating a clinical impression for the purposes of reporting psychological evidence of torture, the following important questions should be asked:

(i) Are the psychological findings consistent with the alleged report of torture?

(ii) Are the psychological findings expected or typical reactions to extreme stress within the cultural and social context of the individual?

(iii) Given the fluctuating course of trauma-related mental disorders over time, what is the time frame in relation to the torture events? Where is the individual in the course of recovery?

(iii) Given the fluctuating course of trauma-related mental disorders over time, what is the time frame in relation to the torture events? Where is the individual in the course of recovery?

(v) Which physical conditions contribute to the clinical picture? Pay special attention to head injury sustained during torture or detention;

(vi) Does the clinical picture suggest a false allegation of torture?

MN v The Secretary of State for the Home Department [2020] EWCA Civ 1746 the Court of Appeal is helpful when considering the weigh to a medical view on credibility and provides a comprehensive review of the case law to that date,

(2) Where a doctor's opinion, properly understood, goes no further than a finding of "mere consistency" with the applicant's account it is, necessarily, neutral on the question whether that account is truthful – see HE (DRC), but the point is in truth obvious.

(3) However, it is open to a doctor to express an opinion to the effect that his or her findings are positively supportive of the truthfulness of an applicant's account (i.e. an opinion going beyond "mere consistency"); and where they do so that opinion should in principle be taken into account – HK; MO (Algeria); and indeed, though less explicitly, Mibanga. In so far as Keene LJ said in HH (Ethiopia) that the doctor in that case should not have expressed such an opinion (see para. 117 (1) above), that cannot be read as expressing a general rule to that effect.

(4) Such an opinion may be based on physical findings (such as specially characteristic scarring). But it may also be based on an assessment of the applicant's reported symptoms, including symptoms of mental ill-health, and/or of their overall presentation and history. Such evidence is equally in principle admissible: there is no rule that doctors are disabled by their professional role from considering critically the truthfulness of what they are told – Minani; HK; MO (Algeria); SS (Sri Lanka). We would add that in the context of a decision taken by the CA on a wholly paper basis, a doctor's assessment of the truthfulness of the applicant may (subject to point (5) below) be of particular value.

(5) The weight to be given to any such expression of opinion will depend on the circumstances of the particular case. It can never be determinative, and the decision-maker will have to decide in each case to what extent its value has to be discounted for reasons of the kind given by Ouseley J at para. 18 of his judgment in HE (DRC).

(vii) Expert evidence

Beyond the scope of this talk but can be helpful in addressing availability of medical services, accessibility and ability of the vulnerable person to cope in the receiving country in accessing documents, employment, housing, medical services, family or other basic services for survival.

(ix) Observations and other evidence

Carers such as family members may be a useful source of evidence. There is a helpful guide as best practice to include carers and recognise the important role they play and evidence they can give. It is an area of evidence all to often missed by practitioners and yet could provide important evidence as to the needs of the individual. See the Carers Trust guidelines for more information.[25]

Observations such as those observed by the case handlers or those involved with the individual can form evidence before the Tribunal and certainly can be useful evidence when seeking to explore the need for further evidence. I have seen this rarely utilised but have secured this evidence myself in practice. It can be helpful if difficulties have been identified such as when trying to take a witness statement such as distress and upset being observed. I have used such evidence to good effect in seeking an adjournment to secure medical evidence.

2. Incorporating into practice all of the above: Checklist

(i) Taking instructions
(ii) Assessing capacity and mental health indicators
(iii) Signposting
(iv) Medico-legal reports (adjustments and diagnosis and future prognosis)
(v) Interviews
(vi) Taking witness evidence
(vii) Preparing for the hearing
(viii) Pleadings (Grounds. ASA)
(ix) Country and other evidence

3. Evidencing the approach for the court or Tribunal

(i) Presidential guidance and bench book
(ii) Case law
(iii)Expert evidence
(iv) Solicitors evidence and records
(v) Other evidence
(vi) Witness evidence
(vii) Documentary evidence
(viii) Bundles

4. Reviewing the evidence

(i) Duty to review
(ii) Addendums
(iii) Updated evidence
(iv) Developments in treatment

I hope you have found this talk helpful and the handout a useful tool with the links to enable you to look at relevant issues as they arise.

[1] Carers Trust (2013) The Triangle of Care. Carers Included: A guide to best practice in mental health care in England (Second Edition)