
# GUIDANCE NOTE ON THE PSYCHOLOGICALLY VULNERABLE APPLICANT IN THE PROTECTION VISA ASSESSMENT PROCESS

**United Nations High Commissioner for Refugees**
**Regional Representation in Canberra**
**November 2017**

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## I. Introduction

1. Applicants for refugee status undertake a series of tasks to complete the assessment of their claims. Applicants are required to articulate and respond to questions about their claims in various settings, including: on arrival; when completing application forms; when instructing a legal representative; in a protection interview and when making submissions upon review.

2. The tasks associated with protection visa assessment require various psychological abilities, for example: to attend to and accurately comprehend questions during an extended interview; to recall events that are legally relevant and to draw on specific knowledge and experiences.

3. The psychological abilities required to undertake the protection visa assessment process may be impaired by: mental illness; psychological trauma; acquired brain injury; neurological disorders; intellectual and developmental disabilities; substance abuse; medications affecting mental state and physical illness. When an applicant's psychological abilities are reduced, the fairness and accuracy of protection visa assessment may be compromised unless each stage of the process is informed by the applicant's mental state and cognitive abilities.

## II. Scope and Purpose of the Guidance Note

4. The *guidance note on the psychologically vulnerable applicant in the protection visa assessment process* (**guidance note**) provides assistance to people in Australia involved in the assessment, such as legal representatives, registry staff and decision-makers both at first instance, upon merits review at the Administrative Appeals Tribunal (AAT) and the Immigration Assessment Authority (IAA), and judicial review.

5. It provides guidance in relation to applicants whose ability to participate in protection visa assessment[7] is reduced due to their disordered mental state and impaired cognitive abilities (**psychologically vulnerable applicants**). It is intended to apply regardless of the cause of the impairment.

6. This guidance note addresses ways to identify and assist psychologically vulnerable applicants. It presents a framework for protection visa assessment

[7] The phrase 'protection visa assessment' is used in this guidance note to describe all the steps leading to the completion of the final refugee status decision: the completion and submission of the application; pre-interview communication; the protection interview; post interview communication; the primary decision regarding refugee status; post primary decision communication; submission preparation for merits review; merits review hearing or interview; post hearing or interview communication; second instance decision regarding refugee status, judicial review, assessing international protection claims in the context of removal processes etc.

in light of an applicant's mental state and it describes a range of procedural modifications designed to facilitate the fair and accurate assessment of the applicant's claims.

7. The role of this guidance note is particularly significant for individuals assessed under the Fast Track process.[8] This process places substantial weight on initial findings because only a review on the papers of the primary decision is likely to be conducted by the IAA and because, in some cases, review is statutorily excluded.[9]

8. Most applicants in the Fast Track process have been living in Australia for many years without having their protection claims assessed. This prolonged period of uncertainty, coupled with the prospect of the grant of only a temporary visa, which prevents family reunification, may be likely to contribute to protracted impairments in mental health.[10] In the context of the Fast Track process, it is thus critical that an applicant's psychological vulnerability is identified as early as possible, and that the implications of such vulnerabilities are considered at every step of the protection visa assessment.

9. This guidance note builds on more general instructions directed at working with mentally unwell and vulnerable protection visa applicants.[11]

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[8] The Fast Track process is an accelerated assessment procedure that was introduced by the Australian Government in 2014. Some asylum-seekers have no access to merits review and those who do are not entitled to appear in person or present new information unless there are 'exceptional circumstances'. Prior to enactment, UNHCR raised significant procedural fairness concerns with the Fast Track determination process. See: UNHCR, *Submission by the Office of the United Nations High Commissioner for Refugees to the Senate Legal and Constitutional Affairs Legislation Committee Inquiry into Migration and Maritime Powers Legislation Amendment (Resolving the Asylum Legacy Caseload) Bill 2014*, 31 October 2014.

[9] See definition of excluded fast track review applicant, s 5 of the *Migration Act 1958* (Cth).

[10] Procter, N; Kenny, M; and Grecj, C; *Lethal Hopelessness: Understanding and Responding to Asylum Seeker Mental Deterioration Shared Learning in Clinical Practice*, University of South Australia, Supplement – September 2016.

[11] Administrative Appeals Tribunal, Migration and Refugee Division, 'Guidelines on the Assessment of Credibility', July 2015.
Administrative Appeals Tribunal, Migration and Review Division, 'Guidance on Vulnerable Persons', July 2017.
Hunter, J; Steel, Z; Pearson, L; San Roque, M; Silove, D; Frommer, N; Redman, R, *Managing and Understanding Psychological Issues Among Refugee Applicants: Resources Manual and Guidelines for Best Practice*, Faculty of Law and Psychiatry Research Unit, University of New South Wales, 2013.
International Association of Refugee Law Judges, *Assessment of Credibility in Refugee and Subsidiary Protection claims under the EU Qualification Directive*, 2013.
UN Office of the High Commissioner for Human Rights (OHCHR), *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment ("Istanbul Protocol"),* 2004.
UN High Commissioner for Refugees (UNHCR), *Handbook on Procedures and Criteria for Determining Refugee Status under the 1951 Convention and the 1967 Protocol Relating to the Status of Refugees.* 2nd ed. Geneva, (Reissued Geneva, December 2011).

## III. Psychological Considerations Relevant to the Protection Visa Assessment Process

10. Mental illness, post-traumatic conditions, brain injury, neurological disorders, intellectual and developmental disabilities and the effects of medication may manifest in a wide range of symptoms. However, with regard to the psychological considerations relevant to protection visa assessment, what is important is how the applicant's ability to participate in the process is affected and accommodated. It may also be necessary to consider whether the applicant's mental disorder gives rise to a claim for protection.

