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# Identification of asylum seekers with special reception and procedural needs in the Dutch asylum procedure

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# Identification of asylum seekers with special reception and procedural needs in the Dutch asylum procedure

**Marcelle Reneman**

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## List of abbreviations

| | |
|---|---|
| ACVZ | Advisory Committee on Migration Affairs (*Adviescommissie voor Vreemdelingenzaken*) |
| AJD | Administrative Jurisdiction Division of the Council of State (*Afdeling bestuursrechtspraak van de Raad van State*) |
| AVIM | Aliens Police (*Vreemdelingenpolitie*) |
| AZC | Asylum Seeker's Centre (*Asielzoekerscentrum*) |
| COA | Centraal Orgaan Opvang Asielzoekers (Reception Organisation) |
| COC | Dutch NGO for LGBTI rights |
| COL | Central Reception Location (*Centrale Opvang Locatie*) |
| DCR | Dutch Council for Refugees (*VluchtelingenWerk Nederland*) |
| DT&V | Repatriation and Departure Service (*Dienst Terugkeer en Vertrek*) |
| EASO | European Asylum Support Office |
| ECHR | European Convention of Human Rights |
| ECtHR | European Court of Human Rights |
| FMMU | Forensic Medical Association Utrecht (*Forensische Medische Maatschappij Utrecht*) |
| GCA | Health Centre Asylum seekers (*Gezondheidscentrum Asielzoekers*) |
| GGD | Public Health Service (*Gemeentelijke/Gemeenschappelijke Gezondheidsdienst*) |
| GGZ | Mental Health Care (*Geestelijke Gezondheidszorg*) |
| GP | General Practitioner |
| HIS | General Practitioners Information System (*Huisartsen Informatiesysteem*) |
| IBIS | Integral Residents Information System (*Integraal Bewoners Informatie Systeem*) |
| IBO | Reception centre with extra supervision (*intensief begeleidende opvang*) |
| IND | Immigration and Naturalisation Service (*Immigratie- en Naturalisatiedienst*) |
| IRCT | International Rehabilitation Council for Torture Victims |
| JGZ | Youth health care (*Jeugdgezondheidszorg*) |
| Kmar | Royal Netherlands Marechaussee (*Koninklijke Marechaussee*) |
| LGBTI | Lesbian, Gay, Bisexual, Transgender, Intersex |
| MCA | Menzis COA Administration |
| NIFP | Netherlands Institute of Forensic Psychiatry and Psychology |
| NFI | Netherlands Forensic Institute |
| NOC*NSF | Netherlands Olympic Committee |
| POL | Process Reception Location (*Proces Opvanglocatie*) |
| RAPD | Recast Asylum Procedures Directive |
| RRCD | Recast Reception Conditions Directive |
| Rva | Measure provisions asylum seekers (*Regeling Verstrekkingen Asielzoekers*) |
| Rza | Regulation care asylum seekers (*Regeling Zorg Asielzoekers*) |
| UNHCR | United Nations High Commissioner of Refugees |

# 1. Introduction

It is widely recognised that some asylum seekers have special reception needs and/or need special guarantees in the asylum procedure, for example because of their age, family situation, sexual orientation, state of health or the fact that they have been the victim of serious violence. Some of these characteristics (such as age, family situation or disability) are usually visible or will become clear during registration of the asylum seeker.[1] However, it is much more difficult to identify asylum seekers, who have special needs for example because they have been victims of serious violence, suffer from mental disorders or invisible illnesses or are homosexual.[2] Many of them do not disclose their traumatic experiences, psychological problems, medical situation or sexual orientation out of shame or lack of trust.[3] An individual assessment will be necessary in order to identify asylum seekers with special needs and to determine which support should be offered to them.[4]

According to United Nations High Commissioner for Refugees[5] (UNHCR) such an assessment should be conducted systematically and 'at the earliest practicable stage'.[6] In UNHCR's view the early identification of asylum seekers with special needs 'could be critical to the quality of the asylum determination'.[7] It is necessary to ensure that asylum seekers are able to communicate effectively and can safely remain in a reception accommodation and that the authorities are able to gather evidence.[8] Furthermore, it is crucial in order to get access to medical care and treatment.[9]

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[1] Boillat, J. and Chamouton, B., *Protect, Process of Recognition and Orientation of Torture Victims in European Countries to Facilitate Care and Treatment*, ACET and others, p. 40,

[2] See eg IRCT, *Position paper on the Proposal for a recast Reception Conditions Directive (July 2016)*, September 2016, p. 2.

[3] UNHCR, *Annotated Comments to Directive 2013/33/EU of the European Parliament and Council of 26 June 2013 laying down standards for the reception of asylum seekers for international protection (recast)*, April 2015, p. 51, Haker, F., Van Bommel, H., Bloemen, E., *Zorg voor Asielzoekers met Psychische Problemen, Het perspectief van de zorgverlener*, 2010, p. 11.

[4] Flegar, V., *Towards Individualized Vulnerability in Migration Policies*, April 2016.

[5] The Office of the United Nations High Commissioner for Refugees (UNHCR), the UN Refugee Agency, is a global organisation dedicated to saving lives, protecting rights and building a better future for people forced to flee, people forced to flee their homes who have remained in their own country and people without a nationality. From this stems also UNHCR's interest and involvement in developing sustainable asylum systems, for example in EU Member States. In this context, among various responsibilities, UNHCR and its partners look out for people with specific needs, i.e. try to identify those who need extra protection and help, in order for them to receive the targeted assistance and services they need (including but not limited to medical assistance, including mental health support, legal help, and psychosocial support). In the exercise of its supervisory responsibility under its Statute and Article 35 of the 1951 Convention relating to the Status of Refugees, UNHCR advocates to safeguard fundamental human rights by monitoring and trying to improve national asylum laws, practice and institutions.

[6] UNHCR, *Comments on the European Commission's amended recast proposal for a Directive of the European Parliament and the Council laying down standards for the reception of asylum-seekers*, July 2012, p. 17. EASO, EASO guidance on reception conditions: operational standards and indicators, September 2016, p. 40.

[7] UNHCR, *Comments on the European Commission's amended recast proposal for a Directive of the European Parliament and the Council laying down standards for the reception of asylum-seekers*, July 2012, p. 17.

[8] UNHCR, *Annotated Comments to Directive 2013/33/EU*, p. 51. See also IRCT, *Falling Through the Cracks, Asylum Procedures and Reception Conditions for Torture Victims in the European Union*, IRCT 2016, pp. 5-6.

[9] J. Boillat and B. Chamouton, p.36, IRCT, *Position paper on the proposal for a recast Reception Conditions Directive (July 2016)*, September 2016, p. 2.

*Implementation of EU legislation*

The recast Reception Conditions Directive (RRCD)[10] and recast Asylum Procedures Directive (RAPD)[11] require the Member States to identify asylum seekers with special needs within a reasonable period of time after the asylum application has been made.[12] The Netherlands transposed the recast of the Reception Conditions Directive and the Procedures Directive in July 2015. The obligation to identify asylum seekers with special needs was laid down in Dutch legislation.[13] At that time the Netherlands already subjected asylum seekers to a medical examination before the start of the asylum procedure. This examination aims to determine whether there are medical limitations which may interfere with the asylum seeker's ability to make complete, consistent and coherent statements on their asylum motives. However, no formal procedures were put in place to identify asylum seekers with special reception needs.[14]

*High influx of asylum seekers*

At the time of the transposition of the recasted Asylum Procedures Directive and Reception Conditions Directive the Netherlands received a high number of asylum seekers. The Netherlands received 43,093 first asylum applications, mainly Syrians, Eritreans, Afghans and Iraqis.[15] Among these asylum seekers were many (unaccompanied[16]) children[17] and young persons (under 25 years of age)[18]. UNHCR was concerned that, as a result of the 2015 refugee situation in Europe, the protection space in the Netherlands was under pressure.[19] Asylum seekers had to wait for a long period of time before they could start the asylum procedure.[20] Furthermore, most asylum seekers were received in crisis and emergency reception centres, which provided more austere facilities than in 'normal' reception centres.[21] The organisations responsible for the reception of asylum seekers (COA) and for asylum decision-making (IND) had to recruit a large number of new (and sometimes inexperienced) employees.[22] This also applied to the organisations providing information (the Dutch Council for Refugees), guardianship services (Nidos) and health care (*Gezondheidscentrum Asielzoekers,* GCA) to

[10] Directive 2013/33/EU of the European Parliament and of the Council of 26 June 2013 laying down standards for the reception of asylum seekers for international protection (recast) [2013] OJ L 180/96.

[11] Directive 2013/32/EU of the European Parliament and of the Council of 26 June 2013 on common procedures for granting and withdrawing international protection (recast) [2013] OJ L 180/60.

[12] Art. 22 RRCD and Art. 24 RAPD.

[13] Art. 18a Regulation Asylum Seekers and Other Categories of Aliens (*Regeling verstrekkingen asielzoekers*), Art. Article 3.108b Aliens Decree 2000 (*Vreemdelingenbesluit*).

[14] The Netherlands Parliamentary documents TK 2015/16, 34088, nr. 21, p. 27.

[15] IND, *Asylum Trends, Monthly Report on Asylum Applications in The Netherlands and Europe*, January 2016, p. 5.

[16] In 2015, 3859 unaccompanied children applied for asylum in the Netherlands. IND, Asylum Trends, January 2016, p. 8.

[17] In 2015, 12,262 children (under 18 years) applied for asylum in the Netherlands. See the Netherlands Parliamentary documents TK 2016/17, 34 334, nr. 24, p. 3.

[18] In 2015, 13,893 young persons (18-25 years) applied for asylum in the Netherlands. See the Netherlands Parliamentary documents TK 2016/17, 34 334, nr. 24, p. 3.

[19] Conversations with UNHCR staff, UNHCR the Netherlands, August/September 2016.

[20] In November 2016 the expected waiting time was six months. State Secretary of Security and Justice, Letter explaining asylum seekers about the reception conditions and the waiting times in the asylum procedure, November 2015.

[21] Ibid.

[22] The Netherlands Parliamentary documents TK 2016/17, 34 550 VI, nr. 11, p. 125.

asylum seekers. This raised the question whether, in particular in this period, the Dutch authorities were able to identify asylum seekers with special needs and whether an appropriate response could be provided.

Even though the influx has decreased[23] and the crisis and emergency reception centres have been closed now[24], the consequences of the high influx can still be noticed. The Dutch Government introduced a special asylum procedure for applications with low chances of success: persons originating from safe countries of origin and granted asylum in another EU Member State. This procedure is faster and offers less procedural guarantees than the general asylum procedure which is applied to most asylum cases and takes eight days from the first interview until the decision.[25] Moreover, reception centres have been closed which leads to (new) relocations of asylum seekers.[26] The waiting times in the asylum procedure have decreased. However in November 2016, the average (expected) period which an asylum seeker would spend in a reception centre was still 12 months.[27]

### 1.1 Research question and scope of the research

This study aims to examine the following questions:

- How do the Dutch authorities identify asylum seekers with special needs?
- What sort of reception facilities, medical care and procedural guarantees are offered to asylum seekers with special needs?
- Can the process of identification and the provision of special facilities and guarantees and/or medical services be improved and if so, how?

These questions will be answered on the basis of the situation in the Netherlands in the period of research: August 2016 - June 2017. The study also pays attention to the particular difficulties the organisations involved faced in the period of high influx. For the purpose of this study we consider the period of high influx, the period in which crisis and/or emergency reception centres were used (from July 2015 until December 2016). Where the findings or conclusions concern only the period of high influx, this will be explicitly mentioned in the report.

*Limitations of the research*

The scope of this study is limited in several ways. First, it will only focus on the identification of asylum seekers with special needs in the period before the start, and in the early stages of the asylum procedure. It will not address identification in return proceedings. It will only briefly discuss the specific situation of asylum seekers who find themselves in detention during the asylum procedure.

Second, the research will mainly address the activities of the Reception Organisation (COA) and the Immigration and Naturalisation Service (IND), because they have the responsibility for the reception

[23] The Netherlands received 7,020 first asylum applications in the first half of 2017 and 18,171 applications in 2016. IND, Asylum Trends, January 2017, p. 5, Ministerie van Veiligheid en Justitie, Rapportage Vreemdelingenketen, januari-juni 2017, p. 19.
[24] The Netherlands Parliamentary documents TK 2016-2017, 34 550 VI, nr. 11, p. 126.
[25] Art. 3.109ca Aliens Decree 2000.
[26] In 2017 45 COA locations will be closed. See COA, Opvangcapaciteit COA voor eind 2017 naar 31.000 plaatsen, 26 April 2017.
[27] The Netherlands Parliamentary documents TK 2016/17, 34 550 VI, nr. 11, pp. 125-126.

of asylum seekers and the asylum procedure respectively. It will only briefly touch upon the activities of other authorities such as the Aliens Police (AVIM) and the Royal Netherlands Marechaussee (Kmar), who also have a responsibility in the identification of asylum seekers with special needs. The research will also assess the work of organisations who perform tasks under the authority of COA and IND, such as GCA, which (until 1 January 2018) provided primary health care to asylum seekers and various organisations providing medical advice in the context of the asylum procedure. Finally, it will touch upon the work of other important players in the asylum system such as Guardianship organisation Nidos, the Dutch Council for Refugees and lawyers.

This study has taken into account literature, reports and case law until 1 June 2017. The study was finalized in October 2017. Developments from October 2017 until the moment of publication of this report, for example with regard to the proposed reforms of the Common European Asylum System are not included in the study.

Finally there are limitations as to methodology, which will be discussed in the next section.

## 1.2 Methodology

The research is based on a review of literature and reports about the Dutch reception system, medical care and asylum procedure. Furthermore, we examined legislation, policy documents, parliamentary documents and case law. In order to see how asylum seekers with special needs are identified and offered special facilities and/or guarantees in practice we interviewed 32 stakeholders working for different organisations in the asylum process and talked to three more stakeholders about specific questions (see for an overview Annex 2). These sources were used for the purpose of all chapters included in this report.

In addition to these sources, in the context of the chapters regarding the Medical advice interviewing and decision-making (Chapter 3) and the Forensic medical examination (Chapter 4), a limited number of medical advice have been assessed. The chapters on reception conditions (Chapter 5) and medical care (Chapter 6) incorporate information from UNHCR which they collected during monitoring visits to and participatory assessments in reception centres in the Netherlands. Information resulting from these monitoring visits and participatory assessments was shared with the researcher during meetings in August and September 2016.[28] In the context of the chapter on special procedural guarantees (Chapter 7) access was obtained to the EASO Module Interviewing Vulnerable Persons and the practical training belonging to this module was attended together with IND officers. See Annex 1 for a more elaborate description of the methodology.

The methodology used has several important limitations. First, the description of the application of legislation and policy in practice is mainly based on reports and the information obtained from the interviews. We did not examine case files, attend IND interviews or observe medical examinations or daily practice in the reception centres. As a result we cannot give a complete picture as to how asylum seekers with special needs are identified and offered special facilities and/or guarantees in practice.

[28] Conversations with UNHCR staff, UNHCR the Netherlands, August/September 2016.

However, this report does provide a good image of the issues which are considered (un)problematic in practice by the different stakeholders working in the field of asylum.

Second, the point of view of asylum seekers has only been taken into account to a limited extend. The view of asylum seekers was only included through reports of research in which asylum seekers were interviewed and the UNHCR information concerning participatory assessments held in 2016.[29]

### 1.3 Vulnerability or special needs?

This study focuses on special needs of asylum seekers rather than on 'vulnerability'. The term 'vulnerable' is vague and its meaning has been widely discussed in earlier publications.[30] Sometimes, all asylum seekers are described as being vulnerable[31], for example 'due to migration and loss of family, friends, home and properties'[32], because they 'are dependent on the country and society which receives them'[33] or because they have another cultural and linguistic background and often a worse state of health and find themselves in an uncertain position[34].

Furthermore, often different groups of asylum seekers are considered vulnerable.[35] The recast Reception Conditions Directive defines the following categories as vulnerable asylum seekers: 'children, unaccompanied children, disabled people[36], elderly people, pregnant women, single parents with minor children, victims of human trafficking, persons with serious illnesses, persons with mental disorders and persons who have been subjected to torture, rape or other serious forms of psychological, physical or sexual violence, such as victims of female genital mutilation'.[37]

However, there is a risk that labelling groups of asylum seekers as vulnerable leads to over generalisation: not all members of a 'vulnerable' group have (the same) special needs. Also it does not recognise that persons who do not belong to one of the recognised categories of vulnerable persons may have special needs on the basis of their individual circumstances.

In EU legislation there seems to be a change of focus from vulnerability to special needs. The recast Reception Conditions Directive and recast Procedures Directive make a distinction between

[29] Ibid.
[30] See for example M. Mustaniemi-Laakso, M. Heikkilä, E. Del Gaudio and others, 'The protection of vulnerable individuals in the context of EU policies on border checks, asylum and immigration', *Frame,* 31 May 2016, M.A. Fineman, 'The Vulnerable Subject: Anchoring Equality in the Human Condition', *Yale Journal of Law and Feminism*, 2008.
[31] ECtHR 21 January 2011, Appl no. 30696/09, *M.S.S. v Belgium and Greece*, para. 251. See also M. Mustaniemi-Laakso, M. Heikkilä, E. Del Gaudio and others, pp.14-16.
[32] Boillat, J. and Chamouton, B., p. 40.
[33] Flegar, V., *Towards Individualized Vulnerability in Migration Policies*.
[34] Van Willigen, L., *Zorg voor Asielzoekers met Psychische Problemen*, Literatuurstudie, ASKV, December 2009, p. 27, Ikram, U. and Stronks, K., *Preserving and Improving the Mental Health of Refugees and Asylum Seekers, A Literature Review for the Health Council of the Netherlands*, February 2016.
[35] M. Mustaniemi-Laakso, M. Heikkilä, E. Del Gaudio and others, pp. 16-18, Flegar, V., *Towards Individualized Vulnerability in Migration Policies*.
[36] See also Crock, M., McCallum, R. and Ernst, C., *Where Disability and Displacement Intersect*, International Association of Refugee Law and Judges World Conference, 2011, p. 1.
[37] Art. 21 Directive RRCD. Art. 31(7)(b) RAPD refers to the categories mentioned in the Reception Conditions Directive.

vulnerable categories of persons and persons with special reception or procedural needs. However, they seem to imply that only asylum seekers belonging to a vulnerable group can have special needs.[38] The proposal for the Reception Conditions Directive of 2016 no longer limits the definition of asylum seekers with special needs to those belonging to a vulnerable group.[39] Also the EASO guidance on reception mentions that the definition of 'special needs' shall not be limited to the categories of asylum seekers mentioned in the Reception Conditions Directive 'but rather include any asylum seeker showing any special reception needs. Gender, gender identity and sexual orientation are particular factors to be taken into account in this regard'.[40]

For these reasons research thus examines how COA, the IND and other organisations in the asylum system identify which individual asylum seekers have special needs, instead of which asylum seekers belong to a vulnerable group.

### 1.4 Outline of the report

This report consists of two parts. The first part (Chapters 2-4) focus on the identification of special needs. The second part (Chapters 4-7) examine how special needs are taken into account in the reception system (reception facilities and medical care) and the asylum procedure. Each chapter is followed by a conclusion.

**Part 1: Identification of special needs**

This report describes in **Chapter 2** how the Dutch authorities in cooperation with lawyers, NGO's and other organisations involved, identify asylum seekers with special needs. It shows which methods are used by the different organisations working in the field and how information regarding vulnerability is registered by and exchanged between these organisations.

**Chapters 3 and 4** will address two types of medical screening/examination which are used during the asylum procedure. **Chapter 3** focuses on the Medical advice interviewing and decision-making (*Medisch advies horen en beslissen*), which is used to identify persons who have medical limitations, which may interfere with their ability to make coherent, consistent and complete statements during the asylum interview. **Chapter 4** concerns the *Forensic medical examination* (*Forensisch medisch onderzoek*), which examines the causal relation between the asylum seeker's scars, physical or psychological scars and the alleged events in the country of origin.

[38] Art. 2(k) RRCD defines an asylum seeker with special reception needs as 'a vulnerable person, in accordance with Article 21, who is in need of special guarantees in order to benefit from the rights and comply with the obligations provided for in this Directive'. Art. 22(3) RRCD provides: Only vulnerable persons in accordance with Article 21 may be considered to have special reception needs and thus benefit from the specific support provided in accordance with this Directive. The Procedures Directive mentions characteristics which may indicate that a person is in need of special procedural guarantees. Point 29 Preamble Directive RAPD.
[39] Proposal for a Directive of the European Parliament and of the Council laying down standards for the reception of asylum seekers for international protection (recast), 13 July 2016, COM(2016) 465 final, Art. 2(12). This change of focus in the proposal is welcomed for example by IRCT. IRCT position paper on the Proposal for a recast Reception Conditions Directive, July 2016, pp. 2, 4.
[40] EASO, *EASO guidance on reception conditions*, p. 9. See also p. 41.

**Part 2: Taking into account special needs**

**Chapter 5** discusses how COA takes into account special reception needs. It will explain the reception system and how COA generally takes into account special reception needs. Furthermore, it pays attention to the facilities offered to specific groups, such as asylum seekers with psychological and/or behavioural problems, unaccompanied children, families with minor children and LGBTI asylum seekers. It will also address the relocations of asylum seekers and the activities offered to asylum seekers during their stay in the reception centres.

**Chapter 6** explains how health care for asylum seekers has been organised in the Netherlands and sets out the organisations involved and the principles underlying this system. It addresses the manner in which asylum seekers are informed about the Dutch health care system and about mental health care and the measures taken in reception centres to prevent psychological problems of asylum seekers. It discusses the health care offered to asylum seekers, including medical care at the reception centres, youth health care and support and specialist mental health care and the accessibility of medical care in practice.

**Chapter 7** discusses which special procedural guarantees are offered to asylum seekers by the IND. It will especially address prioritisation and the application of the border procedure, accelerated asylum procedures, the general asylum procedure and the extended asylum procedure. Furthermore, it will examine which special measures may be taken during the asylum seeker's interview with the IND. Finally it will be assessed how the IND takes into account the (potential) psychological problems of the asylum seeker and medical evidence in its decisions.

**Final remarks**

In **Chapter 8** some general final remarks will be made.

## 2. Identification of asylum seekers with special needs

### 2.1 Introduction

Asylum seekers can only be offered the necessary procedural guarantees and support or reception facilities, if their special needs are identified.[41] Both the recast Reception Conditions Directive and the recast Asylum Procedures Directive require the EU Member States to identify asylum seekers with special needs within a reasonable period of time after the asylum application has been made.[42]
This chapter first sets out the international legal framework (section 2.2.) and UNHCR's position (section 2.3) with regard to the identification of special needs. It discusses how the Dutch authorities, in cooperation with lawyers, NGO's and other organisations involved, identify asylum seekers with special needs. It shows which methods are used by the different organisations working in the field (section 2.4 and how information regarding vulnerability is registered by those organisation (section 2.5) and exchanged between them (section 2.6). Chapters 3 and 4 will address two types of medical screening/examination which are used during the asylum procedure and are designed to identify specific types of asylum seekers with special needs.

### 2.2 International legal framework

Article 22(1) of the recast Reception Conditions Directive (RRCD) provides that Member States shall assess whether the asylum seeker has special reception needs and indicate the nature of such needs. It states: 'That assessment shall be initiated within a reasonable period of time after an application for international protection is made and may be integrated into existing national procedures'. Similarly Article 24(1) recast Asylum Procedures Directive (RAPD) requires Member States to 'assess within a reasonable period of time after an application for international protection is made whether the asylum seeker is an asylum seeker in need of special procedural guarantees'.[43]

Both directives make clear that a person's special needs should be monitored throughout the procedure.[44] If such needs become apparent at a later stage in the asylum procedure they should be addressed.[45] This does not necessarily mean that the asylum procedure needs to be restarted.[46]

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[41] See also Proposal for a Regulation of the European Parliament and of the Council establishing a common procedure for international protection in the Union and repealing Directive 2013/32/EU, COM(2016) 467 final, pp. 14-15.
[42] Directive 2013/33/EU of the European Parliament and of the Council of 26 June 2013 laying down standards for the reception of asylum seekers for international protection (recast) [2013] OJ L 180/96, Art. 22 and Directive 2013/32/EU of the European Parliament and of the Council of 26 June 2013 on common procedures for granting and withdrawing international protection (recast) [2013] OJ L 180/60, Art. 24.
[43] See also EASO, *EASO guidance on reception conditions: operational standards and indicators*, September 2016, p. 40, where it is stated as an indicator that the initial identification and assessment of special needs is conducted as soon as possible and Proposal for a Directive of the European Parliament and of the Council laying down standards for the reception of asylum seekers for international protection (recast), 13 July 2016, COM(2016) 465 final, Art. 21(1) and Proposal for a regulation establishing a common procedure for international protection in the Union and repealing Directive 2013/32/EU, COM(2016) 467 final, Art. 20(1).
[44] See also EASO, *EASO guidance on reception conditions*, p. 40.
[45] Art. 22(1) RRCD.
[46] Art. 24(4) RAPD. See also COM(2016) 465 final, Art. 21(1) and COM(2016) 467 final, Art. 20(1).

Both the Reception Conditions Directive and the Asylum Procedures Directive leave it to the Member States how they want to assess vulnerability during the asylum procedure: they do not need to introduce a special administrative procedure.[47] The assessment in the context of the asylum procedure may also be 'integrated into existing national procedures' and/or into the assessment which is required by the Reception Conditions Directive.[48] EASO states in its guidance on reception that a 'standardised mechanism to identify and assess special reception needs of any asylum seeker' should be in place and effectively applied.[49]

Under the Dublin Regulation Member States are obliged to exchange information about special needs and the measures, which should be taken to address these special needs (including access to health care) in the receiving Member State.[50]

### 2.3 UNHCR's position

UNHCR has recognised the importance of early identification of vulnerable persons in the context of detention and reception conditions.[51] The UNHCR Handbook and Guidelines on Procedures and Criteria for Determining Refugee Status provides that where the officer examining the asylum application is confronted with an asylum seeker having mental or emotional disturbances he should, whenever possible, seek medical expert advice. This advice should 'provide information on the nature and degree of mental illness and should assess the asylum seeker's ability to fulfil the requirements normally expected of an asylum seeker in presenting his case'.[52] UNHCR also stated that

> [w]hile identification and referral are integral parts of registration procedures, opportunities for identification and referral may arise at any stage in the case management process. Following identification, a person should be counselled on all of the options available to them. After counselling, a person can be referred – with his or her agreement – to one of a number of processes and procedures to meet any immediate needs, and/or for further consideration of his or her situation.[53]

### 2.4 Methods of identification of persons with special needs in the Netherlands

In the Netherlands, the main organisations responsible for the identification of persons with special needs are the Central Agency for the Reception of Asylum Seekers (COA, where it concerns reception conditions) and the Immigration Service (IND, where it concerns the asylum procedure). However,

[47] Art. 22(2) RRCD and Art. 24(2) RAPD.
[48] Art. 24 (2) RAPD.
[49] EASO, *EASO guidance on reception conditions: operational standards and indicators*, September 2016, p. 40.
[50] Regulation No 604/2013 of the European Parliament and of the Council of 26 June 2013 establishing the criteria and mechanisms for determining the Member State responsible for examining an application for international protection lodged in one of the Member States by a third-country national or a stateless person (recast) [2013] OJ L180/31, Artt. 31(2)(a) and 32(1).
[51] UNHCR, International Detention Coalition, OAK foundation, *Vulnerability Screening Tool, Identifying and addressing vulnerability: a tool for asylum and migration systems*, 2016, p. 1.
[52] UNHCR, *Handbook and Guidelines on Procedures and Criteria for Determining Refugee Status, Reissued Geneva*, December 2011, para. 208.
[53] UNHCR, *The 10 point plan in action,* 2016, p 119.

there are other organisations which take part in the process of identifying special needs. Some of them are government organisations, such as the Aliens Police and the Royal Netherlands Marechaussee. Others are NGO's, organisations, companies or individuals which perform tasks in the asylum procedure which are paid for by the government:

| | |
|---|---|
| Health Centre Asylum Seekers (GCA) (*Gezondheidscentrum Asielzoekers*[54]) | Provides primary health care to asylum seekers under the responsibility of COA |
| Forensic Medical Society Utrecht (FMMU) (*Forensische Medische Maatschappij Utrecht*) | Screens whether the asylum seeker has medical problems, which may limit his ability to make complete, coherent and consistent statements. |
| Nidos | The guardianship organisation for unaccompanied children |
| The Dutch Council for Refugees (DCR) (*VluchtelingenWerk Nederland*) | Provides information and advice to asylum seekers about the asylum procedure |
| Lawyers | Provide legal assistance to asylum seekers in the asylum procedure |

In detention centres the guards and the medical personnel have a role in the identification of vulnerable asylum seekers.

This section will address the methods for the identification of special needs, used by COA, IND, GCA, lawyers, the Dutch Council for Refugees and Nidos. However, it should be noted that other organisations such as the Aliens Police or the Royal Netherlands Marechaussee have a responsibility in the identification of asylum seekers with special needs. This also applies to (volunteer) organisations who offer activities to asylum seekers in reception centres[55] or schools[56].

### 2.4.1 Identification of special reception needs by COA

The duty laid down in Article 22(1) RRCD to identify asylum seekers with special reception needs has been transposed in Article 18a of the Regulation Asylum Seekers and Other Categories of Aliens (*Regeling verstrekkingen asielzoekers,* Rva). This provision states that COA ensures that during the stay in the reception centre the specific situation of vulnerable persons is taken into account. In this context COA assesses whether the asylum seeker has special reception needs.

[54] From 1 January 2018 the current tasks of GCA will be carried out by another organisation, Arts en Zorg. See section 6.2.2.
[55] Drogendijk, A. et al, *Veerkracht en Vertrouwen, De bouwstenen voor psychosociale hulpverlening aan vluchtelingen*, Arq Psychotrauma Expertgroep, May 2016, p. 30. Interview Red Cross.
[56] Drogendijk, A. et al, p. 33.

The State Secretary of Security and Justice (the State Secretary) did not want to introduce formal proceedings for COA to assess special reception needs and only implemented a duty of care. In his view the introduction of formal proceedings was not desirable because of the administrative burden it would cause. Furthermore, he preferred to provide tailor-made reception facilities on a practical level and to maintain a system which, in his view, works well in practice.[57] The State Secretary also stressed the importance of the role of all COA officers as confidential counsellors. Asylum seekers should have easy access to COA officers in order to talk about their problems.

The State Secretary has introduced coordinating confidential counsellors in all reception centres in response to the concerns about the safety of LGBTI asylum seekers and other vulnerable asylum seekers in the reception centres. They should be able to answer questions of colleagues and asylum seekers, have an overview of all (confidential) reports of incidents regarding LGBTIs at the reception centre and discuss whether incidents should be reported to the police.[58] They are also the contact point for external organisations.[59]

*Types of COA officers*

There are four types of COA employees working at the reception centre, who have a different type of contact with an asylum seeker. They may all pick up signals of special needs. Home counsellors (*woonbegeleiders*) see asylum seekers during their daily life at the centre. They regularly (every six weeks) visit the asylum seekers' rooms. Programme counsellors (*programmabegeleiders*) provide information and training to asylum seekers in groups or individually. Case managers discuss future perspectives (integration or return) with asylum seekers.[60] Finally, care takers (*huismeesters*) coordinate the practical tasks in and around the reception centre and involve asylum seekers in certain activities.

*COA's assessment tool: six domains*

It is COA's task to create a safe place and an adequate standard of living for asylum seekers. Furthermore, collecting signals about medical problems is part of the health care guidance task of COA.[61] One COA officer stated that collecting signals is a matter of attitude and not so much of knowledge. She said that it is the task of every COA officer, including for example the care taker of the reception centre.[62] She described this task as 'ears and eyes open, what do you notice?'. [63]

COA assesses the situation of and provides support to the asylum seekers living in COA reception centres in six domains (or competences), which are necessary to cope with the daily life at the reception centre.[64] The six domains tool, which was first implemented in 2013-2014, helps COA to get to know the asylum seekers and to decide whether COA should intervene.[65] The tool was developed

[57] The Netherlands, Parliamentary documents, TK 2015/16, 34088, nr. 21, p. 27.
[58] The Netherlands, Parliamentary documents, TK 2015/16, 19637, nr. 2179, pp. 6-7.
[59] The Netherlands, Parliamentary documents, TK 2016/17, Aanhangsel van de Handelingen, nr. 1078, p. 2.
[60] Interview COA 1.
[61] Interview COA 2.
[62] Interview COA 2.
[63] Interview COA 2.
[64] COA, De 6 domeinen van de methodiek. Interview COA 1.
[65] Interview COA 1.

by COA and partners such as Mindspring[66] and Healthnet TPO[67] which have expertise in providing psycho-social care to asylum seekers and refugees.

| **Domain** | |
|---|---|
| Personal care | - Is able to carry out personal hygiene<br>- Can take care of their own room, environment, money and possessions<br>- Takes care of his own meals |
| Daily activities | - Plans and controls daily activities<br>- Chooses activities which are useful and feasible in the context given<br>- Carries out optional and obligatory activities during the day |
| Social network | - Has contact with persons in their environment, including COA employees<br>- Has basic social skills which are necessary when living together with others<br>- Can maintain contact and relations with family and friends/acquaintances |
| Personal well-being | - Can properly cope with emotions and tensions in case of a setback, seeks solutions for problems<br>- Can adapt behaviour in interactions with others and act according to the context of living together<br>- Can control, seek treatment for, or accept personal problems and complaints |
| External contacts | - Can plan necessary contacts outside of their direct environment<br>- Can arrange meetings and live up to agreements<br>- Can travel independently |
| Planning of the future | - Can think about and discuss plans for the future<br>- Can carry out a plan for the future<br>- Can cope with developments in the asylum procedure |

The home counsellor, programme counsellor and the case manager may have a different impression of an individual asylum seeker. For that reason they discuss the situation of individual asylum seekers, in particular where there are concerns, on the basis of the six domains tool. Eventually they also 'grade' the asylum seeker for each domain. This helps to get a complete picture of a person. If an asylum seeker scores low in one of the six domains, COA officers discuss what should be done.[68] On

[66] See for information: http://mind-spring.org/.
[67] See for information: http://www.healthnettpo.org/nl/.
[68] Interview COA 1.

the basis of the six domains tool, asylum seekers can also be referred to a special reception centre with extra supervision (*Intensief begeleidende opvang*, IBO).[69]

Despite of the existence of the six domains tool several organisations have been critical about the assessment of special needs by COA. The Netherlands Institute for Human Rights noted in February 2016 that a general policy to recognise asylum seekers with special needs was still lacking. It recommended to introduce such policy in order to ensure that COA systematically assesses special needs of asylum seekers and does not only respond to incidents.[70] Furthermore, the Advisory Board on Aliens Affairs (ACVZ) advised COA to use a screening tool in order to recognise asylum seekers with psychological problems and to ensure that this information is available during the asylum procedure.[71]

COA recognises that during the period of high influx it was not able to systematically implement the six domains tool.[72] Now the application of the six domains tool differs per reception centre. In some reception centres COA only applies the tool, if there are concerns about an asylum seeker. In other centres the tool is also used to assess the situation of persons who often refrain from seeking contact with and assistance from COA, such as LGBTIs and converted asylum seekers. In the coming years COA aims to screen every asylum seeker on the basis of the six domains tool in a more systematic and uniform manner.[73] This way COA will be forced to assess the situation of 'invisible' asylum seekers.[74] COA is examining whether it is feasible to screen asylum seekers before the start of the asylum procedure, during their stay in the Process Reception Location (*Proces Opvanglocatie* or POL). This is much more difficult than in the AZC because the asylum seekers only stays in the POL for a short period of time and need to do all kinds of activities in the context of the asylum procedure (such as the first meeting with the lawyer). COA expects its officers working at the POL to register and exchange signals of special needs.[75]

If COA officers notice that an asylum applicant may have special needs, they need to report that to their team.[76] The Inspection for Security and Justice (*Inspectie voor Veiligheid en Justitie*) concluded in a report of November 2015 that COA officers are well aware of the importance to inform each other about their activities and the situation in the reception centre. [77] It noted that the organisation of the exchange of information within COA is different in each location. However, each reception centre had meetings at fixed moments for that purpose. [78] One COA officer stated that urgent matters are usually

[69] Interview COA 1. See further about the IBO section 5.5.
[70] College Rechten van de Mens, *Aanbevelingen Mensenrechten in de noodopvang Heumensoord*, 10 February 2016, p. 7. See also Drogendijk, A. et al, p. 4. According to Arq there is an urgent need for a simple and accessible tool to support professionals and volunteers to interpret psychosocial problems and for a roadmap to relevant and accessible care.
[71] ACVZ, *Sporen uit het verleden*, July 2014, pp. 74-75.
[72] Interview COA 1.
[73] Interview COA 1. See Annex 3 for more explanation about the Dutch reception system.
[74] Interview COA 1.
[75] Ibid.
[76] Interview COA 2.
[77] Inspectie voor Veiligheid en Justitie, *De tijdelijke (opvang) voorzieningen voor asielzoekers onder de loep*, November 2015, p. 14.
[78] Ibid, p. 14.

discussed during the morning meeting and otherwise in the interdisciplinary meeting.[79] COA officers also frequently contact each other (via mobile phone or radio) in order to solve problems.[80]

*Training of COA officers*

COA officers have a background in social work (*agogische opleiding*), on intermediate level (*MBO*) for home counsellors and higher level (*HBO*) for programme counsellors and case managers.[81] Furthermore, every COA officer has to follow a basic training, which includes a module on preventive counselling. During this training COA officers learn about the six domains tool and its purpose. Furthermore, it is discussed when they should be concerned about an asylum seeker and which signals are particularly worrying. COA officers are made aware of the special living conditions in the reception centres and also about their own prejudices and interpretation of certain situations.[82] These trainings were also obligatory for new COA officers recruited during the period of high influx.[83]

Many COA officers want to practice and receive feed-back on their skills. For that reason it is COA's ambition to develop a national training programme in methodical working and counselling, for which COA officers can get a special certificate.[84] This includes a workshop to practice with the six domains tool and intervision. Until now COA organised these type of trainings on the local level. In the past years trainings were developed on identification of (victims of) human trafficking, radicalisation and LGBTI asylum seekers. COA is now including these trainings in its training programme as advanced training in addition to the basic training.[85] All coordinating confidential agents have followed a special training in the second half of 2016 in order to enhance their knowledge about ensuring security for vulnerable groups such as LGBTIs and to enhance awareness with regard to this area in all reception locations.[86]

### 2.4.2 Identification of special procedural needs by the IND

The obligation of Article 24 RAPD to identify asylum seekers in need of special procedural guarantees has been transposed in the Aliens Decree (*Vreemdelingenbesluit*)[87] and elaborated in the Aliens Circular (*Vreemdelingencirculaire*) and IND Instruction 2015/8.

*A continuous process*

The IND recognises that the need for special procedural guarantees can emerge or reveal itself at various moments in the asylum procedure.[88] Therefore it stresses that the assessment of special needs

[79] Interview COA 2.
[80] Inspectie voor Veiligheid en Justitie, *De tijdelijke (opvang) voorzieningen voor asielzoekers*, p. 14.
[81] Interview COA 1.
[82] Ibid.
[83] Ibid. Most COA officers working in emergency reception centres were hired through an employment agency. See Inspectie voor Veiligheid en Justitie, De tijdelijke (opvang) voorzieningen voor asielzoekers, p. 12.
[84] Interview COA 1.
[85] Interview COA 1.
[86] The Netherlands, Parliamentary documents, TK 2016/17, Aanhangsel van de Handelingen, nr. 1078, p. 2.
[87] Art. 3.108b Aliens Decree 2000.
[88] IND Instruction 2015/8, pp. 4-5.

should take place from the first registration throughout the duration of the asylum procedure.[89] IND officers need to check the whole case file in order to see whether there is information, which is relevant for the assessment whether an asylum seeker needs support during the asylum procedure.[90] According to the IND, a formal approach, in which circumstances emerging after the start of the asylum procedure are not taken into account, would not be in the interest of the asylum seeker nor in the interest of the authorities. In such situation the image which arises from the examination of the asylum application would not be reliable.[91]

Directly after arrival, when the asylum seeker fills out the client form (*klantformulier*) and during the registration interview (*Aanmeldgehoor*), the IND has its first contact with the asylum seeker.[92] Subsequently the IND meets the asylum seeker during the first interview on nationality, identity and travel route (*eerste gehoor*) and the elaborate interview on the asylum motives (*nader gehoor)*.[93] The IND assesses whether an asylum seeker has special needs on the basis of its impression of the asylum seeker during these moments. Furthermore, the IND receives information from other parties in the asylum system such as the Aliens Police, Royal Netherlands Marechaussee, COA, Dutch Council for Refugees and lawyers (see about the exchange of information further section 2.6).[94] According to the district court of Den Bosch the IND should take an active approach and find out for example why an asylum seeker did not appear for the asylum interview.[95]

Several lawyers noted that they do not know how the IND examines whether an asylum seeker has special needs. In their view there does not seem to be a system or method in place, which they find worrying.[96] One lawyer suggests that special IND officers (*regievoerders*) should be made responsible for asylum seekers with special needs.[97]

The IND does not use a screening tool to identify asylum seekers with psychological problems.[98] However, it has taken several measures in order to identify asylum seekers with special needs: the introduction of the Medical advice interviewing and decision-making, training of IND officers and asking questions and picking up signals about the asylum seeker's well-being during the interview.

[89] The Netherlands, Parliamentary documents, EK 2014/15, Handelingen nr. 38, item 8, p. 17**,** IND Instruction 2015/8, p. 4, Explanations with the revision of the Aliens Decree 2000 of 10 July 2015, Staatsblad 2015, nr. 294.
[90] IND Instruction 2015/8, p. 5.
[91] Explanations with the revision of the Aliens Decree 2000 of 10 July 2015, Staatsblad 2015, nr. 294.
[92] Interview COA 3.
[93] Interview IND 5 and 6.
[94] Interview IND 5 and 6 and IND Instruction 2015/8, p. 4.
[95] District court den Bosch 15 December 2015, ECLI:NL:RBDHA:2015:15492.
[96] Interviews Lawyer 3 and 4 and Lawyer 5.
[97] Interview Lawyer 5.
[98] See also Drogendijk, A. et al, p. 4. According to Arq there is an urgent need for a simple and accessible tool to support professionals and volunteers to interpret psychosocial problems and for a roadmap to relevant and accessible care.

*Medical advice interviewing and decision-making*

The most important instrument for the identification of persons in need of special procedural guarantees is the *Medical advice interviewing and decision-making*.[99] In most cases this advice is issued during the rest and preparation period before the start of the asylum procedure.[100] Asylum seekers who do not have the right to a rest and preparation period, such as those originating from safe countries of origin, do not get such a medical advice.[101] A (second) medical advice may be issued during the course of the asylum procedure if (new) physical or psychological problems emerge.[102] The Medical advice interviewing and decision-making will be discussed extensively in Chapter 3 of this report.

*Training of IND officers*

According to the State Secretary there is 'continuous attention for the stimulation of a general awareness for signals which can indicate that a person has become the victim of a form of serious violence'. [103] IND officers follow the EASO training module *Interviewing Vulnerable Persons* of the EU Asylum Curriculum.[104] This training should allow IND officers to pick up signals of vulnerability.[105] See section 7.9.1 for more information about the training.

*Signals of vulnerability during the asylum interviews*

IND officers ask at the beginning of the interview how the asylum seeker feels, whether they have any medical problems, whether they receive medical treatment and/or use medication. This medical information is not provided to the IND by GCA or the FMMU as a result of medical confidentiality.[106] The EASO module mentions that the interviewer should take an active role and ask follow-up questions if the asylum seeker indicates that he has suicidal thoughts, little interest in daily activities, recurrent thoughts or memories of hurtful or terrifying events, recurring nightmares or difficulties concentrating.[107]

Also during the interview an IND officer may ask how the asylum seeker is feeling and whether he is capable to continue the interview.[108] The IND officer should respond to signals that the asylum seeker is not feeling well, even if the FMMU concluded that the asylum seeker has no medical limitations.[109] It has not been researched whether the IND officers systematically do this in practice. However, in the interview attended for the purpose of this study the interviewer asked regularly (after each break) how the asylum seeker felt. The interview was stopped at some point because the asylum seeker suffered from migraine. One IND officer mentioned that he takes into account the fact that the asylum

[99] Para. C1/2.2 Aliens Circular, The Netherlands, Parliamentary documents, EK 2014/15, Handelingen, nr. 38, item 8, p. 17.
[100] Explanations with the revision of the Aliens Decree 2000 of 10 July 2015, Stb 2015, nr. 294, Art. 3.109(6) Aliens Decree 2000.
[101] Art. 3.109ca(1) Aliens Decree 2000. See further section 3.3.1 of this report.
[102] Para. C1/2.2 Aliens Circular.
[103] The Netherlands, Parliamentary documents, TK 2014/15, 19637, nr. 1903, p. 6.
[104] Ibid.
[105] Explanations with the revision of the Aliens Decree of 10 July 2015, Stb 2015, nr. 294, Interview IND 2 and 3.
[106] See further sections 2.6.7 and 3.3.4 of this report.
[107] EASO Module on Interviewing vulnerable persons, accessed in October 2016.
[108] Interview Pharos.
[109] Interview IND 5 and 6.

seeker has declared at the end of the interview that everything went well.[110] It will be explained in section 7.10.1 that both the IND and the Dutch courts attach important weight to the fact that the asylum seeker stated at the end of the interview that he did not experience any problems.

The IND officer's observations as to potential medical limitations (such as emotional reactions and striking behaviour) should be included in the report of the interview.[111] During the training for interviewing vulnerable persons, IND officers were told to describe these signals as specifically as possible.[112]

### 2.4.3 Identification by GCA

According to Article 9(2) Rva a first assessment of the asylum seeker's health situation should take place as soon as possible after arrival at the reception centre. Before the high influx of asylum seekers this first assessment took place after the rest and preparation period, in the POL.[113] In this period GCA wanted to do the assessment as soon as possible, in the COL. However, this did not fit into the schedule of activities that needed to be done in the COL.[114]

The GCA intake only reached a limited number of asylum seekers. The number of asylum seekers which did not show up for their appointment for the intake was high (more than 50 per cent).[115] Furthermore, during the period of high influx, asylum seekers often stayed in emergency reception centres for a long time until the start of the rest and preparation period. During this period of high influx GCA did not always manage to offer a medical intake in time to asylum seekers, because of a lack of capacity[116] and frequent relocations of asylum seekers[117]. As a result, asylum seekers sometimes ended up in reception centres, which were not suitable for their needs, because of a lack of a medical screening in the COL. Some were placed in crisis locations such as sports facilities and had to move to another location when it was recognised that they had medical problems.[118]

At the same time there was a lot of attention for medical risks for asylum seekers, amongst others of the Health Care Inspectorate.[119] In its report of March 2016 the Health Care Inspectorate considered it a risk that no medical intake was offered in the COL to asylum seekers who did not appear to have medical problems. In its view, there was a risk that these asylum seekers could not receive necessary medical care within an adequate time frame.[120] It required GCA in the seven new reception centres examined (of which three were emergency reception centres) to comply with the standards and to

[110] Interview IND 2 and 3.
[111] IND Instruction 2010/13, p. 5 and interview IND 2 and 3.
[112] IND training Interviewing vulnerable persons, November 2016.
[113] Flegar, V., *Quickscan Zorg voor asielzoekerskinderen in Nederland*, Werkgroep Kind in azc, June 2016, p. 17.
[114] Interview GCA 2.
[115] Ibid. See also Inspectie voor de Gezondheidszorg, *Goede vooruitgang in toegankelijkheid huisartsenzorg en bereik publieke gezondheidszorg volgens nieuw zorgmodel voor asielzoekers*, September 2011, p. 17.
[116] Inspectie voor de Gezondheidszorg, *Medische zorg aan asielzoekers onder druk maar ketenpartners beperken gezamenlijk grootste risico's,* March 2016, pp. 15, 25.
[117] Interview GCA 1.
[118] Interview COA 2.
[119] Interview GCA 2.
[120] Inspectie voor de Gezondheidszorg, *Medische zorg aan asielzoekers onder druk,* pp. 15, 20.

assess the compliance by means of an internal audit.[121] In the middle of 2015 the IND and COA were convinced - influenced by the Health Care Inspectorate and Ministry of Health - to grant GCA the opportunity to do a brief medical screening in the COL, focused on urgent medical problems, under the condition that this would not delay the asylum process.[122]

*The urgency medical screening*

In April 2016 GCA introduced a brief urgency medical screening for all new asylum seekers in the three COLs (Veenhuizen, Ter Apel and Budel). This screening has replaced the (much more elaborate) intake (anamnesis) in the POL. The purpose of the medical screening is to identify urgent actual health risks, to start health care if necessary and to advise COA about special reception needs.[123] This way it can be prevented that urgent medical treatment starts too late and asylum seekers are placed in reception centres which are not suited for them.[124] In the next reception centre GCA will invite new asylum seekers in order to assess other risks or needs and to be informed about their medical history.[125]

In March 2017 the percentage of asylum seekers who were subjected to the urgency medical screening was around 95 per cent, much higher than the number of asylum seekers reached by the intake at the POL. The 5 per cent of asylum seekers who did not receive a medical screening by GCA included asylum seekers who arrived at Schiphol Airport and babies born in the POLs and AZCs.[126] Asylum seekers who are detained at Schiphol Airport are screened by Schiphol's medical service in order to see whether they are fit for detention.[127]

COA informs asylum seekers orally (in a group) and with an information leaflet about the purpose of the medical screening carried out by GCA. In spring 2017 GCA was improving the information about the medical screening, amongst other by developing a short film for asylum seekers in the GCA waiting room. The reason for that was that a few incidents were reported to GCA of asylum seekers who did not mention medical problems, because they feared it would influence their asylum procedure [128]

During the screening the asylum seekers fill in a questionnaire (digitally or on paper) in their own language about their health situation. This questionnaire is based on the Dutch Triage Standard (*Nederlandse Triage Standaard)* for urgent care. There is a GP assistant or a nurse (both trained to do triage) available to support the asylum seekers. If the asylum seeker is not able to fill in the questionnaire, because his language is not available or he is illiterate, the questions will be posed orally with the assistance of an interpreter.[129] Afterwards the GP assistant or nurse observes the physical condition of the asylum seeker. This will be registered in the asylum seeker's medical file.[130]

[121] Inspectie voor de Gezondheidszorg, *Medische zorg aan asielzoekers onder druk,* p. 19.
[122] Interview GCA 2.
[123] Ibid.
[124] Interview COA 2 and Flegar, V., *Quickscan Zorg voor asielzoekerskinderen*, p. 17.
[125] Additional information provided by GCA in July 2017.
[126] Ibid.
[127] The Netherlands, Parliamentary documents, EK 2014/15, Handelingen, nr. 38, item 8, p. 27.
[128] Interviews GCA 1 and GCA 2. See also section 2.4.7.
[129] Interview GCA 2.
[130] Additional information provided by GCA in July 2017.

Asylum seekers also fill in a form for their children under the age of 12. Children of 12 years and older can fill in the questionnaire themselves or the parents can do it for them. Unaccompanied children are brought to the urgency screening by COA and fill in the questionnaire themselves. Children get assistance from the GP assistant if necessary.[131] Guardians are not present during the urgency screening[132], because at that moment Nidos has not yet provided the child with a guardian[133].

In the questionnaire asylum seekers are asked whether they have diabetes mellitus, a cardiovascular disease or a lung disease. If that is the case, the asylum seeker will always be seen by a nurse in order to find out whether the asylum seeker needs immediate help of a GP or specialist and still has sufficient and proper medication.[134] This is also done if the asylum seeker indicates on the questionnaire that they use medication for other reasons. If the asylum seeker does not have (sufficient) medication, this will be provided to them.[135] Finally asylum seekers are asked whether they have allergies. Women are asked whether they are pregnant or breast feed their children.[136] The fact that an asylum seeker has an allergy or breastfeeds is registered in the GCA information system (HIS). In case of a pregnant woman GCA determines together with the midwife, which care is necessary.[137]

GCA considers it important that the questionnaire contains the question whether the asylum seeker has another medical problem which requires care.[138] If the asylum seeker answers 'yes' they will be immediately invited for a meeting with a nurse, who assesses the urgency of these medical problems.[139] A GP of GCA always needs to approve the outcome of the urgency screening.[140]

The questionnaire does not include a question about psychological problems.[141] Asylum seekers can mention psychological problems under the general question about medical problems. Moreover, the GP assistant who observes the asylum seekers while they fill in the questionnaire can notice psychological problems. In the medical intake in the POL, GCA used the Protect Questionnaire to identify notably trauma-related psychological problems.[142] GCA contends that it is likely that psychological problems will not be recognised during the urgency screening. Directly after arrival in the COL asylum seekers will feel relieved. Psychological problems often emerge when asylum seekers

[131] Interview GCA 2 and Flegar, V., *Quickscan Zorg voor asielzoekerskinderen*, pp. 17-18.
[131] Interview GCA 2.
[132] Interview GCA 2 and Nidos.
[133] Additional information provided by GCA in July 2017.
[134] Interview GCA 2.
[135] If the asylum seeker still has sufficient medication, he will get an appointment with GCA in the next centre. Interview GCA 2.
[136] GCA, Vragenlijst Medische Intake, provided by GCA in April 2017.
[137] Interview GCA 2.
[138] Ibid.
[139] For this purpose GCA uses the standards which are also used by Dutch GP's (NHG triage standaard). Interview GCA 2.
[140] Interview GCA 2.
[141] GCA indicated that it decided to omit such question in consultation with Pharos. Interview GCA 2. However, this was contested by Pharos. Additional information Pharos provided in September 2017.
[142] Questionnaire and observations for early identification of asylum seekers having suffered traumatic experiences, see http://protect-able.eu/resources/. This questionnaire is also recommended to immigration authorities in the EASO Module Interviewing vulnerable persons, as consulted in November 2016.

are waiting in the POL or AZC[143] and need to talk about their experiences in the country of origin[144]. For that reason GCA pays attention to psychological problems in the POLs and AZCs, for example if an asylum seeker comes to GCA with stress related complaints.[145] In those cases GCA will still use the Protect Questionnaire in order to detect psychological problems resulting from trauma and brings the asylum seeker in contact with the mental health consultant.[146]

The Dutch Centre of Expertise on Health Disparities (Pharos) noted that it is a missed opportunity not to ask asylum seekers about psychological problems. However, an increased attention to psychological problems in the POLs and AZCs could diminish the risk that psychological problems are missed.[147]

If the asylum seeker indicates that they have no medical problems and the GP assistant on the spot does not see any medical problems, the medical screening is finished.[148] Asylum seekers who indicate medical problems are seen by a nurse or a doctor, depending on the seriousness of the medical problems.[149] During this meeting they get the assistance of an interpreter.[150]

GCA indicates to COA whether an asylum seeker can be moved to the next reception centre. There are three possible conclusions of the medical screening.

| | |
|---|---|
| Green | The asylum seeker is not in need of medical care |
| Orange | The asylum seeker is in need of medical care but can be moved to another reception centre, where the asylum seeker can receive the necessary medical care and where the living conditions are suitable for the asylum seeker's situation.[151] |
| Red | The asylum seeker is in need of urgent medical care at the COL and cannot be moved yet.[152] |

In 2016 code red was given in 0,3 per cent and code orange to 0,7 per cent of all asylum seekers.[153] Code red is only given if medical treatment cannot wait until the asylum seeker has been transferred to a POL or AZC[154], for example if the asylum seeker directly needs to go to hospital.[155] The asylum seeker will then always directly receive necessary medical care.[156] Code orange is for example given if the asylum seeker needs to be placed in a reception centre, which is accessible for a wheelchair or close to an academic hospital. If necessary, GCA in the new location is informed by phone or special

[143] Interviews GCA 1 and GCA 2.
[144] See also interviews Pharos and Lawyer 5.
[145] Interview GCA 2.
[146] Ibid.
[147] Additional information provided by Pharos in September 2017.
[148] Ibid.
[149] Interview COA 2.
[150] Ibid.
[151] Interview COA 2.
[152] Interviews COA 2 and GCA 1.
[153] Figures provided by GCA in March 2017.
[154] Interview GCA 2.
[155] The family members stay in the COL. Interviews COA1, COA 2 and GCA 1.
[156] Interview GCA 2.

mail that the asylum seeker concerned needs special attention quickly.[157] The results of the medical screening are registered in the asylum seeker's file, which automatically moves with the asylum seeker to the next reception centre.[158]

At the POL and AZC, GCA immediately invites asylum seekers with urgent medical risks or about whose situation GCA has been informed (for example in case of chronic disease). Also newly arrived asylum seekers, who have not had an urgent medical screening at the COL (for example because they arrived via Schiphol Airport) are instantly invited. Other newly arrived asylum seekers are invited for an introductory consultation, in which they are asked about medical complaints and medical history.[159]

According to GCA the urgency screening has been positively evaluated by a number of GCA's partners and the GCA personnel at the COL.[160] Through this screening urgent medical problems are identified in an early stage, which would otherwise be noted much later in the process. The GCA locations in the POLs and AZCs give feed-back to GCA in the COL about medical problems, which were missed during the urgency screenings.[161]

GCA has not assessed the consequences of the fact that it does not carry out an elaborate medical intake in the POL anymore. However, GCA stated that it has not received signals, that the lack of such intake in the POL has negative effects on the identification of (psychological) problems.[162]

One stakeholder welcomes the urgency screening, but warns for the risk that too much weight will be placed on its outcome. The fact that a medical problem was not recognised during the urgency screening does not mean that the asylum seeker does not have special needs.[163]

### 2.4.4 Identification of special needs by lawyers and the Dutch Council for Refugees

Both lawyers and the volunteers of the Dutch Council for Refugees (DCR) have an important role in the identification of persons in need of special procedural needs or reception conditions. The volunteers of the DCR speak to asylum seekers when they inform them about the asylum procedure during the rest and preparation period in the POL[164] and when they are transferred to an AZC.[165] They are trained to pick up signals of vulnerability. The DCR makes a short report of an information meeting and sends it to the lawyer, if relevant.[166] Furthermore, asylum seekers may come to the desk of the DCR with questions before or during the asylum procedure.

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[157] Interviews COA 2 and GCA 2. A 'warm transfer' can take place from GCA in the COL to GCA in the new reception centre or GCA in the new reception centre is asked to schedule an appointment with the asylum seeker after his arrival.
[158] Additional information provided by GCA in July 2017.
[159] Ibid.
[160] GCA notes that the urgent medical screening and follow up in the POLs and AZCs has been approved by the National GP Association. Additional information provided by GCA in July 2017.
[161] Interview GCA 2.
[162] Additional information provided by GCA in July 2017
[163] Interview DCR 1 and 2.
[164] DCR aims to inform 100% of all asylum seekers. DCR, Kerntaak Algemene Voorlichting POL.
[165] Interview DCR 4.
[166] Ibid.

Lawyers prepare asylum seekers for the asylum procedure during the rest and preparation period. Often, the asylum seeker will then talk about (the details) of his asylum account for the first time. As a result psychological problems may come to the fore. Furthermore, lawyers see the asylum seeker several times, which enables them to build a relation of trust, to compare the asylum seeker's state at different moments and assess whether he may have special needs.[167] It emerged from the interviews with all lawyers that they see it as their task to identify asylum seekers with special needs and inform IND and COA about them.[168]

*Use of the questionnaire physical and psychological problems*

Both volunteers of the DCR and lawyers use a questionnaire (*signaleringslijst*) developed by the Institute of Medical Examination and Human Rights (iMMO) [169].[170] The questionnaire aims to assist volunteers and lawyers (who are not trained in medicine) to identify physical and psychological complaints. It consists of ten possible observations which can be answered by 'yes' or 'no', such as 'client is frightened by certain noises', 'client is crying', 'client has outbursts of anger', 'client is able to tell a coherent story'. The questionnaire offers the opportunity to describe scars and physical problems, which are allegedly caused by events in the country of origin relating to the asylum claim. Finally, the questionnaire contains 14 questions which concern the asylum seeker's mental state, which can be posed to an asylum seeker. It includes questions such as: 'do you have problems sleeping?', 'do you feel down on a daily basis?' and 'do you have problems concentrating?'.

Many volunteers of the DCR who work at the application centres or POLs are trained to use the iMMO questionnaire by a psychologist of iMMO and a trainer of the DCR.[171] During this training they learn to be alert on potential indications of psychological problems that may be relevant for the asylum procedure. The DCR sends the questionnaire to the lawyer, who decides whether it will be submitted in the context of the asylum procedure.[172]

Lawyers get a course on medical aspects during their training.[173] The questionnaire is recommended to lawyers by the Best Practice Guide for asylum lawyers. The guide also advises lawyers to support indications of psychological problems which emerge in a later stage of the asylum procedure with a questionnaire and to contact the IND.[174] Several lawyers use the questionnaire and send it to the IND in some cases, in particular to raise doubts about the Medical advice interviewing and decision-making

[167] See Van Mourik, K, Zwaan, K. and Terlouw, A, *Gehoor Geven*, 2011, pp. 24, 28.
[168] Interviews Lawyer 2, Lawyer 3 and 4 and Lawyer 5.
[169]See http://www.stichtingimmo.nl/wp-content/uploads/2015/11/Signaleringslijst-lichamelijke-en-psychische-problemen-november-2015.pdf. The questionnaire overlaps with the Protect Questionnaire, because both are based on the same source document. Additional information provided by Pharos in September 2017.
[170] Drogendijk, A. et al, p. 30, ACVZ, *Sporen uit het verleden*, pp. 74-75, Interviews Pharos and Legal Aid Board and DCR 5.
[171] Interviews iMMO and DCR 4. This training is not obligatory, but in particular more experienced staff and volunteers have followed the training.
[172] Interview DCR 4.
[173] Interview Legal Aid Board and DCR 5. It concerns Module C of the Refugee Law Course provided by OSR legal education.
[174] Doornbos, N., Koers F. and Wijngaard, Th., *Best Practice Guide Asiel, Bij de Hand in Asielzaken*, September 2012, p. 89.

issued by FMMU.[175] One lawyer noted that this does not have the desired effect. Her experience is that the IND thinks that she does not want her client to be interviewed, while she wants the IND to take into account psychological problems during the interview and when assessing the credibility of her client's statements.[176]

The questionnaires which are filled in by the lawyer or the DCR is used by iMMO in the context of their medical examination of the link between scars and physical or psychological problems and alleged event in the country of origin. The information in the questionnaire may confirm that at a certain moment in the asylum procedure (notably during the interview) the asylum seeker already had certain physical and/or psychological problems.[177]

*Constraints due to special procedures for categories of asylum seekers*
For the DCR it has become difficult to identify vulnerable asylum seekers, because of recent changes in the asylum procedure. First, asylum seekers who enter the Dublin procedure (also called 'track 1', or S*poor 1*) and will (probably) be transferred to another Member State on the basis of the Dublin Regulation do not receive information from the Dutch Council for Refugees before the Dublin interview, but only after transfer to an Asylum Seeker's Centre (AZC). As a result, the asylum seeker only receives information (and speaks to a lawyer) after the most important part of the procedure has been completed.[178]

Secondly the asylum procedure of asylum seekers from safe countries of origin and asylum seekers who have received an asylum status in another EU Member State (who often originate from countries like Syria or Eritrea) are prioritised and accelerated (also called 'track 2' or S*poor 2*).[179] These asylum seekers do not have a registration interview nor a rest and preparation period and receive a decision on their asylum application within an average of ten days from their asylum application.[180] Due to time constraints the DCR can only inform these asylum seekers on the asylum procedure in group sessions. As a result, it is almost impossible for a volunteer of the DCR to recognise asylum seekers with special needs.[181] Furthermore, these asylum seekers do not get a medical examination by FMMU and are not prepared for the asylum seekers by their lawyer.

Finally, the DCR notes that it is difficult for them to predict beforehand which asylum procedure an asylum seeker will follow. Sometimes the IND decides to assess the asylum application of a person who may be transferred to another EU Member State on the basis of the Dublin Regulation in the

[175] See further Chapter 3 of this report.
[176] Interview Lawyer 2.
[177] Interview iMMO.
[178] Interview DCR 4. This situation exists since the implementation of the Asylum Procedures Directive. In the Dublin procedure asylum seekers do not get a registration interview and move straight from the COL to an AZC.
[179] The Netherlands, Parliamentary documents, TK 2016/17, 19 637 and 33 042, nr. 2179, p. 2. On 1 November 2016, 2850 of the 30.080 persons in the COA reception centres originated from safe countries of origin. The Netherlands, Parliamentary documents, TK 2016/17, 19 637, nr. 2262, p. 2. In July and August 2016 20% of all asylum applications were processed in Track 2. The Netherlands Parliamentary documents, TK 2016/17, Aanhangsel van de Handelingen, nr. 47, p. 3
[180] The Netherlands, Parliamentary documents, TK 2016/17, Aanhangsel van de handelingen, nr. 699, p. 4, TK 2016/17, 19 637, nr. 2262, p. 2, TK 2016/17, 19 637 and 33 042, nr. 2179, p. 2.
[181] Interview DCR 1 and 2.

procedure for asylum seekers originating from safe countries of origin. Furthermore, asylum seekers move from one asylum track to another. This makes it difficult for the DCR to know when and about which procedure asylum seekers need to be informed and to pick up signals of vulnerability.[182]

It is important that special needs of persons who may be transferred to another EU state under the Dublin regulation are identified, because these should be taken into account in the assessment whether the transfer will amount to inhuman or degrading treatment.[183] Furthermore, special needs, for example as a result of medical problems, should be taken into account in the assessment whether an asylum seeker risks inhuman or degrading treatment upon return to his country of origin, also if this country is considered to be a safe country of origin.[184]

### 2.4.5 Identification of special needs by Nidos

Unaccompanied children are generally supervised intensively. The type of reception facilities and consequently the intensity of the supervision on unaccompanied children depends on the age of the child and their potential vulnerability.[185] Unaccompanied children younger than 15 years old stay in foster families. Older unaccompanied children first stay in a special COA Process Reception Location (POL) for unaccompanied children. After that they move to small-scale housing provided by COA. If they are granted a residence permit, they move to small-scale housing provided by Nidos (see also section 5.6).

Unaccompanied children have a guardian provided by Nidos and a mentor in the location where they are living. They should see their guardian at least once a month. The COA mentors or Nidos guardians should assess whether an individual unaccompanied child is in need of specialised care.[186] If Nidos concludes that the unaccompanied child may disappear because they are (potential future) victim of human trafficking, it can place them in a secured reception centre.[187]

It depends on the location how often an unaccompanied child has contact with their guardian, sometimes this is daily, sometimes weekly, sometimes once a month.[188] In the POL for example unaccompanied children usually see their guardian more often.

During the high influx some guardians had a very large case load and were not able to visit their pupils very often. Nidos guardians did not always manage to see their pupils once a month.[189] In 2017 the situation is back to normal again.[190]

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[182] Interview DCR 4.
[183] See ECtHR 4 November 2017, Appl. no. 29217/12, *Tarakhel v Switzerland*, CJEU Case C-578/16 PPU, C.K. and others [2017], ECLI:EU:C:2017:127.
[184] ECtHR 13 December 2016, Appl. no. 41738/10, *Paposhvili v. Belgium*.
[185] See further section 5.6 of this report.
[186] Inspectie Jeudgzorg, *Opvang alleenstaande minderjarige vreemdelingen*, September 2016, p. 13.
[187] See further section 5.6 of this report.
[188] Inspectie Jeugdzorg, *Kwaliteit opvang alleenstaande minderjarige vreemdelingen*, September 2016, p. 8.
[189] Interview Nidos.
[190] Additional information Nidos provided in August 2017.

Nidos personnel examines unaccompanied children who are not able to tell their asylum story. They talk with the child about their asylum motives at the child's own pace. Nidos writes a report about these children, which can be taken into account by the IND. These reports are usually written after the interview on the asylum motives.[191]

### 2.4.6 Identification of special needs at Schiphol Airport

Asylum seekers who crossed the Dutch border at Schiphol Airport are taken to the application and detention centre situated next to the Airport. The asylum seekers staying in the detention centre at Schiphol Airport are closely monitored by different organisations present there. Before an asylum seeker can be detained, the authorities need to assess whether there are special and individual circumstances which would render the detention disproportionate. Also during the detention they constantly need to assess whether such circumstances are present. No definition is given of special and individual circumstances, but they may include the medical situation of the asylum seeker, such as an admission to hospital or serious psychological problems.[192]

One lawyer, who often works at the detention centre at Schiphol Airport, mentions that there, persons with special needs are identified more easily, because they have regular contact with guards and the medical personnel. This is different than in large asylum reception centres, such as the reception centre in Gilze-Rijen, where asylum seekers are often less visible.[193] See section 7.6 for more information on the application of the border procedure to vulnerable asylum seekers.

### 2.4.7 Identification during the period of high influx

During the period of high influx there were some specific problems which concerned the identification of asylum seekers with special needs. These will be discussed in this section.

*Lack of capacity*
During the period of high influx COA was overburdened. Asylum seekers had to stay in crisis locations and large emergency reception centres. The Children's Ombudsman mentioned for example in a report of February 2016 that there were only 6-10 COA home counsellors (*woonbegeleiders*) available for the 1,000 residents in emergency reception centre Heumensoord. He stated that, as a result, COA could not take into account individual needs and problems, including those of children.[194] Normally a home counsellor has to take care of around 80 asylum seekers.[195] During the time of high influx the focus was more on providing asylum seekers their basic needs and to cope with the tensions in the reception centres as a result of the insecure situation for many asylum seekers.[196]

[191] Ibid.
[192] IND Instruction 2017/1.
[193] Interview Lawyer 2.
[194] Kinderombudsman, *Wachten op je Toekomst*, 2016, pp. 12-13. See also Interview COA 1 and Interview IND 2 and 3.
[195] Interview COA 1.
[196] Ibid.

Also the IND had to deal with a large amount of cases. One lawyer mentioned that during the high influx IND intakes were brief and sometimes a registration interview was lacking. As a result, vulnerable asylum seekers could be missed, meaning that they would have to join the queue.[197]

Furthermore, the DCR was only able to provide information in group sessions during this period, instead of individual meetings. This was particularly so in situations where all residents of an emergency reception centre were going to start the asylum procedure at the same time.[198]

*Identification of unaccompanied children*

In his report of February 2016 the Children's Ombudsman mentioned that unaccompanied children who stayed in the crisis reception centres were often not identified, because they had not yet been registered in the COL. As a result they did not receive the necessary care and support.[199] In the interviews for this study several lawyers, the DCR and Nidos also noted that during the period of high influx unaccompanied children were not always identified as such by the IND.[200] They recall examples of children who arrived in the Netherlands with family members (uncle, aunt, grandmother) or even with adults with whom they had no family ties, who only received a guardian months after arrival.[201] In some cases the IND even intended to transfer unaccompanied children to another EU Member State under the Dublin Regulation, together with a family they did not belong to.[202] At one point special teams of the IND were sent to reception locations in order to identify unaccompanied children.[203]

Nidos remarked that some children also gave a higher age because they thought that this may help them to work or gain more money. Nidos is sometimes called by a lawyer, the DCR or COA because they have a child who is registered as an adult. Nidos stated that it cannot change the child's date of birth in the IND's registration. As a result, the special policy for unaccompanied children does not apply to this child. [204]

*No access to legal assistance before the start of the asylum procedure*

During the period in which an asylum seeker waits for the start of the asylum procedure they do not have access to a (free) lawyer. One lawyer mentioned that he assisted a few asylum seekers during this waiting periods because they were family members of former clients.[205] Another lawyer mentioned that she assisted unaccompanied children who were waiting for their asylum procedure at the request of Nidos.[206] During the period in which asylum seekers were waiting for the start of the asylum procedure, the DCR was also not capable of providing legal assistance because there were no

[197] Interview Lawyer 5.
[198] Interview DCR 4. Group meetings had as an advantage that asylum seekers would stimulate each other to ask questions or raise problems. Furthermore, individual contact was always possible.
[199] Kinderombudsman, *Wachten op je Toekomst*, 2016, p. 15.
[200] Interview DCR 1 and 2.
[201] Interviews Lawyer 3 and 4, Lawyer 5, DCR 1 and 2 and Nidos.
[202] Interview Lawyer 3 and 4.
[203] Interview Lawyer 3 and 4 and Nidos.
[204] Interview Nidos.
[205] Interview Lawyer 5.
[206] Interview Lawyer 2.

legal documents yet (such as reports of interviews).[207] As a result, it was difficult for asylum seekers to alert the IND and COA that they had special needs and that their case should be prioritised.

*Frequent movements between reception centres*

During the period of high influx asylum seekers had to move many times from one crisis or emergency location to another and stayed in large reception centres. This made it difficult to identify vulnerable persons and to take appropriate action.[208] The Children's Ombudsman reported in February 2016 that the frequent relocations of unaccompanied children had a negative effect on their capacity to establish a relationship of trust with their mentors. This made it difficult to identify behavioural issues (for example as a result of trauma) and prevent incidents.[209]

*Rumours about delays because of medical problems*

According to several stakeholders, asylum seekers (in particular Syrians) told each other that physical or psychological problems should not be mentioned to GCA, FMMU, COA or IND.[210] They believed that this could lead to a (further) delay in the asylum procedure. This would also cause a delay to start of the procedure for family reunification with family members left behind in the country of origin or a third country.[211] Many asylum seekers worried a lot about their family members.[212] Nidos remarked that many unaccompanied children were under a lot of pressure to start the asylum procedure as soon as possible.[213] The fact that unaccompanied children loose the right to family reunification as soon as they turn eighteen may have contributed to this pressure.

One lawyer mentioned examples of a man who did not tell anyone that he had testicular cancer and a woman who did not report that she was 14 weeks pregnant. The lawyer explained to asylum seekers during the preparation meeting before the start of the asylum procedure that medical problems would not lead to delays and tried to convince them to go to GCA.[214] She had the impression that asylum seekers were not informed specifically about the inaccuracy of these rumours. COA and GCA stated that during the urgency medical screening in the COL it is stressed that the result does not influence the asylum procedure and that it is just meant to offer the asylum seeker the necessary medical care. However, COA also recognised that this does not prevent that some people give answers which they think are considered desirable. [215] GCA intends to further improve the information provided about the medical screening in the COL.[216]

[207] Interview DCR 1 and 2.
[208] Interview IND 2 and 3.
[209] Kinderombudsman, *Wachten op je Toekomst*, 2016, p. 30.
[210] Interviews Lawyer 1, Lawyer 3 and 4, FMMU 2, IND 1, Pharos and GCA 2. See also Pharos, *Kennissynthese gezondheid van nieuwkomende vluchtelingen en indicaties voor zorg, preventie en ondersteuning*, 2016, p. 41 and Conversations with UNHCR staff, UNHCR the Netherlands, August/September 2016. See also section 3.7 of this report.
[211] Interview DCR 4. She also mentioned that Syrians told each other that they should not tell a complicated asylum story, because that could also delay the asylum procedure.
[212] Interviews DCR 1 and 2 and DCR 4.
[213] Interview Nidos.
[214] Interview Lawyer 3 and 4.
[215] Interview COA 2.
[216] Interview GCA 2. See also section 2.3.3 of this report.

## 2.5 Registration of special needs

EASO states in its guidance on reception that 'indicators and special needs should be recorded as soon as possible after they are detected and this information should be communicated to the relevant stakeholders in order to provide the necessary guarantees and support'.[217] In the Netherlands there is no central system in which the organisations involved in the asylum procedure register information concerning the special needs of asylum seekers.[218] This section explains how COA, the IND and the DCR register signals of special needs. The exchange of information between the different organisations in the asylum system will be discussed in section 2.6.

### 2.5.1 Registration by COA

COA registers all relevant information about the residents of the reception centres in registration system IBIS (*Integraal Bewoners Informatie Systeem*). All reports made with regard to asylum seekers living in the centre are registered in order to ensure that all COA officers are well informed about them.[219] This includes incidents in which an asylum seeker was involved, (presumed) nationality[220], but also information about (visible) medical problems.[221] COA also registers its screening on the basis of the six domains tool. COA told the Netherlands Institute for Human Rights that it does not register whether a person is LGBTI and that this would be undesirable. As a result it is not possible to identify asylum seekers for separate reception facilities, unless they come forward themselves.[222]

COA officers can see in the system in which domain(s) the asylum seeker has a low(er) or normal score. Each COA employee can enter new signals and scores into the system.[223] COA officers in different reception centres do not register signals in a uniform manner and do not always use the required formats. In the coming years COA wants to make the registration of signals on the basis of the six domains tool more uniform, which will enhance the transfer of cases.[224]

### 2.5.2 Registration by the IND

The IND does not register a 'label' vulnerable/not vulnerable in the asylum seeker's case file.[225] The State Secretary did not want to oblige the IND to register in the case file that a person has become the victim of torture, rape or other forms of serious violence.[226] He mentioned two reasons for this

[217] EASO, *EASO guidance on reception conditions: operational standards and indicators*, September 2016, p. 39.
[218] One IND officer mentioned that such a central system would be helpful. Interview IND 2 and 3.
[219] The Netherlands, Parliamentary documents, TK 2016/17, Aanhangsel van de Handelingen, nr. 699, pp. 1, 3, Inspectie voor Veiligheid en Justitie, De tijdelijke (opvang) voorzieningen voor asielzoekers, p. 14.
[220] The Netherlands, Parliamentary documents, TK 2016/17, Aanhangsel van de Handelingen, nr. 699, pp. 1, 3.
[221] Interview COA 2. See section 2.5 for exchange of (medical and health) information.
[222] College voor de Rechten van de Mens, Aanbevelingen Mensenrechten in de Noodopvang Heumensoord, February 2016, p. 6.
[223] Interview COA 1.
[224] Interview COA 1.
[225] IND Instruction 2015/8, p 5.
[226] The ACVZ recommended the State Secretary in 2015 to include signals that an asylum seeker has become the victim of torture, rape or other forms of serious violence in the asylum seeker's asylum case file. ACVZ, *Sporen uit het verleden*, p. 13.

position. First he noted that such obligation could lead to 'a profound formalisation and legalisation' of the interaction between officer working in the asylum system and asylum seekers. In his view that could make vulnerability a difficult topic. This could result in a situation where officers in the asylum system would feel less free in their personal contact with the asylum seeker and therefore would provide less effective support.[227] Secondly he mentioned confidentiality and privacy of the asylum seeker as an argument against registration. He stated that an asylum seeker must have the opportunity to talk to an IND officer in confidence. In this light it would not be desirable that an officer would be required to register confidential information in the case file.[228]

IND Instruction 2015/8 states that the internal notes (*de minuut*) in the case file need to mention whether a person is in need of adequate support. IND officers use these internal notes in the INDIGO computer system[229] from the registration phase to register signals of special needs.[230] This is also taught to IND officers in the course on interviewing vulnerable persons.[231] These internal notes could also mention which extra support was provided by the IND officer.[232] The signals can be registered in a field 'special circumstances'. However, this field is not directly visible when the asylum seeker's file is opened by an IND officer and is not easy to find. Some IND officers have expressed the wish to make signals concerning special needs more visible in the case files.[233]

Incidents which take place in the Application Centre (for example in the waiting room) can be registered in a separate system (Smartflow), which is accessible only to the IND, COA and security on the centre. Other incidents can be registered in JOOST, which is only accessible to the IND. At Schiphol Airport the senior IND officer on duty reports which asylum seekers need extra attention at the moment an (intended) rejection of the asylum application is given to the asylum seeker.[234]

Furthermore, signals that a person has certain psychological problems which come to the fore during the asylum interview, for example the fact that the asylum seeker cries or seems to be afraid, should be written down in the report of the interview.[235] During the course interviewing vulnerable persons it was stressed that IND officers should write down such signals in detail. For example it was mentioned that the remark that the asylum seeker is 'emotional' is not specific enough, because it does not make clear which emotions were expressed and how.[236] Some IND officers mentioned that it is essential that such signals are written down in the report, in particular where the IND officer who interviewed the asylum seeker is not the same as the officer who takes the decision. Furthermore, the report should mention which special (procedural) measures were taken by the IND officer.[237]

[227] The Netherlands, Parliamentary documents, TK 2014/15, 19637, nr. 1903, p. 6.
[228] Ibid.
[229] INDIGO is the client information system of the IND.
[230] IND Instruction 2015/8, p. 5. Interviews IND 1 and IND 2 and 3.
[231] IND Training Interviewing Vulnerable Persons, November 2016.
[232] Interview IND 1.
[233] IND Training Interviewing Vulnerable Persons, November 2016.
[234] Interview IND 1.
[235] Interview IND 2 and 3.
[236] IND Training Interviewing Vulnerable Persons, November 2016.
[237] Interview IND 2 and 3.

