Psychiatric evidence in UK immigration and asylum cases

ARTICLE

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SUMMARY

This article critically reviews the case law, guidance and standards related to the provision of expert psychiatric evidence in immigration and asylum cases in the UK. It discusses the potentially complex and medico-legally challenging process of psychiatric evaluation of asylum seekers, and the implications of the presence of psychiatric disorders for issues such as the individual's ability to give oral evidence in court, immigration detention, fitness to fly, removal, deportation, ability to reintegrate into the destination country and appeal rights. To give context to the discussion, it outlines the asylum process in the UK from claiming asylum, initial screening and the 'substantive interview' to, if a claim is rejected, appeal to the First-tier Tribunal (Immigration and Asylum Chamber), detention and the removal process.

LEARNING OBJECTIVES

After reading this article you will be able to:

- understand the required standards and describe the pitfalls when writing psychiatric reports in immigration and asylum cases
- understand the framework within which expert reports are written and when medico-legal reports are requested during the decision-making process
- outline the main medico-legal issues that must be addressed in such reports.

KEYWORDS

Trauma and stressor-related disorders; psychiatry and law; mental health services; adjustment disorders; depressive disorders.

The Office of the United Nations High Commissioner for Refugees (UNHCR) reports that at the end of 2022 over 108.4 million people were forcibly displaced worldwide because of the impact of violence, persecution and international conflicts. The vast majority – 62.5 million – were internally displaced people, and 5.4 million were asylum seekers (UNHCR 2023). Asylum seekers are individuals who wish to obtain international protection, usually from conflict or persecution. It should be noted that not all protection claims fall within the remit of the 1951 Refugee Convention and that psychiatric reports may also be relevant to human rights and other claims. Immigration and asylum cases attract high levels of public, political and media attention.

Asylum seekers in the UK often arrive clandestinely, initially as undocumented migrants through illegal and unsafe routes, such as travelling in the back of a lorry or crossing the Channel by dinghy, frequently with the assistance of paid smugglers. They typically report harrowing accounts of trauma, trafficking and torture in their home country. Numerous studies highlight that asylum seekers suffer a range of mental health conditions, such as depression, anxiety and post-traumatic stress disorder (PTSD) (McColl 2008; Duffy 2015; Blackmore 2020). These conditions are often worsened by facing removal to the country in which their reported trauma occurred or where they fear further harm or death. Clearly, there are also numerous economic migrants or those that simply wish to live in the UK for a better a life, and these issues can be complex. The key issue that the court will need to determine is whether there is entitlement to protection.

In the UK, the immigration and appeals process allows judicial review of decisions by the Home Office, such as refusal to grant asylum or revoke deportation orders. Psychiatric evidence is an important consideration for the Home Office and also for the First-tier Tribunal (Immigration and Asylum Chamber), or its Upper Tribunal or the respective appeal court as part of its decision-making on asylum seekers and those facing deportation. This article critically reviews the legal background and medico-legal standards required to provide psychiatric evidence in such cases.

In legal terminology, removal refers to a failed asylum seeker being removed to another country, such as their home country or a safe country other than the UK, whereas deportation is the return of a convicted criminal to their home country.

The asylum process

Asylum seekers who claim international protection on arrival in the UK usually do so by telling an immigration official at the port they enter that they wish to claim asylum. This will usually lead to an initial asylum screening interview with the Home Office the same day. Alternatively, asylum seekers can

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claim asylum at a later point, sometimes several years later, and they do this by calling the Asylum Screening Unit in Croydon or through their legal representative (if they appoint one). After a period of time, sometimes many years, the 'substantive interview' for asylum will be conducted. At that interview, the individual's claim for asylum may will be supported by further evidence that they present themselves or that may be provided by their legal representative, such as evidence of persecution in their home country, character references and a psychiatric report. The Home Office will in due course make a decision on their asylum claim. If they are granted asylum, this is usually in the form of leave to remain as a refugee for a period of 5 years with a right to study, work and access public funds. After 5 years of living in the UK, they are able to apply for indefinite leave to remain in the UK, and then after 12 months of holding this, they can then apply for naturalisation as a British citizen.

