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WORKING PAPER SERIES NO. 100

# **An exploration and critique of the use of mental health information within refugee status determination proceedings in the United Kingdom**

Jenny Barrett ([jennifer.barrett@qeh.ox.ac.uk](mailto:jennifer.barrett@qeh.ox.ac.uk)), Ilim Baturalp ([ilim.baturalp@gmail.com](mailto:ilim.baturalp@gmail.com)), Nath Gbikpi ([nath.gbikpi@gmail.com](mailto:nath.gbikpi@gmail.com)) and Katherine Rehberg ([katherine.rehberg@gmail.com](mailto:katherine.rehberg@gmail.com))

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Refugee Studies Centre  
Oxford Department of International Development  
University of Oxford

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## List of abbreviations

FFT	Freedom From Torture
HBF	Helen Bamber Foundation
ICD	WHO International Classification of Diseases
MLR	Medico-legal report
PTSD	Post-traumatic stress disorder
RSD	Refugee status determination
UKBA	United Kingdom Border Agency

# 1 Introduction

This study seeks to understand the composition, use and cultural orientation of mental health evidence within the UK's refugee status determination (RSD) process. It responds to an increasing importance placed on considering evidence about asylum seekers' mental health within RSD, and a lack of available information about when this evidence is requested and submitted, who is authorised to prepare it, and what it should include. Recognising the cultural heterogeneity of the asylum-seeking population in the UK, this research also explores the extent to which differences in cultural understandings of mental health are accommodated. This exploration provides insight into the construction of "truthful" or "valid" mental health information within RSD. Therefore this study seeks to answer the following two research questions:

1. When, how, and for what purpose is mental health information gathered within RSD?
2. To what extent does the RSD process accommodate varying cultural understandings of mental health?

Analysing data gathered in response to these questions from a constructivist perspective reveals the decision makers' understanding of "credible" and "veracious" evidence.

## 2 Literature review

### **Mental health evidence in RSD**

It has been recognised that asylum seekers' mental well-being may be negatively affected by pre-migration history, the migration journey and the RSD process itself (Silove, Steel and Watters 2000; Palmer and Ward n.d.). Within RSD proceedings, literature suggests that mental ill-health may limit an asylum seeker's ability to provide "credible" testimony, particularly in cases of past experiences of torture or trauma (Henderson and Pickup 2012, Kalin 1986:230, Kneebone 1998, Wilson-Shaw, Pistrang, and Herlihy 2012:2). The 1999 Istanbul Protocol establishes guidelines for investigating and documenting cases involving torture (IARLJ 2010: Section 2.1.2); this includes guidance on conducting mental health examinations and psychological testing in order to "[formulate] a clinical impression for the purposes of reporting psychological evidence" (OHCHR 2004:53). More recently, the 2006 EU-wide Care Full Initiative aimed to improve the quality and uniformity of medico-legal reports (MLRs) in the EU (Vloeberghs and Bloemen 2008). However, UNHCR has expressed concern that "the use and weight of medico-legal reports in asylum procedures vary widely" within different countries' RSD processes (UNHCR, qtd in *ibid.* 2008).

In the UK, the consideration of medical evidence in the asylum determination procedure has been included in the Home Office policy rules (Van Willingen 2008: 135). The UK Home Office explicitly recognises medical evidence provided by Freedom From Torture (FFT) and the Helen Bamber Foundation (HBF) as "objective and unbiased" and as having been undertaken by "qualified, experienced and suitably trained clinicians and health care professionals" (UKBA 2011: 9). However, this guidance is specifically related to medical evidence submitted for the purpose of corroborating claims of torture, and it does not directly address how evidence given for other reasons is to be analysed.

From a more academic perspective, the UK-based Centre for the Study of Emotion and Law has undertaken research into the use of mental health evidence in the UK, including a recent

examination of legal representatives' motivations for deciding to request mental health evidence and the reasons why asylum seekers may be referred for psychiatric assessment during RSD (Wilson-Shaw, Pistrang and Herlihy 2012). However, there are no official guidelines concerning the preferred content, format, and structure of MLRs, and no further literature explaining what is considered to constitute "valid" mental health evidence.

