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Psychiatric reports: preparation and use in cases involving asylum, removal from the UK or immigration detention

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Contents

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Audience and aims

This guidance document is aimed primarily at psychiatrists who are requested to prepare medical reports on the mental health of persons seeking asylum, in immigration detention, and/or facing removal from the UK. In this report, the term 'asylum' is used as an umbrella term that includes claims for humanitarian protection and discretionary leave to remain in the UK as well as conventional asylum/refugee claims. Legal representatives, policy and decision makers and judges (including First-tier and Upper Tribunal judges) may also find some aspects to be of interest.

The purpose of this document is to provide guidance on:

- the purpose of expert medical evidence in such cases
- what to expect during instruction
- the legal requirements when providing an expert witness report to the court
- common issues and problems which may arise
- the legal framework for such reports in asylum and removal cases
- the key components of good quality reports.

The document comprises flexible, principle-based guidance (aside from content which is taken from the Civil Procedure Rules (CPR) and which is legally required) and should not be rigidly construed as the only way to approach a medical report in cases of this nature.

Please note that although every effort has been made to ensure that text, appendices and weblinks are up to date at time of publication, such material is frequently updated and instructing solicitors and experts have a responsibility to check that they are following the most up-to-date official guidance.

Introduction

The starting point for producing this guidance was an ambition among working group members to ensure that psychiatric reports of consistently high quality are written and to ensure that the processes of psychiatric assessment in the context of asylum, immigration detention and removal are well understood, both at the initial decision stage and during any appeal stage.

It is the working group's shared experience that a relatively high proportion of initial decisions or subsequent appeals supported by psychiatric reports are successful, but that such reports are sometimes criticised. This criticism may be legitimate (reflecting a poorly written report), but may also be for reasons with which psychiatrists disagree (reflecting misunderstanding or poor mental health literacy on the part of decision makers). We acknowledge, of course, that the outcome of an individual case is not necessarily a measure of the effectiveness of the psychiatric report; a case may fail on other grounds, despite an excellent report having been submitted.

Clearly, good practice in the writing of such reports needs to be encouraged. The working group hopes these guidelines for good practice will help improve the quality of psychiatric reports and ensure that they are written in a manner that anticipates common misunderstandings and addresses them before they arise. They might also be a useful starting point for the development of good-quality training (face to face and online), not only for psychiatrists but also for legal representatives, caseworkers and judges. In addition, we hope these guidelines will encourage ongoing dialogue between psychiatrists, instructing legal representatives and government/judicial decision makers, which will in turn improve practice and help ensure that fully informed decisions are made in asylum and other immigration cases in which mental health issues are relevant.

Reasons why a psychiatric opinion is sought

The testimony of the applicant in any asylum claim is the core (and often the only available) evidence. It is also the only required evidence (see Office of the United Nations High Commissioner for Refugees (2011) paragraphs 195 to 202). However, to the extent that corroboration may be available, it is expected (by all parties) that such evidence should be sought and adduced. This can have the unintended consequence that the very low standard of proof required in asylum claims (see below) is often inappropriately raised. An assessment of credibility does not require corroborative evidence. However, although medical evidence is not an essential part of any asylum claim, where torture or ill-treatment is raised, the absence of such evidence may be inappropriately invoked as an argument against the applicant's case.

It follows that there may be several reasons (which are not mutually exclusive) why a psychiatric report may be thought by instructing solicitors to be useful:

- in the context of claims made by an applicant, for example that they have been tortured, subjected to ill-treatment, persecuted or trafficked, and that mental illness has arisen as a result;
- in relation to whether an applicant has or has had a mental disorder, and whether this is consistent with (and thereby supports) their account of events, for example that they have been tortured, subjected to ill-treatment, persecuted or trafficked;
- in relation to the effect on an applicant's mental health if detained and/or returned to their country of origin. These mental health consequences may be relevant in

terms of potential breaches of the European Convention on Human Rights (ECHR), which was incorporated into UK legislation via the Human Rights Act 1998. Article 3 (the right to freedom from torture, inhuman and degrading treatment) and Article 8 (the right to respect for private and family life) are particularly important in this context. Article 8 is a 'qualified right' (in contrast to Article 3, which is an 'absolute right') and as such psychiatric reports can be relevant to informing the balance between an individual or family's right to respect for family and/or private life, and the legitimate aims of the government, usually in the context of maintaining the economic well-being of the country through immigration control. In deportation cases, national security or the prevention of disorder or crime may also be invoked as a legitimate aim.

Identifying vulnerability

The primary responsibility for identifying vulnerable individuals lies with the party representing them, but legal representatives may fail to recognise psychological vulnerability. Consideration should be given by the applicant's legal representatives as to whether expert evidence (e.g. as to capacity, disability, age or mental health) is required, particularly if there is a dispute over ability to participate in the proceedings (Wilson-Shaw *et al*, 2012). The Secretary of State for the Home Department (Home Secretary) does not normally seek to adduce expert evidence in asylum claims. The immigration courts may direct that such evidence be adduced and such directions are invariably (because of the convention that the Home Secretary does not adduce such evidence) directed at the applicant's representative. Consideration should also be given to whether an adjournment would be appropriate to enable either party to obtain reports. Relevant policies and practices relied upon by either party should be disclosed (e.g. protocols for victims of trafficking or interview protocols).

Instructions

There are two typical routes regarding instructions to prepare a report.

- Instructions may directly lead to a report being prepared, with minimal communication taking place between the solicitor and psychiatrist.
- Alternatively, initial instructions to prepare a report might – following iterative conversations between the instructing legal representative and the psychiatrist – evolve and change before the report is written. Similarly, once the report has been written, there might be further back-and-forth communication as the legal representative subsequently requests that the psychiatrist clarifies particular aspects of the report before it is thought 'fit for purpose' and finalised.

Upon receipt of instructions, and following assessment of the client, a psychiatrist might seek clarification from the legal representative if, for example, 'stock' questions included in the instructions do not seem to be relevant to the issues on which expert evidence is required. For example, questions about suicide risk might be asked, even though risk of suicide is not a significant issue, which potentially dilutes the significance of the actual issues at hand.

The evolution of instructions or clarification of the submitted report must not jeopardise the neutrality of the psychiatrist with respect to their duty to the court. The psychiatrist is under a duty to set out all instructions received, whether they be written or oral, which are material to the opinions expressed in the report or upon which those opinions are based (Ministry of Justice, 2012a).

Psychiatrists may be asked to provide reports in the following circumstances.

- Before the government has made a decision.
- For a first appeal before the First-tier Tribunal (Immigration and Asylum Chambers) – after a decision from the government.
- For a second appeal, before the Upper Tribunal (Immigration and Asylum Chambers), when all or part of the First-tier Tribunal's determination is being challenged on error of law grounds, or has been set aside and all or part of the appeal is to be re-heard.
- For a fresh claim for protection (Home Office, 2014: para. 353; *WM (DRC) v Secretary of State for the Home Department* [2006]).
- At the point when removal directions are set, either in the context of fresh representations or assessing fitness to fly (International Air Transport Association, 2013).
- In the context of proceedings challenging an applicant's detention under immigration powers.

It is essential for the psychiatrist to establish the terms of appointment at the outset, in particular how the report will be used (i.e. whether it is for the purposes of advice for the legal representative or whether the intention is to submit the report as the expert's evidence in legal proceedings).

The following should be agreed.

- Services required of the psychiatrist (e.g. report, court attendance).
- Timescale for delivery of the report.
- Basis of charges including travelling expenses, disbursements (for example, interpreters' fees), a total estimate and any cancellation charges.
- Whether fees are to be paid by public funding and whether payment has been authorised by the Legal Aid Agency (www.gov.uk/government/organisations/legal-aid-agency). This agency provides guidance on the rates that experts can charge. This is subject to change from time to time and the appropriate rate should be clarified with the solicitor at the time of instruction.

Before a psychiatrist prepares a report for use in legal proceedings, it is the working group's

view that a solicitor should provide the following documents.

- Letter of instruction. Informal instructions are not sufficient. When a matter is urgent, interim verbal instructions should be followed up in writing.
- All available medical records (e.g. community, relevant hospital, detention centre records). Where these are not available, for example on the grounds of protecting third-party confidentiality, this should be made clear in the instructions.
- Any documents that are or might be disclosed in the proceedings. In the immigration, removal and detention context, this should include:
  - records of any interviews (e.g. screening and asylum interviews);
  - any decisions on an applicant's case, including decisions made by the government, tribunal determinations and any other administrative or judicial consideration of credibility.[1] The value of psychiatric evidence will be reduced if the psychiatrist is unaware that the applicant's account has been rejected, and if there is a difference between the facts found in earlier proceedings and those given to the psychiatrist. If an appeal has been dismissed with no psychiatric evidence being presented before such evidence is obtained, the report will need to make it clear that the author is aware of the history, and address the issue of possible fabrication of symptoms. Discrepancies should be noted and addressed (see below);
  - relevant detention centre records, in particular Assessment Care in Detention and Teamwork documents;
  - statements of case (e.g. claimant's judicial review grounds and any defence served by defendant).

The legal representative should make it clear whether proceedings have started and confirm the dates of any court hearings.

The Civil Justice Council suggests that 'experts who do not receive clear instructions should request clarification and may indicate they are not prepared to act unless and until such clear instructions are received' (Civil Justice Council, 2014). Our recommendation is that psychiatrists should indicate that they are not prepared to act unless clear instructions are given. Similarly, they should consider declining to proceed unless all appropriate documentation is made available to them. It may be helpful for the psychiatrist to make clear that finalising the report is dependent on the relevant documents being produced, but that in their absence fees for work done will still fall due.

If there is particular urgency (e.g. an imminent removal case), and it has not been possible to obtain full disclosure of documents in the time available, then this should be made clear in the report. As a minimum, previous consideration of an applicant's credibility should be disclosed, such as reasons provided by the government for refusing an asylum claim on credibility grounds. The psychiatrist should consider explaining how the approach to the report might be different if there had been less time pressure and/or more information available.