### 2.5.3 Registration by the Dutch Council for Refugees

The DCR registers signals in their computer administration system. For example iMMO questionnaires are scanned and inserted into the system. One employee of the DCR mentioned that they are a bit hesitant to register certain signals. If for example an incident in which an asylum seeker behaves aggressively is registered in the system, this is permanent. This may have consequences for the way this asylum seeker will be approached by other employees of the DCR. Therefore, they try to register these signals as cautiously as possible.[238]

## 2.6 Exchange of information

The EASO guidance on reception stresses the importance of properly functioning referral mechanisms in order to communicate special needs in an efficient manner.

> Without prejudice to the principle of confidentiality, national authorities should be able and instructed to share the relevant information on identified special needs. For example, where first-contact officials, such as border guards, have noted that the person has special needs, those should be communicated to the reception authorities in order for them to ensure the necessary guarantees as soon as possible. On the other hand, reception officers would often be in a position to observe the asylum seekers over a longer period of time and to build trust. This would allow them to effectively identify special needs, which may not be initially apparent. To the extent that this information also concerns potential special procedural needs, it is crucial that the reception authority communicate it to the determining authority.[239]

In the Netherlands, after the suicide of asylum seeker Alexander Dolmatov in a detention centre in Rotterdam in 2013 there has been a lot of attention on the exchange of (medical) information within the asylum and return system. Different reports concluded that the exchange of information about special circumstances concerning an asylum seeker (including health situation, background and behaviour) was insufficiently guaranteed.[240] This was caused by the large number of digital systems used by the different organisations in the asylum system, which are not all linked.[241] Also the information included in the information systems was not always complete and correct.[242] In 2013 the Inspection of Security and Justice advised the State Secretary to develop an up-to-date and accurate information system, where information about individuals is combined and which can be accessed by all organisations in the asylum system.[243]

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[238] Interview DCR 1 and 2.
[239] EASO, *EASO guidance on reception conditions*, p. 39. See also p. 40.
[240] Onderzoeksraad voor Veiligheid, *Veiligheid van vreemdelingen*, 2014, p. 97, Inspectie voor Veiligheid en Justitie, *Het Overlijden van Alexander Dolmatov*, 28 March 2013, pp. 17-18, 87-90, Inspectie voor de Gezondheidszorg and Inspectie Veiligheid en Justitie, *Nader onderzoek naar de zorgverlening aan Renata A*, January 2017, pp. 12-13.
[241] Inspectie voor Veiligheid en Justitie, *Het Overlijden van Alexander Dolmatov*, pp. 17-18, 87-90, Onderzoeksraad voor Veiligheid, *Veiligheid van vreemdelingen*, p. 98. This meant that sometimes information was copied by hand from one system to another.
[242] Onderzoeksraad voor Veiligheid, *Veiligheid van vreemdelingen*, p. 99.
[243] Inspectie voor Veiligheid en Justitie, *Het Overlijden van Alexander Dolmatov*, p. 18.

Furthermore, medical information was not always available to persons working with asylum seekers or migrants, amongst others because the possibilities to exchange such information is limited by medical confidentiality.[244] In 2014 the Dutch Safety Board therefore recommended to create clarity on short notice as to the possibilities to share medical information without violating medical confidentiality.[245] Furthermore, it was concluded that communication between care providers (such as GCA) and organisations in the asylum system (such as COA) had to be improved. [246]

Following the critical reports the State Secretary announced and executed several measures intended to improve the exchange of information between the organisations in the asylum and return system.[247] The State Secretary examined in 2014 whether it would be possible to introduce a legal obligation for care providers to exchange medical information with third parties, also without the consent of the asylum seeker concerned. He concluded that such obligation would potentially violate the right to privacy guaranteed by Article 8 ECHR.[248] Instead, he decided to introduce a declaration of (non-) consent which would be signed by the asylum seeker at the start of the asylum procedure. This would ensure that information can be transferred if the asylum seeker moves from one organisation in the asylum system to another.[249] Asylum seekers who do not sign the declaration of consent would be informed of the risks which may result from that.[250] Furthermore, in May 2016 guidelines were adopted on the exchange of medical information.[251]

Even though the exchange of information has improved, there is still no central system in which all organisations involved in the asylum system can register and access information concerning (special needs of) asylum seekers. Exchange of information therefore mostly relies on personal contacts between organisations such as COA and IND, which creates a risk of incomplete information.[252] Furthermore, the exchange of medical information within the asylum system and the tensions with the right to privacy and medical confidentiality still seems to be an important point of concern and discussion.[253] The Health Care Inspection and Inspection of Security and Justice also indicated that awareness of employees on the need to share information within the asylum system remains crucial.[254] A pilot research published in July 2017 shows that a very low percentage of persons working in the asylum system, especially those who are not working for COA, IND and DT&V, finds that crucial

[244] Onderzoeksraad voor Veiligheid, *Veiligheid van vreemdelingen*, p. 8, Inspectie voor Veiligheid en Justitie, *Het Overlijden van Alexander Dolmatov*, p. 18, Nationale Ombudsman, *Medische zorg vreemdelingen, Over toegang en continuïteit van medische zorg voor asielzoekers en uitgeprocedeerde asielzoekers*, 3 October 2013, 2013/125, pp. 20-21.
[245] Onderzoeksraad voor Veiligheid, *Veiligheid van vreemdelingen*, p. 11.
[246] Ibid, p. 106.
[247] The Netherlands, Parliamentary documents, TK 2013/14, 19 637, nr. 1822, TK 2014/15, 19637, nr. 1892, TK 2014/15, 19 637, nr. 1947, TK 2015/16, 19 637, nr. 2186, Inspectie voor de Gezondheidszorg and Inspectie Veiligheid en Justitie, pp. 14-17.
[248] The Netherlands, Parliamentary documents, TK 2014/15, 19637, nr. 1947, p. 1.
[249] The declaration can be found on https://ind.nl/Formulieren/7114.pdf.
[250] The Netherlands, Parliamentary documents, TK 2014/15, 19637, nr. 1947, p. 2, TK 2015/16, 19 637, nr. 2186, p. 2.
[251] Ministerie van Veiligheid en Justitie, *Handreiking uitwisseling medische informatie in de vreemdelingenketen*, May 2016.
[252] See also Inspectie voor Veiligheid en Justitie, *Het Overlijden van Alexander Dolmatov*, p. 90.
[253] Interview COA 2.
[254] Inspectie voor de Gezondheidszorg and Inspectie voor Veiligheid en Justitie, pp. 16-17.

information is exchanged between COA, IND and DT&V.[255] This section will address the exchange of information concerning special needs between the different organisations in the asylum system.

### 2.6.1 Exchange of non-medical information

Information about the asylum seeker's health as well as for example his sexual orientation are special personal data which normally may not be shared by national authorities.[256] The term 'health' is interpreted broadly and includes all information about the mental or physical health of a person, such as the fact that he is ill or uses a wheelchair.[257] Health information needs to be distinguished from medical information which concerns for example the specific diseases or disorders a person suffers from and the treatment which is offered to them.

The Aliens Act provides that the IND, Aliens Police, Sea port police, Royal Netherlands Marechaussee and The Return and Deportation Service (DT&V) may share special personal data 'if they are necessary for the expedient and effective execution of amongst others the admission and reception of aliens'.[258] These organisations may thus share signals with regard to the special needs of an asylum seeker with other organisations in the asylum system (such as COA). However, only information which is 'strictly necessary' should be shared, not information which may be practical to know.[259]

COA is only allowed to share special personal data if the asylum seeker has given their explicit consent for that.[260] This also means that COA may only discuss an asylum seeker in the multidisciplinary meeting on the reception centre with the asylum seeker's permission.[261] One COA officer states that the protection of asylum seekers' privacy may cause risks, in particular in the setting of a reception centre: if someone does not want to be discussed, there are very limited possibilities to do so.[262]

### 2.6.2 Exchange between COA and IND

Where it concerns the exchange of (medical) information there seem to be two separate pillars. One pillar concerns reception and medical care, which is the responsibility of COA. COA, GCA and GGD have regular so-called multidisciplinary meetings at the reception centres, where they discuss persons staying at the reception centre who may have certain problems.[263] The other pillar concerns the asylum procedure, which is the responsibility of the IND.[264] One COA officer states that these two columns remain separate on purpose, because COA and IND have different tasks. Furthermore, she

[255] 12% of those respondents agreed that crucial information was shared between COA, IND and DT&V. 50% of the respondents working for COA, IND or DT&V agreed with this statement. Kantar Public*, Pilotonderzoek klantervaring Kleine Keten (IND, COA en DT&V)*, July 2017, p. 29.
[256] Art. 16 Wet bescherming persoonsgegevens.
[257] Ministerie van Veiligheid en Justitie, H*andreiking uitwisseling medische informatie in de vreemdelingenketen*, p. 17.
[258] Art. 107a(1) Aliens Act 2000.
[259] IND Instruction 2015/8, p. 7.
[260] Ministerie van Veiligheid en Justitie, *Handreiking uitwisseling medische informatie in de vreemdelingenketen*, p. 17.
[261] Interview COA 2.
[262] Ibid.
[263] Inspectie voor de Gezondheidszorg, *Goede vooruitgang in toegankelijkheid huisartsenzorg*, pp. 81-82.
[264] Interview Pharos.

stressed that COA only has health information (things that can be seen, such as a person who misses one leg), which is not useful to the IND.[265] However, Pharos contended that this information is useful to the IND, because such health information may be a reason to postpone or adapt the asylum process, certainly when there are behavioural problems or clear mental health issues.[266]

Both pillars have their own medical screening or examination: the urgency medical screening by GCA in the COA column and the medical examination for the purpose of the Medical advice interviewing and decision-making, in the IND pillar. Information about an asylum seeker's vulnerability is only exchanged in a few places. First, the FMMU and the Netherlands Forensic Institute (NFI) and Netherlands Institute of Forensic Psychiatry and Psychology (NIFP) can request information from GCA in the context of their medical examination. Second FMMU can advise a person with medical problems to consult GCA for medical care (see further section 3.6.7). Third COA and IND work closely together at the COL and jointly plan the start of the asylum procedure. In this context information about special needs may be exchanged.[267] Finally the asylum seeker's lawyer acts as a bridge between the two pillars.[268] He can request medical information from GCA and use that in the context of the asylum procedure or provide information from the asylum procedure to COA.[269] He may for example argue on the basis of this information that the Medical advice interviewing and decision-making was not careful. The lawyer can also contact both the IND and COA in order to ask for special procedural guarantees or reception facilities.[270]

The IND only sees the asylum seeker a limited number of times, usually during interviews. Furthermore, in particular in times of high influx it may take a lot of time before the IND meets the asylum seeker. IND is thus largely dependent on its partners in the asylum system (such as COA and the lawyer) for information on the potential special needs of the asylum seeker.[271]

However, there is no system in place for the exchange of information between COA and IND. In practice the IND receives signals from COA through personal contact.[272] In the COL, where the asylum seeker remains in the first three days after arrival, COA and IND work closely together.[273] Before the start of the asylum procedure COA officers and IND plan the asylum procedure together. COA officers involved in planning have contact with the COA officers working at the POL.[274] COA and IND officers working for regional planning ideally share a room or at least work close to each other which enhances exchange of information.[275]

One IND officer mentioned however, that it depends on the location whether the IND and COA effectively exchange information.[276] Usually COA calls the medical coordinator in order to share

[265] Interview COA 2.
[266] Interview Pharos.
[267] Interview COA 1.
[268] Interview Pharos.
[269] Interview Lawyer 2.
[270] Interviews Lawyer 2 and Pharos.
[271] Interviews IND 2 and 3 and COA 1.
[272] Interviews IND 2 and 3, IND 5 and 6 and COA 1.
[273] Interview COA 3.
[274] Interview COA 1.
[275] Interview COA 3.
[276] IND training Interviewing vulnerable persons, November 2016.

information concerning vulnerability. A medical coordinator mentions that in particular during the period of high influx IND received signals concerning special needs from COA.[277] The IND also shares information with COA. The IND should preferably inform COA about the asylum seeker's medical problems if, because of these problems, the asylum seeker's case has been referred to the extended asylum procedure.[278] During the training interviewing vulnerable persons IND officers were encouraged to share signals with COA. [279]

The IND registers incidents at the application centres in JOOST, which is only accessible to the IND and not to COA and security.[280] However, Since February 2017 the incidents registered in JOOST should also be registered in INDIGO, in order to enable the emergency team (*ketenbreed calamiteitenteam*, KCT) to inform COA and DT&V. This team is used when an asylum applicant threatens to commit suicide, hunger strike or other actions which can put the asylum applicant or others in danger. The emergency team also insets information from COA and DT&V in INDIGO, in order to inform the IND.[281]

### 2.6.3 Transfer of information to GCA

GCA gets most signals about asylum seekers with physical or psychological problems from COA and Nidos.[282] COA and GCA discuss the situation of asylum seekers who potentially have special needs in their multidisciplinary meetings. The IND, the DCR and lawyers indicated that they also inform GCA when they notice that an asylum seeker has medical problems.[283] Sometimes the IND asks the DCR to take the asylum seeker to a doctor.[284]

One lawyer mentioned that she sometimes sends a letter to GCA in which she writes that she is concerned about a client and requests GCA to talk to this client. However, she also tells her client to go to GCA during consultation hours, because GCA does not invite asylum seekers to make an appointment.[285]

To the person who referred an asylum seeker to GCA or provided signals, it is not always clear what follow-up is given by GCA. This is at least partly due to the fact that GCA personnel cannot provide medical information about a person to for example COA or the DCR. This may create incomprehension. For example GCA cannot give explanation about the fact that an asylum seeker keeps coming back to the DCR's office complaining about pain, stating that GCA does not offer any treatment for it.[286]

[277] Interview IND 2 and 3.
[278] IND Instruction 2010/13, p. 3.
[279] IND training Interviewing vulnerable persons, November 2016.
[280] Ibid.
[281] Additional information provided by IND 1 in September 2017.
[282] Interview GCA 2.
[283] Signals of suicidal behaviour are for example referred to GCA, see The Netherlands, Parliamentary documents, TK 2011/12, 19637, nr. 1490, p. 4. Drogendijk, A. et al, p. 30 and interviews IND 2 and 3 and DCR 4.
[284] Interview IND 2 and 3.
[285] Interview Lawyer 2.
[286] Interview DCR 4.

### 2.6.4 Exchange between lawyers and COA/IND

Asylum lawyers are not part of the multidisciplinary meetings which take place at the reception centres or in the detention centre at Schiphol Airport and do not have access to information systems. Lawyers mention that in general COA does not share signals concerning special needs with them. However, some COA officers act very proactively and contact the lawyer if something is wrong with their client.[287] Sometimes COA requests the IND to contact the lawyer about the asylum seeker's special needs.[288] One lawyer indicated that she has the feeling that COA, IND and DT&V exchange more signals amongst each other, than with the lawyer.[289] She sometimes noticed coincidently that COA has exchanged information with the IND concerning psychological problems or potential aggressive behaviour of an asylum seeker.[290]

During the course Interviewing vulnerable persons attended in the context of this study, the IND officers were encouraged to share signals concerning vulnerability with other parties in the asylum system, such as COA and the asylum seeker's lawyer.[291] The trainers also advised the IND officers to contact the lawyer if the interview has been difficult for the asylum seeker.[292] IND officers also mentioned that they sometimes contact the lawyer to discuss an asylum seeker's situation. They noted that a lawyer who has already spoken to their client about their asylum account has a better picture of the asylum seeker than the IND before the start of the interviews.[293] However, the IND does not systematically inform lawyers that their client is identified as a person with special needs.[294] One lawyer also mentioned that in particular new IND officers are often hesitant to contact a lawyer about a case.[295]

*A central contact point for lawyers*

Lawyers who think that their client has special needs do not have a central person or contact point within COA or the IND where they can turn to. One lawyer stated that she just starts calling and sending faxes to all numbers she knows, hoping that it will end up on the desk of someone who thinks that action is required.[296] It is especially problematic to contact the IND about an asylum seeker whose case has not yet been scheduled for the asylum procedure.[297] Then there is no responsible IND officer yet. One lawyer for example never received an answer on her request to the Application Desk (*Aanmeldbalie*) of the IND to prioritise a case of an unaccompanied child. The child concerned did start his asylum procedure soon afterwards.[298] Another lawyer was referred from one person to another

[287] Interview Lawyer 3 and 4, see also interview Lawyer 2.
[288] Interview IND 2 and 3.
[289] Interview Lawyer 3 and 4.
[290] Ibid.
[291] IND training Interviewing vulnerable persons, November 2016.
[292] Ibid.
[293] Interview IND 2 and 3 IND.
[294] Interview Lawyer 3 and 4.
[295] Ibid.
[296] Ibid. See also interview Lawyer 2.
[297] This was particularly relevant during the period of high influx when the period between the day of the application and the start of the asylum procedure could be more than six months. The IND can be reached via the so-called Service phoneline and the phone number of the IND location.
[298] Interview Lawyer 3 and 4.

when he asked for prioritisation of the asylum case of a four-year-old unaccompanied boy.[299] A request for prioritisation of the applications of an elderly couple to COA and the IND was also never answered.[300] If the asylum seeker has started with the asylum procedure the contact details of the responsible IND officer is mentioned in letters to the asylum seeker's lawyer. This makes it easier to discuss the case with the IND.

One lawyer stated that she cannot reach COA, because she does not know who the contact person is. In her experience it also takes weeks to get a response to emails if she gets a response at all. It only works if COA contacts her and she has a name and number.[301] Another lawyer stated that she just calls the location where the asylum seeker is staying if she wants to talk to COA about a client and that this usually works.[302]

The complaints voiced by the lawyers fit with the findings in a pilot research published in July 2017, according to which the IND and COA score relatively low on accessibility (*bereikbaarheid*) and referring (*doorverwijzen*).[303]

Lawyers suggested that the IND and COA should start a special email address or phone number, where lawyers can report cases of clients who (in their view) have special needs.[304] Such a central phone number already exists for cases which are pending in appeal and in which the lawyer urgently needs to talk to the representative of the State Secretary (the so called *PIEP lijn*).[305] This is particularly important in cases where there is not yet an IND officer who is responsible for the case, for example in the situation that the asylum seeker is waiting for the start of the asylum procedure.

### 2.6.5 Exchange of information between the DCR and COA/IND

If volunteers of the DCR receive signals that an asylum seeker has special needs, they will usually inform the lawyer. If no lawyer is available yet, the DCR tries to prevent that the lawyer is confronted with a *fait accompli*.[306]

The DCR also shares information with COA.[307] The effectiveness of the cooperation and exchange of information between the DCR and COA differs per location.[308] Some COA location managers and managers of the DCR see the assets of cooperation, others don't. Sometimes there are regular (weekly or even daily) consultations between COA and the DCR, sometimes such consultations are *ad hoc* or

[299] Interview Lawyer 5.
[300] Ibid.
[301] Interview Lawyer 2.
[302] Interview Lawyer 3 and 4. Also one mental health care provider noted that she usually calls COA at the location and that they usually respond. Interview Centrum '45.
[303] *Kantar Public*, Pilotonderzoek klantervaring Kleine Keten (IND, COA en DT&V), July 2017, p. 27,
[304] Interviews Lawyer 3 and 4 and Lawyer 5.
[305] Interview Lawyer 3 and 4
[306] Interview DCR 1 and 2.
[307] Ibid.
[308] Conversations with UNHCR staff, UNHCR the Netherlands, August/September 2016.

completely lacking. DCR personnel in the reception centres sometimes experiences the relation with COA as distant.[309]

### 2.6.6 Exchange at the application and detention centre at Schiphol Airport

At Schiphol Airport the organisations involved have close contact.[310] The IND receives signals from the Royal Netherlands Marechaussee which stops asylum seekers at the border at Schiphol Airport. They ask asylum seekers whether there are reasons (including medical problems) why they cannot be detained. The IND reads the reports of the Royal Netherlands Marechaussee. The IND also receives signals from volunteers of the DCR or lawyers, who can directly contact the senior IND officer on duty that day.[311]

The IND at Schiphol Airport has regular contact with the Judicial Institutions Service (*Dienst Justitiële Inrichtingen*) and the medical service about vulnerable persons. An IND officer mentioned an example of an asylum seeker who was released from detention on the request of the medical service because he needed treatment in a hospital. In that case the IND sent the asylum seeker to the extended asylum procedure and informed COA that he had to be placed in an open reception centre as soon as possible.[312] When the IND releases a person from detention it informs COA about the case, so that the medical service and psychologists can ensure a transfer of information to the new reception location. Every week there is a meeting with the medical service, the psychologists, the IND, the Return and Expulsion Service (*Dienst Terugkeer & Vertrek*, DT&V), the head of the department of the institution and persons working at the different departments in which persons with special needs are discussed.[313]

### 2.6.7 Exchange of medical information to non-medical personnel

GP's and other care providers of GCA should safeguard patient confidences and privacy (medical confidentiality, *medisch beroepsgeheim*). That means that they may not share (medical) information with for example COA without the asylum seeker's explicit consent.[314] GCA has a standard form for requests to send medical information to a new GP, a lawyer or other third parties.[315] Also mental health care providers will only inform COA about the health of an asylum seeker with their informed consent.[316] The patient should be informed about the recipient, purpose, content and the potential consequences of the transfer of information.[317] Even if the patient has given permission to share medical information the care provider should assess whether sharing the information is in the interest

[309] Interviews DCR 4 and COA 1. According to DCR this may be caused by the fact that DCR works with volunteers and COA with professionals and that both have a relation of confidence with their clients.
[310] Interviews FMMU 2 and IND 1.
[311] Interview IND 1.
[312] Ibid IND 1.
[313] Interview IND 1.
[314] Gezondheidscentrum Asielzoekers, *Your personal information, our responsibility Privacy guidelines for clients of Gezondheidscentrum Asielzoekers (Health Centre Asylum Seekers)*, 1 September 2012.
[315] Gezondheidscentrum asielzoekers, *Consent to share medical information*, 16 August 2016.
[316] MCA, *Convenant GGZ voor asielzoekers*, 5 October 2015, p. 6.
[317] Ministerie van Veiligheid en Justitie, *Handreiking uitwisseling medische informatie in de vreemdelingenketen*, pp. 15, 24.

of the asylum seeker.[318] In this regard the care provider should take into account that IND and COA do not have the duty to keep medical information confidential, as opposed to doctors or nurses.[319] If the patient does not give their explicit consent to share information, the care provider can only share information in extreme situations where it can prevent serious harm to their patient or others. Even in such situations sharing information without consent is only allowed if there is no other option to prevent serious harm and the care provider has a conflict of conscience and has tried everything in his power to get the client's consent.[320]

*Action perspective*

In practice GCA does not share medical information with third parties such as COA. However, if GCA is concerned about a person they do discuss that with COA, for example during the multidisciplinary meetings at the reception centres.[321] The information exchanged is limited to what is strictly necessary.[322] They will not tell COA from which specific medical condition the asylum seeker is suffering and therefore stay within the limits of medical confidentiality. However, they will tell COA officers how they need to approach the asylum seeker or what they need to do in order to prevent harm. This is called 'action perspective' (*handelingsperspectief*).[323] GCA can inform COA for example that an asylum seeker is in need of kidney dialysis. They can also advise COA to keep an eye on the asylum seeker or offer a daily structure, if they are suffering from psychological problems[324] or shows suicidal behaviour.[325] Furthermore, GCA tells COA when an asylum seeker does not appear for his appointments with GCA.[326] However, sometimes action perspective is lacking for example when an asylum seeker returns from a psychiatric institution to a normal reception centre.[327]

Also one specialist mental health care provider mentioned that she tries to involve COA with her client. She asks COA for example to include the client in activities. Sometimes COA officers are relieved to know that an asylum seeker is treated for psychological problems because they are worried about the asylum seeker.[328]

According to the State Secretary, action perspective suffices in order to provide expert and responsible care and to guarantee the safety of the asylum seeker, co-habitants and themselves.[329] However, COA and GCA also remark that for COA personnel working in the reception centres it can be frustrating not to know what is going on with asylum seekers, even though they need to take care of them day and

[318] Ibid.
[319] Ibid, p. 18.
[320] Ibid, p. 16.
[321] Inspectie voor de Gezondheidszorg, *Goede vooruitgang in toegankelijkheid huisartsenzorg*, pp. 81-82.
[322] Ministerie van Veiligheid en Justitie, *Handreiking uitwisseling medische informatie*, p. 19.
[323] The Netherlands, Parliamentary documents, TK 2014/15, 19637, nr. 1947.
[324] Interview GCA 1.
[325] The Netherlands, Parliamentary documents, TK 2011/12, 19637, nr. 1490, p. 4.
[326] Interviews COA 2 and GCA 1.
[327] Inspectie Veiligheid en Justitie, *Monitor Vreemdelingenketen II*, May 2015, p. 40.
[328] Interview Centrum '45.
[329] Parliamentary documents, TK 2014/15, 19 637, nr. 2025, p. 15, Inspectie Veiligheid en Justitie, *Monitor Vreemdelingenketen II*, p. 7. See also interview GCA 1.

night.[330] Often the COA personnel is dependent on what the asylum seekers themselves tell them about their problems.[331]

*Medical information for lawyers*

The asylum seeker's lawyer can ask for medical information from GCA or a specialist for example in order to use this information in the asylum procedure. On the basis of the medical information provided, they may challenge the FMMU advice, ask for (further) special procedural guarantees or postponement of the asylum seeker's departure on medical grounds. This may raise ethical questions for care providers, because in the legal proceedings the nuances of diagnosis and treatment, which are used in medical discourse, may be lost.[332]

Lawyers can contact the local GCA office in order to request for medical information. In the light of privacy GCA asks lawyers to limit requests to the specific medical information which is needed for the asylum procedure instead of asking for the whole medical file.[333] However, lawyers may be asked to pay for a request for specific information, while the medical file is often obtained for free.[334] One lawyer mentions that GCA nurses and doctors in the reception centres (COL, POL, AZC) are not proactive. Only the nurses working in the application centres (AC) signal problems and work together in that respect with the DCR and lawyers.[335]

*Exchange of medical information between medical personnel*

The exchange of medical information between doctors and other medical personnel is less problematic than between medical personnel and non-medical personnel. However, also here the informed consent of the asylum seeker is necessary. One specialist mental health care provider noted that she is seldom able to get in touch with GCA in crisis situations. In the case of a client who expressed suicidal thoughts, she finally contacted COA, because GCA was unreachable.[336]

The care providers of GCA do not share medical information with the medical advisors of FMMU, but FMMU may receive information on request. GCA has a curative and not an advisory task. It therefore does not want to give the asylum seeker the impression that it is on the side of the IND. This would hurt the trust between patient and doctor. [337]

### 2.6.8 Exchange of information in the context of return

For aliens who are detained or are to be expelled from the Netherlands various measures are taken in order to ensure the effective exchange of information. In February 2013 GCA concluded an agreement with the Special Facilities Service (*Dienst Bijzondere Voorzieningen*) about the transfer of medical

[330] Interviews COA 2 and GCA 1.
[331] Interview COA 2.
[332] Kramer, S. And others, *Ethische dilemma's in de GGZ voor asielzoekers*, Johannes Wier Stichting, 2015, p. 33.
[333] https://www.gzasielzoekers.nl/ikbenprofessional/praktischeinformatie/medischegegevensopvragen.
[334] Additional information provided by Pharos in September 2017, see also http://www.gcasielzoekers.nl/professionals/veelgestelde-vragen/.
[335] Interview Lawyer 3 and 4.
[336] Interview Centrum '45.
[337] Interviews GCA 1 and GCA 2.

information from a COA location to a detention centre.[338] Furthermore, IND, DT&V and COA share information in the national return consultation (*nationaal terugkeer overleg*). All information concerning the alien is available online for the organisations concerned with return and expulsion in information system *SIGMA* (which replaced *TISOV*)[339] in order to ensure a careful return procedure.[340] Via this system the DT&V informs the Royal Netherlands Marechaussee or the Maritime Police about all facts and special circumstances, including health information, which may be important for the safety of the alien during the expulsion or the safety of the officers who accompany the alien during the flight.[341] Information is entered into SIGMA as soon as a person is placed in aliens detention (at the border or with a view to expulsion) and is kept up to date until the moment of expulsion or release.[342] This system is not used for asylum seekers during the asylum procedure, who are not place in (border) detention.[343]

Since January 2017 the IND in the detention centre of Schiphol Airport has access to SIGMA.[344] In September 2017 the IND noted that IND officers will be able to put information in SIGMA on short notice. Furthermore, the IND is planning to place information with regard to all aliens in SIGMA and to grant access to all IND officers who have contact with aliens.[345]

## 2.7 Conclusions

COA (reception) and the IND (asylum procedure) are responsible for the assessment of asylum seeker's special needs. Both organisations use their own tools in order to make this assessment and register the results in separate systems.

Special reception needs and the need of medical care is first assessed in the urgency medical screening by GCA, which takes place shortly after the asylum seeker's arrival in the Netherlands. As a result of this screening asylum seekers with (serious) health problems, pregnant women and asylum seekers in need of medication are identified and receive the necessary medical attention. If medical problems are found, GCA will do a follow-up intake when an asylum seeker is moved to a POL or AZC. In the reception centres COA uses the so-called 'six domains tool' in order to assess the wellbeing of asylum seekers and identify their special needs. COA officers are all trained to use this tool.

The IND uses the Medical advice interviewing and decision-making, which is provided by FMMU before the start of the asylum procedure. The advice states whether the asylum seeker can be interviewed and has limitations which may influence his ability to make complete, coherent and consistent statements. This medical advice will be discussed in the next chapter of this report. Furthermore, IND officers may pick up signals that an asylum seeker has special needs during the interviews. IND officers

[338] Inspectie voor de Gezondheidszorg and Inspectie voor Veiligheid en Justitie, p. 15.
[339] Besluit van de Staatsecretaris van Veiligheid en Justitie van 7 december 2016, nummer WBV 2016/18, houdende wijziging van de Vreemdelingencirculaire 2000, Staatscourant 2016, nr. 68723, Inspectie Veiligheid en Justitie, Monitor Vreemdelingenketen II, p. 5.
[340] WBV 2016/18, p. 32.
[341] Ibid, p. 8, Inspectie voor de Gezondheidszorg and Inspectie voor Veiligheid en Justitie, p. 15.
[342] WBV 2016/18, p. 8
[343] Inspectie Veiligheid en Justitie, *Monitor Vreemdelingenketen II,* p. 5.
[344] Interview IND 1.
[345] Additional information provided by IND 1 provided in September 2017.

are trained to identify asylum seekers with special needs in the training interviewing vulnerable persons.

Apart from COA and the IND other players in the asylum system such as the Aliens Police, the Royal Netherlands Marechaussee, Nidos, the DCR and lawyers have an important role in the identification of asylum seekers with special needs. The DCR and lawyers speak to asylum seekers before the start of the asylum procedure in order to provide them information and prepare them for the asylum procedure. Lawyers first talk with their clients about their asylum motives, which may bring psychological problems and other vulnerabilities to the fore. They may use the 'Questionnaire physical and psychological problems', provided by the Institute for Human Rights and Medical Assessment, in order to detect psychological problems.

*Risks of a lack of identification*

Even though COA and IND use these different identification tools there is a risk that asylum seekers with special needs are missed for several reasons. First, asylum seekers who may be transferred under the Dublin Regulation, asylum seekers from safe countries of origin and asylum seekers who received an asylum status in another EU Member State do not have a rest and preparation period. Moreover their asylum claims are processed very quickly by the IND. As a result they do not receive (sufficient and adequate) information from the DCR, no preparation by a lawyer and no Medical advice interviewing and decision-making before the start of the asylum procedure. They only get the urgency medical screening by GCA. This reduces the chance that special needs are noticed before the negative decision on their asylum application. It should be noted that the duty to assess special needs also applies to these categories of asylum seekers. Moreover, special needs should be taken into account in the assessment whether an asylum seeker can be transferred to another Member State and whether the asylum seeker risks inhuman or degrading treatment upon return to the (safe) country of origin.

Furthermore, during the urgency medical screening by GCA psychological problems will often not come to the fore, because asylum seekers generally feel happy and relieved directly after arrival, while psychological problems emerge later. The same may apply to the Medical advice interviewing and decision-making, which normally also takes place shortly after arrival (see further section 3.3.3). It is not clear whether the fact that the more elaborate intake by GCA in the POLs has been replaced with the urgent medical screening has had a (negative) effect on the identification of psychological problems.

Psychological problems may emerge after the medical screenings have taken place. Moreover, medical screenings do not identify special needs for other reasons than medical problems, such as special needs linked to an asylum seeker's sexual orientation. It is thus essential that COA, GCA and IND assess whether the asylum seeker has special needs as a result of psychological problems or non-medical reasons at a later stage. However, COA and GCA do not systematically screen asylum seekers after their arrival in a reception centre (POL or AZC). As a result asylum seekers with special needs may remain hidden. COA intends to screen asylum seekers on the basis of the six domains tool in a more uniform and systematic way in the future.

Stakeholders noticed that In particular during the period of high influx and the resulting long waiting periods asylum seekers did not talk about their medical problems and other vulnerabilities which may give rise to special needs, because they thought that it would prolong their asylum procedure.

*Registration of special needs*
COA and IND register (signals about) special needs in their own registration system, which cannot be accessed by other organisations. For IND officers information on special needs is not directly visible in the computer system.

*Exchange of information*
Exchange of information concerning special needs between COA and IND mainly takes place through personal contact. COA and IND planners work closely together and COA officers may phone the medical coordinator of the IND about an individual case. Furthermore, the lawyer can transfer (medical) information from COA and GCA to the IND and vice versa. This makes the exchange of information on special needs dependent on the sensitivity of individual COA and IND officers.

After several incidents the exchange of information during the return process has been improved by the introduction of regular consultations between the organisations involved and an information system which is accessible to all these organisations. However, such measures have not yet been taken for asylum seekers before and during the asylum procedure. The IND wants to place information with regard to all asylum seekers (not only those in detention) in SIGMA which is accessible to IND, COA and DT&V.

Lawyers experience difficulties if they want to inform COA or the IND about the (potential) special needs of their clients. In particular when the start of the asylum procedure has not been planned yet they have no contact point at COA and IND. This was particularly problematic during the period of high influx. Lawyers plead for a central contact point where they can express their concerns and ask for special facilities or guarantees for their clients.

Furthermore, it became clear from the interviews with the lawyers that they do not know about the tools used by COA, GCA and IND in order to assess special needs. Furthermore, they are often not informed about the fact that the IND or COA picked up and/or exchanged signals about special needs. It depends on individual COA and IND officers whether they are informed and/or asked to think about solutions for their clients.

The possibilities for medical professionals, such as GP's and nurses of GCA and other treating doctors to provide information to COA or other organisations remains very limited. This sometimes leads to insecurity and incomprehension with COA officers and for example the DCR. GCA does provide guidance to COA as to how they should deal with an asylum seeker (for example check on them regularly or offer activities). This should enable COA to provide the necessary support to the asylum seeker concerned.

# 3 The Medical advice interviewing and decision-making

## 3.1 Introduction

In the Netherlands, asylum seekers undergo a medical screening before the start of the asylum procedure.[346] The goal of this medical screening is, first of all, to identify medical problems, which may limit the asylum seeker's ability to make complete, consistent and coherent statements about their asylum motives. Secondly, it aims to establish whether the asylum seeker has medical problems which require immediate treatment. [347] On the basis of the medical screening, the IND is advised how it should take into account such limitations during the interview. The IND can also be advised to cancel or postpone the interview. The advice is called the Medical advice interviewing and decision-making (*Medisch advies horen en beslissen*) and is currently carried out by the Forensic Medical Society Utrecht (FMMU). The IND remains responsible for the decision whether and when an asylum seeker will be subjected to an interview.[348]

This chapter discusses the process of the medical screening and the quality of the medical advice. It will address the procedure of the medical screening (section 3.3), the training of the FMMU nurses and doctors and internal quality checks (section 3.4) and the cooperation of FMMU with the IND and other stakeholders and external quality checks (section 3.5). Furthermore, this chapter describes the content of the medical screening and advice and examines how FMMU examines scars and advises asylum seekers to consult medical care providers (section 3.6). It also reviews (opinions about) the quality of the medical advice (section 3.7).

Conclusions in this chapter about the quality of the medical screening are based on the quality norms set out in the Protocol of the FMMU or the original intent of the medical screening as derived from Parliamentary documents and IND policy.

## 3.2 Background

The medical screening was introduced in the Dutch asylum procedure in 2010. Before 2010, there was no standardised way of medically examining asylum seekers. It was at the IND's discretion to request a medical advice by a locally commissioned practitioner.[349]Asylum seekers were able, however, to submit a medical or psychological report on their own initiative. These reports were prepared by MAPP (*Meldpunt Asielzoekers met Psychische Problemen*), an initiative by ASKV support refugees, a Dutch NGO. The MAPP project raised important awareness with the IND about psychological problems

[346] See Art 3.109(6) Aliens Decree 2000.
[347] Netherlands Parliamentary documents, TK 2008/09, 29 689, nr. 243, pp. 4-7, IND Instruction 2010/13, p. 1. The State Secretary of Justice states (TK 2008/09, 29 689, p. 4): 'The purpose of [the medical screening] is to quickly identify the possible need for starting medical treatment and to prevent this from occurring only in a later stage, for example during the preparation of the return.'
[348] IND Instruction 2010/13, p. 3.
[349] According to Amnesty International this procedure violated the Istanbul Protocol. Letter Amnesty International to Minister Verdonk 'Laat Vluchtelingen tot hun recht komen', 1 November 2005, p. 6.

which may interfere with asylum seeker's ability to make complete, consistent and coherent statements.[350]

In 2010, when mandatory medical screenings were introduced, MediFirst won the public procurement procedure. It conducted the screenings from July 2010 until February 2015. MediFirst is a company specifically created to carry out the medical advice, which acted independently from the IND.[351]

A second public procurement procedure took place after four years and was won by FMMU. Medical screenings have been conducted by FMMU since 1 February 2015. FMMU has provided medical services since 1997 in amongst others detention centres, prisons and mental health care institutions and organisations in the field of substances abuse and homeless care.[352]

FMMU's public procurement bid scored lower than MediFirst on the point of quality but (much) higher on the point of pricing.[353] The public procurement led to controversy and two court cases. MediFirst started a procedure, claiming that FMMU offered fees that could not realistically be maintained (25 per cent under MediFirst's fees[354]). The court rejected MediFirst's claim in first instance[355] and in appeal[356]. However, in interviews conducted for this study, a number of stakeholders voiced their concerns that the lower price of the medical advice also led to a lower quality of the medical advice.[357] Moreover, the MediFirst staff did not introduce the FMMU staff to their new task as a result of the turbulent takeover.[358] FMMU had little time to become operational and cooperation between MediFirst and FMMU did not run smoothly. The experience of the organisation as well as the individual experts of MediFirst were lost.[359] Particularly the IT system of FMMU experienced serious difficulties in the first months of operation. This resulted in advice not being signed by the doctor, all advice indicating that the asylum seeker was screened by the doctor and a glitch that made it impossible to fill out the field in which the limitations had to be mentioned.[360]

[350] Additional information provided by Pharos in September 2017.
[351] See for more information: www.medi-first.nl.
[352] IND and FMMU, Protocol IND en FMMU-Advies, 5 November 2015, p. 5.
[353] MediFirst received 460 points for quality and 190 points for pricing, FMMU got 380 points for quality and 348 for pricing. District Court of the Hague, 6 October 2014, ECLI:NL:RBDHA:2014:13392, para. 2.7. The IND mentioned that quality counted for 70% and pricing for 30%. Interview IND 4. See also interview Lawyer 1.
[354] Interview Pharos.
[355] District Court The Hague, 6 October 2014, ECLI:NL:RBDHA:2014:13392.
[356] Court of Appeal The Hague, 25 November 2014, ECLI:NL:GHDHA:2014:3758.
[357] Interviews Lawyer 1 and Pharos.
[358] Interviews Legal Aid Board and DCR 5, Pharos and IND 4.
[359] Interviews Pharos, Lawyer 1 and Medifirst. Medifirst claims that its nurses did not want to work for FMMU because of the lack of training and the short time available for the examination.
[360] Interviews IND 4 and Legal Aid Board and DCR 5.

## 3.3 Procedure of the medical screening

### 3.3.1 Offer of a medical screening

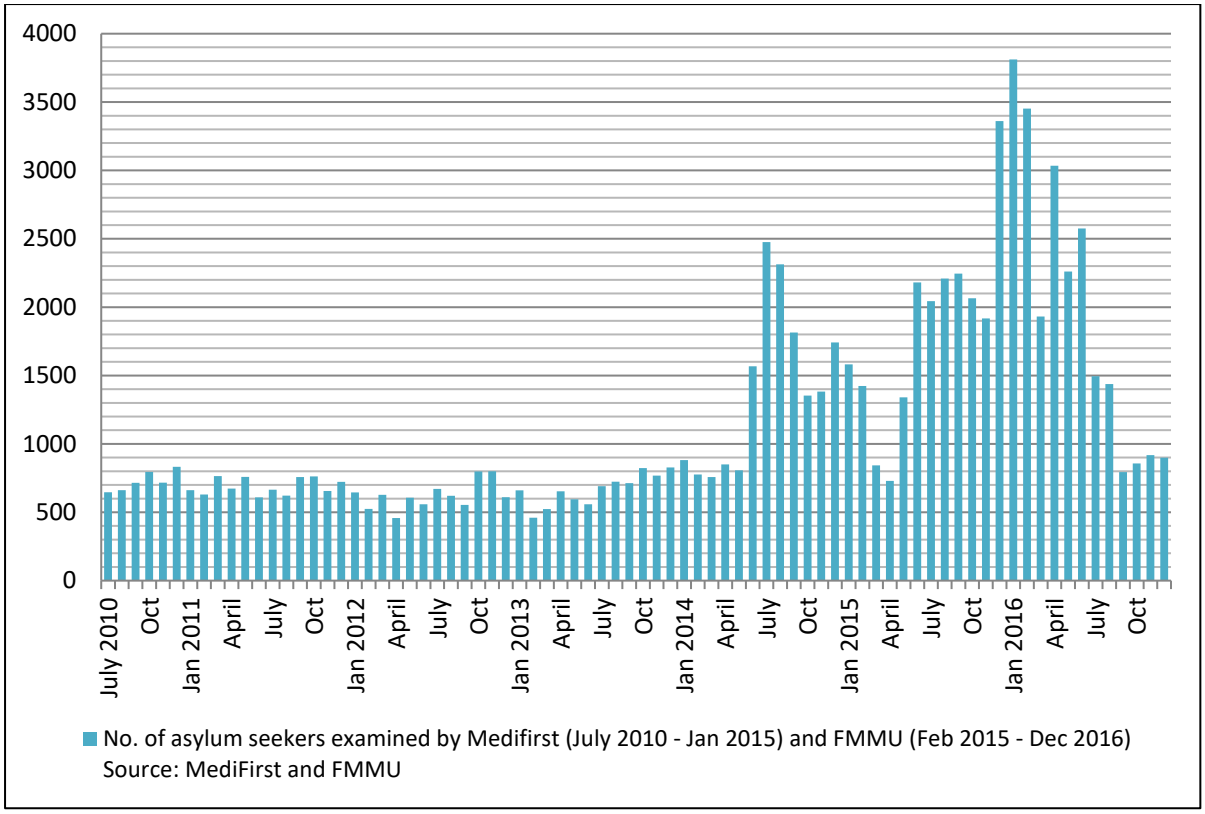
The medical screening is offered to asylum seekers who lodge a first asylum application and who have the right to a rest and preparation period.[361] Persons who enter the Dublin procedure ('track 1' or *Spoor 1*) or the special fast-track procedure for persons originating from a safe country of origin or who have protection in another EU Member State ('track 2' or *Spoor 2*) do not get a medical advice.[362]

The lack of an FMMU advice in these cases may impede the identification of special needs of asylum seekers concerned. The fact that asylum seekers originate from a safe country or have been granted protection in another EU Member State does not exclude that they are in need of medical care or have limitations affecting the quality of the interview with the IND.[363] The category of asylum seekers granted protection in another EU Member States includes, for instance, Syrians who were granted an asylum status in Greece.

In case of a subsequent asylum application, the IND determines whether the asylum seeker has raised new elements or findings which are relevant for the examination of the asylum claim.[364] In a report of the ACVZ, the lack of a medical screening in subsequent asylum procedures was criticised because the (mental) condition of an asylum seeker may deteriorate between the first medical screening and the subsequent asylum application. Therefore, professionals advised to offer every asylum seeker, also in case of a subsequent asylum application, the possibility to be medically screened.[365] This recommendation has not been implemented.

In 2016, 23,467 asylum seekers were subjected to a medical screening by FMMU. The total number of asylum seekers screened by FMMU in 2015 and 2016 is significantly higher than those screened by MediFirst between 2010 and 2014, though 2014 also saw a significant increase. This probably relates to the higher influx of asylum seekers, which started in 2014 with a peak in 2015.[366]

[361] Art. 3.109(6) Aliens Decree 2000.
[362] Art. 3.109ca(1) Aliens Decree 2000 states that the guarantees of Art 3.109, which includes the medical screening, are not applicable. MediFirst could give a medical advice in cases in which the asylum seeker would not be interviewed on his asylum motives (eg Dublin cases). See MediFirst, IND and Vereniging van Indicerende en adviserende Artsen, *Protocol Medisch Advies Horen en Beslissen*, 1 November 2013, Annex D, pp. 31-33.
[363] See also District court Den Bosch 13 December 2017, AWB 16/26212.
[364] Art 3.118b(2) Aliens Decree 2000 states that the guarantees of Art 3.109 Aliens Decree 2000, which includes the medical screening, are not applicable.
[365] ACVZ, *Expertise getoetst*, July 2012, p. 48.
[366] See IND, *Asylum Trends*, January 2016, p. 4.




### 3.3.2 Information and consent

During the rest and preparation period, asylum seekers receive an invitation for a medical screening. An IND leaflet informs asylum seekers about the purpose of the medical screening, the availability of an interpreter (via telephone), the confidentiality of the report and the importance to disclose all physical and mental problems the asylum seeker might have. It is also mentioned that the medical screening is free of charge.[367] Furthermore, the Dutch Council for Refugees (DCR) informs asylum seekers about the medical screening.[368]

The FMMU nurse interviewed for this study stated that at the start of the screening he explains his task, medical confidentiality and his impartiality to the asylum seeker.[369] Despite the information provided by the IND, there is a perceived lack of understanding among asylum seekers about the medical screening. A lawyer interviewed for this study pointed out that her clients regard the screening as a regular visit to a doctor.[370] The asylum seekers do not know what the purpose of the screening is.

Undergoing the medical screening is not compulsory. Asylum seekers should give the FMMU nurse written permission to screen them. Moreover, at the end of the screening the nurse will request

[367] IND, 'Before your asylum procedure begins', August 2015.
[368] Interviews DCR 1 and 2 and DCR 4.
[369] Interview FMMU 2.
[370] Interview Lawyer 2.

consent to send the medical advice to the IND.[371] For children under the age of 16, the parent or guardian (in the case of unaccompanied children) should give permission for the medical screening. Children older than 12 should also give permission themselves.[372] Asylum seeker (and/or their legal representative) need to sign a form.[373] One stakeholder noticed that in Ter Apel there were difficulties in the planning of medical screenings, notably of unaccompanied children. It happened regularly that the medical screening of an unaccompanied child could not take place, because the guardian was not present. He indicated that the problem was caused because FMMU nurses and doctors are not allowed to spend time on arranging logistical issues, such as making sure that the guardian is present.[374] An employee of Nidos, the guardian agency, noted that this situation has been improved because COA (the reception location) now arranges the invitations and transport.[375]

The IND does not refuse the asylum application on the basis that the asylum seeker refused to participate in the medical screening.[376] Asylum seekers are informed that the IND cannot take into account their medical condition if they do not participate in the medical screening.[377] In practice, very few asylum seekers refuse the medical screening or do not consent to send the medical advice to the IND. However, a significant number of asylum seekers do not show up at the medical screening. The reasons for this are not clear.

| | Total number of asylum seekers screened | No permission for medical screening | | No permission to send medical advice to IND | | No show at medical screening | |
|---|---|---|---|---|---|---|---|
| 2011 (MediFirst) | 8,281 | 31 | 0.37% | 20 | 0.24% | 343 | 4.1%* |
| 2012 (MediFirst) | 7,475 | 14 | 0.19% | 19 | 0.25% | 853 | 11.4% |
| 2013 (MediFirst) | 7,997 | 21 | 0.26% | 20 | 0.25% | 1,276 | 16% |
| 2014 (MediFirst) | 16,722 | 27 | 0.16% | 9 | 0.05% | 1,319 | 7.9% |
| 2015 (FMMU) | 20,359 | X | X | X | X | 2,013 | 9.9% |
| 2016 (FMMU) | 23,467 | 21 | 0.09% | 2 | 0.01% | 2,551 | 10.9% |
| ***(only Aug-Dec) , X = no data available, source: MediFirst and FMMU** | | | | | | | |

We compared the no-show figures from 2012 to 2016 for four locations (Gilze-Reijen, Wageningen, Schiphol and Ter Apel, see Annex 5). The locations Gilze-Reijen and Ter Apel have a consistently higher number of no shows compared to the other locations. In 2013, nearly one-third of the asylum seekers did not show up at the medical screenings in Ter Apel. Schiphol consistently has the lowest number of no shows, which can probably be explained by the fact that most asylum seekers are detained there. This means that they are always available in their cell and are taken to their appointment with the FMMU.

[371] Art 3.109(6) Aliens Decree 2000. See also IND, 'Before your asylum procedure begins', p. 3 and interviews FMMU 1 and FMMU 2.
[372] Protocol IND en FMMU-Advies, p. 10.
[373] Protocol IND en FMMU-Advies, Appendix 1, p. 14.
[374] Interview DCR 1 and 2.
[375] Email Nidos 23 March 2017.
[376] IND Instruction 2015/8, p. 2, Para. C1/2.2 Aliens Circular.
[377] IND, *Before your asylum procedure begins*, August 2015.

### 3.3.3 Timing of the medical screening

According to the FMMU Protocol, the medical screening takes place on day 5 of the rest and preparation period[378], which is usually before the asylum seeker has met with his lawyer. During the period of high influx, the medical screening took place longer after the asylum application, because the waiting times for the asylum procedure became longer.[379] This meant that one of the original purposes of the medical screening, to identify medical problems which need medical care, was partly lost. Sometimes asylum seekers had already stayed in the Netherlands for months before they underwent a medical screening by FMMU.[380]

With regard to the timing of the medical screening there are three points of discussion among the stakeholders:

1. The time between the asylum application and the medical screening
2. The time between the medical screening and the start of the asylum procedure
3. Whether the medical screening should take place before or after the asylum seekers' meeting with their lawyer

*The time between the asylum application and the medical screening*

Specialists have noted that if a medical screening takes place within a few days after the asylum application has been submitted, the likelihood of detecting psychological problems might be impeded. Psychological problems (especially post-traumatic issues) often only surface the moment asylum seekers have to talk about what they have experienced in their country of origin with their lawyer and the IND, i.e. after the medical screening.[381] Moreover, there is a 'relief effect' which makes asylum seekers elated in the early days of their arrival in the country. When the procedure carries on and the asylum seekers settle in the country, depressive thoughts might (re)appear.[382] On the other hand, some experts believe that an early screening reduces the likelihood of simulation.[383]

*The time between the medical screening and the start of the asylum procedure*

Secondly, the question is how much time may lapse between the medical screening and the start of the asylum procedure, i.e. the asylum interviews. Generally, professionals are positive that the medical screening takes place right before the start of the asylum procedure, so that there is a very current assessment of the asylum seeker's capability of being interviewed by the IND.[384]

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[378] Protocol IND en FMMU-Advies, p. 8.
[379] Interviews Lawyer 2 and FMMU 1.
[380] See State Secretary of Security and Justice, Letter explaining asylum seekers about the reception conditions and the waiting times in the asylum procedure, November 2015. The letter states that it takes around six months for the procedure to start. This means that the medical screening also took place months after the asylum seeker arrived in the Netherlands.
[381] ACVZ, *Expertise getoetst*, p. 48 and interview Pharos. See also section 2.4.3, where GCA stated that the urgent medical screening which takes place directly after arrival will usually not detect psychological problems.
[382] Interviews FMMU 1, FMMU 2, Pharos and GCA 2. One lawyer also suggested however that then psychological problems may be ascribed to long waiting times and not to trauma. Interview Lawyers 3 and 4.
[383] Haker, F., Van Bommel, H, Bloemen, E., *Zorg voor Asielzoekers met Psychische Problemen, Het perspectief van de zorgverlener,* Pharos/Zapp, 2010, p. 35.
[384] Interviews Lawyer 2 and Lawyer 5.

The director of FMMU, in an interview for this study, noted that the goal was to have a maximum of four days between the medical screening and the interview to make sure the assessment is up-to-date, but that this goal has not been achieved. He considers this problematic because after some time in particular the psychological situation of an asylum seeker may change.[385] A lawyer mentioned that there usually is a gap of around four weeks between the FMMU screening and the start of the asylum procedure.[386] In such situation the advice may not be up to date anymore.

*A medical screening before or after the asylum seeker's meeting with his lawyer*

There is disagreement on whether asylum seekers should be able to meet with their lawyer before the medical screening. Several organisations, such as Pharos and the ACVZ, have argued that the asylum seeker should be able to speak to his or her lawyer and prepare the asylum procedure before the medical screening takes place.[387] In 2014, several lawyers interviewed for an evaluation of the Aliens Act indicated that it would be an improvement if the medical screening would take place after the preparation meeting with the lawyer, so that the lawyer can provide relevant information to the medical advisor.[388] This was confirmed by a lawyer interviewed for this study, who preferred that she could explain the relevance and purpose of the medical screening to the asylum seeker beforehand.[389]

Moreover, preparation prior to the medical screening would allow lawyers to explain the relevance of scars and other afflictions, in order that asylum seekers can mention them during the screening. Finally, when asylum seekers have talked about their experiences in their country of origin this may cause psychological problems to surface. These problems may be missed if the medical screening takes place before the meeting with the lawyer.[390]

However, other professionals are uncertain whether it would be more effective to do the medical screening after the meeting with the lawyer.[391] The IND finds that lawyers should come into the picture after the screening in order to avoid any interference.[392] In a response to the ACVZ report, the Government also held that it does not deem it necessary to schedule a preparation meeting with the lawyer before the medical screening.[393]

Asylum seekers who enter through the Application Centre at Schiphol Airport see their lawyer before they have a medical screening, for logistical reasons.[394] Therefore, in theory, lawyers are able to signal vulnerabilities to FMMU in advance in these cases.[395]

[385] Interview FMMU 1.
[386] Interviews Lawyer 1 and Lawyer 2.
[387] ACVZ, Expertise getoetst, p. 48 and interview Pharos.
[388] Böcker, A.G.M. and others, *Evaluatie van de herziene asielprocedure*, WODC, 2014, p. 91.
[389] Interview Lawyer 2.
[390] Ibid, See also section 2.4.3, where GCA stated that the urgency medical screening which takes place directly after arrival will usually not detect psychological problems.
[391] Interview Lawyer 5.
[392] ACVZ, *Expertise getoetst*, p. 48; ACVZ, Sporen uit het verleden, July 2014, p. 32.
[393] The Netherlands Parliamentary documents, TK 2014/15, 19637, nr. 1903, p. 7.
[394] Interview Legal Aid Board and DCR 5, IND 1.
[395] Interview Legal Aid Board and DCR 5.

It would be useful to do further research on this issue, for example by comparing the experiences of lawyers and asylum seekers at the Application Centre at Schiphol Airport with those of lawyers and asylum seekers in the other application centres.

### 3.3.4 Privacy and medical confidentiality

FMMU only sends its medical advice to the IND. The questionnaire that the nurse or doctor uses to screen the asylum seeker remains confidential and is not sent to the IND. Furthermore, FMMU does not mention in its advice from which specific disease or complaints the asylum seeker is suffering for confidentiality reasons. As a result, the medical advice that the IND receives may remain vague at times with regard to the medical problems and mostly focuses on instructions to the IND (see further section 3.7). There is thus a tension between medical confidentiality and the clarity of the medical advice.[396] Discussions between MediFirst/FMMU and the IND took place, especially at the beginning of their respective work, to determine which information about the asylum seeker could be written in the advice and what should stay concealed from the IND.[397]

An FMMU nurse interviewed for this study noted that, in the advice to the IND, he tries to use lay terms to describe a physical or mental condition without using the medical terminology.[398] This does not apply if the IND officer has to be aware of the condition, for instance when the asylum seeker might need insulin during the interview due to diabetes. Non-physical conditions which are less specific, for instance illiteracy, are described in more general terms by indicating that the interviewer needs to ask questions multiple times and avoid complicated formulations.

### 3.3.5 Access to underlying documentation for lawyers

With the authorisation of the asylum seeker, lawyers are able to obtain the questionnaire underlying the FMMU advice.[399] All the lawyers interviewed for this study mentioned that they regularly ask FMMU for the questionnaire. The director of FMMU also felt that lawyers often request underlying documentation.[400] However, one employee of the DCR mentioned that lawyers in the application centre at Schiphol Airport often do not request for the documents underlying the medical advice. She noticed that lawyers are often disappointed with the medical advice and think that obtaining the underlying documentation will not help.[401]

Because of the speed of the general asylum procedure in which the asylum seeker can be rejected within 8 days (the AA-procedure) some lawyers feel forced to ask asylum seekers for their authorisation to request the questionnaire from FMMU before it is clear that this will be useful in their case. Asylum seekers thus give a blank authorization to their lawyer. One lawyer finds that problematic in light of the asylum seeker's privacy. [402]

[396] See about this tension also section 2.6.7.
[397] Interview IND 4.
[398] Interview FMMU 2.
[399] See further section 3.6.1.
[400] Interview FMMU 1.
[401] Interview Legal Aid Board and DCR 5.
[402] Interview Lawyer 5.

### 3.4 Training and internal quality checks

Doctors and nurses working for FMMU should be registered in the BIG register, the register for healthcare professionals in the Netherlands. The nurses are educated at intermediate vocational education level (MBO), the minimum tertiary education level in the Netherlands. Furthermore, they should have some experience in psychiatric care.[403] No extra requirements regarding the training of FMMU nurses and doctors are laid down in the FMMU Protocol.

The level of education of nurses and doctors required by FMMU is lower than the level of education of the nurses and doctors of MediFirst. The IND indicated that this lower level of education was included in the requirements for the public procurement procedure of 2015.[404] MediFirst employed nurses educated at higher vocational education level (HBO). Some of the nurses also had an additional post-HBO certificate in psychiatric care (SPV). Moreover, the doctors were specifically selected for their social-medical expertise.[405] According to the MediFirst Protocol they had to have ample experience as a medical adviser on psychiatric disorders, preferably have the specialisation Society and Health (*Maatschappij en Gezondheid*) and be a member of the Society of Indicating and Advising Physicians (*VIA*) or registered as a medical adviser (RGA). Finally they had to participate in training of Society of Indicating and Advising Physicians**.**[406]

According to the FMMU Protocol, medical personnel of FMMU is trained to identify psychological and psychiatric problems such as PTSD and to identify and document symptoms such as confusion, anxiety, strong emotions as a result of past experiences and a diminished memory.[407] FMMU designs its own training programme and organises courses.[408] The training plan should be adapted on the basis of regular evaluations and will be provided to the IND.[409] The training consists of the following modules:

| | |
|---|---|
| Module 1 | Introduction on asylum procedures and the IND |
| Module 2 | Presence at an IND interview |
| Module 3 | Legal aspects of interviewing and decision-making (lecture) |
| Module 4 | Psychological and psychiatric problems of asylum seekers |
| Module 5 | Cultural differences in the experience of illness and deviant morbidity patterns outside the Netherlands (lecture) |
| Module 6 | Tropical infection diseases and Tuberculosis |

The FMMU protocol indicates that nurses and doctors are required to do Module 1-3. Persons with relevant experience and competences can be exempted from Module 4-6. Four times a year there is

[403] Interview FMMU 1.
[404] Additional information provided by the IND in September 2017.
[405] Interview MediFirst.
[406] MediFirst Protocol, p. 4.
[407] Protocol IND en FMMU-Advies, p. 6.
[408] FMMU does not include external experts in this training. MediFirst asked Pharos to provide training. Interview MediFirst and MediFirst Protocol, p. 5.
[409] Protocol IND en FMMU-Advies, p. 7.

a meeting to update the FMMU personnel's knowledge on certain current themes. Nurses and doctors are required to attend three of such meetings a year.[410]

Before FMMU started advising the IND, the IND gave information about the asylum procedure to groups of FMMU personnel.[411] Apart from that, the IND is only involved in Module 2, in which FMMU nurses and doctors attend (part of) an IND interview.[412] New nurses and doctors thus do not seem to follow Module 1 and 3.[413] FMMU indicated that apart from the instructions from the IND and a few meetings at the FMMU office during the starting period of their work, nurses were not prepared in any special way for the job except that new nurses were coupled with experienced nurses during their starting period.[414] The lawyer who attended regular meetings with the IND and MediFirst and FMMU during the starting period of their work, noted that in the beginning these organisations did not have knowledge about the asylum procedure and the function of the medical advice in it.[415]

In practice not all FMMU nurses completed the required modules before they started to provide medical advice to the IND. Particularly during the period of high influx it was not possible to offer the training to nurses who screened asylum seekers at the emergency (pre-POL) reception centres. During this time FMMU had nurses on eight locations (instead of the four locations in which MediFirst was present).[416] This meant for example that new FMMU nurses had not attended an IND interview before they started advising the IND.[417] Instead new nurses were coached by an experienced nurse. During at least one day they received information about the process, how to approach asylum seekers and how to work with an interpreter. The doctor also has a coaching role. Usually new nurses did not work alone on a location.[418]

The IND knows when a new FMMU nurse or doctor is hired, but does not check whether FMMU fulfils its educational commitments with regard to this person.[419] The IND leaves it to the initiative of the new FMMU nurse or doctor to contact the medical coordinator in order to attend an IND interview.[420]

Each medical advice of an FMMU nurse is checked by a doctor, who receives the advice on his or her computer. Coordinating FMMU nurses and doctors meet once a month to discuss particular cases.[421] The FMMU nurse interviewed for this study indicated that he also regularly discusses particular situations with other nurses over the phone. Furthermore, he sometimes looks at medical advice issued by FMMU on other locations.[422] At the central office of FMMU one doctor regularly examines

[410] Protocol IND en FMMU-Advies, p. 8.
[411] Interview IND 4.
[412] Interview IND 1, IND 2 and 3.
[413] The IND mentions that instead they discuss individual cases. See further section 3.5.1.
[414] Interviews FMMU 1 and FMMU 2.
[415] Interview Lawyer 1.
[416] Additional information provided by the IND in September 2017.
[417] Interviews FMMU 1 and IND 2 and 3.
[418] Interview FMMU 1.
[419] Interview IND 4.
[420] Ibid.
[421] Interviews FMMU 1 and FMMU 2.
[422] Interview FMMU 2.

the quality of medical advice issued by different locations.[423] He also receives questions if there are uncertainties in specific cases.[424]

## 3.5 Cooperation with the IND and stakeholders and external quality checks

The Protocol mentions that FMMU wants to develop a high standard product and service for the asylum seeker as well as the IND. 'The vision of FMMU is that this takes place in cooperation with all parties who can share their expertise and experiences in this field in order to keep the procedure up to date and keep the standard of the execution of the work as high as possible.[425] According to the FMMU Protocol, a number of meetings with other organisations involved in the asylum procedure takes place.[426] Some of the meetings with IND and COA concern practical issues, such as planning.

### 3.5.1 Cooperation with the IND

In each application centre the IND has two medical coordinators who have special attention for medical aspects of the asylum procedure, answer questions of IND officers and serve as a contact point with the medical advisers such as MediFirst and FMMU.[427] Twice a year the medical coordinators of the IND and the FMMU (coordinating) nurses and doctors have (evening) meetings in which they discuss particular cases.[428] The meetings are organised per location, in order to bring together IND officers and FMMU personnel who work together on the same cases.[429] According to the IND these meetings are not well attended by FMMU personnel.[430] One reason was that FMMU does not reimburse nurses for these evenings. As a result, the IND decided to do so.[431]

Both FMMU and the IND note that there is a feedback loop with the IND. Employees of the IND either call or e-mail the local FMMU nurse if they have enquiries about a medical advice or question the quality of a medical advice issued by FMMU.[432] Moreover, the medical coordinators of the IND at the reception centres are in contact with their local nurses. At Schiphol Airport during the first two years of FMMU, the medical coordinator checked each month the quality of 25 randomly selected medical advices.[433] IND officers note that this works well.[434] FMMU has changed its practice according to this feedback. For example, the IND was critical of the fact that FMMU wrote down which topics could

[423] Interview IND 4.
[424] Ibid.
[425] Protocol IND en FMMU-Advies, p. 5.
[426] Ibid, p. 9.
[427] Interview IND 4. According to MediFirst the medical coordinators were introduced at their suggestion.
[428] The Protocol IND en FMMU-Advies mentions that these meetings are held once a month.
[429] Interview IND 4.
[430] Interviews IND 1 and IND 4. One IND officer mentioned that these meetings were well attended. Interview IND 2 and 3.
[431] Interview IND 4.
[432] Interviews FMMU 1, FMMU 2, IND 2 and 3 and IND 4.
[433] Interview IND 1. From the beginning of 2017 she stopped doing that because the quality of the advice remained constant and there was only one FMMU nurse working at Schiphol Airport. However, she still randomly looks at the medical advice. Additional information provided by the IND in September 2017.
[434] Interviews IND 1, IND 2 and 3 and IND 4. One IND officer noted that contacting the central office of FMMU is much more difficult.

make an asylum seeker emotional or used medical terminology.[435] Furthermore, the IND indicated that the fact that asylum seekers claim that they have problems remembering specific dates should not be reason to refrain from interviewing them.[436] FMMU has a software system where this feedback is noted and stored. Moreover, an internal newsletter is used to send out points of feedback to the entire organisation.[437]

One stakeholder mentioned that there is a risk that FMMU and the IND work too closely together, which may result in the IND influencing the FMMU advice and thus undermines the FMMU's impartiality. In his view MediFirst was more aware of this risk.[438] The IND indicated that the medical coordinators of the IND had to give more explanation to the FMMU than to MediFirst, because the coordinator of the medical screenings for MediFirst had worked for the IND and was familiar with the asylum process. According to the IND this does not mean that the IND and the FMMU are too close.[439] FMMU contended that it has limited the contact between the medical coordinators and FMMU personnel as much as possible. Nurses have to talk to the FMMU doctor if they have questions.

### 3.5.2 Cooperation with stakeholders

There are consultations between FMMU, the medical coordinators of the IND, a representative of the Legal Aid Board and a representative of lawyers who provide legal assistance to asylum seekers. During these meetings specific cases are discussed.[440] According to the representative of the lawyers in these meetings, the meetings took place regularly when MediFirst and FMMU had just started to advise the IND and many things went wrong. Currently these meetings no longer take place and will only be organised again if there is a specific reason for it.[441] The representative of the lawyers is satisfied with this situation and does not receive signals from her colleagues that they have problems with the FMMU advice. If there is such a problem she contacts the IND, there is no direct contact with FMMU.[442] However, the representative of the Legal Aid Board would like to discuss more individual cases with FMMU.[443] The DCR is not present during these meetings, even though they inform asylum seekers about the medical screening carried out by FMMU.[444]

Several stakeholders describe FMMU as a 'closed' organisation, which does not communicate with organisations other than the IND and is not transparent in its working methods.[445] Furthermore, some regret that FMMU does not make use of expertise in the field, such as that acquired by MAPP which screened asylum seekers before the introduction of the Medical advice interviewing and decision-making.[446] MediFirst had more contact with other organisations such as Pharos, the DCR, iMMO and

[435] Interview IND 4.
[436] Interview IND 2 and 3.
[437] Interview FMMU 1.
[438] Interview Legal Aid Board. This also showed from the interview with MediFirst.
[439] Additional information IND September 2017.
[440] Interview FMMU 1.
[441] Interview Lawyer 1.
[442] Interview Lawyer 1. She did have direct contact with the manager of MediFirst.
[443] Interviews Lawyer 1 and Legal Aid Board.
[444] Interview DCR 4.
[445] Interviews Legal Aid Board and DCR 5, Pharos, iMMO and Lawyer 5.
[446] Interview iMMO.

lawyers.[447] The Society of Indicating and Advising Physicians (*Vereniging van Indicerende en adviserende Artsen*) contributed to the development of the MediFirst Protocol. Furthermore, COA, Pharos, MAPP and the DCR were consulted during the developing process.[448] These organisations were not included in the revision of this protocol for FMMU. According to the IND this was not necessary, because the MediFirst protocol was used a basis and changes in the Protocol only concerned more practical issues.[449]

However, there are more substantial differences between the Protocols. The requirements with regard to training and experience were stricter in the MediFirst Protocol than in the FMMU Protocol (this probably already followed from the requirements of the public procurement procedure).[450] Furthermore, the MediFirst Protocol mentions more explicitly to which complaints nurses should pay particular attention than the FMMU Protocol. The MediFirst protocol also mentions the expected duration of the screening (45 minutes), while the FMMU Protocol does not.[451] The MediFirst Protocol also mentioned how long the medical advice could be considered valid, while the FMMU Protocol does not.

The FMMU Protocol was not discussed in the meetings with the representatives of the Legal Aid Board and asylum lawyers.[452] The Protocol was not publicly available until November 2016, when it was placed in the information database of the DCR. Several practitioners were unaware of the existence of a new Protocol. In decisions of the Medical Disciplinary Committee of June 2016, the MediFirst Protocol was still used to assess the actions of the FMMU practitioner.[453]

### 3.5.3 External quality checks

The Medical advice interviewing and decision-making is not subjected to (regular) quality checks by an external organisation[454], which is criticised by several stakeholders.[455] The medical advice does fall under the supervision of the Health Inspectorate. However, the Inspectorate has not examined the quality of the medical advice yet. Furthermore, asylum seekers or their lawyers can complain before the Medical Disciplinary Committees about the quality of a medical advice provided by a nurse and/or doctor. In the past years several cases have been brought before a Medical Disciplinary Committee against MediFirst (at least eight cases) and FMMU (two cases) doctors and nurses.[456] In at least 7 cases

[447] Interviews MediFirst and Lawyers 3 and 4. One lawyer notes that she has regularly threatened to file a complaint against FMMU in order to get contact with them.
[448] MediFirst, *Protocol Medisch advies Horen en Beslissen*, version 1 November 2013.
[449] Interview IND 4.
[450] See section 3.4.
[451] See further section 3.6.5.
[452] Interviews Legal Aid Board and Lawyer 1.
[453] Medical disciplinary committee Amsterdam, 21 June 2016, no. 331/2015.
[454] Interviews IND 4, Lawyer 1, Legal Aid Board and DCR 5 and iMMO.
[455] Interviews Legal Aid Board and DCR 5 and iMMO.
[456] See Regional Medical Disciplinary Committee Zwolle, 30 January 2017, ECLI:NL:TGZRZWO:2017:25 (doctor FMMU), Regional Medical Disciplinary Committee Amsterdam 10 May 2016, no 2015/331 (doctor FMMU), Regional Medical Disciplinary Committee 12 January 2016, ECLI:NL:TGZRSGR:2016:7 (doctor MediFirst), Regional Medical Disciplinary Committee Zwolle 10 April 2015, ECLI:NL:TGZRZWO:2015:37 and ECLI:NL:TGZRZWO:2015:38 (nurse and doctor MediFirst), Regional Medical Disciplinary Committee Zwolle 19 April 2013, ECLI:NL:TGZRZWO:2013:YG2854 (nurse MediFirst), Regional Medical Disciplinary Committee Eindhoven, 7 June 2012, ECLI:NL:TGZREIN:2012:YG2110 and ECLI:NL:TGZREIN:2012:YG2109 (doctor MediFirst),

a MediFirst nurse or doctor received a warning; the cases against FMMU did not result in a warning. In some cases an unaccompanied child was subjected to a medical screening without the consent of their legal guardian.[457] Most cases concerned the quality of the medical advice, especially the failure to mention serious (psychological) problems noted in the questionnaire in the advice to the IND.[458]

## 3.6 Content of the medical screening

### 3.6.1 Central question

The medical screening is based on the Protocol Medical Advice Interviewing and Decision-making. This protocol was initially written by MediFirst, the IND and the Society for Indicating and Advising Physicians (VIA). After its adoption, the Protocol has been amended several times, at the request of the Legal Aid Board and lawyers.[459] FMMU uses a new version of the Protocol, which was established at least five months after FMMU started to advise the IND. During the first five months of its functioning, FMMU used the Protocol of MediFirst.

The point of departure is that every asylum seeker will be interviewed. The central question addressed by FMMU is:

> **How may the potential presence of psychological or other medical limitations influence the asylum seeker's ability to make statements**?[460]

In the Medifirst protocol the term 'medical limitation' is defined as a functional limitation, which is caused by a medical problem, which may render asylum seekers incapable of talking about their asylum claim and may lead to gaps and incoherent or inconsistent statements.[461]

On the basis of a medical screening the FMMU gives a medical advice according to a fixed form. In case the nurse and/or doctor concludes that the asylum seeker cannot be interviewed, the following questions need to be answered:

- If it follows from your screening that an interview is not possible: on the basis of which limitation do you draw this conclusion?

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Regional Medical Disciplinary Committee Eindhoven 21 November 2011, ECLI:NL:TGZREIN:2011:YG1519 and ECLI:NL:TGZREIN:2011:YG1518 (nurse and doctor MediFirst).

[457] Regional Medical Disciplinary Committee Zwolle 19 April 2013, ECLI:NL:TGZRZWO:2013:YG2854, Regional Medical Disciplinary Committee Eindhoven 21 November 2011, ECLI:NL:TGZREIN:2011:YG1519 and ECLI:NL:TGZREIN:2011:YG1518.

[458] Disciplinary Committee Zwolle 10 April 2015, ECLI:NL:TGZRZWO:2015:37 and ECLI:NL:TGZRZWO:2015:38 (nurse and doctor MediFirst), Regional Medical Disciplinary Committee Zwolle 19 April 2013, ECLI:NL:TGZRZWO:2013:YG2854 (nurse MediFirst), Regional Medical Disciplinary Committee Eindhoven, 7 June 2012, ECLI:NL:TGZREIN:2012:YG2110 and ECLI:NL:TGZREIN:2012:YG2109 (doctor MediFirst). These will be discussed in the next sections.

[459] Evaluation of the revised Aliens Act of 2014, p 83. The list of questions was extended to include more specific questions about physical and psychiatric limitations and the doctor was forced to substantiate his conclusions more on the form.

[460] Protocol IND en FMMU-Advies, p 6.

[461] MediFirst, *Protocol Medisch advies Horen en Beslissen*, version 1 November 2013.

- Can you, if an interview is not possible, indicate the necessary measures and a time-limit in which an interview may be possible?
- Is it desirable in this situation to ask for a new medical advice before the interview?

It will only be concluded in exceptional cases that the asylum seeker cannot be interviewed. In such case the FMMU proposes a time-limit for a new screening.[462]

If the nurse and/or doctor concludes that the asylum seeker can be interviewed they have to indicate whether there are limitations:

- Given the medical complaints which have appeared during the medical screening, the following limitations are relevant for the interview and decision-making.

Limitations found, should be described in terms which are medically correct, but also understandable for persons who do not have medical training.[463] The nurse and/or doctor can also indicate that there are no limitations. Finally, the nurse and/or doctor can make remarks on the form which do not concern a limitation for the interview or decision-making, for instance the presence of scars or the advice to consult a general practitioner.[464]

The medical advice is based on a more elaborate questionnaire which is filled out by the FMMU nurse during the medical screening. It includes information about the asylum seeker such as marital status and family members present in the reception centre, education and literacy. Furthermore, the nurses can describe their general impression of the asylum seeker and any particularities. The asylum seeker's blood pressure, pulse, temperature, length and weight are measured. It is noted if the asylum seeker uses any medication and/or has medical or psychological complaints. The questionnaire mentions a whole range of physical problems which the nurse should ask the asylum seeker about, from disorders in the digestive system to hearing problems. The psychiatric complaints section contains separate questions about orientation in time, place and person, memory (short-term and long-term), sleeping problems (falling asleep and continue sleep), nightmares, returning thoughts or memories of painful or fearful events, mood, hallucinations and suicidal thoughts or attempts.[465]

### 3.6.2 Course of the medical screening

In order to write a medical advice, a medical screening will be carried out of physical and psychological factors which may interfere with the asylum seeker's ability to make coherent, consistent and complete statements during the asylum procedure. The asylum seeker is first screened by a nurse. The nurse talks to the asylum seeker with the help of an interpreter via the telephone or (sometimes) in person.[466] The nurse needs to address the physical and psychological problems during the screening. However, the experienced nurse interviewed for this study indicated that he has a conversation with the asylum seeker during which he tries to discover which problems he may have.

