

Towards the Restoration of Individualized Assessment of Mental Health in Refugee Law

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This article identifies problems arising from the failure of Norwegian immigration authorities to conduct formal individual assessments of mental health when processing asylum claims. A call is made for incorporation of health professionals in the asylum determination process.

Introduction

Refugee Law is the field of surrogate protection for those who are at risk of persecution in their home countries or third countries. Internationally, this area is undergoing development and influence from mental health practitioners. Through research and expert testimony, they challenge restrictive interpretations of human rights that negate recognition of various forms of persecution and serious harm. This article reviews problems regarding the administrative processing of asylum cases containing testimony affected by psychological stress or cultural misunderstanding. It is suggested that a holistic evaluation of the *non-refoulement* standard (prohibition of return of a person to persecution or torture) requires the combined perspective of law and psychology. Argument is made for inclusion of health professionals and the adoption of Medical-Legal reports as a formal part of the asylum determination process.

Credibility Determination

The 1951 Convention on the Status of Refugees does not require a refugee to be credible in order to receive protection. If there are objective grounds for believing that a person requires protection (such as ethnic origin in a situation of ethnic cleansing) the fact that there is vagueness in his testimony should not be sufficient to deny him protection. It is important to note that the majority of asylum cases are actually rejected on the basis of an adverse credibility assessment. Coffey (2003), Millbank (2009), and Herlihy & Turner (2007) review the criteria used for credibility assessments: demeanour, consistency, and plausibility of facts. They demonstrate how these criteria are affected by cross-cultural communication, distrust of national authorities, shame, reluctance to discuss traumas, and memory disorders. Vloeberghs & Bloemen (2008:61) explain the discrepancy between the mental state of refugees and the approach of immigration authorities in credibility determination interviews:

Memories of traumatic events such as torture can be incomplete. There is evidence that asylum seekers experience a phenomenon known as 'boundary restriction' - a narrowing of focus that causes a failure to remember information that is on the visual or acoustic periphery of the traumatic experience. Asylum authorities, however, often question asylum seekers about peripheral details of traumatic events such as the number of persons or windows in the room where the torture took place, the colour of the uniforms or the wall,

the date or duration of events, and then draw conclusions about credibility on the basis of these details.

In spite of the complexity of these issues, the Norwegian courts rarely overturn credibility determinations by the administrative agencies. The consequence is that there is little oversight of a practice which by its very nature is problematic. A particular concern is that the caseworker writing the decision is not the same person who conducted the interview. There is no guarantee that the asylum seeker will be granted a right to meet with the caseworkers at the initial or appeal levels. Hence, the credibility assessment is conducted within a structure in which the individual is literally kept distanced from the evaluators and there is little review from above or outside the system.

Non-Recognition of Psychological Harm as Indicative of Torture and Persecution

Traditionally in Norway, evidence of post-traumatic stress or other form of psychological harm has been viewed as a double-edged sword. On the one hand, such factors may be interpreted as grounding a finding of past persecution or torture in support of an asylum claim. On the other hand, it may actually have prompted a downgrade of the case from discussion of persecution to reclassification as a «health» case relevant to secondary protection in the form of a permit for compassionate grounds. The (erroneous) logic is that evidence of anxiety originating from past events, including exposure to severe human rights violations, is irrelevant in the analysis of future risk of persecution. The person's interest in remaining in Norway would then be weighed against the state's interest in controlling immigration of persons sharing the same motive of migration, country of origin, socio-economic status, number of dependents, etc. Had the case remained at the level of asylum, immigration concerns would not be taken into account. Thus, asylum seekers in Norway have often been disadvantaged by non-recognition of mental health factors as a *central aspect* of persecution.

In comparison, Montgomery & Foldspang (2005a) have cited concern for the Danish asylum system's tendency to make decisions based on considerations regarding nationality, or bias as regards the socio-economic background, cultural background, or financial security of the applicant. They call for continuous transparent monitoring of the Danish asylum process, in order to ensure that decisions are correctly founded on consideration of human rights violations and traumas related to war and forced migration.

A holistic assessment of the asylum seeker from the mental health perspective is necessary in order to review whether statements and behaviour affecting credibility are actually indicative of past trauma supporting a protection claim

One of the reasons why caseworkers may fail to acknowledge that the anxiety suffered by an asylum seeker may be supportive of «well-founded» fear of persecution in the future is the tendency to fragment the asylum seeker's story into separate parts: pre-flight, flight, post-flight. The focus of such an approach appears to be to the identification of discrepancies, contradictions and gaps wrongly interpreted to indicate adverse credibility. This results in a tendency towards rejection of the claim, rather than structuring an analysis in favour of protection.