### **The creation of "valid" medical information**

There is, however, an extensive and inter-disciplinary body of literature exploring the relationship between the "objective" articulation of medical findings and the "subjective" experience of the patient (see, for example, Amstrong 1985, Beveridge 2002, Fassin and d'Halluin 2005, King 1982, Malterud 1999). Underpinning this division is a recognition that mainstream biomedicine operates on the "ideal of a dichotomous distinction between the medical symptom and the medical sign" (Malterud 1999:275, see also Foucault 1994, Honkasalo 1991). As Malterud (1999:275) explains, the "sign" is a subjective experience articulated by a patient, whilst the "symptom" is the objective finding discovered by the clinician. In this paradigm, the doctor "is granted a privileged position" built on a contrast between the clinician's "objective, neutral and scientific approach" and the "patient's subjective report" (Beveridge 2002:101). This distinction between the objective and the subjective is rooted in an epistemological claim: the clinician's report represents the "truth" whilst the patient's "is regarded as unreliable, distorted and potentially false" (ibid: 101). As such, "symptoms are considered as secondary subjective reflections of an underlying objective reality" (Malterud 1999:275). Fassin and d'Halluin (2005) explore an implication of this paradigm within the context of RSD. Conceptualising the body as "a place that displays the evidence of truth," they discuss the process through which "medical authority progressively substitutes itself for the asylum seekers' world" (ibid: 597).

### **Cultural construction of mental health**

There is little available literature discussing the treatment of cross-cultural conceptions and perceptions of mental health within UK RSD proceedings. This is true despite an extensive body of literature debating, more generally, the cross-cultural relevance of psychological and psychiatric concepts.

Theoretical positions on the extent to which mental health concepts are culturally bound or universally applicable can be roughly divided into three categories (Baines 2005, Gaines 1992a). This division provides a useful way of conceptualising different perspectives on the relationship between culture and mental health for the purposes of this paper; however these categories should be seen as points along a spectrum rather than being absolute and mutually exclusive.

First is the perspective that understandings of mental health and ill-health are universal. This "universalist" approach to mental health would suggest that illness categories, expressions and treatments can be determined through scientific methods and applied universally. This view was strengthened in the mid-20<sup>th</sup> century, as psychiatry became increasingly focused on treatment methods, including anti-psychotic medication, and it underpins classification and diagnostic tools such as the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the WHO International Classification of Diseases (ICD) (Baines 2005: 144).

A second perspective, shared by the field of transcultural psychiatry, maintains that while categories of mental health may be universal, the manifestation and expression of particular mental health concepts can vary across cultures. This "cross-cultural" perspective "uses Western categories and looks for what are believed to be local permutations" (Gaines 1992a:

4). It assumes that “Western categories and nosologies are universally applicable,” even if expressions may be culturally variable (ibid).

Third is the perspective that views psychiatric concepts as “locally understood, treated, managed and classified” (Gaines 1992a: 4). Rather than considering Western categorisations of disease to be universally “true,” this “ethnopsychiatric” perspective sees Western psychiatry as one of many, equally “valid” systems, of which “one [is] no less culturally constructed than another (ibid).” Thus, it is argued that classifications and effective treatments of psychological illness cannot be “discovered” through scientific means, nor applied universally, but instead are culturally constructed (Gaines 1992b: 4)<sup>1</sup>. Inquiry into the cross-cultural applicability of mental health constructions has been bolstered by the anti-psychiatric movement, which questions the presupposition that “objective” categories of mental illness exist (e.g. Cooper 1967, Foucault 1964, Szasz 1961).

With regard to RSD, this literature is related to debates about the appropriateness of universal diagnoses and labels applied to refugees and survivors of torture and other forms of trauma. It questions whether common Western diagnostic tools are appropriate for use with non-Western populations (Gazioglu and Mitchell 2006, Tempny 2009), and the effects of the application of potentially culturally irrelevant diagnoses (Summerfield 2001: 161). As previously stated though, there is a lack of inquiry into the extent to which non-Western constructions of health are considered within the UK RSD process, and particularly within the production and use of the MLR.

### 3 Methods and methodology

#### Theoretical framework

This project employs a constructivist paradigm, which implies a relativist ontology and a subjectivist epistemology (Denzin and Lincoln 2005). This paradigm underpins our understanding of both “validity” of the MLR, and of conceptions of mental health. With regard to the validity of MLRs, we assume that the UK RSD process dictates what constitutes a “true” or “valid” piece of evidence, and that this construction may differ from another actor’s construction of “validity.” With regard to health, we reject the idea that Western biomedical psychiatric constructions are universally applicable. Though we do not preference either the “cross-cultural” or “ethnopsychiatric” perspectives (as defined above), we do therefore assume that expressions and/or categories of health may vary cross-culturally. It is this paradigm, as well as the aforementioned literature and theoretical debates, which has informed the formulation of our research questions and identification of methods (and may well have informed the data we chose to collect as well).

We acknowledge within this discussion that our analysis of the constructed “validity” is constrained to the type of data we chose to collect. This means that we considered culture to

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<sup>1</sup> As indicated, this definition of the “ethnopsychiatric” perspective is taken from Atwood Gaines’ 1992 *Ethnopsychiatry*. However, as acknowledged by Gaines and others (e.g. Baines 2005), the term “ethnopsychiatry” has been used in different ways over time. It was originally constructed by George Devereux in his 1969 *Mohave Ethnopsychiatry*, and used to refer to both the “cross-cultural” and “ethnopsychiatric” perspectives discussed above (Devereux 1969, Gaines 1992a:4). While acknowledging the many possible meanings of “ethnopsychiatric,” for the purposes of the study we use the term as Gaines has defined it.

be one variable among others that may affect this construction. While we think that this does yield interesting and relevant findings, we do not mean to suggest that there are no other avenues through which to consider what might make “valid” evidence.