[462] Ibid., p. 6.
[463] Ibid., p. 6.
[464] Ibid., p. 16.
[465] Protocol IND en FMMU-Advies, pp. 18-23.
[466] IND, *Before your asylum procedure begins* and interview FMMU 2.

He does not limit himself to ticking the boxes of the questionnaire.[467] The medical advice by the FMMU nurse is always checked by a doctor. In some cases the asylum seeker is (also) screened by an FMMU doctor (see section 3.6.4).

The nurse or doctor may choose to screen an asylum seeker multiple times. This does not happen often, ranging from 4 per cent to 0,5 per cent (see Annex 1).[468] The data show that the number of asylum seekers screened multiple times has decreased since the beginning of 2015. This might be correlated to the decrease in asylum seekers who cannot be interviewed according to FMMU (see further section 3.6.6). According to the IND, if required, the asylum seekers' lawyers should contact FMMU directly to insist that a follow-up screening is done by a doctor.[469]

### 3.6.3 Examination of scars

According to the FMMU Protocol the nurse should ask asylum seekers during the medical screening whether they have scars.[470] If the asylum seeker has scars, this should be mentioned in the medical advice. The asylum seeker is not required to show these scars, nor does the FMMU request for the scars to be shown. If the scars are visible for the nurse (for example on the asylum seeker's face or hands), the advice will mention that the scars have been observed. FMMU is not allowed to screen or make suggestions as to the origin of the scars or other potential sequelae of torture.[471] They also do not document the scars, for instance by making photos or writing down a description of the scar (see further also section 4.3).[472]

An analysis of a limited number of medical advice issued in Wageningen, Schiphol Airport and Ter Apel, suggests that there is no consistency in the examination and mentioning of scars by FMMU. The advice issued in Wageningen and Schiphol always remark whether asylum seekers have indicated that they have scars or not, while advice in Ter Apel sometimes only mention scars if they are present.[473] One FMMU doctor only remarked in the advice that the asylum seeker stated that he had scars, but not where on the body the scars could be found. One lawyer stated that she always checks herself whether the asylum seeker has scars, because the FMMU advice does not always mention whether the asylum seeker has been asked about this.[474]

Secondly, in Schiphol and Ter Apel, the medical advices make an explicit distinction between scars, which were mentioned by the asylum seeker, but not observed and scars which were mentioned and were also observed. However, in the third location, Wageningen, the advices only occasionally mention whether a scar was observed. This creates confusion about whether a scar has been observed

[467] Interview FMMU 2.
[468] Statistics obtained from FMMU for this study.
[469] Interview IND 4.
[470] The FMMU nurse confirmed that he always asks about scars and also remarks in the advice that the asylum seeker has difficulties to talk about them, if that is the case.
[471] Protocol IND en FMMU-Advies, p. 6 and interview IND 2 and 3. Also MediFirst indicated that the IND was very reluctant where it concerned remarks about (the origin) of scars.
[472] Protocol IND en FMMU-Advies, pp. 6, 12 and interview FMMU 1.
[473] The FMMU nurse who was interviewed stated that he remarks in the advice the fact that the asylum seekers says that he does not have any scars. Interview FMMU 2.
[474] Interview Lawyers 3 and 4.

by the nurse or not. Furthermore, the terms used by FMMU create confusion. Often an advice mentions that scars were mentioned by the asylum seeker but were not 'observed' (*waargenomen*). To some employees of the IND it is not clear that this does not mean that the scars do not exist, but only that they have not been checked by the nurse.[475] It is clearer if the advice would state that the scars were mentioned by the asylum seeker but were not 'checked' (*gecontroleerd*) by FMMU, which happened in some of the advice reviewed for this study.

Thirdly, FMMU in Wageningen was not consistent regarding the places on the body that were screened by the nurse. For instance, one nurse examined a scar on the asylum seeker's stomach, while another did not. In most advice, readily perceivable scars were observed by the nurse. However, two advice issued in Wageningen noted that the asylum seeker indicated a scar on his right finger and left wrist without indicating whether they were observed. One lawyer also mentioned a case of an asylum seeker who had striking scars in his face. The FMMU advice mentioned that the scars had not been observed.[476] The fact that a scar has not been mentioned or observed by a nurse can have negative consequences for the asylum seeker. If the asylum seeker requests a forensic medical examination in a later stage of the asylum procedure, the IND may attribute to the asylum seeker that the scars did not exist at the time of the FMMU screening.[477]

### 3.6.4 Screening by a doctor or a nurse?

The original idea of the medical screening was that a nurse would do the primary identification of medical problems. The asylum seeker would be referred to a doctor if there were possible limitations which could interfere with the asylum seeker's ability to be interviewed.[478] In practice the medical screenings are performed by nurses of the FMMU. Each advice is reviewed and signed by a doctor.[479] The doctor has final responsibility. If the nurse finds it necessary, the doctor will screen the asylum seeker and give the advice.[480] The FMMU Protocol does not clarify, however, when this will be the case. Doctors can also decide themselves on the basis of the advice that they want to see the asylum seeker.[481] The FMMU headquarters in Utrecht arranges the availability of doctors at the different locations: a doctor is physically present once a week at the different locations.[482] The MediFirst Protocol stated that the asylum seeker could be screened by a doctor if it appeared or was expected from the screening by the nurse that there would be a medical limitation.[483]

[475] IND training Interviewing vulnerable persons, November 2016.
[476] Interview Lawyers 3 and 4.
[477] Reneman, A.M., De Lange, J. and Smeekes, J., 'Medische waarheidsvinding en geloofwaardigheidsbeoordeling in asielzaken, Interpretatie en waardering van medische rapporten door de IND', *Asiel &Migrantenrecht* 2016, nr. 10, pp. 470-471. It concerned an asylum seeker with a large scar on the underarm, which had not been documented by FMMU. The scar had been considered diagnostic of burning with an iron by iMMO. The IND officer suspected that the scar was self-inflicted.
[478] The Netherlands Parliamentary documents 2009/10, 19637, nr. 1305, p. 4, TK 2008/09, 29 689, nr. 243, p. 6.
[479] Protocol IND en FMMU-Advies, p. 11.
[480] Protocol IND en FMMU-Advies, p. 11. See also section 3.4.
[481] Interview FMMU 1.
[482] Interview FMMU 2.
[483] MediFirst Protocol, p. 10.

Statistics of FMMU and MediFirst show that the large majority of the asylum seekers are only screened by a nurse.[484] The difference between the percentages of FMMU and MediFirst is striking. Between 2012 and 2014, asylum seekers at MediFirst were screened by a doctor at an average of 15 per cent. The percentages (as well as the absolute number) of asylum seekers seen by a FMMU doctor from 2015 onwards are far below these numbers. The percentage of asylum seekers who have been screened by a FMMU doctor (around 2 per cent) lies far below the percentage of asylum seekers who were found to have a limitation (between 8 and 30 per cent), and also below the average percentage of asylum seekers, who are deemed unable to be interviewed by the IND (3 per cent, see further section 3.6.6). This means that not every asylum seeker who has limitations or cannot be interviewed by the IND is screened by a doctor. MediFirst sent asylum seekers to the doctor in case of more serious medical limitations, such as multiple physical limitations and psychological problems.[485] Some lawyers indicated that they think FMMU nurses should refer more cases to a doctor.[486]

The Regional Medical Disciplinary Committee of Zwolle considered in 2013 that unaccompanied children should preferably be screened by a doctor and not only by a nurse.[487] However, in 2015 and 2016 only a very limited number of unaccompanied children were screened by a doctor.[488]

| Year | Total number of asylum seekers screened | Number of asylum seekers screened by a doctor | Percentage of total number of asylum seekers screened by a doctor |
|---|---|---|---|
| 2012 (MediFirst) | 7475 | 1,051 | 14.1% |
| 2013 (MediFirst) | 7,997 | 1,203 | 15% |
| 2014 (MediFirst) | 16,722 | 2,724 | 16.3% |
| 2015 (FMMU) | 20,359 | 540 | 2.7% |
| 2016 (FMMU) | 23,467 | 311 | 1.3% |
| **Source: MediFirst and FMMU** | | | |

The FMMU statistics show that, after a period of four months in 2015, the number of asylum seekers screened by a doctor of FMMU decreased. A reason for this could be that nurses got more experienced over time and felt less need to refer the asylum seeker to a doctor. [489] In contrast, in the second and third year of the period in which MediFirst performed the medical screening, there was a slight increase of the number of asylum seekers screened by a doctor.

The lawyer who participates in meetings with FMMU and the IND suggested that limitation of costs is probably one reason for the low number of asylum seekers screened by a doctor.[490] According to the IND, costs have not been a reason for the lower numbers of screenings by a doctor. In its view there was a low threshold for sending a person to a doctor, for example when asylum seekers stated that

[484] Based on statistics provided by MediFirst and FMMU.
[485] Interview MedFirst.
[486] Interview Lawyers 3 and 4.
[487] Regional Disciplinary Committee Zwolle, 19 April 2013. ECLI:NL:TGZRZWO:2013:YG2854.
[488] In 2015, 3.859 unaccompanied children lodged an asylum application and in 2016, 1707. IND, Asylum Trends, January 2016, p. 8, IND, Asylum Trends January 2017, p. 8.
[489] Interviews Legal Aid Board and DCR 5 and Pharos.
[490] Interview Lawyer 1.

they could not remember dates. In many cases it turned out to be unnecessary to send such asylum seekers to the doctor, because the doctor did not conclude differently than the nurse. Referrals to the doctor did lead to longer waiting times for asylum seekers. Therefore, the IND discussed this issue with the medical advisors, which led to a lower number of referrals to the doctor.[491]

### 3.6.5 Duration of the screening

Even though this has never been researched, it seems like MediFirst took an average of 45 minutes to screen an asylum seeker.[492] There seems to be a lack of clarity about the duration of the medical screening by FMMU. FMMU indicated that a screening takes around 30-45 minutes. Screenings may be shorter if there are no complications and longer if the asylum seeker raises complex problems.[493] Several lawyers indicated that the duration of the screening at FMMU is usually very brief.[494] Some of their clients say that their screening took no more than five minutes; their blood pressure and heart rate was measured, and their lungs were examined. In that regard, the screening was sometimes perceived as a standard medical check-up.[495] Moreover, MediFirst stated that the FMMU screenings are much shorter than those of MediFirst.[496] However, the DCR at Ter Apel stated that they did not see this problem.[497]

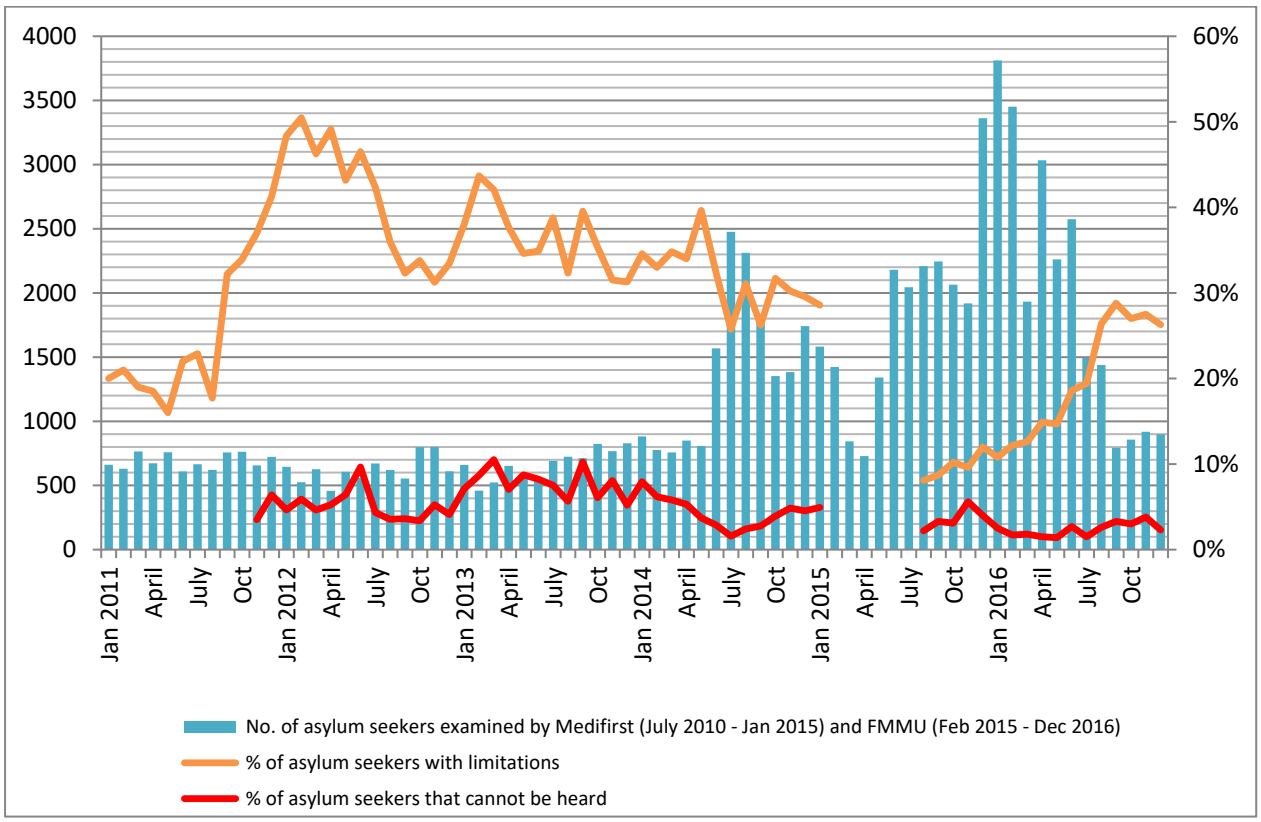
The analysis of medical advices issued in Schiphol, Ter Apel and Wageningen[498] shows differences in the time spent per medical screening. In Schiphol there appeared to be a lot of time between the screenings. An average of three screenings were conducted per day.[499] Three nurses conducted the screenings during the week that was studied. In the same week, two nurses conducted most screenings in Ter Apel. On one day ten screenings were conducted by the same nurse; the time between each screening varied between 14 minutes to more than an hour (according to the time mentioned on the advice). In Wageningen, two nurses conducted all screenings. On an average day, around ten screenings were conducted. The time between two advices was often no more than 20-25 minutes. In this period of time, the nurse should thus have fetched and screened the asylum seeker and typed and processed the advice.

### 3.6.6 Conclusions of the medical advice

In the period 2010-2016 the conclusions of the medical advice have differed substantially. The percentage of asylum seekers who, according to the FMMU advice, could not be interviewed is rather

[491] Additional information provided by the IND in September 2017.
[492] Böcker, A.G.M. and others, p. 84, MediFirst Protocol, p. 10 and interview MediFirst.
[493] Interviews FMMU 1 and FMMU 2.
[494] Interviews Lawyer 2 and Lawyers 3 and 4.
[495] Interview Lawyer 2.
[496] Interview MediFirst.
[497] Interview DCR 1 and 2.
[498] This concerns asylum seekers who go to the Application Centre in Zevenaar.
[499] The nurse working on this location stated that he examines a maximum of 6-7 asylum seekers a day. InterviewFMMU 2.

low and varied between 1.4 and 10.5 per cent. The percentage of asylum seekers in which MediFirst or FMMU found a medical limitation is much higher and varied between 8.1 and 50.5 per cent.[500]




The graph above shows that FMMU concluded in less cases than MediFirst that the asylum seeker could not be interviewed or had medical limitations.[501] On average, MediFirst found in around 34 per cent of its medical advice that the asylum seeker had limitations and in 6 per cent that the asylum seeker could not be interviewed. FMMU concluded in around 17 per cent of its medical advice that the asylum seeker had limitations and in 3 per cent that the asylum seeker could not be interviewed.[502] FMMU and stakeholders confirm that FMMU only concludes in exceptional cases that an asylum seeker cannot be interviewed.[503] Some refer to the negative consequences of such advice for the asylum seeker, because it leads to a delay in the asylum procedure.[504]

It is striking that both MediFirst and FMMU found less limitations in the starting phase of their work. The number of limitations found rose steadily and, in the case of MediFirst, decreased again after a while. In the end of 2016, the percentage of cases in which FMMU found a limitation is rather similar

[500] Statistics obtained from FMMU and MediFirst. Percentages from the first half year of FMMU (February to August 2015) are unavailable.
[501] Böcker, A.G.M. and others, p. 84, who obtained these statistics from MediFirst. Only percentages are available for the number of asylum seekers with limitation or who cannot be interviewed.
[502] According to MediFirst, the differences between MediFirst and FMMU is due the quality of the medical screening. Interview MediFirst.
[503] Interview DCR 4. FMMU stated that if FMMU concludes that an asylum seeker cannot be interviewed, it is (almost) necessary to admit the asylum seeker to hospital. Interview FMMU1, FMMU 2.
[504] Interviews FMMU 1, DCR 1 and 2, Lawyer 1, Lawyer 2 and IND 2 and 3.

to the percentage of cases in which MediFirst found a limitation in January 2015, just before FMMU took over.

From the statistics and the interviews it is impossible to deduce the reason for the (sometimes sharp) increase or decrease in the (relative) number of cases in which it is concluded that the asylum seeker has medical limitations or cannot be interviewed. MediFirst and FMMU were not able to explain these differences. We can however suggest a few factors which might have been of influence. First, there is a decrease in the number of cases in which it is concluded that the asylum seeker cannot be interviewed in periods, where the total number of medical screenings (and thus the influx of asylum seekers) was high (in the summer of 2014 and the end of 2015 until the beginning of 2016). It is not clear, why there should be a correlation between high influx and a low number of advice in which it was concluded that the asylum seeker could not be interviewed. It is possible that, in these periods, asylum seekers did not talk about their problems in order to avoid delays in the asylum procedure[505], or that FMMU nurses were reluctant to conclude that an asylum seeker could not be interviewed, if the asylum seeker would most probably receive an asylum status after a brief interview (as happened to Syrians and Eritreans).

Furthermore, in the period 2015-2016 the number of limitations found by FMMU steadily increased. This was also the period in which the waiting times for asylum seekers became longer and the medical screening thus took place longer after their arrival. Several stakeholders suggested that psychological problems emerge when asylum seekers have been in the Netherlands for a longer period of time. Furthermore, a situation of insecurity may cause physical and psychological problems.[506] Another explanation may lie in the type of asylum seekers who arrived in the Netherlands: people from some countries of origin may have more medical problems than others.[507] Further research should be done however to better understand the fluctuations in the number of asylum seekers found to have medical limitations.

*Conclusions per location*

The relative number of cases in which it was concluded that the asylum seeker had medical limitations or could not be interviewed differs per location (see the graphs in Annex 1). In the application (detention) centre at Schiphol Airport the relative number of asylum seekers with limitations (from 60 to 80 per cent) and asylum seekers cannot be interviewed is far higher than at other locations. In 2016 in Ter Apel, the number of cases in which limitations were found or the asylum seeker could not be interviewed is higher than that in the other open reception centres in Gilze-Reijen and in particular Wageningen.

These differences may be explained by different approaches of FMMU nurses in the different locations. The nurse at Schiphol Airport interviewed for this study, indicated that he regards each medical complaint, including for example headaches, as a limitation.[508] However, we found in our review of the small selection of medical advices that the medical advices issued in Wageningen and Ter Apel often indicated that there are 'medical problems', but no medical limitations. The IND and

[505] See also section 2.4.7.
[506] Interview IND 4.
[507] Ibid.
[508] Interview FMMU 2.

FMMU also suggested that the medical advices of FMMU at Schiphol are more elaborate compared to the advice elsewhere in the country.[509]

The high percentages at Schiphol Airport may also be explained by the fact that asylum seekers are detained during the asylum procedure.[510] Asylum seekers in Schiphol have also just arrived and are held in detention and are therefore less exposed to advice and rumours spread by asylum seekers who have been staying in the Netherlands for a longer time than asylum seekers who stay in an open reception centre. During the high influx asylum seekers told each other that medical problems would lead to longer waiting periods, which influenced their conduct during the medical screening (see also section 2.4.7).

One IND officer noted that there are differences among the type of asylum seekers at the various locations.[511] In Ter Apel, there are relatively more heavily traumatised or disabled persons, which might explain the higher numbers compared to Gilze-Reijen and Wageningen in 2016. Furthermore, it follows from the analysis of FMMU advice for this study that in Ter Apel many asylum seekers mention that they have problems recalling dates, which is regarded as a limitation.[512] It was also suggested that the low number in Wageningen may be attributed to the good care, attention, and sufficient activities that are offered at this location.[513] These are all explanations, which have not been researched. The differences between locations are not a point of discussion in meetings between the IND and FMMU[514] or between FMMU nurses and doctors.[515]

### 3.6.7 Referrals to curative care

Asylum seekers who have physical or psychological problems can be advised to consult the Health Centre Asylum Seekers (*Gezondheidscentrum Asielzoekers*, GCA), which provides primary health care.[516] In such situation, the medical file of the asylum seeker is not shared by FMMU. In serious cases FMMU directly contacts GCA, but only mentions the core of the issue.[517] A lawyer interviewed for this study stated that it is highly unclear what happens after an asylum seeker has been advised to go to GCA: there is no control or guidance on whether asylum seeker actually visits GCA or whether GCA does anything to invite the asylum seekers.[518]

The difference in referrals to GCA – absolute and relative – between FMMU and MediFirst is striking. Although the percentage of referrals by MediFirst decreased yearly, the referrals by FMMU are significantly lower, to below 1 per cent. According to FMMU, a possible explanation for this difference is the definition used for referrals. FMMU only registers a referral to GCA if the practitioner sought

[509] Interview IND 1.
[510] Interview Legal Aid Board and DCR 5.
[511] Interview IND 4.
[512] This was not found in Wageningen and Schiphol Airport.
[513] Email MediFirst.
[514] Interview IND 4.
[515] Interview FMMU 2.
[516] This is called a curative referral (*doorverwijzing curatief*).
[517] Interview FMMU 1.
[518] Interview Lawyer 2, See also interview Lawyer 5.

direct contact with GCA. In other words, if the advice only contains an advice for the asylum seeker to consult GCA, this will not be regarded as a referral in the data.

| | Total number of asylum seekers screened | Number of asylum seekers referred to curative care | Relative number of asylum seekers referred to curative care |
|---|---|---|---|
| 2012 (MediFirst) | 7,475 | 2,342 | 31.3% |
| 2013 (MediFirst) | 7,997 | 2,123 | 26.5% |
| 2014 (MediFirst) | 16,722 | 2,298 | 13.7% |
| 2015 (FMMU) | 20,359 | 306 | 1.5% |
| 2016 (FMMU | 23,467 | 107 | 0.5% |

MediFirst used a bilingual standard form (in Dutch and the asylum seeker's native language) which described the medical problems found by MediFirst, name of the nurse and date. If asylum seekers were considered to be able to find their way to GCA, the form was given to them. In more urgent cases, for example if the asylum seeker was out of medication or there was a risk of psychological decompensation, MediFirst also notified GCA about the asylum seeker or even walked the asylum seeker to GCA.[519]

### 3.7 Quality of the medical advice

According to the FMMU Protocol, the medical advice should comply with several quality standards.[520] They should amongst others be based on objective, correct and complete information and may not contain subjective judgements and conclusions. The advices should be based on the objective professional observation of the nurse and the doctor and on the Protocol. They may not contain a medical diagnosis or any observations which are not relevant to the medical judgment. They should be written in clear and applicable language which is understandable for non-medical personnel.

Despite these quality standards, stakeholders in the asylum procedure have voiced several concerns about the quality of the medical advice of FMMU. Some even doubt the usefulness of the medical advice as it is now.[521] These concerns will be discussed in this section, taking the norms set in the FMMU Protocol as the quality standard.

[519] Interview MediFirst. MediFirst also directly contacted COA if it was worried about an asylum seeker.
[520] Protocol IND en FMMU-Advies, pp. 11-12.
[521] Interviews Pharos, iMMO, Lawyer 2 and Lawyers 3 and 4.

*Medical advice does not address the central question*

The medical advices issued by FMMU normally only describe from which physical or psychological complaints the asylum seeker (allegedly) suffers and under which conditions the IND interview should take place. They do not explain how these complaints *influence* asylum seekers' statements about their asylum motives and how the IND should take this into account when taking the decision. The central question, 'how may the potential presence of psychological or other medical limitations influence the asylum seeker's ability to make statements' is thus not answered. Professionals perceive this as a weakness.[522]

Furthermore, even though the name of the medical advice (interviewing and decision-making) suggests differently[523], the advice only concerns the conditions for the interview and not the decision-making process.[524] This was clearly explained both by the FMMU management and the FMMU nurse interviewed.[525] MediFirst remarked that they gave equal weight to the interviewing and decision-making implications of the medical issues of the asylum seekers. They used to explain to the IND how certain psychological issues, such as the fact that the asylum seeker has problems concentrating, should be taken into account.[526]

*Medical problems are overlooked by FMMU*

Medical conditions might slip through the medical screening without being noticed by FMMU.[527] FMMU recognised that nurses do not always make an accurate estimation of medical problems and that the current FMMU process does not 'fully comply with all requirements to provide a high quality advice'. According to FMMU more time and a more elaborate examination would be needed.[528] The lawyers interviewed, all mentioned one or more examples in which the FMMU advice, in their view, completely disregarded the serious problems of the asylum seeker. One lawyer interviewed had a child client who was mentally ill and not able to speak. The FMMU advised that she could be interviewed, even though the nurse acknowledged in the underlying questionnaire that she was mentally ill.[529] After consulting with the IND, it was decided not to interview the asylum seeker. Another lawyer mentioned that she had a client who had a severe epileptic fit during the first interview, even though FMMU concluded that there were no medical limitations.[530] Also employees of the IND have indicated that the FMMU sometimes overlooks medical problems, such as epilepsy or psychosis.[531]

FMMU is very much dependent on what asylum seekers tell them about their medical problems.[532] There are indications that some asylum seekers do not talk about a medical condition during the medical screening, for example out of fear of prolonging their application or negative effects on their

[522] Interviews Legal Aid Board and DCR 5, Pharos and Lawyer 2.
[523] Protocol IND en FMMU-Advies.
[524] Interviews IND 1 and Lawyer 2.
[525] Interviews FMMU 1 and FMMU 2.
[526] Interview MediFirst.
[527] Interviews Lawyer 1, Lawyer 2 and iMMO.
[528] Interview FMMU 1.
[529] Interview Lawyer 5.
[530] Interview Lawyers 3 and 4.
[531] Report training IND 'Interviewing vulnerable persons' and interview IND 5 and 6.
[532] Interview FMMU 2.

asylum decision (see also section 2.3.7).[533] For instance, in Syrian cases (which were likely to be granted protection) a low number of medical limitations were found during the FMMU screening. The nurse noted that, at the beginning of the screening, he mentions to the asylum seeker that the screening will not influence the asylum procedure.

Furthermore, some (groups of) asylum seekers are very reluctant to talk about psychological problems or traumatic experiences. Several stakeholders mention the example of Eritrean girls who refrained from telling FMMU that they had been raped.[534] According to experts the survival strategy of persons who suffer from severe psychological problems as a result of traumatic experiences is often to keep silent: talking about it may be too painful or shameful.[535] The EASO Module on interviewing vulnerable persons states: 'Talking about very painful experiences may also be seen as inappropriate. Silence may be the predominant coping mechanism for some cultures. Furthermore, traumatic experiences may be shameful. Perceptions of shame may vary among cultures. If you ask about sexual abuse, you might get no answer, an indirect answer or even a denial'.[536] An FMMU nurse stated that he sometimes proposes the asylum seeker to see a psychologist if he notices that the asylum seeker is emotionally suppressing something.[537]

The asylum seeker's medical condition might have evolved between the medical screening and the interview. In these cases, lawyers alert the IND before the interview that the asylum seeker has a condition that may affect their abilities to answer. Pharos mentioned that lawyers are instructed in trainings to actively inform the IND about such unidentified conditions.[538]

*The advice is insufficiently substantiated*

The medical advice of FMMU are perceived as being generally 'very concise' and 'meagre'[539], by stakeholders but (sometimes) also by the IND.[540] Sometimes the wording used is unclear. For instance, some advice state that the asylum seeker may react 'emotionally'. However, FMMU does not discuss what this means for the interview.[541] Another example is that FMMU noted in the case of an 83-year-old woman without further explanation that the asylum seeker had 'problems relating to her age'.[542]

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[533] Interviews iMMO, Lawyer 1, FMMU 2, IND 1 and Pharos.
[534] Interviews Lawyer 1, FMMU 2 and DCR 1 and 2.
[535] Interview iMMO, UNHCR, Beyond Proof, May 2013, pp. 61-64, 72-73 and references, Bloemen, E. and Keunen, A., Ik heb alle bewijzen op mijn lichaam*, Asiel & Migrantenrecht,* 2013, pp. 455-456 and references.
[536] EASO, *Module on Interviewing vulnerable persons*, accessed in October 2016.
[537] Interview FMMU 2.
[538] Interview Pharos.
[539] According to the Medical disciplinary committee of Amsterdam FMMU nurses and doctors are not required to state reasons for their conclusion that the asylum seeker can be interviewed, because it is unreasonable to ask practitioners to list what patients do not have. Medical disciplinary committee Amsterdam, 21 June 2016, no 331/2015.
[540] Interviews Legal Aid Board and DCR 5, DCR 4, iMMO, Pharos, Lawyer 2, Lawyers 3 and 4, Lawyer 5, IND 2 and 3 and IND 5 and 6. Several stakeholders mention that MediFirst improved over time and delivered more elaborate advice than FMMU does now. Interviews Pharos and Lawyers 3 and 4.
[541] Interview Legal Aid Board and DCR 5. In the IND training on interviewing vulnerable persons attended by the researcher, it was explicitly noted that IND officers may not write 'the asylum seeker is emotional' in the report of the interview, because it does not explain which emotions the asylum seeker shows and in what way. Report training IND 'Interviewing vulnerable persons'.
[542] Interview Lawyers 3 and 4.

One lawyer mentioned that she received FMMU advices, in which exactly the same phrases were used.[543]

As was mentioned in section 3.3.4, vagueness in the use of terms is partly caused by medical confidentiality. FMMU is not allowed to mention in the advices from which specific disease or disorder the asylum seeker (claims to) suffer.[544] FMMU may, for instance, mention that the asylum seeker should eat regularly instead of that the asylum seeker has diabetes.[545] The FMMU nurse interviewed for this study stated that he does mention the specific disorder if that is necessary to make it clear to the IND officer or first aid nurse how they should act during the interview (it matters for example whether the asylum seeker may get an diabetic or epileptic fit).[546] However, an IND officer mentioned a case in which FMMU did not make explicit that the asylum seeker had asthma. As a result, security did not allow the asylum seeker to take his inhaler with him.[547] The FMMU noted that it had agreed with the IND on the use of terminology for certain situations (*signaalafspraken*).[548] As a result the meaning of the advice may be clear to the IND, but not to outsiders such as the asylum seeker's lawyer. Sometimes IND officers ask the asylum seeker from which disease or disorder they suffer during the interview.[549]

The IND finds that the FMMU medical advice is not neutral if it mentions the (potential) causes of the medical complaints or topics which may trigger certain psychological problems.[550] For example, the IND would not approve if the FMMU remarks that the asylum seeker will be emotional when they speak about their childhood, because this is 'almost part of the asylum account'.[551] According to the IND, they only need to know whether an asylum seeker is able to start the asylum procedure and whether they should be prepared for challenges during the asylum procedure.[552]

Finally, there seem to be important differences in the approach between FMMU nurses. The FMMU nurse working at Schiphol Airport interviewed for this study remarked that he elaborates on medical problems and notes all of them in the questionnaire, so that they can be checked by the FMMU doctor and the asylum seeker.[553] Indeed the medical advice issued at Schiphol Airport are generally personalised and indicate in some detail what could happen to the asylum seeker during the interview (for instance 'increasing stress, which can be combined with headaches, a depressing feeling and a serious emotional reaction on past events'). However, other nurses are more concise in the description of their findings.[554] In particular, we found that in Wageningen the limitations mentioned were very concise and standard formulations were used. Several advices noted that extra breaks

[543] Interview Lawyers 3 and 4. Also another lawyer mentioned that medical advice are often similar. Interview Lawyer 2.
[544] Interview IND 2 and 3.
[545] This was seen in several medical advice of the POL Wageningen.
[546] Interview FMMU 2.
[547] Interview IND 2 and 3.
[548] Interview FMMU 1.
[549] Interviews IND 2 and 3 and IND 5 and 6.
[550] Interview IND 4.
[551] Ibid.
[552] Ibid.
[553] Interview FMMU 2. This was confirmed by the IND medical coordinator working at the same Application Centre.
[554] Interviews FMMU 2 and IND 1.

should be offered because of 'medical problems' or 'psychological complaints' indicated by the asylum seeker. In Schiphol and Ter Apel, advices addressed more extensively the complaints of the asylum seekers and how these complaints would manifest themselves in an interview.

Several stakeholders stated that the advice often does not reflect the, sometimes serious, medical problems which are described in the questionnaire.[555] One lawyer mentioned the example of a woman who, according to the questionnaire, was raped several times and suffered from nightmares and sleeping problems. According to FMMU there were no medical limitations. The woman was advised to consult GCA for her own reassurance.[556] The medical disciplinary committees have warned several MediFirst nurses and doctors because they failed to mention the serious (psychological) problems noted in the questionnaire in the advice to the IND.[557]

Two lawyers also mentioned a situation of a re-screening after a first FMMU advice which concluded that the asylum seeker could not be interviewed. To them it was unclear why the FMMU concluded after a second screening that the asylum seeker could be interviewed. In one case the asylum seeker, a victim of human trafficking, had been treated in the Netherlands for years. One month after the first (no interview) advice, FMMU concluded that the asylum seeker could be interviewed if sufficient breaks were given, while the asylum seeker's situation had not changed.[558]

*Translation of medical problems to instructions to the IND*

The advice is often based on the medical problems the asylum seeker claims to have.[559] The FMMU manager stated that, therefore, the medical advice is 'very subjective'.[560] The FMMU nurse agreed with this statement. However, the nurse also noted that, if the asylum seeker's claim does not match with his own observations during the screening, he will further investigate this.[561] The wording of the advice indicates whether the nurse has observed the problems claimed by the asylum seeker. If it mentions: 'the application states that he has problems concentrating', this means that this was not observed by the nurse. If the advice mentions that 'the asylum seeker has problems concentrating', this has been observed by the nurse.[562]

Sometimes it is rather clear how medical limitations should be translated into an instruction to the IND. For instance, when an asylum seeker is illiterate, the IND should pose simple questions and grant sufficient time to the asylum seeker to understand and answer the question.[563] Or if a person has back pains, they should be able to move around each 30 minutes.[564] However, FMMU cannot clearly explain how it translates psychological problems into instructions to the IND. According to FMMU, it makes a

[555] Interviews Lawyer 2, Lawyers 3 and 4 and Lawyer 5. Lawyer 1 stated that this was in particular a problem during the first period of FMMU.
[556] Interview Lawyers 3 and 4.
[557] Medical disciplinary committee Zwolle, 10 April 2015, nos 080/2014 and 081/2014, Medical disciplinary committee Eindhoven, 7 June 2012, nos 11152 and 11153.
[558] Interviews Lawyer 2 and Lawyers 3 and 4. See also Rb Den Haag 27 October 2015, AWB 15/13971 & 15/13970.
[559] Interview Lawyer 2.
[560] Interview FMMU 1.
[561] Interview FMMU 2. This was also noted by MediFirst.
[562] Interview IND 4.
[563] Interview FMMU 2.
[564] Interview FMMU 1.

very rough estimation of whether asylum seekers can do the interview or not and whether they need extra breaks. Nurses go by their feeling and experience, and try to imagine whether they would be able to do the interview in the asylum seeker's situation.[565]

*Medical information is not taken into account*

Another perceived flaw of the advice is that FMMU has no medical background information about the asylum seeker.[566] The FMMU nurse interviewed for this study stated that he always asks asylum seekers whether they receive medical treatment and requests information from GCA if asylum seekers do not know which medication they take. He also stated that he asks for information from a treating psychologist.[567] A lawyer interviewed for this study mentioned that in some cases she had medical information about the asylum seeker which would inhibit a standard interview but this information was not available to FMMU. As a result, the medical advice was positive and the lawyer had to inform the IND personally that there was additional medical information that the asylum seeker had limitations that needed to be taken into account.[568] One lawyer mentioned that FMMU disregarded her letter in which she mentioned that the asylum seeker passed out during the preparation of the asylum procedure the previous day.[569] The District Court Roermond ruled in a judgment of 18 August 2016 that the IND should have ensured that FMMU had been informed about the asylum seeker's medical file, so that it could have included this file in its advice. The medical file mentioned that the asylum seeker was lightly mentally handicapped and cognitively retarded.[570]

FMMU stated that when medical information from treating doctors is available, a doctor should screen the asylum seeker.[571] As we have shown in section 3.6.4, only 1-3 per cent of the asylum seekers is screened by a FMMU doctor.

*Insufficient measures in case of limitations*

Moreover, the conditions under which an interview can take place that are proposed by FMMU are criticised. Oftentimes, only extra breaks and a paracetamol are suggested. Lawyers believe such measures are sometimes insufficient, in particular for psychological problems.[572] Indeed we found that in the FMMU advices examined for the purpose of this study the measures proposed for the IND interview were mainly limited to 'extra breaks', offering the possibility to eat and drink or to move around during the interview. In FMMU advices issued in Schiphol and Ter Apel there was more detail and variety in how to deal with the complaints during the interview. For instance, some advices mentioned on which side of the asylum seeker the interpreter has to sit because the asylum seeker has hearing problems. Also some advices mentioned that the asylum seeker preferred a female interviewer and interpreter.

## 3.8 Conclusions

[565] Interview FMMU 1.
[566] This was also argued by the lawyer in the case which led to the judgment of District Court Amsterdam 1 June 2016, AWB 16/9574, para. 4.
[567] Interview FMMU 2.
[568] Interview Lawyer 2. A similar situation was mentioned in the interview with Lawyers 3 and 4.
[569] Interview Lawyers 3 and 4. FMMU concluded that there were no limitations.
[570] District Court Roermond 18 August 2016, NL I6.I800, paras 3-5.
[571] Interview FMMU 1.
[572] Interviews Lawyer 2 and Lawyer 5.

This chapter discussed the medical screening to which asylum seekers in the Netherlands are undergoing before the start of the asylum procedure and the resulting Medical advice hearing and decision-making. The primary goal of this medical screening is to establish whether asylum seekers have medical problems which may limit their ability to make complete consistent and coherent statements about their asylum motives. Another (original) aim of the screening was to examine whether the applicant has medical problems which require immediate treatment.

As of 2015, medical screenings are conducted by FMMU, from 2010 to 2015 the screenings were carried out by MediFirst. FMMU won the public procurement procedure because it could provide the medical advice for a much lower price. Several findings in this study, such as the low number of asylum seekers screened by a FMMU doctor and the apparent short duration of the medical screening at some locations, may suggest that this has led to a lower quality of the medical advice.

The Medical advice hearing and decision-making is an important tool to identify asylum seekers in need of medical care and/or special procedural guarantees. It has led to more awareness of the influence of physical and psychological problems on the capacity of asylum seekers to adequately present their claim during the asylum procedure.

However, the current form of the medical advice also has its limitations. The aim to *identify asylum seekers in need of medical care* was not met during the period of high influx, because asylum seekers underwent the medical screening months after their arrival in the Netherlands. After the period of high influx GCA has introduced its urgency medical screening (see section 2.4.3) which should lead to the identification of (serious) physical problems. This screening takes place only days after arrival, when asylum seekers often feel happy and relieved. Therefore, psychological problems will generally not come to the fore during this screening. Such psychological problems may be identified during the FMMU screening, which takes place a few weeks later. In such situation FMMU may advise the asylum seeker to consult GCA. In practice FMMU actively refers only around one per cent of the asylum seekers to GCA. This is much lower than the estimated percentage of asylum seekers with PTSD and/or depression which lies between 13 and 25 per cent.[573]

The most important function of the medical advice is to identify medical problems which may limit the asylum seekers' ability to make complete consistent and coherent statements about their asylum motives (medical limitations). This study has shown that the following aspects of the medical screening and advice are problematic and/or may be improved:

*Education and preparation of nurses and doctors*
FMMU employs nurses and doctors with a lower level of education, than the level of education that was required by MediFirst. This is the result of the IND's choice to require a lower level of education during the public procurement procedure. FMMU does not ensure that all nurses and doctors have followed the training modules which are required according to the IND and FMMU Protocol. The IND nor any other external organisation has checked whether the FMMU nurses and doctors have followed the required training.

[573] Gezondheidsraad*, Briefadvies Geestelijke gezondheid van vluchtelingen,* February 2016.

*Communication and cooperation*

The FMMU protocol emphasizes the importance of cooperation with all parties in order to develop its service. There is a regular feedback loop between FMMU and IND, according to which FMMU refines its practice. Both parties are generally satisfied with the communication. However, others note that there is a risk that FMMU and the IND work too closely together, which may result in the IND influencing the FMMU advice and may thus undermine the impartiality of FMMU.

Several stakeholders described FMMU as a 'closed' organisation. FMMU does not have contact with important organisations with expertise in the field of medical aspects in asylum procedures, such as iMMO and Pharos. Furthermore, FMMU does not (regularly) discuss (the quality of) their advice with lawyers, the Dutch Council for Refugees and the Legal Aid Board.

*External quality checks*

Currently FMMU's medical advices are not subjected to quality checks by an external organisation. The only supervision has been offered by the Medical Disciplinary Committees, which review cases based on complaints put forward by asylum seekers or their lawyers. The quality of the advices is only reviewed by FMMU's own doctors and by some IND officers.

*Advice by a nurse or a doctor*

Only a small part of all asylum seekers, who are found to have medical limitations are screened by a FMMU doctor. Around 97 per cent of all asylum seekers are only screened by a nurse. The original idea of the Medical screening interviewing and decision-making was that an asylum seeker would be referred to a doctor if there were possible limitations which could interfere with the asylum seeker's ability to be interviewed. The number of asylum seekers referred to a doctor by MediFirst was much higher.

*A fluctuating number of asylum seekers with limitations*

The (relative) number of asylum seekers found to have medical limitations or unable to be interviewed fluctuates over time as well as per location. The scope of this study was too limited to draw conclusions as to the causes of these fluctuations. Part of the differences in the percentages over time may be explained by the fact that in February 2015 FMMU took over the medical screening from MediFirst. In 2015 the percentage of limitations found dropped from 29 per cent to 8 per cent. The fluctuations in the numbers within the MediFirst period and FMMU period might be explained by the type of asylum seekers which arrived in certain periods and high influx (and the resulting longer waiting times which may cause psychological problems). The differences between locations might be explained by the fact that in Schiphol (which has high percentages) asylum seekers are detained and have just arrived in the Netherlands when the medical screening takes place. In the other locations asylum seekers stay in an open reception centre and have stayed in the Netherlands for a longer period of time. Furthermore, differences may be explained by different types of asylum seekers. Finally different approaches of FMMU nurses in the different locations may be relevant, in particular as to when a medical problem is considered a medical limitation.

*Referrals to medical care*

FMMU only contacts GCA if the asylum seeker has medical problems which need urgent medical care (only in around 1 per cent of the medical advice). In other cases of medical problems FMMU tells the asylum seeker to consult GCA. GCA is not informed about this instruction.

*The central question is not answered*

The central question of the medical screening is: How may the potential presence of psychological or other medical limitations influence the asylum seeker's ability to make statements? However, FMMU only examines whether the asylum seeker has medical limitations and suggests measures which the IND can take during the interview (in particular extra breaks or providing the possibility to eat and drink or move around). FMMU does not advise the IND how the quality of the asylum seeker's statements may be influenced by the medical limitations. The advice thus only concerns the interview and not the decision-making by the IND.

*Not all medical problems are identified*

FMMU nurses are dependent on what the asylum seeker tells them about their medical problems. Asylum seekers may have reason to remain silent about their medical problems. For instance, they may believe that such medical problems may prolong or negatively influence their asylum procedure. Furthermore, asylum seekers may be too ashamed or it may too painful to talk about traumatic experiences

*Clarity and substantiation of the advice*

FMMU medical advice are perceived as being generally 'very concise' and 'meagre' and that the description of the asylum seeker's medical limitations is often vague. This vagueness is partly attributed to medical confidentiality: FMMU may not inform the IND about the specific disease the asylum seeker is suffering from.

Another reason for the conciseness of the advices is the IND's point of view that FMMU nurses and doctors may not mention the (potential) causes of the medical limitations or topics which may trigger certain psychological problems, because this may relate to the (credibility of the) asylum account. However, some FMMU nurses provide far more specific information in their advices than others. Another problem is that the FMMU advices do not always reflect the sometimes serious medical problems described in the underlying questionnaire.

Furthermore, FMMU does not have or take into account medical background information about the asylum seeker, even if the asylum seeker has been treated for medical problems before the FMMU screening takes place.

*Consistency between FMMU screening locations*

There are several inconsistencies in the procedure of the screening and the medical advices between different locations where FMMU issued medical advices (Wageningen, Schiphol Airport and Ter Apel). First, there are inconsistencies regarding which scars on the body are checked and how the presence of scars is mentioned in the advice. This sometimes creates misunderstandings among IND officers about whether scars have been mentioned and/or checked by the nurses. Second, advices on some

locations are more elaborate than on other locations in the description of the medical limitations as well as in the (variety) of the measures proposed to the IND.

Finally there seem to be differences in the medical problems considered to be a medical limitation in the context of the interview. Currently, the differences between locations are not a point of discussion in meetings between the IND and FMMU or between FMMU nurses and doctors.

*Translating psychological problems into measures during the interview*
It is not clear how FMMU 'translates' an asylum seeker's psychological limitations into instructions to the IND. FMMU noted that this is done on the basis of the feeling and experience of the FMMU nurses. In particular lawyers consider the measures proposed by FMMU, such as taking extra breaks or providing a paracetamol in case of pain, insufficient to address (serious) psychological limitations.

# 4. Forensic medical examinations

## 4.1 Introduction

Asylum seekers, who have no or insufficient documentary evidence supporting their asylum account may ask a physician to write a medical report on their behalf. In such report conclusions are drawn on the (possible) causal link between the asylum seeker's scars or physical or mental problems and the alleged events in the country of origin.

The attitude of Dutch State Secretaries and Ministers with regard to the role of medical reports in asylum procedures has always been ambiguous. Until 2009 Dutch asylum policy provided that 'in the assessment of an asylum application medical aspects in principle do not play a role, because medically it is (generally) not possible to establish with certainty the cause of medical problems and/or scars'.[574] This policy has changed following the recognition of the importance of medical reports in the case law of the European Court of Human Rights (ECtHR) and Article 18 of the recast Asylum Procedures Directive (RAPD).[575] Now the Dutch authorities recognise that 'medical evidence can provide a very strong indication of past persecution and hence can be a sign of a well-founded fear of persecution or a real risk of a violation of Article 3 ECHR in the future'.[576] At the same time they stress that 'a medical examination cannot answer the question whether there is persecution and therefore, whether the asylum application must be granted'.[577] Medical reports are considered to be supporting evidence (*steunbewijs*) which should be assessed in combination with the asylum seeker's statements and the other evidence available.[578]

Until the transposition of the recast Asylum Procedures Directive medical reports were only written on the request of the asylum seeker. Medical examinations of sequelae of torture were first carried out by the Medical Examination Group of Amnesty International (1977-2012) and the Institute of Human Rights and Medical Assessment (iMMO, since March 2012).[579] iMMO is an NGO, which has been founded by various organisations in the field of refugees, human rights and medical care.[580] iMMO trains and uses volunteer doctors and psychologists to do medical examinations with regard to the consequences of torture and violence and to write expert medical reports.[581] The working methods of iMMO have been described in different documents and articles.[582]

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[574] Para. C14/4.4.2 Aliens Circular (until 2009), author's translation.
[575] Directive 2013/32/EU of the European Parliament and of the Council of 26 June 2013 on common procedures for granting and withdrawing international protection (recast) [2013] OJ L 180/60.
[576] The Netherlands Parliamentary documents TK 2014/15, 19636, nr. 1903, p. 4, author's translation.
[577] Ibid. See also the explanations with the amendment of the Aliens Decree implementing Directive 2013/32/EU, *Staatsblad* 2015, 294, p. 24.
[578] IND Instruction 2016/4, Additional information provided by the IND in September 2017.
[579] See www.stichtingimmo.nl/about-immo/history/?lang=en.
[580] Amnesty International, Arq Psychotrauma Expert Group, ASKV steunpunt vluchtelingen, Stichting Medisch Advies Kollektief, Pharos, VluchtelingenWerk, Nederland and the Johannes Wierstichting.
[581] See for more information: www.stichtingimmo.nl. The training consists of an introduction training of one day, peer review on specific reports and meetings and study days.
[582] See eg iMMO, Leeswijzer bij iMMO-rapportage, November 2015, Bloemen, E. and Keunen, A., 'Ik heb alle bewijzen op mijn lichaam', *Asiel & Migrantenrecht 2013,* pp.454-460, NIFP, *Medische Steunbewijzen in de Asielprocedure*, 3 September 2014.

Since July 2015 Article 18 RAPD has been implemented in the Aliens Decree.[583] It provides that the Minister will arrange for a medical report if he considers it relevant for the assessment of the asylum claim. Since July 2016 the criteria which are used to establish when a medical report is relevant, the content of such report and connecting procedural issues have been laid down in the Aliens Circular[584] and IND Instruction 2016/4[585]. Since January 2016 the IND can request the Netherlands Forensic Institute (NFI) and/or the Netherlands Institute of Forensic Psychiatry and Psychology (NIFP) to write a medical report.

This chapter will first describe the international legal framework (section 4.2). After that it will examine whether and when recent scars or wounds are documented (section 4.3). Such documentation is important because it enhances the possibility to do a forensic medical examination in a later stage of the asylum procedure. Subsequently it will be discussed how the IND interprets Article 18 RAPD and requests for a (further) medical examination (section 4.4). As will be shown, the IND has so far requested a forensic medical examination in a very limited number of cases. Most medical examinations are still carried out by iMMO. In most cases this report either leads to the grant of the asylum application or is set aside by the IND without a further examination (section 4.5). Finally this chapter describes quite extensively the forensic medical examination carried out by the NFI and NIFP (section 4.6). In chapter 7 it will be examined how the medical report issued by NFI/NIFP and iMMO are weighed by the IND in the asylum decision.

## 4.2 International legal framework

The importance of medical reports has been recognised by the ECtHR in many recent judgments.[586] In 2010 in the case of *R.C. v Sweden*[587] the ECtHR made clear that such reports may give a ´strong indication that the asylum seeker's scars and injuries may have been caused by ill-treatment or torture'.[588] It also considered that the authorities should ask for an expert medical report, where the asylum seeker has made out a *prima facie* case as to the origin of his scars or injuries.[589] Such obligation may also arise where the asylum seeker submitted a medical report, which documents serious and recent injuries.[590] If the State authorities do not arrange for an expert medical report, they may not consider the asylum seeker's claim incredible. The fact that there are inconsistencies or other credibility issues in an asylum seeker's case does not dismiss the State from the duty to arrange a medical report.[591] The State authorities are only not bound to ask for a medical report if they are not in the 'position to assess the asylum seeker's individual situation' because the asylum seeker has not provided any proof of their identity and asylum account and their statements give reason to question

[583] Art. 3.109e Aliens Decree 2000.
[584] Para. C1/4.4.4 Aliens Circular.
[585] IND Instruction 2016/4.
[586] See eg ECtHR 15 January 2015, Appl. no. 18039/11, *A.A. v France,* para. 54, ECtHR 15 January 2015, Appl. no 80086/13, *A.F. v France,* para. 55, ECtHR 14 November 2013, Appl. no. 40042/11, *Z.M. v France,* para. 72, ECtHR 18 April 2013, Appl. no. 18372/10, *Mo.M v France*.
[587] ECtHR 9 March 2010, Appl. no. 41827/07, *R.C. v Sweden*.
[588] Ibid, para. 53.
[589] Ibid.
[590] ECtHR 19 September 2013, Appl. no. 10466/11, *R.J. v France,* para. 42.
[591] ECtHR 9 March 2010, Appl. no. 41827/07, *R.C. v Sweden*, para. 52.

their credibility.[592] Moreover no obligation to arrange a medical examination exists if the State accepts 'both the extent of the asylum seeker's injuries and the manner in which the asylum seeker claimed that they had been caused'.[593]

The Committee against Torture also confirmed that medical evidence supporting a claim of torture is pertinent information in an asylum procedure in its General Comment no 1[594] and in its views in individual cases[595]. In 2013 the Committee was concerned that the medical examination, which takes place before the start of the Dutch asylum procedure[596], did not include an examination of the causal relation between the asserted ill-treatment in the asylum application and the findings of actual physical examination in conformity with the Istanbul Protocol. It recommended 'to apply the Istanbul Protocol in the asylum procedure and to provide training thereon for concerned professionals to facilitate monitoring, documenting and investigating torture and ill-treatment, focusing on both physical and psychological traces, with a view to providing redress to the victims'.[597]

Finally Article 18 RAPD provides that where the determining authority 'deems it relevant for the assessment of an application for international protection' it should arrange for a medical examination of the asylum seeker or allow the asylum seeker to arrange such examination. In both situations the State needs to pay the costs of the examination. If the determining authority does not deem a medical examination relevant, it shall inform asylum seekers that they may, on their own initiative and at their own cost, arrange for a medical examination.[598] Medical reports should always be taken into account in the assessment of the asylum claim.[599]

Medical examinations arranged for by the determining authority should be carried out by 'qualified medical professionals'.[600] The Directive mentions that such medical examinations 'may be based on the Manual on Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment' (Istanbul Protocol).[601] This protocol was adopted in 1999 by a large number of NGO's. It contains guidelines for the impartial and objective documentation of torture. The Istanbul Protocol is not legally binding, but it has been recognised internationally.[602] The Istanbul Protocol states that its guidelines are relevant in the context of asylum procedures.[603]

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[592] ECtHR 5 September 2013, Appl. no. 61204/09, *I. v Sweden*, para. 62.
[593] ECtHR 29 January 2013, Appl. no. 60367/10, *S.H.H. v the United Kingdom*, para. 82.
[594] ComAT General Comment No 1 (1997), A/53/44, para. 8(c).
[595] See eg ComAT, 30 November 2015, *M.C. v the Netherlands,* no. 569/2013, 25 June 2015, *E.K.W. v. Finland*, no. 490/2012, para. 9.5, 17 December 2013, *Sathurusinghe Jagath Dewage v Australia*, no. 387/2009, para. 10.7.
[596] See further chapter 3 of this report.
[597] ComAT Concluding Observations the Netherlands, 20 June 2013, CAT/C/NLD/CO/5-6, para. 12.
[598] Art. 18(2) RAPD.
[599] Art. 18(3) RAPD.
[600] Art. 18(1) RAPD.
[601] Preamble RAPD, para. 31.
[602] UN General Assembly Resolution 55/89 of 4 December 2004 and the UN High Commissioner for Human Rights Resolution 200/43 of 25 January 2001, E/CN.4/2001/66 and ECtHR 1 February 2011, Appl. no. 23909/03, *Desde v Turkey*, para. 98, ECtHR 3 June 2004, Appl. no. 33097/96 and 57834/00, *Bati v Turkey*, para. 133. See also Battjes, H., 'Legal effects of the Istanbul Protocol' in *Care Full, Medico-legal reports and the Istanbul Protocol*, Pharos/Amnesty International/Dutch Council for Refugees, 2006.
[603] The introduction to the Protocol states that documentation methods contained in the manual are applicable to amongst others 'political asylum evaluations'. See also Furtmayr, H and Frewer, A,

According to the Istanbul Protocol the physician investigating victims of torture 'should have prior training or experience in documenting torture and in working with victims of trauma, including torture'.[604] It also requires doctors performing a medical examination to have knowledge about torture methods.[605]

### 4.3 Early documentation of (potential) sequelae of torture or ill-treatment

In light of a (potential) medical examination it is important that victims of ill-treatment are identified and that wounds or scars are documented as soon as possible. The forensic physicians of the NFI explained that the potential causes of injuries require a detailed examination of the wound and the skin surrounding it. As time passes, the specific characteristics of the wound diminish. As a result, it becomes more difficult to establish the cause of the injury. Usually the healing process of a wound has finished after a maximum of two years and at that moment a scar has taken its definitive form.[606] One NFI report mentions that 'therefore assessment of injuries in order to establish the cause should ideally take place as soon as possible after the injuries have occurred'.[607]

It may be rare but not unthinkable that an asylum seeker has wounds or recent scars on his body at the moment of his arrival in the Netherlands. In this study a few examples of such cases came to the fore.[608] In the Netherlands, none of the authorities or organisations involved in the asylum process is responsible for the identification of (alleged) victims of torture or ill-treatment and the documentation of their wounds or recent scars. The Aliens Circular mentions that the presence of scars can be revealed by amongst others, the medical examination which takes place before the start of the asylum procedure (currently carried out by FMMU), the reports of the interviews and medical documents.[609]

Via a leaflet asylum seekers are informed that they should tell FMMU that they have scars.[610] As was set out in section 3.6.3, the FMMU medical advice generally mentions that the asylum seeker has told the nurse that he has scars or wounds. However, the FMMU does not systematically document sequelae of ill-treatment. The advice does not describe scars in detail and FMMU does not take photos of them.[611] Scars or wounds which are hidden under the asylum seeker's clothes are not even checked.[612] Finally, particularly when the influx of asylum seekers is high, the medical examination by

'Documentation of torture and the Istanbul Protocol: applied medical ethics, *Medicine, Health care and Philosophy*, 2010, p. 280 and IRCT, *Recognising victims of torture in national asylum procedures*, 2013, p. 58.

[604] Para. 90 Istanbul Protocol.

[605] See eg paras 122, 131 Istanbul Protocol.

[606] NFI reports of 16 June 2016 (case 3, case 4), 20 March 2017 (case 6 ) and 30 May 2017 (case 8 ), Interview NFI 1. See also ACVZ, *Sporen uit het verleden*, July 2014, p. 68.

[607] NFI report 30 May 2017 (case 8 ).

[608] NFI report 16 June 2016 (case 3). In the NFI report the asylum seeker claimed that she had burning wounds caused by ill-treatment when she entered the Netherlands. She was examined by NFI four years later. In the NFI report of 30 May 2017 (case 8 ), the asylum seeker arrived in the Netherlands less than 9 months after the end of the alleged detention and torture. The medical examination took place another 20 months later. See also Medical disciplinary committee Amsterdam, 21 June 2016, no. 331/2015.

[609] Para. C1/4.4.4 Aliens Circular.

[610] IND, *Before your asylum procedure begins*, August 2015', p. 3.

[611] The IND chose not to do this because of the lapse of time since the moment the scars have been caused. Additional information provided by the IND in September 2017.

[612] Interview Lawyer 2.

the FMMU may take place months after the asylum application has been lodged.[613] In the meantime scars or wounds may have fainted or vanished.

Also the Health Centre Asylum seekers (*Gezondheidscentrum Asielzoekers*, GCA), which provides primary health care under the responsibility of COA, does not have the task to document sequelae of ill-treatment. It may mention in the asylum seeker's medical file that the asylum seeker is treated for wounds or specific scars.[614] However, GCA does not share this information with the IND, FMMU or the asylum seeker's lawyer.[615] One stakeholder mentioned that the insurance company (Menzis COA) is not interested in documenting wounds or scars because it is not a curative activity but only relevant in the legal context.[616]

The IND can ask questions during the interviews about the presence of scars, for example if these are mentioned in the medical advice.[617] The IND does not ask the asylum seeker to show his scars or look at the scars if the asylum seeker offers to show them.[618]

Lawyers should thus be very alert on signs of wounds or recent scars, which may result from torture and ill-treatment in the country or origin. The lawyer needs to ask for the GCA file and the questionnaire underlying the FMMU advice. Some lawyers ask their clients to take photos of their wounds or scars with their mobile phone or take photos themselves.[619] However, an NFI forensic physician noted that photos taken by asylum seekers, or other persons (for example with a cell phone) are often useless because they lack reference with regard to colour and size.[620] Therefore he thinks it is a good idea if professional photographs would be made of scars, wounds or bruises.[621]

Several organisations such as the Advisory Committee for Aliens Affairs (ACVZ), iMMO and the Dutch Council for Refugees (DCR) have recommended the State Secretary of Security and Justice (the State Secretary) to include the identification of victims of torture and the documentation of wounds and recent scars in the medical examination before the start of the asylum procedure.[622] iMMO considers that the value of the medical advice would increase if the medical advice would mention the story of ill-treatment. They recommend that if the asylum seeker is the victim of acts of violence which have taken place less than six months ago and has visible scars or bruises, these must be photographed and examined as soon as possible.[623] Also the lawyers interviewed for the purpose of this study are in favour of the FMMU or GCA documenting wounds or recent scars.[624]

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[613] Interview FMMU 1.
[614] Interview Pharos and Lawyer 5.
[615] Interview Pharos. See also interview IND 1 (with regard to the medical service in the detention centre).
[616] Interview Pharos.
[617] Netherlands Parliamentary documents TK 2014/15, 19637, nr. 1903, p. 5.
[618] Interview Lawyer 2.
[619] Interviews Lawyers 3 and 4 and DCR 1 and 2. One stakeholder who gives courses to lawyers said he encourages lawyers to take photos. Interview Pharos.
[620] Interview NFI 1.
[621] Interview NFI 1. See also interview Pharos.
[622] ACVZ, Sporen uit het verleden, pp. 30, 32 and 75, Dutch Council for Refugees, Letter concerning the proposal for the implementation of the recast Asylum Procedures Directive and the Reception Conditions Directive (34 088), 7 April 2015.
[623] The ACVZ has made a similar recommendation, see ACVZ, *Sporen uit het verleden*, pp. 30, 32.
[624] Interviews Lawyer 2 and Lawyer 5.

The State Secretary has indicated that he does not want to extend the tasks of FMMU to the documentation of scars. He refers to the principle that the asylum seekers are not asked about their asylum motives during the rest and preparation period in which the FMMU examination takes place. If asylum seekers would be asked whether they have wounds, scars or other medical problems resulting from ill-treatment the assessment of the asylum application already starts before the procedure has properly begun.[625]

### 4.4 The IND's duty to request a medical examination under Article 18 RAPD

According to the IND the medical examination mentioned in Article 18 RAPD falls within the IND's active duty to investigate, which means that the asylum seeker has no enforceable right to a medical examination.[626] According to Dutch asylum policy the IND decides after the second interview on the asylum motives whether a medical advice is relevant.[627] In exceptional cases a medical examination will take place before the interview, if it has been established that the asylum seeker cannot be interviewed.[628] One of the NIFP reports examined in the context of this study was indeed written in a case where the asylum seeker had not been interviewed by the IND, because he was hardly able to speak about what happened to him.[629] The Guide for NIFP forensic experts mentions that a medical examination can be asked in a first or subsequent asylum procedure. In principle the asylum seeker should 'submit all relevant information during the first asylum application'.[630] However, three out of the eight medical reports received for the purpose of this study were written in the context of a subsequent asylum procedure, which were started on the basis of an iMMO report.[631]

According to Dutch asylum policy the decision to ask for a medical report is based on several circumstances. First of all the asylum seeker's statements and medical documents[632] concerning the presence of significant physical and/or psychological sequelae are relevant. In this context the FMMU advice may be crucial.[633] The IND also looks at the asylum seeker's statements about the cause of the physical and/or psychological sequelae and relates them to country of origin information. Furthermore, the IND takes into account whether there is other evidence in support of the claim that the asylum seeker risks persecution or serious harm upon return.[634] The asylum seeker's mere statement that they suffer from psychological problems is insufficient to ask for a medical advice. Such problems should be substantiated with medical documents.[635]

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[625] The Netherlands Parliamentary documents TK 2014/15, 34088, nr. 6, p. 37 and TK 19637, nr. 1903, p. 5.
[626] NIFP, *Handreiking Rapporteurs NIFP, Forensisch Medisch Onderzoek Asiel (FMOA)*, version 2 March 2017, p. 7.
[627] IND Instruction 2016/4, p. 2.
[628] The Netherlands, Parliamentary documents 2014/15, 19 637, nr. 1903, nr. 3.
[629] NIFP report of 31 May 2016 (case 2). The FMMU had concluded twice (in June and November 2014) that the asylum seeker was not able to make a normal conversation.
[630] Handreiking Rapporteurs NIFP, p. 8.
[631] NIFP report of 23 May 2016 (case 1), NFI report of 16 June and NIFP report of 24 August 2016 (case 3), NFI report of 26 January 2017 and NIFP report of 1 October 2016 (case 5 , no iMMO report).
[632] The NIFP Guidance mentions that the IND will not refer a case for medical examination if psychological problems have not been substantiated with medical documents.
Handreiking Rapporteurs NIFP, p. 8.
[633] Interview iMMO.
[634] Para. C1/4.4.4 Aliens Circular.
[635] Ibid.

The IND does not consider a medical examination relevant if the application will be granted. Furthermore, such examination is not relevant if the application will not be assessed on its merits because the asylum seeker will be transferred on the basis of the Dublin Regulation or because the application is declared inadmissible. Moreover, no medical examination will be requested if the application cannot be granted or a risk of *refoulement*[636] cannot be found, irrespective of the credibility of the asylum account.[637]

The medical examination must thus be able to change the outcome of the asylum application. According to IND policy a medical report should even be of 'crucial importance' for the decision on the asylum application.[638] This may be the case, for example, if asylum seekers have been vague or unclear with regard to some parts of their asylum account, while country of origin information shows that the method of torture as described by them is often applied in their country of origin.[639] On the other hand, a medical examination is not considered relevant where there are serious doubts about the credibility of the asylum seeker's account which make it foreseeable that the examination will not lead to another, positive, judgment.[640] Examples of the last situation mentioned in IND Instruction 2016/4 are that a language analysis shows that it is not credible that the asylum seeker comes from the alleged country of origin, that country of origin information shows that an alleged event cannot have taken place or that the detention during which the asylum seeker would have been tortured is deemed incredible because of contradictory and/or vague statements.[641] In particular the last category of cases (contradictory or vague statements) leaves wide discretion to IND officers to reject applications without a medical examination. Furthermore, the Instruction does not mention that contradictions or vague statements about the past events may be the result of psychological problems which are often caused by torture or ill-treatment.[642]

[636] The risk that a person will be subjected to persecution or serious harm upon return to his country of origin.
[637] Para. C1/4.4.4 Aliens Circular.
[638] Ibid.
[639] IND Instruction 2016/4, p. 2. See also Explanations with the amendment of the Aliens Decree implementing Directive 2013/32/EU, p. 21.
[640] See also The Netherlands Parliamentary documents EK 2014/15, 34 088, C, p. 13 and EK 2014/15, 34 088, E, p. 3.
[641] IND Instruction 2016/4, p. 2.
[642] See eg UNHCR, *Beyond Proof*, May 2013, pp. 61-64.

*Assessment of the 'relevance' in practice*

In 2016 the number of medical examinations requested by the IND (14 between March 2016 and May 2017)[643] turned out to be much lower than was calculated in advance.[644] The Secretary of State told Parliament in April 2015 that he expected that with an influx of 17,000 asylum seekers 200-250 medical examinations would be necessary.[645] One IND officer mentioned a lower expected number of 100-120 per year.[646] The explanation for this large discrepancy given by one IND officer is that the expected number was based on the number of cases which have been brought to iMMO by lawyers.[647] In 2016 iMMO received 160 requests for a medical report, of which 90 per cent was accepted.[648] Lawyers send a case to iMMO if they think that the IND has made a mistake. IND officers only refer a case where they think that the assessment of the credibility of the asylum account can go both ways, if there are still doubts.[649]

The IND policy makers and IND officers could not clearly explain when the IND asks for a medical examination.[650] Several IND officers said that a medical report can be requested if the case can go either way (credible or not credible) and the medical report can make the difference.[651] Apparently in 2016 the IND only found in 14 cases that a medical report could change the initial credibility assessment. In all other cases, including those 160 cases in which asylum seekers' lawyers requested iMMO to write a medical report, the IND did not deem a medical report relevant.

The IND thus sets a very high threshold, maybe even a standard where normally the benefit of the doubt should be applied, before a medical examination is requested. This undermines the effectiveness of Article 18 RAPD. As a result of this high standard victims of torture may not be identified and potential psychological problems which may have caused vague, strange or inconsistent statements may be ignored. This may eventually lead to a negative asylum decision and result in a violation of the principle of *refoulement*.[652]

An IND officer should always consult a medical coordinator, who needs to refer the case.[653] This is also because of the costs of the examination.[654] One of the medical coordinators mentioned that only two IND officers came to her with a case and that she referred these cases to NFI/NIFP. She also assessed 17 cases herself and sent one case to the NFI/NIFP.[655] The question which cases should be referred

[643] The Netherlands Parliamentary documents EK 2016/17, 34088, G, p. 1.
[644] Interviews NIFP 2, NFI 2, IND 4.
[645] The Netherlands Parliamentary documents 2014/15, 34088, nr. 21, p. 22. This was also told to the NIFP. Interview NIFP 2.
[646] Interview IND 4. In interview NFI 2 it was stated that the IND counted on a number between 0 and 200 examinations per year.
[647] iMMO received 150 requests for a medical report in 2014, 142 in 2015 and 160 in 2016. Source iMMO.
[648] Source: iMMO.
[649] Interview IND 4.
[650] Interviews IND 1 and IND 5 and 6.
[651] Interviews IND 1, IND 4 and IND 5 and 6. One lawyer stated that a forensic medical examination seems to be requested only when the asylum account is considered credible. Interview Lawyer 2.
[652] The asylum seeker's lawyer may of course request a medical examination from iMMO. However, the IND and courts do always wait for the iMMO report. See also section 4.5.
[653] Interview IND 1.
[654] Interview IND 5 and 6.
[655] Interview IND 1 and Additional information provided by IND in September 2017.

for a medical examination does not seem to be discussed among the medical coordinators of the IND. These decisions are taken separately for each location.[656] Also to NFI and NIFP it is not clear on the basis of which criteria the IND requests them to do a medical examination in a case (it is a 'black box'). One NIFP forensic psychiatrist noted that in the cases she examined a medical examination was definitely indicated. She thinks it is possible that the IND misses cases of vulnerable asylum seekers who would also benefit from a medical examination.[657]

The IND should mention in the intended rejection of the asylum application (*voornemen*) that it does not consider a medical report relevant.[658] Asylum seeker are informed that they can ask a third party to write a medical report.[659] In such cases, the IND will often continue to process the asylum application in the AA-procedure. The reason for that is that the IND has already concluded that a medical examination is not relevant for the assessment of the asylum application.[660] iMMO mentioned that as a result more iMMO reports can only be submitted in a subsequent asylum procedure.[661]

The following factors relating to the IND's view on the value of medical examinations and practical issues may render the IND officers hesitant to ask for a medical examination:

*The IND's view on the value of medical examinations*
First, the reluctance to request medical reports may relate to IND officer's view on the value of medical reports. They state that the value of medical reports is limited, because it only gives a degree of causality between the asylum seeker's medical complaints and previous events. Furthermore, a medical examination cannot establish the context of the alleged torture or ill-treatment (notably who was the actor and why the asylum seeker was ill-treated). IND officers also find that doctors take the asylum seeker's (implausible) statements as a starting point (see further section 7.10.2).[662]

*Costs*
Secondly the costs of the forensic medical examination were not known to IND officers.[663] It was agreed that the price of the examination would be established after 40 reports have been issued by NFI/NIFP, which number had not been reached yet at the time this study was finalised. Some IND officers thought that the medical examination is very expensive. An IND policy maker mentioned that the price would be more than 15.000 euros, but that he also heard about double this price.[664] A medical coordinator mentioned a price of 10.000-12.000 euros.[665] IND medical coordinators stated

[656] Interview IND 1.
[657] Interview NIFP 1.
[658] IND Instruction 2016/4, p. 3.
[659] Art. 3.109e(1) Aliens Decree, Section C1/4.4.4 Aliens Circular. This is also mentioned in the leaflet 'Your asylum application Information on the General Asylum Procedure', available at www.ind.nl.
[660] IND Instruction 2016/4, p. 3.
[661] Interview iMMO.
[662] Reneman, A.M., De Lange, J. and Smeekes, J., 'Medische waarheidsvinding en geloofwaardigheidsbeoordeling in asielzaken, Interpretatie en waardering van medische rapporten door de IND', *Asiel & Migrantenrecht* 2016, nr. 10, p. 470.
[663] Interview IND 4.
[664] Interview IND 5 and 6.
[665] Interview IND 2 and 3. An iMMO report costs 3675 euros, which need to cover the costs of peer review, administration, training and management, the physicians and psychologists of iMMO are not paid for their

'you do not request a forensic medical examination just like that' and 'you should know very well why you need it and what it can lead to'.[666] The perceived high costs of the forensic medical examination may make IND officers cautious to request such examination.

*Delays in the procedure*

Furthermore, the fact that the medical examination takes a lot of time and cannot be done during the AA-procedure might be a factor which is taken into account by IND officers.[667] According the original working process it should take 15 weeks from the moment the IND sends a request for a report to NFI/NIFP until the final medical report is sent to the IND. However, during the first year of the NFI/NIFP pilot the examinations led to long delays in the asylum procedures due to logistical problems, such as the lack of an examination room for NFI[668], the shortage of psychiatrists and psychologists at the NIFP[669] and/or attendance of interpreters who did not speak the required language.[670] Moreover, requests for (medical) information by the experts took a lot of time.[671] Also the fact that asylum seekers are given the opportunity to make corrections and to decide whether they want to refuse permission to send the report to the IND, takes time.[672] Many lawyers asked for an extension of the deadline of five days, because they needed to arrange a meeting with an interpreter in order to discuss the report with their client. In most cases the examination by the NFI and/or NIFP takes around three to four months[673], but there are incidental cases in which it took much longer.[674]

The fact that all this time the asylum seeker lives in an asylum reception centre also costs a lot of money.[675] Furthermore, the time-limits for decision-making may be exceeded which can lead to a

work. iMMO, *Jaarverslag 2016*, p. 9. In July 2017 NIFP confirmed that a combined NFI and NIFP report would cost more or less this amount. Meeting NIFP, 18 July 2017.

[666] Interview IND 2 and 3.

[667] NIFP, *Handreiking Rapporteurs NIFP*, p. 7. The IND first intended to do the medical examination in the context of the AA-Procedure (see Art 3.115(1)(f) jo 3.115(6) Aliens Decree). However, it turned out that this was impossible.

[668] Interview NFI 1.

[669] Interview NIFP 2, NIFP report 20 April 2017 (case 7 ).

[670] NIFP report 20 April 2017 (case 7 ). These problems have been solved now.

[671] Meeting NIFP 18 July 2017.

[672] Interview IND 4.

[673] Meeting NIFP 18 July 2017. In the cases received for the purpose of this study: for the NIFP report of 23 May 2016 (case 1) the interviews took place on 29 February and 21 March 2016, for the NIFP report of 31 May 2016 (case 2) the first interview took place on 4 April 2016, for the NIFP report of 24 August 2016 (case 3) the interviews took place in March 2016, for the NIFP report of 21 July 2017 the interviews took place on 25 May and 8 June 2016, for the NIFP report of 1 October 2016 (case 5 ) the interviews took place on an unknown date, for the NIFP report of 23 March 2017 (case 6 ) the interviews took place on 4 and 18 January 2017, for the NIFP report of 20 April 2017 (case 7 ) the interviews took place between 12 December 2016 and 16 January 2017, for the NIFP report of 10 June 2017 (case 8 ) the interview took place between 24 November 2016 and 6 March 2017. For the NFI report of 16 June 2016 (case 3) the examination took place on 18 February 2016, for the NFI report of 16 June 2016 (case 4) the examination took place on 12 April 2016, for the NFI report of 26 January 2017 (case 5 )the examination took place on 13 December 2016, for the NFI report of 20 March 2017 (case 6 ) the examination took place on 19 April 2016, for the NFI report of 21 March 2017 (case 7) the examination took place on 2 March 2017, for the NFI report of 30 May 2017 (case 8 ) the examination took place on 10 April 2017.

[674] For the NIFP report of 20 April 2017 the interview took place on 11 August 2016 (the IND's request for an examination was received on 4 August 2016).