Psychological harm (depression/feelings of hopelessness) linked to the forced migration process (such as living in camps, detention/reception centres, being smuggled or trafficked) is usually not

identified or considered relevant to the asylum claim. Obokta (2005) provides a thorough description of the relevant human rights violations experienced by persons subject to smuggling and trafficking. These include: violations of the right to life, liberty, security, health, food, housing, equality, and non-discrimination; as well as freedom from torture, cruel, inhuman, degrading treatment, and prohibition of slavery. Silove, Austin & Steel (2007) examined the mental health impact of indefinite detention upon refugees in Australia. They addressed human rights factors such as the denial of opportunity to study or work, limitation of privacy, the break down of family life, and exposure to derogatory language or treatment by detention centre staff. The study indicates the serious risk of prolonged effects of detention on asylum seekers, in particular, upon the development of children. It calls upon mental health professionals to engage in documentation and research to combat immigration policies which are detrimental to the mental health and human rights of asylum seekers. These issues are indeed relevant to the situation of asylum seekers in Norway and should not be considered peripheral to the determination of the protection claim.

Mixed Motives of Migration

Further problems arise from the fact that refugees often interweave personal or professional aspirations with their testimonies of persecution. This may prompt caseworkers to classify the case as one of socio-economic migrant rather than refugee meriting protection. As confirmed by the United Nations High Commissioner for Refugees (UNHCR) (2007), this is the age of mixed motives for migration. Thus, a protection analysis requires a nuanced approach which recognizes the fact that persecution may be linked to situations involving discriminatory repression or denial of fulfilment of aspirations relating to education or work. The existence of one type of migration motive need not discount the other. There is a need for mental health professionals to explain to caseworkers the tendency of asylum seekers to be reluctant to discuss past harm, and instead identify positive future goals that would demonstrate how they could be a constructive contribution to the host country and a source of strength for their families left behind in the country of origin. Evans Cameron (2009) discusses the psychological and cultural basis for contradictory behaviour among asylum seekers (such as delay in fleeing or return to the country of origin). This is often misinterpreted by caseworkers who cite a lack of subjective fear of persecution. She highlights the following factors: familiarity of risk, variable risk tolerance, optimism bias, passivity in the face of risk, defiance, faith, etc. These criteria require psychological and/or cultural training for proper assessment.

It is important to incorporate an individualized approach to refugee determination which would address the particular forms of psychological harm. This is essential for all asylum seekers, regardless of age

A holistic assessment of the asylum seeker from the mental health perspective is necessary in order to review whether statements and behaviour affecting credibility are actually indicative of past trauma supporting a protection claim. An approach which assesses psychological harm and/or individuals in the form of disconnected components, rather than as a continuum, is unlikely to fulfil expectations of a rights-based protection analysis. The interview's inquiry as to events experienced by the refugee pre-flight, during flight, and post-flight would be improved if the immigration authorities called upon mental health practitioners. It would be beneficial to design specifically formulated questions intended to measure and take into account anxiety, post traumatic stress, and risk of re-

traumatisation as relevant factors for a holistic protection analysis which recognizes the individual's history as interconnected passages rather than separate sections unrelated to each other.

Children as Victims of Persecution or Torture

A recent positive development is that the draft Aliens law §29 (a) refers to psychological violence as constituting persecution. In addition, §29 (f) notes specific ill-treatment directed towards women or children as constituting persecution. The key challenge is to ensure that these categories will actually be recognized in practice. Nevertheless, one may suggest that the law may be in violation of equal protection standards. It includes reference to the protection needs of trafficked women and the «best interests of the child» standard within the section on the permit for compassionate grounds, instead of asylum. Thus, the state may invoke its interest in immigration control to limit the access to protection of these vulnerable persons. There is concern that children are not sufficiently granted procedural and substantive rights regarding presentation and assessment of their asylum claims.

Montgomery & Foldspang (2005b) conducted a study in which they reviewed cases involving refugee children who had experienced war, lived in a refugee camp, experienced detention, had a parent who were subjected to torture, death or disappearance, or witnessed violent events (including house searches, arrest of family, intimidation, torture, killing). The children tended to receive secondary forms of protection, in spite of the fact that it is arguable that they may have qualified for received asylum. In particular, the authors criticize the state's failure to implement the Convention on the Rights of the Child, Article 22, regarding the child's right to participate in decision-making processes relevant to their lives. This perspective is confirmed by the Council of Europe Parliamentary Assembly Report on Promoting the Participation of Children in Decisions that Affect Them (2 June 2008).