The courts have warned against solicitors asking experts leading questions in their instructions. The psychiatrist should be aware that instructing solicitors are unlikely to have any clinical training and that their experience of working with traumatised persons will be varied. Instructions are often based on a template and can suggest more insight than is actually the case (e.g. references to suicidal ideation where no clinical indication is present). Psychiatrists should be cautious in assuming that instructions are necessarily drafted in such a way as to direct their enquiries appropriately. They should not refrain from addressing relevant matters that are not referred to in the instructions. Example instruction questions are provided in Appendix 4, guidance about the acceptance of instructions, withdrawal and the process for asking the court for directions can be found in the Civil Justice Council's (2014) *Guidance for the Instruction of Experts in Civil Claims*.

1 "It is essential that those who are asked to provide expert reports, be they medical or otherwise, are provided with the documents relevant to the matters they are asked to consider. Failure to do so is bound to lead to the critical scrutiny of the expert's report, and may lead to the rejection of the opinions expressed in that report, as it did in this case." *SS (Sri Lanka) v Secretary of State for the Home Department* [2012]

Acting as an expert

If the report is required for civil proceedings (e.g. judicial review) then Part 35 of the CPR applies (Ministry of Justice, 2012b). If the report is required for proceedings in the Immigration and Asylum Chambers of the First-tier Tribunal and the Upper Tribunal, then Part 10 applies. The wording of the former is reproduced below, and is essentially the same as the latter, except for the identity of the setting (court or tribunal).

It is the duty of experts to help the court/tribunal on matters within their expertise. This duty overrides any obligation to the person from whom experts have received instructions or by whom they are paid (Ministry of Justice, 2012a). The following general requirements for expert evidence are stated:

> 2.1 Expert evidence should be the independent product of the expert uninfluenced by the pressures of litigation.
>
> 2.2 Experts should assist the court by providing objective, unbiased opinions on matters within their expertise, and should not assume the role of an advocate.
>
> 2.3 Experts should consider all material facts, including those which might detract from their opinions.
>
> 2.4 Experts should make it clear –
>
> (a) when a question or issue falls outside their expertise; and
>
> (b) when they are not able to reach a definite opinion, for example because they have insufficient information.
>
> 2.5 If, after producing a report, an expert's view changes on any material matter, such change of view should be communicated to all the parties without delay, and when appropriate to the court.

See *Civil Procedure Rules: Part 35 – Experts and Assessors* (Ministry of Justice, 2012b), *Civil Procedure Rules: Practice Direction 35 – Experts and Assessors* (Ministry of Justice, 2012a), and P*ractice Direction of the Immigration and Asylum Chambers of the First-Tier Tribunal and the Upper Tribunal on or after 13 November 2014* (Tribunals Judiciary, 2014) for more detail.

The interview

Preparation

On the basis of the instructions received and review of the included materials, the psychiatrist should consider in advance of the interview which questions they are going to ask and which diagnostic tools they will employ. Depending on the course of the interview, however, they should not limit themselves to those questions or tools considered in advance.

A key consideration both before the interview takes place and during its progress is whether the interview might have a re-traumatising effect (United Nations, 2004). There is a risk that it might, through the applicant's reliving of traumatic experiences, reopen psychological wounds. The psychiatrist must be prepared to bring the interview to an end if necessary. It might be appropriate to give interviewees opportunities for breaks and the psychiatrist should be alert for clinical signs of distress or hyper-arousal. It is important to review the interviewee's clinical state (with particular attention to suicidal thoughts or intent) at the end of the interview and to ascertain what informal or therapeutic support is available to them in the hours and days after the interview.

Psychiatrists should familiarise themselves with the Istanbul Protocol regarding their duty to consider that presented symptoms may be falsified, and be aware that the circumstances might motivate the applicant to falsify or exaggerate symptoms (United Nations, 2004).

Introduction to the interview

The psychiatrist should explain, in plain language, to the applicant:

- who they are;
- who has instructed them and for what purpose;
- the importance of confidentiality and, in that context, what the role of their report is in the legal process (e.g. to which third parties the report may be presented (typically the legal representative and through them to the government and/or an immigration court));
- how many interview sessions are likely to be necessary to prepare the report;
- that the report will be sent to the instructing legal representative within a specified period, and what that period is;
- that the report will be read by the legal representative who should discuss its contents with the applicant to ensure that it is factually accurate;
- that the psychiatrist's primary duty is to the court/tribunal, although this coexists with the psychiatrist's duty towards the patient as codified within the General Medical Council's document *Good Medical Practice* (2013). If it becomes apparent that there is a conflict between these duties, this should be disclosed;
- that the psychiatrist must remain neutral and not be influenced by personal or political opinions;
- that the report will provide an objective, unbiased opinion on the matters within the psychiatrist's expertise;
- that the psychiatrist will not treat the applicant for any illness following the completion of the report but may, with consent, speak or write to their GP about treatment for physical or mental health problems.

Family members

The psychiatrist may find it valuable to speak privately with the applicant's family members, but should be aware of cultural taboos and of the need

for informed consent. In general, family members should not be present during the interview. If the applicant insists on a family member being present, this should be noted in the report.

Suspected traffickers

Psychiatrists should be aware of the complex relationships that can arise between trafficked persons and their traffickers. It is not unheard of for traffickers to attend medical appointments with their victims, and even to try and insist on remaining with the victim during the psychiatric assessment, to maintain control over them. Be alert to the possibility that a 'friend' or 'relative' is no such thing. If the psychiatrist has reason to suspect that a trafficker is accompanying an applicant, then any consequences that this has on either the interview or the applicant's mental health should be documented in the report. In such cases, the psychiatrist should consider whether patient safety issues override their duty of confidentiality.

Conducting the interview

Although leading questions are generally to be avoided, the psychiatrist might decide to deliberately ask some extra questions that are leading to consider the degree to which the interviewee can be led by such questions. They should include this assessment in the report.

A balance must be struck between asking for the applicant's history and waiting for it, and the psychiatrist should be mindful of active listening techniques; that is, the distinction between listening to someone and listening for something. Just as in a clinical interview, some prompting might be necessary and appropriate.

The psychiatrist might find the following tips (adapted from advice produced by the Canadian Immigration and Refugee Board, 2004) useful when conducting the interview:

- try to elicit a detailed description of symptoms;
- look for observed behavioural indicators (e.g. staring, startle, dissociation, depressive facial expression) and accounts of behavioural change (e.g. social withdrawal, avoidance of specific reminders of trauma);
- use multiple sources of data;
- ask open-ended questions and encourage a complete story;
- take a detailed sleep history (Post-traumatic stress disorder (PTSD) is usually associated with middle insomnia and sudden waking in panic);
- assess the nature and extent of avoidant behaviour;
- be wary of an overly 'neat' recitation of symptoms.

Use of interpreters

It is best practice to use an interpreter if there is any doubt about the applicant's ability to communicate in English. Bear in mind that an individual's fluency in a second language might lapse when they become distressed. Professional interpreters are always to be preferred, particularly those with experience in cross-cultural therapy or similar work. An assurance that the interpreter understands confidentiality should be described and translated, even if the psychiatrist is aware that the interpreter understands this duty.

Throughout the interview, the psychiatrist must be satisfied that:

- the applicant and the interpreter understand each other (the capacity to mutually understand one another, as between the interpreter and the applicant, should be tested even if the psychiatrist has worked with the interpreter before);
- the applicant trusts the interpreter sufficiently – the psychiatrist should be aware of gender, culture, political and religious considerations (e.g. disclosure might not be forthcoming to an interpreter of the same cultural or religious background, or alternatively to one from a distinct, conflicted group), as these issues might account for a lack of disclosure at times;
- the applicant is willing/able to use the language in question;

- the interpreter is translating verbatim, rather than summarising or only translating selected phrases or sentences.

It is good practice for the psychiatrist to discuss the necessary style of interpretation with the interpreter before the interview. Future-oriented and hypothetical questions might be conceptually difficult in some languages, for example, and a good interpreter should ask for such questions to be rephrased. This is to be encouraged. The psychiatrist should bear in mind that an interpreter's insights are not verifiable, factual information.

Breaking speech down into sections is helpful as it minimises the chance of the interpreter forgetting something that has been said by either of the other parties. For this reason, the psychiatrist should take particular care to avoid asking multiple questions at once.

It is almost always inappropriate to use a friend or relative of the applicant as interpreter (even when encouraged to do so by those instructing you or the applicant). There is a danger that disclosure will not be facilitated (e.g. because of cultural taboos surrounding mental illness or rape) or that a conflict of interest between applicant and relative distorts the process of interpretation. Using another professional (such as a solicitor or a nurse), as a stand-in interpreter should also be avoided, as this risks blurring the line that demarcates their professional role.

It might, rarely, be necessary to accept the use of a friend, relative or other professional as an interpreter, if the alternative is not carrying out the assessment at all, for example in situations of exceptional urgency. In such cases, the situation and the reasons for proceeding should be documented in the report.

It is often helpful for the psychiatrist to have a short debriefing and clarification session with the interpreter after the interview. It might be germane to seek corroboration of certain points, but it is inappropriate for any new observations or evidence to be gathered as a result. The psychiatrist must bear in mind that the interpreter is not an expert but a conduit. The interpreter's observations and opinions should never be cited in a report. However, matters raised by the interpreter may be discussed with those instructing the psychiatrist if appropriate. For example, if the interpreter raises a relevant issue of his or her shared culture or situation that might be relevant to the report, the psychiatrist should seek to establish whether the applicant shares that view and then discuss the matter with those instructing. The opinion of a country expert might be required.