[675] Interview IND 4.

penalty imposed by a judge.[676] The IND considers the fact that a medical examination is carried out by NFI (not NIFP) as a ground for the extension of the time-limit for the decision with nine months, to 15 months.[677]

*Case law concerning the duty to request a medical examination*
The Administrative Jurisdiction Division of the Council of State (*Afdeling bestuursrechtspraak van de Raad van State*, hereafter: AJD)[678] has not addressed the obligations of the IND under Article 18 RAPD yet. However, in their judgments several district courts have left discretion to the IND to make a decision about the relevance of a medical report. The District court of Haarlem considered for example that the IND's judgment as to the relevance of the medical examination is primarily normative (*in eerste instantie maatgevend*).[679] In most cases the court first concluded that the IND's decision that the core of the asylum account was not credible, was sufficiently reasoned, and subsequently that the IND was not required to request a medical examination.[680] One court considered that the sole fact that the asylum seeker had eye problems and a scar on his leg was not sufficient to oblige the IND to request a medical report. The court also took into account that the asylum seeker requested iMMO to examine him, which was refused by iMMO.[681]

### 4.5 An iMMO report as a ground for further medical examination?

If the IND does not request a medical report on the basis of Article 18(1) RAPD, the asylum seeker may himself ask an expert for a medical report.[682] The IND should take this report into account in its asylum decision.[683] If asylum seekers announce that they have requested a medical report from iMMO the IND often, but not always postpones its decision. In the period July 2015 - July 2016 the IND waited in 32 of the 45 cases, in which the asylum seeker announced that they requested a medical report from iMMO. In the other cases it took a positive (1) or a negative (12) decision.[684]

In many of the 14 cases[685] which were referred for a medical examination in the first year of the pilot, the asylum seeker had submitted a medical report written by iMMO.[686] According to iMMO in 10 out of the 14 cases referred to NFI/NIFP, a medical report had been issued by iMMO.[687] In four out of the eight NFI/NIFP reports received for the purpose of this study, it is mentioned that iMMO had already issued a medical report.[688]

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[676] Interview IND 1.
[677] Art 31(3) Directive 2013/32/EU (complex issues of fact and/or law) implemented in Art 42 (4)(a) Aliens Act 2000. See para. C1/2.13 Aliens Circular.
[678] The AJD is the highest court in asylum cases.
[679] District court Haarlem 20 January 2017, AWB 16/29170. See also Rb Haarlem 20 January 2017, AWB 16/29175
[680] District court Middelburg 8 May 2017, ECLI:NL:RBDHA:2017:4951, District court Haarlem 20 January 2017, AWB 16/29170, District court Haarlem 20 January 2017, AWB 16/29175.
[681] District court Haarlem, 1 May 2017, ECLI:NL:RBDHA:2017:5270.
[682] Art. 18(2) RAPD.
[683] Art. 18(3) RAPD.
[684] IND, Onderzoek naar rol iMMO rapportage in asielzaken, versie 0.1, November 2016.
[685] Cases 1, 2, 3 and 5. See the table in Annex 5.
[686] Interview NFI 1.
[687] Email iMMO 26 June 2017.
[688] NIFP report of 23 May 2016 (case 1), NIFP report of 31 may (case 2), NIFP report of 24 August 2016 and NFI report of 16 June 2016 (case 3) and NIFP report of 1 October 2016 and NFI report of 26 January 2017 (case 5 ).

iMMO reports are considered expert reports by the AJD.[689] The IND is required to take iMMO reports into account in its assessment of the asylum claim in first and subsequent asylum procedures.[690] The IND does not declare subsequent asylum applications which are based on an iMMO report inadmissible, unless a medical examination has already taken place at the IND's request or it is clear in advance that the iMMO report cannot change the earlier decision.[691]

One IND officer said:

> Often the first step is that we do get an iMMO report and that you look at the report as a non-expert and think: I think that these conclusions are very strong. If I look at the case from our perspective… it does not fit together. However, at the moment that, to us, the case is clearly not credible in all aspects of it and in the core of the case, we will put the iMMO report aside and take a decision on the incredibility. If the credibility is more in the middle, we doubt the conclusions of the iMMO report a little bit because it does not fit the rest of the story. Then we can say ok, we request NFI/NIFP to write a kind of contra-expertise.[692]

However, by far most iMMO reports do not lead to a further medical examination, either because the asylum application is granted or because the IND rejects the application without a further medical examination.[693]

### 4.5.1 Asylum applications granted on the basis of an iMMO report

Asylum seekers who submit an iMMO report in support of their asylum claim often receive an asylum status. Between 5 March 2012 and 1 January 2017 iMMO has issued 453 complete medical reports.[694] According to statistics provided by iMMO a status has been granted in 240 cases (53 Per cent). In at least 68 cases (15 per cent) the application was rejected by the IND and confirmed by the Dutch courts.[695] Since the implementation of the RAPD in July 2015 until May 2017, the IND has granted an asylum status in 80 cases in which the asylum seeker submitted an iMMO report, 32 in a first asylum procedure, 48 in a subsequent asylum procedure.[696] In the Netherlands, reasons for a positive asylum decisions are not provided. Therefore it is not possible to see whether the iMMO report has (substantially) contributed to the positive asylum decision. However, an internal IND research on the relevance of iMMO reports shows that between 1 July 2015 and 1 July 2016, 56 asylum permits have been granted in cases where an iMMO report was submitted (45,5 per cent of the cases in which an

[689] AJD 31 July 2013, ECLI:NL:RVS:2013:621, see also District court Arnhem 5 June 2014 AWB 12/27931.
[690] Art 3.109e(4) Aliens Decree 2000.
[691] Para. C1/4.6 Aliens Circular.
[692] Interview IND 5 and 6.
[693] In 2016 iMMO received 160 requests for a medical examination of which 90% was accepted. In that year the IND requested a medical examination in 14 cases.
[694] In this period iMMO rejected an average of 20% of all applications for a forensic medical examination. Source iMMO.
[695] Source iMMO. The outcome of the other cases is (still) unknown because they are pending with the IND or before a national court. See also iMMO Newsletter 10 December 2016.
[696] iMMO, Letter to the Senate (*Eerste Kamer*) of 31 May 2017, p. 4.

iMMO report was submitted).[697] In 22 of those cases (39 per cent) the IND considered the iMMO report decisive for the grant of the asylum status and in 21 cases (38 per cent) the iMMO report contributed together with other elements (documents or statements) to the grant of the asylum decision.[698] In the other cases the iMMO report did not play a role.[699] Apparently the IND does not consider the iMMO report decisive, if other evidence has contributed to the positive decision.

If the asylum application is granted after an iMMO report has been submitted by the asylum seeker (in the meaning of Article 18(2) RAPD) the question rises whether the IND should pay for this report. According to Article 18(1) RAPD medical examinations which are deemed *relevant* for the examination of the asylum application 'shall be paid for out of public funds'. The fact that the application was granted may indicate that a medical examination should have been considered relevant in the meaning of Article 18(1) RAPD in the first place and that the IND should have paid for it.

iMMO does not ask asylum seekers to pay for the medical examination. However, it asks the lawyer to request the IND and/or the court for compensation for the medical examination, which is then paid back to iMMO. On 11 May 2017 the State Secretary informed Parliament that it will pay for the medical report if an iMMO report has been provided after the intended rejection in the first asylum procedure and the report was *decisive* (*doorslaggevend*) for the positive asylum decision. The costs of iMMO reports submitted before the intended rejection or in a subsequent asylum procedure will not be compensated by the IND. The IND pays for it, if the asylum seeker has requested a (decisive) iMMO report as soon as possible in the first asylum procedure and could only submit it in a subsequent procedure because the IND and the court did not want to wait for it.[700] According to iMMO 10 per cent of all iMMO reports are submitted during the first phase of the asylum procedure, 40 per cent is submitted in a subsequent asylum procedure.[701] The IND has paid for 12 iMMO examinations in 2015, 6 iMMO examinations in 2016 and 4 iMMO examinations in the period January to May 2017.[702] This is much less than the number of cases, in which an asylum status was granted after an iMMO report had been submitted.[703] The question may be raised whether the condition that the iMMO report was decisive (instead of relevant) and distinction between reports submitted in a first or subsequent asylum procedure is in conformity with Article 18 RAPD.[704]

[697] IND, Onderzoek naar rol iMMO rapportage in asielzaken, versie 0.1, November 2016.
[698] Ibid.
[699] Ibid. See also the Netherlands Parliamentary documents EK 2016/17, 34088, G, p. 3.
[700] The Netherlands Parliamentary documents EK 2016/17, 34088, G, p. 2.
[701] iMMO, Letter to the Senate (*Eerste Kamer*) of 31 May 2017, pp. 3-4. See also IND, Onderzoek naar rol iMMO rapportage in asielzaken, versie 0.1, November 2016.
[702] iMMO, Letter to the Senate (*Eerste Kamer*) of 31 May 2017, p. 2.
[703] According to iMMO it concerned at least 80 cases in the period July 2015 to May 2017, iMMO, Letter to the Senate (*Eerste Kamer*) of 31 May 2017, pp. 4-5.
[704] iMMO also wrote to Parliament that the IND and iMMO agreed that the IND would pay for the medical examination if the report was decisive (or contributed for more than 50%) in the IND's decision irrespective of the moment the report was submitted. iMMO, Letter to the Senate (*Eerste Kamer*) of 31 May 2017, p. 2.

### 4.5.2 Rejection without a further medical examination

Until January 2016 the IND did not have the opportunity to request its own expert medical examination. It thus rejected asylum claims which were supported by an iMMO report on the basis of its own (non-expert) arguments, not on the basis of another medical report. Since the transposition of Article 18 RAPD the IND may request medical examination from NFI and/or NIFP if it finds that the iMMO report gives rise to doubts about the credibility of the asylum account. Both medical reports will then be included in the integral credibility assessment.[705] Nevertheless, the IND still rejects cases in which asylum seekers have submitted an iMMO report in support of their asylum claim, without requesting a further medical examination.[706] The IND derives from the case law of the AJD[707] that where sufficient reasons have been stated that the cause of the alleged torture is not credible, a further medical examination cannot lead to a different conclusion.[708]

The AJD followed the recent case law of the ECtHR[709] concerning medical reports.[710] It held that medical evidence may provide a strong indication that the alleged ill-treatment in the country of origin or habitual residence has caused the sequelae on the asylum seeker. Such strong indication may trigger a duty to do a further medical examination.[711] According to the AJD not only reports issued by a specialised doctor working in accordance with the Istanbul Protocol can provide such strong indication.[712] Furthermore, the fact that the medical advisor concluded to a lower degree of causality (consistent or very consistent) does not mean that the IND is not obliged to ask for a further medical examination.[713]

The AJD considered that whether medical evidence requires further examination 'must be assessed in the light of the substantiated or credible personal situation of the asylum seeker and against the background of the general situation in the country concerned'. [714] Also the fact that asylum seekers have submitted other evidence in support of their statements that they will be subjected to ill-treatment upon return is relevant in that regard. The fact that parts of the asylum account are not deemed credible does not necessarily take away the duty to request a further examination.[715] The AJD has concluded in several cases that the IND had provided insufficient reasons why the medical report

[705] IND Instruction 2016/4, p 5.
[706] The text of IND Instruction 2016/4 suggests that the IND will only request a second opinion if 'there is a strong causal relationship between physical and/or psychological problems (diagnostic or typical) and the claimed origin of those problems'. IND Instruction 2016/4, p. 5. In practice NFI and NIFP do not carry out second opinions, they only do full forensic examinations.
[707] Eg AJD 10 February 2017, ECLI:NL:RVS:2017:362, AJD 10 September 2016, ECLI:NL:RVS:2016:2589, AJD 10 June 2015, ECLI:NL:RVS:2015:1919, AJD 20 April 2015, ECLI:NL:RVS:2015:1348, AJD 30 January 2015, ECLI:NL:RVS:2015:303, AJD 31 December 2014, ECLI:NL:RVS:2014:4791, AJD 25 August 2014, ECLI:NL:RVS:2014:3262.
[708] IND Instruction 2016/4, p. 5. See also interview IND 5 and 6.
[709] The AJD refers to *R.C. v Sweden*, *D.N.W. v Sweden*, *R.J. v France*, *I v Sweden*, *Mo.M v France* and *Z.M. v France*.
[710] AJD 17 August 2011, ECLI:NL:RVS:2011:BR5421, AJD 26 August 2012, ECLI:NL:RVS:2012:BX5598, AJD 31 July 2013, ECLI:NL:RVS:2012:BX5598.
[711] AJD 19 February 2014, ECLI:NL:RVS:2014:600.
[712] AJD 12 December 2014, ECLI:NL:RVS:2014:4601.
[713] AJD 19 February 2014, ECLI:NL:RVS:2014:600
[714] Ibid.
[715] Ibid.

submitted by the asylum seeker did not require a further medical examination or did not changed its credibility assessment.[716]

However, in several recent judgments the AJD held that the iMMO report submitted by the asylum seeker did not warrant a further medical examination, because the IND had provided sufficient reasons that the asylum seeker had made contradictory and vague statements with regard to the core of the asylum account. Furthermore, the IND had explicitly related the medical report to its assessment of the credibility of the part of the asylum account which the report intends to substantiate and the security situation in the country of origin.[717]

It is questionable whether this case law is in conformity with the ECtHR's and Committee against Torture's case law. The ECtHR held in *R.C. v Sweden* that the State had an obligation to request a further examination even though the Swedish authorities found serious credibility issues with regard to the asylum seeker's escape from an Iranian court.[718] In *I. v Sweden* the ECtHR accepted that serious credibility issues may prevent that a medical report shifts the burden of proof to the State. However, it only seems to accept this if the asylum seeker does not provide statements and/or evidence which place the State 'in a position to assess the asylum seeker's individual situation'.[719] In *I. v. Sweden* the Swedish authorities were not placed in that position, because the asylum seeker who claimed to be at risk because of his work as a journalist, did not support his claim with any evidence such as paper articles or photos.[720] The fact that the asylum seeker submitted vague, inconsistent or strange statements with regard to the core of his asylum account is arguably not sufficient to ignore a medical report and reject the asylum application without a further examination.

The IND uses various arguments in order to refrain from granting decisive weight to a forensic medical report in its asylum decision. These arguments will be discussed in chapter 7.

## 4.6. Medical examinations by NFI and NIFP

### 4.6.1 Introduction

Even though Article 18 RAPD has been transposed since July 2015[721], the IND first requested for a medical examination in March 2016.[722] In January 2016 the IND started a pilot with the Netherlands Forensic Institute (NFI) and the Netherlands Institute of Forensic Psychiatry and Psychology (NIFP).[723]

[716] See eg AJD 31 July 2013, ECLI:NL:RVS:2012:BX5598**,** AJD 19 February 2014, ECLI:NL:RVS:2014:600.
[717] AJD 10 February 2017, ECLI:NL:RVS:2017:362, AJD 10 September 2016, ECLI:NL:RVS:2016:2589, AJD 10 June 2015, ECLI:NL:RVS:2015:1919, AJD 20 April 2015, ECLI:NL:RVS:2015:1348, AJD 30 January 2015, ECLI:NL:RVS:2015:303, AJD 31 December 2014, ECLI:NL:RVS:2014:4791, AJD 25 August 2014, ECLI:NL:RVS:2014:3262.
[718] ECtHR 9 March 2010, Appl. no. 41827/07, *R.C. v Sweden*, para. 52.
[719] ECtHR 5 September 2013, Appl. no. 61204/09, *I. v Sweden*, para. 62.
[720] Ibid, para. 64.
[721] Before January 2016 medical reports were only written on the request of the asylum seeker. The IND did not have the possibility to ask for a medical report or a second opinion and contested the content of medical reports with its own arguments. See Reneman, A.M., De Lange, J. and Smeekes, J., p. 460.
[722] The Netherlands Parliamentary documents EK 2016/17, 34088, G, p. 1.
[723] The pilot will be finalised in the summer of 2017, after which the NFI and NIFP will continue to carry out the forensic medical examinations. Meeting with NIFP 18 July 2017.

The NFI performs the physical examinations, NIFP carries out the psychiatric examinations. NFI and NIFP decided to opt for this assignment together because they do not have the expertise to do both physical and psychiatric forensic examinations.[724]

The pilot was designed by the NFI and NIFP in cooperation with the IND. Within NIFP a project group was set up in order to design the process and the psychiatric examination.[725] During the first year of the pilot many aspects of the examination have been adapted (for example the consent form, the sub questions addressed by NIFP) and many new questions have arisen which needed to be addressed (for example presence of guardians at the examination of an unaccompanied child).[726]

NIFP noted in July 2017 that the low number of asylum cases referred to them made it difficult to build up expertise and develop a routine and format for the forensic examinations.[727] Furthermore, this rendered it difficult to make a planning: psychiatrists and psychologists have to examine asylum seekers incidentally, on top of their normal work load. As a result, it takes three to four months to write a report.[728]

Both the NFI and the NIFP are forensic institutions which fall under the Ministry of Security and Justice. They recognise that this may raise questions as to the independence and impartiality of their examinations.[729] The Guidance for NIFP forensic experts stresses the independence of the experts from the Ministry of Security and Justice and their impartiality.[730] This independent position means that NIFP does not receive directions from the Minister with regard to mediation for or the carrying out of requests for medical reports.[731] All NIFP experts are registered in the Dutch Register for Judicial Experts (*Nederlands Register Gerechtelijk Deskundigen*).[732] NIFP forensic experts declare at the end of the report that they have complied with the code of conduct for Judicial Experts and has written the report truthfully, completely and to the best of their knowledge. This code of conduct mentions that the expert should behave as an independent, impartial, careful, honest and competent expert during the execution of their assignment.[733] In order to promote the impartiality of the NFI/NIFP IND will not inform the NFI/NIFP about the credibility assessment of the relevant elements. However, if the asylum application has already been rejected, NFI/NIFP receive the legal file which includes amongst others

[724] Interview NFI 2. Before the medical examinations were assigned to the NFI and NIFP the IND made a list of requirements on the basis of conversations with experts and doctors in the field and the Royal Dutch Medical Association. This included the requirement that the examination is performed by forensic doctors. The IND first invited tenders for the forensic medical examination, but later withdrew the tender and granted the assignment to NFI and NIFP. According to the IND this was due to a legal requirement to assess whether an assignment can be done by a government institution before starting a tender. Interviews IND 4 and NIFP 2.
[725] The group consisted of a project leader, director, psychiatrist, legal adviser, financial adviser, policy officer and a coordinator of the project. Interview NIFP 2.
[726] Interview NIFP 2.
[727] Meeting with NIFP on 18 July 2017.
[728] Ibid.
[729] Interview NFI 1.
[730] NIFP, *Handreiking Rapporteurs NIFP*, p. 17.
[731] Ibid.
[732] Interview NIFP 3.
[733] Art. 2 Gedragscode voor gerechtelijk deskundigen in civielrechtelijke en bestuursrechtelijke zaken, version 3.7, January 2012. See also Art. 3.3 which states that the expert shall not be influenced by an interest of one or more of the parties concerned in the case, the party which has commissioned the expert advice or any third party with regard to (the results of) the examination and the conclusions based on it.

the intended rejection and the negative decision.[734] The forensic experts of NIFP do not have contact with IND officers or lawyers involved in the case.[735] It is possible to lodge a complaint against the forensic expert(s) with the medical disciplinary committees.

### 4.6.2 Information and consent

If the IND decides to refer a case for a forensic medical examination, it sends a letter with an information sheet and consent form to the asylum seeker's lawyer. The IND requests the lawyer to discuss the medical examination and the consent form with their client. The information sheet mentions that the asylum seeker is not required to undergo the medical examination and that the medical examination can only be carried out with the consent of the asylum seeker.[736] However, it does not mention the consequences if the asylum seeker refuses permission.[737] If the asylum seeker refuses their consent to the medical examination the IND will take into account the reasons for this refusal in the integral credibility assessment.[738] Until December 2016 none of the asylum seekers whose cases the IND intended to refer to the NFI/NIFP had refused to take part in the examination. However, there were asylum seekers who refused to undergo part of the physical or psychological examination.[739]

Asylum seekers are also asked to give permission to NFI and NIFP for requesting medical information from GCA[740] and to the IND to send all relevant information from the legal file to NFI/NIFP. In a separate form NIFP and/or NFI can ask asylum seekers their consent to access medical information from a specific care provider or treating institution.[741] The NIFP forensic expert should also ask an asylum seeker for permission if they want to talk to third persons (for example family members) in the context of the examination or to the general practitioner or treating doctor of the asylum seeker. If the asylum seeker refuses such permission the report shall mention the reason for that.[742]

The NFI/NIFP forensic expert should check before the start of the examination whether asylum seekers understand their rights, such as the right to receive the report, to make corrections and to refuse permission to send the report to the IND.[743] Many of the reports of the NFI and NIFP received

[734] Report NFI of 16 June 2016 (case 3), Reports NIFP of 23 May 2016 (case 1), 24 August 2016 (case 3).
[735] Meeting NIFP 18 July 2017.
[736] IND/NFI/NIFP, *Informatie over het forensisch medisch onderzoek*, version 9 November 2015.
[737] Art 3.109e(2) Aliens Decree 2000, IND Instruction 2016/4, p. 5.
[738] IND Instruction 2016/4, p. 5. The consequences of the refusal are not mentioned in the information sheet.
[739] Interview IND 4. There was one case in which physical examination was proposed to the asylum seeker but refused because it would lead to an increase of medical complaints, anxiety and shame and potentially even retraumatisation. The asylum seeker did cooperate with a psychiatric examination. Report NIFP of 31 May 2016 (case 2). In another case an asylum seeker indicated that he did not want to take part in a psychological test. NIFP report of 23 March 2017 (case 6 ).
[740] This also includes the providing of information by FMMU and GCA. IND/NFI/NIFP, Informatie over het forensisch medisch onderzoek.
[741] Toestemmingsverklaring t.b.v. een psycho-medisch onderzoek door het NIFP, provided by NIFP on 9 November 2016.
[742] NIFP, *Handreiking Rapporteurs NIFP*, p. 12. The forensic expert can request information about the current medical problems established by the treating doctor, the diagnosis, the relevant medical history the nature of the treatment provided and – if applicable – prescribed medication and the course and expected duration of the treatment.
[743] NIFP, *Handreiking Rapporteurs NIFP*, p. 12.

for the purpose of this study indeed mention that the asylum seeker was informed about the procedure to be followed and their rights and had given consent.[744] One NIFP report mentions that the asylum seeker probably did not understand the context and purpose of the examination.[745]

### 4.6.3 Corrections and refusal of permission to send the report to the IND

After the examination the asylum seeker's lawyer receives the NFI/NIFP report.[746] At that point the asylum seeker has the right to see the file, make corrections and to refuse permission to send the report to the IND.[747] The lawyer should discuss the report with the asylum seeker and inform NFI and/or NIFP within five working days[748] whether the asylum seeker wants to make corrections and/or discuss the report in a meeting with the forensic expert. Corrections as regards the facts (such as spelling of names, dates and addresses) will be accepted by NIFP. The experts are not required to change the report in accordance with asylum seekers' comments, if they concern their view of the events described. However, they will put the remarks made by the asylum seekers in an appendix to the report.[749] If asylum seekers made many corrections, NIFP may ask them again whether they agree that the NIFP send the report to the IND.[750] Until July 2017 none of the asylum seekers refused permission to send the report to the IND.[751] If permission is refused, the IND will include the reasons given by the asylum seeker in the integral credibility assessment.[752]

The asylum seeker has the right of access to the file on which the medical report is based and to get a copy of the information in the file. Experts may refuse access to parts of the file in order to protect the privacy of other persons. In such case, they need to inform the asylum seeker about this.[753]

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[744] NIFP Reports of 23 May 2016 (case 1), 24 August 2016 (case 3), 15 July 2017 (case 4), 20 April 2017 (case 7 ) and 10 June 2017 (case7), NFI reports of 16 June 2016 (case 3, case 4), 26 January 2017 (case 5 ), 20 March 2017 (case 6 ), 21 March 2017 (case 7 ) and 30 May 2017 (case 8 ). In the NIFP report of 31 May 2016 (case 2) NIFP mentions that it was not clear whether the person examined understood the explanations about giving his consent to the forensic expert to ask his treating doctors for medical information.

[745] NIFP report 23 March 2017 (case 6 ).

[746] NIFP, *Handreiking Rapporteurs NIFP*, p. 13.

[747] The NIFP Guidance mentions that the NIFP forensic expert may not provide information to the IND without the consent of the asylum seeker. In the consent form signed by the asylum seeker before the medical examination the asylum seeker is asked permission to send the medical report to the IND. However, the asylum seeker may withdraw this permission after s/he has seen the final report. Handreiking Rapporteurs NIFP, p. 12, IND Instruction 2016/4, p. 6.

[748] One lawyer informed the researcher that this time-limit is too short, considering the fact that she had to plan a meeting to discuss the report with the asylum seeker. However, this lawyer asked for and was granted extension of this time-limit. In practice NIFP often grants extension of this time-limit. Email of the lawyer assisting the asylum seeker concerned in NFI report of 16 June 2016 and NIFP report of 24 August 2016 (case 3). Meeting NIFP 18 July 2017.

[749] NIFP, *Handreiking Rapporteurs NIFP*, p. 13. Letter of NFI/NIFP accompanying the medical report as received in July 2017.

[750] Meeting NIFP 18 July 2017.

[751] Interviews IND 4 and NIFP 2.

[752] IND Instruction, p. 5.

[753] NIFP, *Handreiking Rapporteurs NIFP*, p. 13.

### 4.6.4 Expertise and quality guarantees

Before January 2016 both the NFI and the NIFP did not perform forensic examinations in the context of the asylum procedure. NFI is mostly concerned with examinations of the cause of death and sometimes the injuries of living persons in the context of criminal law proceedings. NIFP performs psychiatric and psychological examinations in the context of criminal law proceedings.[754] NFI believes that it is qualified to do the physical part of the medical examination in asylum procedures and NIFP to do the psychiatric part. For this reason both organisations proposed the IND to do the examinations together.[755]

The IND states in an intended rejection that the medical examination has a forensic nature and is therefore carried out by forensic experts (NFI and NIFP) who have experience in examinations and reporting in the context of legal proceedings. A medical coordinator expressed confidence in the expertise of the forensic experts of NFI/NIFP, because they have forensic expertise and experience and they apply 'real science'.[756] She also mentioned the fact that NFI and NIFP have worked in the criminal law context for a long time and thus are trusted by judges.[757]

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According to NFI the forensic examination of the scars and/or injuries of asylum seekers is similar to the work it usually does.[758] The NFI forensic physician, who carried out most of the examinations, considers the forensic examination to be rather universal. For that reason he uses almost the same format for the examination in the context of the asylum procedure as he usually does in criminal law proceedings. However, because in the asylum procedure the NFI report often needs to be combined with the NIFP report, the format looks slightly different. Furthermore, the organisation of the procedure is different, for example because the asylum seeker has the right to make corrections and to refuse permission to send the report to the IND, which is not the case in criminal law proceedings.[759]

NFI initially started with one forensic physician for the medical examination of asylum seekers. This physician indicated during the interview that he did not prepare himself for the forensic medical examination of asylum seekers in any special way. If necessary in the individual case (for example in case of special types of ill-treatment) he will do extra research or consult an external expert. He has for example consulted an expert on burning wounds.[760] At one point a female asylum seeker asked for a female forensic physician. Then another (female) forensic physician was informed of the course

[754] See www.nifpnet.nl/.
[755] Interview NFI 2.
[756] Interview IND 2 and 3.
[757] The same IND officer expressed doubts about the expertise of (some) iMMO physicians and psychologists in an earlier interview with the researcher. See also an intended rejection of 5 May 2017, in which the IND noted that it gave more weight to the NFI report amongst others because the iMMO examination was not performed by a forensic doctor with training and experience in and knowledge of forensic medicine (the examination was done by psychiatrists). See further section 7.10.2 and Annex 6.
[758] Interview NFI 2.
[759] Interview NFI 1 and NFI 2.
[760] Interview NFI 1, NFI report of 16 June 2016 (case 4).

of proceedings and performed the medical examination.[761] The NFI forensic physician mentioned that he attends conferences on forensic medicine, which sometimes address acts of torture.

The NFI forensic physician does not exchange expertise with iMMO, because he wants to guarantee his independence.[762] Also exchange with other experts in the field of forensic medical examinations of asylum seekers has not been established.[763]

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The NIFP forensic experts are registered in the BIG and/or NIP and in the Dutch register for judicial experts (*Nederlands Register voor Gerechtelijk Deskundigen*, NRGD).[764] All experts take part in courses and education, intervision, peer review and feedback.[765] One NIFP psychiatrist has been involved in the development of the examination and has written most NIFP reports. However, more psychiatrists are now trained to do examinations in the context of the asylum procedure. A child was for example examined by a child and youth psychiatrist.[766] Every NIFP report is reviewed by another psychiatrist and (if a psychologist was involved) a psychologist and an a lawyer of NIFP.[767]

NIFP asked a Dutch expert who was involved in the development of the Istanbul Protocol to give advice and explain the context of forensic medical examinations in asylum procedures.[768] Furthermore, the NIFP psychiatrists have received training from an expert in transcultural psychiatry.[769] The NIFP Guidance notes that NIFP experts should be aware of the cultural context and that this requires knowledge of cultural-specific disorders. For this purpose experts can consult literature or colleagues with transcultural expertise. Furthermore, experts need to be aware of the influence of language and habits of expression which are related to culture. The NIFP guide also mentions that transcultural awareness requires that the attitude and interview methods of the expert should create trust. The Cultural Formulation Interview, which is attached to the NIFP guidance should assist the experts in that. [770]

NIFP agreed to discuss cases with iMMO, but only after the first (final) decisions have been taken in cases for which NIFP issued a report, which was still not the case at the time this study was finalised. In this first phase NIFP was also too busy setting up a high quality examination together with NFI and the IND.[771] NIFP therefore also did not exchange expertise in the context of the European project carried out by iMMO, the Cordelia Foundation from Hungary and Parcours d'Exil from France to develop common standards for the medical examination in the asylum procedure Art. 18 Directive 2013/32/EU.[772]

[761] Interview NFI 2.
[762] Interview iMMO.
[763] Interview NFI 1.
[764] NIFP, *Handreiking Rapporteurs NIFP*, p. 17.
[765] Ibid.
[766] NIFP report 20 April 2017 (case 7 ).
[767] Interviews NIFP 2 and NIFP 3. The lawyer looks at consistency and potential unwanted legal connotations of the wording used by the psychiatrist.
[768] Interviews NIFP 1 and NIFP 3.
[769] Interview NIFP 2.
[770] NIFP, *Handreiking Rapporteurs NIFP*, p. 15-16.
[771] Interview NIFP 2.
[772] Interview iMMO.

### 4.6.5 Central question

Both NFI and NIFP use a format for the medical examination, which has been developed together with the IND.[773] The central question posed to the forensic expert(s) of the NFI and/or NIFP is: 'To which extent is there a causal relationship between physical and/or psychological sequelae on the one hand and their origin on the other hand?'.[774] This question is also answered in cases where the asylum seeker has already submitted an iMMO rapport. In such cases NFI and NIFP perform a full examination and their report can therefore not be considered a review or a second opinion on the iMMO report.[775]

The NFI/NIFP central question is more limited than the central question used by iMMO 'Is it plausible that the scars and/or physical and/or psychological problems *result from the alleged events on which the asylum application is based*?'. Some IND officers criticised this central question because it suggests that it relates the scars and physical and/or psychological problems to the whole asylum account. They are of the opinion that as a result iMMO engages in a credibility assessment, which is a task of the IND.[776]

NFI and NIFP have divided the central question in several sub questions. The formulation of these sub questions has changed over time and is still being discussed between the IND and the NFI/NIFP.[777] In the most recent medical reports of NFI and NIFP[778] the sub questions were formulated as follows:

**NFI:**

A. What is the plausibility of the findings during the physical examination related to the following hypotheses:
- Hypothesis 1: the explanation of the asylum seeker is right;
- Hypothesis 2: the explanation of the asylum seeker is false.

**NIFP:**

B. Is there psychological damage/psychopathology? If so, to which degree?
C. Is it plausible that the psychological damage/psychopathology is caused by the alleged asylum account on which the asylum application is based? To which classification (of the Istanbul Protocol) should this lead?

[773] Additional information provided by the IND in September 2017.
[774] Section C1/4.4.4 Aliens Circular. IND Instruction 2016/4, p. 4.
[775] The IND had asked NFI and NIFP to do second opinions. However, because of their own disciplinary rules, the NFI and NIFP chose to do a full examination instead. Interviews NIFP 1 and IND 4. However, the NFI forensic experts stated that a second opinion was never at issue.
[776] Reneman, A.M. De Lange, J. and Smeekes, J., pp. 469-470.
[777] Interview NIFP 3. iMMO has not been included in the process of writing the IND Working Instruction or the central questions. Interview iMMO.
[778] NFI reports of 21 March 2017 (case 7 ) and 30 May 2017 (case 8 ), NIFP reports of 20 April 2017 (case 7 ) and 10 June 2017 (case 8 ).

In earlier reports the NIFP also answered the question whether the psychological damage or psychopathology influenced the anamnesis[779].[780] In two reports it assessed whether the psychological damage/psycho-pathology interferes with the asylum seeker's ability to make complete, coherent and consistent statements.[781] NIFP mentioned for example that inconsistencies in the asylum account during the examination correlate to a certain extent with the asylum seeker's psychopathology and cognitive problems[782] or that the asylum seeker's complaints made the anamnesis more difficult[783] or even impossible[784].

In these (earlier) reports NIFP also addressed the probability that psychological problems interfered with the asylum seeker's ability to make complete, coherent and consistent statements during the interview with the IND. [785] The IND objected against this, because the FMMU already advises on the question whether a person is able to make complete, coherent and consistent statements before the start of the asylum procedure. This may lead to different conclusions on the same question.[786]

For that reason NIFP will not address this issue anymore in its report.[787] However, if necessary it will remark in the report, under the section dealing with the cooperation by the asylum seeker, that the asylum seeker was not able to make complete, coherent and consistent statements and that this influenced the quality of the psychiatric examination.[788] In one report NIFP mentioned that the asylum seeker did not want to talk about what happened to him in his country of origin and failed to give details about that.[789] Here NIFP stressed its independency and noted that it should write its report in conformity with its expertise.[790]

NFI and NIFP write two separate reports in which they answer the sub questions. Together they answer the following question on the front page of the report:

D. What is the reasoned coherence between the physical and/or psychological sequalae/complaints and their origin as alleged in the asylum account and to which degree is there a causal relationship?[791]

[779] According to the MediLexicon (http://www.medilexicon.com/dictionary/3358), an anamnesis is 'the medical or developmental history of a patient'.
[780] NIFP report of 23 May 2016 (case 1) and NIFP report of 31 May 2016 (case 2).
[781] NIFP reports of 15 July 2016 (case 4 ) and 1 October 2016 (case 5 ).
[782] NIFP report of 24 August 2016 (case 3).
[783] NIFP report of 23 May 2016 (case 1).
[784] NIFP report of 31 May 2016 (case 2).
[785] NIFP report of 24 August 2016 (case 3). See also District Court Utrecht 28 March 2017, AWB 17/4601, AWB 17/4603, AWB 17/4598 en AWB 17/4600.
[786] See chapter 3 of this report.
[787] Interview NIFP 3.
[788] Interview NIFP 3. See also Format NIFP established on 28 March 2017, where this is explicitly mentioned under the section 'Cooperation and limitations to the examination'.
[789] NIFP report 23 March 2017 (case 6 ).
[790] Interview NIFP 3. See also Format NIFP established on 28 March 2017, where this is explicitly mentioned under the section 'Cooperation and limitations to the examination'.
[791] Format NIFP established on 28 March 2017. In the NFI report of 21 March 2017 and NIFP report of 20 April 2017 (case 7 ) this question did not include 'to which degree is there a causal relationship?'. The cover letter dated 31 May 2017 with the NFI report of 30 May 2017 and NIFP report of 10 June 2017 (case 8 ) do include these words.

In two combined NFI/NIFP reports received for the purpose of this study the final sub questions were not answered[792] in one it was answered in one sentence.[793] The integration of the conclusions of NFI and NIFP will be further discussed in section 4.6.7.

### 4.6.6 The medical examination

The medical examination may consist of a physical examination, psychological examination and/or a psychodiagnostic examination.[794] On the basis of the legal and medical documentation provided to them the NFI and NIFP decide whether a physical and/or a psychiatric/psychodiagnostic examination is necessary.[795]

During the examinations by NFI and NIFP the expert is usually assisted by an interpreter.[796] In particular during the NIFP interview the role of the interpreter is crucial: the interpreter is not only asked to translate, but also to share knowledge about the culture of the asylum seeker or to interpret non-verbal communication.[797] The expert can ask the interpreter whether the asylum seeker was confused, how they constructed sentences and whether this fits with their level of education.[798]

Both the NFI and NIFP respect the fact that the asylum seeker only wants to be examined by a male or a female expert or be assisted by a male or female interpreter.[799] If the asylum seeker has problems with the interpreter because of his ethnicity or country of origin, this is taken into account. Furthermore, the NIFP psychiatrists and psychologists make sure that the examination takes place in a safe environment. If necessary they talk to the asylum seeker in their own home or another convenient location.[800] Unaccompanied children may be accompanied by their guardian on their request.[801]

*The physical examination*

The forensic physicians of the NFI base their examination on different sources of information, including information received from treating doctors, the iMMO report (if available), photos of injuries

[792] NFI report of 16 June 2016 and NIFP report of 24 August 2016 (case 3), NFI report of 30 May 2017 and NIFP report of 10 June 2017 (case 8 ).
[793] NFI report of 21 March 2017 and NIFP report of 20 April 2017 (case 7 ).
[794] Para. C1/4.4.4 Aliens Circular.
[795] Interview NFI 1. NFI and NIFP arrange an examination room and security. Some of the logistics such as the transportation of the asylum seeker and the presence of an interpreter, are organised by the IND. Procesbeschrijving FMOA, versie 2.0, 27 October 2015.
[796] Interviews NFI 1 and NIFP 1.
[797] NIFP, *Handreiking Rapporteurs NIFP*, p. 15.
[798] Interview NIFP 1.
[799] Interviews NFI 2 and NIFP 1, see also NIFP report 1 October 2016 (case 5 ).
[800] See also the NIFP report of 31 May 2016 (case 2), where the psychiatrist talked to the asylum seeker in the house where he lived and 15 July 2016 (case 4) and 23 March 2017 (case 6 ), where the asylum seeker was interviewed in the reception centre. During the interview the psychiatrist mentioned the example of a woman who came to the meetings with a baby. The rapporteur decided to talk to her a third time in the asylum reception centre without the baby. Interview NIFP 1.
[801] NFI report of 21 March 2017 and NIFP report of 20 April 2017 (case 7 ).

submitted by the asylum seeker and a physical examination of the asylum seeker.[802] The examination consists of:

- a discussion of the asylum seeker's general health situation and potential factors which influence injuries and healing of wounds;
- a summary by the expert of the asylum seeker's statements regarding the physical ill-treatment in the past following from the IND-file;
- a discussion of the mentioned actions of violence in order to specify, correct, date and explore the resulting complaints and the process of healing; and
- the actual physical examination.[803]

According to the NFI forensic physician it happens rather often that the asylum seeker makes additional statements concerning past ill-treatment during the medical examination, especially concerning sexual violence.[804] The physician suspects that this is caused by shame and culture. Apparently asylum seekers feel more at ease to talk about it in a doctor's room than in front of an IND officer.[805] In two cases asylum seekers (one adult asylum seeker and unaccompanied child and his guardian) did not give permission to the NFI doctor to examine their (peri)anal area.[806]

The actual physical examination of the asylum seeker takes an average of 1,5 to 2 hours and focuses on injuries and scars which are allegedly caused by ill-treatment. A forensic medical photographer takes pictures of the scars. If necessary the forensic doctor can ask a hospital to make X-rays or scans.[807] The physician formulates questions for the medical specialist concerned. In one report for example the NFI physician asked two radiologists whether there were indications of injuries to the asylum seeker's feet and if so whether the nature and direction of the action of violence can be explained.[808] In another case a radiologist was asked to re-examine X-rays to see whether the asylum seeker could have had a perforated rib fracture.[809] The physician may also ask treating medical specialists whether they saw any indication of (sexual) violence.[810]

The medical report first summarises the relevant information provided by the IND, the asylum seeker and treating doctors. This is followed by the results of the physical examination and the medical information obtained from other (treating) doctors. Finally, it discusses the probability of each type of ill-treatment on the basis of the medical findings.

[802] NFI report of 16 June 2016 (case 3).
[803] Interview NFI 1. See also eg NFI reports of 16 June 2016 (case 3, case 4).
[804] See also eg NFI report 16 June 2016 (case 4).
[805] Interview NFI 1.
[806] NFI report of 26 January 2017 (case 5 ) and NFI report 21 March 2017 (case 7 ).
[807] IND/NFI/NIFP, *Informatie over het forensisch medisch onderzoek*. In the NFI report of 30 May 2017, a radiologist was asked to look at x-rays taken earlier for a Tubercolosis examination.
[808] NFI report of 16 June 2016 (case 3).
[809] NFI report of 30 May 2017 (case 8 ).
[810] Ibid.

*The psychiatric/psychological examination*

The NIFP examination is conducted in accordance with a format, which indicates all the elements which should be included.[811] However, every psychiatrist has their own style in performing the examination.[812] The examination is based on different sources: the information from the IND file, a iMMO screening form[813], an iMMO report[814], information of (treating) doctors or school[815] and third persons such as the partner or the family members of the asylum seeker and the asylum seeker's guardian or COA officers providing guidance to the asylum seeker in the reception centre[816]. The psychiatrist will see these third persons in person. However, the most important source of information are the asylum seeker themselves.[817]

A standard NIFP examination consists of two meetings of four hours with the asylum seeker and the psychiatrist[818], but more meetings are possible.[819] During this meeting different tests and interviews can be done. One NIFP psychiatrist explained that she usually starts with a cultural interview about the social-cultural background of the asylum seeker.[820] Furthermore, she pays attention to Post Traumatic Stress Syndrome, depression and traumatic grief.[821] The nature of the examination and the interviews or tests used depends on whether the asylum seeker is able to talk about his or her experiences, the intelligence and the level of understanding of the asylum seeker.

If necessary further tests (such as an intelligence test, capacities test or personality test, but also tests concerning malingering) and interviews can be carried out by a qualified psychologist.[822] These tests aim to deepen the examination on specific questions and are integrated in the psychiatric examination.[823] The NIFP Guidance notes however, that many psychological tests have not been validated for asylum seekers. Nevertheless the Guidance states that in some cases a psycho-diagnostic

[811] This includes: relevant information from the file, cooperation and limitations to the examination, biographical anamnesis, psycho-trauma anamnesis, health and addiction anamnesis, information of third persons, special (*speciële*) psychiatric anamnesis, psychiatric examination in a more limited sense, differential diagnosic consideration, multi-disciplinary consideration, summary consideration, answering of the central question.

[812] Interview NIFP 1. Some prefer to have more and shorter meetings with the asylum seeker than others for example.

[813] NIFP report 23 March 2017 (case 6 ).

[814] The iMMO report is considered collateral information, which is taken into account like other medical documents. It is up to the IND or the court to weigh the reports of iMMO and NIFP. Handreiking Rapporteurs NIFP, p. 11.

[815] See eg NIFP report 20 April 2017 (case 7 ).

[816] Meeting NIFP 18 July 2017, NIFP report 1 October 2016 (case 5 ), where the asylum seeker's wife was interviewed.

[817] Interview NIFP 1, NIFP reports of 31 May 2016 (case 2) and 20 April 2017 (case 7 ).

[818] Two meetings are required because a person's mental state may be different at a different time. Interview NIFP 1.

[819] Meeting NIFP 18 July 2017. The NIFP report of 10 June 2017 (case 8 ) was based on four meetings with the asylum seeker which lasted a total of five hours.

[820] See for the format of the interview: http://www.dsm-5-nl.org/documenten/cultural_formulation_interview_clientversie.pdf

[821] The CAPS interview is used for PTSS and LEC for traumatic experiences during a person's lifetime.

[822] See NIFP reports of 24 August 2016 (case 3) and 20 April 2017 (case 7 ).

[823] Meeting NIFP 18 July 2017. Handreiking Rapporteurs NIFP, p. 9.

examination must be done and can be supportive and create a hypothesis.[824] NIFP may also ask for a blood examination or a neurological examination.[825]

The NIFP Guidance mentions that the forensic expert should take into account the impact of the memories on the asylum seeker. For this reason the IND, NFI and NIFP should offer after care to the asylum seeker. The responsibility for this lies primarily with the IND. However, experts need to assess themselves whether there are reasons to stress the importance of aftercare with the responsible party.[826] The NIFP psychiatrist mentioned that she does not give the asylum seeker advice as regards treatment of psychological problems (for example to contact GCA).[827] However, she does contact GCA in case of a crisis.[828]

### 4.6.7 Methodology and conclusions

*Methodology and importance of the Istanbul Protocol*

NFI does not use the degrees of causality set out in the Istanbul Protocol. Instead it has chosen in consultation with the IND to use the Bayesian (mathematical) methodology: it answers two hypothesis: 1. the injuries or scars are caused by the alleged event and 2. the injuries or scars are not caused by the alleged event. The forensic physician assesses which hypothesis is most probable.[829] It is also possible that the NFI physician finds that no conclusions can be drawn as to the probability of the hypothesis, because other causes of the scars are possible. In such case the final conclusion is that the findings of the physical examination are as probable under the first hypothesis as under the second hypothesis.[830] The NFI physician stated that he has taken note of the Istanbul Protocol, but does not need it for the examination in an individual case.

The NIFP sees the Istanbul Protocol as a basic document and finds it very important. It uses the degrees of causality, which are laid down in paragraph 187 of the Istanbul Protocol.[831] The NIFP Guidance mentions that experts are advised to take notice of the Istanbul Protocol and experts can benefit from its guidelines. The NIFP uses the criteria of DSM 5 to come to a diagnosis.[832] The NIFP psychiatrist stressed that NIFP tries to come to a differential diagnosis.[833] The expert needs to start with an open mind and avoid confirmation bias.[834]

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[824] NIFP, *Handreiking Rapporteurs NIFP*, p. 16.
[825] Interview NIFP 1.
[826] NIFP, Handreiking Rapporteurs NIFP, p. 15.
[827] Interview NIFP 1.
[828] Meeting NIFP 18 July 2017.
[829] Interview NFI 1. See also: Nederlands Forensisch Instituut, De reeks waarschijnlijkheidstermen van het NFI en het Bayesiaanse model voor interpretatie van bewijs, October 2014.
[830] NFI reports of 16 June 2016 (case 3), 26 January 2017 (case 5 ) and 21 March 2017 (case 7 ).
[831] NIFP, *Handreiking Rapporteurs NIFP*, pp. 10-11. See also IND Instruction 2016/4, pp. 4 and 8.
[832] Interview NIFP 1.
[833] A differential diagnosis is 'the determination of which of two or more diseases with similar symptoms is the one from which the patient is suffering, by a systematic comparison and contrasting of the clinical findings'. www.medilexicon.com/dictionary/24388.
[834] Interview NIFP 1.

*Causality*

Both the NFI and the NIFP explicitly pay attention to other possible causes of scars or psychological problems in their reports. The NIFP Guidance mentions that the forensic expert should investigate whether there are other causes of the psychological problems. Here the Guidance refers to paragraph 287(iv) of the Istanbul Protocol, which gives as examples of other potential causes: ongoing persecution, forced migration, exile, loss of family and social role. NIFP asks asylum seekers about other traumatic experiences during their lifetime in order to assess whether the psychological problems may be related to these traumatic experiences instead of the experiences related to their asylum account.[835] In one case NIFP concluded that the asylum seeker's complaints did not lead to a psychiatric diagnosis or classification. For this reason no causal relationship could be established with the alleged events in the country of origin. NIFP stresses that the absence of PTSD or other psychiatric illnesses does not indicate that the asylum seeker did not experience traumatic events.[836]

The NFI forensic physician noted that the fact that asylum seekers usually only have (old) scars and no (recent) wounds or injuries, results in less solid interpretations and conclusions than in cases of victims of recent injuries. In case of recent wounds it is much easier to draw conclusions as to the cause and timing of the injury.[837] In the NFI reports received for the purpose of this study, the NFI forensic physician concluded in many instances that no conclusions could be drawn as to the probability of the hypothesis.[838] In one case the physician concluded that the scars may well be caused by the events described by the asylum seeker, but that he could not draw conclusions as to the criminalistic context in which the injuries were caused (ill-treatment by third persons, self-infliction or cultural rites).[839] In four cases the physician concluded that it was more probable that a scar/scars was/were not caused by the alleged event.[840] In two of these cases the physician found that it was more probable that the asylum seekers had inflicted the scars to themselves.[841] In another case the physician concluded that it was unlikely that a perforated rib fracture, which the asylum seeker stated was caused by ill-treatment, left no scars.[842] The NFI physician also explained that the fact that the asylum seeker does not have certain scars or physical problems which can be related to the alleged ill-treatment, does not exclude that the ill-treatment has taken place.[843]

In some of the (small number of) NFI/NIFP reports received for the purpose of this study, the conclusions are more cautious than those of the iMMO report issued in the same case (see the table in Annex 5 for an overview).[844] In the two cases in which no iMMO report had been submitted by the

[835] Ibid.
[836] NIFP report 15 July 2016 (case 4).
[837] Interview NFI 1. See also eg NFI reports of 16 June 2016 (case 3) and 30 May 2017 (case 8 ).
[838] NFI reports of 16 June 2016 (case 3, case 4), 26 January 2017 (case 5 ), 21 March 2017 (case 7 ) and 30 May 2017 (case 8 ).
[839] NFI report of 16 June 2016 (case 4).
[840] NFI reports of 16 June 2016 (case 4), 20 March 2017 (case 6 ), 21 March 2017 (case 7 ) and 30 May 2017 (case 8 ). In case 4, NFI concludes for example that it is more probable that the parallel scars on the asylum seeker's arms have been self-inflicted or caused by cultural rites than that they had been caused by torture.
[841] NFI reports of 16 June 2016 (case 4) and 20 March 2017 (case 6 ).
[842] NFI report of 30 May 2017 (case 8 ).
[843] NFI reports of 16 June 2016 (case 3, case 4), 26 January 2017 (case 5 ), 20 March 2017 (case 6 ), 21 March 2017 (case 7 ) and 30 May 2017 (case 8 ).
[844] This was also confirmed in Interview NIFP 1.

asylum seeker NIFP concluded that the psychological problems were typical[845] of or consistent[846] with the alleged event. One IND coordinator expected that most NFI/NIFP reports will not conclude to a (very) high degree of causal relation. She thinks it makes the reports more reliable.[847]

*Malingering and aggravation*

The NIFP forensic expert takes the asylum seeker's statements as the basis of his or her examination. It is not the task of NIFP to assess the credibility of the asylum account. However, the NIFP expert does examine whether asylum seekers' statements about their psychological problems are false or aggravated in order to get an asylum status.[848] NIFP noted that their experts used to examine persons who have an interest in a specific outcome of the examination. In the context of criminal proceedings the persons examined have an interest in being found completely normal (in order to avoid preventive detention) or to have a psychiatric disorder (in order to get a reduced sentence).[849] If experts suspects that a person is aggravating psychological problems, they will do one or more psychological tests, to check this suspicion. In such case a second expert will often be included in the examination.[850] It has not been established whether these tests are reliable when they are applied to asylum seekers. For that reason the experts need to be reluctant to draw conclusions.[851] Only in rare cases will an expert be able to conclude that an asylum seeker is simulating psychological problems. If the asylum seeker is just reporting many complaints which are probably not that serious, experts will take that into account in their conclusions on the reliability or validity of the examination.[852]

The NIFP psychiatrist also mentioned the possibility that asylum seekers dissimulate psychological problems because they are afraid that they might not get an asylum status or lose their children because of their mental state.[853] She also often sees that asylum seekers are afraid to be expelled and to do something wrong.[854] One NIFP report mentioned that the asylum seeker presented his psychological complaints as less prominent and stated that he is not crazy.[855]

*Integrated conclusions*

NFI does not follow the guidelines of the Istanbul Protocol but uses the mathematical Bayesian method. iMMO expressed serious concerns about NFI's use of the Bayesian method in forensic medical examinations of asylum seekers who are potentially victims of torture. The major drawback of the Bayesian method is that each scar or physical problem is examined separately and not in coherence.[856] This is not in line with the Istanbul Protocol, which states that 'ultimately, it is the overall evaluation of all lesions and not the consistency of each lesion with a particular form of torture that is

[845] NIFP report 20 April 2017 (case 7 ).
[846] NIFP report 10 June 2017 (case 8 ).
[847] Interview IND 2 and 3.
[848] Interview NIFP 1. In the NIFP report of 15 July 2016 (case 4) the NIFP psychiatrist mentions several times that the asylum seeker was not aggravating his complaints or emotions.
[849] Interviews NIFP 1 and NIFP 3.
[850] NIFP, *Handreiking Rapporteurs NIFP*, p. 10.
[851] Ibid., p. 16. See also IND Instruction 2016/4, p. 16.
[852] Interview NIFP 1.
[853] Ibid.
[854] Ibid.
[855] NIFP report 23 March 2017 (case 6 ).
[856] Interview iMMO. This can indeed be observed in the NFI reports of 16 June 2016 (case 3) and 30 May 2017 (case 8).

important in assessing the torture story'.[857] NIFP does assess on the basis of all psychological problems which causal graduation of the Istanbul Protocol is applicable.[858]

The Istanbul Protocol also requires that the conclusions with regard to physical and psychological problems are integrated in the final conclusion.[859] However, the conclusions of the NFI and NIFP reports are not integrated. When the NFI report and the NIFP report are ready the NIFP expert and the NFI expert discuss question regarding the coherence between the physical and/or psychological sequalae/complaints and their origin as alleged in the asylum account and to which degree is there a causal relationship (question D).[860] They also see whether the reports fit together.[861] Then the reports are put together with a staple. However, in practice Question D is not answered[862] or only answered very briefly in the medical reports[863].

Integration of the reports is difficult because the NFI uses the Bayesian model, while the NIFP uses the degrees of causality of the Istanbul Protocol.[864] Furthermore, writing an integrated report is time consuming and difficult because NFI and NIFP work at different locations.[865] NIFP sees the integration of the two reports as an important point of development.[866] The NFI physician remarked however, that physical scars do not always have a logical link with the psychological damage in a person. It is thus possible that the physical and the psychiatric examinations have different results.[867]

iMMO remarks that the idea of the Istanbul Protocol is to combine the conclusions with regard to physical and psychological sequelae. It is for example important to take into account what happens with asylum seekers when they talk about the torture they were subjected to and explain the cause of scars and physical problems. This does not happen in the NFI report.[868] One recent report mentioned for example that no clear coherence is seen between the scars and the psycho-traumatic experiences in Kabul

### 4.7 Conclusions

As a result of the ECtHR's case law under Article 3 ECHR and Article 18 RAPD the role of forensic medical reports in the Dutch asylum procedure has increased. The IND and the Dutch courts have

[857] Para. 188 Istanbul Protocol.
[858] NIFP, *Handreiking Rapporteurs NIFP*, p. 10. See also IND Instruction 2016/4, p. 8.
[859] Annex IV under XIII Istanbul Protocol.
[860] Until recently there were two questions D and E which had to be answered by NFI and NIFP together.
[861] See section 4.6.5 of this report.
[862] NFI report of 16 June 2016 and NIFP report of 24 August 2016 (case 3) and NFI report of 30 May 2017 and NIFP report of 10 June 2017 (case 8 ). In the NFI report of 26 January 2017 and NIFP report of 1 October 2016 (case 5 ) the answer to the question does not address the link between the conclusions of NFI and NIFP, but only concerns NIFP conclusions.
[863] NFI report of 16 June 2016 and NIFP report of 15 July 2016 (case 4) and NFI report of 20 March 2017 and NFI report of 23 March 2017 (case 6 ), where it is stated that, now that NFI has concluded that it did not find evidence in support of the asylum account, it is not possible to describe the relation between the physical and mental findings. See also NFI report of 21 March 2017 and NIFP report of 20 April 2017 (case 7 ).
[864] Interview NIFP 1.
[865] Interview NIFP 3.
[866] Interviews NIFP 1 and NIFP 2.
[867] Interview NFI 1.
[868] Interview iMMO.

accepted the importance of such reports as evidence substantiating the asylum seeker's claims of past torture or ill-treatment. In the Dutch asylum procedure most medical reports are written by iMMO and submitted by the asylum seeker. Since January 2016 the IND has the possibility to ask the NFI and/or NIFP for a (further) medical examination.

In this chapter it was discussed when the IND requests a medical report from NFI and NIFP. It also described the medical examinations carried out by the NFI and NIFP.

*Early documentation of (potential) sequelae of torture or ill-treatment*
In the Dutch asylum system there is no organisation which is responsible for the documentation of wounds or recent scars which are, according to the asylum seeker, the result of torture or ill-treatment in the country of origin. FMMU (in most cases) only mentions in its advice whether the asylum seeker has told the nurse that he has scars. Nurses do not describe the scars or or take photos of them. Often they do not even check whether the scars are present on the asylum seeker's body. This is problematic because forensic medical examinations (by iMMO or NFI) often can only take place months after arrival in the Netherlands. Wounds or recent scars may have fainted or vanished which renders a forensic medical examination more difficult or even impossible.

*Relevance of a medical examination*
According to Article 18 RAPD the IND should request a medical examination of scars and/or medical problems if this is relevant for the examination of the asylum claim. Between March 2016 (when the IND first requested a medical examination) and May 2017 the IND only referred 14 cases to the NFI and/or NIFP. In the same period of time (2016) iMMO accepted 144 requests from lawyers to carry out a medical examination.

According to the IND a medical report should be able to change the outcome of the credibility assessment and this is not possible if the core of the asylum account is deemed implausible. The IND thus seems to set a very high standard, which may render Article 18 RAPD ineffective. Moreover as a result of this high standard victims of torture may not be identified and potential psychological problems which may have caused vague, strange or inconsistent statements may be ignored. This may lead to violations of the principle of *non-refoulement*.

IND officers should consult a medical coordinator before they refer a case to NFI and/or NIFP for a medical examination. However, medical coordinators do not discuss amongst each other when a medical examination should be considered relevant.
Several factors may render the IND officers hesitant to ask for a medical examination, such as the (perceived) high costs of the medical examination and delays in the asylum procedure. Furthermore, the low number of medical examinations requested by the IND may relate to the IND's opinion about the value of medical reports, for example that a medical examination cannot establish the cause of a scar or medical problem with certainty and cannot substantiate the context of the alleged events in the country of origin (who did it and why).

*An iMMO report as a ground for further medical examination*
Asylum seekers may always request iMMO for a medical examination, if the IND refuses to refer their case to NFI and/or NIFP. In many of the cases which were referred to NFI and/or NIFP the asylum

seeker had already submitted an iMMO report. However, in most cases the IND either grants an asylum permit (partly) on the basis of the iMMO report or rejects the application without a further medical examination.

The IND has granted an asylum status in around 50 per cent of the cases in which iMMO issued a medical report. In such cases, the IND only provides compensation for the medical examination if the iMMO report was *decisive* for the positive decision. This seems to be ad variance with Article 18(1) RAPD which requires the IND to bear the costs of a medical examination if it is *relevant* for the examination of the asylum claim.

In cases where the asylum seeker has submitted an iMMO report, the IND may reject the application without a further medical examination, if the asylum seeker has made inconsistent, vague or strange statements about the core of his asylum account. This may be ad variance with the ECtHR's case law according to which the authorities should ask for a further medical examination if a medical report makes out a *prima facie* case as to the origin of the asylum seeker's scars or injuries. Only if the authorities are not in the 'position to assess the asylum seeker's individual situation' because the asylum seeker has not provided any proof of his identity and asylum account and his statements give reason to question his credibility, does the burden of proof not shift to the State.

*Forensic medical examinations by NFI/NIFP*

The IND can request the NFI and NIFP to do a forensic medical examination in an asylum case. Both organisations have extensive expertise and experience in forensic examinations in the field of criminal law proceedings. However, examinations in the context of the asylum procedure were new to them. NFI and NIFP have made a lot of effort to set up a careful and thorough forensic examination. They make sure that the asylum seeker gives his consent for the examination and for sending the report to the IND, and gets the opportunity to respond to the content of the report. NFI and NIFP subject asylum seekers to an extensive medical examination and they write thorough medical reports.

However, a few aspects of the medical examinations by NFI and NIFP may be considered problematic. In particular NFI have so far not exchanged expertise with other organisations involved in medical examinations in the context of asylum procedures. NFI and NIFP were also not involved in iMMO's European project to develop common standards for the medical examination in the asylum procedure Art. 18 Directive 2013/32/EU. While NIFP did ask external experts to be involved in the development of the forensic medical examination, NFI did not do so and did not prepare in any special way for this new task.

Moreover, NFI and NIFP think differently about the relevance of the Istanbul Protocol. NIFP regards the protocol as an important document and used the degrees of causality, which are laid down in paragraph 187 of the Istanbul Protocol. NFI does not work according to the Istanbul Protocol but uses the Bayesian methodology, testing the hypothesis that the injuries or scars are (not) caused by the alleged event. This means that NFI draws conclusions as to potential cause of each separate scar, but does not make an 'overall evaluation of all lesions' as required by Article 188 Istanbul Protocol. In many instances NFI concluded that no conclusions can be drawn as to the probability that the findings have been caused by the alleged event.

The difference in methodology used and conclusions drawn by NFI and NIFP also makes it difficult to integrate the findings by NFI and NIFP in one report, as is required by the Istanbul Protocol. As a result it is not examined whether the findings of each report reinforce each other.

Finally the IND does not allow NIFP to draw conclusions as to the ability of the asylum seeker to make complete, coherent and consistent statements. The reason for this is that FMMU already addresses this question in the Medical advice interviewing and decision-making. However, the medical examination by FMMU has important limitations (see chapter 3). Furthermore, the examination by NIFP is of a completely different nature (as regards expertise and thoroughness) than that of FMMU.

# 5 Special reception needs

## 5.1 Introduction

Reception conditions which take into account the special needs of asylum seekers are important for those asylum seekers' well-being. A lack of support in reception facilities may for example (further) deteriorate the situation of asylum seekers with medical and/or psychological problems.[869] Also long periods of insecurity about the right to stay[870] and relocations from one place to another in the Netherlands are risk factors for the health situation of asylum seekers.[871] At the same time adequate living conditions and social support may have beneficial effects on the well-being of these asylum seekers.[872] For children the well-being of parents is a protecting factor where it comes to psychological problems.[873]

This chapter will discuss how COA takes into account special reception needs. It will first set out the international legal framework (section 5.2) and explain the Dutch reception system (section 5.3 ). After that it is described how COA generally takes into account special reception needs (section 5.4). Furthermore, attention is paid to the facilities offered to specific groups, such as asylum seekers with psychological and/or behavioural problems (section 5.5), unaccompanied children (section 5.6), families with minor children (section 5.7) and LGBTI asylum seekers (section 5.8). Finally this chapter will address the relocations of asylum seekers (section 5.9) and the activities offered to asylum seekers during their stay in the reception centres (section 5.10).

## 5.2 International legal framework

The recast Reception Conditions Directive (RRCD)[874] requires Member States to ensure that material reception conditions provide an adequate standard of living for asylum seekers, which guarantees their subsistence and protects their physical and mental health.[875] It particularly states that the standard of living should be adequate for vulnerable persons.[876] Furthermore, it mentions that reception should be specifically designed to meet asylum seekers' special reception needs.[877] The support provided should take into account asylum seekers' special reception needs throughout the duration of the asylum procedure and shall provide for appropriate monitoring of their situation.[878]

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[869] Boillat, J. and Chamouton, B., *Protect, Process of Recognition and Orientation of Torture Victims in European Countries to Facilitate Care and Treatment*, ACET and others, p. 9.
[870] Van Berkum, M and others, *Zorg, ondersteuning en preventie voor nieuwkomende vluchtelingen, wat is er nodig?*, Pharos, March 2016, p. 9, Gezondheidsraad, *Briefadvies Geestelijke gezondheid van vluchtelingen, February 2016,* Ikram, U. and Stronks, K., *Preserving and Improving the Mental Health of Refugees and Asylum Seekers, A Literature Review for the Health Council of the Netherlands*, February 2016, pp. 21, 40.
[871] See with regard to children: Van Berkum and others, p. 10, Gezondheidsraad, *Briefadvies Geestelijke gezondheid van vluchtelingen*, Ikram, U. and Stronks, K, p. 21.
[872] Van Berkum and others, p. 9, Boillat and Chamouton, p. 45, Van Schayk and Vloeberghs, p. 10.
[873] Van Berkum and others, p. 10.
[874] Directive 2013/33/EU of the European Parliament and of the Council of 26 June 2013 laying down standards for the reception of asylum seekers for international protection (recast) [2013] OJ L 180/96.
[875] Art 17(2) RRCD.
[876] Ibid.
[877] Point 14 Preamble RRCD.
[878] Art. 22(1) RRCD.

With regard to children the Directive requires Member States to ensure a standard of living adequate for the child's physical, mental, spiritual, moral and social development.[879] Children should have access to leisure activities, including play and recreational activities appropriate to their age within the premises of accommodation centres and to open-air activities. Children who have been victims of any form of abuse, neglect, exploitation, torture or cruel, inhuman and degrading treatment, or who have suffered from armed conflicts have access to rehabilitation services for children.[880] The Directive provides for several factors, which should be taken into account when determining the best interests of the child: family reunification possibilities, the child's well-being and social development, taking into particular consideration the child's background, safety and security considerations, in particular where there is a risk of the child being a victim of human trafficking and the views of the child in accordance with his or her age and maturity.[881]

The Directive provides that unaccompanied children should be assisted by a representative who represents and assists the unaccompanied child to enable him or her to benefit from the rights and comply with the obligations provided in the Directive. According to the Directive unaccompanied children should be placed with adult relatives, in foster families, in accommodation centres with special provisions for children or in other accommodation suitable for children. Unaccompanied children aged 16 or over may be placed in accommodation centres for adult asylum seekers, if it is in their best interests. It is also provided that changes of residence of unaccompanied children shall be limited to a minimum.[882]

According to the Convention on the Rights of the Child, children have the right to a standard of living which is adequate for the child's physical, mental, spiritual, moral and social development.[883] Furthermore, they have the right to education[884], rest and leisure and to engage in play and recreational activities appropriate to their age and to participate in cultural life and arts.[885] Children should be protected against abuse and (sexual) exploitation.[886] The Convention states that a child who is seeking refugee status or who is considered a refugee should receive appropriate and humanitarian assistance in the enjoyment of the rights set out in the Convention.[887] Disabled children need to have access to education, training, health care services, rehabilitation services, preparation for employment and recreation opportunities.[888]

Article 5(3) of the Convention on the Rights of Persons with Disabilities (CRPD)[889] states that State Parties shall take all appropriate steps to ensure that reasonable accommodation is provided. According to Article 2 CRPD 'reasonable accommodation' means 'necessary and appropriate

[879] See also ECtHR 4 November 2014, Appl. no. 29217/12, *Tarakhel v. Switzerland*, para 119.
[880] Art. 23 RRCD.
[881] Art 23(2) RRCD.
[882] Art. 24 RRCD.
[883] Art. 27 CRC.
[884] Artt. 28 and 29 CRC.
[885] Art. 31 CRC.
[886] Artt. 19 and 34 CRC.
[887] Art. 22 CRC,
[888] Art. 23 CRC.
[889] The Netherlands has ratified the Convention, see https://tbinternet.ohchr.org/_layouts/TreatyBodyExternal/Countries.aspx?CountryCode=NLD&Lang=EN.

modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms'.[890]

### 5.3 The Dutch reception system[891]

The Dutch reception system has different aims, which may sometimes conflict. The reception of asylum seekers must serve the asylum procedure, making sure that asylum seekers are available when needed. Furthermore, the conditions in reception centres must enable asylum seekers to cope during the asylum procedure. The reception system also aims to provide a safe and suitable living environment to asylum seekers with special needs. However, reception conditions may not promote the asylum seekers' integration into Dutch society or make the Netherlands an attractive destination for them. The facilities offered to asylum seekers may also not be better than those offered to Dutch citizens.[892]

If asylum seekers want to apply for asylum, they need to register at a Central Reception Location (*Centrale Opvang Locatie* or COL). There are three COLs: in Ter Apel, Budel Cranendonck and Veenhuizen.[893] Asylum seekers usually stay in a COL for a maximum of four days. During this period, they are registered and screened for Tuberculosis and other medical problems[894]. Asylum seekers receive meals and have access to medical care.

Before and during the general asylum procedure, asylum seekers stay in a Process Reception Location (*Proces Opvang Locatie* or POL). In a POL, COA provides three daily meals and asylum seekers have access to medical care. Asylum seekers do not receive a financial allowance.[895]

If a (positive or negative) decision on the asylum application is taken in the general asylum procedure or the asylum case is referred to the extended asylum procedure, the asylum seeker moves to an Asylum Reception Centre (*Asielzoekerscentrum* or AZC). There, asylum seekers and status holders receive a financial allowance for food, clothing and other personal expenses[896] and have access to medical care.

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[890] See also Crock, M., McCallum, R. and Ernst, C., *Where Disability and Displacement Intersect: Asylum Seekers with Disabilities, September 2011*, International Association of Refugee Law and Judges World Conference, pp. 6-7.

[891] See also Annex 4 for a chart of the Dutch reception system.

[892] ACVZ, *Pieken en Dalen*, May 2017, p. 23.

[893] https://www.coa.nl/nl/opvanglocaties/typen-locaties.

[894] See about the medical urgency screening section 2.4.3 of this report.

[895] Art. 9(5) and 9(1)(b) Rva.

[896] If the asylum seekers take care of all meals themselves the allowance for food (per week) amounts to € 44,38 for an adult and € 36,54 for a child (household of one or two persons), € 35,49 for an adult and € 29,26 for a child (household of three persons) or € 31,08 for an adult and € 25,55 for a child (household of four or more persons). Asylum seekers receive € 12,95 per person, per week for clothing and other personal expenses. Art. 14 Rva.

If their asylum application is rejected asylum seekers will be prepared for their return and may lose their right to reception if they do not cooperate. If the asylum application is granted the asylum seeker will receive housing in a municipality.[897]

*Crisis and emergency reception centres during the period of high influx*
As a result of the high influx of asylum seekers in 2015-2016 and the absence of sufficient buffer capacity the reception system became overburdened. COA had to make use of crisis reception centres and emergency reception centres. Since December 2016 COA has not made use of crisis or emergency reception centres anymore. In April 2017 the State Secretary of Security and Justice informed Parliament that there was a surplus in regular reception places and that the number of such reception centres would be decreased.[898]

Crisis reception centres were used between September 2015 and January 2016[899] and concerned locations, such as sports halls, which are also used in case of incidents, disasters or crisis in order to provide shelter to the population. They were coordinated by a security region, a province or big city. A crisis reception centre could only be used for 72 hours, which could be extended for another 72 hours.[900] An asylum seeker could be moved to another crisis reception centre after this period of time. Some asylum seekers thus stayed in more (sometimes even seven or eight) crisis locations.[901] In total COA placed 6,000 asylum seekers in crisis reception centres during the mentioned period.[902]

In crisis reception centres, asylum seekers received three meals per day and basic medical care. They did not get a financial allowance. Children did not go to school.[903] There was no privacy in the crisis locations. For activities asylum seekers depended on the initiatives of volunteers.[904]

Emergency reception centres (*noodopvang* or Pre-POLs) are temporary reception centres in congress halls, pavilions (tents) and office buildings, which were adapted to a limited extent in order to become a reception centre. These reception centres were managed by COA and could provide shelter to 300 asylum seekers or more.[905] They were used between July 2015[906] and December 2016[907]. The duration of asylum seekers' stay in the emergency reception centres was meant to be short (a maximum of

[897] COA, *De opvang: stap voor stap, vanaf juli 2010*, September 2012.
[898] Netherlands Parliamentary documents TK 2016/17 19637, nr. 2311.
[899] COA, Press release, *Laatste crisis opvang gesloten*, 29 January 2016.
[900] Bestuursakkoord Verhoogde Asielinstroom, 27 november 2015, p. 2.
[901] College voor de Rechten van de Mens, *Mensenrechten in (tijdelijke) opvanglocaties voor asielzoekers en vluchtelingen*, p. 3, COA, Laatste crisisopvang gesloten, 29 January 2016.
[902] COA, *Laatste crisis opvang gesloten*, 29 January 2016.
[903] Kinderombudsman, *Wachten op je toekomst*, February 2016, p. 14.
[904] College voor de Rechten van de Mens, *Mensenrechten in (tijdelijke) opvanglocaties voor asielzoekers en vluchtelingen*, p. 3.
[905] Bestuursakkoord Verhoogde Asielinstroom, 27 november 2015, p. 2.
[906] COA, *Grenzen*, Jaarverslag 2015.
[907] COA, *Dynamiek*, Jaarverslag 2016.

four to five weeks). However, the period in which asylum seekers stayed in such centres increased[908] and could extend to more than six months.[909]

Emergency reception centres were of a more austere nature than AZCs.[910] In such centres asylum seekers shared bedrooms with two to seven other persons. Also families with children sometimes had to sleep in a room together with other asylum seekers.[911] Often also spaces for recreation and eating were used by large numbers of asylum seekers. As a result there was a lack of privacy and possibilities to be alone or together as a family.[912] There was no possibility to cook meals and asylum seekers did not receive a financial allowance.[913] Also there was often a lack of structural day activities for asylum seekers.[914]

### 5.4 Reception facilities for asylum seekers with special needs

Article 18a of the Regulation Asylum Seekers and Other Categories of Aliens (*Regeling verstrekkingen asielzoekers,* Rva) transposes Article 22 of the recast Reception Conditions Directive. It provides that during the asylum seeker's stay in the reception centre, the specific situation of vulnerable persons shall be taken into account. COA should provide specific support and guidance to asylum seekers with special reception needs.

The EASO guidance on reception conditions mentions that the allocation of particular housing to asylum seekers should be based on an assessment of their special reception needs and that there should be a possibility to transfer an asylum seeker as a result of identified special reception needs.[915]

During the urgency medical check carried out by the Health Centre Asylum seekers[916] (*Gezondheidscentrum Asielzoekers*, GCA), it is sometimes already established that an asylum seeker has special reception needs. Such asylum seeker should, for example, be placed in a reception centre which is accessible for a wheelchair or close to an academic hospital. Furthermore, time may be needed to transfer medical care. COA takes this into account when placing a person in a reception centre.[917] One COA officer stated that COA takes it very seriously, if a doctor finds that an asylum seeker should move to a specific location.[918]

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[908] Inspectie voor Veiligheid en Justitie, *De tijdelijke (opvang) voorzieningen voor asielzoekers onder de loep*, November 2015, p. 20.
[909] College voor de Rechten van de Mens, *Aanbevelingen Mensenrechten in de noodopvang Heumensoord*, February 2016, p. 2, College voor de Rechten van de Mens, *Mensenrechten in (tijdelijke) opvanglocaties voor asielzoekers en vluchtelingen*, p. 4.
[910] Bestuursakkoord Verhoogde Asielinstroom, 27 november 2015, p. 2, Kinderombudsman, *Wachten op je Toekomst*, p. 10.
[911] Kinderombudsman, *Wachten op je toekomst*, p. 10.
[912] Ibid.
[913] Ibid., p. 13.
[914] College voor de Rechten van de Mens*, Mensenrechten in (tijdelijke) opvanglocaties voor asielzoekers en vluchtelingen*, p. 4, College voor de Rechten van de Mens, *Aanbevelingen Mensenrechten in de noodopvang Heumensoord*, p. 9.
[915] EASO, *EASO guidance on reception conditions: operational standards and indicators*, September 2016, p. 15.
[916] See further section 2.4.3 of this report.
[917] Interview COA 3.
[918] The Netherlands Parliamentary documents TK 2015/16, 19637, nr. 2177, p. 3.

Apart from handicaps, illness and pregnancy COA also takes into account other factors such as family ties or personal characteristics of an asylum seeker when placing an asylum seeker in a reception centre. LGBTI asylum seekers and single women for example, are not placed in big asylum reception centres with scattered houses in a wooded area.[919] Also victims of human trafficking and smuggling may need specific facilities. [920] For unaccompanied children and asylum seekers with serious psychological or behavioural problems there are special reception centres. [921] These will be briefly discussed in the next sections.

During the period of high influx COA had less possibilities to take into account individual circumstances than in periods of a low(er) influx. Sometimes reception centres exchanged asylum seekers if that was favourable to both parties. The special needs of asylum seekers sometimes led to discussions between planners and COA officers working in the reception centres.[922]

Asylum seekers are expected to live together with other asylum seekers in COA reception centres. Standard ACZ apartments are shared by six asylum seekers. They have a common kitchen, bathroom and living room. Single asylum seekers often also have to share a bedroom with another person. However, there is a range of different types of centres (bungalows, old school buildings) where the level of privacy differs.[923]

The location manager decides about the type of room which is offered to asylum seekers (a single room or a shared room for example). COA always has to balance several interests; on the one hand that of the individual asylum seeker and on the other hand the safety and atmosphere at the reception centre. COA needs to take into account the balance in the nationalities of residents of a centre.[924] It tries to take special needs into account as far as possible. Only in exceptional cases it is possible to offer an individual room to an asylum seeker or a family.[925]

If a person has special needs, different measures can be taken by COA, depending on the individual circumstances of the case. The home counsellor may intensify his visits to the asylum seeker's room. Furthermore, COA officers can ask the care taker, who coordinates the practical tasks in and around the reception centre, to include an asylum seeker in certain activities. COA may also help asylum seekers to find a buddy in the reception centre or in another reception centre. COA also informs asylum seekers about NGO's and other organisations, which may support them. COA may contact these organisations to make sure that they receive the asylum seeker.[926] COA offers resilience training to vulnerable asylum seekers by certified trainers.[927]

The experiences of stake holders with the manner COA takes into account special needs seem to differ to a certain extent. One lawyer mentioned that usually COA tries its best to provide the facilities or

[919] Interview COA 3.
[920] Ibid.
[921] Interview COA 2.
[922] Interview COA 1.
[923] Ibid.
[924] Ibid. See also ACVZ, Pieken en Dalen, pp. 39-40.
[925] Interview COA 1.
[926] Ibid.
[927] Ibid.

arrange a relocation she requests for her clients with special needs. Her experiences with COA are generally good.[928] Another lawyer stated that her clients with special needs are often placed in the same reception centre and that she does not understand very well why COA chose this centre. It is a quiet location and offers single rooms, which may be beneficial to her clients. However, the asylum seekers living there are isolated from the outside world and little activities are organised for them. Moreover, the lawyer did not have very good experiences with the GCA doctor in this centre. The lawyer mentioned that in reception centres where asylum seekers live in separate houses or compounds spread over a large area, asylum seekers with special needs may not be noticed and can live anonymously. Sometimes, she asks for special facilities for her clients (for example another room for a client who cannot sleep because of kitchen noises). In her view it very much depends on the willingness of individual COA officers whether such requests are fulfilled.[929]

One stakeholder mentioned an example of a woman who had stayed for several years in a reception centre with her handicapped son, who was incontinent and sitting in a wheelchair. She was legally staying in the Netherlands on medical grounds (temporary postponement of departure). The stakeholder was surprised that this woman and her son were not offered a room for themselves.[930]

### 5.5. Asylum seekers with psychological and/or behavioural problems

There are no specific centres where all asylum seekers with psychological problems are housed, because this places a lot of pressure on the staff working in the centre as well as on other residents.[931] If an asylum seeker is not able to cope with life in a reception centre, and shows problematic behaviour (for COA staff or other residents) COA first tries to intervene. If COA's interventions do not work, an asylum seeker can be placed in a special reception centre with extra supervision (*intensief begeleidende opvang*, IBO). Sometimes COA asks its colleagues at the IBO to talk to the asylum seeker first and give an opinion about the asylum seeker.[932]

The IBO has a capacity of 50 places. In the IBO asylum seekers are supervised 24 hours per day and seven days per week.[933] They are observed and they learn the skills which are needed to live in a regular reception centre. Asylum seekers in need of psychological or psychiatric care are treated by a team of a Mental Health Care provider, which consists of a psychiatrist, physician and psychiatric nurses.[934] The asylum seekers' stay in the IBO is in principle limited to a period of three months, which can be extended by COA.[935]

In 2015 the Health Care Inspectorate was concerned about the accessibility and the quality of mental health care for, as well as patient safety of, asylum seekers staying in the IBO. One of the problems was that asylum seekers with complex psychiatric problems were living in the IBO, together with

[928] Interview Lawyers 3 and 4.
[929] Interview Lawyer 2.
[930] Interview DCR 4.
[931] Interview COA 3.
[932] Interview COA 1.
[933] Inspectie voor de Gezondheidszorg, *Algemeen toezichtrapport over de zorg aan asielzoekers met psychiatrische problematiek in de Intensief Begeleidende Opvang (IBO) in Schalkhaar*, September 2015, p. 8.
[934] Ibid., p. 9.
[935] Ibid., p. 8.

asylum seekers with behavioural problems. Moreover, the team providing treatment lacked expertise on transcultural psychiatric care.[936] Since June 2016, asylum seekers with complex psychiatric problems can be placed in the centre for transcultural psychiatry Veldzicht, which is managed by the Judicial Institutions Service (*Dienst Justitiële Inrichtingen*, DJI).[937] It is not clear whether the other problems found by the Inspection have been solved.

