Fight or Flight: The Long Walk to Freedom

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Introduction

- Mental health prevalence in the asylum or refugee cohort.
- Immigration Rules, The Law Society and SRA, Bar Standards Board
- Indicators of mental health needs.
- Being alert to barriers.

Stages:

- On arrival
- In detention
- In the community
- At the office
- Home office interviews (types of questions and how to tackle them) (topics) and (adjustment requests)
- Gathering evidence and the Tribunal proceedings.
- Attendance at the Tribunal.
- Procedure rules, Practice Direction, Presidential guidance, ETBB

Access to services

- GP, Counselling and Support, other, community/charity.

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- Fresh claims
- Review

Evidencing mental health

- *GP records*
- *HA (expert evidence; mental health) Sri Lanka [2022] UKUT 00111 (IAC)*
- *NHS/ambulance/Hospital/counselling/therapy*
- *Medico-legal reports*
- *R (on the application of Hoxha and Others) v Secretary of State for the Home Department (representatives: professional duties)* [2019] UKUT 00124 (IAC)
- *Karanakaran [2000] EWCA Civ*
- Istanbul Protocol (not just about scarring)
- *KV (scarring – medical evidence) Sri Lanka [2019] UKSC 10*
- *MN v The Secretary of State for the Home Department [2020] EWCA Civ 1746*
- *Observations and other 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.”

See Footnote 11

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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.”***

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

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.”**

https://www.rcpsych.ac.uk/international/humanitarian-resources/asylum-seeker-and-refugee-mental-health

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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 they say,

https://www.lawsociety.org.uk/Topics/Client-care/Guides/Meeting-the-needs-of-vulnerable-clients

“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.”

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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;

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See footnote 1

- 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.

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Interviews

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."

"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."

In Detention

*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.*

“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.”

See Footnote 11

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)

- “You’re lying, aren’t you?
- “He didn’t leave, did he?”

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- ***“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***

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

“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.” Asylum interviews (accessible) - GOV.UK (www.gov.uk)

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“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.”

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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.

The Tribunal Procedure (First Tier Tribunal)(Immigration and Asylum Chamber) Rules 2014
Practice Direction of the IAC of the FTT
Practice Direction for the First Tier and Upper Tribunal IAC-Child, Vulnerable Adult and Sensitive witnesses,
Joint Presidential Guidance Note No.2 of 2010
Equal Treatment bench book 2024, Chpt 2: Children, young people and vulnerable adults.
The Inns of Court College Advocacy for Vulnerable people and children (Criminal course)

"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***.

GP services: access
*"**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."***

"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]

R (on the application of Hoxha and Others) v Secretary of State for the Home Department (representatives: professional duties) **[2019] UKUT 00124 (IAC)**

Karanakaran [2000] EWCA Civ

See KV (scarring – medical evidence) Sri Lanka [2019] UKSC 10

- 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.

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.

(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?

(iv) What are the coexisting stressors impinging on the individual (e.g. ongoing persecution, forced migration, exile, loss of family and social role)? What impact do these issues have on the individual?

(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.

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(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).

HE (DRC) [2004] UKIAT 00321

(1) since a doctor would not usually assess the credibility of a patient, a medical report would nearly always accept at face value the patient's account of his or her history; a doctor may be able to offer an opinion as to the degree of consistency between the Claimant's account and the physical condition; a conclusion as to mere consistency with a Claimant's account did not lend significant separate support to the claim, it only had the effect of not negating it; the weight that could be attached to such a report when assessing credibility was limited (*para 17*);

Don't let the HOPO or the Judge suggest a medical opinion on credibility goes beyond the scope of the medical practitioners role if the medical opinion explains how the opinion was critically assessed and is based upon clinical presentation as above.

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Q&A

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