## **Methods**

This study is based on data collected from 14 semi-structured interviews conducted with people involved in the creation of MLRs for use in RSD, six documents which provide guidance about the production of MLRs and three MLRs themselves. A list of interviewees, including their abbreviations used for the purposes of this report, can be found in Appendix A.

## **Research population and sample**

Our research population is comprised of three clusters of people involved in the production of mental health evidence: staff of organisations assisting asylum seekers throughout the RSD process; legal representatives requesting medical evidence; and professionals preparing medical evidence. Though there is overlap between these clusters, particularly when medical professionals have organisational affiliations, this tripartite division reflects distinct roles and functions within the process of obtaining and using medical evidence and allows us to gain multiple complementary perspectives.

We undertook purposive and snowball sampling, considering these to be suitable and rigorous methods for the purposes of this project given the relatively small and specialist community of individuals involved in the production of mental health-related MLRs, and due to the ease of identifying experts within this community through desk research. Continuing to conduct snowball sampling during the collection phase allowed us to make contact with a large number of individuals and organisations.

Furthermore, we utilised the UK Register of Expert Witnesses to identify individuals who have provided relevant evidence within RSD<sup>2</sup>, and information about our project was circulated to two listservs by respondents who acted as gatekeepers: the Refugee Law Group listserv, and a listserv of clinicians completing MLRs. Despite the limitations of these methods in providing a representative sample, they helped us to increase the thoroughness of sampling across each cluster.

In total, we made contact with 59 individuals and organisations and conducted 14 interviews. Our sample was comprised of individuals from the following professional backgrounds and organisations: clinical psychologists, psychiatrists, caseworker, barrister, NHS (Traumatic Stress Clinic), UNHCR, British Red Cross, Forced Migration Trauma Service, City of Sanctuary, and private advocates. We interviewed individuals from each of our clusters, although the majority – 8 out of 14 – were individuals who prepare medical evidence.

## **Data collection and ethical considerations**

As stated, our interviews were semi-structured, following a standard interview guide (see Appendix B), which allowed us to address some specific topics identified prior to the interviews, while retaining flexibility regarding the exact order and wordings of our questions (Denzin and Lincoln 2005).

The interviews were designed in accordance with our methodological perspectives and with our particular research questions in mind. After beginning with more descriptive inquiries

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<sup>2</sup> Available at [www.jspubs.com](http://www.jspubs.com)

about the content, use and purpose of medical evidence and MLRs, we then transitioned to questions aimed at gaining insight into the perspectives of each respondent.

All participants received a participant information sheet (see Appendix C) before participating in the study, which outlined the aims of the project and ethical considerations. We obtained oral consent from our participants at the start of the interview (see Appendix D) and reconfirmed their consent throughout the interview process, ensuring on an on-going basis that respondents understood the purposes and uses of our research in line with ethical guidelines of the University of Oxford. We requested permission to record interviews, transcribed the interviews upon their completion, and subsequently destroyed interview recordings. Transcripts were retained for data analysis purposes. All but two interviews were conducted over the phone. All respondents were given the opportunity to request anonymity for the purposes of this research; two interviewees are therefore anonymous in this report. We did not identify any risks to interviewees inherent in participating in this study.

### **Biases and limitations**

As stated, our methods did not allow us to obtain a representative sample of all people involved in the production of MLRs; however, this is not seen as a significant limitation as our study was conceived as a pilot investigation. Our choice of snowball sampling could have led us to be in contact with other individuals who share the same values and approaches as our first contacts; yet upon completion of the project, we feel our respondents did represent a diversity of educational, professional and other backgrounds. We furthermore attempted to broaden our sample by using the register of expert witnesses and the aforementioned listservs.

## **4 Findings and discussion**

### **When, how, and for what purpose is mental health information gathered within RSD?**

Generally speaking, mental health information is gathered on an ad hoc basis during RSD procedures. The UK Border Agency (UKBA) does not provide health assessments nor actively seek to solicit mental health information as a matter of course<sup>3</sup>. A case owner may receive information about an asylum seeker's mental health when asking the standardised and obligatory question "are you fit and well?" during interviews at first instance decision-making (Interview K). However, observations of this question being asked in practice suggest that it is asked in a "token" fashion without any confirmation that the asylum seeker has understood the question (Interview K). In instances where material that might suggest a concern about mental health has been expressed by the applicant, there are in fact no mechanisms in place for a decision maker to ensure that the applicant knows where s/he might go to get help (Interview K). Throughout all interactions with UKBA, the burden appears to fully and entirely lie with the asylum seeker to bring mental health concerns to UKBA's attention (Interview K).