11. Psychologically vulnerable applicants may have a reduced ability to participate in protection visa assessment due to specific cognitive impairments arising from their mental state. In some instances, usually due to a severe mental or neurological disorder, an applicant may be temporarily or permanently unable to meaningfully participate.

12. 'Capacity' and the ability to participate are always relative to the demands of the task to be undertaken. An applicant may have the capacity to engage in a short interview, but may not be fit to undertake an exhaustive examination of the claims.[12]

13. Unlike in Australian criminal law, there is no statutory definition of 'fitness' in the refugee context. However, the Courts have provided some guidance.[13] A minimum requirement for fitness to participate would appear to be that applicants understand the nature of the proceedings; that they can understand questions put to them and respond relevantly drawing on their experience and knowledge; and that they can comprehend and respond to adverse information.

14. There are a set of psychological abilities necessary for participation in protection visa assessment. The extent of these abilities' impairment will determine the degree to which applicants' capacity to participate is compromised. **Table 1** (pp.18-19 below) identifies these psychological abilities and provides a non-exhaustive list of the causes and consequences of their impairment.

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[12] The terms 'capacity', 'fitness' or 'competence' are employed in many jurisdictions to denote either a dichotomous concept (able or unable to undertake a legal process) or a continuous concept – degrees of ability to undertake the process. In this guidance note, 'fitness' refers to the dichotomous concept, 'capacity' to the continuous concept, and the term 'competence' is not employed.

[13] *Minister for Immigration and Multicultural Affairs v SCAR* (2003) 128 FCR 553; *Minister for Immigration and Citizenship v SZNVW* [2010] FCAFC 41; *Minister for Immigration and Citizenship v SZNCR* [2011] FCA 369; SZQBN v *Minister for Immigration and Border Protection* [2014] FCA 686; *BQC15 v Minister for Immigration and Border Protection* [2016] FCA 946, Gilmour J at [30].

15. The accurate identification of the nature and cause of an impairment in psychological capacity requires psychological, neuropsychological, and/or psychiatric assessment.[14]

## IV. Identifying a Vulnerable Applicant

16. The purpose of gathering relevant health information is to allow people involved in protection visa assessment to identify an applicant who is potentially psychologically vulnerable. In order that the consequences of an applicant's psychological vulnerability properly informs protection visa assessment, early and accurate identification of vulnerability is essential. This allows for the timely provision of:
    - treatment and additional support (where appropriate);
    - legal representation which is informed by the applicant's mental state; and,
    - the timely commission and completion of psychological and medical reports.

17. While the presumption is that an applicant is fit to engage in the protection visa assessment process, decision-makers (at first instance and upon review) should be *alert to the possibility* that an applicant is psychologically vulnerable.

18. Having considered the available evidence as gathered from various sources (described below), where there is *a possibility* that the applicant is psychologically vulnerable a decision-maker should either:
    a. determine that the applicant is *likely* to be psychologically vulnerable and ensure that protection visa assessment processes are conducted in accordance with this guidance note; or,
    b. obtain further information in order to determine whether the applicant is likely to be psychologically vulnerable.

19. If evidence of psychological vulnerability emerges for the first time during the protection visa interview, consideration should be given to:
    a. obtaining expert psychological evidence;
    b. conducting the interview in accordance with this guidance note; and,
    c. if necessary, postponing the interview until further evidence is obtained.

20. A decision-maker may be satisfied there is not a likelihood of psychological vulnerability where none of the sources of information indicate the possibility of its presence.

[14] In this guidance note, the phrases 'psychological assessment', 'psychological evidence' etc., will be considered as inclusive of psychological, neuropsychological and psychiatric assessment and evidence.

## V. Sources of Information to Assist in the Identification of Psychological Vulnerability

21. Sources of information about an applicant's mental state should be broad. A recent assessment by a health provider may establish that the applicant is psychologically vulnerable. An indication by an applicant that they are currently receiving mental health treatment would indicate that they may have a psychological vulnerability. A statement by an applicant that participation in the protection visa interview will be compromised for psychological reasons also raises the possibility of vulnerability.

22. There may be information held in files of the Department of Immigration and Border Protection (including in decision records) indicating that an applicant has a psychological vulnerability. The information may be suggestive, such as the observations of a case officer, or authoritative, for example a report by an immigration detention health provider or another source of health assessment.

23. With the applicant's consent, information may be obtained from a variety of sources, such as:
    - health services;
    - status resolution support services and other community support services that have had dealings with the applicant; and,
    - the applicant's family and friends.

24. Applicants themselves are usually a primary source of information about their potential vulnerability.

25. Relevant information can be acquired through questioning applicants and through observing their behaviour. Whenever possible, questions about the applicant's health status should be asked once rapport has been established with the applicant, whether the context is preparation of an application or a protection visa interview. Out of consideration for the applicant's right to privacy with respect to a health condition and treatment, the applicant must be informed that they are not obliged to disclose anything about their health.

26. The following list of questions may elicit relevant information; they indicate areas that questions should cover, not a script to be followed *verbatim*.
    - Do you suffer from a problem with thinking or memory?
    - Do you suffer from a mental illness, or any other psychological or health condition which may interfere with your ability to prepare your protection visa application and participate in a protection visa interview?
      (If answered in the negative, the questions should be discontinued)
    - Do you know what your health condition is called?
    - Are you receiving treatment for your condition currently? What kind? Have you had treatment for the condition in the past?