In Norway, Liden, Rusten & Aarset (2008) conducted a review of children's right to be heard in immigration cases. They described irregular interviewing proceedings which hindered identification of protection issues related to the child. These practices included: failure to interview children separately from their parents, interruption of the child's testimony, failure to take notes of statements, shift of subject, failure to follow-up questions, failure to interview the child even when his or her protection is a central concern, and failure to recognize the child specific protection concern as the central claim. They also signalled concern for possible re-traumatisation of children by being present during the parent's interview, and failure to identify cases requiring follow-up therapy or investigation. Furthermore, they concluded that the Convention on the Rights of the Child was too narrowly implemented and insufficiently grounded within the decisions. It most often appeared in the form of a standard reference to the best interest of the child, ironically used to reject the case:

Given the data, we have concluded that the Convention on the Rights of the Child is applied exclusively to legitimize rejection: 'The Directorate concludes that the decision is not contrary to the Convention on the Rights of the Child'. Moreover, with the exception of Article 3. 1 on the Best Interests of the Child, Article 9 on the Child's right to a family life, and Article 12 on the right to be heard in any judicial and administrative proceedings affecting the child, the other articles within the Convention on the Right of the Child are not actively taken into consideration within case determination... Within the best interest of the child analysis, there is seldom reference as to how review of the individual concerns of the

child leads to the conclusion that the best interest would be to return the child to the country of origin.

Similarly, Gording Stang (2008) reviewed cases involving allegations of torture by children seeking asylum in Norway. She discussed cases in which the Immigration Appeals Board failed to conduct an analysis of the risk of persecution, torture, inhuman or degrading treatment in relation to the child. This was in spite of evidence of Post-Traumatic Stress Disorder and medical reports indicating possible torture or violent treatment, and/or witness to torture (Ibid:75 &113). Instead, the Board referred only to the parents' situation and actually discounted the evidence of the child's experiences and health problems as irrelevant to the protection determination. In another case, the Immigration Appeals Board conducted a negative credibility determination in a case involving possible sexual abuse of a girl due to vagueness and contradictions in her statements delineating how a soldier had visited her on several occasions and what he had done to her (Ibid:100). Neither the best interests of the child analysis, nor a non-refoulement determination was conducted in relation to the child's experiences. It is essential to ensure that these fundamental standards are always analytically assessed in cases involving children.

In comparison, Tufnell (2003) describes the central role of the Traumatic Stress Clinic in London in cases involving refugee children. It documents what the child has witnessed and the effect of this on their psychological well-being. In addition, the clinic reviews the effect of possible return on the child, the maturity of the child, and impact of the interview process on the child (especially with regard to the risk of re-traumatisation). Tufnell highlights the importance of explaining phenomena such as disassociation, inconsistencies and discrepancies related to trauma that may negatively affect the case if misinterpreted by caseworkers. This serves as a «check» to the administrative agency.

A follow-up of the Norwegian reports, conducted by mental health professionals, would be beneficial. A procedure involving descriptions of the traumatic experiences of children, such as abuse, exploitation, and witnessing atrocities, requires further analysis and discussion. There is a need to apply relevant indicators, such as mental health symptoms for the children. This is necessary in order to comprehend and appreciate the experiences of the child. It can also serve as a means to explain deficiencies within the interview process and suggest a model for correction (See Keselman, Cederbord, Lamb & Dahlsrtrom 2008).

Thus, it is important to incorporate an individualized approach to refugee determination which would address the particular forms of psychological harm. This is essential for all asylum seekers, regardless of age, as there is a clear need for a concrete procedure to document harm and evaluate the present state of health.

Towards Formal Documentation of Stressors and the Adoption of Medical-Legal Reports

The importance of good documentation and description of psychological and physical evidence of torture is clearly argued in the Istanbul Protocol (1999). In paras. 275–285 health professionals are called upon to identify the pre-torture history, post-torture history, and current psychological complaints in order to conduct a complete evaluation of the individual.