Mental health information becomes mental health evidence when it contributes to the RSD decision-making process. The process of obtaining evidence is most often initiated by the legal representative or organisation supporting an asylum seeker through RSD. It is almost always used in support of the asylum claim, most commonly during appeal proceedings, (Interview

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<sup>3</sup>The only exception is asylum seekers on the detention fast-track, who receive a health assessment as part of the RSD process.

C, K) for one of the following three purposes (IARLJ 2010:2, Interview E, K): firstly, to provide a diagnosis or statement that corroborates events upon which an asylum claim is based (this is generally in relation to torture (Interviews G, E, N, I)); secondly, to evaluate how the client's mental health status may impinge on his or her ability to provide "credible" testimony; thirdly, to provide an assessment of future risks, for example, separation from family or harm upon return associated with an asylum seeker's removal from the UK.

Medical evidence can be provided to the court in different formats, including as short letters or statements addressing one particular issue (Interviews D, H, K, M), but most often this evidence is presented in the form of a longer formal medico-legal report. The MLR is considered to be a "neutral, objective piece of evidence" (UKBA, n.d.) serving a distinctly legal purpose. It is not designed to enable an applicant's access to mental health treatment or support services (Interview I).

Specialised medical organisations such as FFT and HBF or other private medical professionals are most frequently asked to provide MLRs. Most often, the MLR is written after one meeting between the author and asylum seeker, except in cases when the clinician has a prior treatment relationship with the asylum seeker (Interviews A, B, C, D, I, F, M).

Interpreters are frequently employed to assist communication between author and asylum seeker. Respondents expressed multiple views of working with interpreters, ranging from very positive to extremely challenging. Several respondents considered the interpreter an integral part of the MLR production process, viewing them as a type of cultural broker, able to assist the author in understanding the client's cultural background and perspective (Interviews B, C, F).

No particular professional or educational qualifications are required for an individual to be eligible to author MLRs, though a preference for clinical qualifications was acknowledged by some respondents (Interviews E, I, M). MLR authors thus include GPs, psychiatrists, clinical psychologists, other specialist doctors, nurses, social workers, and individuals without clinical training but with extensive experience working with refugees (IARLJ 2010:4, UKBA 2011:9, Interviews A, F).

Despite the lack of precise standards on authors' qualifications, many of our respondents stated that the main requirement of the report author is that the court finds his or her credentials sufficient (Interviews, B, E, F, G). On this point, it is important to note that the UKBA's casework instructions specify that due consideration must be given to the medical expert's opinion, and that no report should be dismissed or given little weight solely on the grounds that the author "is not sufficiently qualified to write it" (UKBA 2011: 17). On the other hand though, a 2004 case law that has not been overridden yet, states: "the consideration given to a report depends on the quality of the report and the standing and qualifications of the doctor" (HE (DRC) vs. SSHD, par. 16).

In addition, our findings also highlighted an absence of standards on more general features of MLRs, including format, length, presentation, language and style. This was reflected in the MLRs we analysed and our interviewees' responses (Interviews G, H, I). However, some basic commonalities between MLRs were evident: all MLRs included the professional qualifications of the author, an assessment of the asylum seeker's mental health condition, and a justification of this assessment using particular diagnostic tools or measurements.

## **To what extent does the RSD process accommodate varying cultural understandings of mental health?**

Our findings suggest that differences in the expression of and explanation for mental health conditions are acknowledged within RSD through the production of the MLR. However, an assumption of the universality of concepts and categories of mental health underpins this recognition.

UKBA has explicitly indicated the importance of considering culturally determined manifestations of health and challenges in communication with asylum seekers from non-Western cultural backgrounds. For instance, a UKBA training guide reminds caseworkers that “in cultures where people are less psychologically oriented and are less inclined to look for emotional explanations to situations it is common to communicate a person’s feelings by presenting physical complaints” (UKBA, n.d.). However, the use of the phrase “less psychologically oriented” presupposes a norm to which it is preferable that individuals are oriented towards, rather than understanding that variations stem from an alternative “folk psychiatry” (Gaines 1992a: 5). This indicates an underlying belief in the universality of the conceptualisation of mental health held by UKBA.

Respondents corroborated this finding, explaining that while cross-cultural variation in the expression of conditions is sometimes seen, differing constructions are not considered to be relevant for the production of the MLR. Several interviewees explained this explicitly (Interviews A, B, D, F), particularly those with academic interest or professional experience in cross-cultural or transcultural issues. Some shared anecdotal information about examples of non-Western manifestations of mental ill-health that they had encountered (Interviews B, H). Others acknowledged the difficulty of creating questions that would lead to the asylum seekers’ thorough understanding of “foreign” concepts (Interviews D, F). Despite this acknowledgement of potential cultural difference, however, all respondents indicated that post-traumatic stress disorder (PTSD), depression, or anxiety were the most common findings of MLRs. There was no indication that non-Western constructions or categorisations of health would be included in medical evidence.