- In what way do you believe your ability to prepare your protection visa application and participate in a protection visa interview would be affected?
- Does your health problem interfere with performing normal daily activities? In what way?

27. Observation of the applicant is also a key source of information about their mental well-being and may raise the possibility of psychological vulnerability. Observations alone should not however be taken to positively exclude vulnerability.

28. Any of the following observations may suggest psychological vulnerability. Where the applicant:
    - appears to be disoriented about time and place and confused about the purpose of the meeting/ interview;
    - shows obvious signs of self-neglect;
    - is highly distractible and inattentive;
    - responds with very limited content to all questions and there is little spontaneous speech;
    - provides poorly organized, illogical or irrelevant responses much of the time;
    - appears sad, withdrawn and uncommunicative much of the time;
    - appears highly anxious and distressed much of the time;
    - appears agitated and overactive much of the time;
    - expresses ideas that are markedly strange and irrational;
    - behaves in a way that is markedly odd and socially incongruent;
    - becomes highly distressed or disoriented when speaking of traumatic subjects or instead is incongruously detached;
    - has difficulty recalling recent daily activities or basic autobiographical information or locating autobiographical events in time; or,
    - expresses an intent to harm self or others.

## VI. The Role of Psychological and Medical Evidence

29. Psychological and medical evidence can assist the fair and accurate assessment of the claims of the psychologically vulnerable applicant.

30. Such evidence, whether oral or written, should adhere to expert evidence guidelines and be demonstrably expert and impartial. The decision-maker assesses the value of the evidence and gives weight to it accordingly.

31. A psychological or medical report should be commissioned in the following circumstances:

a. Where the available evidence is sufficient to indicate that there is a reasonable possibility of vulnerability but there is insufficient evidence to determine whether the applicant is likely to be psychologically vulnerable; or,

b. The evidence is sufficient to determine that the applicant is likely to be psychologically vulnerable; however it is of insufficient expertise or particularity to inform the decision-maker of the specific ways the applicant's capacity will be reduced in relation to the protection visa assessment process; and,

c. Only with the applicant's informed consent, the consent being based on an understanding of the purpose of the report.

32. Psychological and medical evidence may be produced by an independent expert who provides opinion evidence or a clinician in a treatment relationship with the applicant. The treating clinician's evidence, while ethically and practically influenced by the treatment relationship, may nonetheless provide valuable factual evidence. For example: regarding the applicants' mental state; cognitive capacities; the experiences they have reported in their country of origin; and their diagnosis and treatment.

33. In order for a commissioned report to be informative in relation to psychological vulnerability, it must address questions of psychological capacity specific to protection visa assessment. The ***Schedule on Mental State and Capacity Assessment*** (below), which was developed in conjunction with this guidance note, describes the areas of mental state functioning which are pertinent to an applicant's capacity to undertake each stage of the assessment. Advice for mental health professionals on the provision of expert reports, diagnoses and management plans for refugee claimants can be found in the manual, ***Managing and Understanding Psychological Issues Among Refugee Applicants***.[15]

34. Psychological and medical evidence should not usurp the function of the decision-maker. The decision-maker is the arbiter as to whether the applicant is fit to undertake the protection visa interview, how credibility is assessed in light of the evidence, and what procedural modifications to protection visa assessment should be adopted.[16]

35. However, probative evidence must be given due weight. The decision-maker should determine the evidence's probity and relevance, weigh it accordingly, and explain how it has been taken into account in reaching conclusions about

[15] Hunter, J; Steel, Z; Pearson, L; San Roque, M; Silove, D; Frommer, N; Redman, R, *Managing and Understanding Psychological Issues among Refugee Applicants: Resources Manual and Guidelines for Best Practice*, Faculty of Law and Psychiatry Research Unit, University of New South Wales, 2013.
[16] International Association of Refugee Law Judges, *Guidelines on the Judicial Approach to Expert Medical Evidence*, June 2010 at [6].

the applicant's claims. These steps in adducing the evidence should be described in the decision record.

36. When further evidence may explain a point of material significance, clarification should be sought from the provider of the evidence or through commissioning an additional report.

37. Psychological evidence can serve numerous purposes, including:
- In deciding whether the applicant is fit to undertake a protection visa interview;
- In understanding how the applicants' reduced psychological capacity affects their ability to articulate their protection claims and respond to questions about them;
- In understanding the applicant's psychological presentation and conduct during the interview;
- In understanding, through the evidence of a medical practitioner, how a medical condition or the effect of medication may affect mental state;
- In deciding what procedural modifications to the protection visa interview, hearing or IAA review should be made;
- In deciding whether an apparent inconsistency, confusion or inability to remember events in relation to the applicant's evidence is explicable in terms of the applicant's mental state;
- In deciding whether a lack of specificity in recollection of legally relevant events or a lack of knowledge about relevant matters may be explicable in terms of the applicant's mental state;
- In deciding whether behaviour in relation to claimed events may be explicable in terms of the applicant's mental state;
- In deciding whether the applicant's late disclosure of a claim is explicable in terms of the applicant's mental state;
- In considering whether an applicant's psychological presentation is consistent with their claims in relation to experiences of trauma;
- In understanding whether the discrimination the applicant might suffer if repatriated would, owing to the applicant's psychological vulnerability, amount to serious harm and persecution;
- In understanding whether the repatriation of the psychologically vulnerable applicant might cause, owing to severe mental disorder, a threat to the person's capacity to subsist, or result in them being subject to inhuman or degrading treatment;
- In considering whether internal relocation is reasonable in the country of origin for the psychologically vulnerable applicant.