Psychiatric reports are sometimes requested prior to the Home Office making a decision on whether to grant asylum. In cases where the Home Office refuses to grant asylum, there is usually a right of appeal to the First-tier Tribunal (Immigration and Asylum Chamber). A further psychiatric report may be requested at this stage or a first report if an initial report had not previously been requested. Psychiatric reports are also often requested if the individual's mental health deteriorates at any stage during the above process, for example if placed in pre-removal detention awaiting removal or deportation. The complicating factor in the process is the newly passed Illegal Migration Act 2023, which makes asylum claims by those who have entered the UK through unsafe routes such as by small boat across the Channel inadmissible, with the prospect that such asylum seekers could be removed to another safe country, such as Rwanda. For updates on how this act may change the asylum process please see resources provided by Right to Remain at https://righttoremain.org.uk/toolkit/claimasylum.

Psychiatric assessment

A number of articles and book chapters are available that provide guidance on the assessment of asylum seekers, refugees, undocumented migrants and those who have experienced torture (e.g. Duffy 2015; Katona 2020; Waterman 2020). The starting point for a thorough psychiatric assessment is a detailed psychiatric interview, ideally in person. However, most assessments in immigration and asylum cases are now conducted remotely by a video call, especially as research has identified that use of video calls for psychiatric assessments provides similar clinical information to that obtained by in-person interviews (Lexcen 2006). There are also advantages to remote assessments, such as the individual being in a place they consider comfortable, safe and familiar. If a remote assessment is performed its limitations should be noted in the report, for example that it might not have been possible to seamlessly respond to changes in the individual's responses, including their body language and behaviour, which might have affected rapport building and disclosure during the assessment. The length of the assessment and whether an interpreter was used should also be stated. Experts should be cautious about allowing a family member or friend of the individual to interpret, as this allows criticism that the history obtained is unreliable.

A careful approach should be taken when obtaining an account of the claimed history of trauma, and sensitivity is required to help avoid harm caused by re-traumatisation.

A detailed mental state examination should also be completed. It is fairly standard in immigration cases to complete a battery of rating scales, such as the Patient Health Questionnaire (PHQ-9) to help evaluate depression, the Generalised Anxiety Disorder scale (GAD-7) for anxiety and the Impact of Events Scale – Revised (IES-R) to help evaluate trauma-related symptoms and PTSD. These scales provide guidance when considering the severity of a condition and are especially helpful in monitoring changes in the severity of a condition over time. It should also be noted that some scales, such as the Montgomery–Åsberg Rating Scale for Depression (MADRS) and the Brief Psychiatric Rating Scale (BPRS), are clinician rated rather than self-completed. It should be made clear in the report that self-reported scales are subjective tools, they are not diagnostic and can be easily manipulated by the individual, should they wish to obtain a higher score to try to show they are more unwell than they actually are, and can only provide an indication of whether someone might be suffering from a mental health problem.

In writing their report, the expert should not stray into commenting on the credibility of the individual's account, as this is a matter for the Home Office and tribunal or court to determine. The expert should instead highlight whether any trauma-related symptoms or PTSD, if diagnosed, appear clinically plausible and consistent with the individual's autobiographical account and whether there are any aspects of their mental state that call into question the reliability or genuineness of their mental health presentation.

An important issue to consider is whether the individual's account in the psychiatric assessment is consistent with their initial Home Office screening interview (which is usually taken within days of their arrival in the UK) and the later substantive interview for their asylum application. A significant

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discrepancy, such as not reporting their history of trauma at the time of their initial screening interview, would need to be explained, for example by the fact that they had just arrived in the UK and did not feel comfortable disclosing their history of trauma at that stage, especially if they were already suffering from PTSD and were avoidant of disclosing this. The individual should be asked carefully why they did not mention their history of trauma when first interviewed and the reasons for this explored. It should also be noted in the report that trauma can adversely affect the memory of traumatic events and disclosure of such experiences (Herlihy 2002). Asylum seekers also often have an incomplete understanding of the system in which the medico-legal report is being prepared and fear the perceived stigma of being diagnosed with mental health problems. The Centre for the Study of Emotion and Law (CSEL) highlights the importance of developing a greater understanding of emotions within law and practice, including when interviewing vulnerable individuals (csel.psychologyresearch.co.uk).

Fitness to provide instructions

Legal representatives often ask for a psychiatrist to confirm that their client is fit to provide instructions in relation to the immigration and appeals process and to provide a witness statement. The general legal principles to be applied in England and Wales when determining whether a person has capacity to conduct legal proceedings are set out in the Mental Capacity Act 2005 and in the Mental Capacity Act Code of Practice 2015, as applied by a series of reported cases, including *LBL v RYJ* [2010], C*C v KK and STCC* [2012] and A *Local Authority v P* [2018].