Informants

In some cases, it might be necessary for the psychiatrist to interview people who know the applicant to complement aspects of their medical examination. This may take place either during the interview or in private without the applicant present. This is particularly important for the most vulnerable applicants, such as those with suspected intellectual disability or dementia and those exhibiting pseudo-seizures or dissociation. It is important to exercise the same objectivity as with the applicant, and to be mindful that their friends, housemates or relatives might have their own agenda. The psychiatrist should ensure that the applicant provides informed consent for them to talk to the informant.

Clinical issues

Diagnosis

Some diagnoses, such as PTSD or depressive disorder, are made more frequently than others in the client group discussed in this document, although this should of course not limit or direct the psychiatrist's diagnosis of the individual applicant.

If PTSD is being considered as a diagnosis, it is important for the psychiatrist to take into account the complexity and enduring cumulative effects of multiple traumatic experiences, rather than to focus only on one acute experience. The importance of repeated and extreme trauma on clinical presentation and extent of associated disability is reflected in the ICD-10 (World Health Organization, 1992) diagnostic category of 'enduring personality change as a result of extreme trauma'.

It is important to bear in mind that a diagnosis of PTSD alone might not fully account for an applicant's symptoms, and consideration should be given to the existence of comorbid disorders such as psychogenic psychosis. In our collective experience of this client group, it is not uncommon for a spectrum of clinical features to exist for a single applicant that ranges from flat affect to hypervigilance. This might seem counterintuitive to a lay audience and, where it does occur, it should be explained in the written report to avoid confusion.

Evaluative strategies

Previous illnesses and hence a detailed medical and psychiatric history, not limited to acts of ill-treatment, persecution and the like, should be taken to consider or rule out other causes for the diagnosis made. Where no previous illness or psychiatric history is elicited and none appears in any of the documents provided, this should be noted. The absence of evidence is not of course evidence of absence. The reporting psychiatrist is not expected to speculate, and is indeed cautioned against speculation.

The internal consistency (or otherwise) of the applicant's description of their experiences and symptoms should be considered in a number of ways, including the objective appearance, affect and demeanour of the applicant, descriptions relevant to mental health present in other documentation, and consistency of the pattern of symptoms with those typical of psychiatric disorder. Possible reasons for apparent inconsistencies, such as the effect of traumatic memories on the ability to recall events in an accurate and consistent temporal sequence, should be discussed in the report (Herlihy & Turner, 2007).

Capacity

According to the Mental Capacity Act 2005, a person lacks capacity if, at the time a decision needs to be made, the person is unable to make or communicate the decision because of an impairment of, or a disturbance in the functioning of, the mind or brain.

The Act contains a two-stage test of capacity:

1. Is there an impairment of, or disturbance in the functioning of, the person's mind or brain?
2. If so, is the impairment or disturbance sufficient that the person lacks the capacity to make a decision in relation to the matter in question?

When considering whether a person is unable to make a particular decision, the psychiatrist should consider whether they are able to:

- understand the information relevant to the decision
- retain that information

- use or weigh that information as part of the decision-making process
- communicate their decision (including by non-verbal means).

The Mental Capacity Act 2005 Code of Practice contains a number of guiding principles (Department for Constitutional Affairs, 2007), including that a person:

- must be assumed to have capacity unless it is established through evidence that they lack capacity;
- is not to be treated as unable to make a decision unless all practicable steps to help them do so have been taken without success (e.g. very simple verbal or pictorial explanations, interventions to improve vision or hearing);
- is not to be treated as unable to make a decision simply because they make an unwise decision.

It is important to note that capacity is not absolute, but is specific to the action or decision concerned and can change over time. Capacity must also be kept under review by both the psychiatrist and the instructing legal representative. If it is the psychiatrist's opinion that a person lacks capacity, they might consider recommending that the position should be reviewed in a certain period of time.

Specific evidence must be provided to substantiate any statement about lack of capacity. It might be helpful to include an overall assessment of cognitive function as well as assessment of the applicant's current understanding of the action or decision in question.

Capacity to instruct

Typically, a relatively low threshold is used. The psychiatrist will assess whether the applicant has a broad understanding of the asylum/removal/detention process and the current state of their case, plus the ability to communicate their own wishes clearly to others, and in particular to the instructing representative.

Capacity to give evidence (during a Home Office interview or in court)

A higher threshold than that for instruction would typically be applied when considering the applicant's capacity to give evidence to the Home Office or in court. The psychiatrist should assess whether the applicant has the ability to give a coherent account, the ability to fully answer questions and the ability to withstand adversarial questioning.

It might be necessary to advise that the applicant might become distressed and incoherent when being questioned, and to explain how this might manifest. Distress and incoherence do not necessarily amount to incapacity, but even where capacity is retained they can indicate vulnerability or disability. Efforts should be made to establish whether the applicant has capacity to give evidence, and the report might need to provide guidance to the court as to the specific barriers to capacity and how they can practically be mitigated. It is possible for example to conduct a cross-examination in chambers with just the judge, applicant and legal representatives present (Tribunals Judiciary, 2010). This might ameliorate the applicant's distress to a tolerable level. However, there might be cases where, despite measures being taken to ameliorate distress, the applicant is unlikely to have the capacity to be cross-examined and, if so, the psychiatrist must make this clear.

Particular (if not exclusive) issues to consider when assessing capacity in an asylum/removal context include:

- PTSD-related phenomena
  - dissociation
  - traumatic re-experiencing
  - panic attacks
- intellectual disability
  - difficulties inherent in making a brief but culturally and educationally valid assessment
  - the distinction between intellectual disability and lack of education; if the psychiatrist feels that more formal assessment is necessary than is possible in their expertise (e.g. by an educational psychologist or a neuropsychologist) then this should be indicated in the report
- organic brain disease
  - where there is a history of head injury it might be necessary to give an interim

report if this has not been fully explored; appropriate investigations can also be recommended in the interim report
    - HIV/AIDS-related cognitive impairment
    - dementia
- past or current alcohol misuse/dependence.

Fitness to give evidence

It is important to distinguish, in clinical terms, between the clinical plausibility of the presentation and the impact on the applicant of giving such evidence. If giving evidence is likely to have a deleterious effect and the psychiatrist is therefore of the opinion that for clinical reasons, the applicant should not be required to give evidence, then this must be made clear. On the other hand, if the individual is thought able to give evidence but is likely to be distressed by the experience or to dissociate under questioning to the extent that the accuracy of their testimony will be affected by their psychological state, then this should also be made clear. A legal representative's instructions as to fitness to give evidence can cover either or both of the issues of capacity and fitness and the report should make clear which is being addressed.

Lesbian, gay, bisexual and transgender (LGBT) issues

In 2010, a Supreme Court judgment established that LGBT asylum seekers cannot be returned to a country if the only way they can avoid persecution or serious harm is to 'be discreet' and hide their sexuality (*HJ (Iran) v Secretary of State for the Home Department* [2010]). As a result, the focus in many cases has moved to challenging the credibility of the applicant's professed sexuality, and the psychiatrist might be asked to give an opinion on the applicant's sexuality or transgender status. Being gay, lesbian or bisexual is, of course, not a psychiatric condition. It might occasionally be necessary to consider the possibility of gender dysphoria, but that is quite different. Instructing legal representatives might ask for such an opinion, and the psychiatrist should make it clear that judging whether or not the applicant is LGBT is not a psychiatric diagnostic exercise. This can be dealt with during the iterative process of clarifying instructions (as above) or responded to in the body of the report. On the other hand, the psychiatrist should be aware that LGBT people have higher rates of mental illness and suicide (King *et al*, 2008; Chakraborty *et al*, 2011).

Key issues to address in reports on such applicants include:

- sexual development history
- psychological impact of the applicant's experiences related to their sexuality (both positive and negative)
- stigma (objective and internalised)
- consequences of return (e.g. forced marriage, fear of persecution and the psychological consequences of needing to hide sexual orientation).

Late disclosure

The psychiatrist should be aware that the applicant might delay disclosure of the full extent of their experiences. This might be viewed with suspicion, and it is important that legitimate explanations for a delay in disclosure are explored and, if applicable, discussed in the report.

Reports should document not only what is said but also how it is said – and, in some cases, what is conspicuously left unsaid. For example, people who have been subjected to sexual trauma as part of their torture or ill-treatment might be reticent about describing their torture in any detail or at all; sexual trauma might be denied in circumstances that seem implausible (e.g. 'all of the other women were raped, but I was not'). If the psychiatrist feels that there is a significant 'elephant in the room', they should consider whether another session might be necessary to give the applicant sufficient opportunity for disclosure.

In general, people whose PTSD arises in the context of sexual trauma have particular difficulty in fully and clearly disclosing what has happened to them, or sometimes in disclosing the events at all. This difficulty has been shown in the specific context of Home Office interviews (Hook & Andrews, 2005; Bogner *et al*, 2007). Rape (which

is particularly likely to result in the development of PTSD) is associated with overwhelming feelings of shame, humiliation and low self-esteem (Welch & Mason, 2007). These psychological responses to rape make its disclosure particularly difficult.

Other barriers to disclosure that the psychiatrist should be aware of and, if applicable, discuss in their report include:

- shame
- threats having been made or a genuine fear of a threat being made to the applicant or their family at home
- fear/lack of trust of authority figures (i.e. the psychiatrist, the legal representative or Home Office staff)
- trauma/memory loss
- complex relationships with traffickers, such as:
  - Stockholm syndrome
  - oath-taking/juju/witchcraft
  - perception of ongoing debt bondage
- inability to speak English well enough to communicate complex experiences
- lack of familiarity with UK law/culture
- lack of awareness that the applicant is a victim of crime
- reluctance to consider themselves victims
- self-blame
- cultural concepts of family honour
- male rape and concepts of masculinity
- the applicant's lack of awareness of where they are, due to being moved frequently
- symptoms associated with long-term solitary confinement and being under control for long periods
- reluctance to confront the possibility of sexually transmitted infections.