38. In none of these areas of decision making is the expert evidence determinative; however at times it may be highly persuasive. The extent to which the expert evidence is capable of being persuasive depends both on the question to be decided and the probity and relevance of the evidence. This is most easily explained by example, as set out below.

- A treating clinician's evidence that the applicant currently suffers severe memory impairment due to a major depressive disorder and that this episode is likely to resolve in the next six months may provide a cogent reason for finding the applicant currently not fit and for the interview to be delayed.
- Evidence of post-traumatic symptoms strongly consistent with the experience of sexual violence and incarceration may make the applicant's claim of imprisonment and sexual abuse persuasive. However, the decision-maker may also consider the possibility that these experiences occurred in a context other than what has been claimed.
- Evidence that the applicant has, as an apparent consequence of trauma and shame, generally disclosed personal history progressively, may persuasively explain a delay in the disclosure of claim relevant experiences.
- The applicant's claims are based on sexual orientation. The decision-maker may consider that the authenticity of the applicant's claimed sexual orientation is not a matter expert evidence can address; nonetheless the decision-maker may find that the psychological report provides an account of the applicant's reported psychosexual development and experiences of discrimination which is relevant and cogent evidence.
- The applicant claims to be imputed with an allegiance to a political movement but knows less than would be expected about the movement. Psychological evidence indicating that the applicant has a learning disability is likely to be relevant to determining the knowledge the applicant would reasonably be expected to possess.

## VII. Accommodating Psychological Vulnerability in the Preparation of the Application

39. Psychologically vulnerable applicants may require more time than other applicants to prepare an application.

40. Legal assistance in preparing the application will be critical to ensure an application accurately and thoroughly represents the applicant's claims.

41. In the preparation of an application, a psychological or medical report may serve several purposes:
    - to assist the legal representative's understanding of the applicant's mental state and current treatment;
    - to inform the legal representative with respect to difficulties that may arise in gathering information from the applicant as a consequence of the applicant's impaired psychological capacity;

- to inform the legal representative of aspects of the applicant's personal history, including experiences of trauma, which may not have been previously disclosed or will be difficult to elicit;
- to provide evidence as to whether the applicant's mental state is relevant to protection claims; and,
- to inform submissions regarding the implications of the applicant's mental state for the conduct of the protection visa interview.

42. When there is corroborative evidence available of psychological vulnerability, the applicant's legal representative should ensure that the evidence accompanies legal submissions.

## VIII. Conducting the Protection Visa Interview

43. The ability of the psychologically vulnerable applicant to participate in a protection visa interview may be reduced in specific ways. Psychological and medical evidence should elucidate the specific difficulties the applicant may face.

44. The interview should be conducted in a way that minimizes the obstacles to full participation faced by the psychologically vulnerable applicant. The interview may be modified in content and procedure to ensure that the applicant's reduced psychological capacity does not prevent them from participating effectively.

45. Modifications to the conduct of the interview in order to accommodate the applicant's vulnerabilities must be consistent with and delimited by adherence to the legal requirements of the interview including those of procedural fairness.

46. Modifications to the conduct of the interview should reduce the intellectual and emotional demands of the interview on the applicant. According to the specific needs of the applicant, the following procedural modifications are recommended.

47. *Prior to the interview or hearing*

The following steps are advisable prior to the interview or hearing:

- alert applicants in writing to aspects of their claims about which the interview will seek clarification and further particulars;
- provide in writing adverse information to the applicant; and,

- allow the applicant to provide a written response to aspects of the claims requiring clarification.

48. *During the interview*

At the commencement of the interview, applicants should be assisted by their legal practitioner, when present, and the decision maker to make a statement of their relevant personal history *prior to* testing their claims. The statement should focus on only aspects of the personal history which are materially relevant to the applicant's claims and which cannot be accepted without further information. The decision-maker should seek to clarify any inconsistency or contradiction in the applicant's account of their experience relevant to their claims, rather than using such inconsistency to draw inferences about credibility. Once the applicant has provided an account of the relevant history which is as complete as possible, the applicant should be informed of the reason for any doubts about elements of the history's veracity and be given a chance to respond.

49. Personal history associated with trauma may be relevant to the assessment of claims. However, exploration of these experiences can cause distress, confusion and disorientation. The available psychological evidence may indicate the likely response of the applicant. Careful consideration should be given as to whether the details of the traumatic event, as distinct from the fact of the event's occurrence, require close examination. A written statement or psychological report may provide such details if they are required. Where close examination of traumatic experiences is likely to cause distress and disruption to the interview, the legal utility of exploring the traumatic experience needs to be carefully weighed.

50. *After the Interview*

Despite adoption of these procedures, the applicant may still not have had a reasonable opportunity to respond to adverse information during the interview. This may be due to capacity related difficulties experienced by the applicant during the interview or because information provided by the applicant at the interview raised new credibility concerns. In such instances, after the interview the psychologically vulnerable applicant should be given an opportunity to submit a response, prepared with legal assistance, to a written set of considerations that may lead to the application being refused.

51. *Other procedural approaches to consider*:

- The interview should be conducted in a way that is supportive and not confrontational.

- The presence of a legal representative should be considered highly desirable.
- The applicant should be encouraged to consider inviting a support person to the interview and interviewers should ensure that the interview is conducted in circumstances that allow a support person as well as a legal representative to attend. Interview rooms must be large enough for the interviewer, applicant, interpreter, support person and legal representative and interviews should be scheduled at times when all parties are available. The presence of support persons may assist the applicant to feel safe, trust the process, and tolerate a degree of distress.