The assessment of capacity being a two-stage process, initially a diagnostic test considers whether the person has an impairment of their mind or brain – a mental disorder – and then a functional test assesses whether the impairment means they are unable to make a specific decision.

The question of 'fitness' relates to broad issues and includes the potential adverse consequences of evidence-giving as well as the narrow one of capacity within the meaning of the Mental Capacity Act.

In relation to court proceedings, it is sufficient that the individual is able to comprehend and weigh the salient details relevant to decisions in the proceedings. This includes their ability to provide reasons for why they may wish to remain in the UK and wish to avoid being returned to their home country. The focus is on whether they can follow the legal proceedings in general rather than the technical detail of the proceedings.

In relation to providing a witness statement, this should nearly always be possible. Where there are concerns, for example an individual has chaotic thoughts due to psychosis such that it is not possible to obtain a succinct history, the expert witness can advise the legal representative to ask one closed question at a time and record the response for each question or simply submit to the tribunal a record of the interview questions and each response.

Where an individual lacks capacity to provide instructions in relation to the immigration and appeals process, the legal representative would need to identify a litigation friend to provide instructions in the best interests of the individual.

Vulnerable witnesses

A Presidential Guidance Note published by the Tribunals Judiciary (2010) outlines the circumstances in which an appellant could be considered to be a vulnerable witness, for example because of innate characteristics such as age rather than a specific diagnosis or mental disorder. The note also highlights factors such as intellectual disability (called learning disability or learning difficulties in the guidance) or other impairments that can affect giving evidence. Further guidance is contained in a Practice Direction (Tribunals Judiciary 2008).

Providing evidence in a Home Office interview or before an immigration judge at a tribunal hearing on their claimed history of trauma, trafficking or torture within an adversarial setting can be a harrowing and traumatic experience for an asylum seeker. Arguably, it is an ordeal that involves painfully re-living their trauma, often in the knowledge that the Home Office does not accept their account. In relation to a tribunal hearing, an expert called in to make a psychiatrist assessment should consider whether the appellant meets the criteria for vulnerability and whether providing oral evidence, especially in a judicial setting, would adversely effect the quality of their evidence, damage their mental health in the short or long term, or unacceptably increase their risk of self-harm or suicide.

Clearly, a vulnerable and traumatised appellant might provide unduly short answers, omit important information, provide information in the wrong chronological order or simply agree with the person asking questions, as they are distressed and feel intimidated. In a small number of cases where these issues cannot be overcome by special measures and adaptations to the tribunal process, the expert should consider making a recommendation to the tribunal that the appellant is not required to give oral evidence and instead the expert's report should be relied on or other measures could be used, such as providing written answers to specific questions. However, the immigration tribunal regularly deals with vulnerable witnesses and is

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experienced in making adaptations to the process of how witnesses give evidence. Therefore, it would be prudent for the expert to provide recommendations regarding adaptations and special measures to enable the appellant to provide oral evidence. Suggested measures are outlined in Box 1.

Immigration detention

Asylum seekers face being detained under immigration powers at numerous points during their journey to obtain refugee status, including on arrival, if required to report at a Home Office reporting centre, directly from the community, at the end of a prison sentence if facing deportation and as part of pre-removal detention if their removal is due to occur within a reasonably short period of time.

Immigration detention usually takes place in an immigration removal centre, but could also occur within prison, for example at the end of a prison sentence. Psychiatrists need to be aware of the implications of detention for asylum seekers. The adverse impact of detention on the mental health of detainees is strongly supported by research into the effects of detention in the UK. These studies consistently report high levels of mental health problems among detainees, including anxiety, depression and PTSD, as well as self-harm and suicidal ideation. It has also been reported that time in detention was positively associated with the severity of the distress experienced (Robjant 2009; Shaw 2016). A systematic review in 2018 into the impact of immigration detention on the mental health of detainees identified 26 studies reporting on a total of 2099 individuals (von Werthern 2018). These studies showed more clearly than was evident in Robjant et al's review in 2009 that detention duration was positively associated with severity of mental symptoms. Greater trauma exposure prior to detention was also associated with symptom severity. Recommendations based on these findings are presented in the review and include 'increased focus on the identification of vulnerability and on minimising the duration of detention' (von Werthern 2018).