### 5.6 Unaccompanied children

Unaccompanied children are supervised by a guardian provided by Nidos in accordance with a special methodology for unaccompanied children.[938] The State Secretary of Security and Justice noted in 2016 that Nidos works according to methods which are in conformity with the requirements for certified institutions for youth protection. He stated that all child protectors are trained to use the methods. The methods are evaluated and adapted if necessary and reviewed by inspections. Not only the guardian, but also a mentor or the foster family has (daily) contact with the unaccompanied child. Furthermore, the children have regular contact with teachers and mentors at school.[939]

An unaccompanied child should see his guardian at least once a month.[940] The Youth Inspectorate concluded in a report of September 2016 that in all of the 20 reception locations for unaccompanied children, all children had a guardian and a mentor.[941] It depended on the location how often an unaccompanied child had contact with his guardian. Sometimes this was daily, sometimes weekly, sometimes once a month.[942] Furthermore, how often the guardian had contact with the child depended on the methodological desirability, the available time and the necessity.[943] During the period of high influx Nidos guardians did not always manage to see their pupils once a month, due to a shortage of guardians.[944]

*Reception facilities*

Until 1 January 2016 unaccompanied children between 15 and 18 years old were placed in a large scale campus (maximum of 100 persons). Younger unaccompanied children were housed in foster families (until 12 years old) or small-scale facilities (12-15 years old). The campus model was criticised by several organisations.[945] In 2012 the Youth Inspectorate concluded amongst others that there was insufficient attention for the (emotional) development of the children and that education was insufficiently adapted to the needs of the children.[946]

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[936] Ibid., pp. 14 and 23.
[937] The Netherlands Parliamentary documents TK 2016/17, 29668, nr. 41, annex 1, TK 2015/16, 19637, nr. 2186, Annex, Interview COA 3.
[938] See www.nidos.nl/home/missie-en-visie-van-nidos/methodiek/.
[939] The Netherlands Parliamentary documents TK 2015/16, Aanhangsel van de Handelingen, nr. 2948, p. 2.
[940] Interview Nidos.
[941] Inspectie Jeugdzorg, *Kwaliteit opvang alleenstaande minderjarige vreemdelingen*, September 2016, p. 8.
[942] Ibid., p. 8. See also The Netherlands Parliamentary documents TK 2015/16, Aanhangsel van de Handelingen, nr. 2948, p. 2.
[943] The Netherlands Parliamentary documents TK 2015/16, Aanhangsel van de Handelingen, nr. 2948, p. 2.
[944] Interview Nidos. See also Kinderombudsman, *Wachten op je toekomst*, pp. 30-31.
[945] See eg Inspectie Jeugdzorg, *Grootschalige opvang van alleenstaande minderjarige vreemdelingen*, April 2012, Guardians Against Child Trafficking and Exploitation (GATE), European Report, March 2013, pp. 44-47, 68, Defence for Children and Unicef, *Jaarbericht Kinderrechten 2016*, p. 29.
[946] Inspectie Jeugdzorg, *Grootschalige opvang van alleenstaande minderjarige vreemdelingen*, April 2012.

In September 2014 the Dutch Government decided to change the reception system for unaccompanied children. The campuses have been closed since 1 July 2016. [947] The type of reception offered depends on the children's age and on whether they have been granted a residence permit or not.[948] Unaccompanied children younger than 15 years old fall under the responsibility of Nidos and are placed in foster families directly after their asylum application. Nidos is also responsible for unaccompanied children of 15 years and older who have been granted a residence permit. These children stay in small-scale reception facilities (groups of 12, 8 or 4 children). In the groups of 12 children there is full time supervision, while less intensive supervision is available in the smaller groups.[949]

COA is responsible for unaccompanied children of 15 years and older who have not (yet) been granted a residence permit.[950] They first stay in the COL and a POL which is adapted to the needs of unaccompanied children. According to the State Secretary of Security and Justice this is necessary to efficiently organise all the activities in the rest and preparation period.[951]

After the POL the unaccompanied children are housed in small-scale reception centres (a maximum of 20 children), where there is full time supervision.[952] COA is also responsible for unaccompanied children under 15 years old who have not (yet) been granted a residence permit and for whom no foster family is available. Unaccompanied children older than 17,5 years stay in small-scale facilities in a regular reception centre.[953]

In a report of September 2016 concerning 20 reception locations for unaccompanied children the Youth Inspectorate concluded that in most locations the basic requirements for the reception of unaccompanied children were fulfilled. However, the Inspectorate found that a few locations did not meet all the standards. In these locations the mentors did, for example, not systematically apply the methodology for the supervision and the mentors had insufficient knowledge about the security of the children. The Inspectorate also stressed the need for individual assessment of the needs of unaccompanied children and the adaption of the care and education offered to those needs.[954] In November 2016 the State Secretary of Security and Justice informed Parliament that COA and Nidos would take measures to improve the reception conditions for unaccompanied children in accordance with the recommendations of the Inspectorate.[955]

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[947] The Netherlands Parliamentary documents TK 2016/17, 19 637, nr. 2287, p. 41.
[948] The Netherlands Parliamentary documents TK 2015/16, Aanhangsel van de Handelingen, nr. 2947, p. 2, TK 2016-2017, 34 550 VI, nr. 11, p. 137.
[949] Inspectie Jeugdzorg, *Kwaliteit opvang alleenstaande minderjarige vreemdelingen*, September 2016, p. 4.
[950] The Netherlands Parliamentary documents TK 2015/16, Aanhangsel van de Handelingen, nr. 2947, p. 2, TK 2016-2017, 34 550 VI, nr. 11, p. 137.
[951] The Netherlands Parliamentary Documents 2015/16, Aanhangsel van de Handelingen nr. 3430. In the past the Youth Inspectorate voiced concerns about the circumstances for (unaccompanied) children in the POLs. See Inspectie Jeudgzorg, *Grootschalige opvang van alleenstaande opvang van alleenstaande minderjarige vreemdelingen*, November 2012.
[952] Inspectie Jeudgzorg, *Opvang alleenstaande minderjarige vreemdelingen*, September 2016, p. 4.
[953] The Netherlands Parliamentary Documents TK 2013/14, 27 062, nr. 95.
[954] Inspectie Jeugdzorg, *Opvang alleenstaande minderjarige vreemdelingen*, September 2016.
[955] Netherlands Parliamentary documents TK 2016/17, 27062, nr. 104.

An employee of Nidos mentioned that unaccompanied children who cause troubles or do not fit in the regular reception facilities for unaccompanied children now often end up in a closed institution for youth care. In her view special accommodation for this specific group of children should be created.[956]

*Secured reception centres*

If Nidos thinks that unaccompanied children may disappear because they are a (potential future) victim of human trafficking, it can place them in a secured reception centre.[957] Yearly an average of 150 unaccompanied children stay in a secured reception centre during an average period of between six and nine months.[958] The children live in small-scale reception centres under full time supervision and extra security measures.[959] If a child wants to leave the reception centre early, the employees try to persuade the child to stay. If the child runs away, this will be reported to the police. If the child is found, they will be returned to the reception centre. If not, the guardian will report the child as a missing person. In 2016, 30 children left the reception centre early. It mostly concerned Vietnamese unaccompanied children. If Nidos expects that a Vietnamese unaccompanied child will run away from the reception centre, it will seriously consider to ask a judge permission for a placement in a closed institution for youth care.[960] The number of unaccompanied children who disappear from the secured reception centres was much lower in earlier years.[961]

In 2016 the Youth Inspectorate concluded that in the secured reception centres the security risks for individual asylum seekers were not systematically assessed. Furthermore, the living conditions (austere décor, non-secure division of the living spaces) and atmosphere (limited activity programme) were not sufficient. Also the children were insuffiently supervised and guided. The methodology was not systematically followed and the employees working with the children were insufficiently trained. Limitations of freedom of movement were not carefully applied, the complaints procedure was insufficiently accessible and information about the children was not adequately shared when they left the secured reception centre. The Inspectorate required the organisations involved to make a plan in order to improve the situation in the secured reception centres. In September 2016 the State Secretary of Security and Justice informed Parliament about the plans for improvement of the secured reception centres. He stated that COA took measures in all the fields for which the Inspectorate considered the reception insufficient.[962]

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[956] Interview Nidos. See also Kinderombudsman, *Wachten op je toekomst*, p. 30.

[957] EASO states that in facilities hosting unaccompanied children specific preventive measures should be in place to prevent children going missing. EASO, *EASO Guidance on reception conditions*, p. 20.

[958] Inspectie Jeugdzorg, Opvang alleenstaande minderjarige vreemdelingen, September 2016, p. 7.

[959] Ibid., p. 6.

[960] The Netherlands Parliamentary documents TK 2016/17, 28638, nr. 159.

[961] 1 child in 2012 and 2013, 11 children in 2014, 24 children in 2015. See Kinderombudsman, *Kinderrechtenmonitor 2016*, p. 56.

[962] COA took amongst others the following measures: introduction of a tool to assess the risks for unaccompanied children and a security plan, the involvement of the children in the activities offered, improvement of the methodology for the supervision of the children and training in the methodology, better alignment of activities and learning goals with other organisations, such as schools, the introduction of a complaint procedure and a confidential counsellor and improvement of the exchange of information when the child leaves the secured reception centre for another reception centre. The Netherlands Parliamentary documents TK 2015/16, 27062, nr. 103.

*Reception during the period of high influx*

During the period of high influx the number of unaccompanied children, who applied for asylum in the Netherlands increased from 960 in 2014 to 3,859 in 2015 and then decreased to 1,701 in 2016.[963] The period of high influx led to an increase of relocations of unaccompanied children. The frequent relocations made it difficult for the children to establish a relationship with their mentors.[964] In November 2015 the Dutch government promised to prevent as much as possible that unaccompanied children would be placed in crisis or emergency reception centres and to keep the length of stay in such centres as short as possible. In principle unaccompanied children would be relocated as little as possible and continuity in reception, guidance and education would be ensured.[965]

*Separated children with family members*

Some children travel to the Netherlands with family members other than their parents, such as uncles, aunts, cousins or (adult) siblings. These children usually stay with the adults who brought them to the Netherlands.[966] The Children's Ombudsman noted in 2016 that these children did not receive any extra supervision or a contact person on location, but only a guardian provided by Nidos. He concluded that this could entail risks for the development and security of these children, in particular if the child did not belong to the family before the flight.[967] During UNHCR's visits to reception centres in the first half of 2016 it received signals that these children received insufficient attention and care from Nidos.[968] Some asylum seekers informed UNHCR that Nidos had not contacted the children or had only contacted them once.[969] Nidos stated that this situation occurred during the period of high influx, during which this group of children was frequently relocated.[970]

## 5.7 Families with children

The State Secretary acknowledges that children are in a vulnerable position and that reception facilities should be adapted to their special needs.[971] According to Article 18c(a) Rva children should be able to take part in leisure activities, including playing and recreational activities, which are suited to their age and in activities in the open air. In the reception centres children go to school.[972] Most reception centres have a playground for children.[973] COA organises activities specifically for children, often in cooperation with other organisations.[974] A helpline for children (*Kindertelefoon*) developed a website made by and for asylum seeker children with information about all aspects of their life.[975]

[963] IND, *Asylum Trends*, January 2017, p. 8, Kinderombudsman, *Wachten op je toekomst*, p. 29.
[964] Kinderombudsman, *Wachten op je toekomst*, p. 30.
[965] Bestuursakkoord Verhoogde Asielinstroom, 27 november 2015, p. 4.
[966] Kinderombudsman, *Wachten op je toekomst*, p. 30.
[967] Ibid.
[968] Conversations with UNHCR staff, UNHCR the Netherlands, August/September 2016.
[969] Ibid. See also interview Lawyer 5, who mentioned that Nidos contact did not contact the child or only very late.
[970] Additional information provided by Nidos in September 2017.
[971] The Netherlands Parliamentary documents TK 2014/15, 34088, nr. 6, p. 40.
[972] See for details about the education system for asylum seeker children: the Netherlands Parliamentary documents TK 2016/17, 34 334, nr. 24. See for concerns about the education system: Werkgroep Kind in azc, *Zo kan het ook*, November 2016, pp. 10-12.
[973] Interview COA 1.
[974] An example is Stichting de Vrolijkheid, https://vrolijkheid.nl/.
[975] http://www.tell-me.nl/.

Several organisations find that the reception centres are insufficiently adapted to the needs of children. They argued for example that large scale reception centres do not provide sufficient privacy and security for children and that there is a risk that COA does not know what is going on in the centre.[976] Furthermore, the activities organised and the play facilities offered vary per location. In some locations there are hardly any activities or playing facilities.[977] One report of May 2016 concluded that in the 28 reception centres reviewed no sports activities were organised for girls aged 13-18 years.[978]

*Situation during the period of high influx*

Many children applied for asylum in 2015 and 2016.[979] The Children's ombudsman published a report in 2016 about their situation in the emergency reception centres. He describes a lack of privacy and of special areas for children and their family members to play and relax or to do their homework.[980] Another report concluded that the situation in the emergency reception centres was not beneficial to the health of children and that it should be examined how it can be prevented that children are placed in such centre.[981]

### 5.8 LGBTI asylum seekers

In the past years there was a lot of attention for the safety of LGBTI asylum seekers in the COA reception centres. This issue was discussed multiple times in Parliament[982] and several political parties made the safety of LGBTI asylum seekers in reception facilities a point in their programme for the elections of 2017.[983]

In the Netherlands COC is the most important NGOs advocating for the rights of lesbian women, gay men, bisexuals and trans genders. COA and COC received signals from LGBTI asylum seekers who did not feel safe in the reception centres, because of discriminating or aggressive behaviour from other asylum seekers and sometimes COA staff.[984] In 2016 the Netherlands Institute for Human Rights reported that LGBTI asylum seekers did not feel safe in the emergency reception centre in Heumensoord and were subjected to bullying, name calling, theft and threats.[985] According to this

[976] Werkgroep Kind in azc, Zo kan het ook, p. 9.
[977] Ibid., p. 16, Kinderombudsman, Kinderrechtenmonitor, 2016, pp. 180-181.
[978] Westerhof, W., Vlasveld, A. and de Ridder, E., *Inventarisatie sport en bewegen op en rondom COA opvanglocaties*, Kenniscentrum Sport, May 2016, pp. 9, 12.
[979] In 2015, 12,262 children (under 18 years) applied for asylum in the Netherlands. See the Netherlands Parliamentary documents TK 2016/17, 34 334, nr. 24, p. 3
[980] Kinderombudsman, *Wachten op je Toekomst*.
[981] Flegar, V., *Quickscan Zorg voor asielzoekerskinderen in Nederland*, Werkgroep Kind in azc, p. 31.
[982] See eg the Netherlands, Parliamentary documents, TK 2015/16, 19637, nr. 2219, pp. 8, 11, 31, TK 2015/16, 19637, nr. 2078, TK 2015/16, Aanhangsel van de Handelingen, nr. 1208, TK 2015/16, 30420, nr. 238, TK 2016/17, Aanhangsel van de Handelingen, nr. 1078, p. 2.
[983] The Christenunie, D66, PvdA and VVD. See Reneman, M, *Verkiezingen 2017: Opvang van asielzoekers en asielstatushouders*, March 2017.
[984] COA and COC Nederland, *Convenant inzake de samenwerking tussen COA and COC Nederland*, May 2014, p. 1.
[985] College Rechten van de Mens, *Aanbevelingen Mensenrechten in de noodopvang Heumensoord*, p. 6. See also Gemeente Nijmegen, Gemeente Heumen, *Noodopvang Heumensoord, Een terugblik*, May 2016, p. 23.

report COA management was insufficiently aware of these problems.[986] UNHCR also spoke to several LGBTI asylum seekers who did not feel safe in the reception centre and were subjected to verbal abuse, threats and harassment. For this reason some of them stayed with friends in Amsterdam.[987] Finally, several stakeholders mentioned that LGBTI's were bullied or felt unsafe in the reception centre during the interviews for this report.[988]

COA has recognised that LGBTI asylum seekers are a group which need specific attention, because they may be subjected to discrimination or aggression because of their sexual orientation or gender identity.[989] COA takes into account sexual orientation when placing an asylum seeker in a reception centre.[990] Furthermore, COA has a confidential counsellor for vulnerable groups, including LGBTI asylum-seekers, which support them in the reception centres.[991] The Secretary of State and COA are not in favour of separate reception facilities for LGBTI asylum seekers. This would give a signal that the normal reception centres are not safe for LGBTIs, which in their view is not correct. Furthermore, COA wants that all people live together, as is the habit in the Netherlands. Isolation of vulnerable groups would also lead to stigmatisation.[992] The city of Amsterdam did offer special reception places for LGBTI asylum seekers in 2016.[993]

Instead COA sought practical solutions for violence against LTBTI's in reception centres, such as creating a special wing in reception centres for LGBTI asylum seekers or providing them with rooms close to the reception area.[994] In Heumensoord, cases of LGBTI asylum seekers were discussed between COA, COC, the police, Safety house and the municipalities, in order to decide how to deal with the situation. Some asylum seekers were relocated.[995] The Netherlands Institute of Human Rights advised COA in 2016 to relocate LGBTI asylum seekers if their safety cannot be guaranteed in a reception centre.[996] The State Secretary of Security and Justice indicated that relocations are possible in emergency situations and that LGBTI asylum seekers can be placed in a safe house if necessary.[997]

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[986] College Rechten van de Mens, *Aanbevelingen Mensenrechten in de noodopvang Heumensoord*, p. 7.
[987] Conversations with UNHCR staff, UNHCR the Netherlands, August/September 2016.
[988] Interview Lawyer 2, Lawyers 3 and 4, DCR 4.
[989] COA and COC Nederland, *Convenant inzake de samenwerking tussen COA and COC Nederland*, May 2014, p. 3.
[990] Ibid., p. 1.
[991] The Netherlands, Parliamentary documents, TK 2016/17, Aanhangsel van de Handelingen, nr. 1078, p. 2.
[992] The Netherlands, Parliamentary documents, TK 2015/16 19637, 33042, nr. 2179, TK 2015-2016, Aanhangsel van de Handelingen, nr. 1208, College Rechten van de Mens, Aanbevelingen Mensenrechten in de noodopvang Heumensoord, p. 6.
[993] The Netherlands, Parliamentary documents, TK 2015/16, Aanhangsel van de Handelingen, nr. 1208.
[994] The Netherlands, Parliamentary documents, TK 2015/16, 19637, nr. 2219, p. 31, TK 2015/16 19637, 33042, nr. 2179, p. 5.
[995] Gemeente Nijmegen, Gemeente Heumen, *Noodopvang Heumensoord, Een terugblik*, Mei 2016, p. 23.
[996] College Rechten van de Mens, *Aanbevelingen Mensenrechten in de noodopvang Heumensoord*, p. 7. EASO also states that measures could for example 'include the possibility to accommodate asylum seekers with a different sexual orientation separately from other asylum seekers from the same sex, or the transfer of an asylum seeker who is at risk of becoming or has become subject to gender-based violence'. EASO, *EASO Guidance on reception conditions*, p. 20.
[997] The Netherlands, Parliamentary documents, TK 2015/16, 19637, nr. 2219, p. 31, TK 2015/16, Aanhangsel van de Handelingen, nr. 1208, TK 2015/16 19637, 33042, nr. 2179.

UNHCR noticed during its visits to reception centres in 2016 that the measures taken, differed in the reception centres. In the POL Ter Apel LGBTI asylum seekers were hosted in a separate location, in order to reduce the risk of incidents of discrimination or aggression against them.[998] In Budel, COA placed LGBTI asylum seekers together in one room, because this could increase their feeling of safety and reduce the risk of discrimination or aggression.[999] In some centres COA does not place LGBTI asylum seekers together in a living unit.[1000] In Oranje COA did, at the moment of the visit, not know whether any LGTBTI asylum seekers were residing at the centre. In principle, COA would not host LGTBI asylum seekers in separate facilities, because it wished to treat everyone equally.[1001]

Several of the LGBTI asylum seekers interviewed by UNHCR in 2016 stated that they did not feel safe and spent most of their time in their rooms, even though COA had transferred and/or placed them in a single room or a room with other LGBTI asylum seekers. One had even left the COA reception centre.[1002] Some LGBTI asylum seekers indicated that they felt or would feel most safe in centres where primarily families with children and single women are residing.[1003]

COA collaborates with organisations for LGBTIs in the Netherlands, amongst others in a working group on fundamental rights.[1004] In 2014 it concluded a covenant with COC, which aims to improve the position of LGBTI asylum seekers in reception centres and create a safe living environment for them.[1005] COC supports COA in informing asylum seekers and COA staff about the specific vulnerability of LGBTI asylum seekers and in the training of COA staff. Furthermore, COA discusses incidents of harassment of LGBTI asylum seekers with COC and signals are shared. The Ministry of Education, Culture and Sciences developed an app, which provides information about LGBTI rights, organisations which can be contacted if an LGBTI asylum seeker feels unsafe or has experienced discrimination and helps LGBTI asylum seekers to get in touch with other LGBTIs.[1006] However, in practice it may not always be easy to contact LGBTI organisations. One lawyer mentioned that her client first could not attend COC meetings because it was too far from the reception centre and later because COA would not reimburse travel expenses.[1007] One lesbian couple told UNHCR that they did not know about LGBTI organisations in the Netherlands.[1008]

COA informs asylum seekers about the rules and values they have to comply with. During a meeting shortly after arrival in a reception centre the asylum seeker is informed about the principle of equal treatment laid down in Article 1 of the Constitution, the principle of non-discrimination and human

[998] Conversations with UNHCR staff, UNHCR the Netherlands, August/September 2016.
[999] Ibid.
[1000] Ibid.
[1001] Ibid.
[1002] Lawyer 2 also mentioned that her LGBTI clients often stayed with friends outside the reception centre.
[1003] Conversations with UNHCR staff, UNHCR the Netherlands, August/September 2016.
[1004] The Netherlands Parliamentary documents, TK 2016/17, Aanhangsel van de Handelingen, nr. 1078, Interview COA 1.
[1005] COA and COC Nederland, Convenant inzake de samenwerking tussen COA and COC Nederland, May 2014.
[1006] The Netherlands Parliamentary documents, TK 2016/17, Aanhangsel van de Handelingen, nr. 1078. Interview COA 1.
[1007] Interview Lawyer 2.
[1008] Conversations with UNHCR staff, UNHCR the Netherlands, August/September 2016.

rights. Also during their stay asylum seekers are informed about equality and freedoms as well as security.[1009]

COA can take measures against asylum seekers who do not comply with the rules and repeatedly behave aggressively or intimidate or discriminate other asylum seekers or COA staff. They may be placed in a special reception centre with a strict regime.[1010] Furthermore, COA informs the police about crimes and encourages asylum seekers to report crimes to the police.[1011]

### 5.9 Relocations

Asylum seekers in the Netherlands are often relocated.[1012] Relocations are partly related to the stage of the asylum procedure: the COL in the first days after they have lodged their asylum application, the POL before and during the general asylum procedure and the AZC during an extended asylum procedure and after the asylum decision. After the asylum procedure, status holders move to a house in a municipality. Families with minor children who need to leave the Netherlands move to a family location.

Relocations are also caused by the influx of asylum seekers. During the period of high influx for example, new (crisis and emergency) reception centres had to be opened in order to be able to offer a place to stay to all new asylum seekers.[1013] As a result of the increased waiting period between the moment of the asylum application and the start of the asylum procedure and a higher number of relocations, asylum seekers had to stay in different reception centres for longer periods of time. It therefore took longer before asylum seekers reached a more stable location.[1014]

The ACVZ has advised the State Secretary in May 2017 to reduce the number of types of reception centres, which would also reduce the amount of relocations.[1015] This would not only benefit asylum seekers, but also enhance the efficient processing of asylum applications and decrease the need for transportation of asylum seekers from one location to another.[1016] This could amongst others be achieved by taking away the need for crisis reception centres as far as possible in the future. Furthermore, the ACVZ advises the Dutch Government to make more flexible use of the available places in the different types of reception centres.[1017]

[1009] The Netherlands Parliamentary documents, TK 2016/17, Aanhangsel van de Handelingen, nr. 1078, TK 2015/16 19637, 33042, nr. 2179.
[1010] The Netherlands Parliamentary documents TK 2016/17 19637, nr. 2336, TK 2016-2017, Aanhangsel van de Handelingen, nr. 1078, TK 2015/16, Aanhangsel van de Handelingen, nr. 1208, TK 2015/16 19637, 33042, nr. 2179.
[1011] The Netherlands Parliamentary documents TK 2016/17, Aanhangsel van de Handelingen, nr. 1078.
[1012] For his report of 2016 the Kinderombudsman spoke to children who relocated more than 7 times. Kinderombudsman, Wachten op je Toekomst, p. 14.
[1013] The Netherlands Parliamentary documents TK 2015/16, Aanhangsel van de Handelingen, nr. 2947, p. 2.
[1014] ACVZ, Pieken en Dalen, pp. 41-42.
[1015] Ibid., p. 20.
[1016] Ibid., p. 68.
[1017] Ibid., p. 69.

*Relocation of (families with) children*

Relocations have particularly serious consequences for (families with) children.[1018] According to many organisations and experts the relocations are a (extra) risk to children's development and therefore need to be limited as much as possible.[1019] Research in the Netherlands and Denmark shows that asylum seeker children feel less safe, experience problems making new friends, perform less at school and have a higher risk of mental distress. This is because the families lack support, resilience, confidence and flexibility to cope with a relocation.[1020] One study showed that children who have been exposed to violence and children whose mothers had been diagnosed with PTSD or depression seemed to be at increased risk of newly recorded mental distress.[1021] Frequently relocated children might have a greater need for parental support in a new environment. However, parents with PTSD and depression can be emotionally and functionally unavailable to their children.[1022] Furthermore, relocations can prevent the continuity of the education of the children.[1023]

COA has as a starting point that asylum seekers and in particular children should not be relocated if it is not necessary.[1024] State Secretary also recognised the need to minimise the number of relocation of families with children.[1025] Therefore he announced several measures in November 2016:

- During new periods of high influx families with children and unaccompanied children will not be placed in short-term emergency reception centres.[1026]
- COA will place (as much as possible) families with minor children in an AZC which will be opened for a longer period of time in order to prevent that they have to move to another AZC before they can be housed in a municipality (if their application is granted).
- COA will place families with minor children in, or as close as possible to the municipality where they will be housed in the future.
- The waiting period in the POL will be further reduced.[1027]

[1018] See eg Ikram, U and Stronks, p. 41, Van Berkum, M. and others, p. 10.
[1019] See eg Kinderombudsman, *Verhuizen zonder afscheid*, February 2017, p. 14. Drogendijk, A. et al, *Veerkracht en Vertrouwen, De bouwstenen voor psychosociale hulpverlening aan vluchtelingen*, Arq Psychotrauma Expertgroep, May 2016, p. 4, College voor de Rechten van de Mens, *Mensenrechten in (tijdelijke) opvanglocaties voor asielzoekers en vluchtelingen*, p. 5, Kinderombudsman, *Wachten op je Toekomst*, p. 14, Werkgroep Kind in azc, *Ontheemd, De verhuizingen van asielzoekerskinderen in Nederland*, January 2013, p. 20.
[1020] Werkgroep Kind in azc, *Ontheemd*, p. 20. This publication refers to Nielsen, S.S. Norredam , M. , Cristiansen, K.L., Obel, C. , Hilden, J. & Krasnik, A., Mental health among children seeking asylum in Denmark – the effect of length of stay and number of relocations: a cross-sectional study. BMC Public Health, 2008.
[1021] Goosen, S. Stronks, K and Kunst, A.E. , 'Frequent relocations between asylum-seeker centres are associated with mental distress in asylum-seeking children: a longitudinal medical record study', *International Journal of Epidemiology*, 2014, pp. 94-104.
[1022] Ibid., p. 100.
[1023] Werkgroep Kind in azc, *Zo kan het ook*, p. 10.
[1024] Interview COA 1.
[1025] The Netherlands Parliamentary documents TK 2016/17, 19637, nr. 2261, p. 1, TK 2015/16, 34300 XVI, nr. 116, p. 2, TK 2015/16, 19637, nr. 2219, pp. 35, 53.
[1026] The Netherlands Parliamentary documents TK 2016/17, 19637, nr. 2261, p. 2, TK 2015/16, 34300 XVI, nr. 116, p. 2.
[1027] The Netherlands Parliamentary documents TK 2016/17, 19637, nr. 2261, pp. 2-3.

The State Secretary does not want to change the fact that families with children need to relocate as a consequence of the asylum procedure. In his view the asylum procedure promotes a quick and careful asylum decision, which is in the asylum seeker's interest.[1028] Furthermore, he does not deem it feasible to introduce mobile IND teams, which can interview families on location. On location some of the necessary partners (interpreters, the Dutch Council for Refugees (DRC) etc.) are not available and mobile teams cost a lot of money (facilities, security, travel costs).[1029]

COA stresses that sometimes relocations cannot be prevented, for example when a reception centre will be closed. COA cannot predict how long an asylum seeker will stay in a reception centre, because this depends on the length of the asylum procedure. Therefore it is difficult to take into account that a reception centre will be closed within a certain period of time. Furthermore, it is not known beforehand which reception centres will be closed as a result of the lower influx.[1030]

If a relocation of a family with children is necessary, COA uses a check list[1031] in order to prepare and support the family and to take into account the well-being and the interests of the child.[1032] This check list was developed in 2013 in cooperation with NGO's.[1033] The State Secretary has asked COA to make full use of the check list again, now that the influx of asylum seekers has decreased.[1034] The check list has different purposes. First, it forces a COA officer to examine whether the relocation is necessary and to prevent further relocations in the future. The checklist asks for example whether the family will be able to stay in the next reception centre for a long period of time. Second, the check list helps the COA officer to reduce the negative impact of the relocation. It forces the COA officer to assess when the relocation can best take place in the light of the children's planned exams or school vacations and to think about a proper goodbye at school.[1035] However, if the relocation is caused by a next step in the asylum procedure, it is the IND and not COA who decides about the timing of the relocation.[1036] Finally, the check list assists the COA officer in the preparation of the relocation. It contains questions with regard to the information provided to (new and old) schools, the transfer of medical information and continuity of medical treatment, educational support and child protection.[1037]

*Relocation of persons in need of medical care*

Another group of asylum seekers for whom relocations have particularly negative consequences are asylum seekers in need of medical care. The relocations may endanger the continuity of medical

[1028] Ibid, p.1, See also TK 2013/14, 19 637, nr. 1761, p. 8.
[1029] Ibid., p. 3.
[1030] Interview COA 1.
[1031] The Netherlands Parliamentary documents TK 2016/17, 19637, nr. 2261, Annex.
[1032] Ibid., p. 2.
[1033] Kinderombudsman, *Verhuizen zonder afscheid*, p. 3.
[1034] The Netherlands Parliamentary documents TK 2016/17, 19637, nr. 2261, p. 2.
[1035] According to EASO it is good practice 'to transfer families with school children while taking into consideration school holidays at the end of the school year'. EASO, *EASO Guidance on reception conditions*, p. 16.
[1036] The Netherlands Parliamentary documents TK 2016/17, 19637, nr. 2261, p. 2. Kinderombudsman, *Verhuizen zonder afscheid*, p. 6.
[1037] The Netherlands Parliamentary documents TK 2016/17, 19637, nr. 2261, Annex, TK 2016/17, 19637, nr. 2261, p. 2.

care.[1038] Doctors experience difficulties establishing a confidential relationship with asylum seekers, because of their frequent relocations.[1039] Asylum seekers with chronic diseases are sometimes forced to find another specialist doctor as a result of their relocation to another reception centre. This limits their free choice of a doctor.[1040] If an asylum seeker moves from one reception centre to another, the medical file will be transferred through the GP information system (*Huisartseninformatiesysteem*, HIS) of GCA to the new care provider.[1041] However, some specialists do not realise that they need to inform the GP who referred the patient to them in time because of frequent relocations. As a result the information of the specialist cannot be easily transferred to the new GP.[1042]

Arq Psychotrauma Expert Group noted in a report of 2016 that there is no common approach in the transfer of information nor continuity in medical care when a person is moving from an emergency reception centre, to the regular reception centre and further on to the municipality. According to Arq this poses a risk to vulnerable persons.[1043] Similarly in 2014 the Dutch Safety Board (*Onderzoeksraad voor de Veiligheid*) reported that doctors are not always aware that their patients are relocated or will be expelled. As a result they are not able to complete the treatment or to transfer care to another doctor.[1044] GCA mentioned that during the period of high influx COA's administration was not always up to date. This was problematic because GCA's administration system HIS is linked to COA's administration. As a result GCA did not always know when an asylum seeker would be transferred.[1045] During this time COA's main priority was to provide shelter to asylum seekers. It could not always take into account asylum seekers' medical needs when making decisions about relocations.[1046]

COA and mental health care providers agreed that COA tries to minimise the relocations and that care providers take into account that the asylum seeker needs to be relocated when he moves to a different stage in the asylum procedure.[1047]

### 5.10 Activities in reception centres

Activities and exercise help asylum seekers staying in reception centres to prevent the development of psychological problems.[1048] At the same time a lack of useful day activities can lead to passive behaviour, stress and isolation and have a negative influence of asylum seekers' mental[1049] and

[1038] Convenant GGZ, *Verslag werkgroepbijeenkomst* , 29 January 2016, Werkgroep Kind in azc, *Zo kan het ook*, pp. 14-15.
[1039] Nationale Ombudsman, *Medische zorg vreemdelingen, Over toegang en continuïteit van medische zorg voor asielzoekers en uitgeprocedeerde asielzoekers*, 3 October 2013, nr. 2013/125, p. 18.
[1040] Ibid., p. 22.
[1041] Interview COA 1.
[1042] Flegar, V. *Quickscan Zorg voor asielzoekerskinderen in Nederland*, p. 27.
[1043] Drogendijk, A. and others, p. 4. See also Flegar, V., *Quickscan Zorg voor asielzoekerskinderen in Nederland*, p. 27.
[1044] Onderzoeksraad voor Veiligheid, *Veiligheid van vreemdelingen*, 2014, p. 50, Interview GCA 1.
[1045] Interview GCA 1. See also Onderzoeksraad voor Veiligheid, *Veiligheid van vreemdelingen*, p. 50, Nationale Ombudsman, Medische zorg vreemdelingen, p. 27
[1046] Interview GCA 1.
[1047] MCA, *Convenant GGZ voor asielzoekers*, 5 October 2015, p. 8.
[1048] Van Schayk, M.and Vloeberghs, E., *Podium voor preventie*, Pharos, December 2011, pp. 16, 22, Interview Centrum '45.
[1049] ACVZ, *Verloren tijd*, March 2013, p. 32.

physical health. Care providers think that the most important need of asylum seekers is to do useful activities during the day, such as sports, education and work. This forces asylum seekers to use their healthy side and diminishes the time available to worry.[1050] Van Schayk and Vloeberghs mention that it is known that structured day activities may help vulnerable persons and in particular victims of violence to develop feelings of safety and basic trust. They think that it should not be entirely left to their initiative to come up with activities.[1051] Several reports show that asylum seekers themselves stress the necessity of activities.[1052]

According to Article 9(1)(d) Rva, reception facilities include recreational and educational activities. COA should offer the asylum seeker a programme for education and development.[1053] This obligation does not apply in the period before and during the general asylum procedure.[1054]

Several years ago the Dutch Government cut the budget for the organisation of day activities for asylum seekers. As a result COA and the DCR had to give up their role as organisers of activities in the reception centres. It became the asylum seekers' own responsibility to initiate activities, which could be supported by COA.[1055] Some activities, such as Dutch language classes became unavailable for asylum seekers who received a negative decision.[1056]

In 2013 the ACVZ published a report called 'lost time' (*Verloren tijd*) which criticised the lack of activities in the reception centres and the resulting 'forced inactivity' and dependency of asylum seekers.[1057] The ACVZ recommended the Dutch Government to re-establish COA's task to take care of the non-material aspects of the reception of asylum seekers and provide sufficient financial means to enable COA to carry out this task. The ACVZ also recommended to provide programmes in all reception centres which are adapted to the type of reception centre and the phase of the asylum procedure. Moreover it found that adults should be enabled to take part in social-cultural activities, sports (at the reception centre and in associations) and make use of internet and study areas.[1058]

In response to this report the State Secretary of Security and Justice indicated that COA was improving the counselling methodology, which should enable asylum seekers as much as possible to remain active. He also announced that he would examine whether wireless internet and sports facilities could be introduced at the reception centres.[1059] COA officers interviewed for the purpose of this study mentioned that after the ACVZ report, more resources became available for asylum seekers' activities.

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[1050] Haker, F., Van Bommel, H., Bloemen, E., *Zorg voor Asielzoekers met Psychische Problemen, Het perspectief van de zorgverlener,* Pharos/Zapp , September 2010, p. 12, Interview Centrum '45.
[1051] M. van Schayk, E. Vloeberghs, pp. 20-21.
[1052] S. Kramer et al., *Ethische dilemma's in de GGZ voor asielzoekers*, Johannes Wier Stichting 2015, p. 45, ACVZ, Verloren tijd, pp. 41-49.
[1053] Art. 9(3)(d) Rva.
[1054] Art. 9(5) Rva.
[1055] ACVZ, Verloren tijd, p. 38.
[1056] Ibid., p. 36
[1057] Ibid.
[1058] Ibid., p. 10. See also Wetenschappelijke Raad voor het Regeringsbeleid, WRR policy brief 4, *Geen tijd verliezen: van opvang naar integratie van asielmigranten*, December 2015, p. 39.
[1059] The Netherlands Parliamentary documents TK 2012/13 19637, nr. 1721, pp. 30-31. See also S. van Maanen, 'Vluchtelingen en Sport', *Sport & Gemeenten*, September 2016.

From 2014 COA started an activity programme again.[1060] One COA officer stated that there is a lot more attention for the daily activities and the well-being of the asylum seekers living in the reception centres.[1061] The COA year plan 2017 indeed mentions as a key theme that all inhabitant prepares themselves each day in a useful manner for their future by developing a social network, learning Dutch, working towards (paid or unpaid) employment or return.[1062]

Activities may be adapted to the asylum seeker's state of health or mental state.[1063] In the emergency reception centre Flierenboschdreef for example, which was visited by UNHCR in June 2016, GCA collaborated with COA in case they deem a daily structure of activities important for the psychosocial wellbeing of a patient.[1064]

The COA activity programme consists of three parts: recreation (culture and sports), education and work. The programme first focused on the recreation part. Recently, more attention has also been paid to education and work. The type of activities offered to asylum seekers depends on the type of reception centre and the phase of the asylum procedure in which they find themselves. In the POL, where asylum seekers are waiting for or involved in the asylum procedure, asylum seekers can participate in short programmes which are mostly of a recreational nature. In AZCs activities are also aimed at education and work, early integration and participation. COA informs asylum seekers about the activities offered, shortly after their arrival in the reception centre.[1065]

In several of the reception centres visited by UNHCR COA organised activities[1066] and/or supported organisations or volunteers offering activities to asylum seekers.[1067] Such activities may include sports, music activities, Dutch classes and self-study.[1068] Some reception centres had special rooms for women where they could do their own activities.[1069] However, in other reception centres the activities offered were limited.[1070] In some UNHCR participatory assessments the asylum seekers indicated that they would like more activities, including activities to get more knowledge about the Netherlands and Dutch language classes.[1071] Also in some centres women indicated that most common rooms and sports facilities were only used by or suitable for men.[1072]

*Recreation*

COA has received funds to organise sports activities for asylum seekers and refugees. In July 2016 the Minister of Health stated that several initiatives have started amongst others by COA to enable asylum seekers to do sports and exercise. COA has appointed exercise coaches in each reception location.

[1060] Interview COA 1 and COA 2. See also ACVZ, Pieken en Dalen, p. 46.
[1061] Interview COA 1.
[1062] COA, *Jaarplan COA 2017, 'Uitdagingen'*, https://www.coa.nl/sites/www.coa.nl/files/paginas/media/bestanden/jaarplan_2017_coa_uitdagingen.pdf.
[1063] Interview COA 1.
[1064] Conversations with UNHCR staff, UNHCR the Netherlands, August/September 2016.
[1065] Interview COA 1.
[1066] Conversations with UNHCR staff, UNHCR the Netherlands, August/September 2016.
[1067] Ibid.
[1068] Ibid.
[1069] Ibid.
[1070] Ibid.
[1071] Conversations with UNHCR staff, UNHCR the Netherlands, August/September 2016.
[1072] Ibid.

Moreover, the National Olympic Committee NOC*NSF examined in cooperation with municipalities, COA and the DCR how refugees can be involved in sports clubs (to do sports or to do volunteer work). In some municipalities the community sports coach organises activities for refugees.[1073] Most reception centres have a recreation area and a playground.[1074] Apart from sports other recreational activities are offered such as music, sewing and art classes.[1075] In all reception centres there is access to wireless internet.[1076]

*Education*

COA offers basic Dutch courses to asylum seekers, in particular to those persons who need to speak some Dutch. For example asylum seekers who have medical problems should be able to speak some Dutch in order to communicate with doctors and nurses about their problems.[1077] COA offers Dutch language (NT2) courses to asylum status holders in the AZCs and (from the beginning of 2017) also to asylum seekers with high chances of success in the POLs.[1078] Asylum seekers can also learn computer skills. Each reception has an open learning centre, where asylum seekers can study.[1079]

*Work*

Asylum seekers may work after six months under certain conditions, and participate in volunteer work. The State Secretary stated that COA supports initiatives which enable asylum seekers to do unpaid work and to follow language courses, in particular for asylum seekers who have a high chance of getting an asylum status.[1080] Also COA noted that the focus lies on early integration and participation of asylum status holders. There are lots of initiatives to offer asylum status holders work and internships which are supported by COA.[1081]

Article 18 Rva provides that asylum seekers may work for COA in and around the reception centre. They may receive compensation for their work of a maximum of 14 euros per week. The work needs to be divided evenly between the asylum seekers who would like to participate. The work includes: cleaning, maintaining the green areas or supervising the learning centre.[1082]

*Involvement of communities and local organisations*

Local COA officers should arrange activities in cooperation with local organisations and communities[1083], which may include local sports clubs, volunteer organisations and municipalities.[1084] Many reception centres do projects with other organisations with regard to daily activities and psychosocial support. This is not imposed by the central office of COA; COA decides on the local level what is necessary.[1085]

[1073] The Netherlands Parliamentary documents TK 2015/16 Aanhangsel van de handelingen, nr. 3049, p. 2.
[1074] Interview COA 1. See also Westerhof, W., Vlasveld, A. and de Ridder, E., p. 5
[1075] Interview COA 2.
[1076] The Netherlands Parliamentary documents TK 2015/16, 19637, nr. 2219, pp. 31-32.
[1077] Interviews COA 1 and COA 2.
[1078] ACVZ, Pieken en Dalen, p. 47.
[1079] Interview COA 2.
[1080] The Netherlands Parliamentary documents TK 2015/16, 19637, nr. 2219, p. 33.
[1081] Interview COA 1.
[1082] Ibid.
[1083] Interview COA 2.
[1084] The Netherlands Parliamentary documents TK 2015/16, nr. 2947, Aanhangsel van de Handelingen, p. 2.
[1085] Interview COA 1.

*Activities during the period of high influx*

During the period of high influx many asylum seekers had to stay in emergency reception centres and POLs during longer periods of time, before they could start the asylum procedure. The Netherlands Human Rights Institute found in December 2015 and February 2016 that in different emergency reception centres there were no or insufficient activities organised. According to the Institute this could result in the asylum seekers becoming passive and isolated.[1086] Also the ACVZ noted in its evaluation of the working of the asylum and reception system during the high influx that most of the persons interviewed were concerned about activation and counselling of asylum seekers.[1087]

Asylum seekers who reside in the COL and (pré-)POL before the start of the asylum procedure do not have the right to an allowance. They are provided with meals and necessary sanitary utilities. Asylum seekers, who had to wait for a long time in the emergency reception centres, have experienced this as a disadvantage. They could not buy small things for themselves and their children. There were increasing reports of theft in emergency reception centre Heumensoord, because the residents did not have any money of their own anymore.[1088]

The Netherlands Human Rights Council recommended to provide asylum seekers in emergency reception centres with financial means.[1089] Scholars Slingenberg and Groenendijk argued that the fact that asylum applicants do not receive an allowance before the start of the asylum procedure violates Article 2(g) of the recast Reception Conditions Directive. This provision defines **'**material reception conditions' as the reception conditions that include housing, food and clothing provided in kind, or as financial allowances or in vouchers, or a combination of the three, and a daily expenses allowance.[1090] In their view the provisions of the Reception Conditions Directive apply as soon as the asylum seekers have indicated that they want to claim asylum (made an application for international protection on the territory).[1091] Moreover it is their view that the distinction between asylum seekers awaiting the start of the asylum procedure or the decision in the general asylum procedure (who do not get a financial allowance) on the one hand and asylum seekers awaiting the asylum decision in the extended asylum procedure (who do get a financial allowance) on the other hand is not justified. They state that for that reason the non-discrimination provision of Article 1 of the Constitution is violated.[1092] However, the State Secretary did not see it as a reason to change the policy regarding financial allowances, because the waiting periods have decreased again.[1093]

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[1086] College voor de Rechten van de Mens, *Mensenrechten in (tijdelijke) opvanglocaties voor asielzoekers en vluchtelingen*, pp. 4-5, College Rechten van de Mens, *Mensenrechten in de noodopvang Heumensoord*, p. 8. See also Kinderombudsman, *Wachten op je toekomst*, p. 12

[1087] ACVZ, Pieken en Dalen, p. 45.

[1088] College voor de Rechten van de Mens, *Aanbevelingen. Mensenrechten in de noodopvang Heumensoord*, 10 February 2016, p. 8.

[1089] College voor de Rechten van de Mens, *Aanbevelingen, Mensenrechten in (tijdelijke) opvanglocaties voor asielzoekers en vluchtelingen*, pp. 4-5.

[1090] Emphasis added.

[1091] Art. 3 RRCD.

[1092] K. Groenendijk and L. Slingenberg, 'Niet bij brood alleen'*, Asiel & Migrantenrecht* 2016, nr. 3, pp. 112-114.

[1093] The Netherlands Parliamentary documents TK 2015/16, Aanhangsel van de Handelingen, nr. 3561, p. 2.

In May 2016 the Secretary of Security and Justice stated that COA was paying more attention to improvement of the quality of the emergency reception centres and the activities for the asylum seekers living in those centres. COA was for example looking at possibilities for asylum seekers staying in emergency centres to cook their own meals. In all emergency centres there was wireless internet available, so people could keep in touch with their family members.[1094] However, activities often relied on the local organisation of volunteers. The State Secretary noted in January 2016 for example that Dutch language classes in emergency reception centres depended on local initiatives.[1095]

Even though during the high influx there was criticism on the lack of activities in emergency reception centres, the high influx also led to an increase in the activities offered in the reception centres. The State Secretary of Justice and Security stated that the high influx led to a 'tsunami of volunteers'. [1096] Furthermore, many of the asylum seekers during this time had a very big chance to receive an asylum status (Syrians and Eritreans). As a result more emphasis was placed on activities, which aimed at their early integration, such as volunteer work, employment skills training and language courses.[1097]

### 5.11 Conclusions

Moreover, the reception system must serve the asylum procedure. In the Netherlands the type of reception facilities offered to asylum seekers depends on the stage of the asylum procedure. After each stage asylum seekers move to another reception centre, which offers better reception facilities. They start in the basic COL at the registration phase, move to the POL during before and during the general asylum procedure asylum and finally stay in the AZC after the asylum decision has been made or they have been referred to the extended asylum procedure.

The aims of the reception system sometimes (seem to) conflict. Offering activities in asylum reception centres benefits asylum seekers. At the same time it was believed that activities, such as learning the Dutch language, may lead to integration and complicate return. Moreover, linking the type of reception centre to the stage of the asylum procedure benefits the efficiency of the asylum procedure, but also leads to frequent relocations, which may harm asylum seekers with special needs.

During the period of high influx the Dutch reception system became overburdened. As a result asylum seekers had to stay in crisis reception centres and emergency reception centres for long periods of time before they could enter the asylum procedure. This situation made it particularly difficult for COA to provide reception facilities which were adapted to the special needs of asylum seekers.

At the same time the high influx has further developed the already increasing attention for the importance of useful activities for asylum seekers. Many initiatives have been taken by COA and national and local (volunteer) organisations to provide activities to asylum seekers. Moreover, integration activities for asylum seekers, in particular asylum applicants with high chances of success (Syrians and Eritreans) and status holders, were promoted.

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[1094] The Netherlands Parliamentary documents TK 2015/16, 19637, nr. 2219, pp. 31-32.
[1095] The Netherlands Parliamentary documents TK 2015/16, 19637, nr. 2168, p. 41.
[1096] Ibid.
[1097] ACVZ, *Pieken en Dalen*, May 2017, pp. 24, 45. Interview COA 2.

*Reception facilities for asylum seekers with special needs*

COA takes into account special needs of asylum seekers in different ways. First, when placing a person in a reception centre COA tries to take into account the special needs of an asylum seeker. Asylum seekers who are ill and in need of treatment in an academic hospital, will for example be placed in a reception centre in the vicinity of such hospital. LGBTI asylum seekers or single women will not be placed in big asylum reception centres with scattered houses in a wooded area. However, the possibilities of COA to take into account special needs are limited by more general interests which COA needs to take into account, such as the safety and atmosphere in the reception centre. Moreover in times of high influx the possibilities to take into account special needs are more limited than when the influx is low.

COA can also take measures in a reception centre to guarantee an adequate standard of living for an asylum seeker with special needs. COA may for example provide extra support to asylum seekers or place them in a special (safe) area of a reception centre.

Finally COA has special reception centres for specific categories of asylum seekers with special needs, such as unaccompanied children. Aylum seekers with serious psychological and/or behavioural problems can be placed in a special reception centre with extra supervision (IBO) for a period of three months. These asylum seekers are observed and treated for psychological problems and they learn the skills which are needed to live in a regular reception centre. Asylum seekers with complex psychiatric problems can be placed in the centre for transcultural psychiatry Veldzicht.

*Unaccompanied children*

Unaccompanied children are supervised by a guardian provided by Nidos in accordance with the methodology developed by Nidos for this specific group. It depends on the location where the unaccompanied child is staying, the available time and the necessity how often the guardian has contact with the child. During the period of high influx guardians did not always manage to see their pupils once a month, due to a shortage of guardians.

Concerns have been raised with regard to the supervision of unaccompanied children who arrived in the Netherlands with adult family members. These children receive a guardian, but do not have a COA contact person in the reception centre. During UNHCR's visits to reception centres in the first half of 2016 it received signals that these children received insufficient attention and care from Nidos.[1098]

Unaccompanied children are hosted in foster families or small-scale reception centres. A child can be placed in a secured reception centre, if Nidos thinks that an unaccompanied child may disappear, because he is a (potential future) victim of human trafficking. The Youth Inspectorate has raised concerns and made recommendations amongst others about the quality of the supervision and guidance provided to unaccompanied children in both regular and secured reception facilities for unaccompanied children.

[1098] Conversations with UNHCR staff, UNHCR the Netherlands, August/September 2016.

Both Nidos and the Children's Ombudsman indicated that unaccompanied children who cause troubles or do not fit in the regular reception facilities for unaccompanied children now often end up in a closed institution for youth care.

*Families with children*

COA takes into account the special needs of children by providing play grounds and organising activities specifically for children. In the reception centres children go to school. However, some organisations argue that large reception centres are not suitable for children and that in some reception centres there are insufficient activities or playing facilities available for children. During the period of high influx children often had to stay in crisis and emergency reception centres, where the situation was not beneficial to children.

*LGBTI asylum seekers*

There has been a lot of attention for the safety of LGBTI asylum seekers in the reception centres. COA has taken several measures to improve their situation. Nevertheless, several reports issued in 2016 and UNHCR monitoring visits in 2016 showed that LGBTI asylum seekers still did not feel safe in the reception centres.[1099] The Secretary of State and COA are not in favour of separate reception facilities for LGBTI asylum seekers, because they think that isolation of this group is not in conformity with norms in Dutch society and may lead to stigmatisation. Instead, in some reception centres practical measures are taken, including the creation of a special wing in reception centres, housing LGBTIs together in a room or provide them rooms close to the reception area. However, these measures are not taken in all reception centres and may not be sufficient to make LGBTI asylum seekers feel safe. In emergency situations LGBTI asylum seekers are transferred to another location or a safe house. COA also informs asylum seekers about the Dutch norms including the principle of non-discrimination and takes measures against asylum seekers who behave aggressively or intimidate or discriminate LGBTI asylum seekers.

*Relocations*

In the Netherlands asylum seekers often need to relocate as a result of the Dutch reception system, in which the type of reception centre is linked to the stage of the asylum procedure. Furthermore, the opening and closure of reception centres, in particular those caused by changes in the influx of asylum seekers, results in many relocations of asylum seekers. These relocations have a particularly negative effect on the well-being of unaccompanied children, families with children and asylum seekers in need of medical care.

In November 2016 the State Secretary has announced several measures to reduce the number of (involuntary) relocations of families with children and unaccompanied children. Furthermore, COA uses a checklist in order to assess the necessity of a relocation and to prevent relocations in the future. Moreover, the checklist helps COA to prepare a planned relocation in order to reduce the negative impact of the relocation on the asylum seekers, for example by looking at the best timing and ensuring a proper transfer of information. However, if the relocation is the result of a next step in the asylum procedure, the IND decides about the timing of the relocation.

[1099] Ibid.

For asylum seekers in need of medical care, no specific measures are taken to prevent and prepare relocations. COA and mental health care providers agreed that COA tries to minimise the relocations of persons in need of mental health care. In practice the continuity of medical care and the transfer of medical information is not always guaranteed.

*Activities in reception centres*

Recently, more attention has been paid to the organisation of useful activities for asylum seekers in the reception centres. COA has received more resources for such activities and intends to ensure that each inhabitant prepares himself each day in a useful manner on his future by developing a social network, learning Dutch, working towards (paid or unpaid) employment or return. The COA activity programme consists of recreation (culture and sports), education and work. For asylum status holders and asylum seekers with high chances of success COA organises activities aimed at integration, such as Dutch language classes. The availability of such activities and the space offered to (specific groups of) asylum seekers to undertake activities, such as rooms for women and children, differs per reception centre.

Several reports mentioned that during the period of high influx insufficient activities were organised in part of the emergency reception centres, where asylum seekers had to stay for a long period of time. During their stay in the emergency reception centres asylum seekers also did not receive a financial allowance to enable them to undertake activities or cook their own meals.

# 6. Access to medical care

Some asylum seekers deal with physical problems[1100] and/or psychological problems[1101]. It is important that asylum seekers with physical or psychological problems have access to good medical care. This can prevent further complications and enhance asylum seekers (social) functioning.[1102] However, factors such as a lack of knowledge about the health care system and (mental) health care may prevent effective access to medical care.

This chapter first describes the international legal framework (section 6.1). Moreover, it explains how health care for asylum seekers has been organised in the Netherlands. It will set out the organisations involved and the principles underlying this system (section 6.2.). Subsequently, the manner in which asylum seekers are informed about the Dutch health care system and about mental health care specifically will be discussed (section 6.3). Section 6.4 addresses the measures taken in reception centres to prevent psychological problems of asylum seekers. The health care offered to asylum seekers, including medical care at the reception centres, youth health care and support and specialist mental health care will be discussed in section 6.5. Finally section 6.6 will address the accessibility of medical care in practice.

## 6.1 International legal framework

*The right to health care*

The RRCD provides that the Member States should 'ensure that applicants receive the necessary health care which shall include, at least, emergency care and essential treatment of illnesses and of serious mental disorders'. Furthermore, they shall provide necessary medical or other assistance to asylum seekers who have special reception needs, including appropriate mental health care where needed.[1103]

According to Article 12 of the International Covenant on Economic, Social and Cultural Rights everyone has the right to the enjoyment of the highest attainable standard of physical and mental health. In this light States need to create conditions which would assure access to all medical service and medical attention in the event of sickness. Article 24 of the Convention on the Right of the Child and Article 25 of the Convention on the Rights of Persons with Disabilities, contain a similar provision specifically for children and persons with a disability respectively.

*Medical care for victims of torture and other forms of violence*

The RRCD provides that persons who have been subjected to torture, rape or other serious acts of violence 'should receive the necessary treatment for the damage caused by such acts, in particular

[1100] Pharos, *Kennissynthese gezondheid van nieuwkomende vluchtelingen en indicaties voor zorg, preventie en ondersteuning*, January 2016, p. 5 mentions that attention should be paid to diabetes, overweight, lack of exercise and chronic pain.
[1101] *Gezondheidsraad*, *Briefadvies Geestelijke gezondheid van vluchtelingen*, February 2016, p. 2, mentions that refugees suffer more often from PTSD and depression than the Dutch population.
[1102] Ibid., p. 4 and Pharos, *Kennissynthese*, p. 5.
[1103] Art. 19 RRCD.

access to appropriate medical and psychological treatment or care'.[1104] Furthermore, children 'who have been victims of any form of abuse, neglect, exploitation, torture or cruel, inhuman and degrading treatment, or who have suffered from armed conflicts' should have access to rehabilitation services, appropriate mental health care and qualified counselling.[1105]

The obligation to provide the necessary treatment to victims of torture also follows from Article 14 of the UN Convention against Torture. It states that the victim of an act of torture should obtain 'the means for as full a rehabilitation as possible'. According to the Committee against Torture, this obligation also applies to asylum seekers and refugees.[1106] Means for rehabilitation include medical and psychological care.[1107] States should 'adopt a long-term and integrated approach and ensure that specialised services for the victim of torture or ill-treatment are available, appropriate and promptly accessible'.[1108] This should include a procedure for the assessment and evaluation of an individual's therapeutic and other needs.[1109] 'Rehabilitation for victims should aim to restore, as far as possible, their independence, physical, mental, social and vocational ability; and full inclusion and participation in society.'[1110]

## 6.2 Health care for asylum seekers in the Netherlands

The *Regulation care asylum seekers* (*Regeling Zorg Asielzoekers*, RZA) provides an overview of all the services and kinds of treatment that are available to asylum seekers.[1111] The obligation of the RRCD to provide medical care to (minor) victims of torture and other forms of serious violence has been transposed in the Regulation Asylum Seekers and Other Categories of Aliens (*Regeling verstrekkingen asielzoekers,* Rva).[1112]

### 6.2.1 Organisations involved

COA is responsible for the health care for asylum seekers. COA hires other organisations which organise and provide health care for COA.[1113] These organisations will be briefly introduced in this section.

*Menzis COA Administration (*Menzis COA Administratie , *MCA)*
COA has contracted insurance company Menzis to organise medical care of asylum seekers, which task is executed by MCA. Asylum seekers can only receive services and treatment from care providers

[1104] Art. 25 RRCD.
[1105] Art. 23(4) RRCD.
[1106] Committee against Torture, *General Comment nr. 3, Implementation of article 14 by States parties*, 19 November 2012, para. 14.
[1107] Ibid., para. 11.
[1108] Ibid, para. 13.
[1109] Ibid, para. 13.
[1110] Ibid, para. 11.
[1111] Regeling Zorg Asielzoekers 2017.
[1112] Art 18c(a) and (b) Rva.
[1113] Interview COA 2.

which have a contract with MCA.[1114] MCA pays the medical costs directly to the care provider.[1115] All asylum seekers get a card with which they can prove that they have a right to free medical care.

*Health Centre Asylum Seekers (Gezondheidscentrum Asielzoekers,* GCA*)*
Every asylum seeker is registered in a Health centre for asylum seekers (GCA), which is located in the reception centre and is assigned a general practitioner (GP). Apart from GP's, also GP assistants, nurses and mental health care consultants work for GCA at the reception centres (see further section 6.5.1). GCA offers primary health care to asylum seekers. Asylum seekers who have a medical problem can call a central phone number (*Praktijklijn*), which operates 24 hours a day, seven days a week. They may also go to GCA during consultation hours. The GP can refer an asylum seeker to a medical or mental health care specialist.[1116]

During the high influx crisis reception locations were used, in which the health care which is normally provided by GCA, was not available. For these asylum seekers medical care was arranged for and facilitated by the municipalities.[1117] Local GP's, dentists and pharmacies provided the necessary medical care[1118], which was paid by COA.[1119]

*GGD-GHOR*
The GGD-GHOR[1120] is an umbrella for municipal health services and regional medical assistance organisations. It screens asylum seekers on tuberculosis and other diseases and is responsible for preventive health care. Furthermore, it provides care to children, which includes an intake by a youth nurse and a youth practitioner and a regular check. Furthermore, it takes care of the vaccination programme.[1121]

*The Health Care Inspectorate* (*Inspectie voor de Gezondheidszorg*)
The Health Care Inspectorate supervises the health care system in the Netherlands, including the medical care for asylum seekers.[1122] It assesses the accessibility and quality of the curative and preventive health care to asylum seekers. It also examines whether COA meets its internal standards.[1123] In 2015 and 2016 the Health Care Inspectorate intensified its supervision on the medical care to asylum seekers because of the risks for the availability, accessibility and quality of medical care

[1114] Regeling Zorg Asielzoekers 2017, p. 7.
[1115] Ibid., p. 11.
[1116] Ibid., pp. 5-7.
[1117] *GHOR*, Veiligheidsregio Noord- en Oost-Gelderland, GGD Noord- en Oost-Gelderland, *Draaiboek Gezondheidskundige aandachtspunten crisisnoodopvang regio Noord- en Oost-Gelderland*, December 2015. Interview COA 2.
[1118] See Format Zorgplan crisisopvang asielzoekers, Draaiboek Gezondheidskundige aandachtspunten crisisnoodopvang.
[1119] COA, *Bericht Medische kosten gemeentelijke crisisopvang in de veiligheidsregio's*, October 2015.
[1120] GGD stands for *Gemeentelijke of Gemeenschappelijke Gezondheidsdienst,* GHOR for *Geneeskundige Hulpverleningsorganisatie in de Regio*.
[1121] Draaiboek Gezondheidskundige aandachtspunten crisisnoodopvang, p. 21.
[1122] www.igz.nl/english/.
[1123] Flegar, V., *Quickscan Zorg voor asielzoekerskinderen in Nederland*, Werkgroep Kind in azc, June 2016, p. 16.

to asylum seekers, caused by the high influx and the resulting rapid expansion of the number of places in reception centres.[1124]

### 6.2.2 End of contract Menzis/GCA in 2018

The contract with Menzis and GCA will end on 1 January 2018. After a public procurement procedure COA has awarded a contract to a new party, Arts en Zorg[1125], which will carry out the tasks currently done by GCA for a (much) lower price than the price offered by GCA and MCA.[1126] In the assessment of the tenders, quality counted for 70 per cent, the price for 30 per cent.[1127]

The change from GCA to Arts en Zorg means that all tasks have to be transferred. [1128] In September 2017 the expectation was that GCA will end to exist and that all GCA personnel will lose their jobs. At that moment Menzis COA and Arts and Zorg could not agree on a transfer of personnel from GCA to Arts en Zorg.[1129] It thus seems inevitable that (part of the) experience gained by GCA will be lost.[1130] Furthermore, it may be expected that ongoing projects will be put on hold, if the implementation cannot be finalised before 1 January 2018. Furthermore, the question is whether Arts en Zorg will be able to provide the same quality health care as GCA for a much lower price.

COA stated that the change of care provider will not lead to a change of the system or the requirements that need to be met. COA has asked parties involved in the health care system for asylum seekers, such as the national association of general practitioners, the Health Care Inspectorate and health care insurances whether the system should be changed before the tender. They indicated that the system works well, also in times of high influx.[1131]

### 6.2.3 Resemblance to the regular health care system

The starting point of the Dutch health care system for asylum seekers is that it resembles as much as possible the 'regular' health care system in the Netherlands.[1132] The services and treatment offered to asylum seekers are therefore to a large extent comparable to the services and treatment that are

[1124] Inspectie voor de Gezondheidszorg, *Medische zorg aan asielzoekers onder druk maar ketenpartners beperken gezamenlijk grootste risico's*, March 2016, p. 5.
[1125] www.artsenzorg.nl/zakelijk/coa. Since January 2018 Arts en Zorg has provuided health care in the regular health care system.
[1126] Interview GCA 1. According to COA the price of the Arts and Zorg tender was not much lower than the price for which MCA and GCA currently carry out their tasks. Additional information provided by COA in September 2017.
[1127] Additional information provided by COA in September 2017.
[1128] Interview GCA 2.
[1129] http://www.gcasielzoekers.nl/over-gc-a/overdracht-zorg-naar-arts-en-zorg/ [accessed 26 September 2017].
[1130] See also the statement of the spokesperson of the employee council of GCA in Algemeen Dagblad, Onrust rond medische zorg voor asielzoekers, 30 August 2017.
[1131] Interview COA 2.
[1132] Interview COA 2. Nationale Ombudsman, *Medische zorg vreemdelingen, Over toegang en continuïteit van medische zorg voor asielzoekers en uitgeprocedeerde asielzoekers*, 3 October 2013, nr. 2013/125, p. 11.

available to Dutch citizens and persons with a residence permit.[1133] This includes amongst others the types of medical treatment and medicine for which the asylum seeker is insured.[1134]

At the same time there are several differences between the two systems. These differences partly relate to the special situation of asylum seekers, who are not familiar with the health care system in the Netherlands, who are not free to choose their place of living and who do not speak the language.[1135]

- health care is provided to asylum seekers on the spot (at the reception centres or close by) and there is a phone number which they can call day and night for their medical questions;
- asylum seekers do not have to contribute to the costs of medical treatment.[1136]
- asylum seekers are insured for some extra treatments and some treatments are excluded.[1137]

Examples of extra treatment or facilities for which asylum seekers are insured are urgent dental care for adults[1138] (children receive full dental care), physiotherapy (only for a limited number of medical problems)[1139], glasses, walking aid, and hearing aid.[1140] Nevertheless asylum seekers may not be able to get the treatment they need or desire because of insurance coverage limitations.[1141] Examples mentioned by asylum seekers[1142] and stakeholders include dental care, physiotherapy and psychological and psychiatric care.[1143] It should be noted however, that part of these problems may be solved as a result of the extension of the medical insurance of urgent dental care and psychiatric treatment in 2017.[1144] In contrast to Dutch citizens, asylum seekers are not insured for IVF treatment and sex change procedures.[1145]

If asylum seekers do not receive medical treatment as a result of limitations in the insurance coverage this is problematic, particularly if the asylum procedure takes a very long time. It may influence for example the asylum seeker's participation in activities at the reception centre, the effectiveness of

[1133] COA, GGD GHOR, MCA, Gezondheidscentrum Asielzoekers, *Factsheet Gezondheidszorg voor Asielzoekers in Nederland*, June 2015.
[1134] The Netherlands Parliamentary documents TK 2010/11, Aanhangsel Handelingen, nr. 2751, p. 3.
[1135] The Netherlands Parliamentary documents TK 2010/11, 19 637, nr. 1414, p. 19. Interview COA 2.
[1136] Regeling Zorg Asielzoekers 2017, p. 9.
[1137] Interview COA 2.
[1138] Regeling Zorg Asielzoekers 2017, p. 40. Urgent dental care is defined as the cure of imminent serious pain and or significant loss of the chewing function. See Regeling Zorg Asielzoekers, Bijlage 5. Until 2017 with ermergency dental care was insured until a maximum of 250 euros. Now this maximum does not apply anymore, but permission has to be asked from MCA if the costs of the dental care exceed 250 euros. See Regeling Zorg Asielzoekers 2016, p. 40.
[1139] See Besluit Zorg Asielzoekers, Bijlage 1.
[1140] Interview COA 2 and Nationale Ombudsman, Medische zorg vreemdelingen, p. 11.
[1141] Interview iMMO, Centrum '45. For Dutch citizens the basic insurance also does not cover these types of treatment.
[1142] Conversations with UNHCR staff, UNHCR the Netherlands, August/September 2016.
[1143] Interview Centrum '45, which mediates with the insurance and care providers because physical problems may stand in the way of effective psychological treatment. Interview Lawyer 2.
[1144] In 2017 insurance for dental care has been extended to costs exceeding 250 euros, insurance for treatment in a psychiatric hospital has been extended from a maximum of 365 days to a maximum of 1095 days. Regeling Zorg Asielzoekers, pp. 22 and 40, compare with Regeling Zorg Asielzoekers 2016, pp. 22 and 40.
[1145] Raad voor Volksgezondheid en Samenleving, *Grensconflicten Toegang tot sociale voorzieningen voor vluchtelingen*, October 2016, p. 21.

psychological treatment[1146] and his ability to make complete, coherent and consistent statements during the asylum procedure.

There are several reasons for the similarity between the health care system for asylum seekers and the normal health care system. The level of health care provided to asylum seekers is a political issue. Dutch society would probably not accept a system in which asylum seekers receive more medical services for free than Dutch citizens.[1147] The Dutch government spends an average of 23,000 euros per asylum seeker per year. Around 25 per cent of this amount consists of health care expenses.[1148]

| | Housing | Health Care | Counselling | Living expenses |
|---|---|---|---|---|
| Admission | 30% | 27% | 19% | 24% |
| Reception | 20% | 25% | 40% | 15% |
| Return | 38% | 24% | 24% | 14% |
| Unaccompanied children | 16% | 11% | 66% | 7% |

Source: The Netherlands Parliamentary documents, TK 2016/17, 34 550 VI, nr. 11, p. 130.

Furthermore, asylum seekers need to get used to the Dutch health care system, which is often different from the system in their country of origin. This prepares them for the situation that they receive an asylum status and need to arrange their own insurance and health care. Moreover, the idea is that asylum seekers are people that can take care of themselves and therefore should take responsibility for their own health.[1149]

### 6.2.4 Responsibility of the asylum seeker

There is a tension between on the one hand the sometimes vulnerable position of asylum seekers and the point of departure of the health care system that asylum seekers are responsible for their own health on the other hand. COA and GCA stress that it is the asylum seeker's own responsibility to seek help.[1150] A medical care system which would take away this responsibility from the asylum seeker, would spoil the asylum seeker and would reinforce a passive attitude and wrong expectations.[1151] This means for example that GCA does not actively contact asylum seekers who may have physical or psychological problems.[1152]

[1146] Interview Centrum '45.
[1147] Interview COA 2. See also Raad voor Volksgezondheid en Samenleving, p. 22, The Netherlands Parliamentary documents TK 2013/14, 19 637, nr. 1761, p. 2.
[1148] The Netherlands Parliamentary documents TK 2016/17, 34 550 VI, nr. 11, p. 130. This is an average of all asylum seekers, irrespective of the phase of the asylum procedure and whether it concerns an unaccompanied child or not.
[1149] The Netherlands Parliamentary documents TK 2015/16, 19637, nr. 2177, p. 3. Nationale Ombudsman, Medische zorg vreemdelingen, p. 23.
[1150] Interview COA 2. See also Haker, F. Van Bommel, H, Bloemen, E., *Zorg voor Asielzoekers met Psychische Problemen, Het perspectief van de zorgverlener,* Pharos/Zapp 2010, p. 19.
[1151] Ibid., pp. 45-46.
[1152] Ibid., pp. 19-20.

One lawyer mentioned for example that she sends a letter to GCA if she is very concerned about a client. However, she needs to urge the asylum seeker to go to GCA's consultation hours, because GCA will not invite the asylum seeker.[1153] On the other hand, COA stated that if it knows that a person has medical problems and fails to show up at appointments with GCA, COA visits them to ask what is going on.[1154] Also GCA notes that its policy is to to reach out to asylum seekers if alerted about them.[1155]

Several organisations, lawyers and care providers have been critical of the emphasis on the asylum seeker's own responsibility. They note that some asylum seekers are not so self-reliant as a result of psychological or psychiatric problems. [1156] A supporting and outreaching approach to vulnerable asylum seekers from GCA and GGD would limit the risks for the health care of such asylum seekers.[1157] This may be extra important now that GCA does not do an intake anymore after arrival at the reception centre. The urgency medical screening which takes place directly after arrival is not a suitable tool to detect psychological problems (see further section 2.4.3).

Some care providers think that the emphasis on the asylum seeker's responsibility may reinforce a passive attitude in asylum seekers and does not stimulate them to seek help.[1158] Finally the Dutch Council for Refugees (DCR) points at a 'remarkable contradiction whereby the asylum system to a large extend takes the personal control from asylum seekers and at the same time expects them to show self-reliance where it concerns their right to good health care'.[1159]

### 6.3 Informing asylum seekers about health care

The Dutch health care system is rather complex which makes it difficult for asylum seekers to know where to ask for help and which rules are applicable.[1160] Asylum seekers can only be self-reliant if they understand the health care system.[1161] Furthermore, a lack of knowledge about the Dutch health care system may lead to wrong expectations about medical care. Therefore it is important that asylum seekers are informed about this system. Moreover many asylum seekers are not familiar with mental health care or do not ask for psychological help because they are afraid to be stigmatised. Information about mental health care is therefore important to ensure the accessibility of such care. This section will address the provision of information with regard to the Dutch health care system and mental health care to asylum seekers.

[1153] Interview Lawyer 2.
[1154] Interview COA 2.
[1155] Additional information provided by GCA in July 2017.
[1156] See also IRCT, *Position paper on the Proposal for an Asylum Procedures Regulation (July 2016)*, 6 September 2016, p. 2, Nationale Ombudsman, *Medische zorg vreemdelingen*, p. 23. See also interview Lawyer 2.
[1157] Inspectie voor de Gezondheidszorg, *Goede vooruitgang in toegankelijkheid huisartsenzorg*, p. 76.
[1158] Haker, F. Van Bommel, H, Bloemen, E., pp. 45-46.
[1159] Dutch Council for Refugees, Letter to the Dutch Parliament concerning medical care to asylum seekers, 27 March 2014.
[1160] Van Schayk, M.and Vloeberghs, E., *Podium voor preventie*, Pharos, December 2011, p. 15.
[1161] Interview Centrum '45.

### 6.3.1 Information about the Dutch health care system

Medical care in the Netherlands is organised differently than in the asylum seekers' countries of origin[1162], for example where it concerns access to medical specialists or the prescription of antibiotics[1163]. Asylum seekers are also not familiar with the role of the GP as the gate keeper of the health care system.[1164]

COA is responsible for informing asylum seekers about their right to medical care and the organisation of medical care in the Netherlands (guidance task health care). This is done orally as well as in writing.[1165] Some information meetings organised by COA on health care issues are obligatory, but others are not.[1166] When they arrive in an asylum reception centre, asylum seekers have to go to an information meeting in which they are informed about practical issues. This includes information on what to do in a medical emergency and how to make a doctor's appointment. This meeting also addresses the organisation of the Dutch health care system.