- The applicant should be oriented to each part of the interview: "I now wish to ask you about…" ('signposting'). Summarize what the applicant has said every few minutes or at the end of the discussion of a particular subject. Actively check whether the applicant wishes to correct or add anything.
- Use short simple sentences to ask questions.
- Applicants should be encouraged to bring to the interview and make use of any mnemonic assistance that might help them provide an account of their personal history, such as statements, photographs, timelines represented graphically. Visual representation of timelines, for example on a white board, may also assist. Populating the timeline with events salient to the applicant, for example, significant family occasions, personal milestones, events in the community such as religious celebrations, rather than dates, may assist in constructing the chronology.
- In some instances, questions about what is known may not be the preferable approach to establishing whether the applicant possesses particular knowledge; the applicant may know the information but be unable to retrieve it when questioned. A test of recognition rather than free recall may be preferable, such as multiple choice questioning or showing several photographs of a subject (e.g. photos of a location or person the applicant claims knowledge of).
- Where available, allow the testimony of witnesses or other forms of available evidence, when this would reduce the demands on the applicant.
- Allow regular breaks whenever required and a chance for the applicant to confer with the legal representative and support person. Consider conducting the interview over a number of sessions if the applicant's capacity for sustained attention or tolerance of the demands of the interview is markedly reduced.

## IX. Assessing the Credibility of the Psychologically Vulnerable Applicant

52. As a general principle, some grounds for making adverse credibility findings are less reliable when considering the claims of the psychologically vulnerable applicant.

53. Demeanour is an uncertain basis for credibility assessment in any context. When an interviewer and interviewee have different cultural backgrounds and first languages, and the interview is conducted with an interpreter, the complexity of assessing demeanour increases. Many mental illnesses and neuropsychological conditions alter the expression of emotion. The addition of mental disorder to the complexity of the interpretative task renders demeanour an unreliable source of credibility assessment. Demeanour should not be relied upon in making credibility assessments of psychologically vulnerable applicants.

54. Credibility assessments based on the specificity and detail of an account of a legally relevant event should be considered in the context of psychological evidence. A want of detail where detailed knowledge would be expected may have a number of psychological explanations (see Table 1). A psychological assessment may be able to determine whether the lack of specificity is explicable in terms of particular memory deficits. For example, severe depression can cause a tendency to recall significant personal events in general terms only with an associated poverty of specific contextual information that might otherwise be expected to be present. A post-traumatic condition may cause the applicant to avoid recalling the events in detail and to recollect the most alarming and threatening components of the memory with limited contextual information.

55. An adverse credibility assessment may be founded on applicants not possessing knowledge which they would be expected to possess. General knowledge is usually relatively well preserved and accessible despite mental disorder and impairment in cognitive functioning. However, some psychologically vulnerable applicants may take longer to recollect personal knowledge and initially provide incomplete statements about what they know. Furthermore, the store of general knowledge possessed by the applicant may have been restricted by limited educational opportunities or developmental disability.

56. The provisos about what it is reasonable to expect an applicant to know have been described elsewhere.[17] Culture, education, life experiences and intellectual functioning are considerations in determining what applicants would be expected to know if their claims are credible.

57. A cautious approach to determining the plausibility of an applicant's account of their behaviour in relation to a legally relevant event should be taken. Some psychologically vulnerable applicants may be less able to provide a persuasive account of their reasons and motivations for particular actions. If an applicant was mentally unwell or traumatised at the time of the actions in question, their conduct may have been influenced by an abnormal mental state. Cultural

[17] Administrative Appeals Tribunal, Migration and Refugee Division, 'Guidelines on the Assessment of Credibility'. July 2015 at [32]-[33].

habits, social norms, personality and the perceived exigencies of the situation combine to shape conduct.[18]

58. Inconsistencies in an applicant's testimony often form the basis of an adverse credibility assessment.[19] There are different kinds of inconsistency. Some kinds of inconsistency are less reliable as a basis for an adverse credibility finding when assessing a psychologically vulnerable applicant:

- Where an applicant's claim is directly inconsistent with reliable country information, the inconsistency will raise doubts about the claim's credibility regardless of the applicant's mental state;
- Where an applicant makes a positive assertion about a significant life event (e.g. undertaking military service) and then later makes a directly contradictory statement (that military service was never undertaken) this inconsistency is unlikely to be explained by the applicant's mental state unless the applicant suffers from a mental disorder or condition which severely impairs memory;
- Where an applicant discloses new information which relates to traumatic events, this may be explicable in psychological terms. Particularly among applicants with a post-traumatic condition, disclosure of traumatic events often unfolds over time;
- When an applicant recounts an event at different times, there will often be some variation of detail. It is a normal characteristic of human memory that accounts of a personal experience will differ to some extent each time they are retold, while the central elements of the event may be relatively stable. This is because memory is reconstructive. Memories for traumatic events have been shown to be subject to wider variation over time than recollection of significant non-traumatic events. There are a number of reasons for this:

    - During the traumatic event, it is common that only some aspects of the event are registered owing to the person's psychological and neuropsychological state. Subsequently there may be attempts to reconstruct what occurred, sometimes from other sources of information;
    - Details of the traumatic event may be suppressed and subsequently retrieved. Other details may be forgotten through a normal process of forgetting;
    - The severity of the person's current post-traumatic condition affects the details recollected and the vividness of those details; The severity

[18] Coffey, G (2003) 'The Credibility of Credibility Evidence at the Refugee Review Tribunal', *International Journal of Refugee Law*, 15, pp. 377- 417.