Where relevant, psychiatric evidence should highlight the large body of research on the adverse impact of detention on the mental health of detainees and advise the Home Office or tribunal where it is foreseeable that the individual would suffer from psychiatric harm in detention.

Psychiatric reports are often required for the assessment of suitability for detention and they must be relevant to the specific problems and needs of the individual being assessed. They are also often required to assess the impact of alleged unlawful detention. The evidence must be balanced, and highlight that there are interventions during detention that can help control its adverse effects as well as mitigate the risk of self-harm and suicide. These include the availability of primary and secondary care mental health services, the provision of psychological therapies (although these are often limited or not available) and use of an 'assessment care in detention and teamwork' (ACDT) plan or psychiatric/therapeutic observation to manage the risk of self-harm and suicide.

Immigration removal centres employ medical practitioners and visiting psychiatrists. Rule 35 of the Detention Centre Rules 2001 (SI 2001/238), as amended by the Detention Centre (Amendment) Rules 2018 (SI 2018/411), outlines a framework for doctors working in immigration detention centres. This includes completion of a Rule 35(1) report if the doctor concludes that a detainee's health 'is likely to be injuriously affected by continued detention', a Rule 35(2) report if they are concerned that a detainee may have suicidal intentions or a Rule 35(3) report if they are concerned that a detainee may have been the victim of torture.

At the time of assessing an individual in detention, if it is identified that they have already suffered psychiatric harm as a result of detention or it is likely that further harm would occur, the Adults at Risk in Immigration Detention policy requires the expert to inform the healthcare team of their concerns (Home Office 2024). This should be done in person at the time of the assessment by discussion with the onsite healthcare team. Interestingly, the policy advises that greater weight should be placed on in-person assessments of detainees (Home Office 2024: p 17). If the assessment took place remotely, the expert should therefore explain in their report why this was necessary, outline the limitations of the

BOX 1 Special measures a psychiatrist might suggest to enable an asylum seeker to provide oral evidence before a court or tribunal

- The option to visit the court room beforehand and familiarise themselves with the environment
- If an interpreter is required, provision of adequate time to build up rapport with them
- Additional breaks if required
- A closed hearing and as few people in the court room as possible, to minimise anxiety levels
- The option of someone of their choice being present to support them
- Pre-agreed restriction of how long the questioning will last and which topics will be discussed
- The requirement that those asking questions take a non-confrontational and sensitive approach
- The use of short questions in plain English, one question at a time and giving time to allow an answer to each question
- Avoidance, if possible, of questions related to their history of trauma, to reduce the risk of re-traumatising the individual
- The use of follow-up questions if required to ensure the best evidence possible has been provided.

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remote assessment and offer to conduct an in-person assessment when possible.

Where the Adults at Risk in Immigration Detention policy is invoked, and harm to mental health in detention is identified, the Home Office will then weigh up the risks associated with further detention against what it describes as adverse 'immigration factors', such as previous absconding or delay in seeking asylum, and make a decision whether to authorise release on immigration bail or maintain detention.

Fitness to fly

If an asylum claim is refused, the individual will face forced removal or deportation from the UK. Therefore their fitness to fly may be relevant to their case. Psychiatrists do not generally have knowledge or expertise in aviation, and therefore a careful approach is required to consider the issue of whether a individual may be considered fit to fly. The International Air Transport Association (2020) outlines relevant information for health professionals on assessing fitness to fly, the main points being detailed in Box 2. It is appropriate for a psychiatrist to opine whether any mental disorders identified may lead to a risk of unpredictable, aggressive, disorganised or disruptive behaviours that would indicate that the individual is not medically fit to fly and recommend that these factors be taken into account by the captain of the plane when determining the safe conduct of the flight. The psychiatrist should restrict their comments in relation to fitness to fly to conclusions about which they can legitimately claim knowledge and expertise. They should highlight that experienced escorts, flight controllers and healthcare professionals on the flight might mitigate risks to a certain extent, and that the risks may logistically be easier to manage and control on a charter flight, rather than a scheduled commercial flight, where members of the public may also be on board. The expert should also highlight whether restraint as part of the removal process, for example mechanical head or body restraints during the flight, would affect the individual's mental health, especially if the process of restraint would be re-traumatising and remind them of their history of trauma.

