The footnotes are laid out according to the section of the report in which they are likely to be first relevant. Footnotes relevant to young people are listed first. To find specific footnotes (e.g immigration detention, sexual orientation) – use control-F.

Key to footnote colours.

Orange = specifically for young people
Grey = already included in template for MLRs
Blue = everything else - and less likely to be needed for pre-decision reports

Summary page for MLRs

Clinical report. This report has been prepared from information obtained and clinical observations made during one appointment (usually 2 to 2.5 hours). Medico-legal standards have been applied (see declarations). The clinical history and examination are targeted depending on the account of abuse given and the clinician's knowledge of how this might translate into symptoms and signs. This is usual practice in medicine and allied professions when time constraints dictate that the clinician attempts to ascertain a diagnosis or formulation in an efficient manner. The assessment therefore seeks to establish key findings and does not purport to cover entire clinical histories, examination of all areas of the body, documentation of every scar or mark on a body, or all the possible psychological symptoms and signs an individual might have.

Report context

Name: As the client is young, I will refer to them by their first name.

GP records may be challenging to read without missing information, especially for those unfamiliar with using them. Print-outs may take from several minutes to several hours to read. They may contain large amounts of information such as blood test results, templated entries and appointment reminders. They often use abbreviations. Often the context of entries is not apparent. Occasionally important information is recorded in free text and may be easy to miss amongst all the formulaic material. Occasionally correspondence that contains key information is not included in the print-out supplied.

When the GP record is not available. TID requests that referrers provide copies of GP records. Occasionally there are instances when the GP records are not available despite the best efforts of the referrer. In such situations, in order to provide a timely assessment, the clinician may proceed without the record.

(Internal note – it is probably less important to have records for pre-decision cases, but we are asking for them)

Interpretation and consultations in a second language carry a higher risk of misunderstanding and errors. The TortureID assessment format does not include an opportunity for the individual to review the report and therefore they do not have opportunity to identify any errors,

except when these are obvious at the time. Consultations conducted in a language that a person speaks imperfectly or with a strong accent can also increase the risk of misunderstandings.

Declarations

Istanbul Protocol I: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. Professional training series No. 8 / Rev 2, United Nations (2022). Istanbul-Protocol_Rev2_EN.pdf (ohchr.org)

Annex IV: The following guidelines are based on the Istanbul Protocol. They are not intended to be a fixed prescription but should be applied taking into account the purpose of the evaluation and after an assessment of available resources.

The Istanbul Protocol Manual includes guidelines for clinicians preparing reports (Annex IV) stating that they 'are not intended to be a fixed prescription but should be applied taking into account the purpose of the evaluation and after an assessment of available resources.
'

SA (Somalia) v. Secretary of State for the Home Department [2006] EWCA Civ 1302. Sir Mark Potter, P, paragraph 29: 'In cases where the account of torture is, or is likely to be, the subject of challenge, Chapter Five of the United Nations Document, known as the Istanbul Protocol, submitted to the United Nations High Commissioner for Human Rights on 9 August 1999 (Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment) is particularly instructive. …'

Duty to the Court. General Medical Council guidance: 'Whether you are acting as an expert witness or witness of fact, 'you have a duty to the court and this overrides any obligation to the person who is instructing or paying you. This means you have a duty to act independently and to be honest, trustworthy, objective and impartial. You must not allow your views about a person to affect the evidence or advice you give.' https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/acting-as-a-witness/acting-as-a-witness-in-legal-proceedings

Duty to the Court: British Psychological Society Practice Guidelines state that (p.20) "Psychologists may be asked to act as professional or expert witnesses in court. The main difference between an expert witness and an ordinary witness (i.e. a witness to fact), is that the former are able to give an opinion, whereas ordinary witnesses can give only factual evidence. A professional witnesses' remit can cross the boundary of both fact and opinion" and (p.21) "Expert evidence in civil court proceedings is governed by Part 35 of the Civil Procedure Rules 1998, and its associated practice direction. This rule makes clear that an expert's overriding duty is to help the court on matters within their expertise and that this duty overrides the expert's duty to the person from whom they are receiving instructions". https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/BPS%20Practice%20Guidelines %20%28 Third %20 Edition%29.pdf

Background information

Background information: The background information given in this report is based on the history provided directly by the client. The report does not rely on material from any other source unless specifically stated. It may not provide a complete description of all aspects of the ill treatment experienced by the individual, but it covers some key aspects as told to the clinician during our single, time limited consultation. The individual is not offered further appointments to corroborate the details recorded. The absence of an event does not mean it was not described to me and nothing in my summary of the client's account should be taken as a finding of fact in relation to their immigration case.

Early life

Awareness of sexual orientation and gender identity: The Istanbul Protocol (2022) Annex II states 'It is important to remember that in all cultures the development of self-awareness of one's own sexual orientation and gender identity takes place over time, often years or decades and that, in areas in which minority sexual and gender identities are met with violent repression, such self-awareness may have been suppressed.'

Report of human rights abuses

Disclosure of sexual torture or ill-treatment in young people: 'Disclosure of sexual torture or ill-treatment may be so difficult that a person prefers not to talk about it at all or it may be disclosed only long afterwards during therapy. However, without disclosure of such experiences, documentation will be incomplete and an assessment of resulting health-care needs compromised.' Istanbul Protocol (2022) paragraph 274.

TID is not offering follow up appointments to allow the time for gradual disclosure and is not always in a position to offer its clients a choice of gender of clinician and interpreter. This may have an impact on what a person feels comfortable disclosing. In addition, with young people, there may have been a limited sex education, which means they may not comprehend what sexual assault is.