[19] Stephen Paskey (2016) 'Telling Refugee Stories: Trauma, Credibility and the Adversarial Adjudication of Asylum Claims.' *Santa Clara Law Review* 56, 3, 458-499, 462. Amnesty International (2004), *Get It Right – How Home Office decision making fails refugees*; Coffey, G (2003) 'The Credibility of Credibility Evidence at the Refugee Review Tribunal.' *International Journal of Refugee Law*, 15, pp. 377-417.

of the post-traumatic condition fluctuates over time and in response to treatment;
- Experiences of fear, shame, guilt and loss associated with the traumatic experience influence when aspects of the trauma are spoken about;
- When multiple traumas have been experienced there may be a conflation of the details of the separate traumas.

59. The most common pattern in the recollection of trauma over time is that the central elements of the experience are relatively stable but contextual details vary. The details that have been found to vary most commonly are of the following kind: precise times and dates, the sequence of events, visual and spatial details, the number of people present, and who did what.

**Table 1: Psychological Abilities Relevant to Participation in the Protection Visa Assessment Process**

**ATTENTION**

| Psychological ability | Consequences of impairment | Condition causing impairment |
|---|---|---|
| **Concentration and sustained attention** | Distractibility<br><br>Short attention span<br><br>Slow speed of processing<br><br>Difficulty shifting between one topic and another<br><br>Becoming overwhelmed<br><br>Forgetting question asked<br><br>Losing train of thought<br><br>Repeating oneself | Many mental disorders may cause inattention including anxiety, depression and a post-traumatic reaction (whether or not resulting in Post-traumatic Stress Disorder ('PTSD')).<br><br>A situational crisis or severe ongoing stress in the absence of mental disorder may cause preoccupation and distractibility.<br><br>Concentration is generally reduced by intense emotion.<br><br>Fatigue; sedating medication; alcohol and drug abuse; chronic sleep deprivation, sleep disorders; some medical and neurological disorders and traumatic brain injury can all impair attention.<br><br>Pre-existing learning difficulties can reduce attentional capacity.<br><br>Severe malnourishment, both acutely and sometimes permanently, impairs a range of cognitive skills including attention.<br><br>An acute brain syndrome caused by infection (elderly especially vulnerable). |

**SPEECH AND THOUGHT**

| Psychological ability | Consequences of impairment | Condition causing impairment |
|---|---|---|
| **Speech production** | Difficulty with speech production or word finding | Developmental speech disorders; certain acquired brain injuries (aphasias) and neurodegenerative disorders (e.g. dementia).<br><br>Extreme fatigue and acute stress production can reduce speech production and lead to word finding problems.<br><br>The current effects of medication, drugs or alcohol. |
| **Amount of thought expressed** | Reduced production and unelaborated content | Depression and psychotic disorders; aphasia; some types of dementia; language based learning difficulties; moderate to severe traumatic brain injury.<br><br>Exposure to prolonged trauma and abuse through childhood may produce a range of developmental delays, including language comprehension and expressive difficulties.<br><br>An acute brain syndrome caused by infection (elderly especially vulnerable). |
| **Organization of speech and thought** | Speech not logically connected<br><br>Over-inclusive or tangential | Psychotic disorders; traumatic dissociation; elevated mood in bipolar disorder; alcohol related brain injury; moderate to severe traumatic brain injury; other acquired brain injuries e.g. stroke; encephalopathies; some types of dementia.<br><br>An acute brain syndrome caused by infection (elderly especially vulnerable). |

**COMPREHENSION**

| Psychological ability | Consequences of impairment | Condition causing impairment |
|---|---|---|
| **Comprehension** | Difficulty comprehending verbal communication. | Developmental disorders or acquired brain injury ('receptive aphasias'); intellectual disability; some types of dementia; inattention or disorientation due to severe mental illness.<br><br>Prolonged history of childhood trauma or abuse may disrupt development of language skills including comprehension.<br><br>An acute brain syndrome caused by infection (elderly especially vulnerable). |

**AUTOBIOGRAPHICAL MEMORY – the store of memory for personal experiences and acquired knowledge**

| Psychological ability | Consequences of impairment | Condition causing impairment |
|---|---|---|
| **Recent memory (recall of events in previous days and months)** | Impaired ability to recall recent experiences or recently acquired information (e.g. conversations, appointments, read material, names, new routes, placement of belongings).<br><br>(If due to acquired brain injury, dementia, or severe trauma, early memories may be intact but the retention of information from the time of the injury, illness or trauma is impaired) | Many forms of severe mental illness (including PTSD, major depressive disorder) and some forms of acquired brain injury (e.g. stroke, alcohol abuse, traumatic brain injury).<br>Hypoxia through suffocation, cardiac arrest or respiratory arrest, attempted hangings, chemical poisoning, e.g. carbon monoxide, or chronic severe asthma or sleep apnoea.<br>Neurological disorders such as epilepsy, meningitis and other brain infections, and neurodegenerative syndromes e.g. dementia.<br>Severe liver disease.<br>Prolonged periods of malnourishment (including through refusal to consume food) can impair many aspects of cognition including attention and memory functions.<br>Some developmental disorders.<br>The current effects of medication, illicit drugs or alcohol.<br>An acute brain syndrome caused by infection (elderly especially vulnerable). |
| **Long Term Recall:**<br>**(Recall of earlier life experiences and events and knowledge acquired years ago)** | Inability to fully recall previously acquired information, experiences or previous life events. | Some forms of severe acquired brain injury (e.g. stroke, severe brain damage from alcohol abuse, severe traumatic brain injury). An acute brain syndrome caused by infection (elderly especially vulnerable), Psychogenic amnesia due to severe trauma. |
| **Memory for details of events experienced** | Recollection of events is generalized and lacking in specific details. Recollection takes more time and effort. | Severe mental illness including severe depression and PTSD are associated with a tendency to provide generalized recollections rather than distinguishing details.<br>PTSD is often associated with greater inconsistency in peripheral and contextual information than in central narrative content.<br>Severe mental illness is associated with slowing of mental processes including recollection. |