In reception centres there are medical information points where asylum seekers can find written information in different languages about health care and contact details of locally contracted care providers.[1167] For children staying in reception centres there is a special website (in Dutch) with information about different themes, including health care.[1168] COA officers also assist asylum seekers to fill in forms, contact care providers or to find their way to a hospital.[1169] There are special COA officers who focus on pregnant asylum seekers and organise information meetings for this group.[1170]

GCA noted that asylum seekers are not familiar with or cannot apply the information provided by COA.[1171] The nurses and doctors of GCA still spend a lot of time explaining the Dutch health care system.[1172] Besides COA and GCA there are several other organisations which provide information on health care to asylum seekers. On COA's request, the Parent and Child teams of the GGD-GHOR give information about the Dutch health care system to parents.[1173] Furthermore, the GGD-GHOR

[1162] Inspectie voor de Gezondheidszorg, *Medische zorg aan asielzoekers onder druk*, pp 16-17. Van Berkum, M., et al, *Zorg, ondersteuning en preventie voor nieuwkomende vluchtelingen, wat is er nodig?*, Pharos, March 2016, p. 20, See also pp 21 and 34. See also Haker, F. Van Bommel, H, Bloemen, E., p. 18, Onderzoeksraad voor Veiligheid, *Veiligheid van vreemdelingen*, 2014, p. 49.
[1163] In the Netherlands doctors are very reluctant to prescribe antibiotics.
[1164] Van Willigen, L., *Zorg voor Asielzoekers met Psychische Problemen*, ASKV, December 2009, p. 70, See also College Rechten van de Mens, *Aanbevelingen Mensenrechten in de noodopvang Heumensoord*, February 2016, p. 8.
[1165] Factsheet Gezondheidszorg voor Asielzoekers in Nederland, Menzis COA Administratie, Convenant GGZ voor asielzoekers, October 2015, p. 8.
[1166] Interview COA 2.
[1167] Interviews COA 1 and COA 2. See also Inspectie voor de Gezondheidszorg, *Goede vooruitgang in toegankelijkheid huisartsenzorg*, pp. 81-82, 92.
[1168] http://www.tell-me.nl/onderwerpen/gezondheid.
[1169] Interview COA 2.
[1170] Interviews COA 1 and COA 2.
[1171] Additional information provided by GCA in July 2017.
[1172] Interview GCA 1.
[1173] A Drogendijk, A. et al., *Veerkracht en Vertrouwen, De bouwstenen voor psychosociale hulpverlening aan vluchtelingen*, Arq Psychotrauma Expertgroep, May 2016, p. 17.

organises meetings on health risks.[1174] The topics which are addressed in these meetings depend on the local needs (this may include sexually transmitted diseases, dental care, alcohol abuse etc). Information meetings may be aimed at a specific group of asylum seekers, such as women, parents or children).[1175]

Despite these efforts the provision of information about the health care system to asylum seekers remains problematic.[1176] The Health Care Inspectorate found in 2016 that COA complied with the requirements because it generally[1177] informed asylum seekers concisely about the manner in which they could get access to general health care and emergency care. However, it also noticed during its conversations with asylum seekers that they had insufficient knowledge of the health care available to them.[1178]

Different reasons are mentioned why the information provided does not lead to sufficient knowledge about the health care system. Asylum seekers have problems to digest all information about the Dutch system at once during their stay in the reception centre because they have too many other things on their mind.[1179] Furthermore, the (low) level of education of some asylum seekers may be problematic. In this context a Pharos report of 2016 mentions the need to adapt information to some Eritrean youth.[1180] Another report states that more and specific attention for children' health care is desirable.[1181] The EASO guidance on reception state that information should be provided in an adapted manner to for example children, illiterate persons and persons with visual impairments or intellectual disabilities. Furthermore, it considers it good practice to use interpreters or cultural mediators and to verify that the asylum seeker has understood the information provided.[1182]
If asylum seekers do not understand the health care system, they cannot take responsibility for their medical care, as is expected of them. They may not know where to seek medical help. Some stakeholders noted that even COA officers and care providers do not always understand the health care system for asylum seekers.[1183] One mental health care provider states that she sometimes

[1174] Interview COA 2. Menzis COA Administratie, Convenant GGZ, pp. 8-9. GGD GHOR Nederland, Publieke gezondheidszorg borgen, Een eerste inzicht in de staat van de GGD'en, March 2016, p. 49. The last report mentions that the GGD has around 10 full time jobs available per 3500 asylum seekers. The GGD receives around 300 euros per asylum asylum seeker.
[1175] Flegar, V., *Quickscan Zorg voor asielzoekerskinderen in Nederland*, pp. 20-21.
[1176] Van Berkum, M., et al, pp. 19-20, Kramer. S. et al., *Ethische dilemma's in de GGZ voor asielzoekers*, Johannes Wier Stichting 2015, p. 46, Nationale Ombudsman, *Medische zorg vreemdelingen*, p. 19. Haker, F. Van Bommel, H, Bloemen, E., pp. 29, 50. Interviews Centrum '45 and DCR 4.
[1177] COA complied in 7 out of 10 inspected reception centres. In one reception centre the Health Care Inspectorate found that COA employees were insufficiently aware of their task to inform asylum seekers about the Dutch medical care system. See Inspectie voor de Gezondheidszorg, *Medische zorg aan asielzoekers onder druk*, p. 23. In an earlier report the Health Care Inspectorate concluded that COA in practice did not always comply with the requirements. Inspectie voor de Gezondheidszorg, *Naleving normen nieuwe zorgmodel voor asielzoekers verder verbeterd en grotendeels op orde*, May 2012, p. 17.
[1178] Inspectie voor de Gezondheidszorg, *Medische zorg aan asielzoekers onder druk,* pp 16, 20 and 23. See also Haker, F. Van Bommel, H, Bloemen, E., p. 18, interview DCR 4. Also GCA mentioned that the information provided to asylum seekers is a vulnerable issue. Interview GCA 2.
[1179] Van Berkum, M., et al, p. 19. Interviews GCA 1 and DCR 4.
[1180] Van Berkum, M., et al, p. 20, See also Pharos, *Factsheet Eritrese Vluchtelingen*, June 2016, p. 3.
[1181] Flegar, V., *Quickscan Zorg voor asielzoekerskinderen in Nederland*, p. 24.
[1182] EASO, *EASO guidance on reception conditions: operational standards and indicators*, September 2016, p. 36.
[1183] Interview Centrum '45, Pharos.

arranges necessary medical care for her clients because COA and GCA do not know how to do it.[1184] Furthermore, the asylum seeker may not know that, in the Dutch system, it is expected that patients explain clearly to a doctor why they are seeking help.[1185]

A lack of knowledge about the Dutch health care system may also lead to wrong expectations and result in dissatisfaction about the health care offered.[1186] Some asylum seekers have the unrealistic expectation that in the Netherlands they can fully recover from all their medical problems which have been left untreated in the country of origin.[1187] Asylum seekers often complain that GCA usually gives them a valium or paracetamol or tells them to take some rest.[1188] In the Dutch system it is normal in case of common and viral diseases to wait a few days to give the body the chance to overcome this disease by itself.[1189] However, asylum seekers may experience the frequent prescription of paracetamol as a sign of a lack of interest and denial of health problems by the health care system.[1190] They may even think that they receive less quality health care than Dutch citizens and that they are thus discriminated upon.[1191] This may negatively influence their judgment about and use of medical care.[1192] Some asylum seekers miss personal contact and experience distance in the Dutch health care system.[1193] Furthermore, some asylum seekers lose trust in the health care system as a result of rumours about medical mistakes.[1194]

Several organisations have recently recommended that COA improves the information to asylum seekers.[1195] The Dutch Red Cross developed the idea of medical buddies: medically trained volunteers who could assist asylum seekers with practical things, explain the insurance system and talk about cultural differences in medical care. However, meetings with COA and GCA did not lead to implementation of the project.[1196]

It should be noted that it is not certain that better information will take away all the asylum seeker's frustrations about Dutch health care. One COA officer mentions that some asylum seeker do

[1184] Interview Centrum '45.
[1185] Interview Pharos.
[1186] College Rechten van de Mens, *Aanbevelingen Mensenrechten in de noodopvang Heumensoord*, p. 9. Inspectie voor de Gezondheidszorg, *Medische zorg aan asielzoekers onder druk,* pp 16, 23. Flegar, V., *Quickscan Zorg voor asielzoekerskinderen in Nederland*, p. 24, Haker, F. Van Bommel, H, Bloemen, E., p. 18. See also The Netherlands Parliamentary documents TK 2013/14, 19 637, nr. 1761, p. 6, Onderzoeksraad voor Veiligheid, *Veiligheid van vreemdelingen*, p. 49, Interview Lawyer 5.
[1187] Nationale Ombudsman, *Medische zorg vreemdelingen*, p. 19.
[1188] Conversations with UNHCR staff, UNHCR the Netherlands, August/September 2016. See also Nationale Ombudsman, Medische zorg vreemdelingen, p. 19.
[1189] Nationale Ombudsman, *Medische zorg vreemdelingen*, p. 19.
[1190] Dutch Council for Refugees, Letter concerning medical care to asylum seekers.
[1191] Interview COA 2.
[1192] Van Willigen, L., p. 33.
[1193] Kramer, S. et al., p. 43, Van Schayk, M and Vloeberghs, E., p. 15.
[1194] Conversations with UNHCR staff, UNHCR the Netherlands, August/September 2016. Van Willigen, L., p. 33.
[1195] College Rechten van de Mens, *Aanbevelingen Mensenrechten in de noodopvang Heumensoord*, p. 9, Inspectie voor de Gezondheidszorg, *Medische zorg aan asielzoekers onder druk*, p. 20, Nationale Ombudsman, Medische zorg vreemdelingen, p. 27.
[1196] Interview Red Cross. The Red Cross was setting up such a medical buddy project in the municipalities for persons with an asylum status.

understand, but do not agree with the Dutch health care system.[1197] She states that some asylum seekers ask their family members for antibiotics or order them on the internet, like many expats in the Netherlands do.[1198] Furthermore, frustration can of course be caused by an actual lack of access to medical care. This will be discussed in section 6.6.

### 6.3.2 Information about mental health care

Many asylum seekers are not familiar with psychological problems and mental health care[1199], which may be a barrier to medical care.[1200] Asylum seekers may have difficulties finding words for their complaints.[1201] Furthermore, often there is a stigma associated with psychosocial problems and help seeking which prevents asylum seekers to ask for psychological help.[1202] A care provider of Centrum '45 noted that most asylum seekers with psychological problems do not want to participate in group therapy because they are ashamed.[1203] Finally some asylum seekers think that a residence permit may be refused, that a future employer may not accept them or that they may lose their children, because of their psychological problems.[1204]

The Health Council of the Netherlands (*Gezondheidsraad*) noted in 2016 that refugees do not always find their way to mental health care.[1205] Persons who have been granted an asylum status (hereafter: status holders) and who have been staying in the Netherlands for a longer time have less problems accessing mental health care, because they are more familiar with the health care system.[1206] Pharos states that the number of asylum seekers who access mental health care is low compared to the mental health problems they have. They have data from 2013 which indicate that 0,6 per cent of the Syrians, 1,3 per cent of the Eritreans, 5,9 per cent of the Iraqis and 9,6 per cent of the other asylum seekers made use of mental health care.[1207] This is much lower than the estimated percentage of asylum seekers with PTSD and/or depression which lies between 13 and 25 percent.[1208] One of the reasons for that could be that asylum seekers were not familiar with mental health care.[1209] Asylum seekers miss comprehensible information on mental health care.[1210]

In 2015 MCA and mental health care providers concluded a Covenant on mental health care for asylum seekers. The Covenant states that many care providers spend a lot of time explaining asylum seekers

[1197] This was also mentioned by GCA.
[1198] Interview COA 2. See also Flegar, V., *Quickscan Zorg voor asielzoekerskinderen in Nederland*, p. 24.
[1199] Haker, F. Van Bommel, H, Bloemen, E., p. 18, Kramer, S. et al., p. 45, Interview Lawyer 2.
[1200] Ikram, U. and Stronks, K., *Preserving and Improving the Mental Health of Refugees and Asylum Seekers, A Literature Review for the Health Council of the Netherlands*, February 2016, p. 22. Interviews iMMO, Lawyers 3 and 4 and Pharos.
[1201] Interview Lawyer 2.
[1202] Ikram, U. and Stronks, K., p. 22, Drogendijk, A. et al., pp. 26, 32, Pharos, *Kennissynthese*, p. 41. Van Schayk, M and Vloeberghs, E., p. 15, L. Van Willigen, *Zorg voor Asielzoekers met Psychische Problemen*, Literatuurstudie, ASKV 2010, p. 79, Interview Lawyer 2.
[1203] Interview Centrum '45.
[1204] Kramer, S. et al., p. 43, Interview NIFP 1.
[1205] Gezondheidsraad, *Briefadvies, p. 3.*
[1206] Pharos, *Kennissynthese*, p. 41.
[1207] Pharos, *Kennissynthese*, p. 41. See also Van Schayk, M and Vloeberghs, E., p. 15, Van Willigen, L., p. 79.
[1208] Gezondheidsraad, *Briefadvies*.
[1209] Pharos, *Kennissynthese*, p. 41. See also Van Schayk, M and Vloeberghs, E., p. 15, Van Willigen, L., p. 79.
[1210] Van Berkum, M., et al.

what they can expect from psychological treatment.[1211] However, some asylum seekers still think that the information provided is insufficient.[1212] In the Covenant the parties agreed that asylum seekers who are referred to a mental health care provider will be provided information on the nature of the care they will receive, the position of the care provider in relation to the IND, COA and themselves, the services the care provider can and cannot offer, the asylum seekers' rights and obligations and communication with the help of an interpreter.[1213] The Covenant mentions that for that purpose information material and a method will be developed.[1214]

Pharos and ASKV have published a leaflet which explains where asylum seekers can get help for their mental problems.[1215] The leaflet addresses the different types of treatment that may be offered by different care providers. These organisations have also published leaflets on long term stress-related symptoms and what you can do about them and on concentration problems, nightmares, anxiety and depression.[1216] For example asylum seekers who suffer from stress are advised to seek distraction, to do sports, a hobby or small jobs in or around the reception centre. Finally a short film was made in order to inform asylum seekers about psychological problems and seeking psychological help. The Pharos/ASKV leaflets are available through an internal information platform of GCA. GCA personnel can print the leaflets and offer them to asylum seekers to whom this information is relevant.[1217]

### 6.4 Preventive measures in reception centres

Several recent reports concluded that psycho-social support and preventive measures may help to prevent psychological problems in asylum seekers. However, there is a lack of scientific research about the effectiveness of such support and measures. [1218] Social support may consist of organising of activities, teaching the Dutch language and preparation for education and work.[1219] Van Schayk and Vloeberghs concluded in 2011 on the basis of interviews with persons who organised preventive activities for asylum seekers that asylum seekers benefit from activities, psycho-education and empowerment.[1220] Asylum seekers receive tools to cope with the new situation they find themselves in, get the power to form a new identity, receive knowledge on the Dutch care system and escape isolation.[1221]

Psycho-education is considered an important preventive measure. Pharos defines psycho-education as a methodology in the care for persons with psychological problems, which refers to a number of

[1211] Kramer, S. et al., p. 45, Haker, F. Van Bommel, H, Bloemen, E., p. 18.
[1212] Kramer, S. et al., p. 45.
[1213] Menzis COA Administratie, Convenant GGZ, p. 9.
[1214] The material was not ready yet in April 2017. Interview GCA 2.
[1215] Pharos and ASKV, Where can you get help for your mental problems?, http://www.pharos.nl/documents/doc/webshop/brochure_1_waar-kunt-u-hulp-vinden_engels.pdf
[1216] Pharos and ASKV, Long-term stress-related symptoms and what you can do about them, http://www.pharos.nl/documents/doc/webshop/brochure_2_langdurige-stressklachten_engels.pdf and Are you suffering from concentration problems, nightmares, anxiety or depression?, http://www.pharos.nl/documents/doc/webshop/brochure_3_als-u-last-heeft-van_engels.pdf.
[1217] Interview GCA 2.
[1218] Gezondheidsraad, *Briefadvies*, Van Schayk, M and Vloeberghs, E., pp. 79, 86-87, Drogendijk, A. et al., p. 36.
[1219] Van Berkum, M., et al, p. 49, *Gezondheidsraad, Briefadvies*, Haker, F. Van Bommel, H, Bloemen, E., p. 50.
[1220] Van Schayk, M and Vloeberghs, E., p. 77. See also Drogendijk, A. et al., p. 22.
[1221] Van Schayk, M and Vloeberghs, E., p. 78.

educational interventions which teach people to cope with their limitation. It can be offered individually or in a group. Psycho-education creates mutual confidence and understanding and motivates people to comply with agreements.[1222] Explanation about normal stress and possibilities for psychological help, can also help to make care more accessible and to break taboos.[1223]

In regular reception centres for asylum seekers, who are referred to the extended asylum procedure or who have been granted an asylum status (AZCs) many different programmes are offered to adults and specifically to children. These programmes are organised by COA and (in cooperation with) different (private) providers with regard to supply of information, day activities and reinforcing resilience.[1224] Arq Psychotrauma Expert Group concluded in a report of 2016 that there is a lack of overview, quality control and central points of departure or guidelines as well as best practices.[1225] According to Arq there is an urgent need for some central principles, guidelines, a code of good practice with regard to how to deal with psychological problems and care, which support the initiatives. Guidelines with do's and don't's and a roadmap towards care for the care providers and the volunteers and institutions working with asylum seekers.[1226]

MCA finances psycho-education for asylum seekers, which is facilitated by COA. Psycho-education is offered by the Public Health Service (GGD), Mental Health Care (GGZ) consultant or the mental health care providers.[1227] The support provided depends on what the local GP and/or mental health consultant finds necessary.[1228] Preventive activities organised by GGD aim to strengthen the abilities of vulnerable groups, enhance social cohesion in the reception centre, reduce nuisance and reinforce the manageability in the centre.[1229] Furthermore, MCA supports two preventive programmes: Mindspring and programmes of mental health care organisation GGNet[1230].

Mindspring is available to all reception centres in the Netherlands, but is not offered in all reception centres.[1231] Mindspring provides psycho-education to groups of asylum seekers. The trainers are asylum seekers and refugees who have received a special training for this purpose.[1232] Asylum seekers are informed about 'stress, depression, apathy, trauma, mourning, feelings of guilt, displacement, acculturation, loss of assets in the country of origin and daily bothers at the reception centre'.[1233] The programmes of GGNet are offered in a few specific regions.[1234] They aim to prevent the development or escalation of psychological problems and enhance resilience.[1235]

[1222] Van Schayk, M and Vloeberghs, E., p. 17.
[1223] Van Berkum, M., et al, p. 49.
[1224] Drogendijk, A. et al., pp. 4, 19.
[1225] Ibid, p. 19.
[1226] Ibid, p. 19.
[1227] Menzis COA Administratie, Convenant GGZ, p. 9.
[1228] Interview COA 2.
[1229] GGD Nederland and Menzis COA Administratie, Protocol OGGZ. See also Van Schayk, M and Vloeberghs, E., p. 17.
[1230] See www.ggnet.nl.
[1231] Interview COA 2.
[1232] Van Schayk and Vloeberghs concluded that programmes in which asylum seekers or status holders lead the activities are effective. Van Schayk, M and Vloeberghs, E., pp. 77, 84.
[1233] Drogendijk, A. et al., p. 23. see also www.mindspring.org.
[1234] Drogendijk, A. et al., p. 23.
[1235] Ibid.

Psycho-education and other specific preventive care is only financed for AZCs and not for COLs, POLs and emergency and crisis reception centres. In times of a normal influx asylum seekers stay in emergency and crisis reception centres and reside in COLs and POLs for short periods of time. However, during periods of high influx asylum seekers had to stay in emergency and crisis reception centres for a long period of time.[1236] In these reception centres preventive activities should be adapted according to the time asylum seekers spend in these centres.[1237] The Red Cross and other organisations are setting up a project called 'care café' where effective psycho-social support is offered to asylum seekers who may be relocated on short notice.[1238]

Arq Psychotrauma Expert Group also concluded in 2016 that preventive programmes are scattered. It argued for a structural preventive programme.[1239] In order to develop such programme, it is important to identify groups at risk. According to Arq unaccompanied children, asylum status holders who are placed in a municipality, adolescents and young adults, single mothers and persons who entered the Netherlands as the family members of an asylum status holder are specifically at risk of psychological problems.[1240]

## 6.5 The health care system

Asylum seekers have a right to medical examinations and treatment which are necessary and efficient. An asylum seeker must be reasonably reliant on the medical care. Furthermore, medical treatment may not be unnecessarily expensive in comparison to another, equivalent type of care.[1241] COA and GCA aim to offer accessible health care.[1242] In this section the accessibility of health care of asylum seekers is addressed. It will be explained which types of care are available to asylum seekers. Furthermore, it will be shown how the (phase of) the asylum procedure may influence the health care offered to asylum seekers in practice.

### 6.5.1 Medical care at the reception centre

GCA provides medical care to asylum seekers at the reception centres or in the direct vicinity (on walking distance).[1243] GCA has consultation hours at the reception centre, mostly several times a week

[1236] Ibid.
[1237] Van Schayk, M and Vloeberghs, E., p. 85.
[1238] Interview Red Cross.
[1239] Drogendijk, A. et al., pp. 25, 37. See also Van Schayk, M and Vloeberghs, E., p. 87, who pleaded for a permanent and comprehensive preventive programme, instead of local and temporary programmes.
[1240] Drogendijk, A. et al., pp. 25, 37.
[1241] Regeling Zorg Asielzoekers 2017, p. 12 and Menzis COA Administratie, Algemene Inkoopvoorwaarden Zorg Menzis COA Administratie B.V. (2015), versie 1.0, p. 4.
[1242] Interview COA 2.
[1243] Interview COA 2. A report of 2010 states that care provides disagree whether it is best to have GCA in or outside the reception centre. Haker, F. Van Bommel, H, Bloemen, E., pp. 27-28. Asylum seekers in need of medical treatment are not allowed to make use of special arrangements for asylum seekers who want to live outside a COA reception centre.

(this depends on the number of persons living in the centre).[1244] GCA provides care through a doctor (a general practitioner, GP) as well as a GP assistant, a nurse and a mental health consultant, who work under the responsibility of the doctor.[1245] When an asylum seeker has a medical problem, the GP assistant will do the first triage. In case of some less serious medical complaints the assistant will give advice to asylum seekers. Nurses and mental health care consultants diagnose and treat medical problems on the basis of a protocol. The GP focuses on complex medical tasks and on the supervision of the nurses and GP assistants.[1246] The GP approves the nurses' consults and discusses cases with the nurses and GP assistants.[1247] This fits into a trend in the Dutch health care system in which GP's treat more complex medical problems and nurses take over easier tasks, within their professional competences and is in conformity with the guidelines of the Netherlands GP society (*Nederlands Huisartsen Genootschap*).[1248] GP's do not examine asylum seekers with minor complaints including flue, headaches, stomach aches, neck and back pain.[1249] According to GCA many of those complaints are related to stress, insecurity, boredom and experiences in the country of origin.

GCA mentioned that it has invested over the past years in the quality of the personnel and trained them to deal with asylum seekers from different backgrounds and with different knowledge about health issues.[1250] Also during the period of high influx, when GCA had to recruit a lot of new personnel, it paid strong attention to training. Employees who did not complete their training within a year had to leave the organisation.[1251]

GCA registers all medical information about an asylum seeker in the national GP digital information system (HIS). When the asylum seeker moves to another reception centre GCA opens the system, so that the new GP can see the asylum seeker's medical file. However, GCA is not always informed in time by COA about a relocation, which make a transfer of medical information and continuity of medical treatment difficult.[1252] See further section 5.9 for the consequences of relocations for the continuity of medical care.

*Mental health care*

Asylum seekers with psychological problems first need to meet the GP assistant during consulting hours and subsequently the GP or the mental health consultant who works under responsibility of the

[1244] Interview COA 2. One laywer finds that limited opening hours are a hurdle for asylum seekers. Interview Lawyer 2. See also Dutch Council for Refugees, Letter concerning medical care to asylum seekers. Another lawyer thinks that GCA is well accessible for his clients. Interview Lawyer 5.
[1245] The Netherlands Parliamentary documents, TK 2013/14, 19 637, nr. 1761, pp. 2-3.
[1246] Interview GCA 1, *Factsheet Gezondheidszorg voor Asielzoekers in Nederland*, p. 6.
[1247] Inspectie voor de Gezondheidszorg en Inspectie voor Veiligheid en Justitie, *Nader onderzoek naar de zorgverlening aan Renata A*, January 2017, p. 23. The Inspections concluded that this did not happen in the case of Renata A by the GP of AZC Baexem in 2012.
[1248] Interview GCA 1. Additional information provided by GCA in July 2017. See also NHG/LHV-Standpunt, Het (ondersteunend) team in de huisartsenvoorziening, June 2011.
[1249] Ibid.
[1250] Ibid.
[1251] Ibid.
[1252] Nationale Ombudsman, *Medische zorg vreemdelingen*, pp. 21-22.

GP. GCA uses the Protect Questionnaire to identify psychological problems caused by trauma, when they suspect that asylum seekers have psychological problems.[1253]

Mental health consultants are social psychiatric nurses, who support the GP's and the nurses.[1254] They often have experience in specialist mental health care and have more knowledge and competences on psychological treatments than nurses that treat psychological problems in a regular GP practice.[1255] They have knowledge about the asylum procedure and the living conditions in the reception centre and support asylum seekers in this specific situation.[1256] They help people cope with common problems, such as depression, anxiety and panic disorders and PTSD. Treatment usually consists of five to ten meetings.[1257] The mental health consultant works according to the stepped care principle.[1258] This means that it is first examined whether the complaints can be addressed with a light type of treatment, before turning to a more intense type of treatment. This also limits the costs of medical treatment.[1259] In the Dutch health care system it has become normal that GP's and/or nurses (first) treat (psychological) problems.[1260] If necessary (for example in crisis situations) the asylum seeker will be referred to specialist treatment[1261] by the GP or a youth practitioner (in case of children).[1262] According to the State Secretary the mental health consultant is easily accessible for the residents of the reception centre.[1263]

The Children's Ombudsman was critical about the fact that no mental health care consultant, who particularly focused on children, was available.[1264] GCA has initiated a pilot with such youth mental health consultants. The project aims to enhance the quality of care for children and their parents, to organise quicker and more adequate help and to prevent unnecessary referrals to specialist mental health care.[1265] Arq Psychotrauma Expert Group noted in 2016 that care providers were concerned about whether unaccompanied children and children in families received the mental health care they needed.[1266]

*The GCA helpline*

Asylum seekers can (24 hours per day) phone a special telephone number (*de Praktijklijn*, henceforth: GCA helpline) in order to pose their medical questions or make an appointment with GCA. This

[1253] ACET et al., Questionnaire and observations for early identification of asylum seekers having suffered traumatic experiences. Interview GCA 2. See also section 2.4.3.
[1254] They have a post higher vocational training (*post-HBO opleiding*).
[1255] Interview GCA 1.
[1256] Ibid.
[1257] Gezondheidscentrum asielzoekers, Consulent GGZ voor asielzoekers Snel en dichtbij, http://www.ggdghorkennisnet.nl/?file=6643&m=1325587981&action=file.download.
[1258] The Netherlands Parliamentary documents, Annex to TK 2015/16, 34300-XVI, Handelingen 21 item 3, pp. 65-66.
[1259] Interview GCA 1.
[1260] Interviews Pharos and GCA 1.
[1261] The Netherlands Parliamentary documents TK 2010/11, Aanhangsel Handelingen, nr. 2751, p. 3. See however section 6.6.
[1262] Regeling Zorg Asielzoekers 2017, pp. 26-27.
[1263] The Netherlands Parliamentary documents TK 2015/16, Aanhangsel van de Handelingen, nr. 2948, p. 1. Interview COA 2.
[1264] Kinderombudsman, *Wachten op je Toekomst*, 2016, p. 19.
[1265] A Drogendijk, A. et al., p. 19.
[1266] Ibid, p. 32.

enhances the accessibility of medical care and should stimulate asylum seekers to use the phone as they would be supposed to in the regular health care system.[1267] During the evening and night asylum seekers are referred via the GP of the GCA helpline to the central GP post (Huisartsenpost) or GP on duty.[1268] According to the standards 85 per cent of the regular medical questions should be addressed within 120 seconds and minimum of 95 per cent of the emergency calls should be answered by a medically qualified person within 30 seconds.[1269]

In each reception centre COA provides special mobile telephones to asylum seekers to phone the GCA helpline.[1270] This enables asylum seekers to talk to the GCA helpline in a private place. [1271] In several reception centres there is also a fixed phone available close to the reception, so support can be offered while making the call if necessary.[1272] According to COA officers it is difficult for asylum seekers to explain their medical problems by phone with the help of an interpreter.[1273]

### 6.5.2 Youth Health Care and Youth support

Some organisations are concerned about the health of children staying in the reception centres. The Children's Ombudsman noted in a report of 2016 that nurses see many children with social-emotional and psychological problems. Children would experience tension and stress because of their experiences, the instability of their living conditions and the insecurity about their asylum procedure. Also nurses stated that children suffer from the tensions between their parents.[1274] However, Arq Psychotrauma Expert Group noted in a report of 2017 that there is no research which supports these concerns about the psycho-social health of children and adolescents.[1275] Some argue that better monitoring of children's needs is necessary.[1276]

In all reception centres (emergency reception centres, POLs, and AZCs), children are all offered youth health care (*Jeugdgezondheidszorg* or JGZ) by the GGD.[1277] In the POL where asylum seekers are waiting for the start of the asylum procedure, JGZ has been available to all children since April 2016.[1278] Before that date JGZ was only available to part of the children in the POL. Since the start of 2016 all children between 0-4 years old receive the full JGZ programme.[1279] In 2015 during the high influx of asylum seekers, many children stayed in centres (POL and Pre-POL) awaiting their asylum procedure for long periods of time. During this time children of 18 months and older did not have access to the

[1267] Inspectie voor de Gezondheidszorg, *Goede vooruitgang in toegankelijkheid huisartsenzorg*, pp. 81-82.
[1268] Inspectie voor de Gezondheidszorg, *Medische zorg aan asielzoekers onder druk*, p. 24.
[1269] Ibid, p. 26.
[1270] Inspectie voor de Gezondheidszorg, *Goede vooruitgang in toegankelijkheid huisartsenzorg*, pp. 81-82.
[1271] The Netherlands Parliamentary documents, TK 2013/14, 19 637, nr. 1761, p. 6.
[1272] Inspectie voor de Gezondheidszorg, *Medische zorg aan asielzoekers onder druk*, p. 26.
[1273] TK 2013–2014, 19 637, nr. 1761, p. 6, Inspectie voor de Gezondheidszorg, Medische zorg aan asielzoekers onder druk, p. 25. See also Haker, F. Van Bommel, H, Bloemen, E., p. 28, Nationale Ombudsman, *Medische zorg vreemdelingen*, p. 15, Flegar, V., *Quickscan Zorg voor asielzoekerskinderen in Nederland*, pp. 27-28.
[1274] Kinderombudsman, pp. 18-19.
[1275] Drogendijk, A. et al., p. 35.
[1276] Flegar, V., *Quickscan Zorg voor asielzoekerskinderen in Nederland*, pp. 31-32.
[1277] COA had contracted the GGD GHOR for this purpose. Flegar, V., *Quickscan Zorg voor asielzoekerskinderen in Nederland*, pp. 20-21.
[1278] Flegar, V., *Quickscan Zorg voor asielzoekerskinderen in Nederland*, pp. 17-18.
[1279] Inspectie voor de Gezondheidszorg, *Medische zorg aan asielzoekers onder druk*, p. 21.

JGZ, children between 12 and 18 months only had access to the national vaccination programme. According to the Health Council there was a risk that problems in the physical, social or psychological development of these children would not be noticed.[1280] Therefore the Health Council requested COA and GGD GHOR to provide the full JGZ programme to all children irrespective of the type of reception centre they are staying in. Furthermore, they recommended that all children get an appointment with JGZ within six weeks after arrival.[1281] During the period of high influx this was not always possible.[1282]

The JGZ monitors the physical, social and psychological development of the child, provides information and advice to parents and assesses whether help or guidance is needed in for example the upbringing of the child.[1283] If necessary, JGZ refers the child to other care providers. JGZ is tasked with coordinating the medical care for children.[1284] The JGZ programme includes:

- an intake by a nurse
- a medical examination which includes making a schedule for the national vaccination programme
- contact moments between age 0-19 years which are also offered to Dutch nationals[1285]
- extra contact moments (once per year for age 0-4 years and twice for age 4-19 years) because of the health risks for these children[1286]

During the intake a nurse and a doctor see the child and examine whether there are physical, psychological and or psycho-social problems. They ask about the medical history, health situation and vaccination status of the child. [1287] On the basis of the intake the doctor will make a plan for health care and vaccination. If necessary the child will catch up with the national vaccination programme.[1288]

JGZ aims to document information about the development of asylum seeker children in a file, which needs to be transferred within a week after they have moved to another reception centre.[1289] If necessary the JGZ nurse in the new place of residence will be contacted by phone.[1290] However, the Children's Ombudsman considered in 2016 that the frequent relocations of children make it difficult to ensure the continuity of the JGZ, because children may disappear to another reception centre (see also section 5.9 about the effect of relocations on the continuity of medical care).[1291]

[1280] Ibid.
[1281] This also the aim of GGD GHOR. See *GGD GHOR*, Basistakenpakket JGZ asielzoekerkinderen 0-19 jaar, May 2014, p. 17, see also Flegar, V. *Quickscan Zorg voor asielzoekerskinderen in Nederland*, pp. 17-18.
[1282] Inspectie voor de Gezondheidszorg, *Medische zorg aan asielzoekers onder druk,* p. 21. See also Kinderombudsman, p. 20, where it was stated that due to practical problems an intake within six weeks was not always possible.
[1283] GGD GHOR, Basistakenpakket JGZ, pp. 7-11.
[1284] Ibid, p. 28.
[1285] Ibid, pp. 7-11.
[1286] Ibid, p. 6.
[1287] Ibid, p. 28, Flegar, V., *Quickscan Zorg voor asielzoekerskinderen in Nederland*, pp. 17-18.
[1288] Flegar, V., *Quickscan Zorg voor asielzoekerskinderen in Nederland*, pp. 17-18.
[1289] GGD GHOR, Basistakenpakket JGZ, p. 15.
[1290] Ibid, p. 15.
[1291] Kinderombudsman, p. 20.

GCA and GGD can refer children to youth support (*jeugdhulp*).[1292]Also COA can identify children in need of youth support[1293]. Youth support can consist of support and aid to and care for children and their parents. It may aim to decrease, stabilise, treat, solve or cope with the consequences of psychological problems and diseases, psychosocial problems, behavioural problems or a mental limitation of the child or problems experienced by parents in the upbringing of their children.[1294] The Factsheet Youth Support (*Factsheet Jeugdhulp*) written by COA and other parties involved in care for asylum seeker children, mentions that intensive youth support requires relative stability and time. Therefore, it is preferable to apply such support (unless really necessary) on reception locations where children reside for longer periods of time (AZCs or small scale reception locations for unaccompanied children). On other locations asylum seekers are relocated too often.[1295]

Since 2015 youth support for children has been normally organised by the municipalities, through district and multidisciplinary teams. However, these teams are not available for asylum seeker children.[1296] COA therefore needs to organise youth support for these children, which is difficult because of the small scale on which youth support is necessary (it may concern a few children in one reception centre). COA remarks that the well-being of children is well monitored in the reception centres, by COA, GCA, GGD and the schools. However, according to COA, it would best if youth support would be provided by the municipalities.[1297] COA has started a pilot in ten municipalities in order to coordinate youth support better with the youth support offered in those municipalities to children.

### 6.5.3 Specialist mental health care

Psychological problems should be treated where possible within the framework of basic mental health care. For specific interventions specialist mental health care can be provided for the shortest possible period.[1298] Specialist mental health care can be provided by institutions, which are contracted by MCA.[1299] Mental health care is provided by different care providers depending on the seriousness and complexity of the mental problems. COA should be included in the process of making a treatment plan by the mental health care provider, because it is part of the system in which the asylum seeker lives.[1300]

Asylum seekers who have a disorder mentioned in the *Diagnostic and Statistical Manual* of Mental Disorders (DSM) can be treated**.** The length of the treatment depends on the treatment plan which the care provider makes together with their clients. The scope of the treatment is limited by the

[1292] Flegar, V., *Quickscan Zorg voor asielzoekerskinderen in Nederland*, p. 22.
[1293] Interview COA 2.
[1294] Regeling Zorg Asielzoekers 2017, p. 29.
[1295] See COA, GCA, GGD-GHOR, MCA, Nidos, Factsheet Jeugdhulp, May 2017, p. 3.
[1296] Ibid.
[1297] Interview COA 2.
[1298] Menzis COA Administratie, Convenant GGZ, p. 12.
[1299] Flegar, V., *Quickscan Zorg voor asielzoekerskinderen in Nederland*, p. 12.
[1300] Menzis COA Administratie, Convenant GGZ, p. 6.

treatment psychiatrists or clinical psychologists usually offer according to their professional guidelines, the law or other documents.[1301]

Specialist mental health care is provided to asylum seekers with complex and/or multiple mental disorders, where the active involvement of a psychiatrist or a clinical psychologist is necessary and where a multi-disciplinary approach is often desirable. Again, the scope of the treatment is limited by the treatment psychiatrists or clinical psychologists usually offer according to their professional guidelines, the law or other documents.[1302] If necessary the asylum seeker can be admitted to a psychiatric hospital or psychiatric department of an hospital for a maximum of 1.095 days.[1303] Very few asylum seekers are treated in-patient in a mental health care institution. In November 2016 the Minister of Justice wrote that from 1 January 2015, 26 care programmes were started in which the asylum seeker was treated in an institution.[1304] Specialist care is offered to asylum seekers by four specialist centres: Centrum '45, Pro Persona, GGZ Drenthe and Reinier van Arkel as well as a few institutions with special programmes aimed at specific vulnerable groups.[1305]

In October 2015 MCA, GCA, GGD GHOR and specialist mental health care providers concluded the Covenant Mental Health Care for Asylum seekers (the Covenant). The parties to the Covenant aim to get to know each other better, to make agreements about cooperation and to inform and to define how they relate to each other. The aims should be prevention of psychological problems and use of specialist mental health care, effective referral if necessary, cooperation at different levels, sharing of information, focus of treatment on recovery and self-reliance and referral back to basic mental care.[1306] The Covenant was followed by meetings in which the agreements were further discussed.[1307] COA and the DCR were also present at (some of) those meetings about for example identification of persons with psychological problems.[1308] However, it is not clear whether this process will be continued, because GCA will be replaced by Arts en Zorg from January 2018.

According to the Covenant, care providers who treat asylum seekers should meet a number of quality requirements. They should have a vision on treatment of asylum seekers and use modern, most effective methods and programmes of treatment.[1309] Furthermore, the care providers should exchange information and knowledge about treatment of asylum seekers with mental problems.[1310]

### 6.6 Accessibility of medical care in practice

[1301] Regeling Zorg Asielzoekers 2017, pp. 20-21. See for an explanation of the term treatment usually offered (*plegen te bieden*): Zorginstituut Nederland, Bevorderen van participatie van cliënten met een psychische stoornis, 29 August 2016, pp. 34-36.
[1302] Ibid. See also interview iMMO.
[1303] Regeling Zorg Asielzoekers 2017, pp. 22-23. In 2016 the maximum was 365 days. See Regeling Zorg Asielzoekers 2016, pp. 22-23.
[1304] The Netherlands Parliamentary documents, 2016/17, 34 550 VI, nr. 11, p. 130.
[1305] A Drogendijk, A. et al., p. 28.
[1306] Menzis COA Administratie, Convenant GGZ, p. 3.
[1307] www.rzasielzoekers.nl/zorgsoorten/convenant-ggz.html.
[1308] Interview DCR 4.
[1309] Menzis COA Administratie, Convenant GGZ, p. 11.
[1310] Ibid., p. 12.

Asylum seekers often seem to be dissatisfied with the medical care offered to them.[1311] As was explained in section 6.3.1 this may be due to their lack of knowledge and/or understanding of, as well as disagreement with the Dutch health care system. However, this does not seem to be the sole reason for their dissatisfaction. Several stakeholders have the impression that not all asylum seekers receive the medical care they need.[1312] They mentioned examples of asylum seekers with serious health issues who were advised to rest and to take paracetamol or tranquillizers and/or were not referred to specialist medical care.[1313] Such cases created dissatisfaction about the medical care provided by GCA among those stakeholders. As was set out in sections 2.4.3 and 2.6.7 GCA cannot explain its approach in such individual cases to the stakeholders, because they are not allowed to share medical information.[1314] At the same time some stakeholders indicated that they receive little complaints about the medical care offered to their clients.[1315]

The consequences of a lack of medical care may be serious. A care provider of Centrum '45 noted that she regularly sees clients who have been taking paracetamol for months. These clients did not understand that they should only take paracetamol during a short period of time.[1316] A lawyer stated that some of her clients languish in the reception centre.[1317]

Sometimes the reasons for a lack of medical care seem to be related to the asylum procedure and the unstable situation asylum seekers find themselves (see further section 6.6.3). Other reasons mentioned are the aim to limit the costs of health care to asylum seekers and the Dutch system, in which GP's try to fix medical problems themselves. Furthermore, it may be caused by reluctance to diagnose psychological problems. These reasons will be discussed in the following sections.

### 6.6.1 Reduction of costs and stepped care system

Several organisations have suggested that asylum seekers are not referred to specialist medical care in order to limit costs.[1318] The International Rehabilitation Council for Torture Victims (IRCT) for example concluded that the State does not ensure torture victims the necessary medical and psychological treatment, because the insurance companies tend to discourage referrals for treatment in order to reduce costs.[1319] A lawyer noted that clients who stay outside the reception centre and go to a regular GP often do get referred to a psychologist.[1320] She noted that asylum seekers in the

[1311] Conversations with UNHCR staff, UNHCR the Netherlands, August/September 2016. See also Nationale Ombudsman, Medische zorg vreemdelingen, p. 19, Pharos, *Kennissynthese*, p. 19.
[1312] Interviews Pharos, DCR 1 and 2, Lawyer 2, Lawyers 3 and 4 and Lawyer 5.
[1313] Interviews Lawyer 2, Lawyers 3 and 4 and DCR 4. One lawyer also felt the need to contact GCA in such cases to explain the asylum seeker's situation.
[1314] One employee of DCR mentioned that she tries to create more understanding between GCA and DCR by organising meetings in which GCA explains its working methods.
[1315] Interviews Lawyer 5 and DCR 3.
[1316] Interview Centrum '45.
[1317] Interview Lawyer 2.
[1318] Nationale Ombudsman, *Medische zorg vreemdelingen*, p. 26, Dutch Council for Refugees, Letter to the Dutch Parliament concerning the report of the Dutch Safety Board, Veiligheid van vreemdelingen, 23 May 2014. Interviews Pharos, DCR 1 and 2.
[1319] IRCT, *Falling Through the Cracks, Asylum Procedures and Reception Conditions for Torture Victims in the European Union*, IRCT 2016, p. 33.
[1320] Interview Lawyer 2.

reception centres only get a referral if they convince GCA that their situation is more serious than that of other asylum seekers.

Some stakeholders mentioned as a point of criticism that GCA tries to deal with physical and psychological problems itself and only refers a patient to a specialist in exceptional cases. Some contend that the stepped care system, in which the GP only sees asylum seekers with complex medical problems, may render asylum seeker's access to medical care more difficult.[1321] The Ombudsman considered in 2013 that the asylum seekers are dependent on the assessment of the GP assistant whether they will get access to the GP. While every asylum seeker formally has access to the GP, the GP assistant and the nurse are there to act as gate keepers for the GP and deal with many complaints. Even if asylum seekers insist that they want to see the GP, the GP assistant or nurse will often tell them that this is not necessary because the GP will repeat what they have said.[1322] In the Ombudsman's view, these hurdles aim to reduce the costs of health care or asylum seekers. He also found that insufficient attention was paid to the possibilities to reduce or prevent medical complaints of asylum seekers.[1323]

In response to this report the State Secretary of Justice and the Minister of Health wrote that they did not recognise that the GP's were too much protected by the nurses.[1324] GCA noted that the mental health consultant provides attention and support to psychological problems, in order to help asylum seekers to cope with these problems during the asylum procedure. This prevents that asylum seekers are directly sent to secondary (*tweedelijns*) mental health care, which costs a lot of money.[1325] GCA contends that it refers asylum seekers with more serious psychological problems to secondary or specialist mental health care.[1326]

### 6.6.2 Reluctance to diagnose psychological problems

Haker, Van Bommel and Bloemen mentioned in a report of 2010 that nurses do not want to diagnose psychological problems too quickly.[1327] Therefore they may be reluctant to refer a person to the GP or mental health consultant for psychological problems. Unless the psychological problems are severe, they wait some time and see whether asylum seekers come back with their psychological complaints. They advise these persons for example on useful day activities.[1328] GCA noted that it actively assesses whether asylum seekers have psychological problems and refers them to the mental health consultant, if necessary.

Haker, Van Bommel and Bloemen also stated that some mental health care providers find rest important and mention the danger to diagnose Post Traumatic Stress Disorder too quickly.[1329] A

[1321] Flegar, V., *Quickscan Zorg voor asielzoekerskinderen in Nederland*, pp. 27-28, interviews Lawyer 2 and Lawyers 3 and 4.
[1322] Nationale Ombudsman, *Medische zorg vreemdelingen*, p. 23.
[1323] Ibid., p. 26.
[1324] The Netherlands Parliamentary Documents, TK 2013/14, 19 637, nr. 1761, p. 7.
[1325] Interview GCA 1.
[1326] Additional information GCA provided in July 2017.
[1327] Haker, F. Van Bommel, H, Bloemen, E., pp. V and 12.
[1328] Ibid., p. 13.
[1329] Ibid., pp. 29-30.

diagnosis is also difficult because both psychopathology and the asylum seeker's living conditions can cause psychological problems. [1330]

### 6.6.3 Relevance of (the phase of) the asylum procedure

According to MCA a care provider should take into account the social and living environment of asylum seekers and the fact that their stay in the Netherlands may only be temporary. The choice of care provided should be in line with the temporary stay of the asylum seeker in the Netherlands and aims to respond to the asylum seeker's needs in this situation.[1331] Several reports and stakeholders contend that GCA is reluctant to refer asylum seekers to specialist medical care for reasons connected to the (phase of) the asylum procedure. These reasons will be discussed in this section.

*Postponement of care*
Adult asylum seekers who stay in a POL location get necessary medical care, which can be offered in the (usually) short period of time they are staying in the POL. That means that care sometimes has to be postponed and will not be provided at a POL location.[1332] The doctor decides which medical care is necessary.

Several organisations and stakeholders are critical about the postponement of care.[1333] Some point at the fact that, in particular during periods of high influx, it could take a very long time before asylum seekers received treatment.[1334] In 2016 the Ombudsman recommended the government to refer asylum seekers sooner to specialist help, including specialist psychological care.[1335] One lawyer stated that GCA treats symptoms instead of causes. She mentioned the example of a client with severe medical problems, who only got heavy medication but no psychological treatment for his nightmares and reliving of traumatic experiences.[1336] One mental health care provider of Centrum '45 stated that she seldom receives new clients via GCA. They almost all come via a regular GP, when they have left the COA reception centre.[1337] GCA noted on the other hand that during the period of high influx COA gave permission to GCA to start treatment in an earlier stage.[1338]

Even though children have the right to a broader package of medical care, the Children's Ombudsman found in 2016, during the period of high influx, that only children with serious problems were referred to specialist care. Other children had access to little help, they needed to wait until they had received an asylum status and a house in a municipality.[1339]

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[1330] Kramer, S. et al., p. 26.
[1331] Menzis COA Administratie, Algemene Inkoopvoorwaarden, p. 4. See also Commissie Medische zorg voor (dreigend) uitgeprocedeerde asielzoekers en illegale vreemdelingen, *Arts en Vreemdeling*, 2017, p. 42.
[1332] Interview COA 2. See also Pharos, Kennissynthese, p. 18, Interviews Pharos, DCR 1 and 2 and DCR 4.
[1333] Interviews iMMO, Pharos, Lawyer 2, Lawyers 3 and 4. Dutch Council for Refugees, Letter to the Dutch Parliament about emergency reception centres, 20 May 2016.
[1334] Interview Lawyer 2, Lawyers 3 and 4 and Pharos.
[1335] Nationale Ombudsman, *Rapportage Bezoek noodopvang Heumensoord*, 10 February 2016, nr. 2016/013, p. 4.
[1336] Interview Lawyers 3 and 4.
[1337] Interview Centrum '45. According to GCA this is the result of the short duration of the asylum procedure.
[1338] Additional information provided by GCA in July 2017.
[1339] Kinderombudsman, *Wachten op je Toekomst*, pp. 20-21.

*Medical care and the asylum seeker's perspective*

The treatment offered to asylum seekers may be adapted to their perspective: the expected stay in a particular reception centre or their (expected) right to stay in the Netherlands.[1340] GCA mentioned the example of an asylum seeker who needs a special shoe. In such case it will take a lot of time to make and adjust the shoe. This is not possible if an asylum seeker will have to leave the Netherlands within a short period of time. It is also not useful to provide asylum seekers with a high tech hearing device, if they may have to return to Africa where the necessary batteries are not available. According to GCA it is sometime worse to interrupt treatment than to refrain from treatment.[1341]

Where it concerns psychological problems, treatment may also not be started because the continuity of the treatment cannot be guaranteed if asylum seekers are waiting for the start of the asylum procedure or their asylum decision.[1342] Asylum seekers who know that they will stay in a reception centre for a relatively short time, because they have already obtained an asylum status or know that they will obtain an asylum status (Syrians and Eritreans), may not start treatment for psychological problems until they have a house in the municipality.[1343]

*Use of medical care in the context of the asylum procedure*

Care providers realise that a diagnosis can have an impact on the asylum procedure[1344] or may be used in order to get postponement of expulsion on medical grounds.[1345] Some asylum seekers become aggressive because they want a statement from the doctor that they are seriously ill.[1346] In some cases lawyers urge their clients to ask for mental health care. Sometimes they intend to use that in the asylum procedure.[1347] Some lawyers interfere with medical care, asking a doctor to refer their client to mental health care. This causes negative emotions with the care providers.[1348] It may also lead to reluctance to refer an asylum seeker to specialist (mental health care).[1349] One lawyer mentions that some GCA GP's refuse to provide medical information for the purpose of an application for postponement of expulsion on medical grounds.[1350]

*Treatment of psychological problems in an unstable situation*

Thirdly some care providers think that treatment of trauma is only sensible if clients find themselves in a stable and safe situation and that mental help should be offered at a lower level as long as the

[1340] Nationale Ombudsman, *Medische zorg vreemdelingen*, p. 18.
[1341] Interview GCA 1.
[1342] Kramer, S. et al., pp. 29-30, Kinderombudsman, *Wachten op je Toekomst*, p. 21, Onderzoeksraad voor Veiligheid, *Veiligheid van vreemdelingen*, pp. 48, 110, Conversations with UNHCR staff, UNHCR the Netherlands, August/September 2016.
[1343] Pharos, *Kennissynthese*, p. 41.
[1344] Kramer, S. et al., p. 26.
[1345] Interview COA 2.
[1346] Interview GCA 1.
[1347] Haker, F. Van Bommel, H, Bloemen, E., p. 21, Kramer, S. et al., p. 43.
[1348] Haker, F. Van Bommel, H, Bloemen, E., p. 23, Onderzoeksraad voor Veiligheid, *Veiligheid van vreemdelingen*, p. 49.
[1349] Raad voor Volksgezondheid en Samenleving, p. 22, Flegar, V., *Quickscan Zorg voor asielzoekerskinderen in Nederland*, pp. 27-28, Nationale Ombudsman, *Medische zorg asielzoekers*, p. 26.
[1350] Interview Lawyers 3 and 4.

asylum seekers have not received a status.[1351] The 2015 report on ethical issues in mental health care for asylum seekers noted that care providers do not think that it is problematic to offer support, coaching and stabilisation to an asylum seeker. However, they have doubts about offering treatment. Care providers stated that clients who are treated for depression or trauma should not find themselves in a crisis situation and that asylum seekers are almost always in a crisis situation.[1352] There is also an assumption that the psychological state of a person will deteriorate at the start or during the first phase of the treatment.[1353] Furthermore, frequent relocations and waiting periods make treatment during the asylum procedure difficult (see also section 5.9).[1354] GCA states that it therefore gives attention and support to asylum seekers with psychological problems so that they can cope with this period of insecurity and that the need for treatment can be postponed if possible until it will be more effective. A COA officer noted that asylum seekers are sometimes more open to treatment after they have been granted an asylum status and offered a house, because this takes away concerns about their unstable situation.[1355] GCA mentioned that sometimes treatment is not necessary anymore when asylum seekers have received a status because then they can get on with their lives.[1356]

Some care providers disagree with such policy and contend that asylum seekers should not be forced to wait for years in a reception centre before they receive treatment.[1357] They think that the sooner treatment starts, the better.[1358] This is in line with the opinion of IRCT, which states that torture trauma rarely fades over time and is actually often exacerbated if left untreated, especially when the victim lives in a state of uncertainty and in poor asylum conditions.[1359] Arq Psychotrauma Expert Group states that more knowledge is need on the question in which phase of the asylum procedure/reception and for which complaints trauma therapy should be started.[1360]

### 6.6.4 High influx

Despite the high influx and the quick increase of reception centres resulting from that, GCA and MCA managed to organise health care (including contracts with pharmacies, dentists and midwifes) each time before the opening of the reception centre.[1361] Sometimes GCA was notified of the opening of a new reception location one day before the first asylum seekers arrived. However, it always managed to organise medical care in time. New GCA personnel were trained by experienced personnel.

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[1351] Haker, F. Van Bommel, H, Bloemen, E., p. 15, Onderzoeksraad voor Veiligheid, *Veiligheid van vreemdelingen*, p. 48, Flegar, V., *Quickscan Zorg voor asielzoekerskinderen in Nederland*, p. 18.
[1351] Kramer, S. et al., p. 26. Interview GCA 1, Conversations with UNHCR staff, UNHCR the Netherlands, August/September 2016.
[1352] Kramer, S. et al., p. 27.
[1353] Ibid., p. 29-30.
[1354] Interview Pharos.
[1355] Additional information provided by COA in September 2017.
[1356] Interview GCA 1.
[1357] Kramer, S. et al., p. 27. Interview Centrum '45. In practice only very few asylum seekers stay in reception centres for years. In the first half of 2017, 61 % left the COA reception centre within a year, 28% of the asylum seekers stayed in a COA reception centre (including locations for persons who received a final negative decision on their application) for a period of between 1 and 2 years. Ministerie van Veiligheid en Justitie, Rapportage Vreemdelingenketen, januari-juni 2017, p. 23.
[1358] Interview Centrum '45. See about these different views Menzis COA Administratie, Convenant GGZ, p. 4.
[1359] IRCT, *Falling Through the Cracks*, p. 6.
[1360] Drogendijk, A. et al., p. 40.
[1361] Inspectie voor de Gezondheidszorg, *Medische zorg aan asielzoekers onder druk,* p. 16.

However, there were also several problems due to the high influx, including a lack of knowledge of the health care systems of new (COA) personnel and long waiting times in order to get help from GCA in emergency reception centre Heumensoord or via the GCA helpline. Some asylum seekers also believed that it was better to keep silent about medical problems because they could delay the asylum procedure (see further section 2.4.7).[1362] Finally, the frequent relocations of asylum seekers, from crisis reception centres, to emergency receptions centres and further, may have prevented asylum seekers to ask for or receive medical care (see further section 5.9).[1363]

*Lack of knowledge of new personnel*

Some stakeholders mentioned that many new persons, including those working for the municipal service for public health care (*GGD*), the Red Cross or volunteers of churches, became involved in the (medical) care for asylum seekers, but did not know the system and possibilities of medical care.[1364] Centrum '45 noted for example that COA did not know about the existence of Centrum '45 and that GCA could refer asylum seekers to them.[1365]

*Waiting times at GCA*

The Ombudsman found in a report of February 2016 that asylum seekers in emergency reception centre Heumensoord ( which had a capacity of almost 3000 asylum seekers) had to wait for a long time for their turn at GCA. As a result mothers with children and pregnant women often left the queue.[1366]

*Availability of interpreters*

During the period of high influx there was a lack of (notably Arabic and Tigrinya) interpreters. Therefore sometimes there was no interpreter available for appointments with GCA. If medical care had to be provided, sometimes GCA chose to talk to asylum seekers without an interpreter.[1367] In the normal situation GCA always uses an interpreter if this is necessary for effective communication.[1368]

*Waiting times at the GCA helpline*

Finally the accessibility of the GCA helpline for asylum seekers with regular medical questions deteriorated (emergency questions were addressed in time).[1369] According to GCA the problems were partly caused by the fact that COA employed a large number of new personnel, who couldn't yet answer questions about the health care system. As a result asylum seekers called the GCA helpline with all kinds of (non-medical) questions, such as the address of the dentist or optician.[1370] In November 2015 only 50 per cent of the regular calls were answered within 120 seconds.[1371] Asylum seekers complained about the long time they had to wait before they could talk to a GCA employee.

[1362] Interview Lawyers 3 and 4.
[1363] Ibid.
[1364] Interview Pharos.
[1365] Interview Centrum '45.
[1366] Nationale Ombudsman, *Rapportage Bezoek noodopvang Heumensoord*, pp. 3-4.
[1367] Interview GCA 2.
[1368] Ibid.
[1369] Inspectie voor de Gezondheidszorg, *Medische zorg aan asielzoekers onder druk,* p. 20.
[1370] Interview GCA 1.
[1371] Inspectie voor de Gezondheidszorg, *Medische zorg aan asielzoekers onder druk,* p. 26.

According to the Health Council there was a risk that asylum seekers did not receive (timely) necessary medical care outside consultation hours. Residents of the emergency reception centre Heumensoord complained at the National Ombudsman that GCA was not available during the night and that this made them feel desperate.[1372] GCA has taken measures which have improved the accessibility of the GCA helpline.[1373] GCA has for example asked nurses of the Red Cross to provide assistance to asylum seekers in large reception centres when GCA was closed (for example at night).[1374]

## 6.7 Conclusions

In the Netherlands COA is responsible for the medical care of asylum seekers. Medical care is currently provided by the Health Centre Asylum seekers (GCA). From 1 January 2018, Arts en Zorg will take over the tasks of GCA, because they have won the latest public procurement procedure.

*Scope of medical care*

The Dutch health care system for asylum seekers resembles as much as possible the 'regular' health care system in the Netherlands.[1375] In a few important aspects medical insurance for asylum seekers is more extensive than for Dutch citizens, for example where it concerns urgent dental care and physiotherapy. Nevertheless there still seem to be situations, in which asylum seekers who are seriously suffering from medical problems may not get the medical help they need, as a result of the limitations of the medical insurance coverage. Most asylum seekers will not be able to pay for medical treatment themselves, because they are not allowed to work in the first six months of their stay in the Netherlands. If an asylum seeker does not receive necessary medical care, this may influence for example the asylum seeker's participation in activities at the reception centre, the effectiveness of psychological treatment, and his ability to make complete, coherent and consistent statements during the asylum procedure.

*Responsibility of the asylum seekers*

The point of departure of the Dutch health care system is that asylum seekers are responsible for their own health. This is problematic, in particular where it concerns asylum seekers with special needs, for example because of psychological problems. Asylum seekers with psychological problems will generally not be identified by the urgency medical screening directly after arrival. Therefore, it is important that GCA (and COA) are extra alert and take an outreaching approach where it concerns asylum seekers who are (potentially) suffering from psychological problems.

*Information about the health care system*

Asylum seekers are not able to take responsibility for their own health if they do not understand the Dutch health care system. This system is complex and differs from health care systems in the asylum seekers' countries of origin. COA has the task of informing asylum seekers about their right to medical care and the organisation of medical care in the Netherlands. COA provides information on the

[1372] Nationale Ombudsman, *Rapportage Bezoek noodopvang Heumensoord*, p. 3.
[1373] Inspectie voor de Gezondheidszorg, *Brief aan ketenpartners, naar aanleiding van bezoeken 2016*, 13 October 2016.
[1374] Interview GCA 1.
[1375] Interview COA 2. Nationale Ombudsman, *Medische zorg vreemdelingen*, *Over toegang en continuïteit van medische zorg voor asielzoekers en uitgeprocedeerde asielzoekers*, 3 October 2013, nr. 2013/125, p. 11.

medical care system in different ways. However, in practice many asylum seekers still lack knowledge about this system. This may result not only in a lack of access to medical care, but also to unrealistic expectations, frustrations about the medical care provided and the feeling of being discriminated against.

Several stakeholders indicated that sometimes also COA officers, GCA personnel and other organisations involved in the asylum system do not have sufficient knowledge of the health care system. This was particularly the case during the time of high influx when many new personnel was employed.

Many asylum seekers are not familiar with psychological problems and mental health care. Furthermore, often there is a stigma associated with psychosocial problems. This may prevent asylum seekers to ask for psychological help.

*Preventive measures*

In regular reception centres (AZCs) psycho-social support and preventive measures are offered to asylum seekers in different programmes and by a variety of organisations. There are no common guidelines for these programmes and it is unclear whether they are effective. MCA supports psycho-education offered by the GGD, Mindspring and GGNet. However, the availability of such programmes depends on whether the local GP and/or COA manager finds it necessary. Furthermore, psycho-education and other specific preventive care is only financed for regular reception centres and not for COLs, POLs and emergency and crisis reception centres. This is problematic, in particular when asylum seekers have to wait in a (Pre-)POL for a long time before they can start the asylum procedure.

*The health care system*

Medical care for asylum seekers is offered by GCA in accordance with the stepped care principle. This means that asylum seekers first talk to a GP assistant who estimates the seriousness of the medical complaint. The GP assistant may provide medical advice to the asylum seeker. Less complex medical problems are diagnosed and treated by nurses on the basis of a protocol. The GP only focuses on complex medical tasks and on the supervision of the nurses and GP assistants.

Also asylum seekers with psychological problems first need to turn to the GP assistant and subsequently the GP or the mental health consultant who works under responsibility of the GP. Specialist mental health care is provided to asylum seekers with complex and/or multiple mental disorders, where the active involvement of a psychiatrist or a clinical psychologist is necessary and where a multi-disciplinary approach is often desirable. In October 2015 MCA, GCA, GGD GHOR and specialist mental health care providers concluded the Covenant Mental Health Care for Asylum seekers, which aims at better cooperation between the different care providers.

Asylum seekers can phone the GCA helpline 24 hours a day and each day of the week in order to pose their medical questions or make an appointment with GCA. However, for many asylum seekers it is difficult to explain their medical problems by phone with the help of an interpreter, which may render access to medical care difficult.

In all reception centres children are all offered youth health care (JGZ) by the GGD. The JGZ monitors the physical, social and psychological development of the child, provides information and advice to parents and assesses whether help of guidance is needed in for example the upbringing of the child. It also makes sure that children catch up with and follow the national vaccination programme. GCA and the GGD can refer children to youth support. This can consist of support and aid to and care of children and their parents and may aim to decrease, stabilise, treat, solve or help them cope with the consequences of psychological problems and diseases, psychosocial problems, behavioural problems or a mental limitation of the child or problems experienced by parents in the upbringing of their children.

*Accessibility of medical care in practice*

In this study several factors came to the fore which may impede asylum seekers' access to medical care. First of all some stakeholders and reports contend that asylum seekers are not referred to specialist medical care in order to reduce costs. Furthermore, it is argued that the stepped care system has as a consequence that GCA tries to deal with physical and psychological problems itself and only refers a patient to a specialist in exceptional cases. Some nurses are also reluctant to diagnose psychological problems and refer a person to the GP or mental health consultant.

Medical and psychological treatment often seems to be postponed when an asylum seeker is still waiting for the start of the asylum procedure or even until the asylum seeker has received an asylum status. Some stakeholders state that treatment is aimed at reducing symptoms instead of addressing the causes. Sometimes the reason for this is that the continuity of the treatment cannot be guaranteed as a result of future relocations. This is particularly problematic when the waiting times are long, such as in periods of high influx.

Care providers may also be reluctant to refer an asylum seeker to specialist care because they think that the asylum seeker may want to use this in order to ask for postponement of expulsion on medical grounds.

There seems to be disagreement among mental health care providers whether asylum seekers who are still in or waiting for their asylum procedure should be treated for their psychological problems. Some think that asylum seekers should find themselves in a stable position before they can be treated. Until that moment they should receive psychological support in order to cope with their situation. Others think that treatment should start as soon as possible.

*Accessibility during high influx*

During the period of high influx GCA managed to organise medical care before the opening of each reception centre. Some problems were reported, which limited the accessibility of medical care during the period of high influx, including relocations, long waiting times during consultation hours of GCA in reception centre Heumensoord and for the GCA helpline and a lack of interpreters.

# 7 Special procedural guarantees

## 7.1 Introduction

There are many ways in which asylum seekers with special needs can be offered support during the asylum procedure. Support may consist for example of shorter waiting periods or more time for preparation of the interview and/or legal assistance. Furthermore, the circumstances of the interview may be adapted to the asylum seeker's individual needs.

Such measures may enhance the asylum seekers' ability to talk about their asylum motives. At the same time it should be noted that such special measures during the interview will not guarantee that asylum seekers are able to provide a complete, coherent and consistent asylum account. As was mentioned before, it may be too shameful or painful to talk about past events in the country of origin. Asylum seekers may also have difficulties remembering (parts of) their experiences.[1376] The fact that asylum seekers may have difficulties telling their asylum account to the authorities, for example as a result of psychological problems, should be taken into account in the asylum decision.[1377]
This chapter will discuss which special procedural guarantees are offered to asylum seekers by the IND. It will first set out the international legal framework (section 7.2) and UNHCR's position (section 7.3. Subsequently it will describe the types of support which may be offered during the asylum procedure (section 7.4). Moreover, it will pay attention to waiting times and prioritisation (section 7.5), the application of the border procedure (section 7.6) and accelerated asylum procedures (section 7.7). It will also examine when an interview can be omitted (section 7.8) and which special measures may be taken during the asylum seeker's interview with the IND (section 7.9). Finally it will be assessed how the IND takes into account the (potential) psychological problems of the asylum seeker and medical reports in its decision-making (section 7.10).

## 7.2 International framework

In asylum cases the burden of proof is generally on the asylum seeker.[1378] According to Article 4(1) of the recast Qualification Directive[1379] Member States have the duty to assess the relevant elements of the application in cooperation with the asylum seeker. This means 'that if, for any reason whatsoever, the elements provided by an asylum seeker for international protection are not complete, up to date or relevant, it is necessary for the Member State concerned to cooperate actively with the asylum

[1376] EASO, Module on Interviewing vulnerable persons, accessed in October 2016, UNHCR, *Beyond Proof*, May 2013, pp. 61-64, 72-73 and references, UNHCR, *The Heart of the matter*, December 2014, pp. 61-70 and references, Bloemen, E. and Keunen, A., 'Ik heb alle bewijzen op mijn lichaam'*, Asiel & Migrantenrecht,* 2013, pp. 455-456 and references, Interview iMMO.
[1377] See also UNHCR, *Note on Standard and Burden of Proof*, 16 December 1998, para 9.
[1378] Art. 4(1) Directive 2011/95/EU, ECtHR 17 July 2008, Appl. no 25904/07, *NA v the United Kingdom*, para 111.
[1379] Directive 2011/95/EU of the European Parliament and of the Council of 13 December 2011 on standards for the qualification of third-country nationals or stateless persons as beneficiaries of international protection, for a uniform status for refugees or for persons eligible for subsidiary protection, and for the content of the protection granted [2011] OJ L 337/9.

seeker, at that stage of the procedure, so that all the elements needed to substantiate the application may be assembled'.[1380]

Article 24(2) Recast Asylum Procedures Directive (RAPD) requires Member States to provide asylum seekers in need of special procedural guarantees with adequate support in order to allow them to benefit from their rights and comply with their obligations throughout the duration of the asylum procedure.[1381] The directive indicates which special guarantees may be offered to vulnerable asylum seekers. The examination of their application for international protection may be prioritised.[1382] Also, accelerated procedures or border procedures may not be applied if adequate support cannot be provided in such procedures. This is particularly the case 'where Member States consider that the asylum seeker is in need of special procedural guarantees as a result of torture, rape or other serious forms of psychological, physical or sexual violence'.[1383]

Furthermore, Member States should ensure that personal interviews 'are conducted under conditions which allow asylum seekers to present the grounds for their applications in a comprehensive manner'. This means that the person who conducts the interview is competent to take account of the personal and general circumstances surrounding the application, including the asylum seeker's vulnerability.[1384] They should also 'have acquired general knowledge of problems which could adversely affect the applicants' ability to be interviewed, such as indications that the applicant may have been tortured in the past'.[1385]

In cases of unaccompanied children Member States should 'ensure that the representative is given the opportunity to inform the unaccompanied child about the meaning and possible consequences of the personal interview and, where appropriate, how to prepare himself or herself for the personal interview'. Furthermore, a representative and/or a legal adviser or other counsellor should be present at the unaccompanied child's interview and have 'an opportunity to ask questions or make comments, within the framework set by the person who conducts the interview'.[1386]

An interview may even be omitted 'where the determining authority is of the opinion that the asylum seeker is unfit or unable to be interviewed owing to enduring circumstances beyond his or her control'. When in doubt, the determining authority shall seek medical advice to establish 'whether the condition that makes the asylum seeker unfit or unable to be interviewed is of a temporary or enduring nature'.[1387]

[1380] CJEU Case C-277/11, *MM v Minister for Justicem Equality and Law Reform Ireland* [2012], para 66.
[1381] Directive 2013/32/EU of the European Parliament and of the Council of 26 June 2013 on common procedures for granting and withdrawing international protection (recast) [2013] OJ L 180/60.
[1382] Art. 31(7)(b) RAPD.
[1383] Art. 24(3) RAPD and point 30 of the Preamble to the RAPD.
[1384] Art 15(3) RAPD.
[1385] Art 4(3) RAPD.
[1386] Art 25(1)(b) RAPD.
[1387] Art 14(2)(b) RAPD.

### 7.3 UNHCR's position

Also according to the UNHCR Handbook and Guidelines on Procedures and Criteria for Determining Refugee Status the burden of proof is on the asylum seeker, but the duty to ascertain and evaluate all the relevant facts is shared between the asylum seeker and the examiner.[1388] The Handbook mentions that it 'frequently happens that an examiner is confronted with an applicant having mental or emotional disturbances that impede a normal examination of his case'. Such cases call for 'different techniques of examination'.[1389] The examiner should, in such cases, whenever possible, obtain expert medical advice. The medical report 'should provide information on the nature and degree of mental illness and should assess the applicant's ability to fulfil the requirements normally expected of an asylum seeker in presenting his case'.[1390] The expert medical report should determine the approach taken by the examiner of the asylum claim.[1391] According to the Handbook, it will be necessary to lighten the burden of proof normally incumbent on the asylum seeker. Furthermore, information that cannot easily be obtained from the asylum seeker should be sought elsewhere, for example from people closely acquainted with the applicant.[1392]

UNHCR Guidelines on International Protection provide specific guidance for dealing with child asylum claims and victims of trafficking, including substantive analysis of the claim and procedural guarantees. The Guidelines on child asylum claims state that qualified guardians should be appointed in the case of unaccompanied or separated children, that appropriate communication methods should be used for children, and highlight the challenges which children may face in articulating their experiences. 'It may be necessary for an examiner to assume a greater burden of proof in children's claims, especially if the child concerned is unaccompanied'.[1393]

The guidelines related to victims of trafficking[1394] and on gender-related persecution[1395] highlight the importance of providing a supportive environment where claimants can be reassured of the confidentiality of their claim, including providing interviewers of the same or preferred sex, establishing trust, and the provision of expert medical and/or psycho-social assistance where necessary.

### 7.4 Adequate support in the Dutch asylum procedure

Article 3.108b(2) Aliens Decree provides that if the asylum seeker is in need of special procedural guarantees, adequate support will be offered during the examination. The IND decides whether and

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[1388] UNHCR, *Handbook and Guidelines on Procedures and Criteria for Determining Refugee Status*, Reissued Geneva, December 2011, para 196.
[1389] Ibid., para 207.
[1390] Ibid., para 208.
[1391] Ibid.
[1392] Ibid., para. 210.
[1393] UNHCR, *Guidelines on International Protection:* Child Asylum Claims under Articles 1(A)2 and 1(F) of the 1951 Convention and/or 1967 Protocol relating to the Status of Refugees, 2009, HCR/GIP/09/08, para 73.
[1394] UNHCR, *Guidelines on International Protection: The application of Article 1A(2) of the 1951 Convention and/or 1967 Protocol relating to the Status of Refugees to victims of trafficking and persons at risk of being trafficked*, HCR/GIP/06/07, 7 April 2006, para 46.
[1395] UNHCR, *Guidelines on International Protection: Gender-Related Persecution within the context of Article 1A(2) of the 1951 Convention and/or its 1967 Protocol relating to the Status of Refugees*, HCR/GIP/02/01, 7 May 2002, para 36.

how adequate support is offered.[1396] The IND bases this decision on several sources of information. In this regard the Medical advice interviewing and decision-making currently provided by FMMU[1397] is very important. However, IND officers should also take into account their own observations before, during and after the interviews, the statements and/or behaviour of the asylum seeker, the fact that the asylum seeker belongs to a vulnerable group and signals of other organisations in the asylum system including the Aliens Police, COA, the Dutch Council for Refugees (DCR) and the asylum seeker's lawyer.[1398] When problems arise during the interview or are substantiated by the FMMU questionnaire or medical information from treating doctors, the IND does (sometimes) assess at its own discretion which measures should be taken.[1399]

The decision whether a person is vulnerable and in need of special procedural guarantees is not a separate (written) decision which can be appealed in court. Asylum seekers may argue that they have not received the adequate support they need in their reaction (*zienswijze*) to the intended rejection (*voornemen*) or during the appeal before the court.[1400]

IND Instruction 2015/8 mentioned that on the basis of the medical advice at least the following consequences are possible:

- No special guarantees are necessary;
- The interview on the asylum motives will not take place in the general asylum procedure;
- The start of the general asylum procedure will be postponed;
- The IND takes special measures during the interviews in the general asylum procedure;
- A combination of those measures.[1401]

The IND measures should be tailor-made and thus depend on the specific circumstances of the case.[1402] One IND officer mentioned that there are two limitations to such measures: costs and capacity. If extra costs and capacity are involved the IND officer should ask permission from a manager.[1403]

[1396] IND Instruction 2010/13, p. 3.
[1397] See Chapter 3 of this report for more information on the Medical advice interviewing and decision-making.
[1398] IND Instruction 2015/8, p. 5, Interview IND 5 and 6. See further Chapter 2 of this report.
[1399] Interview IND 5 and 6 and Lawyers 3 and 4.
[1400] IND Instruction 2015/8, p. 6, Besluit van 10 juli 2015, houdende wijziging van het Vreemdelingenbesluit 2000 en het Besluit vergoedingen rechtsbijstand 2000 in verband met de implementatie van Richtlijn 2013/32/EU van het Europees Parlement en de Raad van 26 juni 2013 betreffende gemeenschappelijke procedures voor de toekenning en intrekking van de internationale bescherming (PbEU 2013, L 180) en Richtlijn 2013/33/EU van het Europees Parlement en de Raad van 26 juni 2013 tot vaststelling van normen voor de opvang van verzoekers om internationale bescherming (PbEU 2013, L 180), Stb 2015, 294, p. 23.
[1401] IND Instruction 2015/8, p. 2. See also IND Instruction 2010/13.
[1402] Besluit van 10 juli 2015, Stb 2015, 294, p. 24, The Netherlands Parliamentary documents, Handelingen EK 2014/15, nr. 38, item 8, p. 17.
[1403] Interview IND 5 and 6.

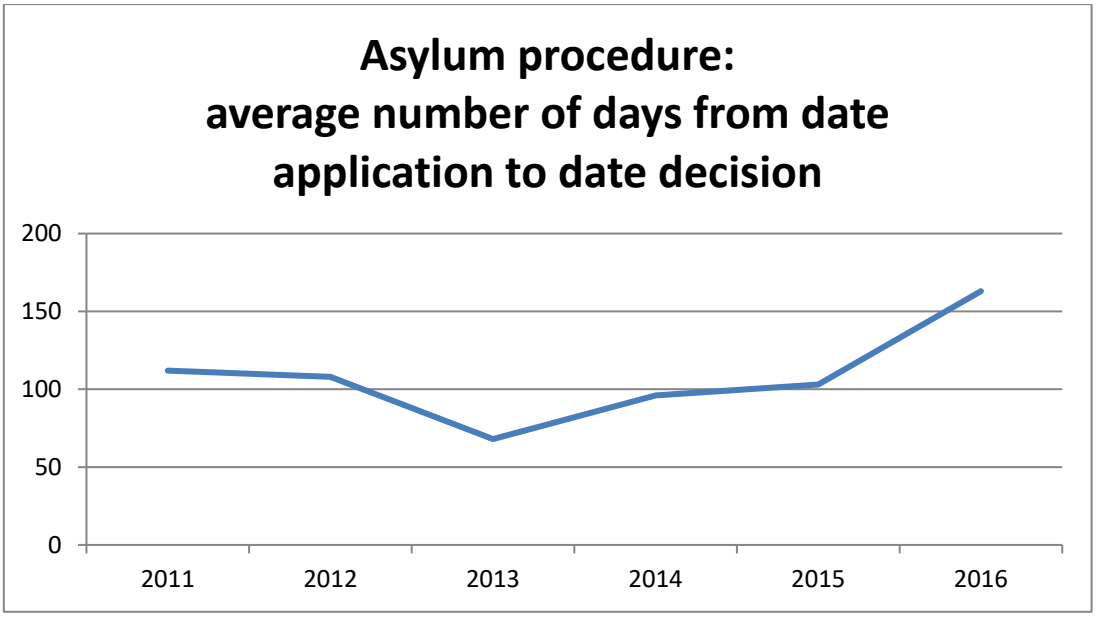
## 7.5 Waiting times and prioritisation

In 2015 the IND was able to take a decision within the time-limit of six months in 96 per cent of all asylum cases. [1404] However, in the second half 2015 and in particular in 2016 the waiting times for asylum seekers increased as a result of the high influx. In November 2015 the expected waiting time before an asylum seeker could start the asylum procedure was six months.[1405] In February 2016 the time-limit for taking a decision in asylum cases was prolonged from six months to 15 months on the ground that the influx was high.[1406] The IND indicated that it still aimed to process asylum seekers as quickly as possible, but that it could not comply with the time-limit of six months in all cases.[1407] In February 2017 the time between the application and the start of the asylum procedure was reduced again to 8 weeks on average.[1408] From February 2017 also the regular time-limit for asylum decisions of six months applied again.[1409]

The IND could not provide statistics on the waiting times (the period between the asylum application and the moment the asylum seeker entered the general asylum procedure). However, it did provide statistics on the total length of the administrative phase of the asylum procedure (from the date of application to the date of the decision of the IND. As can be seen in the table below, the total length of the administrative phase of the asylum procedure increased from 2014 on to an average of more than five months. [1410]

The waiting times were much longer for asylum seekers with high chances of success than for asylum seekers with (very) low chances of success. From 1 March 2016 the applications of asylum seekers originating from safe countries of origin and asylum seekers who have been granted an asylum status in another EU Member State have been prioritised and accelerated (*Spoor 2*).[1411] In July and August 2016 it concerned 20 per cent of all asylum cases.[1412] In November 2016 the State Secretary of Security and Justice reported that in such cases it takes an average of ten days from the application to the rejection of the asylum application.[1413]

[1404] The Netherlands Parliamentary documents TK 2016/17, 34 550 VI, nr. 11, p. 129.
[1405] State Secretary of Security and Justice, Letter explaining asylum seekers about the reception conditions and the waiting times in the asylum procedure, November 2015.
[1406] Art. 42(4)(b) Aliens Act 2000.
[1407] Besluit van de Staatssecretaris van Veiligheid en Justitie van 9 februari 2016, nummer WBV 2016/3, houdende wijziging van de Vreemdelingencirculaire 2000, Stb 2016, no. 7573 (WBV 2016/3).
[1408] See also the Netherlands Parliamentary documents TK 2016/17, 19637, nr. 2288. In June 2017 a COA officer involved in planning of asylum cases mentioned that the waiting time was still around 10 weeks.
[1409] WBV 2016/3.
[1410] Source: IND. The length of the asylum procedure has been calculated on the basis of the date of the asylum decision in each calendar year. This does not automatically mean that the applications in which the decision has been taken were submitted in the same year. The application on which no decision has been taken yet have not been included in this calculation. For this reason the average length of the asylum procedure is only an indication
[1411] From 1 March 2016 until 1 January 2017 2.270 cases (rounded off on tens) were decided in Track *2*. Source: IND.
[1412] The Netherlands Parliamentary documents, TK 2016/17, Aanhangsel van de Handelingen, nr. 47, p. 3.
[1413] The Netherlands Parliamentary documents, TK 2016/17, 19 637, no. 2257, p. 2.