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Physical health

History

Interpreting the GP record. When using GP records as evidence of past heath and healthcare, it is important to take into account their nature and limitations, and the variation between GP practices. A GP record is created for the purposes of recording health and health interventions, and for clinicians and others to communicate with one another. It is not written with a view to being comprehensively relied upon in medico-legal situations. When reviewing a GP record the following points are relevant:

- **Attendance**. Patients with significant health problems will not necessarily be attending their GP practice. Reasons include: barriers to registering with a GP; cultural differences in health service use; not being aware of what can be offered; fearfulness and lack of trust; difficulty getting appointments including through lack of assertiveness and language barriers. Patients' attempts to register or to get an appointment are not generally recorded, so apparent lack of contact with primary care is not necessarily because the patient has not tried to get an appointment. In addition, clinicians differ in the frequency with which they offer follow-up appointments.
- **Workload pressures** are now very intense in general practice, and have a bearing on availability of support.
- **Gaps in GP records**. There are many reasons why there may be gaps in a GP record or an apparent delay in registration, including all of the reasons for non-attendance listed above. A GP record only starts when someone arrives in the UK or later and will only cover healthcare from that point. It is not rare for patients to have more than one NHS number and set of records due to mistakes with the spelling of names and other personal details. If this comes to light the records can be merged, but otherwise it results in a gap in the record.
- **Contributors**. A GP record contains entries made by many different members of the primary care team such as nurses and receptionists. They may also contain records from other services which have been imported into the GP record.
- **Interpreting**. Use of interpreters is irregularly recorded in GP records, so it is often not possible to know whether an interpreter has been used. The quality of interpreting in the NHS cannot be guaranteed. Most is now via telephone interpreting services. Regrettably some consultations have to be conducted without interpreters. As a consequence, information available may be limited, and/or errors may be introduced.
- **Accuracy**. Whilst every effort is taken to ensure accuracy, GP records can be inaccurate and imprecise, especially when interpreters are not used, and there are time pressures. It may not be possible to determine if a patient was present when an entry about them was made. Records may contain unclear abbreviations. There may be typing errors. Misunderstandings and interpreting mistakes are not uncommon. Patients do not get any opportunity to correct factual errors.
- **Disclosure**. A significant proportion of patients do not disclose details of past trauma unless asked directly. Clinicians do not necessarily ask directly about trauma. Even when asked, some patients may still take months to disclose full details. Some will never disclose everything that has happened to them. Some even deny that anything adverse has happened because they are not comfortable, at that point in time, with a disclosure.
- **Mental health care**. The absence of appointments, medications and referrals for mental health need does not mean there is no mental health need. There are cultural differences in readiness to disclose mental heatlh problems. GP practices and individual clinicians vary in their interest, skills and confidence around mental health, in their readiness to enquire about it and to screen for depression and PTSD, in the amount of mental health prescribing they are happy with, and in their readiness to make referrals. Not many GPs have training in trauma and asylum related issues. In many areas it is also very difficult to get access to counselling and therapy for people seeking asylum because of a lack of resources in mental health services. Patients are often treated by default with medications for sleep and depression/anxiety. Non-adherence to medication prescribed, in the absence of other support, does not indicate that a person is free of mental health difficulties; if people are prescribed medications without adequate engagement and follow up, it is common for them to discontinue the medication and stop seeking help.
- **Continuity of care**. A clinician who has seen a patient a number of times is more likely to ask questions about trauma and mental health.
- **Examinations of injuries and scars relating to ill-treatment**. If there have been any examinations made in general practice these are not likely to be comprehensive. Many GPs will be unaware of the significance of physical injuries in asylum claims

Examination

Refusal of examination Individuals may refuse or limit examination for many reasons which it may not be able to establish in a one-off appointment.

Body chart: Cross hatched areas on the body chart indicate areas which have not been examined.

Photographs: Where a lesion photographs clearly, a photograph may be taken. Photographs will often only be useful when viewed electronically as paper print outs may lack resolution or colour.

Healed and non-specific scarring. 'Torture victims may have injuries that are not substantially different from other forms of trauma. Although acute lesions may be characteristic of the injuries described, most lesions heal within weeks of torture, leaving no scars or, at the most, non-specific scars. This is often the case when torturers use techniques that prevent or limit detectable signs of injury. Blunt trauma is one of the most common modes of injury in torture and tends to cause mainly bruising and abrasions, which may heal without lasting physical evidence. Under such circumstances, the physical examination may be within normal limits, but this in no way negates allegations of torture. A detailed account of the person's observations of acute lesions and the subsequent healing process often represents an important source of evidence in corroborating specific allegations of torture or ill-treatment.' The Istanbul Protocol (2022) paragraph 399.

Nature of TID physical examination: The TID physical examination is a screening and not an extensive or complete examination. The examining doctor will make a decision about the extent of physical examination needed based on reported injury, relevance, additional value in limited examination time, age and maturity, personal choice, intimate areas and privacy/appropriateness of the examining venue. If the individual is offered a more comprehensive examination of their whole body in the future, it is possible that there could be other physical findings

Psychological health

Psychological Assessment: A psychological assessment is based on symptoms (self-reported and third-party reports, such as GP records) and objective psychological observations of a person in a clinical interview. Observations include their moment-to-moment interactions, narrative style, emotional reactions at interview and impact on the clinician. These can provide insight into their psychology, including their patterns of relating to others, their conscious and unconscious view of themselves and others, and patterns of managing emotion. The traditional psychiatric 'Mental State Examination' covers the following aspects: appearance and behaviour, speech, affect, thoughts, perception, cognition, insight, impact on clinician. TID report writers often consider all of these but write only about those aspects where they have made relevant findings.

History

Children and young people manifest distress differently to adults: 'The clinician …….may need to rely on a child's behaviour and reports from others rather than predominantly on narratives provided by the child. A range of psychological diagnostic techniques may be required as children, especially teenagers, may present themselves as having no difficulties in their lives until more specific questions are asked.' The Istanbul Protocol (2022) Annex II, page 177.