Credibility

It is not the medical expert's role to make judgments of credibility – that is a matter for the court, and the psychiatrist should be extremely wary of being seen to usurp the function of the judge.[2] A distinction can be drawn however between giving an opinion on the credibility of the applicant's account (which the psychiatrist should not do) and addressing the clinical plausibility of the applicant's symptoms (which the psychiatrist absolutely should do). It is therefore perfectly reasonable – and in fact advisable – for the psychiatrist to make statements to the effect that they have considered the possibility that the applicant was feigning or exaggerating their symptoms and have come to the clinical conclusion that this is or is not the case. In such circumstances it is desirable to specify how this conclusion was reached.[3]

It is important to remember that people with PTSD experience particular difficulty in dealing with direct interviewing, especially in contexts that seem adversarial to them. The research evidence suggests that such difficulties should not be seen as evidence of reduced credibility (Cohen, 2001; Herlihy & Turner, 2007) and this should be made clear in the written report, if applicable. It might also be important to discuss the potential difficulties an applicant might face during cross-examination.

Memory, recall and PTSD are complex issues that psychiatrists should already be familiar with and will not be described here. In taking a history and reviewing statements and testimony documented elsewhere, it is extremely likely that discrepancies will become apparent. Indeed, even allowing for unimpaired recall, it would be surprising if there were none. Where discrepancies arise, they should be noted and described. Trying to resolve the discrepancy is not generally the function of the psychiatrist's report, but if noted and explored it provides an opportunity to discuss the impact

2 '… it was not for the doctor to reach an overall conclusion on the credibility or otherwise of the victim's account. The most that any doctor could say was the physical and psychological condition of an appellant was consistent with her story.' *HH (Ethiopia) v Secretary of State for the Home Department* [2007]

3 '… to say that it is not the duty of a doctor to disbelieve the account given by a patient may be correct but takes one absolutely nowhere. It is plain that a psychiatrist does exercise his critical facilities and experience in deciding whether he is being spun a yarn or not, and all of us sitting in these courts in different jurisdictions from time to time have heard psychiatrists saying that they do believe an account or that they do not believe an account. It is, therefore, wrong to suggest, as part of support for his conclusion, that doctors do not look into anything critically'. *R (on the application of) Minani v IAT* [2004]

of PTSD or other conditions and circumstances upon memory and recall.

If instructed to do so, it is appropriate to comment on the applicant's fear of return, as long as this is done in a clinical context. The focus should be on whether an applicant's experience of fear is or was clinically genuine, as opposed to whether it is or was objectively well-founded in the circumstances. Discussion of the genuineness (or otherwise) of fear is not an opinion on the credibility of the applicant but rather a clinical opinion on the psychological impact of traumatic events. It is important, however, not to assume that the said events must, therefore, have taken place, as that would be a consideration of the overall credibility of the applicant's claim to asylum. Such discussion might be relevant when discussing the applicant's ability to access clinical services, irrespective of their availability.

For cases in which an applicant's credibility is a central issue, it is particularly important that a psychiatric report explains that the author of the report has not taken everything said by the applicant at face value, that critical faculties have been applied, and that the assessment and diagnosis involved draws on professional experience and expertise. It might be important to anticipate the potential criticism that the time spent with the applicant was insufficient for a full assessment and diagnosis, and to explain how it compares with the time available for routine diagnostic assessments in National Health Service (NHS) out-patient clinics. If there were any difficulties, these should be set out in the report.

Ensuring that all documents are provided and demonstrating that they have been thoroughly reviewed can be critical to the way in which the report is received. An apparent failure to be familiar with past negative findings on credibility might be commented upon unfavourably by those to whom the report is addressed (*SS (Sri Lanka) v Secretary of State for the Home Department* [2012]).

Fabrication of symptoms

Although it might be relatively easy to feign individual mental symptoms (Rosenhan, 1973), it is very difficult to fabricate the full picture of a mental illness such as PTSD. The psychiatrist should make it clear that a single or a small number of positive features are not being relied on in making a diagnosis, rather that the diagnostic process involves looking at the whole picture provided by the history, mental state and any corroborative information available. This includes attending closely to the applicant's facial expressions, tone of speech, non-verbal gestures and general behaviour, as well as to the content of what the applicant is saying. Any apparent inconsistencies (such as exaggerated distress or apparent indifference) can contribute significantly to the overall conclusions drawn.

Professional actors feigning symptoms ('simulated patients') are sometimes used in the process of training and assessing the clinical skills of medical students and psychiatrists. Even these actors, who are trained by psychiatrists in how to present feigned symptoms of mental illness and are usually able to perform very well in simulating a small number of pre-specified symptoms, have great difficulty in sustaining credibility over a full clinical interview.

However, the psychiatrist must be mindful of the judge's responsibility to be alert to the question of the applicant's credibility. If the psychiatrist is confident that the applicant is genuinely suffering from a mental disorder then they should assert their confidence that the condition present is not being fabricated and explain the specific reasons why they have confidence in that opinion.

Where the applicant gives an account of torture, psychiatrists should state their awareness of the Istanbul Protocol regarding their duty to consider that presented symptoms might be falsified, and state that they are aware that the circumstances might motivate an applicant to falsify or exaggerate symptoms (United Nations, 2004).

The psychiatrist might subsequently have been asked if an applicant's symptoms (if taken to be genuine) are consistent with their account of their experiences regarding the claim. It might not be possible to say that no other circumstances aside from those described by the applicant could have led to the development of the symptoms in question. However, what is of key importance is whether

the symptoms could have been the result of the experiences described. If so, then the psychiatrist should record the degree of consistency (and should also record any inconsistencies as appropriate). The psychiatrist might be able to say that one explanation is more likely than another; they should also be able to say that one explanation is no less likely than another – or that two explanations are equally likely.

When writing the report, it might be helpful for the psychiatrist to anticipate points that might be raised in refusal letters or during a cross-examination and address them in advance.

Issues relating to return

The psychiatrist might be asked to assess the possible consequences of returning an applicant to their country of origin (or a particular region within that country) on their mental health. Put at its highest, it might be 'inhuman and degrading', according to the provisions of Article 3 (European Convention on Human Rights), to return an individual to circumstances in which their mental health would be in peril, although the threshold for demonstrating this is very high. The decision maker must also give consideration to the 'moral and physical integrity' of the applicant as part of their right to a 'private and family life' (ECHR Article 8), within which the individual's mental health is crucial (see below regarding the reasonableness of 'internal relocation').

It is important to bear in mind that the corollary of an individual's return to the country of origin is departure from their current setting (and treatment) in the UK. The impact of the sudden loss of, for example, family and other social supports or treatment networks on the applicant who has engaged in treatment in the UK should be considered in this context. If the applicant relies on a network of professionals to be able to function without being admitted to hospital, this should be detailed in the report, along with an exploration of friends, relatives or groups (religious or community) on whom the applicant relies.

The psychiatrist should consider whether a currently well-managed or previous mental illness will worsen or recur respectively and also the gravity of the consequences of that worsening or recurrence. The applicant's ability to access mental health services in their destination country will frequently be relevant. It should be noted that 'availability' and 'ability to access' are not the same thing. Psychiatrists must avoid straying outside their expertise in terms of the quality and availability of services in other countries. If they have particular expertise through, for example, direct experience of working in a particular country, this should be demonstrated – although it should be borne in mind that such expertise has a 'shelf life'. These are matters for country experts, but psychiatrists may nonetheless comment on country information supplied with their instructions. However, the applicant's ability as determined by their psychological resources to access healthcare might be something that can be described. For example, if Mr X were to be returned to country Y, he would be unable to access mental healthcare, irrespective of whether it was or was not potentially available to him, because of his psychological state. Discussion might take place describing Mr X's genuine fear of authorities (whether real or imagined), which would inhibit him from seeking or engaging in a therapeutic relationship.

The psychiatrist may also comment clinically on whether the applicant is likely to have the necessary insight into their condition and trust in local services to be likely to access such services (should they exist) appropriately.

It is frequently argued that return to the country of origin is possible if the applicant were to relocate to an area (such as the country's capital) that would mitigate further risk of persecution or ill-treatment ('internal relocation'). The courts have held that decision makers must consider whether internal relocation is reasonable or unduly harsh in the particular circumstances of the individual. Psychiatric evidence can be important in determining that reasonableness. In one case, it was held that the applicant was 'particularly vulnerable' because she 'has no formal qualifications; and … was traumatised and suffering from anxiety and depression' (*AA (Uganda) v Secretary of State for the Home Department* [2008]). A psychiatric report concluded that 'if AA were to return to Uganda she would present a very severe suicidal risk'. The extent to which safety can be assured for

the particularly vulnerable in camps for internally displaced people was discussed in *Secretary of State for the Home Department v AH (Sudan) and others (FC)* [2007].[4]

A psychiatrist might be asked to give an opinion on the risk of self-harm or suicide in the event of return. It is important to point out that measures taken to prevent a suicidal act (such as restraint or medication) do not address the underlying suicide risk, cannot be kept up indefinitely and do not constitute psychiatric treatment. Clinical assessments of risk and their prevention in the context of deportation or removal are quite different from risk assessments in other contexts and this needs to be understood and, if necessary, clinical issues expanded upon. The Home Office will seek to minimise the risk of harm upon removal, but will not concern itself with the avoidance of risk through not taking steps towards that removal. For example, exacerbation of a current state of mental ill-health can be avoided by not removing an individual and, similarly, any steps towards removal could exacerbate an individual's mental ill health. Nor will Home Office officials necessarily have concerns about risks that might emerge after removal. Thus a 'medical evacuation' might be seen as a proper means to remove people in some circumstances; clinicians should be aware of these differences and not take it for granted that there is a shared safeguarding culture.

Psychiatrists should be mindful that, from a legal standpoint, returning an applicant with a mental illness to their country of origin is not always inappropriate, and should say in their written report that they have considered this. In essence, the law requires a finding of specific vulnerability.