The State Secretary has also taken measures to accelerate the processing of Dublin cases. He deployed extra personnel in order to reduce the length of the Dublin procedure (*Spoor 1*) with ten weeks.[1414] In July and August 2016 36 per cent of all new asylum applications were Dublin cases.[1415] The aim of the quick processing of these cases was to make room in the reception centres for 'genuine' asylum seekers and to deter asylum seekers from safe countries of origin.[1416]
At the same time the State Secretary refused to use the special simplified asylum procedure for asylum seekers with high chances of success.[1417] This meant that asylum seekers with higher chances of success (44 per cent in July and August 2016[1418]) had to wait for long periods of time. This included Syrians and Eritreans, who were almost certain[1419] that they would be granted an asylum status.[1420] As long as they had not received an asylum status, they could not apply for family reunification. This caused a lot of stress and concern with many asylum seekers, who had left their family members behind.[1421]

COA and IND cooperate in planning teams and decide together when asylum seekers start their asylum procedure.[1422] The IND decides how many cases of each nationality can be processed in the general

[1414] Ibid, p. 2.
[1415] The Netherlands Parliamentary documents, TK 2016/17, Aanhangsel van de Handelingen, nr. 47, p. 3.
[1416] Besluit van 17 februari 2016 tot wijziging van het Vreemdelingenbesluit 2000, houdende de invoering van bijzondere procedurele bepalingen die kunnen worden toegepast in situaties waarin sprake is van een aanzienlijke toename van het aantal asielaanvragen en enkele andere wijzigingen, Stb 2016, 87, p. 9.
[1417] Art. 3.123a Aliens Decree 2000.
[1418] The Netherlands Parliamentary documents, TK 2016/17, Aanhangsel van de Handelingen, nr. 47, p. 3
[1419] In the period January-September 2016, 92% of decisions in Syrian cases were positive and 87% in the Eritrean cases. Ministry of Security and Justice, *Kerncijfers Asiel en Migratie*, December 2016**.**
[1420] Interview DCR 1 and 2. However, one report mentions that the IND could process more cases of asylum seekers from Eritrea and Syria than cases of asylum seekers from other countries, because they required less work. This implied that asylum seekers from other countries than Eritrea and Syria needed to wait longer before their application could be processed. Inspectie Veiligheid en Justitie, Het overlijden van een Irakese Asielzoeker in de Noodopvang in Alphen aan de Rijn, August 2016, p. 26
[1421] Interview DCR 1 and 2.
[1422] Interview COA 1.

asylum procedure.[1423] COA decides which asylum seekers are sent to the Procedural Reception Location (POL) for the processing of their asylum application. In principle the date of registration determines when the asylum seeker is referred to a POL for the start of the asylum procedure.[1424] However, COA also takes into account special circumstances such as medical needs, the preference of the POL (for families, single men or vulnerable groups), language and nationality in its decision to refer to a POL.[1425]

From a certain period the IND started the asylum procedure at the same time for all asylum seekers living in a specific reception centre.[1426] The reason for this was that the IND capacity available at the application centres could not be efficiently utilized as a result of logistical problems. As a consequence the IND had to depart from the principle that asylum applications would be processed according to the date of the application.[1427]

*Information about the length of the asylum procedure*

Asylum seekers were informed about the length of the asylum procedure by the IND and COA.[1428] In November 2015 the State Secretary issued a general letter to all asylum seekers to inform them that the waiting time was six months.[1429] This letter was provided to asylum seekers by COA.[1430] From 25 April 2016 all asylum seekers received a personal letter during the registration interview (*Aanmeldgehoor*) with the IND, in which the maximum time-limit for the decision on the asylum application was announced.[1431] In a letter dated 26 May 2016 asylum seekers were informed that the waiting period would at least be seven months and that the time-limit for the decision by the IND was extended to 15 months with a possibility for another extension of three months.[1432] From September 2015 sessions were held in the reception centres to inform asylum seekers about the waiting times, living conditions, reception facilities and the asylum procedure.[1433]

It follows from the reports of several organisations and UNHCR participatory assessments that despite this information, it was often not clear to asylum seekers when they would start their asylum procedure.[1434] This caused unrest and a tense atmosphere in the reception centres.[1435] Asylum seekers felt stressed and frustrated or even developed psychological problems because of the uncertain situation.[1436] The perceived lack of information had several reasons. At least in one reception location

[1423] Interview DCR 4.
[1424] Inspectie Veiligheid en Justitie, Het overlijden van een Irakese Asielzoeker, p. 24.
[1425] Ibid, p. 9.
[1426] Interview DCR 4.
[1427] Interview COA 3.
[1428] The Netherlands Parliamentary documents, TK 2015/16, Aanhangsel van de Handelingen, nr. 3561, p. 2
[1429] State Secretary of Security and Justice, Letter explaining asylum seekers about the reception conditions and the waiting times in the asylum procedure.
[1430] The Netherlands Parliamentary documents, TK 2015/16, Aanhangsel van de Handelingen, nr. 3561, p. 1.
[1431] Ibid, p. 2. See also The Netherlands Parliamentary documents TK 2015/16, Aanhangsel van de Handelingen, nr. 1712, pp. 2-3.
[1432] State Secretary of Security and Justice, Asylum application in the Netherlands, February 2017.
[1433] The Netherlands Parliamentary documents TK 2015/16, 19637, nr. 2168, p. 40.
[1434] College Rechten van de Mens, *Aanbevelingen Mensenrechten in de noodopvang Heumensoord*, 10 February 2016, p. 8, Kinderombudsman, *Wachten op je Toekomst*, February 2016, p. 13, Nationale Ombudsman, *Rapportage Bezoek noodopvang Heumensoord*, 10 February 2016, nr. 2016/013, p. 5, Inspectie Veiligheid en Justitie, *Het overlijden van een Irakese Asielzoeker*, p. 7.
[1435] Inspectie Veiligheid en Justitie, *Het overlijden van een Irakese Asielzoeker*, pp. 6, 14.
[1436] Conversations with UNHCR staff, UNHCR the Netherlands, August/September 2016, Interview DCR 4.

COA chose not to provide the letter of November 2015 to asylum seekers, staying in a reception centre which was about to close, in order to avoid (more) unrest.[1437] Furthermore, the running and effect of the information sessions varied. In some cases no professional interpreter was present and translation had to be done by an IND employee or an asylum seeker.[1438] Sometimes such sessions caused unrest.[1439] Then the DCR often provided support to the asylum seekers after the meeting.[1440]

Asylum seekers also did not understand why other asylum seekers (who sometimes arrived later in the Netherlands) could start their procedure earlier than them. Asylum seekers believed that they were treated unequally.[1441] Furthermore, asylum seekers wanted to be informed about their individual procedure. However, COA often did not know when the procedure would start and therefore could not inform asylum seekers about that, while the IND was not available in the reception centres.[1442] The DCR received a lot of questions about the duration of the asylum procedures, but also did not know when an asylum seeker would start the asylum procedure.[1443] The National Ombudsman recommended in February 2016 to improve the provision of information by setting up an IND office in the emergency reception centre Heumensoord.[1444]

*Prioritisation*

IND officers in Ter Apel indicated that, during the period of high influx, they prioritised a reasonable number of individual cases, including those of asylum seekers who were ill or heavily pregnant and children. Another possibility was to decide directly to process a case in the extended asylum procedure. Then the asylum seeker could be placed in an Asylum Seeker's Centre (AZC) and receive more facilities as compared to those in the processing location ((pre)-POL). This particularly applied to asylum seekers with physical and psychological problems.[1445]

The IND received most suggestions for prioritisation from COA.[1446] COA officers working at location could inform COA planning about an asylum seeker in need of prioritisation, which could in turn ask the IND to prioritise a case.[1447] During the period of high influx COA planning received several requests for prioritisation per week.[1448] The IND also asked The DCR in Ter Apel to report cases which had to be prioritised. At the same time they made clear that this was possible only for a limited number of very special cases.[1449] The DCR has sometimes requested a lawyer to ask the IND for prioritisation.[1450]

[1437] The Netherlands Parliamentary documents TK 2015/16, Aanhangsel van de Handelingen, nr. 3561, pp. 1-2.
[1438] Ibid., p. 2, Interview DCR 1 and 2.
[1439] Ibid, p. 2.
[1440] Interview DCR 1 and 2.
[1441] Inspectie Veiligheid en Justitie, *Het overlijden van een Irakese Asielzoeker*, p. 6, Interview DCR 4.
[1442] Kinderombudsman, *Wachten op je Toekomst*, p. 13, Interview DCR 4.
[1443] Interview DCR 4.
[1444] Nationale Ombudsman, *Rapportage Bezoek noodopvang Heumensoord*, p. 5.
[1445] Ibid.
[1446] Interviews DCR 1 and 2 and COA 1.
[1447] Interview COA 3.
[1448] Ibid.
[1449] Interview DCR 1 and 2.
[1450] Interview Lawyer 2.

Also Nidos indicated that it was in the position to request the IND to prioritise specific poignant cases of unaccompanied children.[1451] It is not clear whether cases of unaccompanied children were always prioritised.[1452] In any case it could still take months before they entered the asylum procedure.[1453] At some point Nidos has asked lawyers to urge the IND to prioritise certain cases of children who had been waiting for a very long time and were longing for their parents.[1454] The Netherlands Human Rights Council recommended in December 2015 to prioritise the applications of children.[1455]

The lawyers and the DCR employees interviewed for this study only knew a few individual cases which received priority.[1456] These seem to be incidental cases in which a lot of effort was made by lawyers and/or the DCR. Moreover, it is not always clear why these cases succeeded and others did not. An employee of the DCR remembered one case of a transgender asylum seeker who was threatened in an emergency reception centre. At the same time a lawyer noted that she tried to get priority for a case of an LGBTI asylum seeker, who had problems in the reception centre, which was denied.[1457] However, several stakeholders noted that vulnerable groups such as children and/or single women were not prioritised because there were too many of them.[1458]

### 7.6 Application of the border procedure

Cases of asylum seekers who arrive at Schiphol Airport are generally processed in the border procedure.[1459] During this procedure asylum seekers are detained in the detention centre at Schiphol Airport for a maximum of four weeks.[1460] If the asylum application is rejected, the detention measure can be prolonged.[1461] Cases of unaccompanied children[1462] and families with children[1463] are excluded from the border procedure and are referred to an open centre.

Asylum seekers in need of special procedural guarantees, because they have been subjected to torture, rape or other serious forms of psychological, physical or sexual violence are not necessarily referred to the general asylum procedure in an open centre. In their cases the IND assesses whether adequate support can be offered during the border procedure. Only if this is not possible, the application will not be (further) examined in the border procedure.[1464] The Medical advice

[1451] Interview Nidos.
[1452] Interview IND 2 and 3.
[1453] Interview IND 2 and 3, Lawyer 2.
[1454] Interview Lawyer 2.
[1455] College voor de Rechten van de Mens, *Aanbevelingen Mensenrechten in (tijdelijke) opvanglocaties*, pp. 6, 9.
[1456] Interview Lawyer 2, Lawyers 3 and 4, Lawyer 5.
[1457] Interview Lawyers 3 and 4.
[1458] Interview DCR 4, IND 2 and 3.
[1459] The number of persons who applied for asylum at the border was 620 in 2015 and 490 in 2016. Ministerie van Veiligheid en Justitie, Rapportage Vreemdelingenketen, Periode januari-december 2016, March 2017, p. 30.
[1460] Art. 3(4) Aliens Act 2000. The decision to detain a person during the border procedure can be appealed before the court. See Art. 94 Aliens Act 2000.
[1461] Art. 6(6) Aliens Act 2000, Art. 5.1a(4) and 5.1a (1) Aliens Decree 2000.
[1462] Art. 3.109b(7) Aliens Decree 2000, IND Instruction 2017/1, p. 6.
[1463] Para. A1/7.3 Aliens Circular 2000, IND Instruction 2017/1, p. 6.
[1464] Besluit van 10 juli 2015, Stb 2015, 294, p. 25, The Netherlands Parliamentary documents, Handelingen EK 2014/15, nr. 38, item 8, pp. 20-21, IND Instruction 2017/1, p. 6. According to the IND the fact that the asylum seeker needs adequate support does not mean that there are special circumstances which renders the

interviewing and decision-making issued by FMMU is an important instrument in this assessment. As has been shown in section 3.6.6 of this report, the number of asylum seekers who have medical limitations or cannot be interviewed according to FMMU at Schiphol Airport is relatively high. However, that does not mean that all these asylum seekers are referred to an open centre.
The border procedure (detention) will also not be applied if there are special individual circumstances which render the detention measure disproportionally burdensome.[1465] Examples of such circumstances may be the medical state of an asylum seeker, such as an admission to hospital for an urgent medical condition for a longer period or serious psychological problems.[1466]

This study has not examined when the IND accepts in practice that an application cannot be processed in the border procedure, because the asylum seeker cannot be offered adequate support or has special individual circumstances.
A representative of the Legal Aid Board at Schiphol Airport noted that the applications of vulnerable asylum seekers should not be processed in the border procedure.[1467] According to UNHCR's detention guidelines decisions to detain are to be based on a detailed and individualised assessment of the necessity to detain in line with a legitimate purpose.[1468] Furthermore, victims of torture and other serious physical, psychological or sexual violence as well as asylum-seekers with long-term physical, mental, intellectual and sensory impairments need special attention and should generally not be detained.[1469]

### 7.7 General, extended or accelerated asylum procedure?

Asylum seekers who arrived via the land border stay in an open reception centre during the asylum procedure. The IND decides whether the asylum seeker can be interviewed and whether this can be done in the general asylum procedure.[1470] In principle all asylum seekers are interviewed on their asylum motives in the general asylum procedure.[1471] Most asylum seekers (74 per cent in 2015) also receive a decision in this procedure.[1472] The general asylum procedure takes a maximum of eight days from the first interview to the (positive or negative) decision. The procedure is preceded by a rest and preparation period of (at least) six days.[1473] Also the appeal against the negative asylum decision in

detention disproportionate. See also District court Amsterdam 24 February 2017, AWB 17/1639, which found that the IND was not required to send an asylum seeker who stated during the FMMU medical examination and the first interview that he had been kidnapped and raped to the normal asylum procedure.
[1465] Art. 51a (3) Aliens Decree 2000.
[1466] IND Instruction 2017/1, p. 5.
[1467] Interview Legal Aid Board. See also IRCT position paper on the Proposal for an Asylum Procedures Regulation (July 2016), 6 September 2016, p. 2.
[1468] UNHCR, *Detention Guidelines*, 2012, p. 15.
[1469] Ibid, pp. 33, 38. See also IRCT, position paper on the Proposal for an Asylum Procedures Regulation (July 2016), September 2016, p. 2.
[1470] IND Instruction 2010/13, p. 3.
[1471] Art. 3.113(2) Aliens Decree 2000, IND Instruction 2010/13, p. 1.
[1472] The Netherlands Parliamentary documents TK 2016/17, 34 550 VI, nr. 11, p. 115. The estimated percentage was 50% in 2011, more than 60% in 2012 and more than 70% in 2013. K. Zwaan e.a., Evaluatie Herziene Asielprocedure, WODC 2014, p. 50.
[1473] Art. 3.109 Aliens Decree. It should be noted that the time between the application and the start of the general asylum procedure is often (much) longer than six days. See for the waiting times during the period of high influx, section 7.5.

the general asylum procedure is processed in a short period of time (an average of 5 weeks in 2016).[1474]

Only cases in which no careful decision can be taken in the general asylum procedure, are referred to the extended asylum procedure after the interview on the asylum motives. In the extended asylum procedure the time-limits for the steps in the asylum procedure are much longer (see Annex 3 for a more detailed description of the Dutch asylum procedure).[1475] Also the appeal phase takes longer (an average period of 12 weeks in 2016), because in many cases the courts are not required to decide on the appeal within a time-limit of four weeks (as is the case if the application was rejected in the general asylum procedure).[1476]

The Aliens Decree mentions that the interview will not be held in the general asylum procedure if the asylum seeker cannot be subjected to an interview for medical reasons and in cases of children below 12 years old.[1477] The IND recognises that it is not always possible or desirable to interview asylum seekers with limitations as a result of, for instance, psychological problems during the general asylum procedure.[1478] If the medical advice states that the asylum seeker currently cannot be interviewed or if the asylum seeker has submitted a medical statement that they currently cannot be interviewed, the IND discusses with the asylum seeker's lawyer whether the asylum seeker's case should be referred to the extended procedure.[1479] The IND stated that in particular for Syrians and Eritreans it may be better to proceed with the interview, because they will usually be granted an asylum status. For such asylum seekers postponing the asylum procedure may have very negative consequences.[1480] If the advice concludes that the asylum seeker has limitations which interfere with their ability to make complete and coherent statements, the IND officer assesses whether the necessary extra guarantees can be offered during the general asylum procedure.[1481] The IND officer may also stop the interview if the asylum seeker shows severe psychological problems and the officer thinks this would undermine the quality of the interview.[1482]

Some state that in practice the IND tries to examine as many cases in the general asylum procedure as possible.[1483] In some cases the strict time limits during the general asylum procedure are problematic.[1484] One lawyer mentioned that he had several cases in which the asylum seeker became unwell during the meeting in which he discussed the report of the asylum interview with his client. As

[1474] Ministerie van Veiligheid en Justitie, Rapportage Vreemdelingenketen, Periode januari-december 2016, March 2017, p. 24.
[1475] Art. 3.116 Aliens Decree 2000.
[1476] Ministerie van Veiligheid en Justitie, Rapportage Vreemdelingenketen, Periode januari-december 2016, March 2017, p. 24. Art. 83b Aliens Act 2000.
[1477] Article 3.113 (7) Aliens Decree 2000.
[1478] IND Instruction 2010/13, p. 2.
[1479] Ibid.
[1480] Interviews IND 2 and 3 and IND 4. See also IND Instruction 2010/13, p. 2.
[1481] IND Instruction 2010/13, p. 3.
[1482] Ibid., Interview IND 5 and 6. See also District court Middelburg, 18 April 2017, AWB 17/6329, para. 12.
[1483] Interview Legal Aid Board and DCR 5. See also K. Zwaan e.a., *Evaluatie Herziene Asielprocedure*, WODC 2014, p. 109. This report mentioned that several lawyers said that the IND focuses too much on taking decisions in the general asylum procedure. IND officers stressed the importance of production within the IND.
[1484] ACVZ, *De geloofwaardigheid gewogen. Een advies over het onderzoeken, integraal beoordelen en toetsen van verklaringen in de asielprocedure*, 2016, p. 62.

a result he could not properly go through the whole report. In his view the fact that the asylum seeker does not feel well during the meeting may be a sign that he has psychological or physical problems, which should be examined. Such examination is not possible during the general asylum procedure. Nevertheless, the IND did not refer these cases to the extended asylum procedure.[1485]

In this light it is important to note that IRCT argues that cases of victims of torture should not be processed in an accelerated procedure because such procedure does not allow them to obtain a forensic medical examination and to present all relevant elements at their disposal to the determining authorities.[1486]IRCT recommends that 'The asylum procedure duration should, to a reasonable extent, integrate the time needed for the medical or psychological treatment to have effect.'[1487]

If the interview on the asylum motives has not been held (or finalised) in the general asylum procedure, the interview will be held as soon as possible after referral to the extended asylum procedure.[1488] According to IND Instruction 2010/13 the asylum seeker's lawyer should receive a letter in which they are requested to think about how and when the asylum seeker may be interviewed at a later stage. The IND should contact the asylum seeker's lawyer within a month unless the asylum seeker's file mentions that a longer period of time is needed before the asylum seeker can be interviewed. The IND should discuss with the lawyer which measures are necessary to carry out the interview in a careful manner.[1489] The agreement between the IND and the lawyer about the special guarantees which will be offered during the interview should be confirmed by the IND in a written statement.[1490] It is not clear whether the IND (always) complies with the instruction in practice.[1491]
The IND applies an accelerated procedure to cases of asylum seekers originating from safe countries of origin and asylum seekers granted asylum in other Member States of the European Union.[1492] In July and August 2016 it concerned 20 per cent of all asylum applications.[1493] In this procedure there are less procedural guarantees. Asylum seekers do not get a rest and preparation period or the opportunity to prepare the procedure with their lawyer. Furthermore, there is only one interview instead of two. Asylum seekers first meet their lawyer after their interview. As was already noted in section 3.3.1 of this report the fact that an asylum seeker originates from a safe country or has been granted protection in another EU Member State does not exclude that they have limitations affecting the quality of the interview with the IND. The fact that they do not receive (proper) information from the DCR, no preparation by a lawyer and no Medical advice interviewing and decision-making before the start of the asylum procedure may impede the identification of special needs. The limitation of procedural guarantees and short time limits during the accelerated procedure is problematic for asylum seekers with such special needs.

[1485] Interview Lawyer 5.
[1486] IRCT, *Position paper on the Proposal for an Asylum Procedures Regulation*, p. 2.
[1487] Ibid., p. 4.
[1488] Art. 3.113(8) Aliens Decree 2000.
[1489] IND Instruction 2010/13, p. 4.
[1490] Ibid.
[1491] Earlier research published in 2011 showed that the IND did not comply with this requirement (at the time laid down in IND Instruction 2008/6). Van Mourik, K, Zwaan, K. and Terlouw, A, *Gehoor Geven*, 2011, p. 36.
[1492] Art. 3.109ca Aliens Decree 2000.
[1493] The Netherlands Parliamentary documents, TK 2016/17, Aanhangsel van de Handelingen, nr. 47, p. 3.

## 7.8 Omitting the interview

The IND takes as a point of departure that every asylum seeker can be interviewed and that only in exceptional cases the interview should be omitted.[1494] In some cases however, it turns out that the asylum seeker cannot be interviewed at all. For example the IND does not subject a child younger than 12 years old to an asylum interview if pedagogical or psychological examinations shows that the child has problems, which impede such interview.[1495] The asylum seeker's handicap or psychological problems may also prevent an interview.[1496] The IND could not provide statistics about the number of asylum applications in which the interview was omitted.

If an asylum seeker cannot be interviewed, alternative means of gathering information should be applied, including obtaining information from family members, the treating doctor, the asylum seeker's lawyer or the DCR, ordering an individual report by the Ministry of Foreign Affairs, or asking a written statement from the asylum seeker.[1497] If no information is available and it cannot be assessed whether there is a risk of *refoulement*, the application will be refused.[1498]
The IND instruction does not mention the possibility of asking a forensic medical examination if the asylum seeker is not capable of doing an interview with the IND. The ACVZ suggested in 2014 that the fact that an asylum seeker cannot be interviewed may be reason for the IND to request a medical examination. A psychologist/psychotherapist/psychiatrist may be able to get relevant information on the asylum seeker's asylum account from the asylum seeker without doing harm.[1499] For the purpose of this study one report was examined, in which the Netherlands Institute of Forensic Psychiatry and Psychology (NIFP) carried out a forensic examination of an asylum seeker who, according to MediFirst and FMMU, could not be interviewed.[1500]

## 7.9 Special guarantees during the interview

In Dutch asylum law, the burden of proof is on the asylum seeker.[1501] This means that asylum seekers are expected to substantiate their asylum claim as much as possible with documents and statements.[1502] According to the Administrative Jurisdiction Division of the Council of State (AJD), the highest court in asylum cases in the Netherlands:

> It is up to the asylum seeker to clearly bring his asylum motives to the fore and not up to the State Secretary to – further – reveal them by asking questions. This also applies to contradictions in the asylum seeker's statements. The fact that the State Secretary has not

[1494] IND Instruction 2010/13, p. 1.
[1495] Para. C1/2.11 Aliens Circular.
[1496] Lawyer 5 mentioned the example of a mentally retarded girl. Furthermore, no interview could be held one of the cases in which the NIFP issued an report ( 31 May 2016, case 2) because MediFirst and FMMU advised that the asylum seeker was not able to be interviewed. See further about NIFP reports Chapter 4 of this report.
[1497] IND Instruction 2010/13, p. 5. See also K. Zwaan e.a., *Evaluatie Herziene Asielprocedure*, p. 85.
[1498] IND Instruction 2010/13, p. 6. See for an example District Court Middelburg 6 April 2017, NL 16.3400. The IND rejected the application because the identity and nationality of the asylum seeker could not be established. The court quashed the rejection.
[1499] ACVZ, *Sporen uit het verleden*, July 2014, p. 25.
[1500] NIFP report of 31 May 2016. See also Chapter 4 of this report.
[1501] Art. 31(1) Aliens Act 2000.
[1502] IND Instruction 2014/10, p. 6.

> asked any specific questions to the asylum seekers, does not mean that he did not have the opportunity to bring forward of his own motion what he deems important in order to support his asylum claim, for example by making corrections and additions to the interviews.[1503]

For asylum seekers with special needs, for example as a result of psychological problems, this may be a difficult or even impossible task. For this reason the RAPD requires that interviewers take into account the asylum seeker's vulnerabilities during the interview. EASO notes that in interviews with vulnerable asylum seekers the immigration authorities' 'responsibility to ensure that all relevant topics are explored increases; sometimes this will also mean asking for more specific information that could contribute to identifying possible indicators of vulnerability'.[1504] Furthermore, EASO states that:

> Inconsistencies in the story may be due to factors such as: symptoms of stress or trauma affecting the asylum seeker's consistency of memory, misunderstandings due to differences in culture, moral, religion, misinterpretations or miscommunication, due to feelings of shame or guilt. It is therefore important that all inconsistencies are addressed in a respectful manner. You should of course point out to the asylum seeker where there are inconsistencies, giving the asylum seeker a chance to make necessary clarifications or corrections.[1505]

In this context EASO defines a vulnerable person as 'an asylum seeker whose ability to understand and effectively present their case or fully participate in the process is limited due to his/her individual circumstances'.[1506]

This section will examine how the IND provides support to asylum seekers with special needs during the interview. It will address the quality and training of IND officers, special measures taken during the interview, attendance of interviews by volunteers of the DCR and recording of interviews.

### 7.9.1 Quality and training IND officers

IND officers need to follow the three EASO modules on inclusion, interviewing techniques and evidence assessment. All IND officers also must follow the training Interviewing vulnerable persons.[1507] The IND trainers of the Training interviewing vulnerable persons noticed that IND officers get several trainings and are supervised during their first period at the IND. However, after this period there is often a lack of review of and feed-back on the IND officer's interviewing techniques. This is due to a lack of time. The trainers were in favour of more regular coaching and feed-back.[1508] In May 2016 the ACVZ also noted that training beforehand is not sufficient. It established that IND officers received insufficient feed-back and recommended that IND officers should review and monitor each other's decisions.[1509]

[1503] AJD 12 April 2017, ECLI:NL:RVS:2017:1040.
[1504] EASO, Module Interviewing Vulnerable Persons as consulted in November 2016.
[1505] Ibid.
[1506] Ibid.
[1507] See also section 2.4.2.
[1508] IND training Interviewing vulnerable persons, November 2016. See also Van Mourik et. al., p. 43.
[1509] ACVZ, *De geloofwaardigheid gewogen*, p. 56. See also UNHCR, *Beyond proof*, pp. 81, 177.

During the period of high influx the IND employed many new (temporary) officers via employment agencies.[1510] The main task of these new officers was to interview asylum seekers. They did not follow the three basic EASO modules (inclusion, interviewing and evidence assessment)[1511] before they started interviewing asylum seekers, but received a basic training for example on asylum policy and interviewing persons.[1512] They mostly had to learn on the job under the supervision of an experienced IND officer.[1513]

One employee of the DCR stated that the quality of the interviews is generally good and has increased over the past years.[1514] The level of education of new IND officers is generally high.[1515] Some lawyers indicated that they see good interviews, but that the quality of the interviews depends on the IND officer.[1516] Some organisations doubted whether the temporary IND officers had sufficient knowledge and sensitivity to adequately interview asylum seekers.[1517] The DCR for example heard some complaints about new interviewers who were more focused on posing their questions than on the interaction with the asylum seeker. At the same time, it was noted that there are sometimes also complaints about interviews carried out by IND officers, who have been working for the IND for a very long time. They may be suspicious because they have heard many similar stories from asylum seekers.[1518]

*Training interviewing vulnerable persons*

According to the Secretary of State the EASO Training interviewing vulnerable persons helps IND officers to assess whether an asylum seeker has special procedural needs and to recognise and deal with signals of vulnerability.[1519] Most participants have between six months and three years of experience. But sometimes also much more experienced IND officers take part in the training. New (temporary) IND officers initially did not follow the Training interviewing vulnerable persons. Only those who could stay in September 2016 could participate in the training on a shorter notice.[1520] During the fall of 2016 many training sessions were held.[1521]

[1510] In August 2016 the IND fired 300 temporary officers working in the asylum process and replaced another 350. This is more than 20% of the total amount of people working for the IND (2946 in 2016), and a much higher percentage of the IND officers working in the asylum process. NRC, IND stuurt 300 tijdelijke krachten weg, 22 August 2016, IND, Jaarverslag 2016, p. 28.
[1511] See https://training.easo.europa.eu/lms/.
[1512] ACVZ, *De geloofwaardigheid gewogen*, p. 56, Onderzoeksraad voor Veiligheid, *Veiligheid van vreemdelingen*, April 2014, p. 38, Interviews IND 2 and 3 and IND 5 and 6.
[1513] ACVZ, *De geloofwaardigheid gewogen*, p. 56, Onderzoeksraad voor Veiligheid, *Veiligheid van vreemdelingen*, p. 38.
[1514] Interview DCR 1 and 2.
[1515] Ibid.
[1516] Interviews Lawyer 2 and Lawyer 5.
[1517] ACVZ, *De geloofwaardigheid gewogen*, p. 43, Onderzoeksraad voor Veiligheid, *Veiligheid van vreemdelingen*, pp. 38, 56, Interview iMMO.
[1518] Interview DCR 4.
[1519] Besluit van 10 juli 2015, pp. 24-25, The Netherlands Parliamentary documents, Handelingen EK 2014/15, nr. 38, item 8, p. 17.
[1520] Interview IND 5 and 6.
[1521] Ibid.

The trainers are experienced IND officers who do not have a medical background. Some medical experts are critical about the fact that the IND does not include persons from outside the IND with medical or psychological expertise and knowledge of the asylum system in this training.[1522]

The training 'Interviewing Vulnerable Persons' consists of an online module and a three-day face to face training. The online module pays attention to the definition of vulnerability and indicators of vulnerability.[1523] Furthermore, it explains how the interviewer can identify vulnerability and respond to it in an adequate way during each stage of the interviewing process. It discusses the qualities the interviewer should display during the interview, such as open-mindedness, flexibility, empathy, fairness and good listening. The module explains several psychological, psychiatric and physical factors which can influence the asylum seeker's ability to present a coherent asylum account.[1524] It also addresses what an interviewer can do in order to support the asylum seeker.[1525]
During the three-day face to face training, the trainers discuss more theoretical aspects of interviewing vulnerable during the first day.[1526] They for example address the type of questions which may help asylum seekers to go back to their memories and talk about what happened to them. They explain that it may sometimes be better to ask about experiences and sensations then about persons, dates and places. They also try to make IND officers feel what they actually require from an asylum seeker during an interview, for example when they ask them to recall details of events and talk about intimate experiences. During the second day of the training the IND officers practice with a professional actor to recognise and respond to non-verbal communication, before, during and after the interview.[1527] They also do mock interviews (for example with a person with a depression, low intelligence, anxiety or difficulties talking about traumatic experiences).[1528] During the final day an IND policy maker talks about Dutch law, policy and case law with regard to medical aspects of the asylum procedure. This includes the Medical advice interviewing and decision-making and the Forensic Medical Examination.

Asylum seekers with special needs are not always interviewed by IND officers who have followed the Training interviewing vulnerable persons. Sometimes the special needs only become apparent during the interview. In some situations the interview will then be stopped, but this is not always considered the best solution.[1529] If it is known before the start of the interview that an asylum seeker has special

[1522] Interviews Pharos and iMMO.
[1523] The module mentions the following indicators: war and conflict, torture, gender related persecution, LGBTs, sexual violence, human trafficking, the journey and the asylum procedure.
[1524] Some IND officers found that this information was very detailed. They wondered whether they should make a diagnosis of an asylum seeker's psychological problems. The trainers stressed that IND officers only need to be able to recognise when a person is in need of special procedural guarantees and when he should receive treatment.
[1525] EASO, Module Interviewing Vulnerable Persons as consulted in November 2016.
[1526] During the training reference is made to the EASO Tool For Identification Of Persons With Special Needs. In this tool decision parties involved in the asylum procedure can mark relevant indicators of vulnerability, discover to which categories of vulnerable persons these indicators may be linked and find general guidance on how to address the special needs of these categories of asylum seekers in different stages of the asylum procedure.
[1527] IND training Interviewing vulnerable persons, November 2016.
[1528] Ibid.
[1529] Interviews IND 2 and 3 and IND 5 and 6.

needs, a more experienced IND officer will do the interview.[1530] Unaccompanied children are interviewed by IND officers, who have followed a special training on interviewing children.[1531]

### 7.9.2 Measures taken by the IND

On the basis of the Medical advice interviewing and decision-making, the IND decides which measures should be taken during the interview.[1532] IND officers are encouraged to discuss with the asylum seeker's lawyer which support should be provided during the asylum procedure[1533] and this also happens in practice.[1534] Furthermore, during the training Interviewing vulnerable persons IND officers were advised to contact the lawyer after a difficult asylum interview.[1535] However, lawyers indicated that (in particular new) IND officers are sometimes not open to discussions with lawyers about how the interview could best take place in an individual case, which they regret.[1536]

Special guarantees which are too costly or time consuming, may not be possible.[1537] The IND may also deviate from the agreements made after consultation with the lawyer or from the Medical advice, if that seems adequate at that moment.[1538] If for example an asylum seeker is in the middle of their asylum account and doing well, the IND may refrain from taking a break.[1539] On the other hand if an asylum seeker seems to have physical or psychological problems during the interview, which need attention, a GCA nurse is available to examine the asylum seeker.[1540] If necessary, the IND can ask for a new FMMU medical advice.

Special measures may include:

- extra breaks or explanation during the interview
- allowing an asylum seeker with back pains to stand up and move around
- guiding an asylum seeker with poor eyesight to the interview room
- the presence of the lawyer, a person from the DCR or a family member
- the division of the interview in several parts which may be spread over several days
- holding the interview outside an IND office

[1530] Interviews IND 1 and IND 2 and 3. At Schiphol Airport the senior IND officer on duty discusses the planning with the planners and if necessary the planning is adapted in order to make sure that the right IND officer will do the interview.
[1531] Besluit van 10 juli 2015, Stb 2015, 294, p. 25. See on this issue also UNHCR, The Heart of the matter, pp. 95, 173.
[1532] IND Instruction 2015/8, p. 2, IND Instruction 2010/13, UNHCR, the Heart of the matter, December 2014, p. 47.
[1533] IND Instruction 2015/8, IND training Interviewing vulnerable persons, November 2016.
[1534] Interviews IND 1 and IND 2 and 3.
[1535] IND Training Interviewing vulnerable persons, November 2016.
[1536] Interview Lawyers 3 and 4. See also Van Mourik et. al, pp. 36-37 and 55, a research of 2011 in which it was concluded that the IND does not always contact the lawyer and that lawyers wanted the IND to be more pro-active in cases where they had reported potential psychological problems of their client.
[1537] IND Instruction 2010/13, p. 4, Interviews IND 2 and 3 and IND 5 and 6.
[1538] IND Instruction 2010/13, p. 5.
[1539] Interview IND 4.
[1540] Additional information provided by GCA in July 2017.

- planning of the interview at a certain time of the day (taking into account the fact that the asylum seeker needs to take medication at a certain moment).[1541]

Furthermore, asylum seekers may request a (fe)male IND officer and/or interpreter. The IND has a duty to do its best to comply with this request.[1542] Other measures mentioned during the interviews and the training Interviewing vulnerable persons were repeating and checking the asylum seeker's statements, (refrain from) asking follow-up questions and making a person feel at ease for example by taking simple practical measures such as closing or opening windows or curtains[1543], deviating from the interview format and taking extra time for the interview[1544]. Interviewing an asylum seeker at another location is more exceptional.[1545] An asylum seeker who has problems remembering dates will be asked to relate his asylum account to important generally known events or holidays.[1546] The IND interviews children below 12 years old in a special child friendly room.[1547]

During the interview the IND officer should take into account the medical limitations of the asylum seeker and comply with the measures described in the Medical advice interviewing and decision-making[1548] If the medical advice concluded that special guarantees should be offered, the case file should mention what the IND has done with that advice. Furthermore, the report of the interview should mention which special measures were taken during the interview.[1549] The report should also mention emotional reactions or special behaviour of the asylum seeker.[1550] During the Training interviewing vulnerable persons the IND officers were told to always mention the measures taken in the report of the interview and to describe the asylum seeker's emotional state during the interview as specifically as possible.[1551] The ACVZ noted in a report of 2016 that in practice the report of the interview does not always make clear whether the interview has been conducted in an adequate way.[1552]

It is generally perceived that during the interview the IND complies with the measures advised by FMMU.[1553] Others indicate that the observance of the measures varies depending on the interviewer.[1554] One lawyer noted that the IND is very good at complying with the practical measures suggested by FMMU, in particular for persons with physical limitations. However, in her view the IND does not know how to deal with psychological problems.[1555] She does not see other measures than

[1541] IND Instruction 2010/13, p. 4, IND Instruction 2015/8, p. 6, Besluit van 10 juli 2015, Stb 2015, 294, p. 24, The Netherlands Parliamentary documents, Handelingen EK 2014/15, nr. 38, item 8, p. 17.
[1542] Para. C1/2.11 Aliens Circular.
[1543] Interview IND 5 and 6.
[1544] IND Training Interviewing vulnerable persons, November 2016.
[1545] IND Instruction 2010/13, p. 5.
[1546] Interview IND 5 and 6.
[1547] Para. C1/2.11 Aliens Circular, Art. 3.45a Voorschrift Vreemdelingen 2000.
[1548] IND Instruction 2010/13, p. 5.
[1549] Ibid., p. 3.
[1550] Ibid., p. 5.
[1551] IND Training Interviewing vulnerable persons, November 2016.
[1552] ACVZ, *De geloofwaardigheid gewogen*, p. 41.
[1553] Interviews Lawyer 2, FMMU 2 and DCR 1 and 2.
[1554] Interview Lawyer 5.
[1555] Interview Lawyers 3 and 4.

taking extra breaks.[1556] It was concluded in section 3.7 of this report that indeed the FMMU often advises the IND to take extra breaks, offer the asylum seeker the possibility to eat and drink or to move around during the interview. The lawyer mentioned a case of a six-year-old boy who was left alone by his mother at Schiphol Airport. The IND did not adapt the questions to the age and situation of the boy, which led to an unusable interview. The next day the IND issued an intended rejection.[1557] Some indicated that the observance to the measures how much attention is paid to special needs varies depending on the IND officer.[1558]

### 7.9.3 Attendance of interviews

In conformity with Article 25(1)(b) RAPD the asylum interviews of unaccompanied children are attended by the guardian provided by Nidos or a volunteer of the DCR.[1559] In principle Nidos attends all interviews of unaccompanied children younger than 16 years old. It assesses the need to attend interviews of unaccompanied children of 16-17 years old. Nidos can ask the lawyer to request the DCR to attend the interview.[1560] The DCR gives high priority to interviews of unaccompanied children, who cannot be attended by Nidos.[1561] During the interview Nidos supports the unaccompanied child, makes comments on the course of the interview or stops the interview if the child is not able to proceed.[1562] In particular during the periods of high influx, it was impossible for Nidos to attend all interviews.[1563] Nidos sometimes also attends the first (preparatory) meeting with the lawyer.[1564] Defence for Children and Unicef contended in their year report of 2016 that it is impermissible that the IND interviewed children without the presence of their guardian.[1565]

The DCR also attends interviews of adult asylum seekers at the request of the lawyer, the asylum seeker[1566] or the IND or of their own motion.[1567] The Best Practice Guide Asylum for asylum lawyers advises lawyers to request the DCR to be present during the interview, in particular where limitations were found during the medical examination.[1568] The DCR gives priority to such requests.[1569] The DCR always checks beforehand whether an asylum seeker wants a volunteer of the DCR present during the interview.[1570] Some IND officers who took part in the Training Interviewing vulnerable persons mentioned that they sometimes find the attendance of a volunteer of the DCR disturbing, because they sometimes act overprotectively. The volunteer sometimes only first meets the asylum seeker

[1556] Interview Lawyers 3 and 4. See also Interview Lawyer 2.
[1557] Interview Lawyers 3 and 4. The IND decided that another interview was necessary.
[1558] Interviews Lawyer 5 and DCR 4.
[1559] Besluit van 10 juli 2015, Stb 2015, 294, p. 25, Art 3.109d(4) Aliens Decree 2000. Interview Nidos.
[1560] Interview Nidos.
[1561] Interview DCR 4, Dutch Council for Refugees, *Kerntaak Bijwonen van Gehoren*.
[1562] Interview Nidos.
[1563] Ibid.
[1564] Interview DCR 1 and 2, Lawyer 2.
[1565] Defence for Children and Unicef, *Jaarbericht Kinderrechten 2016*, p. 29.
[1566] Asylum seekers are informed that DCR can attend their interview during the rest and preparation period. DCR, Kerntaak Algemene Voorlichting POL.
[1567] This is allowed according to Para. C1/2.11 Aliens Circular.
[1568] N. Doornbos, F. Koers and Th. Wijngaard, *Best Practice Guide Asiel, Bij de Hand in Asielzaken*, September 2012, p. 66.
[1569] Interview DCR 4.
[1570] Interview DCR 4 and Dutch Council for Refugees, Kerntaak Bijwonen van Gehoren.

directly before the interview and they doubt sometimes whether the asylum seekers appreciates the presence of the volunteer.[1571]

The purpose of the observations is to support the asylum seeker during the interview. Volunteers can for example suggest the IND to take a break when a person is tired.[1572] Furthermore, the observations aim to ensure and monitor the quality of the interview. During the interview volunteers may see signals of special needs, and then inform the asylum seeker's lawyer about it. They write a (verbatim) shadow report of the interview. Furthermore, they fill out a report in which they describe the atmosphere during the interview. The DCR uses national standards for the observation of interviews.[1573] Volunteers of the DCR are trained to observe IND interviews during a one day practical training, which aims at clarifying the roles and positions of the persons present during the interview and effective observing and intervening.[1574]

Lawyers do not often attend the interview of their client. Reasons for that are the planning of interviews at the application centre and the fact that lawyers do not receive any compensation for attending the interview.[1575] The ACVZ noted that the lawyers' attendance of the interview would contribute to the quality of the interview. It stated that lawyers could, in addition to the medical advice, indicate before the interview their impression of the physical and mental state of their client. Furthermore, the lawyer is better able to check whether the report of the interview provides a correct picture of the interview.[1576]

### 7.9.4 Recording of interviews

The DCR has recently started a pilot to record interviews in the reception centre in Zevenaar. The lawyer needs to request a recording or at least confirm that this would be useful. The recording is sent to the lawyer, the DCR does not keep a copy. The DCR also informs the lawyer about important parts of or events during the interview. After an evaluation the DCR will decide whether they will start recording interviews on a larger scale.[1577]

The question whether asylum interviews should be recorded by the IND has been discussed for years.[1578] The National Ombudsman advised to make audio recordings of hearings by the IND, particularly in cases where the medical report has warned for limitations on the asylum seeker's ability to answer questions.[1579] Furthermore, the Ombudsman has declared complaints about the IND's rejection to permit asylum seekers to make recordings of their own interviews well-founded.[1580] The IND did not want asylum interviews to be recorded, because the quality of the interviews is sufficiently

[1571] IND Training Interviewing vulnerble persons, November 2016.
[1572] Interview DCR 4.
[1573] Dutch Council for Refugees, *Kerntaak Bijwonen van Gehoren*.
[1574] Interview DCR 4 and Dutch Council for Refugees, *Kerntaak Bijwonen van Gehoren*.
[1575] ACVZ, *De geloofwaardigheid gewogen*, p. 41, Interview Legal Aid Board and DCR 5.
[1576] ACVZ, *De geloofwaardigheid gewogen*, p. 42.
[1577] Interview DCR 4.
[1578] See eg the Netherlands Parliamentary Documents, TK 2000/01, 26 732, nr. 95.
[1579] Nationale Ombudsman, case report no. 2015/052. Also the Committee which assessed complaints against interpreters (Klachtenadviescommissie Tolken) was in favour of recording interviews. See Bot, H., Reneman, M. and Samson, A., Klachtenadviescommissie Tolken, *Nieuwsbrief Asiel- en Vluchtelingenrecht,* 2008, nr. 5, p. 312.
[1580] See eg Nationale Ombudsman, case report no. 2012/142.

guaranteed and the benefits of recording weigh less than the potential negative effects. According to the IND recordings could be edited. Furthermore, (discussions about recordings) would cost time and money. Finally asylum seekers could use the recordings to make their asylum account known to the authorities of the country of origin in order to be granted protection under Article 3 ECHR.[1581] However, during the training Interviewing vulnerable persons several IND officers mentioned that they think it is a good idea to record interviews of vulnerable persons.[1582]

In 2014 the Ombudsman issued rules for recording conversations with administrative bodies, including the IND. These state amongst others that the administrative body may not refuse permission to record. The asylum seeker should inform the administrative body about the recording, may not edit the recording and may not make the recording public or provide it to third parties without the administrative body's permission.[1583] After the publication of the rules the IND started a pilot with recordings of interviews. However, very few requests for recordings were made.[1584]

## 7.10 Decision-making

IND workers who take the asylum decision need to determine whether and how the asylum seeker's vulnerability affects their decision.[1585] IND officers do not only look at the medical circumstances but also at the education and cultural background of the asylum seeker. Furthermore, the IND officer's own observations during the interview are taken into account. Finally the IND attaches weight to the fact that the asylum seeker has declared during the interview that they were feeling fine and were well able to do the interview.[1586] IND officers balance all the circumstances and decide whether inconsistencies or vagueness can be attributed to the asylum seeker's personal circumstances and mental state.[1587]

### 7.10.1. The weight of the Medical advice interviewing and decision-making

The IND views the Medical advice interviewing and decision-making as being primarily focussed on the interview rather than decision-making.[1588] It is mainly left to the discretion of the IND officer who takes the asylum decision to determine whether and how the detected medical conditions affect their decision.[1589] The IND acknowledges that an asylum seeker with medical or psychological problems may not be able to make coherent and consistent statements, even if special guarantees are provided

[1581] Nationale Ombudsman, *Spelregels voor het maken van geluidsopnamen*, 27 November 2014, report no. 2014/166, p. 13, Nationale Ombudsman, *Terugblikonderzoek spelregels geluidsopnamen*, 9 November 2016, report no. 2016/105, p. 9.
[1582] IND Training Interviewing vulnerable persons, November 2016.
[1583] Nationale Ombudsman, *Spelregels voor het maken van geluidsopnamen*, 27 November 2014.
[1584] Nationale Ombudsman, *Terugblikonderzoek spelregels geluidsopnamen*, 9 November 2016, report no. 2016/105, p. 10.
[1585] Interviews IND 1, Interview IND 5 and 6, IND Instruction 2010/13, p. 6.
[1586] Interviews IND 2 and 3 and IND 4. See also Van Mourik et al, p. 47 and eg AJD 21 September 2016, ECLI:NL:RVS:2016:2589, AJD 15 September 2015, ECLI:NL:RVS:2015:3010.
[1587] Interview IND 2 and 3. See also IND Instruction 2014/10, p. 7.
[1588] Interviews Lawyer 2, IND 1 and IND 5 and 6.
[1589] Interviews IND 1 , IND 5 and 6 and IND Instruction 2010/13, p. 6.

during the interview. The IND officer needs to keep this in mind as much as possible when answering the question whether inconsistencies may be attributed to the asylum seeker.[1590]

IND Instruction 2010/13 notes that if incoherent and inconsistent statements can be attributed to the medical/psychological situation of the asylum seeker, these will not easily be held against the asylum seeker. Nevertheless, the core of an asylum account can be deemed incredible, because the alleged events are very implausible or because it is not in line with information from public sources.[1591] The IND assumes that all asylum seekers, irrespective of their medical limitations, are able to provide the main lines of their asylum account.[1592] In contrast, if the asylum seeker's medical or psychological problems may have caused incoherences or contradictions in the details of the asylum account, they may not be held against the asylum seeker.[1593] The IND has to show in its decision how it has taken into account the asylum seeker's medical limitations.[1594]

Several stakeholders have argued that the IND does not take sufficient account of the asylum seeker's vulnerability or psychological problems of asylum seekers in its decision-making[1595] and therefore does not comply with Instruction 2010/13.[1596] Some indicated that there is a risk that the IND believes that it acts carefully as long as it complies with instructions of the Medical advice interviewing and decision-making.[1597] Intended rejections refer to the fact that the IND has complied with the medical advice and that the asylum seeker has not indicated any problems during the interview.[1598] The IND does not take into account for instance that some asylum seekers are not able to talk about certain (details of) events, because they are too painful or blocked from their memory.[1599] In such situations taking extra breaks or adapting the way of questioning will often not help. However, the IND expects asylum seekers to provide detailed and consistent statements about the core of the asylum account, including traumatic events. Indeed the IND expects for example that asylum seekers who claim to be victims of torture are able to state the names of the persons who were detained in the same cell[1600] or to know the type of jeep which was used to kidnap them[1601]. One lawyer stated that the IND assumes that if you experienced such traumatic event, you must be able to remember when it took place and what exactly happened.[1602]

[1590] IND Instruction 2010/13, p. 6.
[1591] Ibid.
[1592] Interview IND 5 and 6.
[1593] The Netherlands Parliamentary documents, Handelingen EK 2014/15, nr. 38, item 8, p. 17, Interview IND 5 and 6.
[1594] Interview IND 5 and 6.
[1595] Interviews Lawyer 2, Lawyers 3 and 4, Pharos, iMMO, Nidos.
[1596] ACVZ, *De geloofwaardigheid gewogen*, p. 56. It specifically mentions children and traumatised persons.
[1597] Interviews Pharos, Lawyer 2, Lawyers 3 and 4 and iMMO. See for examples of cases where the IND argues that it complied with the FMMU advice and therefore it could hold inconsistencies against the asylum seeker: AJD 10 February 2017, ECLI:NL:RVS:2017:362, AJD 8 July 2016, ECLI:NL:RVS:2016:2004, AJD 22 February 2016, ECLI:NL:RVS:2016:564, AJD 15 September 2015, ECLI:NL:RVS:2015:3010, AJD 24 August 2015, ECLI:NL:RVS:2015:2783, District court Arnhem 3 April 2017, AWB 16/7496. See also Van Mourik et. al., p. 46.
[1598] Interview Lawyer 2.
[1599] Ibid.
[1600] AJD 10 September 2016, ECLI:NL:RVS:2016:2589.
[1601] AJD 10 February 2017, ECLI:NL:RVS:2017:362.
[1602] Interview Lawyer 2.

*Weight attributed in Dutch case law*

The AJD regards medical advice by FMMU (and before that MediFirst[1603]) as an expert opinion.[1604] This means that, if the IND bases its decision on a MediFirst/FMMU advice, it should check whether the advice is insightful (*inzichtelijk*) and conclusive (*concludent*). If the IND has complied with this duty, the asylum seeker can only challenge the medical advice successfully by submitting another expert opinion which comes to a different conclusion.[1605] In several earlier cases, the AJD ruled that the MediFirst advice was not properly reasoned because it did not explain why there was no medical limitation which could influence the asylum seeker's statements.[1606] Later cases all state that 'although [the medical advice] is concise, it is nevertheless insightful'.[1607] What appears to be different in these later cases is that the advice mention several measures, for instance taking extra breaks, if the asylum seeker has medical limitations.

Asylum seekers' claim that they could not make complete, consistent and coherent statements because of psychological problems, may be refuted by the IND with reference to the MediFirst or FMMU medical advice, if they have not further substantiated this claim.[1608] Asylum seekers often try to challenge the conclusions of the MediFirst/FMMU advice submitting a report written by the Institute of Human Rights and Medical Assessment (iMMO). iMMO writes medical reports with regard to the link between scars or medical problems and events in the country of origin. However, it often also addresses the question whether at the time of the examination and at the time of the IND interview asylum seekers had psychological problems which interfered with their ability to make complete, consistent and coherent statements about their asylum motives. iMMO may conclude that such limitations were (with certainty, most probably or probably) present during the IND interview on the basis of indications in the case file from the period of the interview, including medical information from GCA, MediFirst/FMMU (advice and questionnaire) and medical specialists, the report of the interviews and/or a questionnaire filled out by the lawyer or the DCR.[1609] iMMO reports are written by psychologists, psycho-therapists and doctors who are trained and experienced in the field of psychological problems. Some asylum seekers provide a statement of their treating doctor in order to challenge the MediFirst/FMMU advice.

In practice the case law of the Dutch courts, in particular the AJD, makes it very difficult for asylum seekers to challenge a MediFirst/FMMU advice. The courts do not (always) oblige the IND to postpone the asylum decision or wait with their own judgment in the appeal if the asylum seeker has requested a report from iMMO.[1610] Furthermore, the AJD often attaches more weight to the MediFirst/FMMU advice than to the iMMO report or a statement from a treating doctor. The fact that the

[1603] AJD 25 August 2014, ECLI:NL:RVS:2014:3271, para. 3.1.
[1604] AJD 10 February 2017, ECLI:NL:RVS:2017:362, para. 5.3.
[1605] AJD 25 August 2014, ECLI:NL:RVS:2014:3271, para. 3.1.
[1606] AJD 13 November 2012, ECLI:NL:RVS:2012:BY3393; AJD 20 September 2012, ECLI:NL:RVS:2012:344; AJD 1 June 2012, ECLI:NL:RVS:2012:1306; AJD 14 October 2011, ECLI:NL:RVS:2011:BU1283.
[1607] AJD 28 May 2015, ECLI:NL:RVS:2015:1783; AJD 25 August 2014, ECLI:NL:RVS:2014:3262; AJD 10 June 2013, ECLI:NL:RVS:2013:CA3593; AJD 10 June 2013, ECLI:NL:RVS:2013:CA3594.
[1608] AJD 15 November 2016, ECLI:NL:RVS:2016:3008.
[1609] iMMO, *Leeswijzer bij iMMO-rapportage*, p. 6.
[1610] AJD 20 June 2014, ECLI:NL:RVS:2014:2282, District court The Hague 9 June 2016, ECLI:NL:RBDHA:2016:6470.

MediFirst/FMMU advice is not provided by a specialist in psychological problems (in contrast to many of the iMMO reports) does not play a role.[1611] In some cases the AJD refers to the difference in timing of both medical examinations: the MediFirst/FMMU advice is given shortly before the IND interview, while the iMMO examination sometimes takes place months after the interview.[1612]

In some cases the AJD found that the iMMO report or the statement by the treating doctor did not specifically contest the MediFirst/FMMU advice or support that the IND did not take sufficient account of this advice during the interview.[1613] For instance, in a judgment of 22 February 2016, iMMO wrote that the asylum seeker clearly had medical limitations and that the asylum seeker was not able to make proper statements, which could lead to incomplete, incoherent and inconsistent statements. According to the AJD, this letter did not imply that the IND had taken insufficient account of the limitations found in the MediFirst advice and that the inconsistencies are the result of the psychological problems of the asylum seeker.[1614] In another judgment, the AJD considered that it did not follow from the iMMO report that the asylum seeker was not able to make complete, coherent and consistent statements with regard to the core of the asylum account. The iMMO rapporteur wrote that the asylum seeker may have had difficulties to tell her asylum story 'in detail'. Here, the rapporteur referred to traumatic experiences which were crucial to her asylum account.[1615]

In cases where asylum seekers challenged that they were able to make complete, coherent and consistent statements, the AJD considered the report of the IND interview pivotal in order to determine whether the authorities have taken sufficient account of the asylum seeker's psychological limitations. It noted that when the report shows that the asylum seeker was able to properly answer the questions, the authorities have carefully conducted the interview.[1616] The AJD attached great weight to the response of asylum seekers to the question 'How are you feeling?' during the interview. If asylum seekers reply that they feel fine, the AJD regards this as an indication that their medical conditions did not obstruct their ability to make statements.[1617] Furthermore, the AJD takes into account whether the DCR volunteer who attended the interview made remarks about the course of the interview.[1618] In one case the AJD ruled that the fact that the asylum seeker mentioned during the interview that he heard voices which told him to commit suicide did not raise doubts about the quality

[1611] AJD 5 April 2011, ECLI:NL:RVS:2011:BQ0751.
[1612] AJD 10 February 2017, ECLI:NL:RVS:2017:362; AJD 8 July 2016, ECLI:NL:RVS:2016:2004; AJD 28 May 2015, ECLI:NL:RVS:2015:1783; Court The Hague 18 January 2016, ECLI:NL:RBDHA:2016:401. See however conversely, Court The Hague 24 February 2017, ECLI:NL:RBDHA:2017:3804.
[1613] AJD 22 February 2016, ECLI:NL:RVS:2016:564; AJD 27 June 2014, ECLI:NL:RVS:2014:2384; AJD 12 March 2013, ECLI:NL:RVS:2013:BZ8665.
[1614] AJD 22 February 2016, ECLI:NL:RVS:2016:564.
[1615] AJD 21 September 2016, ECLI:NL:RVS:2016:2589.
[1616] AJD 10 February 2017, ECLI:NL:RVS:2017:362, AJD 8 July 2016, ECLI:NL:RVS:2016:2004, AJD 22 February 2016, ECLI:NL:RVS:2016:564; AJD 21 October 2015, ECLI:NL:RVS:2015:3328; AJD 15 September 2015, ECLI:NL:RVS:2015:3010; AJD 24 August 2015, ECLI:NL:RVS:2015:2783; AJD 10 June 2015, ECLI:NL:RVS:2015:1919; AJD 28 May 2015, ECLI:NL:RVS:2015:1783; AJD 25 August 2014, ECLI:NL:RVS:2014:3262; AJD 27 June 2014, ECLI:NL:RVS:2014:2384; AJD 12 May 2014, ECLI:NL:RVS:2014:1824; AJD 12 May 2014, ECLI:NL:RVS:2014:1831; AJD 14 May 2013, ECLI:NL:RVS:2013:3301. See also District court Middelburg 18 January 2016, AWB 15/9526, District court Den Bosch 20 April 2016, AWB 16/5688.
[1617] AJD 10 February 2017, ECLI:NL:RVS:2017:362; AJD 4 October 2013, ECLI:NL:RVS:2013:1451. See also eg District Court Den Bosch 18 May 2016, AWB 16/8078, District Court Utrecht 18 February 2016, AWB 16/1389 and AWB 16/1391.
[1618] AJD 15 September 2015, ECLI:NL:RVS:2015:3010.

of the MediFirst advice. According to the AJD, the report of the interview showed that the asylum seeker was able to tell an extensive and coherent asylum account. Furthermore, the report of the mental health care consultant, the asylum seeker's medical file and a statement from an iMMO doctor did not substantiate that the asylum seeker could not be interviewed.[1619]

Stakeholders interviewed for this study objected to the equal treatment and even prioritisation of the MediFirst/FMMU advice in relation to other expert opinions, such as iMMO reports. They think that the fact that the iMMO examinations and advices are carried out by medical experts, psychologists and doctors and demand an extensive period of time[1620], should lend them more authority than the nurses who perform the shorter FMMU examination.[1621] Also district courts seem to be more willing than the AJD to attach important weight to iMMO's conclusions as to the asylum seeker's ability to make complete, consistent and coherent statements. However, many of their judgments were overturned by the AJD after an appeal of the State Secretary of Security and Justice.[1622]

The weight attached to the FMMU advice in the AJD's case law is also problematic in the light of the findings in Chapter 3 of this report about the quality of the FMMU advice: the lack of regular quality checks on the advice, the lack of preparation and training of FMMU nurses and doctors and the lack of clarity and substantiation of the medical advice and the inconsistencies between them.

Furthermore, it is clear that the AJD and also some district courts[1623] do not take into account the possibility that the situation that an asylum seeker with medical or psychological problems cannot make coherent and consistent statements 'can still apply even if special guarantees are offered during the asylum interview'.[1624]

### 7.10.2 The weight of forensic medical reports

It was shown in section 4.5.1 that in many cases iMMO forensic medical reports lead to a grant of the asylum application. However, section 4.5.2 also mentioned that the case law of the AJD leaves the IND wide discretion to reject an asylum application on credibility grounds even though it is supported by a medical report. This section will further discuss how the IND and the courts take into account forensic medical reports.

[1619] AJD 29 July 2015, ECLI:NL:RVS:2015:2539. See also AJD 11 March 2014, ECLI:NL:RVS:2014:1030.
[1620] iMMO rapporteurs need an average of 35 hours to complete the report. See iMMO, Toelichting Inspanningsverklaring kostenvergoeding iMMO.
[1621] Interviews iMMO and Lawyer 2.
[1622] See eg recently District court Haarlem 19 juli 2016, AWB 15/15836 overturned by AJD 25 oktober 2016, ECLI:NL:RVS:2016:2932, District Court Rotterdam, 17 februari 2016, AWB 14/3507, AWB 14/3509 overturned by AJD 8 July 2016, ECLI:NL:RVS:2016:2004, District Court Arnhem 21 July 2015, overturned by AJD 22 February 2016, ECLI:NL:RVS:2016:564, District Court Haarlem, 19 July 2015, AWB 15/15836 overturned by AJD 24 August 2015, ECLI:NL:RVS:2015:2783, District Court Amsterdam 21 november 2014 AWB 13/19439, overturned by AJD 15 September 2015, ECLI:NL:RVS:2015:3010.
[1623] District court Middelburg 18 April 2017, AWB 17/6329, para. 12, District court Den Bosch 18 January 2017, AWB 16/29169.
[1624] IND Instruction 2010/13, p. 5. See however for a court which does take this into account: District Court Roermond 2 June 2016, AWB 15 /12673.

*Weight attributed to iMMO reports by the IND*

Earlier research with regard to the interpretation of and weight attached to iMMO reports in IND decisions showed that in particularly serious credibility issues, such as a language analysis or an individual report by the Ministry of Foreign affairs which contests the asylum seeker's statements, will not easily be remedied by such report. Furthermore, the IND will more likely hold on to its conclusion that the asylum account is not credible if the asylum seeker made contradictory or incoherent statements on core parts of the asylum account (in contrast to vague or strange statements).[1625] Finally if the medical report is submitted in a subsequent asylum procedure, the IND may see no reason to change its credibility assessment, because the court in the first asylum procedure has accepted this assessment.[1626]

Earlier research also showed that the IND sometimes doubts the genuineness of the statements made by the asylum seeker during the iMMO examination concerning the existence or the seriousness of (notably psychological) problems, the cause of scars or medical problems or the context in which these were caused. IND officers have difficulties to accept iMMO reports which only establish a causal link between psychological problems and events in the country of origin. They think that the degree of the causal relationship established by iMMO is often (too) strong. They submit that these problems can also be caused by other circumstances such as stress about the outcome of the asylum procedure or separation from family members. Furthermore, they submit that iMMO departs from and accepts the asylum seeker's asylum account, which has been deemed incredible by the IND.[1627] Also in case of scars the IND often considers in its decisions that if iMMO found a lower degree of causal relation (consistent or very consistent) other causes are possible.[1628]

Furthermore, IND officers think that psychological problems cannot be established objectively.[1629] The IND seems to be more inclined to accept iMMO reports which document large and impressive scars, which (in the IND officer's view) cannot easily be caused by other events than ill-treatment. This also applies if the iMMO report has examined other possible causes of the problems at issue and has assessed whether the asylum seeker aggravates or lies about their medical problems.[1630] The IND also questions the expertise of iMMO physicians and psychologists, stating that they do not have a training in forensic medicine and only received a few days training from iMMO.[1631]

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[1625] Reneman, A.M., De Lange, J. and Smeekes, J., 'Medische waarheidsvinding en geloofwaardigheidsbeoordeling in asielzaken, Interpretatie en waardering van medische rapporten door de IND', *Asiel & Migrantenrecht* 2016, nr. 10, pp. 463-466.

[1626] Ibid, pp. 464-465.

[1627] See also the State Secretary's argumentation in eg District Court Utrecht 18 February 2016, AWB 16/1389 en AWB 16/1391, para. 12, District Court Haarlem, 19 July 2015, AWB 15/15836, para. 7.1, District Court Haarlem 15 December 2014 AWB 14/4179 and District Court Amsterdam 21 November 2014 AWB 13/19439, para. 3.12.

[1628] See eg the IND's arguments submitted in AJD 20 April 2015, ECLI:NL:RVS:2015:1348, District court Haarlem 15 December 2014, AWB 14/4179, District court Rotterdam 9 October 2014 AWB 14/9140, District Court Den Bosch 16 July 2013, AWB 12/39711 and IND, Onderzoek naar rol iMMO rapportage in asielzaken, versie 0.1, November 2016.

[1629] Ibid, pp. 466-468. See also the State Secretary's argumentation in eg District Court Haarlem, 19 July 2015, AWB 15/15836, para. 7.1.

[1630] Ibid, p. 469.

[1631] Additional information provided by the IND in September 2017.

The IND and iMMO disagree on the boundary between a medical examination and credibility assessment. They blame each other for trespassing on the other's expertise. The IND finds that iMMO is assessing credibility, where it draws conclusions as to the context in which medical problems are caused. It thinks that the question by whom, where and why an asylum seeker was ill-treated cannot be established on the basis of a medical examination.[1632] Furthermore, the IND often argues that iMMO takes the asylum seeker's statements (which were found not credible by the IND) as a point of departure.[1633] iMMO finds that IND officers do not understand how iMMO rapporteurs work on the basis of their professional standards and test the statements of the asylum seeker.[1634]

*Weight attached to NFI/NIFP reports by the IND*

The IND should take the NFI/NIFP report into account in the integral credibility assessment.[1635] If a causal relationship is established in the medical report, a negative asylum decision should address the findings in the medical report in relation to the asylum account.[1636] In May 2017 the State Secretary informed Parliament that out of the 14 asylum seekers who were examined by NFI and/or NIFP two asylum seekers have been granted asylum[1637] and two asylum seekers have received a rejection. One of those rejecting decisions was confirmed by a district court.[1638] No decision had been taken yet in the ten other cases.[1639]

In four of the eight cases received for the purpose of this study an intended rejection was issued by the IND. In one of these four cases the application has been granted during the appeal phase (case 3), two resulted in a negative decision (cases 1 and 4) and in one case (case 5) a decision still had to be taken (see Annex 5). In three out of the four cases, which resulted in an intended rejection, an iMMO report had been submitted in a subsequent asylum procedure by the asylum seeker (cases 1, 3 and 5). In the fourth case an NFI/NIFP report had been requested in a first asylum procedure. The four intended rejections (*voornemen*)/negative decisions are discussed in Annex 6. In three of the eight cases an asylum status was granted directly after the medical report had been issued. In one of these cases (case 2) an iMMO report had been submitted by the asylum seeker in a subsequent asylum procedure. The other cases concerned first asylum procedures, where no iMMO report had been available.

The intended decisions show that both the NFI/NIFP reports and the iMMO reports are rather easily put aside by the IND, because their conclusions leave the possibility that the scars or medical problems are caused by other events that the alleged ill-treatment in the country of origin. The NFI/NIFP and iMMO reports did not contradict each other, but only differed as to the strength of the causal

[1632] See also AJD 10 February 2017, ECLI:NL:RVS:2017:362 and the State Secretary's argumentation in eg District Court Haarlem, 19 July 2015, AWB 15/15836, para. 7.1.
[1633] A.M. Reneman, J. de Lange en J. Smeekes, p. 470. See also AJD 10 February 2017, ECLI:NL:RVS:2017:362, AJD 25 October 2016, ECLI:NL:RVS:2016:2932.
[1634] Ibid, pp. 469-471.
[1635] Para. C1/4.4.4 Aliens Circular, IND Instruction 2016/4, pp. 2-3.
[1636] IND Instruction 2016/4, p 3.
[1637] This includes the case of the NIFP report of 31 May 2016 and the case of the NFI report of 21 March 2017 and NIFP report of 20 April 2017.
[1638] District Court Utrecht 28 March 2017, AWB 17/4601, AWB 17/4603, AWB 17/4598 en AWB 17/4600.
[1639] Netherlands Parliamentary documents EK 2016/17, 34088, G, p. 3.

relationship found. It is striking that two out of the three intended rejections do not even mention the conclusions of iMMO or weigh the two reports. This is not in conformity with the IND instruction on forensic medical examinations.[1640]

*Weight attached to medical reports by courts*
At the moment of conclusion of this study there was no case law yet of the AJD and only one judgment of the district courts on the weight of NFI/NIFP reports.[1641] The ADJ's standing case law with regard to iMMO reports was already discussed in section 4.5.2 of this report. It entails that the IND is allowed to reject an asylum application without a further medical examination, if its conclusion that the core of the asylum account is sufficiently reasoned and the asylum seeker has not further substantiated this core.

The IND's arguments set out above which are used to disregard iMMO reports are often brought before the courts. In a limited number of cases the courts explicitly accepted this argumentation. The district court of Utrecht for example agreed with the IND's reasoning that the NIFP report left room for other causes of the psychological problems.[1642]

## 7.10 Conclusions

In the Netherlands asylum seekers with special procedural needs can be provided different types of support, mainly relating to the applicable time-limits and the conditions of the interview. The IND aims to provide tailor-made solutions to asylum seekers within reasonable time and financial limits. This chapter discussed the various measures available to the IND and how they are applied in practice. Furthermore, it was assessed how the IND has regard to the asylum seeker's psychological problems and takes into account medical evidence, in particular the Medical advice interviewing and decision-making and the forensic medical examination in the asylum decision.

*Waiting times and prioritisation*
In 2015 the IND was able to decide on 96 per cent of all asylum cases within the time limit of six months. However, from the second half of 2015 the waiting times for asylum seekers between the moment they applied for asylum and the moment they entered the asylum procedure increased. In particular asylum seekers with high chances of success had to wait for more than six months before they could start the asylum procedure. This implied that they also had to wait before they could apply for family reunification, which caused a lot of stress and concern. At the same time asylum seekers with low chances of success were processed in a very short period of time: asylum seekers from safe countries of origin received a negative decision within ten days after their application.

Even though the IND and COA provided information about the waiting times in the asylum procedure amongst others in letters and information sessions, asylum seekers felt insufficiently informed about when their asylum procedure would start. Furthermore, it was not clear to them why asylum seekers

[1640] IND Instruction 2016/4, para. 4.
[1641] District Court Utrecht 28 March 2017, AWB 17/4601, AWB 17/4603, AWB 17/4598 en AWB 17/4600.
[1642] Ibid. In District Court Den Bosch 6 October 2014, AWB 13/6598, the court doubted the context of the alleged ill-treatment.

who had arrived later could sometimes start their asylum procedure sooner. This caused feelings of uncertainty and stress as well as unrest in the reception centres.

During the period of high influx cases of asylum seekers with special needs could be prioritised by the IND. This often happened at the request of COA officers who provided counseling to the asylum seeker in the reception centre. Also organisations such as the DCR and Nidos as well as lawyers could ask the IND for prioritisation. However, there was no central point or standard procedure for requests for prioritisation. Also the criteria for prioritisation were not clear to these organisations and lawyers.

*Application of the border procedure*

Asylum seekers who arrive at Schiphol Airport, except unaccompanied children and families with children, follow the border procedure and stay in the detention centre at Schiphol Airport. Asylum seekers who have special needs and cannot be offered adequate support during the border procedure are referred to an open reception centre. The IND assesses whether there are special individual circumstances, such as serious physical or psychological problems, which render the detention measure disproportionally burdensome. The fact that an asylum seekers is a victim of torture or has psychological or other medical problems, which limit their ability to make complete, consistent and coherent statements is not in itself a reason to refer them to an open reception centre.

*General, extended or accelerated asylum procedure*

In the Netherlands the large majority of asylum applications is processed in the general asylum procedure which takes eight days. Only cases in which no careful decision can be taken in the general asylum procedure are referred to the extended asylum procedure after the interview on the asylum motives. There are indications that the IND does not always see reason to refer a case to the extended procedure, even though there are signals that the asylum seeker needs extra time, for example because of medical problems. As a result the asylum seeker may not be able to receive effective legal assistance or to obtain a further medical examination before the asylum decision is taken.

It was already concluded in chapters 2 and 3 that there is a risk that special needs of persons who are going to be transferred to another Member State under the Dublin Regulation, persons originating from safe countries of origin and persons granted asylum in another EU Member State, are not identified. These persons are not offered a Medical advice interviewing and decision-making and do not have contact with the DCR and a lawyer before the start of the asylum procedure. The applications of these asylum seekers are processed in an accelerated asylum procedure (Track 1 and 2) with less procedural guarantees, including less assistance by a lawyer. Therefore there is a risk that during this procedure special needs will not come to the fore and that adequate support is not provided.

*Omitting the interview*

In exceptional cases the IND concludes on the basis of medical information that the asylum seeker cannot be interviewed. It then tries to gather information from other sources, such as family members. The IND instruction does not mention the possibility of asking a forensic medical examination if the asylum seeker is not capable of doing an interview with the IND.

*Special guarantees during the interview*

According to the AJD, it is up to the asylum seeker to clearly bring his asylum motives to the fore and not up to the State Secretary to reveal them by asking questions. This stands in sharp contrast with the opinion of EASO, according to which the immigration authorities have an increased responsibility to ensure that all relevant topics are explored in interviews with vulnerable asylum seekers.

All IND officers are required to follow the EASO modules on Interviewing skills and Interviewing vulnerable persons.[1643] However, during the period of high influx the IND employed interviewers, who did not take part in the training on interviewing vulnerable persons. Furthermore, after the period of high influx many (also more experienced) IND officers still had to undertake this training.

During the training Interviewing vulnerable persons IND officers learn in theory as well as in practice (by role play) how they can identify vulnerability and respond to it in an adequate way in each stage of the interviewing process. However, after the training there seems to be a lack of review of and feed-back on the IND officer's interviewing techniques and several IND officers indicated that they were in favour of more regular coaching and feed-back.

In IND Instructions and interviews a wide variety of practical measures is mentioned, which can be taken during the interview to address an asylum seeker's special needs. However, in practice the Medical advice interviewing and decision-making propose a limited number of measures, in particular taking breaks and allowing the asylum seeker to eat and drink or to move around.[1644] It is generally perceived that the IND applies these measures during the interview. However, some lawyers doubt whether this is sufficient to address the asylum seeker's special needs. Even though IND officers are encouraged during trainings and in IND instructions to consult with the asylum seeker's lawyer to discuss the measures which should be taken for an asylum seeker with special needs, this does not always happen in practice.

Interviews of unaccompanied children are attended by the child's guardian or a volunteer of the DCR. Furthermore, the DCR observes interviews of asylum seekers at their request, at the request of their lawyer or the IND or at the DCR's own motion. The purpose of the observations is to support the asylum seeker during the interview and to ensure and monitor the quality of the interview. The volunteer makes a report of the interview, which is sent to the lawyer. In some cases the volunteer also records the interview, which is permitted as a result of recent reports of the Ombudsman.

*Decision-making*

When taking the decision IND officers take into account the medical state and other circumstances such as the education and cultural background of the asylum seeker. For this purpose they have regard to the Medical advice interviewing and decision-making, but also to their own observations and the asylum seeker's declarations during the interview. IND officers balance all the circumstances and decide whether inconsistencies or vagueness can be attributed to the asylum seeker.

[1643] See also section 2.4.2.

[1644] See section 3.7 of this report.

*Weight of the Medical advice interviewing and decision-making*

The IND views the Medical advice interviewing and decision-making as being primarily focussed on the interview rather than decision-making. It is mainly left to the discretion of the IND officer who takes the asylum decision to determine whether and how the detected medical conditions affect their decision. The IND acknowledges that an asylum seeker with medical or psychological problems may not be able to make coherent and consistent statements, also if special guarantees are provided during the interview. However, it also assumes that all asylum seekers, irrespective of their medical limitations, are able to tell the main lines of their asylum account. The IND expects asylum seekers to provide detailed and consistent statements about the core of the asylum account, including traumatic events. Furthermore, the IND refers in its decisions to the fact that it has complied with the medical advice and that the asylum seeker has not indicated any problems during the interview, suggesting that the asylum seeker was thus able to make complete, coherent and consistent statements.

The Dutch courts regard the Medical advice interviewing and decision-making issued by FMMU (and before that MediFirst) as an expert opinion. The AJD has considered in recent cases that 'although [the medical advice] is concise, it is nevertheless insightful'. For asylum seekers it is very difficult to challenge a MediFirst/FMMU advice or the IND's decision that gaps or inconsistencies can be attributed to them. The AJD often attaches more weight to the MediFirst/FMMU advice than to an iMMO report or a statement from a treating doctor submitted by the asylum seeker. The reason for that is that often the iMMO took place months after the interview, while the MediFirst/FMMU advice was given shortly before the IND interview. In some cases the AJD found that the iMMO report or the statement by the treating doctor did not specifically contest the MediFirst/FMMU advice or support that the IND did not take sufficient account of this advice during the interview.

The AJD considers the report of the IND interview pivotal in order to determine whether the authorities have taken sufficient account of the asylum seeker's psychological limitations. It attaches great weight to asylum seekers' statement that they feel fine during the interview. It also refers to the fact that the report of the interview showed that the asylum seeker was able to tell an extensive and coherent asylum account and could answer the questions posed by the interviewer.

It is problematic that the MediFirst/FMMU advice is given more weight than other expert opinions, such as iMMO reports. The AJD does not take into account that the iMMO examinations are carried out by medical experts, psychologists and doctors and demand an extensive period of time. It was explained in Chapter 3 of this report that the FMMU advice has a very limited nature and is carried out by a nurse. Furthermore, there are concerns about the quality of the FMMU advice. There is, amongst others, a lack of quality checks on the advice, a lack of preparation and training of FMMU nurses and doctors and a lack of clarity and substantiation of the medical advice and the inconsistencies between them.

Moreover, the AJD does not take into account the possibility that the situation that an asylum seeker with medical or psychological problems cannot make coherent and consistent statements can still apply even if special guarantees are offered during the asylum interview. Also the fact that the asylum seeker tells the IND officer that he feels fine and has answered the IND's questions does not guarantee that the applicant has talked about all the (details of) events which are relevant for the examination

of his asylum claim. Talking about these events may be too painful or shameful and applicants may therefore prefer to remain completely silent about them.

*Weight of forensic medical reports*

In its decision the IND may invoke different reasons why an iMMO report or NFI/NIFP report does not change its judgment that the core of the asylum account is not credible. One important reason is that the conclusions in the medical report leaves the possibility that the scars or medical problems are caused by other events than torture or ill-treatment in the country of origin. Another reason is that a medical examination cannot establish the context of the alleged events (who the actor is, and why the events took place). These arguments apply to virtually all medical reports (only in very exceptional cases will a doctor conclude that other causes are excluded). Ignoring such reports as evidence in support of the asylum seeker's asylum account for these reasons violates Article 3 ECHR and Article 3 CAT.

## 8. Final remarks

The Netherlands has a rather sophisticated system of identification of applicants with special needs. In particular during the first phase of the asylum procedure, there are fixed moments at which special needs are assessed from different perspectives. A few days after arrival asylum applicants undergo an urgency medical screening, which aims to identify urgent actual health risks, to start medical care if necessary and to advise COA about special reception needs. Before the start of the asylum procedure asylum seekers are examined by a nurse in order to establish whether they have medical problems which may limit their ability to make complete, coherent and consistent statements about their asylum motives. This leads to a Medical advice interviewing and decision-making to the IND, which indicates whether the asylum seeker can be interviewed or whether measures may be taken during the interview in order to enable the asylum seeker to tell his asylum account. During the asylum interview IND officers ask asylum seekers about their physical and mental state and should respond to signals that an asylum applicant is not feeling well. The IND has the possibility to ask the NFI and NIFP for a medical report on the possible causal relation between the asylum seeker's scars or physical or psychological problems and the alleged events in the country of origin. Finally, COA assesses the situation of asylum seekers staying in the reception centres on the basis of the six domains tool. At the same time, other organisations involved, such as the Aliens police, lawyers, volunteers of the Dutch Council for Refugees and Nidos may pick up signals that an asylum seeker has special needs and share these with COA and/or IND. Nevertheless, this study concluded that there is room for improvement on several points and made recommendations for that purpose. Here some general final remarks will be made, which regard more than one topic covered in this study.

*Negative effects of public procurement procedures in the asylum system*

In the Dutch asylum system several important tasks, such as primary health care for asylum seekers and the Medical advice interviewing and decision-making, are carried out by private companies. This means that after a fixed period of time COA (healthcare) or the IND (medical advice) should start a public procurement procedure, which may lead to another private party taking over. This happened in 2014 when MediFirst lost the Medical advice interviewing and decision-making to FMMU and in 2017 when GCA lost the task of providing health care to asylum seekers to Arts en Zorg.