CRIES-8: This is a screening tool which can give an indication of the likelihood of a fully diagnosable condition of PTSD. It has been validated for use in translated versions of a few different languages, although not necessarily in comparable populations. If there is a translation available, this is stated. If not, the questions are interpreted by the attending interpreter. Used in this context it need to be interpreted cautiously. Child Revised Impact of Events Scale (CRIES) (corc.uk.net)

Mood and feelings questionnaire: This is a screening tool which can give an indication of the likelihood of a fully diagnosable condition of depression. It has been validated for use in translated versions of a few different languages, although not necessarily in comparable populations. Where there is a translation available, this is stated. If not, the questions are interpreted by the attending interpreter. Used in this context, it needs to be interpreted cautiously. https://devepi.duhs.duke.edu/measures/the-mood-and-feelings-questionnaire-mfq/

The term '**flashback**' describes involuntary re-experiencing a past event as if it were happening in the present, while awake and conscious.

Psychotic is a term used to refer to phenomena such as an altered sense of reality, unusual beliefs, and unusual perceptual experiences, and to conditions in which these occur.

Observations

Psychodynamic practitioners are trained to minutely observe how clients interact during appointments, and to use these observations to develop understanding about the person's conscious and unconscious psychological patterns.

Diagnosis

Developmental delay: Asylum seeking young people are at particular risk of developmental delay. They are likely to have had experiences which can impair development. These might include attachment disruption and trauma as well as limited schooling and play opportunities in their home country and during the journey to the UK. Their ability to benefit from school in the UK may be reduced due to issues such as language, culture and discrimination. They may be experiencing mental health problems such as PTSD, depression and anxiety, which can be associated with additional effects on learning and development. (This can happen through impairments in concentration and memory, intrusive memories, difficulty understanding instructions and impaired play etc). They may have a history of poor nutrition, which may independently affect development. Because of these different factors, cognitive abilities may change over time, and may get either better or worse. Identifying intellectual disability, particularly lesser degrees of disability, is likely to be particularly difficult as documentary and third party evidence are likely to be unavailable. [Schutzenhofer,E. (2018) Evaluating the Effects of Refugee Experiences on Cognitive and Social-Emotional Development in Refugee Children in the Primary Care Setting. Accessed on line 4.1.20 at: https://med.virginia.edu/family-medicine/wp-content/uploads/sites/285/2018/08/Schutzenhofer_IFMCProjectFinal080818.pdf
Kaplan, I., Stolk, Y., Valibhoy, M., Tucker, A., Baker, J. (2016) Cognitive assessment of refugee children: Effects of trauma and new language acquisition. *Transcult Psychiatry*. 53(1): 81–109.]

ICD-11 PTSD: Post-traumatic stress disorder (PTSD) is a disorder that may develop following exposure to an extremely threatening or horrific event or series of events. It is characterized by all of the following: 1) re-experiencing the traumatic event or events in the present in the form of vivid intrusive memories, flashbacks, or nightmares. These are typically accompanied by strong or overwhelming emotions, particularly fear or horror, and strong physical sensations; 2) avoidance of thoughts and memories of the event or events, or avoidance of activities, situations, or people reminiscent of the event or events; and 3) persistent perceptions of heightened current threat, for example as indicated by hypervigilance or an enhanced startle reaction to stimuli such as unexpected noises. The symptoms persist for at least several weeks and cause significant impairment in personal, family, social, educational, occupational or other important areas of functioning.
https://icd.who.int/browse11/l-m/en#/http%3a%2f%2fid.who.int%2ficd%2fentity%2f2070699808

ICD-11 complex PTSD: In complex PTSD, diagnostic requirements for PTSD are met. In addition, Complex PTSD is characterized by severe and persistent 1) problems in affect regulation; 2) beliefs about oneself as diminished, defeated or worthless, accompanied by feelings of shame, guilt or failure related to the traumatic event; and 3) difficulties in sustaining relationships and in feeling close to others. These symptoms cause significant impairment in personal, family, social, educational, occupational or other important areas of functioning.
https://icd.who.int/browse11/l-m/en#/http%3a%2f%2fid.who.int%2ficd%2fentity%2f585833559
The diagnostic requirements for PTSD: PTSD is a disorder that may develop following exposure to an extremely threatening or horrific event or series of events. It is characterized by all of the following: 1) re-experiencing the traumatic event or events in the present in the form of vivid intrusive memories, flashbacks, or nightmares. These are typically accompanied by strong or overwhelming emotions, particularly fear or horror, and strong physical sensations; 2) avoidance of thoughts and memories of the event or events, or avoidance of activities, situations, or people reminiscent of the event or events; and 3) persistent perceptions of heightened current threat, for example as indicated by hypervigilance or an enhanced startle reaction to stimuli such as unexpected noises. The symptoms persist for at least several weeks and cause significant impairment in personal, family, social, educational, occupational or other important areas of functioning.
https://icd.who.int/browse11/l-m/en#/http%3a%2f%2fid.who.int%2ficd%2fentity%2f2070699808

Culture and the expression of psychological distress. 'While some symptoms may be present across different cultures, it is important to consider culture-specific ways of experiencing, expressing and describing psychological distress in order to recognize and document the broad range of suffering that may remain invisible if the PTSD concept is uncritically applied. Such expressions of distress shaped by culture might be more relevant to the survivor than PTSD symptoms.' The Istanbul Protocol (2022) paragraph 494.

ICD-11 depressive disorders: Depressive disorders are characterized by depressive mood (e.g., sad, irritable, empty) or loss of pleasure accompanied by other cognitive, behavioural or neurovegetative symptoms that significantly affect the individual's ability to function. Single episode depressive disorder is characterized by the presence or history of one depressive episode when there is no history of prior depressive episodes. A depressive episode is characterized by a period of almost daily depressed mood or diminished interest in activities lasting at least two weeks accompanied by other symptoms such as difficulty concentrating, feelings of worthlessness or excessive or inappropriate guilt, hopelessness, recurrent thoughts of death or suicide, changes in appetite or sleep, psychomotor agitation or retardation, and reduced energy or fatigue. Recurrent depressive disorder is characterized by a history or at least two depressive episodes separated by at least several months without significant mood disturbance. https://icd.who.int/browse11/l-m/en#/http%3a%2f%2fid.who.int%2ficd%2fentity%2f1563440232