When asked whether it is important for the MLR author to understand the asylum seeker’s own conceptions of health, all respondents indicated that it was, insofar as it enabled the author to understand the client’s own experiences and feelings. One respondent explained the challenge of trying to understand differences in understandings of health and challenges in communication saying, “you ask a question and then you get a very strange answer” (Interview A).

However, despite this agreement among respondents that cultural variation is frequently evident, several interviewees also stated that the client’s particular understanding of their health condition is not relevant to the MLR (Interviews C, F, L). “This doesn’t seem to be relevant to the straightforward question “how can this person get the right to remain in Britain?”” stated one respondent, demonstrating that the purpose of mental health evidence is to support an individual’s claim (Interview L). Thus, our findings indicate that varying cultural understandings are acknowledged within the MLR in order to make the clinician’s diagnosis – which is always of a Western-relevant diagnostic category – more convincing (Interview D).

Because we were interested in the extent to which cross-cultural perspectives were accommodated within RSD proceedings and the MLR itself, we did not attempt to understand the clinician’s own acceptance or rejection of a cross-cultural or ethnopsychiatric approach. In general, however, respondents did not criticise this exclusive use of Western diagnoses. One

notable exception was seen in a respondent who defined PTSD as a “western culture-bound syndrome” that was wholly inappropriate for “non-Western” clients (Interview L). Articulated further in his extensive published work, this respondent’s position offered an important critique of the exclusive use of Western constructions as being not only irrelevant but also imperialistic (e.g. Summerfield 2005).

In summary, legal representatives request MLRs from clinicians on behalf of asylum seekers, and most often for the purposes of an appeal. While individuals involved in the production of MLRs acknowledged that mental health conditions might be expressed, experienced and described differently by individuals from different cultures, they also indicated that non-Western ethnopsychiatry are not relevant for this purpose.

### **Discussion: The construction of “valid” mental health evidence within RSD**

These findings provide insight into the construction of “valid” medical evidence in the context of RSD. From our gathered data, we identify two components central to this construction: first, the perceived credibility of the MLR itself and second, the perceived veracity of the mental health information it contains. The credibility of the MLR is signalled through the qualifications of its author. As stated, authors are required to justify their status as an “expert” to the person assessing the evidence and asylum claim. Our data clearly indicates that authors are aware of this requirement; thorough explanation of qualifications was included in all MLRs we obtained, and two respondents stated this need explicitly (Interview E, I). One interviewee further discussed the need to reinforce and defend her qualifications to the court on occasions when her expertise and qualifications had been challenged (Interview M). This highlights that burden of proof to justify credibility is placed on the report author, but that the court sets the standard required for the author to be deemed credible.

If considered credible, the MLR author thus serves as a gatekeeper to a particular body of knowledge: expert medical evidence. Rooting the validity of this evidence in the credibility of the author shows that the health knowledge preferred in RSD is the knowledge of a particular type of “credible” person. This is further evidenced by UKBA’s statement that “due consideration must be given to the medical expert’s opinion” (UKBA 2011), and the aforementioned recognition that reports from FFT and HBF are “preferred” because they have been authored by “qualified individuals.”

Second, the veracity of the information contained in the MLR is measured by the manner in which it is explained. This hinges on the use of particular tools used to assess and describe mental health. Respondents stated that using certain diagnostic tools makes their reports more valid<sup>4</sup> (Interviews A, D, M). One respondent explained further, saying:

*Our diagnoses are Westernised, we use the Diagnostic and Statistical Manual of the Medical Psychiatric Association, and we use the ICD 10... When you look up a diagnosis in those books, they are from a Westernised way of understanding mental health. (Interview A)*

The MLR author, if deemed credible, is recognised as being the authoritative user of these tools, and therefore permitted by the court to generate “true” information that can be used as evidence as intended. However, respondents also claimed to frame their findings in a certain

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<sup>4</sup> Diagnostic tools referenced with particular frequency in interviews, MLRs and training and guidance materials were the Clinician Administered PTSD Scale; Diagnostic and Statistical Manual of Mental Disorders; International Classification of Disease 10; and the Diagnostic Statistical Manual 4.

way in order to be considered authoritative based on their perceptions of what the decision-maker would think is most “true”:

*The report should be produced within the Western framework, because the judges would have to understand it, but the information and the interpretation would be based on something much richer than it may be now. (Interview 1)*

This reveals the underlying assumption that the use of specific diagnostic tools by a credible professional effectively identifies and describes “truth” about an asylum seeker’s experience and psychological condition.