In Norway, the Directorate of Health, in consultation with the Immigration Appeals Board, issued a guideline, «Rundskriv» IS-3/2003, which sets forth the criteria for health professionals in the preparation of reports addressing allegations of torture or other forms of extreme abuse/trauma. It is

strange that the guidelines appear to be designed to assess the credibility of the health professional's assessment rather than set forth the framework for a clear communication of medical/psychological evidence of torture and expert clinical evaluation thereof. The criteria are as follows:

- 1 Explanation of the health professional's extent of knowledge of the asylum case. Clarification of whether the asylum seeker's interview/application has been a central part of the diagnosis.
- 2 Date and Description of events. Identification of the source of the background information.
- 3 Description of the patient's physical and/or psychological symptoms.
- 4 Specific and systematic description of the signs of psychological illness.
- 5 Specific and systematic description of physical injuries. Such findings should be documented with photographs, or alternatively by drawings.
- 6 Assessment of the connection between the trauma/injuries and the alleged traumatic events.

The Norwegian guidelines set forth that the reports should *not* include opinions regarding the possibility of treatment in the country of origin or what the result of the asylum/immigration case should be. This complicates the pursuit of holistic analysis in torture cases. The Norwegian guidelines do not appear to seek assessment and documentation of the consequences of torture. Nor do they refer to any of the manuals developed for this purpose: the Istanbul Protocol (Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment of Punishment); the Guidelines for examination of survivors of torture, developed by the Medical Foundation; or A Health Professional's Guide to Medical and Psychological Evaluations of Torture, developed by «Physicians for Human Rights». The guide calls upon health professionals to correlate the degree of consistency between the history of acute and chronic physical symptoms and disabilities, with allegations of abuse. According to the manuals or guides described above health professionals are encouraged to correlate the degree of consistency between examination findings of the individual with knowledge of torture methods and their common after-effects used in a particular region. In addition, they should correlate the degree of consistency between the psychological findings and the alleged report of torture.

With regard to the psychological elements, a medical-legal report should include an assessment of whether psychological findings are expected and typical reactions to extreme stress within the cultural and social context of the individual. This provides a broader scope of analysis which goes far beyond the Norwegian guidelines and may well move into the area which the Immigration Appeals Board deems to constitute «illegitimate» opinions on the desired result of the case.

Further, the Physicians for Human Rights Guide calls for indication of the status of the individual in the fluctuating course of trauma related mental disorders over time, thereby inviting a protection continuum approach. Health professionals are called upon to identify any coexisting stressors impinging on the individual (e.g. ongoing persecution, forced migration, exile, loss of family and social role) and the impact these may have on the individual. The guide's conclusion encourages a statement of opinion on the consistency between all sources of evidence (physical and psychological findings, historical information, photographic findings, diagnostic test results, knowledge of regional practices of torture, consultation reports, etc.) and allegations of torture and ill treatment.

Unlike the Norwegian guidelines, both the Physicians for Human Rights Guide and the Istanbul Protocol specifically recognize that the absence of physical evidence does not exclude the possibility that torture/ill treatment occurred, as there may not be physical scars or marks left behind. The Istanbul Protocol, paragraph 158 notes:

It is important to realize that torturers may attempt to conceal their acts. To avoid physical evidence of beating, torture is often performed with wide, blunt objects, and torture victims are sometimes covered by a rug or shoes, in the case of falanga, to distribute the force of individual blows. Stretching, crushing injuries and asphyxiation are also forms of torture that have the intent of producing maximal pain and suffering with minimal evidence. For the same reason, wet towels may be used with electric shocks.

Paragraphs 286–289, instruct health professionals to consider whether the clinical picture suggests a false allegation. It recommends that in cases where there is an indication of exaggeration or fabrication of a torture claim, additional examinations and documentation by the opinions of two clinicians should be provided. This is due to the fact that inconsistencies may be due to memory impairment, cultural differences in perception of time, dissociation, confusion or repression of memories. In short, whereas the Norwegian immigration authorities view credibility determination as the exclusive domain of the caseworkers; the Protocol suggests that as to the pertaining veracity of a torture claim there is a need for *increased* participation of health professionals, not less.

The UK Medical Foundation for the Care of Victims of Torture's Methodology in the Preparation of Medico-Legal Reports (Cohen & Rhys Jones 2006) provides an example of the medical approach to fabrication:

It is not the role of the report writing doctor to assess credibility. However, doctors do not, even in their everyday practice, accept at face value everything they are told by their patients. For example, amounts of alcohol consumed, exercise taken or severity of pain reported- all these are carefully interpreted by a doctor in the light of their observations of the patient's appearance, mobility and answers to questions exploring ability to function in everyday activities. During the examination Medical Foundation doctors critically assess the account given in relation to the injuries described and the examination findings, in the light of their own experience and the collective experience of colleagues at the Medical Foundation, and may decline to write a report if the account and the findings do not correlate.