BOX 2 UK Civil Aviation Authority information regarding assessing the fitness to fly of people with psychiatric conditions

'The key consideration in this area is identical to other medical conditions, i.e. will the condition interfere with the safe conduct of the flight or will the flight environment exacerbate the condition?

With the modern management of many psychiatric conditions, air travel should not be a problem for the majority of individuals. It is however essential that the condition is stable and if medication is required it is taken regularly.

The main areas for concern are people whose behaviour may be unpredictable, aggressive, dis-organised or disruptive. In these circumstances, air travel would be contra-indicated. Patients with well-managed psychotic conditions may require an escort to ensure regular medication and to assist in case of problems. The escort may be a reliable companion or in more difficult cases, a qualified health professional. Taking a careful history eliciting, especially, details of previous disturbed or disorientated behaviour is particularly important.'

(UK Civil Aviation Authority 2024)

Impact of removal on mental health

The expert should consider whether the individual may suffer a deterioration in their mental health on forced removal or deportation and whether their risk of self-harm and suicide would increase on return to their home country. Central to this issue is whether the individual has a strong subjective fear of being returned. This fear may be due to perceived political persecution on return or fear of physical harm or being killed by a certain individual or group. Although their fear may be subjective and not objectively well-founded, which is clearly a matter for the tribunal to determine, the expert may wish to highlight that the person's subjective fear, if genuine and strongly held, would still be a reason to trigger a substantial deterioration in mental health on return. Separation from family, friends and networks of support in the UK when returned may also further worsen their mental health.

Measures that would mitigate risks of deterioration in mental health on return should also be highlighted, such as access to support or psychiatric treatment. Where relevant, it should be highlighted that the predicted deterioration in mental health on return may mean that the individual is not able to engage in and benefit from treatment, even if it were available. Research has identified that depressive symptoms are associated with impaired everyday problem-solving ability, directly and indirectly mediated via impairments in learning, memory, reasoning and speed of processing (Yen 2011; Lam 2014). In addition, if the individual suffers from anxiety or PTSD, this may make them anxious and fearful of other people, such that they are unlikely to be able to feel safe and secure enough to trust others, including therapists, in order to engage in treatment.

The expert should confine their opinion solely to how the individual's mental health conditions might affect their ability or otherwise to reintegrate on return, such as depression making it harder for them to concentrate or problem solve effectively and therefore impairing their ability to obtain or maintain employment. The expert should note that anxiety and PTSD, should they be present, can impair the individual's ability to form relationships of trust with family, members of the community, potential employers or health professionals on return, making it harder for them to trust and seek protection from the authorities in their home country. In cases where substance misuse is a relevant

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issue, the person's prognosis if returned to a country where drugs and alcohol are not available should be considered. Curiously, if the individual is currently abstinent, then the effect of being returned to such a country would mean that a relapse into substance misuse on return would be unlikely. However, if they are still using drugs or alcohol, the effect on their physical or mental health of sudden enforced abstinence should be considered. The medico-legal report should also highlight, where relevant, the individual's vulnerability to criminalisation if drugs and alcohol cannot be obtained legally and access to other means of alleviating distress are lacking.

Pitfalls

Psychiatrists may fall foul of a range of pitfalls that could potentially arise when preparing psychiatric reports in immigration and asylum cases. A thorough understanding of the required standards, expectations and case law is required to help avoid such failures. Psychiatry trainees should ideally gain experience in preparing such reports with the supervision of a consultant psychiatrist experienced in writing them.

A primary error is accepting at face value the account provided by the individual. The Court of Appeal in *MN and IXU v The Secretary of State for the Home Department* [2020] highlights that less weight will be given to a report that accepts the appellant's account without considering other possible causes of their symptoms. Therefore, the expert should consider possibilities such as whether the individual's unstable immigration status and fear of being returned would in itself explain their poor mental health.

Psychiatrists should not provide evidence outside their area of expertise. In *Rehman v The Secretary of State for the Home Department* [2023] it was clearly identified that psychiatrists should not provide country evidence, unless they declare themselves as a country expert. However, it is reasonable for a psychiatrist to comment on country information made available to them, for example in Home Office country policy and information notes (CPIN; www.gov.uk/government/collections/country-policy-and-information-notes) or in the reports of country experts that have been submitted as part of the evidence bundle.