However, referring back to our finding that authors are frequently aware of and able to consider cross-cultural expressions of health while producing the MLR, the author can also be seen as a type of “cultural broker” for the court. Ensuring that mental health information “makes sense to” the decision maker, the MLR author seeks to understand cultural differences and re-appropriate them into a paradigm that is understandable by the decision maker, and that is considered to be “objective.”

The perception that evidence is “valid,” therefore, can be seen as proportionate to the extent to which the report author is considered to be credible and able to frame and articulate information in a “neutral and objective way.” However, this “objectivity” is an expression of a particular, culturally specific conception of mental health: one that is framed within a Western, biomedical paradigm. As such, the MLR author structures and channels a range of cross-cultural information into a particular, culturally-specific model.

## 5 Future research

Although it responds to several gaps in the literature, this project should be seen as a pilot study which has illuminated several areas for further theoretical and policy-oriented inquiry.

First, as previously mentioned, our analysis of the construction of “valid” evidence was limited to our research questions and framed by the discussion of cultural variation within the MLR production process. Further research into decision makers’ own perceptions of what constitutes “valid” evidence is therefore needed. Though it was outside the scope or purposes of this project to solicit feedback from judges, this would be particularly relevant in light of our findings.

Second, the role of the MLR author as gatekeeper and cultural broker could be further investigated and theorised. While there has been reflection about interpreters as cultural brokers in medical and mental health settings (e.g. Gong-Guy, et al 1991, Singh et al 1999, Davidson 2002), less is available on the role of the medical evidence provider as a similar type of broker.

Any inquiry into cultural brokerage should involve the participation of asylum seekers themselves. For the purposes of this discussion we have assumed, and our data has corroborated, that culture often has some effect on one’s expression or construction of health. However, this assumption could be interrogated with regard to individuals’ and particular

communities' understandings of health. Several respondents indicated that asylum seekers are rarely shown their MLRs after completion (Interviews A, I); doing this could be a useful method for gaining a deeper understanding of the extent to which cultural meaning is translated for the court.

Third, our findings relate to broader theorisation of the role of medical evidence and expert testimony within asylum proceedings (Fassin and d'Halluin 2005, 2007). Recalling the critique of the imperialistic nature of allegiance to Western disease categories, it may be important to further reflect on the implications of the court's construction of validity for the asylum process in general and conceptualisation of refugees more broadly (see, for example Pupavac 2006, Fassin and d'Halluin 2007).

Finally, it was outside the scope of this study to assess the normative value of a cross-cultural or ethnopsychiatric approach. It is obvious that the court must base its decision about asylum claims and the associated pieces of evidence on some type of standardised, shared knowledge. Coming from a Western cultural perspective itself, it may be impractical to allow for a wholly constructivist approach to definitions of mental health. It was not the intention of this inquiry to investigate this further, though our findings do suggest this as an area for future research.

## 6 Conclusion

To conclude, this research has on the one hand filled the informational gap on the process of gathering and using mental health evidence during RSD; and on the other hand explored the extent to which different cultural understandings of mental health have a place in RSD procedures. By addressing these two issues through a constructivist lens, this study has furthermore revealed several assumptions and perspectives underpinning decision makers' perception of "valid" evidence. Mainly, an MLR is seen as "valid" when the author is considered to be credible by decision makers, and when it is articulated in a "neutral and objective way," where "objectivity" is an expression of a specifically Western conception of mental health.

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## 8 Appendices

### Appendix A: Respondent Information

Code	Name	Title and organisational affiliation (if any)	Sampling Cluster
INTV A	Anonymous 1	Chartered Clinical Psychiatrist	Medical professional
INTV B	Anonymous 2	Independent Medical Practitioner - UKCP Registered Psychotherapist	Medical professional
INTV C	Danny Allen	Consultant Adult & Addiction Psychiatrist	Medical professional (formerly)
INTV D	Jocelyn Blumberg	Clinical Psychologist	Medical professional
INTV E	Brock Chisholm	Clinical Psychologist - Forced Migration Trauma Service (FMTS)	Medical professional
INTV F	Lars Davidsson	Consultant Psychiatrist	Medical professional
INTV G	Barbara Harrell-Bond	Legal Anthropologist - Co-Founder of the Refugee Studies Center at Oxford University	Advocate
INTV H	Pam Inder	Chair of 'Leicester, City of Sanctuary	Advocate
INTV I	Piotr Kuhniewicz	Project Worker - British Red Cross (Specialist in Migration & Refugee Support)	Advocate
INTV J	Wendy McManus	Case Worker - Bury Law Centre	Legal professional
INTV K	Sarah-Jane Savage	UNHCR Protection Associate, Quality Initiative Project	Advocate
INTV L	Derek Summerfield	Honorary Senior Lecturer - the Institute of Psychiatry & Chair of Mental Health (previously worked with Medical Foundation)	Medical professional (formerly)
INTV M	Eileen Walsh	Clinical Psychologist - Traumatic Stress Clinic	Medical professional

INTV N	Jo Wilding	Self-employed Barrister	Legal professional
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## Appendix B: Interview Guide

### Purpose of this guide

This interview guide is intended to be used by group members conducting interviews with preparers of medico-legal reports used during the RSD process. Interviews are semi-structured in nature, and interviewers should feel free to rearrange the order of these questions or ask follow up questions not contained here. However, interviewers should ensure that, at minimum, the following topics are discussed.