| | | |
|---|---|---|
| **Memory for general knowledge (information gathered from learning and experience rather than memory for specific events)** | In mental illness and acquired brain injury, memory for general knowledge is usually preserved better than memory for specific events. | Specific neurodegenerative diseases (e.g. some forms of dementia) can cause loss of general knowledge.<br>Developmental learning disabilities can affect the learning of general knowledge.<br>A history of childhood trauma can inhibit the learning of general knowledge and academic skills. |
| **Memory for basic autobiographical chronology of events** | Large periods of autobiography cannot be recalled. | In rare cases due to 'suppression' of memory for psychological reasons (psychogenic amnesia) and occasionally due to severe depression or psychosis.<br>As a result of an acquired brain injury (e.g. stroke, alcohol, traumatic brain injury) or medical condition (e.g. liver disease).<br>An acute brain syndrome caused by infection (elderly especially vulnerable) |
| **Memory for events associated with trauma** | Memories are often associated with intense fear, grief, shame or guilt. There may be vivid detail for part of the event; and no recollection for other parts of the event (e.g. lack of contextual detail: exact time, place and sequence).<br>The details of what is recalled may vary over time and with treatment. | PTSD or symptoms of trauma without full diagnosis of PTSD. Psychogenic amnesia.<br><br>Traumatic brain injury at the time of the traumatic event. |

# SCHEDULE: MENTAL STATE AND CAPACITY ASSESSMENT

**Scope and Purpose of the Schedule**

The *schedule on mental state and capacity assessment* (the schedule) for clinicians conducting assessments for the protection visa process was developed in conjunction with the *guidance note on the psychologically vulnerable applicant in the protection visa assessment process* and the two documents should be regarded as complementary.

The information provided in this schedule should inform decisions about applicants' capacity to participate in the assessment of their claims; and what procedural modifications to the conduct of the assessment may be required.

This schedule can be used as a stand-alone assessment of current mental state and capacity by an appropriately trained clinician. It can also be used as a guide to assist in the completion of the mental state examination section of an evidentiary psychological or medical report submitted for the assessment process. It may be either incorporated into a report or appended to a report.

The information collected in the schedule has a different emphasis, organization and purpose to that of a standard mental state examination conducted in a clinical setting. The schedule aims to assist in the documentation of information about mental state that will assist legal representatives and decision makers in their task.

The schedule does not replace a comprehensive psychological or medical report. Whereas the schedule's function is confined to the question of mental state and capacity, psychological and medical reports may serve many purposes in the assessment of an applicant's claims.

**Instructions for completion**

Plain language understood by a reader not trained in a mental health discipline should be used (for example use 'emotion', not 'affect'; 'loss of interest and pleasure in normal activities', not 'anhedonia').

When the schedule is completed on the basis of case file notes, the point of reference is the most recent clinical assessment. Note this may not be the most recent clinical contact.

If during the past two years there has been marked variations in mental state, current mental state should be described and in addition the presence of prior significant

symptomatology not currently present should also be documented and dated. For example, "is able to attend well during an extended interview" could be framed as follows: "when suffering from severe depression one year ago significant distractibility was observed, together with functional impairment in daily life - unable to learn in English classes; frequently misplaced personal belongings …(list)".

Mental state should be described in as much detail as possible with respect to information relevant to interviewing the applicant. For example, rather than simply noting 'distractible' and 'sometimes not communicative', indicate, when available, the practical consequences with examples and could be framed as follows: "the applicant loses her train of thought every few minutes and becomes exhausted and uncommunicative after thirty minutes of an interview".

Ensure that where a mental state element is not commented upon it can be safely assumed that the element is absent. If the element is not commented upon because it was not elicited or observations were limited, "not explored" should be recorded. For example, "for clinical reasons a traumatic memory may not have been explored" rather than documenting an "absence of traumatic memories".

Where the phenomena reported may be attributable to a number of causes, record under the most likely cause. For example, "the applicant reports retaining little of what is read in a newspaper some hours after reading it" could be qualified as "this could be due to an attentional impairment or a retention of new information difficulty".

In making observations under memory for traumatic experiences, traumatic experiences are defined as exposure to the events defined in Criterion A of Posttraumatic Stress Disorder in DSM-5. If details of the trauma are not known, it may be still possible to note the category of the traumas experienced (for example, according to the categories used in the Harvard Trauma Questionnaire).

## 1. SOURCE OF INFORMATION

**Include**

- Whether information is produced by an independent assessor or a treating clinician or compiled from case notes;
- The date(s) of the assessment;
- If information is based on file notes,
  - The date of the most recent clinical assessment; designation and health service of person completing notes;

*Note: Information from other sources may include: educational, psychological and medical.*

## 2. SUMMARY OF PREVIOUS MENTAL HEALTH DIAGNOSES AND TREATMENT RECEIVED

**Include**

- Diagnoses of mental disorder during the past two years and most recent diagnoses;
- Presence of cognitive deficits and whether secondary to mental disorder, brain injury, neurological disorder, developmental disorder, intellectual disability or other cause;
- Purpose of treatment received;
- Nature of treatment* - pharmacological – type of medication only (e.g. anxiolytic); psychological; psychosocial support;
- Period treatment received (commencement and end dates; whether current).