Sub-threshold psychological symptoms and variability in intensity of symptoms:
Sub-threshold symptoms (this means symptoms are present but not enough to 'diagnose' a particular condition) can have as much impact on functioning as a diagnosable psychiatric condition.
'In most cases, the intensity of trauma-related psychological symptoms changes over time depending on personal trauma processing, the effectiveness of available coping strategies, as well as external factors. There might be subthreshold symptoms at the time of assessment or reported for phases since the traumatic event that do not amount to a diagnosable mental disorder. The expression of distress may be nuanced or mediated by culture and social context, for example according to the experience of shame, fear of reprisals and fear of further stigma or ostracization within the family or community. It is important to recognize that the absence of a formal diagnosis not exclude the presence of severe mental suffering and disability and is not inconsistent with torture or ill-treatment having taken place. The psychological assessment should aim to reach an understanding of the multiple short- and long-term psychological, psychosomatic and psychosocial reactions beyond and not limited to a possible psychiatric classification.' The Istanbul Protocol (2022) paragraph 498.

Relationship between PTSD and depression: There is a significant overlap of symptoms and co-morbidity between depression and PTSD.' The Istanbul Protocol (2022) paragraph 513.

Dissociation: 'Dissociation is a disruption in the integration of consciousness, self-perception, memory and actions. Individuals may be cut off or unaware of certain actions and may feel detached from themselves or their bodies as if observing themselves from a distance (depersonalization). Derealization describes the subjective experience of the unreality or distortion of the outside world or environment. Dissociative phenomena can be present during traumatic events as a result of the extreme physical and psychological stress, leading to changes in perception and information processing with a feeling of distance and detachment from the traumatic event and the accompanying emotions. Certain sensory impressions are not registered whereas others might be perceived very intensely. Peritraumatic dissociation, as well as repression and avoidance of traumatic memories, may cause incomplete or fragmented memories of the traumatic event and may impede a coherent and complete narration of it. Dissociation can also occur when the victim is confronted with the traumatic event during the evaluation. In this case, individuals frequently appear to be distant, cut off from their emotions, showing indifference or other emotional states incongruent with the trauma.' The Istanbul Protocol (2022) paragraph 506.

'Somatisation refers to physical symptoms caused wholly or partly by psychological factors**:** Pain, headaches or other physical complaints, with or without objective physical findings, are common problems among torture survivors. Pain may be the only manifest complaint and may shift in location and vary in intensity. Somatic symptoms can be directly due to the physical consequences of torture or psychological in origin. For example, pain of all kinds may be a direct physical consequence of torture or of psychological origin. Typical somatic complaints include back pain, musculoskeletal pain and headaches. Headaches are very common among torture survivors and may be due to torture-inflicted injury (head and neck injuries are a common part of torture), as well as being caused or exacerbated by poor sleep patterns, stress and anxiety.' The Istanbul Protocol (2022) paragraph 507.

Formulation and prognosis

Impact of immigration status on child development: In Conversation with Dr Dickon Bevington MA MBBS MRCPsych PGCert, Consultant in Child and Adolescent Psychiatry (NHS), Medical Director (Anna Freud National Centre for Children and Families). Question posed was about the impact of delay in informing a child or young person that they are to be protected and kept safe. "There are strong parallels with child placements in foster care and adoption: leaving the child in uncertainty is fundamentally unhealthy at a critical developmental stage. Children held thus will – from a *neurodevelopmental* as well as an *attachment* perspective - by continuing to adapt *to the context in which we (the UK) are holding them*, and all the evidence in child development suggests that insecurity, chronic fear, and especially these experienced in isolation from trusted others, is deeply harmful to long term outcomes. "

Impact of immigration status on PTSD treatment: For children with PTSD, being safe from further persecution is required to optimise treatment and in some cases to make effective treatment possible. According to NICE, '*Until there is safety from further persecution, there may be a limit to the depth of therapeutic work that can be delivered. It can be hard to confront trauma memories anyway, but if the PTSD sufferer faces a realistic prospect of being returned to face more trauma, then it can be impossible*.' National Institute for Health and Care Excellence Post Traumatic Stress Disorder 2005. National Clinical Practice Guideline No. 26. Full Guideline Section 10.5. p.120-21.

Accessed on line https://www.nice.org.uk/guidance/ng116/evidence/march-2005-full-guideline-pdf-6602623598 (Although NICE guidance on PTSD was updated in 2018, this part of the full guideline was not changed)

PTSD symptoms vary over time……. 'The onset of PTSD symptoms is usually within the first month after the experience of torture, but there may also be a delay of months or years before symptoms start to appear. Symptoms of PTSD can be chronic or fluctuate over extended periods of time. During some intervals, symptoms of hyperarousal and irritability may dominate the clinical picture. At these times, the survivor will usually also report increased intrusive memories, nightmares and flashbacks. At other times, the survivor may appear relatively asymptomatic or emotionally constricted and withdrawn. Consistent avoidance behaviour sometimes is not easy to detect, but can result in low levels of intrusive symptoms.' The Istanbul Protocol (2022) paragraph 518.

Factors influencing the course of PTSD External stressors, the breakdown of individual coping mechanisms and loss of social support are among the factors that influence the course of the disorder and possible aggravation. On the other hand, social support, individual coping strategies, ideological or religious commitment, justice and official recognition of responsibility may contribute to a process of recovery.' The Istanbul Protocol (2022) paragraph 518.

PTSD, depression and anxiety in people seeking asylum. Isolation, restrictions, and insecure immigration status are significantly associated with PTSD severity, independently of the level of trauma pre-migration. Having been refused asylum is the strongest predictor of depression and anxiety in people seeking asylum. (Morgan G, Melluish S, Welham A. Exploring the relationship between postmigratory stressors and mental health for asylum seekers and refused asylum seekers in the UK. Transcult Psychiatry. 2017 Oct-Dec;54(5-6):653-674. doi: 10.1177/1363461517737188. Epub 2017 Nov 14. PMID: 29134922.)