Interviews will be conducted with members of the medical, psychological, psychiatric and social work professions who complete assessments of the mental health condition of asylum seekers for the purposes of the RSD process. This guide is designed for use in these cases.

Interviews may also be conducted with representatives of advocacy or research organisations (e.g. Centre for the Study of Emotion and Law, Asylum Welcome, Freedom from Torture); people who request medico-legal reports (e.g. advocates, lawyers) or others who support asylum seekers during the RSD process (e.g. community organisations, mental health organisations). This guide may also be helpful for conducting these interviews, but some questions may be more or less applicable.

As it is outside the scope of this project, this guide is unsuitable for use with asylum seekers or families of asylum seekers themselves.

### Interview format

At least two group members should be present for all interviews. If only one person is able to conduct an interview, the reasons for this should be well documented. Interviews should ideally be audio recorded. Informed consent must be obtained prior to the beginning of the interview, including a full explanation given of the aims, objectives and use of the project. Consent should be reconfirmed orally throughout the interview and discussed upon its completion. If interviewees request to stop the interview or to withhold consent for any particular part of the interview, this must be fully accommodated.

### Interview Format:

- Introductions & Overview of MSc program, group research requirement, and proposed research questions
- Informed consent, discussion of recording

NOTE: Questions in *italics* are specifically for lawyers, advocates, and requestors of medico-legal reports, rather than providers. If *italic* text is provided in parenthesis, you may disregard the question in roman text. All other questions are relevant for both providers and requestors.

### Respondent Information

- How long have you worked in your current position/been providing medico-legal reports? (*In what capacity have you requested medico-legal reports or witnessed the use of medico-legal reports in the RSD process?*)

- How long have you been providing medico-legal reports? Approximately how many have you completed? (*Approximately how many times have you requested medico-legal reports or witnessed their use in RSD proceedings?*)

### **Procedure Questions: Medico-legal reports**

- What is a medico-legal report, and what information do reports contain?
- Who is authorised to complete a medico-legal report?
- How are medico-legal reports conducted? (Does the author meet with asylum seeker? For how long?)
- Do you have a sense of how often medico-legal reports are requested? (Roughly what % of asylum claims)?
- What training is available for people preparing medico-legal reports? Training manuals, best practices, templates, handbooks?
- *For what reason would you request a medico-legal report?*
- *From whom would you request a medico-legal report?*

### **Interpretation Questions**

- In your experience, how ‘valid’ are mental health reports? What does ‘validity’ mean in this context?
- How valid do you think your reports are generally considered to be by the court? (*Have any of your mental health experts ever been deemed not credible witnesses?*)
- From your experience as a provider of mental health services (not just as a provider of medico-legal reports), what about the medico-legal report or the process of obtaining the medico-legal report would you change, if anything? (*Based on your experience with medico-legal reports, how would you suggest changing their quality, format, structure, or other?*)
- What are the most common findings, in your experience, of mental health assessments for the purpose of medico-legal reports?

### **Cross cultural issues/transcultural psychiatric perspective**

- Have you ever had difficulty communicating with an asylum seeker you were evaluating? Can you give examples/describe your experience? (*Do you have any knowledge of your client’s satisfaction with their medico-legal report?*)
- How well do you think you understand asylum seekers’ own perception of their mental health condition? Is it valuable to understand their perspective? Does it tend to be the same or different from your own interpretation? (*In your opinion, how similar are the findings of medico-legal reports to your understanding of the asylum seeker’s expression of their mental health condition or situation?*)
- How do you conduct assessments with asylum seekers who do not speak English? (*Any knowledge of how interpretation is provided?*)
- (If there are training materials available for medico-legal report authors), to what extent do they consider varying interpretations of health?
- Based on your experience, to what extent should the medico-legal report process consider non-Western understandings of mental health?