It is worth reiterating at this point that the psychiatrist should not comment on, for example, whether there is an objective risk of an applicant being persecuted upon return to their country of origin. However, a psychiatrist is well placed to offer a clinical opinion as to whether an applicant's fear of persecution is genuinely held, whether real or imagined.

4 *Secretary of State for the Home Department v AH (Sudan) and others (FC)* [2007] UKHL 49, Baroness Hale citing UNHCR's intervention with approval: '... the correct approach when considering the reasonableness of [internal relocation alternative] is to assess all the circumstances of the individual's case holistically and with specific reference to the individual's personal circumstances (including past persecution or fear thereof, psychological and health condition, family and social situation, and survival capacities). This assessment is to be made in the context of the conditions in the place of relocation (including basic human rights, security conditions, socio-economic conditions, accommodation, access to healthcare facilities), in order to determine the impact on that individual of settling in the proposed place of relocation and whether the individual could live a relatively normal life without undue hardship'.

Writing the report

Legal requirements

Although tribunal proceedings are not governed by the CPR (which apply to the higher courts), it is good practice to consider these standards in any legal proceedings. The First-tier and Upper Tribunals (Immigration and Asylum Chambers) have their own practice direction (Tribunals Judiciary, 2014), which is broadly similar to the CPR standards, and psychiatrists should familiarise themselves with these as well if this is the setting for which they are preparing reports. The CPR and the Immigration Courts practice directions were not drafted with medico-legal reports exclusively in mind and are intended for general application for any and all expert reports.

Civil Procedure Rules: Practice Direction 35 – Experts and Assessors (Ministry of Justice, 2012a) describes the form and content required of an expert report:

> 3.1 An expert's report should be addressed to the court and not to the party from whom the expert has received instructions.
>
> 3.2 An expert's report must:
>
> (1) give details of the expert's qualifications;
>
> (2) give details of any literature or other material which has been relied on in making the report;
>
> (3) contain a statement setting out the substance of all facts and instructions which are material to the opinions expressed in the report or upon which those opinions are based;
>
> (4) make clear which of the facts stated in the report are within the expert's own knowledge;
>
> (5) say who carried out any examination, measurement, test or experiment which the expert has used for the report, give the qualifications of that person, and say whether or not the test or experiment has been carried out under the expert's supervision;
>
> (6) where there is a range of opinion on the matters dealt with in the report –
>
> (a) summarise the range of opinions; and
>
> (b) give reasons for the expert's own opinion;
>
> (7) contain a summary of the conclusions reached;
>
> (8) if the expert is not able to give an opinion without qualification, state the qualification; and
>
> (9) contain a statement that the expert –
>
> (a) understands their duty to the court, and has complied with that duty; and
>
> (b) is aware of the requirements of Part 35, this practice direction and the Guidance for the Instruction of Experts in Civil Claims 2014.

Instructions (which include any documents provided with the instructions by the instructing solicitor, as well as instructions given other than through the letter of instruction, such as by telephone and email) are not privileged against disclosure, but the court will not, in relation to those instructions:

- order disclosure of any specific document, or
- permit cross-examination on the contents of those instructions unless the court 'is satisfied that there are reasonable grounds to consider the statement of instructions in the expert's report is inaccurate or incomplete' (Ministry of Justice, 2012b).

Cross-examination will only be permitted where the court considers that 'it appears to be in the interests of justice' (Ministry of Justice, 2012a).

It should be assumed that reports prepared at the stage of an earlier decison will be disclosed in higher courts. The instructing solicitor should advise the expert whether (and if so, when) the report is to be disclosed to other parties to the proceedings. Deadlines and hearing dates should

always be provided at the time of instruction or as soon as they become known.

Experts should not be asked to, and should not, amend, expand or alter any parts of reports in a manner that distorts their true opinion, but may be invited to amend or expand reports to ensure accuracy, internal consistency, completeness and relevance to issues and clarity (Civil Justice Council, 2014). It is good practice for instructing solicitors to make any requests to amend reports in writing.

In the majority of cases, the psychiatrist who has authored the medical report will not be required to attend court or be cross-examined on it. It is therefore important that the report be comprehensive, as there will probably be no opportunity to discuss issues that might arise once the report has been submitted. If the psychiatrist is required to attend court, they should consider likely cross-examination questions in advance.

Statement of truth

CPR Practice Direction 35 states that an expert's report must be verified by a statement of truth in the following form (Ministry of Justice, 2012a):

> I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer.

In a 'removal' case that is proceeding in the High Court, the expert will also have to confirm that they have read *Civil Procedure Rules. Part 35 – Experts and Assessors* and *Civil Procedure Rules. Practice Direction 35 – Experts and Assessors* (Ministry of Justice, 2012a,b). The forum in which the case is being heard should be made clear in the instructions.

Reports that are not prepared for use in the higher courts do not need reference to the CPR. The following 'statement of truth' may be used:

> I have read the Immigration and Asylum Chambers of the First-tier Tribunal and the Upper Tribunal Practice Directions as they relate to expert evidence and I confirm that insofar as the facts stated in my report are within my own knowledge I have made clear which they are and I believe them to be true, and that the opinions I have expressed represent my true and complete professional opinion.

See *Practice Direction of the Immigration and Asylum Chambers of the First-Tier Tribunal and the Upper Tribunal on or after 13 November 2014* (Tribunals Judiciary, 2014) for more detail.

If unsure which of the above statements is necessary, check with those providing the instructions.

Style of the report

Psychiatrists should clearly explain how they arrived at their diagnosis. The diagnosis itself should be clearly explained in the context of the interview, supporting documentation and any other relevant material employed.

If the applicant was in detention, the expert should consider explaining any limitations to the assessment arising from the assessment taking place in detention (distress of applicant, lack of privacy, noise). Where the detention environment has a more profound effect (e.g. dissociation, flashbacks) this should, of course, be commented on in clinical terms.

Diagnostic criteria should be listed, and if possible should be linked to quotes or examples from the interview or other documentation to illustrate the application of the relevant criteria. Such illustration can also assist in distinguishing trauma-related issues from other possible causes. For example, dissociative episodes triggered specifically by probing questions related to torture or ill-treatment or the content of flashbacks should be described in detail and their aetiological significance explained in the report.

It is for the psychiatrist to decide whether to use rating scales or diagnostic interview schedules, depending on their own practice, but such scales should be viewed as complementary to, rather than a replacement for, sound clinical judgement. The psychiatrist must form an expert opinion based 'in the round' on their interview with the applicant, accompanying documentation and other medical records.

Needless jargon should be avoided but appropriate technical language should be used with an

explanation as necessary. Psychiatrists must have confidence in their authority and skill and express themselves appropriately. Clinical opinions should be stated as such rather than in vague terms: 'in my clinical opinion' rather than 'I believe'.

Factive verbs such as 'claims' or 'alleges' should be avoided. 'He said' or 'she reported' are neutral and do not allow for reading anything into the words used to preface the statement. It is often useful to quote an applicant's detailed description of clinical symptoms verbatim, although very lengthy quotations without specific clinical significance should be avoided.

Home Office refusal letters and tribunal determinations will contend, from time to time, that if the applicant were as ill as asserted, they would be in receipt of treatment. In anticipation of or in response to such assertions, it may be observed that the absence of any previous mental health assessment or treatment in the UK does not necessarily mean that a mental disorder was not present, especially given the difficulty typically experienced by this client group in accessing services and the stigma attached to mental illness in some cultures. This can be contextualised with the 'treatment gap' evident in the general public, where only a quarter of people with common mental disorders and two-thirds of people with psychosis are in receipt of treatment (McManus *et al*, 2009). In some cases, a lack of engagement with services can be related to the existence of a disorder, although this is obviously not always the case and psychiatrists should always consider the specific circumstances of each individual.

Similarly, many refusal letters and determinations will comment upon lack of engagement with clinical services and the absence of medication. It should be noted that such observations can amount to clinical judgements, which decision makers are instructed not to make. It is therefore important to be clear that psychiatric care does not necessarily involve medication, which, depending on the circumstances, can quite legitimately play a relatively minor role in the treatment of serious mental disorders. National Institute for Health and Care Excellence (NICE) guidelines on PTSD and depression, for example, emphasize the primacy of psychological approaches rather than medication (NICE, 2005, 2009).

Good and bad practice in report writing

The following things should be avoided:

- expressing legal opinions
- straying outside your field of expertise or competence (where questions are put or matters arise that are outside one's field of expertise or comepetence, this should be made clear)
- advocacy
- exaggeration
- hyperbole (be understated)
- pointers to personal or political opinions
- making points about 'the unfairness of the system'
- findings of fact (as opposed to your opinion) – let the evidence speak for itself
- bias
- being too credulous (or encouraging this perception)
- appearing inadequately qualified by failing to provide a comprehensive biography – it is presumed that actual inadequate qualification will mean that the offer to prepare a report is declined on that basis
- ignoring the history taken being inconsistent with what the applicant has said elsewhere – this can be a consequence of mental illness or have other legitimate explanations (e.g. intellectual disability, length of interval, immaturity), but should be addressed
- lacking, or using flawed, reasoning
- disregarding alternative explanations.

Trafficking in persons

Trafficking is a complex area and cannot be fully explored here. See, for example, *Caring for Trafficked Persons: Guidelines for Health Providers* (International Organization for Migration *et al*, 2009) and the Organization for Security and Co-operation in Europe's publication on *Trafficking in Human Beings Amounting to Torture and Other Forms of Ill-Treatment* (OSCE, 2013) for a fuller discussion of the mental health aspects of human trafficking.

Where there is an allegation of trafficking, the psychiatrist should be aware of the common patterns of trafficking experiences and also of the likely mental health consequences. They should be familiar with the various types of human trafficking:

- sexual exploitation
- commercial sex
- increased pattern of use of residential homes to avoid detection
- labour exploitation (i.e. use/employment of a person for labour or involuntary servitude via debt bondage or slavery)
- other forms of exploitation:
  - benefit fraud
  - petty crime
  - baby farming
  - organ harvesting.