Impact of immigration status on post-traumatic symptoms: For people with PTSD, being safe from further persecution is required to optimise treatment and in some cases to make effective treatment possible. National UK guidance on PTSD treatment states: , 'Until there is safety from further persecution, there may be a limit to the depth of therapeutic work that can be delivered. It can be hard to confront trauma memories anyway, but if the PTSD sufferer faces a realistic prospect of being returned to face more trauma, then it can be impossible.' National Institute for Health and Care Excellence Post Traumatic Stress Disorder 2005. National Clinical Practice Guideline No. 26. Full Guideline Section 10.5. p.120-21. Accessed on line https://www.nice.org.uk/guidance/ng116/evidence/march-2005-full-guideline-pdf-6602623598 (Although NICE guidance on PTSD was updated in 2018, this part of the full guideline was not changed).

Exacerbation of post-traumatic symptoms in response to new threat depends on the perceived of danger (rather than actual danger), and on the level of disturbance generated by the new traumatic events (rather than the actual severity of the event). Both of these are likely to be of greater magnitude for someone with a history of trauma, particularly if there are multiple traumas and/or a diagnosis of PTSD.

Trust. NICE PTSD (2018) states 'A priority is to support the development of a trusting relationship that can help in the provision of other phases of the intervention.'

Immigration detention. Research shows that immigration detention has a negative impact on mental health including on PTSD, depression and mental health-related disability, and that this persists beyond the period of detention and increases with the time in detention. Detention is likely to serve as a reminder of prior traumatic experiences, increase fear of imminent return, and disrupt social and professional support, all of which are likely to worsen mental health. PTSD cannot be effectively treated in detention, and appropriate treatment is unlikely to be available in such settings. Those with pre-existing vulnerabilities such as mental health issues or torture are at particular risk of harm as a result of their detention and in most cases there is a likely to be a significant deterioration in mental health. von Werthern, M., Robjant, Chui K et al. (2018) The impact of immigration detention on mental health: a systematic review, BMC Psychiatry 18: 382 9 https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-018-1945-y; Steel, Z et al 2006, Impact of immigration detention and temporary protection on the mental health of refugees, British Journal of Psychiatry https://doi.org/10.1192/bjp.bp.104.007864; Royal College of Psychiatrists (2021), Position statement: Detention of people with mental disorders in immigration removal centres. Online at position-statement-ps02-21---detention-of-people-with-mental-disorders-in-immigration-removal-centres---2021.pdf (rcpsych.ac.uk)

Safeguarding and Risk

Suicide risk is best assessed by structured professional judgement, that is, by combining clinical assessment and formulation with available evidence about suicide risk factors. Current evidence does not support the use of standalone risk assessment tools. (Saab, M.M., Murphy,M., Meehan, E. et al (2021) Suicide and Self-Harm Risk Assessment: A Systematic Review of Prospective Research, Archives of Suicide Research, DOI: 10.1080/13811118.2021.1938321)

Known risk factors include those which are fixed ('static') or relatively fixed ('stable') including : family history of suicide ; childhood adversity ; older age, male gender and unmarried status ; history of previous self-harm, serious previous suicidality, history of mental disorder, substance use disorder, personality disorder or certain personality traits; and previous hospitalisation. In addition, there are 'dynamic' factors which change over time, such as: suicidal ideation, communication and intent; hopelessness; current psychological symptoms; treatment adherence; current substance use; psychiatric admission and discharge; psychosocial stress; and problem-solving deficits. Risk also depends upon contingencies such as access to preferred method of suicide; future service contact; future response to drug treatment and psychosocial intervention; and future stress. (Bouch, J., & Marshall, J. (2005). Suicide risk: Structured professional judgement. Advances in Psychiatric Treatment, 11(2), 84-91. doi:10.1192/apt.11.2.84.)

Applying structured professional judgement involves weighing risk factors as well as any protective factors, considering which are most important and developing a risk management plan, which needs to be reviewed as dynamic and future factors change. In considering future stress, attention needs to be given to predictable future developments which may precipitate or aggravate suicidal ideation.

GP records and suicide risk. The recording of suicide risk assessment in GP records is variable. Comments such as 'not suicidal', 'no suicide risk', 'no thoughts of deliberate self-harm' are commonly made. GP suicide risk assessments usually apply to the particular moment in time, and to acute suicidal ideation, rather than to chronic, background risks due to life experience, social circumstances, and personality style. There can be sudden changes in risk level in response to changes in a person's circumstances. Presence or absence of acute suicidal ideation at a particular moment is only one component of overall suicide risk assessment, and cannot be taken as a measure of risk at a different point in time.

The TID assessment of risk and safeguarding matters (self-harm, suicide, harm to others, child protection issues, risk of harm from others and self-neglect) is based on one assessment at one point in time and any information shared with the assessor prior to the appointment. Risk assessments need repeating whenever there are negative developments in an individual's circumstances.

Clinical evidence of human rights abuses

Clinical evidence -'First and foremost, the reliability of clinical evidence is reflected in the level of consistency between specific allegations of abuse and the documentation of physical and psychological findings. Similarly, the degree of consistency between the description of physical injuries and reports of subsequent acute symptoms, the healing process (taking into consideration relevant mitigating factors) and chronic symptoms and disabilities may also support the internal consistency of the clinical findings. Observations of congruency between an alleged victim's observed affect (emotional state) during the interview and the content of the evaluation, for example, psychological distress in relating painful experiences, may reflect internal consistency of the clinical findings, bearing in mind that appropriate affect can vary widely due to an individual's circumstances and coping mechanisms.'
Istanbul Protocol (2022) para 350.

Istanbul Protocol (2022) guidance on assessment of reported ill-treatment. The Istanbul Principles requires clinicians to provide an 'interpretation as to the probable relationship of the physical and psychological findings to possible torture or ill-treatment. At a minimum this should include an assessment of the level of consistency between all clinical evaluation findings and the allegations of torture or ill-treatment. If the clinician considers that there are clinical reasons for an inconsistent finding, this should be discussed.