* Treatment includes interventions for trauma related and other conditions where no mental health diagnosis is met.

## 3. ELEMENTS OF MENTAL STATE

## A) ORIENTATION

**Observations: current presence – presence in the past two years**

- In relation to time, place and person;
- Specific examples of disorientation; duration and frequency;
- Situational context for loss of orientation;

  Causes – e.g. severe mental illness; substance intoxication; dissociation; or medical illness.

## B) ATTENTION AND CONCENTRATION

**Observations: current presence - presence in the past two years**

Evidence of impairment in the components of attention:

- Focused attention – difficulty focusing on a task;
- Sustained attention (difficulty holding focus on a task) evidenced by being distractible, losing train of thought; repeating self; not returning to a task after interruption; not persisting with a task or conversation; shifting from one task or thought to another;
- Divided attention (difficulty attending to more than one task at a time);
- Processing speed (performs tasks slowly, 'effortful' attention);

Working memory (difficulty holding in mind information required for use during a task, e.g. dialling a phone number, working out change due).

## C) SPEECH AND THOUGHT FORM

**Observations: current presence - presence in the past two years**

- Rate, tone, intonation;
- Latency – speed of response;
- Spontaneity and fluency (expresses self without prompting; compared to only when prompted);
- Aphasic like symptoms (abnormal pronunciation; poor sentence construction and grammar; neologisms; word finding difficulty; difficulty with comprehension; difficulty following instructions);
- Relevance and focus of responses:
  - Do responses cover subject matter of question or are they poorly organised with a focus on peripheral detail?;
  - Formal thought disorder: over-inclusive, tangential, themes not logically connected (note degree);
- Note if abnormalities are contingent on subject matter or emotional state;

Note if disorganisation causes comprehension difficulties for the interpreter.

## D) SPEECH AND THOUGHT CONTENT

**Observations: current presence - presence in the past two years**

- Responses are monosyllabic or impoverished, compared to normally elaborated;
- Generality and detail of response is congruent with the question asked. Further detail is provided when sought;

- Reticence or guardedness in relation to particular subject matter (name subject matter);
- Vocabulary and sentence structure suggests low intelligence, minimal formal education or poor proficiency in the language;
- The presence of repetitive themes, preoccupations and perseveration which disrupt providing relevant responses;
- The presence of delusions and other abnormal ideation. Note content and extent they disrupt providing relevant responses.

## E) AUTOBIOGRAPHICAL MEMORY

### - RECENT MEMORY

**Observations: current presence - presence in the past two years**

- Ability to recall events of previous days and months and recently acquired information (e.g. conversations, appointments, read material, names, new routes, placement of belongings);
- Completeness of recollection; whether requires prompts.

### - LONG TERM MEMORY/LONGER TERM MEMORY

**Observations: current presence - presence in the past two years**

- Quality of recollection of events across life span: chronology and sequencing; ability to set within a narrative; ability to locate an event in time; recollection of detail and specificity of an event (note generalised descriptions and lack of detail in recollection);
- Speed of recollection;
- Significant amnesia for a period in life;
- A tendency to remember events markedly differently across interviews; or to conflate or substitute events;
- A tendency to avoid recollection of particular events, or to decline to speak of them.

### - MEMORY FOR TRAUMATIC EVENTS

**Observations: current presence - presence in the past two years**

- The traumatic events described (or categories of trauma);
- Able to provide a chronology and sequence of traumatic events, compared to the sequence is disorganised;
- Able to provide details of traumatic events, compared to significant gaps in recall;
- Evidence of avoidance when speaking about traumatic events;

- Strong emotion associated with speaking of traumatic events which disrupts/does not disrupt recounting the events;
- Evidence of emotional detachment and numbing is present when speaking of traumatic events;
- Dissociation occurs (describe extent) when an attempt is made to describe traumatic events;

Memory for traumatic events has been disclosed (or partially disclosed) progressively over time.

## F) BEHAVIOUR WHEN INTERVIEWED

**Observations**

- Note elements of behavioural presentation: attention; engagement and rapport; composure; emotions expressed, their congruency, range and reactivity (note lability, hostility, aggression, threats of self-harm, agitation); disorganised behaviour; any other notable abnormalities in behaviour.

## G) OTHER RELEVANT INFORMATION

**Observations**

- Any other relevant information not already covered that may affect the capacity of the applicant to participate in refugee status determination, e.g.:
  - Current situational crisis;
  - Medical condition ( e.g. Chronic pain syndrome);
  - Presence of any cognitive effects of current treatment (e.g. pharmacotherapy causing sedation, poor attention, impaired memory, restlessness); Problems with substance addiction.

## H) CLINICAL FINDINGS AND RECOMMENDATIONS

**Observations**

- A descriptive summary of current mental state and diagnoses;
- Prognosis;
- A summary of elements of mental state which are likely to reduce the capacity of the applicant to prepare their protection claims and to participate in a protection visa interview;
- Specify in what way capacity is relevantly reduced;
- When reduced capacity is present, recommendations regarding how to manage the applicant's reduced capacity when preparing claims and undertaking a protection visa interview.