The *Rehman* case also concluded that a single telephone assessment was not adequate to assist the tribunal and reiterated the conclusion that screening tools such as the PHQ-9 and GAD-7 can only provide an indication of whether someone might be suffering from a mental health problem. This judgment builds on the most significant case in relation to the standards required in immigration and asylum cases, that of *HA (Expert Evidence; Mental Health) Sri Lanka* [2022], which is outlined in Box 3. The learning points in this case are the

BOX 3 Outline of the case of *HA* before the Upper Tribunal (Immigration and Asylum Chamber)

The appellant, HA, is a citizen of Sri Lanka who entered the UK in January 2010 as a 21-year-old student. He was living with friends and had a cousin/sister in South East England. His father had died when he was 1 year old and he reported having visions of his father coming to his room and inviting him to 'the other side'. He also reported suicidal feelings.

Dr A, as part of detailed assessment of the appellant, administered the PHQ-9 and GAD-7 by post and on considering all of the available evidence concluded that the appellant suffered from serious psychiatric disorder, including major depression, visual hallucinations and suicidal ideations, and that his risk of suicide was very high as he was extremely hopeless about the future.

Dr B formed the opinion that the individual was suffering from a moderately severe depressive disorder, that his mood varied over time and that his risk of suicide was not high or imminent. Dr B noted that, other than in November 2020, the appellant's GP had not referred him on to specialist support, which would have been expected to happen if the GP or social prescriber considered the suicide risk to be high. Dr B noted that, when seen by a specialist mental health service in 2020, the appellant was not found to be at substantial risk of suicide and his mental healthcare could be effectively managed within primary care.

In relation to psychiatric evidence, the Hon. Mr Justice Lane, President of the Upper Tribunal Immigration and Asylum Chamber, records:

> 'Notwithstanding their limitations, the GP records concerning the individual detail a specific record of presentation and may paint a broader picture of his or her mental health than is available to the expert psychiatrist, particularly where the individual and the GP (and any associated health care professionals) have interacted over a significant period of time, during some of which the individual may not have perceived themselves as being at risk of removal.
>
> Accordingly, as a general matter, GP records are likely to be regarded by the Tribunal as directly relevant to the assessment of the individual's mental health and should be engaged with by the expert in their report. Where the expert's opinion differs from (or might appear, to a layperson, to differ from) the GP records, the expert will be expected to say so in the report, as part of their obligations as an expert witness. The Tribunal is unlikely to be satisfied by a report which merely attempts to brush aside the GP records.'

The Upper Tribunal concluded that the appellant was at moderate, not very high, risk of suicide. His mother in Sri Lanka would be able and willing to assist him on return. His cousin/sister in the UK would be able to assist him financially, as the cost of living was significantly less in Sri Lanka than in South East England. He was capable of making friends. The tribunal accepted the expert opinion of Dr B that once the appellant had come to terms with his return, his mental health was likely to improve and he would be able to obtain employment, which would also improve his mental health, and that the initial period of return would be daunting but not such as to cause a real risk of suicide. It was concluded he could return to Sri Lanka and there were no significant obstacles to return in his case.

(*HA (Expert Evidence; Mental Health) Sri Lanka* [2022])

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need to engage with health records and to provide reasons for any deviation from the opinions in those records and especially those of the treating general practitioner (GP). This means that the prison, detention centre, GP and hospital records must be meticulously analysed and any opinions put forward by health professionals such as the treating GP, visiting psychiatrist to the prison or detention centre, community psychiatrist, psychologist or nursing staff that the individual is stable or does not appear to have a particular mental heath problem cannot be brushed aside. Instead, they should be highlighted in the report and engaged with appropriately, with a cogent explanation provided as to any deviation from their views.

A recent example of an expert witness being criticised can be found in *CE (Cameroon)* [2023]. The expert was criticised for making a diagnosis of PTSD without expressly or implicitly engaging with relevant health records, for uncritically accepting information provided by the appellant, and for a lack of objectivity in relation to the risk assessment conducted. Medico-legal report writers should be aware of the above pitfalls and the need to consider the guidance within *HA* to avoid such criticism when writing reports. Medico-legal reports in immigration and asylum cases should be objective and should clearly explain the expert's reasoning, so that non-experts can use the information to assist the decision-making process. Medico-legal reports should be seen as a teaching process to help those reading them understand the complex issues involved.