Trafficking cases can differ from other asylum claims in a number of ways. There is rarely an overt political aspect, the applicant's vulnerability frequently arises as a result of issues that predate the trafficking, and exploitation often continues in tthe UK (sometimes even after a claim for international protection has been made). In a conventional asylum case, persecution and ill-treatment has (usually) been left behind in the country of origin (although, of course, a victim of trafficking and an asylum seeker might both fear return). However, the clinical presentation of people who have been trafficked can be similar to that of people who have been tortured.

Immigration detention

Detention of persons without leave to remain in the UK can occur in a number of situations. Asylum seekers may be detained on arrival to determine their identity, or detention may be used for the process of examining those who are seeking asylum and/or preventing unauthorised entry of the person to the country. This process is currently described as the 'detained fast track'. Upon refusal in the detained fast track, administrative detention may then be extended to effect removal if the Home Office's general criteria are met. These require that there be a reasonably imminent prospect of removal and an unacceptable risk of absconding. People without authorisation to be in the UK or whose authorisation has expired may also be detained to effect their removal.

The psychiatrist may be asked to provide an expert opinion on whether immigration detention is appropriate in the individual's particular circumstances. This could be for example to support an application to the Home Office for temporary release, for bail before the First-tier Tribunal or to support a claim for unlawful detention.

There are broad statutory powers of immigration detention. However, these powers are circumscribed, including by the requirement that the government follows its own, published policy on detention, Chapter 55 of the *Enforcement Instructions and Guidance* (UK Visas and Immigration, 2013). Paragraph 55.10 provides, broadly, that the following groups should not ordinarily be detained:

- Those suffering from serious medical conditions which cannot be satisfactorily managed within detention.
- Those suffering from serious mental illness which cannot be satisfactorily managed within detention [...] In exceptional cases it may be necessary for detention at a removal centre or prison to continue while individuals are being or waiting to be assessed, or are awaiting transfer under the Mental Health Act.
- Those where there is independent evidence that they have been tortured.
- People with serious disabilities which cannot be satisfactorily managed within detention.
- Persons identified by the competent authorities as victims of trafficking [...].

Any report will need to distinguish the consequences of detention from the effects of earlier trauma or pre-existing mental illness.

Detention and mental illness

The Royal College of Psychiatrists (2013) has released a position statement on mental illness and detention. Its conclusions are reproduced below.

> In the recent judgement Aswat v UK [Aswat v UK app no 17299/12, ECtHR, 16 April 2013], the ECtHR observed that both the fact of detention of a person who is ill and the lack of appropriate medical treatment may raise Article 3 issues (i.e. may constitute inhuman or degrading treatment).
>
> There are three main elements to be considered in relation to the compatibility of an individual's health with her/his stay in detention:
>
> a) the individual's medical condition;
>
> b) the impact of detention on the individual's health
>
> c) the adequacy of the medical assistance and care provided in detention
>
> 1. In our view, people with mental disorder should only be subjected to immigration detention in very exceptional circumstances.
>
> 2. We believe that detention centres are likely to precipitate a significant deterioration of mental health in the majority of cases, greatly increasing both the suffering of the individual and the risk of suicide and self-harm.
>
> 3. We believe that individuals with mental disorder should receive the same optimum standard of care

if they are in a detention centre as they would in any other NHS setting.

4. We feel that detention centres are not appropriate therapeutic environments to promote recovery from the mental ill health due to the nature of the environment and the lack of specialist mental health treatment resources.

5. We would like to emphasise that the current ethos of mental health services is on recovery and community rehabilitation, and this cannot be provided in a detention centre.

6. Current guidelines for good clinical practice also emphasise protecting individual rights through providing the least restrictive treatment option. This is reflected in the new Mental Health Act and Mental Capacity Act legislation, and is consistent with an ethos of avoiding inpatient admission or detention under the Mental Health Act where possible. In this context, it is therefore inappropriate to base judgements of the seriousness or severity of mental illness on 'the need for inpatient admission'.

7. We define 'serious mental illness' as a mental disorder that significantly impairs the individual's ability to engage constructively in society, to care for him/herself and/or to work.

8. In our opinion it is also inappropriate to consider inpatient hospitalisation as equivalent to, or as the only alternative to detention centre. We believe this creates a false dichotomy and a revolving door syndrome between detention centre and inpatient admission.

9. It remains of great concern that there are repeated cases where asylum seekers are detained despite a clear and documented history of mental illness and against the specific advice of mental health professionals. (This occurred in both [*R (S) v Secretary of State for the Home Department* [2011] EWHC 2120 (Admin)] and [*R (BA) v Secretary of State for the Home Department* [2011]], where the judgment concluded that they had suffered serious further deterioration in their mental state as a result of their detention).

10. It is also of great concern that there are repeated examples where mental disorder has not been satisfactorily or adequately managed in the detention centres. These examples have been taken to the High Court and the provision of psychiatric care in these instances was not only found to be woefully below that considered best practice but to be so poor that the overall treatment of the people concerned was found to be inhuman and degrading. There is no evidence to suggest that practice has changed since these rulings. It is noteworthy that in both the cases cited above, there was also failure to transfer the detainee for compulsory psychiatric treatment. In *R (S) v Secretary of State*, the judge found [UK Border Agency] policy was not properly understood and applied by those authorising detention, and that the decision and subsequent reviews failed to assess and understand the impact of detention on S's mental health. In [*R (D) v Secretary of State for the Home Department* [2012] EWHC 2501 (Admin)] the claimant (who had a diagnosis of paranoid schizophrenia), was denied treatment for several months and was segregated despite clearly documented prior knowledge of his illness and current treatment. There was also evidence of neglect and recourse to disciplinary sanctions.

11. It is therefore crucial that clinical and other staff working in detention centres were given adequate training and support to identify mental disorder when it does arise or deteriorate significantly in a detention centre setting, and clear guidelines on how to manage this appropriately and link up with existing local mental health provision outside the detention centre. This should include specific attention to appropriate monitoring and management of risk.

There is evidence of an association between a high prevalence of mental illness and being placed in immigration detention. Robjant *et al* (2009) conducted a systematic review of studies investigating the impact of immigration on the mental health of children and adult detainees. They identified ten studies, all of which noted high levels of mental health problems (especially anxiety, depression, self-harm, suicidal ideation and PTSD) among detainees. Time spent in detention was shown to be positively associated with the severity of mental health problems experienced. Release from detention led to an initial improvement in mental health, although symptoms did persist in the longer term.

Sultan & O'Sullivan (2001) found high prevalence rates for mental symptoms among long-term immigration detainees: 85% had chronic depressive symptoms; 65% expressed suicidal ideation and 21% showed evidence of psychotic features. Keller *et al* (2003) found diagnostic prevalence rates among immigration detainees of 77% for anxiety, 86% for depression and 50% for PTSD.

The key issue is whether the applicant's mental health needs can be satisfactorily met in detention, and consideration should be given not only

to their current needs but also to any realistic exacerbation of their condition as a consequence of detention.

There are numerous cases in which the courts have provided guidance as to the meaning of policy relating to the detention of those with mental illness (see, in particular, the judgment of the Court of Appeal in *R (Das) v Secretary of State for the Home Department* [2014]). The following principles emerge from those authorities:

- a mental illness needs to reach a threshold of seriousness before the policy is engaged
- the emphasis is on whether treatment necessary to adequately manage the condition is available in the immigration removal centre.
- the policy requires the detaining authority to look forward (i.e. to consider whether a detainee's mental illness is likely to deteriorate within the envisaged period of detention)
- there need to be compelling factors in favour of detention to justify the immigration detention of someone who is mentally ill, usually relating to the risk that they will abscond or commit criminal offences if released.

The *Detention Centre Rules 2001*

The Secretary of State for the Home Department contracts out the running of immigration removal centres to private contractors. The NHS is responsible for primary and secondary care, although in practice primary care services at such centres are often contracted out to private companies. The Home Office, its contractors and healthcare providers must comply with the *Detention Centre Rules 2001* (Home Office, 2001). Under rules 34 and 35, doctors at immigration removal centres are required to report to the manager of the centre on the case of any detained person whose health is likely to be injuriously affected by continued detention or any conditions of detention. The manager must pass this report to the Secretary of State without delay. The process is to pass the report to the Home Office manager on site, who is then responsible for forwarding the information to the Home Office case manager with the authority to review the decision to detain.

Where the doctor considers that a detainee might have been the victim of torture, a report should be made to the detention centre manager (Home Office, 2001). This implies that there is a need for a value judgement and that it is not sufficient merely to report complaints of torture; the doctor is referring based on their concerns (but not preparing a medico-legal report). The centre manager then has a responsibility to ensure that a copy of the report is passed to the Secretary of State (in practice the Home Office case manager) without delay (Home Office, 2001).

It is the policy of the Home Office that, where there is independent evidence that an individual is a victim of torture, they should not be subject to detention except in very exceptional circumstances. Depending on the circumstances, a report from a medical practitioner based in a detention centre may be accepted as independent evidence of torture.

Transfers under the Mental Health Act 1983

If the Home Office is willing to authorise the release of a detainee or a court orders their release from an immigration detention centre, detainees may be detained compulsorily as ordinary community patients under the Mental Health Act 1983 or treated as voluntary patients.

However, if detention is maintained, the Secretary of State for Justice (as opposed to Secretary of State for the Home Department) may make a 'transfer direction' under section 48 of the Mental Health Act 1983 when they are satisfied, by reports from at least two registered medical practitioners, that:

- the person is suffering from mental disorder of a nature or degree that makes it appropriate for them to be detained in a hospital for medical treatment;
- they are in 'urgent' need of such treatment; and
- appropriate medical treatment is available for them (i.e. a bed must be available).