### **Further contacts & medico-legal reports**

- Do you have any ideas/contacts for other people who might be interested in participating in our study?
- We have been able to obtain some anonymised medico-legal reports – do you have any you are able to share? (i.e. reports by participants have been anonymised and necessary procedures have been followed to ensure that it can be shared)

## **Appendix C: Participant Information Sheet**

### **Name of the study**

An exploration and critique of the use of mental health information within refugee status determination proceedings

### **Researchers carrying out the study (name, status, contact)**

*Names:* [REDACTED]

*Statuses:* University of Oxford post-graduate students in MSc in Refugee and Forced Migration Studies

*Contacts:*

- [REDACTED]: email: [REDACTED]; phone number: [REDACTED]
- [REDACTED]: email: [REDACTED]; phone number: [REDACTED]

### **Purpose and value of the study**

This project explores the use of mental health information within the UK's refugee status determination (RSD) process and seeks to understand the extent to which asylum seekers' own perceptions of health and mental health are considered, valued, and understood during mental health evaluations.

### **Why participants are being invited to take part in the research**

*Who we are interviewing:* we are interviewing preparers of medico-legal reports; representatives of advocacy or research organisations; people who request medico-legal reports; others who support asylum seekers during the RSD process.

### **Why participants are being invited to the interview**

You are being invited to participate to our study through interviewing because you belong to one of the categories aforementioned.

### **What the study will involve for participants**

We will interview you to collect information on medico-legal reports (when and how they are used; for what purposes; by who are they conducted) and on your views on medico-legal reports and their validity/usefulness. The interview will be structured in the following manner: ideally two people will conduct the interview; it will last between 45 minutes and one hour; and will be held in a location that suits the interviewee, possibly in a quiet and comfortable environment. You should only be interviewed once, but you can contact us at any time after the interview for follow ups on the project. Subject to your consent, the interview might be recorded.

### **Conditions and ethics**

- You are free to ask any questions about the study before you decide whether to participate.
- If you decide to participate, you may withdraw from the study without penalty at any time by advising the researchers of this decision.
- You may request your anonymity to be preserved; and will be granted it.
- This project has been reviewed by, and received ethics clearance through, the University of Oxford Central University Research Ethics Committee

### **Access to data**

We will store and use data in line with the University of Oxford Central Research Ethics Committee. Each participant will be able to see any of their personal data held by us.

The University of Oxford is committed to the dissemination of its research for the benefit of society and the economy and, in support of this commitment, has established an online archive of research materials. This archive includes digital copies of student theses successfully submitted as part of a University of Oxford postgraduate degree programme. Holding the archive online gives easy access for researchers to the full text of freely available theses, thereby increasing the likely impact and use of that research. If you agree to participate in this project, the research will be written up as a group research project. On successful submission of the project, it will be deposited in print in the University archives, to facilitate its use in future research.

If you agree for your interview to be recorded, we will then transcribe the interview in a written document, and destroy the original recording.

### **Benefits and risks involved in the study**

All participants will receive a copy of the final project.

The project hopes to highlight some of the pitfalls in the current use of medico-legal reports, which should be of benefit for all practitioners in the field.

We did not identify any risk inherent in participation in the project. If you have any concern though, please let us know. If any participant does identify any risk, all future participants will be informed of those felt/stated risks.

### **Procedure for raising concerns and making a complaint.**

If you have a concern about any aspect of this project, please speak to [REDACTED] [REDACTED] who will do her best to answer your query.

If you remain unhappy and wish to make a formal complaint, please contact the Research Ethics Committee at the University of Oxford (ethics@socsci.ox.ac.uk; +44 (0)1865 614871; Social Sciences & Humanities Inter-Divisional Research Ethics Committee, Oxford University, Hayes House, 75 George Street, Oxford, OX1 2BQ, UK).

## **Appendix D: Consent form**

UNIVERSITY OF OXFORD DEPARTMENT OF INTERNATIONAL DEVELOPMENT  
PARTICIPANT CONSENT FORM

### **Name of the study**

An exploration and critique of the use of mental health information within refugee status determination proceedings

### **Name of Researchers**

Nath Gbikpi, Katherine Rehberg, Jennifer Barrett, Ilim Baturalp

### **What will participation involve?**

A single interview conducted by the researchers as outlined in the participant information form.

1. I, the participant, agree to be interviewed for the purposes of this study as outlined in the participant information form;
2. I have understood the purpose and nature of the study, and consent that the data collected as a result of this interview may be used as part of this study;
3. My participation is voluntary and I understand that I may withdraw from participation at any time prior to, during or after the interview process;
4. I agree that any personal data collected as a result of the interview will be held & used in line with University of Oxford's ethics guidelines;
5. I understand that I may ask questions or ask for clarification at any point.

*For the Following, please tick YES or NO*

6. I agree that the interview may be recorded.

YES NO

7. I agree to be contacted via email with additional/follow up questions and understand that I can choose to not reply.

YES NO

8. I understand that should I wish to make a complaint at any point during the course of the research, I may do so through the channels outlined in the participant information form.

9. While the researchers of this experiment have not identified any risks inherent in participation in the project, I agree to contact the researchers with any concerns that may arise during the research.

Name of Interviewee: \_\_\_\_\_

Signature of Interviewee: \_\_\_\_\_

Date: \_\_\_\_\_