The levels of consistency for such correlations are commonly expressed as follows:
(a) "Not consistent with": the finding could not have been caused by the alleged torture or ill-treatment;
(b) "Consistent with": the finding could have been caused by the alleged torture or ill-treatment, but it is non-specific and there are many other possible causes;
(c) "Highly consistent with": the finding could have been caused by the alleged torture or ill-treatment and there are few other possible causes;
(d) "Typical of": the finding is usually observed with this type of alleged torture or ill-treatment, but there are other possible causes;
(e) "Diagnostic of": the finding could not have been caused in any way other than that described.'
The Istanbul Protocol (2022) paragraphs 379-380.

Physical findings

Interpreting physical findings
'The clinician should correlate the following:
(a) To what extent is the history of acute and chronic physical symptoms and disabilities consistent with the allegations of torture and/or ill-treatment?
(b) To what extent are the findings of the physical examination consistent with the allegations of torture and/or ill-treatment? (Note: the absence of physical findings does not exclude the possibility that torture or ill-treatment was inflicted.)

(c) To what extent are the findings of the examination consistent with known torture methods and their common after-effects used in a particular region?'
The Istanbul Protocol (2022) paragraph 417.

Psychological findings

Variability in psychological effects of torture and ill-treatment. 'It is important to remember that the features and psychological effects of torture and ill-treatment depend on a child's developmental stage and the social norms of the community in which they have been raised.' The Istanbul Protocol (2022) paragraph 286.

Absence of a psychiatric diagnosis. 'It is important to recognize that not everyone who has been tortured develops a diagnosable mental illness. However, most victims experience profound emotional reactions and psychological symptoms often also including serious cognitive and behavioural changes.' The Istanbul Protocol (2022) paragraph 493.

Cultural considerations in PTSD. '….it should be noted that psychiatric classifications are generally considered to be based on Western medical concepts and that their application to non-Western populations presents certain difficulties. It can be argued that Western cultures suffer from an undue medicalization of psychological processes. The idea that mental suffering represents a disorder that resides in an individual and features a set of typical symptoms may be unacceptable to many members of non-Western societies. Nonetheless, there is considerable evidence of biological changes that occur in PTSD and, from that perspective, PTSD is a diagnosable syndrome amenable to treatment biologically and psychologically.' Istanbul Protocol (2022) para 497.

The role of the medical expert is not to offer opinions or make conclusions about credibility but rather to offer critical analysis of the clinical findings.

Interpretation of psychological findings in relation to reported ill-treatment? 'Clinicians should comment on the consistency of psychological findings and the extent to which these findings correlate with the alleged torture or ill-treatment' To this end, the emotional state and expression of the person during the interview, the reported psychological, psychosocial and social impact of the alleged torture, clinical observations, the alleged history of detention and torture and the personal history prior to torture, the onset and evolution of specific symptoms related to the alleged torture, the specificity of any particular psychological findings and patterns of psychological functioning, as well as possible interactions, should be taken into consideration. Likewise, possible reasons for inconsistencies (e.g. memory gaps, cognitive impairment, dissociation, distrust, feelings of shame or guilt or other factors that may hinder disclosure) should be described and discussed (see paras. 343–353 above). Physical conditions, such as head trauma or brain injury, and additional factors should be considered, such as ongoing persecution, forced migration, resettlement, difficulty of acculturation, language problems, unemployment, loss of home, and family and social status. The relationship and consistency between events and symptoms should be evaluated and described (Istanbul Protocol (2022), Paragraph 541)

Factors considered in assessing the reliability of psychological evidence. 'Clinicians who conduct evaluations of psychological evidence of torture or ill-treatment may consider a number of additional factors that may be relevant to the reliability of psychological findings – for example, the temporal relationship between the alleged abuse and onset of psychological symptoms as well as fluctuations in psychological symptoms in relation to internal and external psychological stressors and mitigating factors. The individual meaning assigned to the alleged abuse in light of individuals' psychosocial history may also be an indicator of internal consistency, as well as the congruency between individuals' emotions (both reported and observed by the clinician) and their coping mechanisms. Some psychological symptoms of PTSD may refer specifically to the alleged abuse rather than other traumatic experiences. For example, intrusive recollections and nightmares or triggers for intrusive recollections, reliving experiences and avoidance thoughts and behaviour that refer to the alleged torture or ill-treatment are more likely to be caused by the experience of torture or ill-treatment rather than by other traumatic experiences.'
The Istanbul Protocol (2022) paragraph 352.

Grading consistency of psychological findings The meaning and implications of the terms 'consistent' 'highly consistent' 'typical' and 'diagnostic' differ when used to evaluate physical findings and psychological features. There is also a different meaning of these terms in when used in everyday language. The Istanbul Protocol (2022) alludes to some of the problems of using these terms in interpreting psychological findings, and clinicians differ in their interpretations of the guidance. Although in some countries there is a tradition of using this terminology for both physical and psychological findings, this is not the case for UK and among UK report writers there is ongoing discussion about incorporating this approach to describing psychological findings. In the meantime TID has a position of trying to ensure that psychological and overall findings are conveyed as clearly as possible for the reader and to restrict the use of terminology when it can cause confusion.

Overall findings

Torture and ill-treatment can affect development stage leading to problems with accurate recall. 'The effects of torture and ill-treatment need to be considered in the context of the psychological and physical developmental stages of children and adolescents. While torture and

ill-treatment have both physical and psychological consequences on all individuals, the effects on children and adolescents can potentially lead to more long-term and far-reaching changes in the course of their psychological and physical development. Developmental factors should always be considered in clinical evaluations of torture and ill-treatment of children. Estimates of the age at which children become capable of accurate recall of events vary greatly, and range between the ages of 3–6 and 14–15. Furthermore, the ability of children to recount events and establish coherent narratives is affected by cognitive and language abilities, and social and cultural contexts. Nonetheless, information that is valuable and truthful can be obtained from children of varying ages. The Istanbul Protocol (2022) Annex II.