Reports from at least two medical practitioners

There is no statutory time limit between the date of the report and the date of the decision of the Secretary of State for Justice to direct transfer. However, the practice of the Mental Health Unit at the Ministry of Justice is to require two medical reports, which must not be more than 2 months old and dated within 2 weeks of the examination. One of the registered medical practitioners must be approved under section 12 of the Mental Health Act 1983 (for detailed guidance, see Department of Health, 2011).

In practice, the Secretary of State for Justice will normally want at least one of the two doctors to be practising at the hospital named in the proposed transfer direction, 'so as to ensure that there is agreement as to the hospital's reception of the patient and as to [their] diagnosis, treatability and detention' (*R (on the appl'n of D) v Secretary of State for the Home Office (1) National Assembly for Wales (2)* [2004]).

Guidance for the preparation of section 48 reports is found in Appendix 5 of the Department of Health's (2011, p. 31) guide to such transfers:

> i. Please provide a full report to support the application for the Secretary of State's agreement to transfer the prisoner to hospital, based on your assessment of the prisoner, clearly setting out the reasons for your conclusions and recommendations.
>
> ii. The report should refer to the level of physical, relational and procedural security appropriate to the clinical needs of the prisoner and include a recommendation for the level of security (PICU, low, medium or high) in which treatment is required.
>
> iii. If the prisoner has a learning disability, the report should demonstrate how this is associated with abnormally aggressive or seriously irresponsible conduct. In that case, the report should indicate if the prisoner is suffering from an associated mental disorder.
>
> iv. The report must set out the nature and degree of mental disorder that makes detention for treatment in hospital appropriate and indicate the urgency of the need for treatment. The report must make it clear that appropriate medical treatment is available to the prisoner and indicate where this treatment is available.
>
> v. The Secretary of State's decision whether to direct transfer to hospital is based on an assessment of risk. It will take account of a range of issues including public protection, and the need to ensure that the remand or sentence of the Court is preserved.
>
> vi. The physical security and clinical needs of the prisoner based on their individual circumstances, previous history, including offending history, and treatment requirements, are essential elements of the decision.

Where there is a difference of clinical opinion on the need for transfer, and a resolution cannot be agreed by the two doctors undertaking the assessments, an agreement should be made about seeking a third-party view (Department of Health, 2011).

'Urgent' need of treatment

In their report, the Reed Committee expressed concern 'that the requirement under section 48 that the need for treatment should be "urgent" is often interpreted narrowly' (Langdale Reed & Reed, 1992). The Committee concluded that this section 'should be applied where a doctor would recommend in-patient treatment if a person were seen as an out-patient in the community'. However, this is absent from the 2011 guidance, which states that there must be an 'urgent' need for treatment in respect of unsentenced prisoners (which includes immigration detainees; Department of Health, 2011).

The procedure for transfers with 'suggested timeframes' is set out at paragraph 4.5 of the Department for Health (2011) guidance, and summarised below.

Stage 1 (suggested timeframe within 2 days)

The first doctor makes an assessment and produces a medical report. The healthcare team at the immigration removal centre should take the following actions.

- Contact the Mental Health Casework Section at the Ministry of Justice for advice on the level of secure mental health service likely to be required, and send form H1003.

- Gather other information necessary to support transfer process (offending, security and medical information).
- Contact the responsible NHS commissioner to alert to the need for assessment and funding for in-patient treatment.
- Make a formal referral to a responsible mental health provider and make an appointment for a second doctor's assessment.

Stage 2 (suggested timeframe up to 7 days)

The second doctor makes an assessment and produces a medical report. An appropriate bed is identified and remaining information needed for transfer sent, with confirmation of bed availability in an appropriate service, to the Mental Health Casework Section at the Ministry of Justice.

Stage 3 (suggested timeframe up to 5 days)

The Mental Health Casework Section at the Ministry of Justice approves and issues a warrant. The mental health service provider confirms the admission date to the immigration removal centre. The Home Office arranges escorts and transport for the detainee to hospital.

Children in immigration detention

Following sustained criticism of the deleterious physical and mental health consequences of the detention of children in the immigration system (including concerns raised by some medical Royal Colleges; e.g. Royal College of Psychiatrists *et al*, 2009), the Government announced that they were committed to ending the detention of children in the immigration system (HM Government, 2010). Following a UK Border Agency review of alternatives to detention, it was announced that the charity Barnardo's would manage 'family focused pre-departure accommodation', which would be for a maximum period of 72 h (Casciani, 2011). Independent evaluation of the mental and physical health of detainees at this pre-departure accommodation centre was yet to take place at the time of writing.

Appendix 1. Legal framework and precendents

Psychiatrists might find it helpful to be familiar with the legal framework within which expert reports are considered.

Case law

Mibanga v Secretary of State for the Home Department [2005]

- Decision makers should not draw conclusions on the applicant's credibility and then consider the medical evidence separately. In fact, the medical evidence will be beneficial in aiding them to come to their conclusions, as it will provide a factual context to the evidence.

Karanakaran v Secretary of State for the Home Department [2000]

- The *Karanakaran* case indicated that the key test is whether the evidence must lead to the conclusion that the injuries could not have been inflicted in the circumstances described.
- However, even in these circumstances, the clinical evidence of torture contained in a report cannot be completely dismissed.
- When assessing past events, including the allegation of torture, it is important that the decision maker bears the *Karanakaran* framework in mind.

Y (Sri Lanka) and Z (Sri Lanka) v Secretary of State for the Home Department [2009]

- Where there is medical evidence that is uncontradicted, the judge must have and must give acceptable reasons for rejecting it. This obligation is particularly strong when it directly relates to the claimant's fundamental human rights.
- Where two experts are thought to have contradicted each other, the judge might have to choose between them, but may not for

that reason alone reject both. The judge must still carefully decide whether the evidence of one or other of the doctors is cogent.

- The judge must respect uncontradicted expert evidence as to reasons why the claimant should not give evidence.
- When considering the factual basis of psychiatric findings and whether a claimant has exaggerated their symptoms when examined by a doctor, it is a matter for the expert in the first instance to evaluate the patient's account of their symptoms and 'it is only if the tribunal has good and objective reason for discounting that evaluation that it can be modified or – even more radically – disregarded'.
- If the judge has concerns about an aspect of an expert's evidence, these concerns should be put directly to the expert when they are giving their evidence and not reserved until the written judgment.
- When the expert evidence is 'all one way and not materially shaken in terms of either authorship or content' the judge must accept and act on it.

XS (Kosovo – Adjudicator's conduct, Psychiatric report) Serbia and Montenegro [2005]

- It is important to distinguish whether the relevance of psychiatric or other medical evidence is wholly or in part to support the truthfulness of the account given by the claimant, and whether its relevance is that the illness or condition exists, regardless of its cause. One medical report may be relied on for both arguments.
- Where a medical report seeks to 'identify the extent to which the diagnosis is dependent on the applicant's account of what had happened', and reach a conclusion, based on experience and expertise that is 'objectively supportable rather than one which simply accepted symptoms which could be described but which could not be verified', these 'material facts' should not be ignored.

HE (DRC – Credibility and Psychiatric reports) Democratic Republic of Congo [2004]

- It is wrong to ignore a medical report if it offers some corroboration for what a claimant is saying, though there is no necessary obligation to give a report weight.
- The consideration given to a report depends on the quality of the report and the standing and qualifications of the doctor.
- A doctor does not usually assess the credibility of an applicant; it is the task of the fact-finder 'who will have often more material than the doctor, and will have heard the evidence tested'.
- The report might be able to offer a description of physical conditions and an opinion as to the degree of consistency of what has been observed with what has been said by the claimant.

- ‘Rather than offering significant separate support for the claim, a conclusion as to mere consistency generally only has the effect of not negating the claim.’
- ‘Where the report is specifically relied on as a factor relevant to credibility, the Adjudicator should deal with it as an integral part of the findings on credibility rather than just as an add-on, which does not undermine the conclusions to which he would otherwise come.’
- Where a medical report is used to support credibility findings, the advocate ‘must identify what about it affords support to what the claimant has said and which is not dependent on what the claimant has said’.

JL (Medical reports – Credibility) China [2013]

From the judgment:

1 Those writing medical reports for use in immigration and asylum appeals should ensure where possible that, before forming their opinions, they study any assessments that have already been made of the appellant’s credibility by the immigration authorities and/or a tribunal judge (SS (Sri Lanka) [2012] EWCA Civ 155 [30]; BN (psychiatric evidence discrepancies) Albania [2010] UKUT 279 (IAC) at [49], [53])). When the materials to which they should have regard include previous determinations by a judge, they should not conduct a running commentary on the reasoning of the judge who has made such findings, but should concentrate on describing and evaluating the medical evidence (IY (Turkey) [2012] EWCA Civ 1560 [37].

2 They should also bear in mind that when an advocate wishes to rely on their medical report to support the credibility of an appellant’s account, they will be expected to identify what about it affords support to what the appellant has said and which is not dependent on what the appellant has said to the doctor (HE (DRC, credibility and psychiatric reports) Democratic Republic of Congo [2004] UKAIT 000321). The more a diagnosis is dependent on assuming that the account given by the appellant was to be believed, the less likely it is that significant weight will be attached to it (HH (Ethiopia) [2007] EWCA Civ 306 [23]).

3 The authors of such medical reports also need to understand that what is expected of them is a critical and objective analysis of the injuries and/or symptoms displayed. They need to be vigilant that ultimately whether an appellant’s account of the underlying events is or is not credible and plausible is a question of legal appraisal and a matter for the tribunal judge, not the expert doctors (IY [47]; see also HH (Ethiopia) [2007] EWCA Civ 306 [17]-[18]).