The Norwegian Immigration Appeals Board's evaluation of the role of health professionals in this arena is characterized by scepticism as to the quality of the reports. The Immigration Appeals Board (2001/2002) described health professionals as being unable to conduct an objective diagnosis based on concrete findings, precisely due to the prevalence of psychological problems among the asylum seekers. The Board concluded that doctors and psychologists largely base their evaluations on the patient's own statements. This is interpreted by the Board as rendering the health professional's «discretionary evaluation» central; thereby challenging traditional principles of justice, in particular the requirement that similar cases should have the same result. This line of reasoning reveals a profound misunderstanding of the process of psychological/psychiatric/medical evaluation and a direct rejection of the principle of individual diagnosis. The key dilemma is that there is no formal procedure for adoption of a medical-legal report, and the prevalence of distrust of health professionals.

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The UN Committee Against Torture recommends that states abide by the Istanbul protocol as a regular procedure in asylum determinations. A positive development is the publication of a report by the Norwegian Centre on Violence and Traumatic Stress Studies, reviewing the value of the use of psychometric instruments among asylum seekers in Norwegian reception centres and calling for the development of assessment procedures based on self-report and clinical evaluation to detect mental illness (Jakobsen, Sveaass, Eide Johansen & Skogøy 2007). The study revealed that 57.3 % of asylum seekers report having been subjected to torture. The issue is whether the Immigration Appeals Board would discount the merit of any evaluations utilizing self reporting methods.

It should be noted that at the international level, legal standards refer to the importance of considering relevant documentation in asylum cases. For example, the EU Qualification Directive, Article 4 (3), sets forth individual documentation relevant to past or future persecution or serious harm should be taken into account during the protection assessment. Similarly, the UN Committee Against Torture, in General Comment 1, calls for consideration of medical or other independent evidence to support the claim by the author that he/she has been tortured or maltreated in the past. In short, evaluations by health professionals must receive greater recognition by the Norwegian immigration authorities as an integral part of case processing.

The immigration administrative agencies would benefit from the incorporation of procedures in which medical, psychiatric and psychological assessments are formally taken into account

A positive step would be the adoption of Medical-Legal Reports, similar to those produced by the Medical Foundation in the UK and the Medical Examination Group at Amnesty International Dutch Section. Such reports would present a structured assessment of the consistency between the medical findings and the allegations of torture or inhuman treatment (See Bruin, Reneman, & Bloemen, (Ed.s), (2006). Both the European Court of Human Rights and the UN Committee Against Torture have recognized the value of medical reports in the determination of cases involving allegations of torture. In particular, they support the active use of manuals in conducting assessment and documentation of torture. The British Home Office considers that recognition of the torture claim in a Medical-Legal report creates a rebuttable presumption in favour of the claimant.

Conclusion

Norway's draft Aliens law §28 proposes recognition of persons facing a real risk of torture or inhuman or degrading treatment as meriting asylum. This is positive, as it increases the right of asylum to persons normally receiving secondary humanitarian protection. There is a need for increased knowledge on the part of caseworkers, lawyers, and mental health professionals to assess the scope of torture, inhuman and degrading treatment in its various forms.

The immigration administrative agencies would benefit from the incorporation of procedures in which medical, psychiatric and psychological assessments are formally taken into account. Health

professionals should provide assistance in the assessment of concrete cases and help in the design of relevant guidelines in the area of conducting interviews addressing traumatic events. They should receive additional training on the proper examination of torture victims and the physical and psychological consequences of torture. Medical-legal reports should be adopted as a standard tool in all asylum determination procedures.

Finally, the implementation of the draft Alien's law requires a holistic recognition of the scope of mental harm according to age, gender, and cultural background. This is important within the context of persecution, torture, or inhuman treatment; as well as the return, separation, or other consequences of forced migration. It is essential that mental health professionals assist refugee lawyers and caseworkers in restoring an individualized approach to assessing mental health as an integral part of asylum determination and refugee protection in Norway.

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This article identifies problems arising from the failure of Norwegian immigration authorities to conduct formal individual assessments of mental health when processing asylum claims. A call is made for incorporation of health professionals in the asylum determination process and the adoption of Medical-Legal reports.

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