Interpreting overall findings The Istanbul Protocol (2022) states 'Clinicians should formulate a clinical opinion on the possibility of torture or ill treatment based on all relevant clinical evidence' (paragraph 546) and 'Ultimately, it is the overall evaluation of all clinical findings and not the consistency of one finding in particular that is important in assessing allegations of torture or ill-treatment (Paragraph 383) . When physical and psychological evidence are documented in a single report by one examiner, the conclusion on all of the clinical evidence should be the highest level of consistency reported.' (paragraph 383).

Absence of clinical evidence. 'The absence of physical and/or psychological evidence of torture or ill-treatment…does not mean that it did not take place.' The Istanbul Protocol (2022) Paragraph 390.

False allegations of torture and other forms of abuse. 'It is important to recognize that some people falsely allege torture for a range of reasons. Others may exaggerate a relatively minor experience for personal or political reasons. The clinician must always be aware of these possibilities and try to identify possible exaggeration or fabrication. The clinician should keep in mind, however, that such fabrication requires detailed knowledge about trauma-related symptoms that individuals rarely possess. Effective documentation of physical and psychological evidence of torture or ill-treatment requires clinicians to have a capacity to evaluate consistencies and inconsistencies in the report.' The Istanbul Protocol (2022) paragraph 348.

Probability of human rights abuse. 'Clinicians should formulate a clinical opinion on the possibility of torture or ill treatment based on all relevant clinical evidence' and 'it is the overall evaluation of all the clinical findings, and not the consistency of each lesion or symptom with a particular form of torture or ill-treatment, that is important in assessing the allegations of torture or ill-treatment.' The Istanbul Protocol (2022) paragraph 546.

Grading consistency of overall clinical findings. 'In some cases, the overall evaluation may report a higher level of consistency than each individual clinical finding, especially if there are many clinical findings that, when taken together, confirm the same conclusion. It is important to note that the highest level of consistency of an individual finding often determines the level of consistency for all of the clinical evidence'. The Istanbul protocol (2022) paragraph 381.

Ability to give their account / Clinical vulnerability in giving their account

Clinical effects on ability to give their account

Memory and cognition in children: 'Memory and cognition in children are dependent on development as well as the trauma and its frequency and social context. Development of cognitive processes required for adult memory storage – recalling and recounting in a coherent chronological manner – is a gradual process and may be delayed in children who are traumatized. In considering memory and recall of traumatic events, it is important to consider some unique issues among children. While both single and repeated traumas can affect a young person's language, development and memory, repeated trauma may have a more serious effect. Part of a child's memory can form from their family remembering and retelling experiences, which helps to reinforce memory. If a child has been separated from their family at a young age or if the family does not speak of certain experiences, the memories of such experiences may as a result be fragile and sparsely detailed and may be lost altogether as the child grows up. Children who have suffered traumatic experiences and those who have been separated from their caregivers may show particularly uneven development. Such children may be adept in some ways due to having an early responsibility to care for themselves or others despite lacking formal education. Experience of torture or ill-treatment, subsequent mental health conditions and pre-existing developmental difficulties, such as learning difficulties or disabilities, may all influence a child's understanding of events and their ability to recount them.' The Istanbul Protocol (2022) paragraph 287. Ability to report life experiences with adult level detail and coherence is still developing throughout adolescence and is not fully developed until the early twenties. In asylum seeking children these abilities may also be affected by developmental delay and limited opportunities to talk about life experiences with caregivers, as well as by language and culture. Given-Wilson, A., Hodes, M., Herlihy, J. (2017) A review of adolescent autobiographical memory and the implications for assessment of unaccompanied minors' refugee determinations. *Clinical Child Psychology and Psychiatry* 23,2, 209-222.

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Limited information: ' Children typically provide less information than adults. This is partly because they are less capable of, and less skilled at, generating cues independently.' The Istanbul Protocol (2022) paragraph 293.

The adept child. 'Children who have suffered traumatic experiences and those who have been separated from their caregivers may show particularly uneven development. Such children may be adept in some ways due to having an early responsibility to care for themselves or others despite lacking formal education.' Istanbul Protocol (2022) paragraph 287.

Concealment of Vulnerability. In Conversation with Dr Dickon Bevington MA MBBS MRCPsych PGCert, Consultant in Child and Adolescent Psychiatry (NHS), Medical Director (Anna Freud National Centre for Children and Families). Question posed was 'Why is it that a child or young person may appear to cope and function so well once they arrive in the UK?'

"This is an exact analogue of the phenomenon of "parentification" that is often observed in children who have been severely neglected. It is an adaptive state (*appropriate* to conditions where there is significant danger and a complete lack of trustworthy support/help) that rapidly becomes highly non-adaptive in less hostile environments. It can look superficially as though the child is precociously mature and capable, inviting withdrawal of the potential helping agency, but in fact – psychologically-speaking – this reaction is an example of the child's repression of vulnerability and need; it results in an explicit (reflex) rejection of help, presumably on the basis that in the child's experience 'help' has no track record of proving *helpful*, but has instead become known as being more likely to lead to further exploitation and harm. It represents a sealing over of the very door to help (trust in another appropriate person) that, as a child, bearing the harms of trauma and separation, they most need. Long term associations with (mostly unsuccessful) attempts at 'self-medication' (especially vulnerability to substance use disorders, abusive relationships, loneliness, depression, etc.)"

Emotional reactions to interview: 'Emotional reactions among children may vary. Children may become silent for a long period of time, avert their gaze or change the topic altogether when they become overwhelmed by a question. In those cases, it is usually best to follow their lead and switch, at least temporarily, to a less threatening subject. The ability to concentrate and participate in interviews may also be affected by heightened emotionality and limited capacity to regulate their affect, especially in adolescents. Explanations of events that appear shallow or implausible to an adult may be a reflection of a child or adolescent's limited reasoning or more impulsive behaviour. The Istanbul Protocol (2022), paragraph 290.

Psychological symptoms may interfere with a person's ability to give their account. For example, PTSD , depression and dissociation are associated with impaired attention, concentration and memory, particularly under conditions of stress.