4 For their part, judges should be aware that, whilst the overall assessment of credibility is for them, medical reports may well involve assessments of the compatibility of the appellant’s account with physical marks or symptoms, or mental condition:

(SA (Somalia) [2006] EWCA Civ 1302). If the position were otherwise, the central tenets of the Istanbul Protocol would be misconceived, whenever there was a dispute about claimed causation of scars, and judges could not apply its guidance, contrary to what they are enjoined to do by SA (Somalia). Even where medical experts rely heavily on the account given by the person concerned, that does not mean their reports lack or lose their status as independent evidence, although it may reduce very considerably the weight that can be attached to them.

The standard of proof

The burden of proof in an asylum claim or appeal rests on the applicant. The standard of proof is that there is a reasonable degree of likelihood of persecution and/or a serious/real risk to the applicant. Decision makers and judges must not exclude from their consideration matters that they think might not have occurred, but that they cannot rule out (*Karanakaran v Secretary of State for the Home Department* [2000]). This is a very low standard and significantly lower than the civil standard of a 'balance of probabilities'. Furthermore, if an applicant has already been subjected to, or threatened with, persecution or serious harm, this should be regarded as a serious indication that persecution or harm might happen again.

It has been argued that requiring the consideration of other possible causes and a statement of which of those other possible causes is 'more likely' shifts the degree of consistency from 'a reasonable degree of likelihood' to 'more likely than not', in other words 'on a balance of probabilities'. The CPR Practice Direction 35 states that where there is a range of opinion on matters dealt with, this should be summarised and the reasons for the expert's own opinion should be stated (Ministry of Justice, 2012a). However, case law has taken the requirement a stage further by asking physicians to identify "pointers" … which may make the particular explanation for the injury advanced by the complainant more or less likely' (*RT (medical reports - causation of scarring) Sri Lanka* [2008]).

By the insertion of a 'more or less likely' test, torture survivors seem to be required to demonstrate through an expert's evidence that, on a balance of probabilities, they have been tortured. The CPR are written with the civil standard 'more probable or not' in mind (*Miller v Minister of Pensions* [1947]). However, this applies the wrong standard of proof. 'A reasonable degree of likelihood' and the approach set out in *Karanakaran* allows for a number of alternative explanations for an injury to be available simultaneously, and for the consideration of matters that cannot be ruled out, provided that 'a reasonable degree of likelihood' that any of them is plausible remains.

Only when it can be established that the injuries could not have been inflicted in the circumstances described can alternative explanations be given weight (*Karanakaran v Secretary of State for the Home*

Department [2000]). Furthermore, the context for this consideration is based on 'what is known about the individual's life history and experiences' rather than speculation (*RT v Secretary of State for the Home Department (Medical reports – Causation of scarring) Sri Lanka* [2008]).

Appendix 2. Summary of law: ECHR article 3 in suicide cases

Article 3 of the ECHR provides that 'no one shall be subjected to torture or to inhuman or degrading treatment or punishment'. The European Court has held that there are two types of obligation on states:

- negative – 'to refrain from inflicting serious harm on persons within their jurisdiction'.
- positive – 'to take measures designed to ensure that individuals within their jurisdiction are not subjected to torture or inhuman and degrading treatment or punishment'.

Bensaid v UK [2001] concerned a man from Algeria with schizophrenia who had been on temporary admission and reliant on antipsychotic medication and specialist psychiatric treatment in the UK. The court held that, in principle, deterioration in mental illness as a consequence of removal could breach article 3:

> The difficulties in obtaining medication and the stresses inherent in returning to this part of Algeria, where there is violence and active terrorism, are alleged to endanger seriously his health. Deterioration in the applicant's already existing mental illness could involve relapse into hallucinations and psychotic delusions involving self-harm and harm to others, as well as restrictions in social functioning (e.g. withdrawal and lack of motivation). The Court considers that the suffering associated with such a relapse could, in principle, fall in the scope of Article 3.

However, the court found no violation of article 3 in that case, for the following reasons:

- the applicant faced a risk of relapse even if he remained in the UK
- medical treatment was available to him in Algeria
- the fact that his circumstances in Algeria would be less favourable than his circumstances in the UK was not decisive
- having regard to the high threshold set by article 3, 'particularly where the case does not concern the direct responsibility' of the expelling state, there was not a sufficiently real risk that his removal would breach article 3.

The Court also stated that mental health must be regarded as a crucial part of private life associated with the aspect of moral integrity under article 8. Article 8 protects a right to identity and personal

development, and the right to establish and develop relationships with other human beings and the outside world. The preservation of mental stability is, in that context, an indispensable precondition to effective enjoyment of the right to respect for private life. Where treatment (in this context, deterioration in mental health consequent on removal) does not reach the severity of article 3 treatment, it might nonetheless breach article 8 if there are sufficiently adverse effects on physical and moral integrity.

The leading domestic case on suicide risk arising from removal and article 3 is *J v Secretary of State for the Home Department* [2011]. A tribunal had concluded that J had no well-founded fear of persecution on return to Sri Lanka. However, J maintained he had a fear of returning to Sri Lanka to the extent that he would commit suicide after expulsion. The Court of Appeal drew a distinction between 'domestic cases' (where the risk of suicide arose while still in the UK's jurisdiction (which included 'when he is physically removed by airplane to Sri Lanka')) and 'foreign cases' (where the risk arose after expulsion). The Court of Appeal laid down six principles to be applied when deciding such cases.

1. The treatment must reach the minimum level of severity.
2. There must be a causal link between the threatened expulsion and the risk of ill-treatment under article 3.
3. In the context of a 'foreign case' the article 3 threshold is 'particularly high [...] And it is even higher where the alleged inhuman treatment is not the direct or indirect responsibility of the public authorities in the receiving state, but results from some naturally occurring illness, whether physical or mental'.
4. Suicide cases can, in principle, form the basis of a claim to remain in the UK under article 3. The threshold for such claims, however, is very high.
5. It is important to consider whether the applicant's fear of returning to the receiving state is objectively based. If the fear is not well-founded, expulsion is less likely to give rise to a breach of article 3.
6. It is also important to consider whether the UK or the receiving state has 'effective mechanisms' to reduce the risk of suicide, which might avoid a breach of article 3: the presence of such mechanisms will weigh heavily against the claim. Courts are entitled to take into account measures put in place by the Secretary of State for the Home Department to minimise risks when expelling the vulnerable.

Y (Sri Lanka) and Z (Sri Lanka) v Secretary of State for the Home Department [2009] concerned two Tamils who had suffered past ill-treatment by agents of the Sri Lankan state. The psychiatric evidence showed that return would cause deterioration in their mental health and create a risk that they would commit suicide. The Court of Appeal held that, in such cases, the cause of harm is not the naturally occurring illness but intentional action by the receiving state: 'the

anticipated self harm would be […] the product of fear and humiliation brought about by the brutality to which both […] were subjected before they fled'.

In relation to the fifth principle set out in *J v Secretary of State for the Home Department* (i.e. whether the applicant's fear of returning to the receiving state is objectively based), the court held that if an applicant has a genuine fear of ill-treatment as a result of an accepted history of torture or other ill-treatment which, whether or not that fear is now objectively well-founded, creates a risk of suicide in the event of enforced return, that will weigh in favour of a finding of breach of article 3.

In relation to the sixth principle set out above, if because of past torture or ill-treatment an applicant is so traumatised and so subjectively terrified at the prospect of return to the place of their ill-treatment they will be simply unable to seek and obtain the treatment they require (even if it is available), this will weigh in favour of a breach of article 3.

Appendix 3. Example instruction questions

General questions

- Please describe, in lay terms, [*applicant*]'s mental health history.
- Please provide your opinion with regard to current diagnoses by reference to current DSM or ICD criteria (or such alternative diagnostic criteria as you consider appropriate).

Asylum and deportation questions

- On the basis of the available information, including [*applicant*]'s account of the mental trauma they have suffered and the medical records, is it possible to observe that they did suffer such trauma and have any symptoms persisted?
- What evidence, if any, is there that such trauma was suffered and that it is attributable to the events in [*country of origin*]?
- Can the trauma be described as a recognised psychiatric disorder and, if so, what kind of disorder? Can it be diagnosed now from any persisting symptoms?
- In the context of the reasons provided by the Home Office for refusing [*applicant*]'s asylum claim, do you find any objective grounds to doubt [*applicant*]'s account of ill-treatment?
- Further, in the context of the reasons provided by the Home Office for refusing [*applicant*]'s asylum claim, do you agree that removal (including the act of forced removal itself) would create a risk of suicide? Are you able to comment on the relationship between any risk you identify and [*applicant*]'s fears arising from the traumatic events they experienced in [*country of origin*]?
- Please offer your opinion on whether and to what extent the maintenance of [*applicant*]'s family life will assist the management of any mental health conditions from which you find them to be suffering.

- If you are aware of the available mental health treatment/services in [*country of origin*], in your opinion would [*applicant*] be able to access the treatment they need?
- In the context of [*applicant*]'s forthcoming deportation appeal, please offer your views as to whether [*applicant*] is fit to give evidence on their own behalf, particularly with regard to the traumatic events prior to their arrival in the UK. Please also consider whether a requirement to give evidence would be likely exacerbate their current condition?

Detention

- Please offer your opinion on whether detention between [*date*] (when they were subjected to immigration detention) and [*date*] exacerbated and/or precipitated psychiatric illness (including whether this fell within any of the categories of mental illness in the Judicial College's *Guidelines for the Assessment of General Damages in Personal Injury Cases*.
- Please offer your opinion of [*applicant*]'s fitness to remain in immigration detention, including the risks associated with continued detention and the availability of necessary treatment for any mental disorder you have identified.
- Please provide your opinion on the most appropriate clinical context for [*applicant*]'s treatment and care.

Capacity

- Please offer your views with regard to [*applicant*]'s current capacity to (a) understand legal advice and (b) to offer instructions in his/her own best interest by reference to the Mental Capacity Act 2005.

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