Where PTSD is at issue and the GP records do not contain an established diagnosis of the disorder, the reasons for this should be explained, for example the constraints GPs face during short consultations may mean they have insufficient time to consider the diagnosis of PTSD, or their focus is more on appropriate treatment of the individual rather than diagnostic labelling. In addition, the individual may have been reluctant to disclose their history of trauma or their symptoms of PTSD.

Conclusions

Psychiatric evidence is an important part of the immigration and asylum process in the UK. Psychiatrists providing expert evidence in this field need to be aware of the public, political and media attention such cases attract and the standards and practices required when preparing psychiatric reports. The immigration and asylum process needs more psychiatric report writers to inform fair decisions where such reports are relevant. Psychiatrists wishing to gain expertise in this area would benefit from training offered by specialist organisations such as Medical Justice, Freedom from Torture and the Helen Bamber Foundation.

Asylum seekers often report a claimed history of trauma, trafficking or torture. The credibility of their account remains a matter for the Home Office and immigration and asylum tribunal to determine. Objective and reasoned psychiatric evidence can assist the Home Office, tribunal and courts in this determination, and also on a number of other issues, including diagnosis of mental disorder, fitness to provide instructions, and the potential impact of detention and removal or deportation on mental health and risk of self-harm and suicide. When preparing psychiatric reports in such cases, the standards and expectations of the First-tier Tribunal (Immigration and Asylum Chamber) and its Upper Tribunal should be followed to enable the tribunal to make decisions in often complex and contested cases. The individual's health records must be consulted and any reasons for any apparently missed diagnoses, such as PTSD, should be given.

MCQ answers
1 c 2 a 3 b 4 b 5 b

Data availability

Data availability is not applicable to this article as no new data were created or analysed in this study.

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Declaration of interest

N.G. was criticised in *CE (Cameroon)* [2023]. This relates to a report written in 2020 and subsequent addendum reports that failed to expressly or implicitly engage with medical opinion provided by the prison healthcare team and GP records and uncritically accepted information provided by the appellant. The risk assessment conducted was also criticised.

Transparency declaration

I am the lead author and manuscript guarantor and affirm that the manuscript is an honest, accurate and transparent account of the issues reported; no actual study has been conducted.

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MCQs

Select the single best option for each question stem

1 Which of the following statements regarding immigration detention is true?

a immigration detention is always lawful
b when considering the effects of immigration detention, pre-existing mental health problems can be ignored
c a large body of research highlights that immigration detention is associated with an adverse impact on the mental health of detainees
d immigration detention can only be conducted within an immigration removal centre
e a maximum time limit of 6 months applies to immigration detention.

2 Which of the following statements about asylum seekers giving evidence before the First-tier Tribunal (Immigration and Asylum Chamber) is false?

a asylum seekers are always required to give evidence at their immigration and asylum tribunal hearing
b giving evidence at the tribunal hearing may be distressing
c being asked questions about their claimed history of trauma could be re-traumatising
d if found to be vulnerable, the tribunal can agree that they can have someone of their choice present to support them
e if found to be vulnerable, the tribunal can agree that extra breaks be provided if required.

3 Which of the following statements about impact of removal to the home country for asylum seekers is false?

a asylum seekers can choose to return to their home country
b removal flights are always charter flights
c being removed can potentially occur at any time of day or night
d healthcare professionals can be provided on the removal flight
e it is up to the captain of the plane to determine the safe conduct of the flight.

4 Which of the following statements about preparing an expert psychiatric assessment in an immigration case is true?

a the person's GP records can not be considered relevant
b any information in the GP records that undermines the expert's opinion should be highlighted in the report and explained
c it is not necessary to read all of the GP records
d if the GP records are not available a psychiatric report cannot be written
e psychiatrists with no country expertise can provide opinions on whether the home country is safe.

5 Which of the following has been found to be true?

a screening tools such as the PHQ-9 and GAD-7 are accepted diagnostic tests in immigration and asylum cases
b the PHQ-9 and GAD-7 can only be used to provide an indication of whether someone might have a mental health problem
c it is impossible for a person to manipulate their results on the PHQ-9 and GAD-7
d screening tools are essential when conducting a psychiatric assessment
e psychiatrists must always diagnose severe depression when the PHQ-9 score is above 20 out of 27.

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