Memory for traumatic events: 'In extreme emotional arousal, when the body is under threat, memory storage is impaired. Memories of traumatic experiences may as a result be fragmented and poorly located in the overall context of chronology or location. Details central to the experience are recalled better than peripheral details (date and number detail is particularly poorly recalled), but even some details core to the experience may not be reliably recalled. The ability to recall and recount details of traumatic events may vary over time, particularly when an individual has PTSD. Differences in the history (particularly, variable ability to recall details about torture and ill-treatment experiences) obtained from interviews conducted at different times are to be expected.' The Istanbul Protocol (2022) paragraph 345.

Difficulty recalling and recounting. Torture survivors may have difficulty recounting the specific details of the torture or ill-treatment for several important reasons, including: (a) Factors during torture itself, such as blindfolding, drugging, lapses of consciousness, etc.; (b) Fear of placing themselves or others at risk; (c) A lack of trust in the examining clinician or interpreter; (d) The psychological impact of torture and trauma, for example high emotional arousal, cognitive avoidance due to painful emotions, such as guilt and shame, and impaired memory, secondary to trauma-related mental illnesses, such as depression and PTSD; (e) Neuropsychiatric memory impairment from head trauma, suffocation, near drowning or starvation; (f) Protective coping mechanisms, such as denial, avoidance and dissociation;(g) Culturally prescribed sanctions that allow traumatic experiences to be revealed only in highly confidential settings. The Istanbul Protocol (2022), Paragraph 331.

Impaired recall: Autobiographical memory is prone to error and 'someone may be telling the truth exactly as they recall it and yet still appear inconsistent, incomplete or inaccurate in their account.' Impaired recall may occur for multiple reasons including the normal limitations of recall, being asked to recall under conditions of stress and by post-traumatic memory impairments and avoidance. People with a history of trauma, PTSD and depression have particular difficulties with autobiographical memory and impairments in recall, particularly for traumatic events but not restricted to these. Herlihy, J., Jobson, L. and Turner, S. (2012). Just Tell Us What Happened to You: Autobiographical Memory and Seeking Asylum. Applied Cognitive Psychology 26: 661–676; Cameron, H.E. (2010). Refugee Status Determinations and the Limits of Memory. International Journal of Refugee Law, 22,4: 469-511.

Inconsistencies: Inconsistencies between a person's allegations of abuse and the findings of the evaluation may arise from any or all of the aforementioned factors and should not be assumed to indicate untruthfulness. Clinicians have a duty to pursue possible explanations of such inconsistencies. If possible, the clinician should ask for further clarification. When this is not possible, the clinician should look for other evidence that supports or refutes the account of events. A network of consistent supporting details can corroborate and clarify the person's allegations. Although the individual may not be able to provide the details desired by the interviewer, such as dates, times, places, frequencies and the exact identities of the perpetrators, a broad outline of the alleged traumatic events will emerge and stand up over time. The Istanbul Protocol (2022) paragraph 347.

Effect of dissociation on memory. Peritraumatic dissociation, as well as repression and avoidance of traumatic memories, may cause incomplete or fragmented memories of the traumatic event and may impede a coherent and complete narration of it. Dissociation can also occur when the victim is confronted with the traumatic event during the evaluation. In this case, individuals frequently appear to be distant, cut off from their emotions, showing indifference or other emotional states incongruent with the trauma. The Istanbul Protocol (2022) paragraph 506.

Difficulty with details and certainty: A high level of detail, or a strong degree of certainty with which a memory is held, are helpful when present, but their absence cannot be taken to indicate that the memory is unreliable.
The Istanbul Protocol (2022), Paragraph 331.

Memory for traumatic events is likely to be 'fragmented' with some moments remembered vividly, other parts that are 'more vague, have some gaps, in jumbled order and, possibly, contain inaccuracies. Also, during a traumatic event some people dissociate or go blank, which disrupts their ability to remember the whole event. Thus, people with PTSD may have gaps in their memory of the event.
Guidelines on Memory and the Law. Recommendations from the Scientific Study of Human Memory. The British Psychological Society (2008) Pages 26-27 http://www.human.cornell.edu/hd/outreach-extension/upload/Guidelines-on-Memory-and-the-Law.pdf

Conclusions and recommendations

Minimising Disruption: The mental health of young people seeking asylum is likely to be helped by developing stable new attachments, peer relationships and educational achievements and from progressing towards their life goals. Interventions that support these aims are beneficial for health as well as other reasons. Disruptions to new attachments should be minimised and when unavoidable should be planned and gradual.

Also we perhaps need a reference here. We could use our book Dobler, V., and Nelki, J. (2022) Children, Families and Young People. in Maloney, C., Nelki, J., and Summers A. (Eds) *Seeking Asylum and Mental Health* Cambridge: 2022, pages 218-220.

Recommendations regarding communication

Interviewing Children:
Presentation of information. ' Information on procedures needs to be tailored for children and communicated in ways they can understand. Although they may physically resemble adults, it is increasingly recognised that brain development continues into early adulthood, and interviews with older children, adolescents and young adults should be tailored to their individual cognitive and verbal capacity.' The Istanbul Protocol (2022) paragraph 286.
Building Rapport with Children:. 'Building rapport with children can be facilitated by taking measures to ensure the environment and tone of the interview is as informal and comfortable as possible. It is helpful to allow children some input into the flow of interviews by letting them know approximately how long the conversations will last and that breaks are available on demand. Children's attention spans can be quite short, so it may be necessary to take breaks during the interviews or conduct them over multiple sessions.' The Istanbul Protocol (2022) paragraph 288.

Vulnerable witness guidance. See Immigration and Asylum Chamber of the First-tier Tribunal 17 May 2022, Practice Direction 7: Circumstances under which a child, vulnerable adult or sensitive witness may give evidence and Practice Direction 8: Manner in which evidence is given. See also Joint Presidential Guidance Note No. 2, Child, vulnerable adult and sensitive appellant guidance, 2010 for a description of measures to reduce the adverse impact of mental health problems in Court hearings.

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