Both FMMU and Arts en Zorg won the public procurement procedure, because they could carry out the tasks for a lower price. Quality counts for 70 per cent in the public procurement procedure and costs for 30 per cent. Nevertheless, there were concerns that lower prices would also lead to lower quality. Arts en Zorg will start from 1 January 2018. Therefore, the quality of the care provided by this organisation could not be assessed yet. With regard to the FMMU, it was concluded in Chapter 3 that several findings may suggest that the lower costs indeed led to lower quality, in particular the low number of applicants examined by a doctor and the short duration of the medical examination in some locations.

It is clear that both public procurement procedures led to great loss of experience and expertise. Both the personnel of MediFirst and that of GCA lost or will lose their jobs. Furthermore, the transfer of information and expertise is problematic, in particular where the outcome of a public procurement procedure is contested by the company which was carrying out the task and lost the procedure. FMMU

for example started its task in January 2015 without much knowledge of the context in which it had to provide the medical advice, also because MediFirst challenged the outcome of the public procurement procedure before the courts. The statistics show that both MediFirst and FMMU found a low number of limitations in the beginning of their task. This may indicate that both organisations needed time to build expertise, which led to a higher number of advice in which limitations were found.

Providing medical advice or primary health care is a highly specialised and complicated task. Moreover, the quality of medical advice and health care is fundamental for asylum applicants' chances in the asylum procedure and their well-being. It is therefore problematic that there is no continuity and steady increase of expertise and experience in these fields.

*External supervision and expertise*

It follows from this study that external supervision on many aspects of the asylum system works well. The Health Inspectorate (*Inspectie voor de Gezondheidszorg*) has intensively supervised the primary health care to asylum seekers during the period of high influx and required measures for improvement. The Youth Inspectorate (*Inspectie Jeugdzorg*) has regularly examined the quality of the reception facilities for unaccompanied children and ensures that these facilities meet the standards. The Inspection for Security and Justice (*Inspectie voor Veiligheid en Justitie*) and the Dutch Safety Board (*Onderzoeksraad voor de Veiligheid*) have written reports on for example the crisis and emergency reception centres during the period of high influx and the exchange of information in the asylum system.

However, some aspects of the asylum procedure have not been subjected to any external supervision. The Medical advice interviewing and decision-making has been applied in the asylum procedure for more than seven years. As was shown in this study both the IND and courts attach important weight to this advice. However, the quality of the advice has never been systematically assessed by an expert organisation, such as the Health Inspectorate. Findings in this study suggests that FMMU does not always comply with its Protocol and does not apply its methods consistently.

Furthermore, it follows from this study that several organisations in the asylum system are perceived to be 'closed'. It would enhance the quality of the services provided by all organisations and companies involved in the asylum procedure and also create more understanding of their work, if they are transparent and open to exchange of views and expertise with NGO's and experts in the field. Medical advisers should for example exchange expertise and arrange feedback on their work from other medical experts working in the field of asylum. IND and COA should include external experts in the training of their personnel.

*The period of high influx*

During the period of high influx COA and the IND as well as other organisations in the asylum system had to work under severe pressure. However, the system did not collapse. All asylum seekers received reception facilities, although of a lesser quality than usual. In all reception centres health care for asylum seekers was organised in time. Even though the waiting times before asylum applicants could enter the asylum procedure increased, the IND did manage to assess all asylum applications and has now reduced the waiting times again.

During the period of high influx the organisations in the asylum system were not able to systematically assess the special needs of all asylum seekers. The focus was on providing basic services (shelter, basic health care, an asylum decision). COA, the IND, GCA and FMMU worked with large numbers of new personnel. They were not always sufficiently trained to assess special needs. Moreover, because of the large numbers of asylum seekers there was less room to take into account special needs when placing a person in a reception centre or to provide special procedural guarantees during the asylum procedure (such as prioritisation).

However, it should be noted that the period of high influx also led to important improvements in the asylum system. GCA introduced the urgency medical screening directly after arrival. Youth health care has become available to all asylum seeker children. Moreover, COA and many (volunteer) organisations have (further) increased the activities offered to asylum seekers in the reception centres.

*Future*

At the moment this reports was finalised the influx of asylum applicants had decreased again. Therefore this is the moment to further implement the systematic assessment of special needs. COA should for example start applying the six domains tool as soon as possible after the asylum seeker's arrival and in a systematic and uniform manner. The quality of the Medical advice interviewing and decision-making should be increased. Also the exchange of information between the different organisations in the asylum system should be improved. Finally, there is now more room and flexibility in the asylum system to take into account special needs when placing asylum seekers in a reception centre and during the asylum procedure.

In October 2017 the new coalition partners announced that legal assistance for asylum seekers will be reduced.[1645] Asylum seekers will first see their lawyer after an intended rejection of their asylum claim. This study showed that lawyers have an important role in the identification of asylum applicants with special needs and requesting special reception facilities or procedural guarantees for them. A confidential relationship with the lawyer and contacts between lawyer and asylum seekers during the course of the asylum procedure is necessary to fulfil this role. If the asylum seeker only first meets his/her lawyer after the intended rejection of the asylum application this role will be largely lost. Lawyers will not be able anymore to pick up signals that an asylum seeker has special needs during the rest and preparation period and the first stage of the general asylum procedure and share them with the IND and COA. This will reduce the likelihood that special needs of asylum applicants will be identified and that information is exchanged between the reception pillar (COA and GCA) and the asylum procedure pillar (IND).

[1645] VVD, CDA, D66 en ChristenUnie, Regeerakkoord 2017-2021, Vertrouwen in de Toekomst, 10 October 2017.

# Annex 1 Methodology

This annex will explain which methodology and sources were used for the purpose of this study.

### Literature and reports

For the purpose of all chapters a review was done of literature and reports available on the topics included in this report. The literature and reports were obtained through searches on the internet and via the persons interviewed during this study. Literature and reports were included until 1 June 2017.

### Legislation, policy documents and Parliamentary documents

For the purpose of all chapters legislation, policy documents and Parliamentary documents were taken into account. Policy documents included the Aliens Circular and the Instructions of the IND which are publicly available. Furthermore, COA and GCA documents which are available via their websites were examined. Parliamentary documents were searched through www.officiëlebekendmakingen.nl. Documents were included until 1 June 2017.[1646]

### Case law

With regard in particular to the application of Article 18 RAPD, the weight attached to medical reports in asylum decisions and how the asylum seeker's special needs are taken into account in the asylum decision, case law of the Dutch district courts and the Administrative Jurisdiction Division of the Council of State (AJD) was examined. Case law was obtained through searches on www.rechtspraak.nl and Vluchtweb (the database of the Dutch Council for Refugees).[1647] Furthermore, decisions of the Medical Disciplinary Committees, which were found through http://tuchtrecht.overheid.nl/zoeken, were included in the chapter concerning the Medical advice interviewing and decision-making. Case law was taken into account until 1 June 2017.

### Interviews

For the purpose of this interview 32 stakeholders were interviewed in a total number of 28 interviews. Four interviews were held with two persons, mostly working for the same organisations (one interview with two lawyers working for the same firm, two interviews with two IND officers working in the same function at the same location and one interview with a representative of the Legal Aid Board and an employee of the Dutch Council for Refugees working at the same location). The interviews were semi-structured and lasted between 1 and 2,5 hours. All interviews but one were held in person. All interviews were recorded and transcribed. Apart from the 32 persons interviewed, 3 stakeholders (COA 3, GCA 2 and Lawyer 5) were approached with more specific questions, which were answered during a phone call.

[1646] For this purpose the Parliamentary documents regarding the implementation of the RAPD and RRCD (nr. 34088) were examined. Furthermore, documents were searched using terms such as 'MediFirst', 'FMMU' and 'GCA'.

[1647] Search terms included amongst others FMMU, MediFirst, medisch rapport, Article 18 Procedurerichtlijn, speciale procedurele garanties.

All persons interviewed received the possibility to read the chapters of the report which referred to their interviews and to provide feed-back as regards factual issues in July/August 2017. Most stakeholders provided written comments (COA, DCR (except DCR 1 and 2), FMMU, GCA, all lawyers, the representative of the Legal Aid Board, MediFirst, Nidos and Pharos), others provided feed-back in a personal meeting (IND, NIFP). NFI and iMMO indicated that they were not able to provide comments. Some stakeholders provided relevant additional information in response to the draft text, which has been included in the report.[1648]

The persons interviewed were selected on the basis of their expertise on one or more of the topics addressed in this study. The COA officers work at the COA head office in the field of general reception conditions and medical care. Three IND officers work at the head office as policy officers or advisor on medical issues and three work(ed) as medical coordinators at an application centre. The employees of the Dutch Council for Refugees work either at the head office or as coordinators at the application centres. The lawyers were chosen because of their specific interest in medical aspects of the asylum procedure and/or asylum seekers with special needs. They, for example, give training to other lawyers on this topic or have been involved in organisations in the field of medical aspects of asylum procedures.

### Information from UNHCR

The chapters on reception conditions (Chapter 5) and medical care (Chapter 6) incorporate information from UNHCR the Netherlands, which they collected during monitoring visits to and participatory assessment in reception centres in the Netherlands. During the visits UNHCR usually met with COA and the Dutch Council for Refugees.[1649] In participatory assessments UNHCR spoke with groups of asylum seekers about amongst others the reception conditions. Information resulting from these monitoring visits and participatory assessments was shared with the researcher during meetings in August and September 2016. In the footnotes these meetings are referred to as: 'Conversations with UNHCR staff, UNHCR the Netherlands, August/September 2016'.

### Statistics

For the purpose of this study statistics were obtained from the IND about the length of the waiting period between asylum application and start of the asylum procedure and the number of cases processed in the accelerated procedure for asylum seekers who originate from safe countries of origin or have received an asylum status in another Member State.[1650] These statistics were used for section 7.5 on waiting times and prioritisation.

Furthermore, for the purpose of Chapter 3 on the Medical examination interviewing and decision-making we received statistics from FMMU (period February 2015-December 2016) about:

[1648] In that case the footnote mentions: 'Additional information provided by [name organisation] in [month] 2017.
[1649] Conversations with UNHCR staff, UNHCR the Netherlands, August/September 2016.
[1650] The IND could not provide the requested number of asylum applications in which an interview was omitted and the number of asylum applications in which the border procedure was applied.

- medical examinations per month;
- asylum seekers who did not give permission for the medical examination;
- asylum seekers who did not give permission to send the medical advice to the IND;
- asylum seekers who did not show up at the medical examination;
- asylum seekers who were examined by a doctor;
- asylum seekers who, according to the medical advice, cannot be interviewed;
- asylum seekers who, according to the medical advice, have medical limitations;
- asylum seekers referred to curative care.

Most statistics were provided per month and per location (except the referrals to curative care).

Subsequently we requested the same statistics from MediFirst for the period July 2010-January 2015). These numbers were also provided per month and per location (only from 2013). The statistics provided by MediFirst and FMMU were combined in several tables and graphs, which allow the reader to see trends over the total period in which the Medical examination interviewing and decision-making was applied (July 2010-December 2016).

Where differences in the statistics of MediFirst and FMMU on specific topics could not be explained, MediFirst and FMMU were asked for an explanation. Furthermore, we asked explanations for certain developments in the numbers (for example a steep rise in the number of asylum seekers with medical limitations).

### Medical advice interviewing and decision-making

For Chapter 3 of this report we analysed medical advice from three different FMMU examination locations: Wageningen, Schiphol Airport and Ter Apel. These locations are spread across the Netherlands and give a representative picture of FMMU's practice. The analysis is based on all medical advice issued during one week (28 November - 4 December 2016) at the three locations.

| Location | Number |
|---|---|
| Ter Apel | 30 |
| Schiphol | 18 |
| Wageningen | 47 |
| Total | 95 |

The advice were obtained from the medical coordinators of the IND at the different locations. To analyse the advices we categorized each data point that was relevant for the study:

- time of approval by the nurse and doctor;
- name of nurse and doctor;
- nationality and gender of the asylum seeker;
- whether the asylum seeker can be interviewed;
- whether the asylum seeker has medical limitations or scars;
- whether the asylum seeker needs to be seen by the FMMU doctor or referred to curative care.

This allowed us to get some insight into how much time was spent on a medical examination, how FMMU mentions in its advice whether an asylum seeker has or claims to have scars, and the level of reasons given for the medical advice. The medical advice also allowed us to compare and assess the consistency of the medical advice between the three mentioned FMMU locations. It should be noted that the medical advice only concerned 95 of the 23.467 asylum seekers examined in 2016 and thus only provide a very limited picture of the total number of medical advice issued by FMMU. Therefore the analysis of these advice was mainly used to complement the information about the content of the Medical advice interviewing and decision-making obtained through the review of documents, statistics and the interviews.

### Medical advice NFI and NIFP

For Chapter 4 of this report concerning the forensic medical examinations we looked at eight medical reports issued by the Netherlands Forensic Institute (NFI) and Netherlands Institute of Forensic Psychiatry and Psychology (NIFP). Between March 2016 (when the IND first requested a medical examination) and May 2017 the IND referred 14 cases to NFI and/or NIFP.[1651] During the course of this study the IND took a decision in only a few of the cases in which NFI and/or NIFP issued a medical report. The IND did not give permission in the context of this study to see the case files in which the NFI and/or NIFP reports were requested as long as no final decision had been taken.

The eight medical reports examined for this study were obtained through the lawyers of the asylum seekers concerned. These lawyers were found as a result of requests on Vluchtweb (a database which is often consulted by asylum lawyers) and via lawyers who knew that a colleague had a case in which a NFI/NIFP report was requested or issued. In all cases lawyers were asked to send the medical report (anonymised and with the permission of his client). The medical reports were used to complement the information obtained from the IND Instruction and guidelines and NIFP internal documents and the interviews held with the persons working for NFI/NIFP.

Lawyers were also asked whether iMMO had issued a medical report before and what the conclusion of the iMMO report was. This mad it possible to assess how often the iMMO report was reason for the IND to request a medical report from NFI and/or NIFP and to compare the outcomes of the iMMO and NFI/NIFP examination. The lawyers were also requested to share the outcome of the case and to send the intended decision and negative decision[1652] or court judgment if available. From this documents it could be derived how the IND had weighed the medical report in its decision.

### Observation Training interviewing vulnerable persons and IND interview

In order to see how IND officers are trained to interview asylum seekers with special needs, a training Interviewing vulnerable persons provided by the IND was attended in November 2016. Also access was provided to the EASO module, which the participants had to prepare before the training. The information obtained was used for Chapters 2 on identification and 7 on procedural guarantees,

[1651] The Netherlands Parliamentary documents EK 2016/17, 34088, G, p. 1.
[1652] Positive decisions are not reasoned. Therefore the weight attached to the medical report cannot be derived from that decision.

particularly section 7.9.1. Furthermore, one IND interview was observed. The observations were included in the part on the asylum interview and the asylum decision in Chapter 7 on special procedural guarantees.

## Annex 2 List of interviews

| Organisation | Abbreviation used in footnotes | Date of the Interview |
|---|---|---|
| Centrum '45 | Centrum '45 | 23 November 2016 |
| Centraal Orgaan Opvang Asielzoekers (COA) | COA 1 | 19 May 2017 |
| | COA 2 | 8 March 2017 |
| | COA 3 | 12 June 2017 |
| Dutch Council for Refugees | DCR 1 and 2 | 12 January 2017 |
| | DCR 3 | 12 January 2017 |
| | DCR 4 | 6 April 2017 |
| | DCR 5 | 25 August 2016 |
| Forensic Medical Association Utrecht (FMMU) | FMMU 1 | 13 October 2016 |
| | FMMU 2 | 3 March 2017 |
| Health Centre Asylum Seekers (GCA) | GCA 1 | 17 March 2017 |
| | GCA 2 | 11 April 2017 |
| Institute of Human Rights and Medical Examinations (iMMO) | iMMO | 25 October 2016 |
| Immigration and Naturalisation Service (IND) | IND 1 | 21 November 2016 |
| | IND 2 and 3 | 12 January 2017 |
| | IND 4 | 12 December 2016 |
| | IND 5 and 6 | 8 November 2016 |
| Lawyers | Lawyer 1 | 16 February 2017 |
| | Lawyer 2 | 25 October 2016 |
| | Lawyers 3 and 4 | 1 November 2016 |
| | Lawyer 5 | 5 October 2016 |
| Coordinator Legal Aid Board Schiphol (in his own capacity) | Legal Aid Board | 25 August 2016 |
| MediFirst | MediFirst | 17 January 2017 |
| Nidos | Nidos | 24 October 2016 |
| Netherlands Institute for Forensic Psychiatry and Psychology (NIFP) | NIFP 1 | 10 November 2016 |
| | NIFP 2 | 10 November 2016 |
| | NIFP 3 | 10 November 2016 |
| Netherlands Forensic Institute (NFI) | NFI 1 | 22 November 2016 |
| | NFI 2 | 31 October 2016 |
| Pharos | Pharos | 12 September 2016 |
| Red Cross | Red Cross | 1 December 2016 |

# Annex 3 The Dutch Asylum Procedure

## 1. Grounds for asylum

The Dutch Aliens Act[1653] provides for two grounds for asylum which are both based on international law and EU law (Directive 2011/95/EU[1654], the recast Qualification Directive). The first ground is that a person qualifies as a refugee under the Refugee Convention (or the Qualification Directive). The second ground is that the asylum seeker has shown substantial grounds for believing that he, if expelled, would face a real risk of (a) the death penalty or execution, (b) torture or inhuman or degrading treatment or punishment of an asylum seeker in the country of origin or (c) serious and individual threat to a civilian's life or person by reason of indiscriminate violence in situations of international or internal armed conflict.[1655] Also family members of persons who have received an asylum status may under certain conditions be granted asylum.[1656] All asylum seekers who qualify as a (family member) of a refugee or person in need of subsidiary protection are granted an asylum status, with the same material rights.

## 2. A variety of asylum procedures

The Netherlands has different types of asylum procedures, some of which are called 'tracks' (*sporen*). The general asylum procedure (or AA-procedure) is considered the standard asylum procedure. However, in 2015 and 2016 special procedures (tracks) have been introduced for asylum seekers with low chances of success: Track 1 for Dublin cases and Track 2 for asylum seekers from safe countries of origin and asylum seekers who have been granted an asylum status in another EU Member State. These procedures will be briefly discussed below. Furthermore, simplified procedures have been designed which can be applied to cases with a high chance of success in a situation of high influx. The State Secretary should take a special decision to apply these procedures. This has not happened so far. For this reason these procedure will not be further discussed in this annex. There is also a special procedure for subsequent asylum applications. As this report does not address subsequent asylum procedure, this procedure will also not be further discussed here.

| **Asylum procedures in the Netherlands** | | | | | |
|---|---|---|---|---|---|
| Procedure | Track | Legal basis Aliens decree | Rest and preparation period | Number of interviews | Legal Assistance? |
| Dublin | 1 | Art. 3.109c | No | 1 | After the interview |

[1653] Art. 29(1) Aliens Act 2000.
[1654] Directive 2011/95/EU of the European Parliament and of the Council of 13 December 2011 on standards for the qualification of third-country nationals or stateless persons as beneficiaries of international protection, for a uniform status for refugees or for persons eligible for subsidiary protection, and for the content of the protection granted [2011] OJ L 337/9.
[1655] See Art. 2f and 15 Qualification Directive.
[1656] Art. 29(2) Aliens Act 2000.

| | | | | | |
|---|---|---|---|---|---|
| Safe countries of origin | 2 | Art. 3.109ca | No | 1 | After the interview |
| General asylum procedure (*AA-procedure*) | 4 | Art. 3.110 and further | Yes | 2 | During rest and preparation period |
| Extended Asylum Procedure (*VA-procedure*) | | Art. 3.116 | Yes | 2 | During rest and preparation period |
| Border procedure | | Art. 3 Aliens Act 2000 | Yes, but may be shorter | 2 | During rest and preparation period |
| Subsequent asylum applications | | Art. 3.118b | No | 1 | After the interview |
| **Procedures in times of high influx (have not been applied so far)** | | | | | |
| Simplified grant of asylum status | 3 | Art. 3.123a | | 1 | No |
| Special follow-up procedure | 5 | Art. 3.123c | | 2 | During rest and preparation period |

## 3. The general asylum procedure (AA-procedure, Track 4)

In principle, all asylum seekers will get their interviews and submit corrections and additions to the reports of these interviews during the AA-procedure. Many asylum seekers also receive a positive or negative asylum decision in the AA-procedure. If it is not possible to take a careful decision in the AA-procedure, the asylum seeker will be sent to the extended asylum procedure. The AA-procedure is preceded by a rest and preparation period. The procedure itself takes a maximum of eight (working)days from the first interview to the decision on the asylum application.

### 3.1 The rest and preparation period

Before the asylum procedure starts, the asylum seeker has six working days to rest, prepare for the asylum procedure and undergo a medical examination (the rest and preparation period). During this period the IND examines the asylum seeker's identity and travel route and assesses whether it can file a Dublin claim. This has the advantage that asylum seekers have time to rest next to all the preparation activities. Unaccompanied children get a rest and preparation period of three weeks in order to give their guardians the opportunity to gain the children' trust.[1657] In practice an asylum seeker will not start the rest and preparation period directly after arrival. In particular during the period of high influx asylum seekers had to wait for a long time before the rest and preparation period begins.[1658]

[1657] Ibid, p. 97

[1658] In November 2015 it took six months before the asylum seeker actually entered the asylum procedure. State Secretary of Security and Justice, Letter of 19 November 2015 in which he gives explanation to asylum seekers about the reception conditions and the waiting times in the asylum procedure,

*Medical examination*

Almost all asylum seekers are subjected (on a voluntary basis) to a medical examination by a nurse and/or a doctor of a private organisation (now FMMU). The goal of this medical examination is to establish whether there are medical limitations, which may interfere with the asylum seeker's ability to make complete, coherent and consistent statements talk about his asylum motives (see further Chapter 3 of this report).

*Preparation by a lawyer*

The asylum seeker is assisted by a free lawyer during the whole asylum procedure. Almost all asylum seekers who lodge a first asylum procedure prepare the asylum application with their lawyer during the rest and preparation period.[1659] This preparation meeting normally takes place at the office of the lawyer. Lawyers find it important that they first meet the asylum seeker outside the application centre, because it helps them to gain the asylum seeker's trust. Most lawyers also find the preparation meeting important, because they can explain the procedure and the importance of documents and other evidence to the asylum seeker.[1660]

*Preparation by the Dutch Council for Refugees*

Volunteers of the Dutch Council for Refugees give information on the asylum procedure to asylum seekers in a group and individually.[1661] In some cases they also make a first assessment of the asylum account and/or fill in an observation list on psychological problems which are made available to the lawyer.

## 3.2 The course of the AA-procedure

After the rest and preparation period the general asylum procedure starts. Every asylum seeker follows a fixed schedule in which some days are attributed to the IND and some to the lawyer to perform a certain activity.[1662] On the first day the IND interviews the asylum seeker on his identity, nationality and travel route. On day 2 the lawyer discusses the report of this interview with the asylum seeker and sends corrections and additions to the IND. He also prepares the asylum seeker for the second interview on the asylum motives, which takes place on day 3. On day 4 the lawyer discusses the report of the second interview with the asylum seeker and sends corrections and additions to the IND. On day 5 the IND grants the asylum application or sends an intended rejection to the lawyer. On day 6 the lawyer discusses the intended rejection with the asylum seeker and gives his view. On day 7 and 8 the IND makes and distributes the asylum decision.

https://www.rijksoverheid.nl/documenten/brieven/2015/10/19/brief-van-de-staatssecretaris-van-veiligheid-en-justitie-aan-asielzoekers.

[1659] Ibid, p. 92.

[1660] Ibid, p. 94.

[1661] Art. 3.109(2) Aliens Decree 2000.

[1662] Arts. 3.109-3.115 Aliens Decree 2000.

| Day | Activity | IND/Lawyer |
|---|---|---|
| 1 | First interview (identity, nationality, travel route) | IND |
| 2 | Preparation second interview | Lawyer |
| 3 | Second interview (asylum motives) | IND |
| 4 | Corrections and additions on report second interview | Lawyer |
| 5 | Intended decision | IND |
| 6 | View on intended decision | Lawyer |
| 7 | Preparation decision | IND |
| 8 | Distribution decision | IND |

During the AA-procedure the asylum seeker is assisted by the same lawyer as during the rest and preparation period. This lawyer is assigned to the asylum seeker. The Council of Legal Assistance (*Raad voor de Rechtsbijstand*) makes a schedule in which each lawyer starts the AA-procedure on day 2 and works on a maximum of three cases simultaneously. In some situations it is possible to extend the AA-procedure to 14, 16 or 22 days, for example if no interpreter is available or where the asylum seeker changes his statements on his nationality or identity.[1663]

### 4. The extended asylum procedure (VA-procedure)

If the IND is not able to reach a decision during the AA-procedure the asylum seeker will be sent to the extended asylum procedure. Unaccompanied children below 12 years old and persons who cannot be interviewed because of medical problems are interviewed in the extended asylum procedure.[1664]

The time-limit for taking the decision in the extended asylum procedure is six months.[1665] This time-limit can be extended with one year if the situation in the country of origin is uncertain or will expectedly improve soon.[1666]

### 5. The Dublin procedure (Track 1)

Asylum seekers who are claimed at another EU Member State under the Dublin Regulation do not get a rest and preparation period. This means, amongst others, that they have no right to prepare for the interview with a lawyer and that they are not offered a medical examination. In this track asylum seekers have one interview with the IND, which concerns the asylum seeker's objections to the Dublin transfer.[1667] The asylum seeker is not asked about his asylum motives. After the interview the asylum seeker receives an intended decision to refuse to examine the asylum application (*buiten behandeling stelling*). The asylum seeker is granted two weeks (or one week if the asylum seeker is detained) to provide corrections to the report of the interview and to respond to the intended decision.[1668] For that purpose he has access to a free lawyer. After that the IND will take a decision. If the IND decides that

[1663] Art. 3.115 Aliens Decree 2000.
[1664] Art. 3.113(5) Aliens Decree 2000. In case an asylum seeker cannot be interviewed the IND can also extend the waiting time before the asylum seeker starts the asylum procedure.
[1665] Art. 42(1) Aliens Decree 2000.
[1666] Art. 43 Aliens Decree 2000.
[1667] Art. 30(2) Aliens Act 2000.
[1668] Art. 3.109c Aliens Decree 2000.

the asylum seeker cannot or will not be transferred under the Dublin Regulation, the asylum seeker will be moved to another track: Track 2 if the asylum seeker is from a safe country of origin or has received an asylum status in another EU Member State or Track 4, the general asylum procedure.

### 6. The procedure for asylum seekers with low chances of success (Track 2)

Track 2 can applied on two grounds: the asylum seeker has been granted an asylum status in another EU Member State or the asylum seeker originates from a safe country of origin[1669].[1670] In this track asylum seekers do not have the right to a rest and preparation period and the safeguards linked to this period (legal assistance and a medical examination). They have one interview with IND, which takes place as soon as possible after the application. During the interview the IND asks questions amongst others about the asylum seeker's personal details, including his identity, nationality and ethnic background, date of departure of the country of origin, date of arrival in the Netherlands, possession of identity documents and the personal details and place of residence of family members.

If the IND intends to declare the asylum application inadmissible because the asylum seeker has been granted an asylum status in another EU Member State, the asylum seeker gets the opportunity to give his view on that. If the IND intends to declare the asylum application manifestly unfounded, because the asylum seeker originates from a safe country of origin, the IND asks the asylum seeker to make statements about his asylum motives.[1671] As soon as possible after the interview the asylum seeker receives a report of the interview and an intended decision to declare the application inadmissible or manifestly unfounded.[1672] The asylum seeker may give his view on the intended decision within a time-limit of two days. For this purpose he has access to free legal assistance. The IND takes a decision within eight days after the interview.[1673] If the IND does not declare the application inadmissible or manifestly unfounded on the two grounds mentioned above, the asylum seeker will be referred to the general asylum procedure (Track 4).[1674]

### 7. The border procedure

Asylum seekers who arrive at the external border of the Netherlands (mainly Schiphol Airport) are usually detained during the asylum procedure. Their asylum applications are processed at the application centre at Schiphol Airport. The border procedure follows the same steps as the general asylum procedure.[1675] However, asylum seekers often chose to shorten the rest and preparation period in order to reduce the length of their detention.[1676] In the border procedure the IND should

[1669] On 27 September 2017, the following countries were considered safe countries of origin: Albania, Algeria, Andorra, Australia, Bosnia-Herzegovina, Brazil, Canada, Georgia, Ghana, India, Jamaica, Japan, Kosovo, Macedonia, Morocco, Monaco, Mongolia, Montenegro, New-Zealand, San Marino, Senegal, Serbia, Switzerland , Togo, Trinidad and Tobago, Tunisia, Ukraine, Vatican City State and the United States.
[1670] Art. 3.109ca Aliens Decree 2000.
[1671] Art. 3.109c(4) Aliens Decree 2000. See Annex 13 to the Aliens Regulation 2000 (*Voorschrift Vreemdelingen*).
[1672] Art. 3.109c(5 and 6) Aliens Decree 2000.
[1673] Art. 3.109c(11) Aliens Decree 2000.
[1674] Art. 3.109c(7) Aliens Decree 2000.
[1675] Art. 3.109b Aliens Decree 2000.
[1676] Art. 3.109b(2) Aliens Decree 2000. K. Zwaan e.a., Evaluatie Herziene Asielprocedure, WODC 2014, p. 99.

decide about asylum applications within four weeks. Otherwise, the asylum seeker should be released and placed in the normal prolonged procedure.[1677] The asylum seeker is also released and referred to the general asylum procedure if the IND thinks that his asylum application cannot be refused under the Dublin Regulation or declared inadmissible or manifestly unfounded.[1678]

## 8. Legal remedies

All decisions in which an asylum application has been rejected can be appealed before the district court.[1679] Subsequently the asylum seeker or the IND can appeal the judgment of the district court before the Administrative Jurisdiction Division of the Council of State (AJD).[1680] The nature of this higher appeal before the AJD is limited: the large majority of the cases are dealt with without a hearing and most of the AJD's judgments are not reasoned.[1681]

[1677] Art. 3(7) Aliens Act 2000.
[1678] Art. 3.109b Aliens Decree 2000.
[1679] Art. 8:1 General Administrative Law (*Algemene wet bestuursrecht*).
[1680] Art. 8.104 General Administrative Law.
[1681] Raad van State, Jaarverslag 2012, available at: http://jaarverslag.raadvanstate.nl/downloadattachment.aspx?intLSAttSetId=133.

## Annex 4 The reception system

COA Centraal Orgaan opvang asielzoekers

# The reception: step by step

*from July 1, 2010*

**Central reception location (col)**

Asylum seekers report to the reporting unit of the Aliens Police (AP) in Ter Apel. After identification and registration by the AP, the rest and preparation period starts. Asylum seekers are received at the CRL of the COA.

***Start of the rest and preparation period (rvt)*** *(at least 6 days)*

At the CRL, the COA will provide, among other things, meals accommodation, access to medical care and assistance, where necessary.

Asylum seekers are given an appointment card for all appointments as a preparation for the new asylum procedure.

Asylum seekers move to the process reception location. The COA will consult various chain partners as to which location this will be.

Asylum seekers will have a compulsory TB screening. The COA and GGD will take care of the planning together.

**Process reception location (pol)**

The COA will provide, among other things, meals, accommodation,a ccess to medical care and assistance, where necessary.

Asylum seekers are given basic information about life at a COA reception location through a DVD, information booklet, house rules and an overview of rights and duties.

Asylum seekers prepare for the asylum procedure. The COA facilitates an interview room for the Dutch Council for Refugees and MediFirst

Through the COA, asylum seekers are given proof of lawful residence.

The COA informs asylum seekers of when the 1st day of the general asylum procedure will be.

The COA organises transport from the PRL to the IND application centre and back.

***Start of the General Asylum Procedure*** *(starting point: 8 days)*

The general asylum procedure starts at the 1st hearing with the IND.

At the end of their stay at the PRL, asylum seekers are given a money card, into which their weekly allowance is paid during their stay at the asylum seekers' centre.

After the end of the general asylum procedure, the IND will inform asylum seekers of the decision on the request for asylum, or whether the IND will conduct further investigation.

Asylum seeker moves to follow-up reception.

**Asylum seekers' centre (azc)**

All occupants must comply with:

House rules are explained; meeting on rights and duties.

Asylum seekers are given a weekly allowance by the COA and will take care of their own meals.

Duty to report weekly.

No decision

***Start of Extended Asylum Procedure***

Assistance focused on orientation to the future.

Decision by IND on the request for asylum will be known.

Granting

***Start of Pre-Civic Integration***

Assistance focused on preparing for civic integration.

On a voluntary basis start learning the Dutch language.

Asylum seekers are received at the ASC until they find or are offered suitable accommodation in a municipality.

Rejection

***Start of Repatriation***

Assistance focused on repatriation.

The COA will provide reception at the ASC for as long as asylum seekers are entitled to it.

**Freedom-restricting location (vbl) or Family Location**

Possible transfer to Freedom Restricted Location (vbl) or Family Location (gl).

The COA provides accommodation at the FRL to asylum seekers who have exhausted their appeals.

Duty to report daily.

The COA has quality of life and safety meetings with individual asylum seekers.

*September 2012*

Source: www.coa.nl

## Annex 5 Tables and Graphs

**Chapter 3 The medical advice interviewing and decision-making**

**1. MediFirst and FMMU: No show at medical screening per location (% of total)**

| | Gilze-Reijen | Wageningen | Schiphol | Ter Apel |
|---|---|---|---|---|
| 2012 (MediFist | 337 (15%) | 198 (9%) | 28 (3%) | 290 (15%) |
| 2013 (Medifirst) | 360 (17%) | 193 (7%) | 34 (3%) | 689 (28%) |
| 2014 (MediFirst) | 337 (13%) | 248 (7%) | 44 (4%) | 406 (10%) |
| 2015 (FMMU) | X | X | X | X |
| 2016 (FMMU) | 314 (11%) | 257 (8%) | 47 (6%) | 589 (12%) |

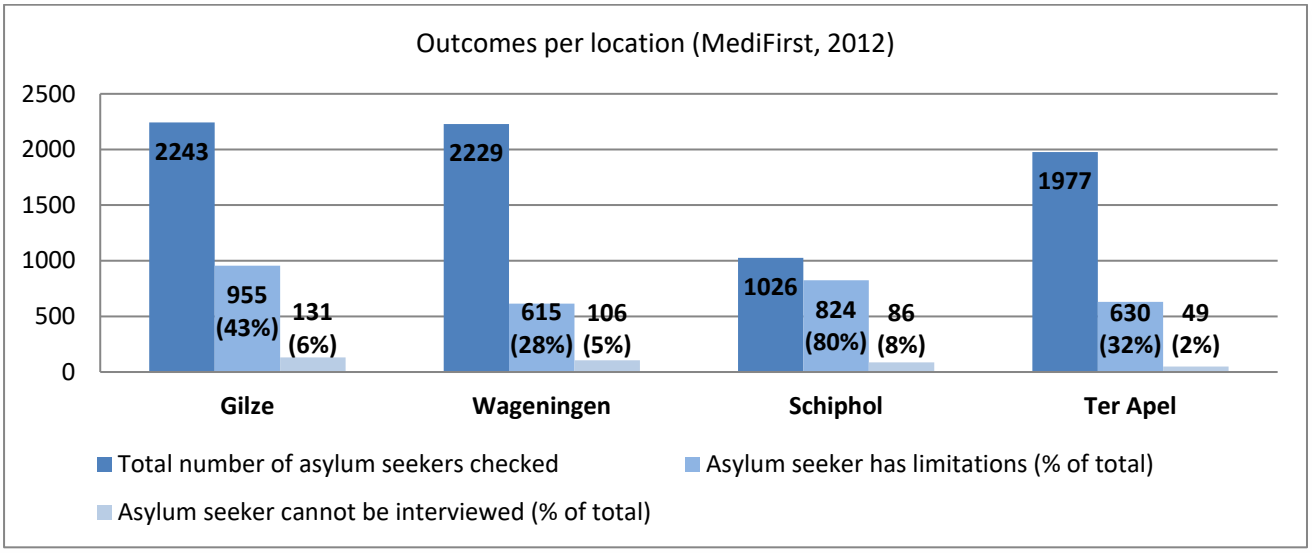
X = no data available

**2. FMMU: Number of asylum seekers screened multiple times**

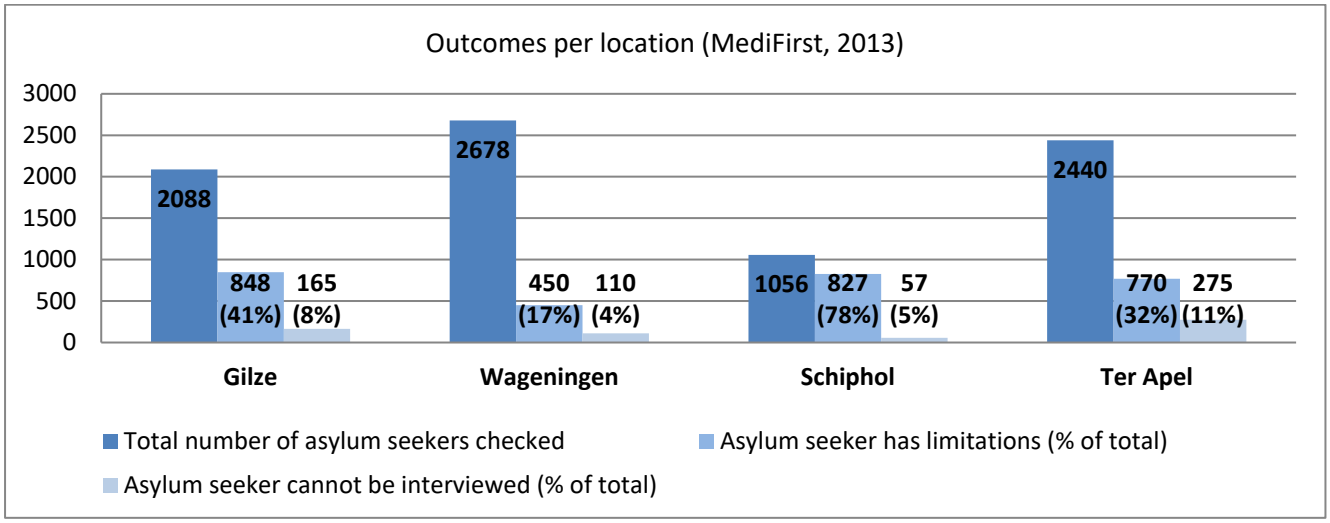
| | Total number of asylum seekers screened by FMMU | Number of asylum seekers screened multiple times |
|---|---|---|
| Feb 2015 | 1423 | X |
| March | 843 | X |
| April | 729 | 28 (3.8%) |
| May | 1341 | 46 (3.4%) |
| June | 2181 | 33 (1.5%) |
| July | 2044 | 32 (1.6%) |
| Aug | 2209 | 17 (0.8%) |
| Sep | 2245 | 34 (1.5%) |
| Oct | 2065 | 33 (1.6%) |
| Nov | 1918 | 53 (2.8%) |
| Dec | 3361 | 82 (2.4%) |
| Jan 2016 | 3812 | 39 (1.0%) |
| Feb | 3452 | 31 (0.9%) |
| March | 1932 | 13 (0.7%) |
| April | 3034 | 12 (0.4%) |
| May | 2261 | 7 (0.3%) |
| June | 2575 | 16 (0.6%) |
| July | 1495 | 13 (0.9%) |
| Aug | 1438 | 8 (0.6%) |
| Sept | 794 | 10 (1.3%) |

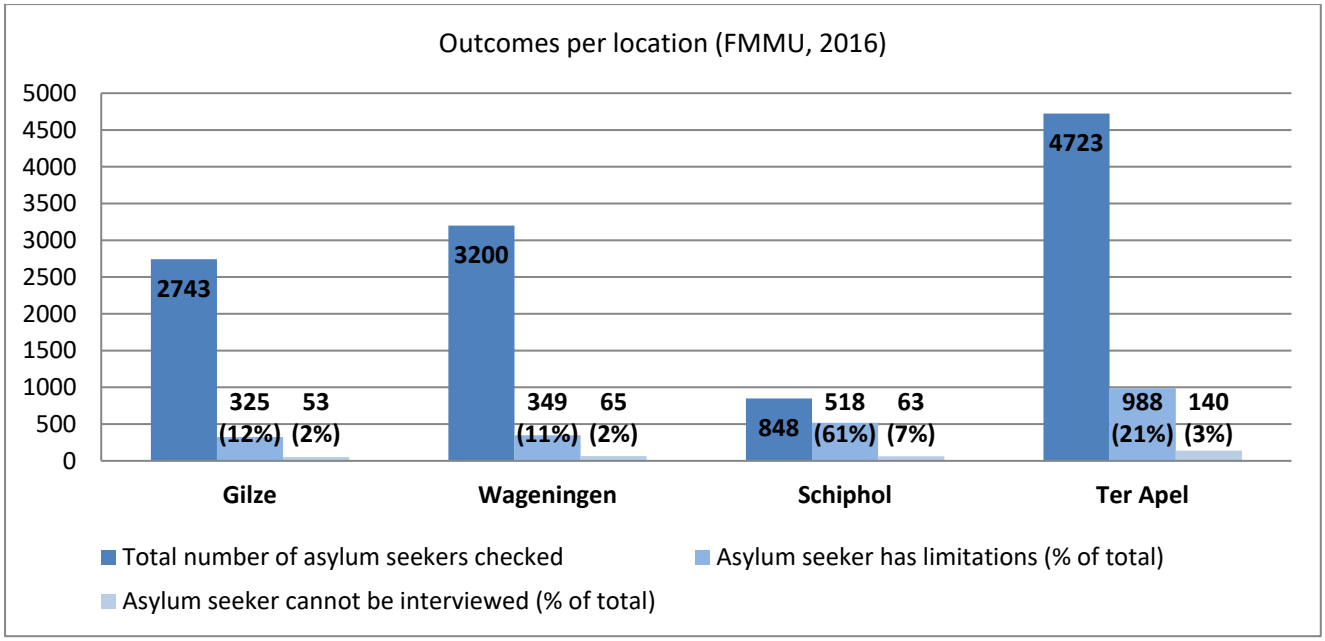
| | | |
|---|---|---|
| Oct | 857 | 8 (0.9%) |
| Nov | 918 | 12 (1.3%) |
| Dec | 899 | 4 (0.4%) |

X = no data available




**3. MediFirst and FMMU advice: Outcomes per location**




Outcomes per location (FMMU, 2016)
5000
4500
4000
3500
3000
2500
2000
1500
1000
500
0
2743
325 (12%)
53 (2%)
3200
349 (11%)
65 (2%)
848
518 (61%)
63 (7%)
4723
988 (21%)
140 (3%)
Gilze
Wageningen
Schiphol
Ter Apel
Total number of asylum seekers checked
Asylum seeker has limitations (% of total)
Asylum seeker cannot be interviewed (% of total)

**Chapter 4 Forensic medical examinations**

**Table overview NFI/NIFP reports**

| | **Date report** | **Report submitted in first or subsequent asylum procedure** | **iMMO (scars)** | **NFI (scars)** | **iMMO (psychological problems)** | **NIFP (psychological problems)** | **Decision IND** |
|---|---|---|---|---|---|---|---|
| 1 | 23-5-2016 (NIFP) | Second (iMMO and NFI) | Not examined | No NFI report | Typical | Very consistent | Application rejected |
| 2 | 31-5-2016 (NIFP) | First (iMMO and NIFP) | Not examined | No NFI report | Typical | Very consistent or even typical | Asylum granted |
| 3 | 16-6-2016 (NFI)<br><br>24-8-2016 (NIFP) | Second (iMMO and NFI/NIFP) | Consistent, very consistent, typical | As probable as not that the findings have been caused by the alleged events | Typical | Consistent | Asylum granted (after negative decision) |
| 4 | 16-6-2016 (NFI)<br><br>15-7-2016 (NIFP) | First | No iMMO report | As probable as not that the findings have been caused by the alleged events | No iMMO report | Consistent | Application rejected |
| 5 | 26-1-2017 (NFI)<br><br>1-10-2016 (NIFP) | Second (iMMO and NFI/NIFP) | Very consistent | As probable as not that the findings have been caused by the alleged events | Typical | Very consistent | Intended rejection |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 6 | 20-3-2017 (NFI)<br><br>23-3-2017 (NIFP) | First | No iMMO report | It is more probable that the scars are not caused by the alleged events | No iMMO report | At least very consistent | Asylum granted |
| 7 | 21-3-2017 (NFI)<br><br>20-4-2017 (NIFP) | First | No iMMO report | It is more probable that the scars on the arm are not caused by the alleged events, No conclusion can be drawn as to the other findings. | No iMMO report | Typical | Asylum granted |
| 8 | 30-5-2017 (NFI)<br><br>10-6-2017 (NIFP) | First | No iMMO report | It is more probable that the scars are not caused by the alleged events | No iMMO report | Consistent | No decision yet |

# Annex 6 Intended decisions/rejections in medical cases

### Intended decision case 1

The iMMO report submitted by the asylum seeker concluded that the psychological problems were typical for the alleged events and undoubtedly interfered with her ability to make complete, consistent and coherent statements. The NIFP report concluded that the psychological problems were very consistent with the alleged events and that they probably interfered with her ability to make complete, consistent and coherent statements. The IND considered that this implies that 'there are several other causes for the asylum seeker's complaints'. For that reason the IND did not see reason to change its initial conclusion that the core of the asylum seeker's asylum account was not credible. [1682] The reasons for the incredibility was that some of the asylum seeker's statements were considered strange. Furthermore, the asylum seeker failed to mention an incident which her husband did mention and they had remained in Azerbaijan for more than a year without problems. [1683]

### Intended decision case 3

iMMO had concluded that the scars and physical problems were consistent, very consistent and typical of the alleged ill-treatment. However, NFI could not conclude whether it was more probable than not that the asylum seeker's scars/physical problems were caused by the alleged ill-treatment. The IND considered that as a result 'the scars or physical problems cannot support the asylum seeker's asylum account. There is no clear result or even a result which gives any indication'.[1684] The NIFP report concluded that the psychological problems were 'consistent' with the alleged events. iMMO had found a higher degree of causal relation ('typical'). The IND found no reason to change its conclusion that the asylum seeker's account of ill-treatment is not credible. It considered that the NIFP report indicates that 'the complaints are not specific and that they have many other causes'.[1685] The asylum claim was initially rejected. However, the IND decided to withdraw this decision before the appeal hearing and to grant the asylum seeker an asylum permit.[1686]

### Decision case 4

In case 4 the reports of NFI and NIFP were requested and obtained between the intended decision and the decision of the IND. In the intended decision the IND deemed the asylum seeker's asylum account not credible. The NFI concluded that it is as probable as not that the asylum seeker's scars were caused by the alleged torture and rape. NIFP concluded that the psychological complaints (including sleeping problems and nightmares) did not lead to a psychiatric diagnosis or classification. Therefore no causal relationship could be established with the alleged events in the country of origin. The IND writes in its decision that it cannot be derived from the forensic medical examination that there is a causal relation between the physical and psychological damage on the one hand and the

[1682] Intended decision 1 December 2016.
[1683] The asylum seeker claimed that she and her husband were unconscious when they were taken to hospital by their parents. Their parents stated to the hospital that the asylum seekers were ill-treated by the authorities. According to the IND this is strange, because the parents could not have known that the asylum seeker and her husband were ill-treated by the authorities because they were unconscious. The asylum seeker's explanation that her parents derived this from the fact that they knew about the asylum seekers problems with the authorities was deemed speculative.
[1684] Intended decision 2 January 2017.
[1685] Ibid.
[1686] E-mail of the lawyer in this case of 12 June 2017.

asylum account on the other hand. Therefore, no other conclusion can be made as to the credibility of the asylum account on the basis of this forensic medical examination.[1687]

### Intended decision case 5

In this case iMMO concluded that the asylum seeker's scars were 'consistent' with and the psychological problems 'typical' of the alleged events. The IND weighed the NFI and NIFP report against the iMMO report. It considered that with regard to the asylum seeker's scars it attached more weight to the NFI report, which concluded that it is as probable as not that the findings have been caused by the alleged events. The IND gave two reasons for this: The iMMO examination was not performed by a forensic doctor with training and experience in and knowledge of forensic medicine (the examination was done by psychiatrists). Furthermore, the IND stated that the NFI report was more insightful than the iMMO report, because it gave more explanation than the iMMO report. With regard to the psychological problems the IND considered that NIFP concluded that they were 'very consistent', which indicates (like the iMMO report) that there are also other potential causes. Therefore, the IND found no reason to change its conclusions as to the credibility of the (core of the) asylum account. Also here the IND doubted the expertise of the iMMO psychiatrists in forensic medicine and found the NIFP report more insightful than the iMMO report.[1688]

[1687] Decision of 6 October 2016.
[1688] Intended decision of 5 May 2017.

## List of sources

**Literature**


- Battjes, H, 'Legal effects of the Istanbul Protocol '**,** in: Bloemen, E., Bruin, R., Reneman, M., *Care Full, Medico-legal reports and the Istanbul Protocol*, Pharos/Amnesty International/Dutch Council for Refugees, 2006.

- Bloemen, E., 'Medisch advies in de asielprocedure, meer aandacht voor kwetsbare asielzoekers', *Phaxx,* 2010, nr. 3.

- Bloemen, E. and Keunen, A., 'Ik heb alle bewijzen op mijn lichaam'*, Asiel & Migrantenrecht,* 2013, pp. 454-460.

- Bot, H., Reneman, M. and Samson, A., 'Klachtenadviescommissie Tolken', *Nieuwsbrief Asiel- en Vluchtelingenrecht*, 2008, pp. 305-318.

- M.A. Fineman, 'The Vulnerable Subject: Anchoring Equality in the Human Condition', *Yale Journal of Law and Feminism*, 2008, http://digitalcommons.law.yale.edu/cgi/viewcontent.cgi?article=1277&context=yjlf [accessed 30 October 2017].

- Flegar, V., *Towards Individualized Vulnerability in Migration Policies*, April 2016, https://ghlgblog.wordpress.com/2016/04/01/towards-individualized-vulnerability-in-migration-policies/ [accessed 2 June 2017]

- Furtmayr, H and Frewer, A, 'Documentation of torture and the Istanbul Protocol: applied medical ethics', *Medicine, Health care and Philosophy*, 2010, pp. 279-86.

- Goosen, S., Stronks, K., and Kunst, A.E., 'Frequent relocations between asylum-seeker centres are associated with mental distress in asylum-seeking children: a longitudinal medical record study', *International Journal of Epidemiology,* 2014, pp. 94-104

- K. Groenendijk and L. Slingenberg, 'Niet bij brood alleen'*, Asiel & Migrantenrecht* 2016, nr. 3, pp. 112-114

- Huijbregts, V., 'Onderwijs aan jeugdige asielzoekers', *Cogiscope* 2016, nr. 1

- Ikram, U. and Stronks, K., *Preserving and Improving the Mental Health of Refugees and Asylum Seekers, A Literature Review for the Health Council of the Netherlands*, February 2016, www.gezondheidsraad.nl/sites/default/files/201601briefadvies_geestelijke_gezondheid_van_vluchtelingen.pdf [accessed 2 June 2017]

- Van Mourik, K, Zwaan, K. and Terlouw, A, *Gehoor Geven*, Nijmegen: Wolf Legal Publishers 2011.

- M. Mustaniemi-Laakso, M. Heikkilä, E. Del Gaudio and others, 'The protection of vulnerable individuals in the context of EU policies on border checks, asylum and immigration', *Frame* 31 May 2016, http://www.fp7-frame.eu/wp-content/uploads/2016/08/Deliverable-11.3.pdf [accessed 30 October 2017]

- Reneman, M, *Verkiezingen 2017: Opvang van asielzoekers en asielstatushouders*, March 2017, www.verblijfblog.nl/?p=2145 [accessed 23 August 2017].

- Smulders, S., 'Medisch steunbewijs en de implementatie van de herziene procedurerichtlijn', *Journaal Vreemdelingenrecht*, 2015, nr. 3 /26, pp. 41-56.


**Reports and policy documents**


- ACVZ, *Expertise getoetst*, July 2012, https://acvz.org/wp-content/uploads/2015/05/Advies-ACVZ-NR35-2012.pdf [accessed 2 June 2017]

- ACVZ, *Verloren tijd*, March 2013, https://acvz.org/wp-content/uploads/2015/05/22-03-2013_Advies36-web.pdf [accessed 28 August 2017]

- ACVZ, *Sporen uit het verleden*, July 2014, http://acvz.org/wp-content/uploads/2015/04/03-07-2014_ACVZ_Advies_40-web.pdf [accessed 2 June 2017]

- ACVZ, *De geloofwaardigheid gewogen. Een advies over het onderzoeken, integraal beoordelen en toetsen van verklaringen in de asielprocedure*, May 2016, https://acvz.org/wp-content/uploads/2016/05/De-geloofwaardigheid-gewogen.pdf [accessed 9 June 2017]

- ACVZ, *Pieken en Dalen*, May 2017, https://acvz.org/wp-content/uploads/2017/05/70519-14961-Pieken-en-dalen-web-2.pdf [accessed 28 August 2017]

- Arq Psychotrauma Expert Group, *Veerkracht en Vertrouwen, De bouwstenen voor psychosociale hulpverlening aan vluchtelingen*, May 2016, [accessed 9 June 2017] http://www.pharos.nl/documents/doc/veerkracht_en_vertrouwen_arq.pdf

- Van Berkum, M., et al, *Zorg, ondersteuning en preventie voor nieuwkomende vluchtelingen, wat is er nodig?*, Pharos, March 2016, http://www.pharos.nl/documents/doc/zorg%20ondersteuning%20en%20preventie%20voor%20nieuwkomende%20vluchtelingen%20wat%20is%20er%20nodig.pdf [accessed 2 June 2017]

- Böcker, A.G.M., Grütters, C.A.F.M., Laemers, M.T.A.B., *et al.*, *Evaluatie van de herziene asiel-procedure*, WODC, September 2014, https://www.wodc.nl/binaries/2347-volledige-tekst_tcm28-73097.pdf [accessed 9 June 2017]

- Boillat, J. and Chamouton, B., *Protect, Process of Recognition and Orientation of Torture Victims in European Countries to Facilitate Care and Treatment*, ACET and others, www.pharos.nl/documents/doc/protect_full-2-english.pdf [accessed 2 June 2017]

- COA, *Grenzen*, Jaarverslag 2015, https://www.coa.nl/sites/www.coa.nl/files/publicaties/bestanden/grenzen_jaarverslag_coa_2015.pdf [accessed 28 August 2017]

- COA, *Dynamiek*, Jaarverslag 2016, https://www.coa.nl/sites/www.coa.nl/files/publicaties/bestanden/dynamiek-coa-jaarverslag-2016.pdf [accessed 28 August 2017]

- College voor de Rechten van de Mens, *Aanbevelingen Mensenrechten in (tijdelijke) opvanglocaties voor asielzoekers en vluchtelingen*, December 2016, https://mensenrechten.nl/publicaties/detail/36221 [accessed 2 June 2017]

- College Rechten van de Mens, *Aanbevelingen Mensenrechten in de noodopvang Heumensoord*, February 2016, https://mensenrechten.nl/publicaties/detail/36372 [accessed 2 June 2017]

- Commissie Medische zorg voor (dreigend) uitgeprocedeerde asielzoekers en illegale vreemdelingen, *Arts en Vreemdeling*, 2017, https://www.knmg.nl/advies-richtlijnen/dossiers/asielzoekers-en-ongedocumenteerde-vreemdelingen.htm [accessed 22 September 2017]

- Crock, M., McCallum, R. and Ernst, C., *Where Disability and Displacement Intersect: Asylum Seekers with Disabilities*, International Association of Refugee Law and Judges World Conference, September 2011, https://www.iarlj.org/general/images/stories/BLED_conference/papers/Disability_and_Displacement-background_paper.pdf [accessed 2 June 2017]

- Defence for Children and Unicef, *Jaarbericht Kinderrechten*, May 2016, https://www.defenceforchildren.nl/images/68/4572.pdf [accessed 2 June 2017]

- Drogendijk, A. et al*., Veerkracht en Vertrouwen, De bouwstenen voor psychosociale hulpverlening aan vluchtelingen*, Arq Psychotrauma Expertgroep, May 2016, www.zonmw.nl/fileadmin/documenten/GGz/2016_Rapport__Veerkracht_en_vertrouwen_.pdf [accessed 2 June 2017]

- EASO, *EASO guidance on reception conditions: operational standards and indicators*, September 2016, https://www.easo.europa.eu/sites/default/files/EASO%20Guidance%20on%20reception%20conditions%20-%20operational%20standards%20and%20indicators%5B3%5D.pdf [accessed 7 September 2017]

- European Parliament, *The conditions in centres for third country national (detention camps, open centres as well as transit centres and transit zones) with a particular focus on provisions and facilities for persons with special needs in the 25 EU member states*, December 2007, http://www.europarl.europa.eu/RegData/etudes/etudes/join/2007/393275/IPOL-LIBE_ET(2007)393275_EN.pdf

- Flegar, V., *Quickscan Zorg voor asielzoekerskinderen in Nederland*, Werkgroep Kind in azc, June 2016, http://www.kind-in-azc.nl/docs/20160601_quick_scan_gezondheidszorg.pdf [accessed 2 June 2017]

- Gemeente Nijmegen, Gemeente Heumen, *Noodopvang Heumensoord, Een terugblik*, May 2016, https://praktijkvoorbeelden.vng.nl/databank/asiel-en-integratie/noodopvang-en-azc/noodopvang-heumensoord-een-terugblik.aspx [accessed 28 August 2017]

- Gezondheidsraad, *Briefadvies Geestelijke gezondheid van vluchtelingen***,** February 2016 www.gezondheidsraad.nl/sites/default/files/201601briefadvies_geestelijke_gezondheid_van_vluchtelingen.pdf [accessed 2 June 2017]

- GGD GHOR Nederland, *Publieke gezondheidszorg borgen, Een eerste inzicht in de staat van de GGD'en*, March 2016, http://www.ggdghor.nl/media/filebank/72da1e7fdfa54e27b83567e60892af66/publieke-gezondheid-borgen-ggd-ghor-nederland-2016.pdf [accessed 2 June 2017]

- Guardians Against Child Trafficking and Exploitation (GATE), *European Report*, March 2013, http://www.gate-eu.org/files/GATE%20EU%20Report%20e-version%20final.pdf [accessed 28 August 2017]

- Haker, F., Van Bommel, H., Bloemen, E., *Zorg voor Asielzoekers met Psychische Problemen, Het perspectief van de zorgverlener,* Pharos/Zapp , September 2010, http://www.askv.nl/wp-content/uploads/2016/09/Zapp-Het-perspectief-van-de-zorgverlener-2010-1.pdf [accessed 2 June 2017]

- Inspectie Jeugdzorg, *Grootschalige opvang van alleenstaande minderjarige vreemdelingen*, April 2012, https://www.coa.nl/sites/www.coa.nl/files/documenten/onderzoek_naar_opvang_amv.pdf [accessed 22 August 2017]

- Inspectie Jeugdzorg, *Kwaliteit opvang alleenstaande minderjarige vreemdelingen*, September 2016, https://www.rijksoverheid.nl/documenten/rapporten/2016/11/02/tk-bijlage-kwaliteit-opvang-alleenstaande-minderjarige-vreemdelingen [accessed 28 August 2017]

- Inspectie voor de Gezondheidszorg, *Goede vooruitgang in toegankelijkheid huisartsenzorg en bereik publieke gezondheidszorg volgens nieuw zorgmodel voor asielzoekers*, September 2011, http://www.igz.nl/zoeken/document.aspx?doc=Goede+vooruitgang+in+toegankelijkheid+huisartsenzorg+en+bereik+publieke+gezondheidszorg+volgens+nieuw+zorgmodel+voor+asielzoekers&docid=3751&URL [accessed 2 June 2017]

- Inspectie voor de Gezondheidszorg, *Naleving normen nieuwe zorgmodel voor asielzoekers verder verbeterd en grotendeels op orde*, May 2012, https://zoek.officielebekendmakingen.nl/blg-168321.

- Inspectie voor de Gezondheidszorg, *Algemeen toezichtrapport over de zorg aan asielzoekers met psychiatrische problematiek in de Intensief Begeleidende Opvang (IBO) in Schalkhaar*, September 2015, file:///C:/Users/mreneman/AppData/Local/Packages/Microsoft.MicrosoftEdge_8wekyb3d8bbwe/TempState/Downloads/Intensief%20Begeleidende%20Opvang%20(IBO)%20van%20asielzoekers%20Schalkhaar%20februari%202015.pdf

- Inspectie voor de Gezondheidszorg, *Medische zorg aan asielzoekers onder druk maar ketenpartners beperken gezamenlijk grootste risico's*, March 2016, https://www.igz.nl/actueel/nieuws/medische-zorg-aan-asielzoekers-onder-druk-doo.aspx [accessed 2 June 2017]

- Inspectie voor de Gezondheidszorg and Inspectie Veiligheid en Justitie, *Nader onderzoek naar de zorgverlening aan Renata A*, January 2017, https://www.igz.nl/Images/20170130%20Openbaar%20rapport%20zorgverlening%20Renata%20A_tcm294-382928.pdf [accessed 2 June 2017]

- Inspectie Veiligheid en Justitie, *Het overlijden van een Irakese Asielzoeker in de Noodopvang in Alphen aan de Rijn*, August 2016, https://www.inspectievenj.nl/Publicaties/rapporten/2016/08/15/het-overlijden-van-een-irakese-asielzoeker-in-de-noodopvang-in-alphen-aan-den-rijn [accessed 2 June 2017]

- Inspectie voor Veiligheid en Justitie, *De tijdelijke (opvang) voorzieningen voor asielzoekers onder de loep*, November 2015, https://zoek.officielebekendmakingen.nl/blg-619091 [accessed 2 June 2017]

- Inspectie voor Veiligheid en Justitie, *Het Overlijden van Alexander Dolmatov*, March 2013, https://www.rijksoverheid.nl/documenten/kamerstukken/2013/04/12/rapport-inspectie-veiligheid-en-justitie-het-overlijden-van-alexander-dolmatov [accessed 9 June 2017].

- IRCT, *Position paper on the Proposal for a recast Reception Conditions Directive (July 2016)*, September 2016, http://irct.org/uploads/media/c66c84583c480bece331863378dcef8b.pdf [accessed 2 June 2017]

- IRCT*, Position paper on the Proposal for an Asylum Procedures Regulation,* July 2016, September 2016, https://irct.org/uploads/media/9c66d5c8b0793cde5d47802f3c2059bc.pdf [accessed 28 August 2017].

- IRCT, *Falling Through the Cracks, Asylum Procedures and Reception Conditions for Torture Victims in the European Union*, 2016, http://irct.org/uploads/media/55a4e96eae76586a7abbc18633bd61a0.pdf [accessed 10 July 2017]

- IRCT, *Recognising victims of torture in national asylum procedures*, A comparative overview of early identification of victims and their access to medico-legal reports in asylum-receiving countries, 2013, http://irct.org/assets/uploads/pdf_20161120143448.pdf [accessed 28 August 2017]

- Kantar Public, *Pilotonderzoek klantervaring Kleine Keten (IND, COA en DT&V)*, July 2017, https://www.coa.nl/sites/www.coa.nl/files/nieuws/media/bestanden/kantar_public_rapport_-_pilotonderzoek_klantervaring_kleine_keten_voorjaar_2017.pdf [accessed 22 August 2017]

- Kinderombudsman, *Wachten op je Toekomst*, February 2016, www.dekinderombudsman.nl/ul/cms/fck-uploaded/2016.KOM008.Wachtenopjetoekomst.pdf [accessed 9 June 2017]

- Kramer. S. et al., *Ethische dilemma's in de GGZ voor asielzoekers*, Johannes Wier Stichting, 2015, https://www.johannes-wier.nl/wp/wp-content/uploads/2015/03/Onderzoeksverslag-Ethische-dilemmas-in-de-GGZ-voor-asielzoekers-rev.pdf [accessed 9 June 2017]

- Van Maanen, S,' Vluchtelingen en Sport', *Sport & Gemeenten*, September 2016, http://sportengemeenten.nl/wp-content/uploads/2016/09/Artikel_Vluchtelingen_en_Sport_SGnr3-2016.pdf [accessed 27 September 2017].

- Nationale Ombudsman, *Medische zorg vreemdelingen, Over toegang en continuïteit van medische zorg voor asielzoekers en uitgeprocedeerde asielzoekers*, nr. 2013/125, October 2013, https://www.nationaleombudsman.nl/uploads/2013-125_rapport_medische_zorg_vreemdelingen_webversie_0.pdf [accessed 9 June 2017]

- Nationale Ombudsman, Ra*pportage Bezoek noodopvang Heumensoord*, nr. 2016/013, February 2016, [accessed 9 June 2017]

- Nationale Ombudsman, *Terugblikonderzoek spelregels geluidsopnamen*, nr. 2016/105, November 2016, https://www.nationaleombudsman.nl/system/files?file=onderzoek/161107%20RAP%20Geluidsopnamen%202016-105.pdf [accessed 9 June 2017]

- Nationale Ombudsman, *Spelregels voor het maken van geluidsopnamen*, nr. 2014/166, November 2014 https://www.nationaleombudsman.nl/system/files/bijlage/NO-02_Rapport%20Geluidsopnamen%20-%20Printversie_0.pdf [accessed 9 June 2017]

- NIFP, *Medische Steunbewijzen in de Asielprocedure*, 3 September 2014, http://www.stichtingimmo.nl/wp-content/uploads/2014/12/Onderzoeksrapport-NIFP.pdf [accessed 12 June 2017]

- Onderzoeksraad voor Veiligheid. *Veiligheid van vreemdelingen*, April 2014 https://www.onderzoeksraad.nl/uploads/phase-docs/566/35f9d09a0e79rapport-vreemdelingen-interactief.pdf [accessed 9 June 2017]

- Pharos, K*ennissynthese gezondheid van nieuwkomende vluchtelingen en indicaties voor zorg, preventie en ondersteuning*, January 2016 http://www.pharos.nl/documents/doc/kennissynthese%20gezondheid%20van%20nieuwkomende%20vluchtelingen%20en%20indicaties%20voor%20zorg%20preventie%20en%20ondersteuning.pdf [accessed 9 June 2017]

- Raad voor Volksgezondheid en Samenleving, *Grensconflicten, Toegang tot sociale voorzieningen voor vluchtelingen*, October 2016, https://www.raadrvs.nl/uploads/docs/Grensconflicten_-_webversie.pdf

- Van Schayk, M.and Vloeberghs, E., *Podium voor preventie*, Pharos, December 2011 http://www.pharos.nl/documents/doc/podium_voor_preventie1.pdf [accessed 9 June 2017]

- Transkom et. al., *Comparative Study on Language and Culture Mediation in different European countries*, 2012, http://transkom.info/pdf/transkom_en.pdf [accessed 28 June 2017]

- UNHCR, *The 10 point plan in action,* 2016, http://www.unhcr.org/publications/manuals/5846d0207/10-point-plan-action-2016-update-chapter-5-mechanisms-screening-referral.html

- UNHCR, *Annotated Comments to Directive 2013/33/EU of the European Parliament and Council of 26 June 2013 laying down standards for the reception of asylum seekers for*

*international protection (recast)*, April 2015, http://www.refworld.org/docid/5541d4f24.html [accessed 10 July 2017]

- UNHCR, *The Heart of the matter*, December 2014, http://www.refworld.org/pdfid/55014f434.pdf [accessed 23 June 2017]

- UNHCR, *Beyond Proof*, May 2013, http://www.unhcr.org/protection/operations/51a8a08a9/full-report-beyond-proof-credibility-assessment-eu-asylum-systems.html [accessed 12 June 2017]

- UNHCR, *Comments on the European Commission's amended recast proposal for a Directive of the European Parliament and the Council laying down standards for the reception of asylum-seekers*, July 2012 http://www.unhcr.org/protection/operations/513da1cc9/unhcr-comments-european-commissions-amended-recast-proposal-directive-european.html [accessed 9 June 2017]

- UNHCR, *Detention Guidelines*, 2012, http://www.unhcr.org/505b10ee9.pdf [accessed 10 July 2017]

- UNHCR, *Handbook and Guidelines on Procedures and Criteria for Determining Refugee Status*, Reissued Geneva, December 2011, http://www.unhcr.org/publications/legal/3d58e13b4/handbook-procedures-criteria-determining-refugee-status-under-1951-convention.html [accessed 9 June 2017]

- UNHCR, *Guidelines on International Protection:* Child Asylum Claims under Articles 1(A)2 and 1(F) of the 1951 Convention and/or 1967 Protocol relating to the Status of Refugees, 2009, HCR/GIP/09/08, http://www.refworld.org/docid/4b2f4f6d2.html [accessed 20 July 2018]

- UNHCR, *Guidelines on International Protection: The application of Article 1A(2) of the 1951 Convention and/or 1967 Protocol relating to the Status of Refugees to victims of trafficking and persons at risk of being trafficked*, HCR/GIP/06/07, 7 April 2006, http://www.unhcr.org/publications/legal/443b626b2/guidelines-international-protection-7-application-article-1a2-1951-convention.html [accessed 20 July 2018]

- UNHCR, *Guidelines on International Protection: Gender-Related Persecution within the context of Article 1A(2) of the 1951 Convention and/or its 1967 Protocol relating to the Status of Refugees*, HCR/GIP/02/01, 7 May 2002, http://www.unhcr.org/publications/legal/3d58ddef4/guidelines-international-protection-1-gender-related-persecution-context.html [accessed 20 July 2018]

- UNHCR, *Note on Standard and Burden of Proof*, 16 December 1998, http://www.refworld.org/docid/3ae6b3338.html [accessed 9 October 2017].

- UNHCR, International Detention Coalition, OAK foundations, *Vulnerability Screening Tool, Identifying and addressing vulnerability: a tool for asylum and migration systems*, 2016, http://www.unhcr.org/protection/detention/57fe30b14/unhcr-idc-vulnerability-screening-tool-identifying-addressing-vulnerability.html?query=vulnerable [accessed 9 June 2017]

- Werkgroep kind in azc, *Zo kan het ook*, November 2016, http://www.kind-in-azc.nl/wp-content/uploads/2016/11/Rapport-Zo-kan-het-ook.pdf [accessed 28 August 2017]

- Werkgroep Kind in azc, *Ontheemd, De verhuizingen van asielzoekerskinderen in Nederland*, Januari 2013 https://www.defenceforchildren.nl/images/69/2112.pdf [accessed 9 June 2017]

- Westerhof, W., Vlasveld, A. and de Ridder, E., *Inventarisatie sport en bewegen op en rondom COA opvanglocaties*, Kenniscentrum Sport, May 2016, http://www.kennisbanksportenbewegen.nl/?file=6674&m=1463646109&action=file.download [accessed 28 August 2017]

- Wetenschappelijke Raad voor het Regeringsbeleid, WRR policy brief 4, *Geen tijd verliezen: van opvang naar integratie van asielmigranten*, December 2015, https://www.wrr.nl/publicaties/persberichten/2015/12/16/geen-tijd-te-verliezen-van-opvang-naar-integratie-van-asielmigranten [accessed 28 August 2017]

- Van Willigen, L., *Zorg voor Asielzoekers met Psychische Problemen*, *Literatuurstudie*, ASKV, December 2009 http://www.askv.nl/wp-content/uploads/2016/09/Zapp-literatuurstudie-2010.pdf [accessed 9 June 2017]

- Zorginstituut Nederland, *Bevorderen van participatie van cliënten met een psychische stoornis*, 29 August 2016, https://www.zorginstituutnederland.nl/publicaties/rapport/2016/08/29/bevorderen-van-participatie-van-clienten-met-een-psychische-stoornis [accessed 27 September 2017]


**Other documents**


- ACET et al., *Questionnaire and observations for early identification of asylum seekers having suffered traumatic experiences*, http://protect-able.eu/resources/

- Algemeen Dagblad, *Onrust rond medische zorg voor asielzoekers*, 30 August 2017, https://www.ad.nl/binnenland/onrust-rond-medische-zorg-voor-asielzoekers~afb6ec84/ [accessed 26 September 2017]

- Besluit Zorg Asielzoekers, Bijlage 1, http://wetten.overheid.nl/BWBR0018492/2017-01-01#Bijlage1

- Bestuursakkoord verhoogde Asielinstroom, 27 november 2015, https://vng.nl/files/vng/nieuws_attachments/2015/20151127-bestuursakkoord-asiel.pdf [accessed 9 June] 2017]

- COA, *Bericht Medische kosten gemeentelijke crisisopvang in de veiligheidsregio's*, October 2015, www.coa.nl/sites/www.coa.nl/files/paginas/media/bestanden/bericht_medische_kosten_gemeentelijke_crisisopvang_oktober_2015_2.pdf [accessed 9 June 2017]

- COA, *De opvang: stap voor stap, vanaf juli 2010*, September 2012, https://www.coa.nl/sites/www.coa.nl/files/paginas/media/bestanden/asielprocedure.pdf [accessed 7 September 2017]

- COA, *Opvangcapaciteit COA voor eind 2017 naar 31.000 plaatsen*, 26 April 2017, https://www.coa.nl/nl/actueel/nieuws/opvangcapaciteit-coa-voor-eind-2017-naar-31000-plaatsen [accessed 11 September 2017]

- COA, *Laatste crisisopvang gesloten*, 29 January 2016, https://www.coa.nl/nl/actueel/persberichten/laatste-crisisopvang-gesloten [accessed 7 September 2017]

- COA and COC Nederland, *Convenant inzake de samenwerking tussen COA and COC Nederland*, May 2014, https://www.coa.nl/sites/www.coa.nl/files/nieuws/media/bestanden/convenant_coc_en_coa.pdf [accessed 27 September 2017]

- COA, GCA, GGD GHOR, MCA, Nidos, *Factsheet Jeugdhulp*, May 2017, https://www.rzasielzoekers.nl/dynamic/media/28/documents/Factsheet%20jeugdhulp%20asielzoekerskinderen%20nieuwe%20versie%20mei%202017.pdf [accessed 27 September 2017]

- COA, GGD GHOR, MCA, Gezondheidscentrum Asielzoekers, *Factsheet Gezondheidszorg voor Asielzoekers in Nederland*, June 2015, https://www.coa.nl/sites/www.coa.nl/files/paginas/media/bestanden/factsheet_gezondheidszorg_voor_asielzoekers_in_nederland_2015.pdf [accessed 9 June 2017]

- Convenant GGZ, *Verslag werkgroepbijeenkomst*, 29 January 2016, https://www.rzasielzoekers.nl/dynamic/media/28/documents/overige_documenten/Verslag_eerste_werkgroepbijeenkomst_GGZ_convenant_voor_asielzoekers.pdf [accessed 28 August 2017]

- Doornbos, N., Koers, F. and Wijngaard, Th., *Best Practice Guide Asiel, Bij de Hand in Asielzaken*, September 2012, http://www.rvr.org/binaries/content/assets/rvrorg/informatie-over-de-raad/krav/guide-asiel-binnen.pdf [accessed 9 June 2017]

- Dutch Council for Refugees, *Kerntaak Bijwonen van Gehoren*.
- Dutch Council for Refugees, Letter to the Dutch Parliament about emergency reception centres, 20 May 2016
- Dutch Council for Refugees, Letter concerning the proposal for the implementation of the recast Asylum Procedures Directive and the Reception Conditions Directive (34 088), 7 April 2015
- Dutch Council for Refugees, Letter to the Dutch Parliament concerning the report of the Dutch Safety Board, Veiligheid van vreemdelingen, 23 May 2014
- Dutch Council for Refugees, Letter to the Dutch Parliament concerning medical care to asylum seekers, 27 March 2014, available at Vluchtweb
- EASO, *Tool For Identification Of Persons With Special Needs*, https://ipsn.easo.europa.eu/easo-tool-identification-persons-special-needs [accessed 23 June 2017]
- Gedragscode voor gerechtelijk deskundigen in civielrechtelijke en bestuursrechtelijke zaken, version 3.7, January 2012, https://www.rechtspraak.nl/SiteCollectionDocuments/Gedragscode-voor-gerechtelijk-deskundigen-in-civielrechtelijke-en-bestuursrechtelijke-zaken.pdf [accessed 11 September 2017]
- Geregistreerde COA en Politie meldingen op en rondom COA opvanglocaties, Bijlage bij TK 2015-2016, 33042, nr. 22, February 2016, https://zoek.officielebekendmakingen.nl/blg-672482 [accessed 9 June 2017]
- Gezondheidscentrum asielzoekers, *Consulent GGZ voor asielzoekers Snel en dichtbij*, March 2011 http://www.ggdghorkennisnet.nl/?file=6643&m=1325587981&action=file.download [accessed 9 June 2017]
- Gezondheidscentrum asielzoekers, *Overdracht medisch dossier naar nieuwe huisarts*, http://www.gcasielzoekers.nl/wp-content/uploads/2016/09/GC-A-formulier-toestemming-overdracht-medisch_dossier-naar-nieuwe-huisarts.pdf [accessed 27 September 2017]
- Gezondheidscentrum asielzoekers, *Toestemming delen medische gegevens*, http://www.gcasielzoekers.nl/wp-content/uploads/2016/09/GC-A-formulier_Toestemming-delen-medische-gegevens.pdf [accessed 27 September 2017]
- Gezondheidscentrum asielzoekers, *Your personal information, our responsibility Privacy guidelines for clients of Gezondheidscentrum Asielzoekers* (Health Centre Asylum Seekers),

http://www.gcasielzoekers.nl/wp-content/uploads/2016/10/Privacyfolder_NL.pdf [accessed 27 September 2017]

- GGD GHOR Nederland, *Basistakenpakket JGZ asielzoekerkinderen 0-19 jaar*, May 2014, https://www.ggdghorkennisnet.nl/?file=7111&m=1400681179&action=file.download [accessed 9 June 2017]

- GGD GHOR Nederland, Landelijke Huisartsenvereniging, *Toelichting Format Medische Gegevens Patiënt Noodopvanglocatie,* December 2015*,* www.ggdghorkennisnet.nl/?file=26189&m=1450960012&action=file.download [accessed 9 June 2017]

- GHOR, Veiligheidsregio Noord- en Oost-Gelderland, GGD Noord- en Oost-Gelderland, *Draaiboek Gezondheidskundige aandachtspunten crisisnoodopvang regio Noord- en Oost-Gelderland*, December 2015 http://www.ggdghorkennisnet.nl/?file=26187&m=1450959914&action=file.download [accessed 9 June 2017]

- iMMO, *Jaarverslag 2016*, http://www.stichtingimmo.nl/wp-content/uploads/2017/08/Jaarverslag-iMMO-2016.pdf [26 september 2017]

- iMMO, *Leeswijzer bij iMMO-rapportage*, November 2015, http://www.stichtingimmo.nl/wp-content/uploads/2016/06/Leeswijzer-bij-iMMO-rapportage-nov.2015.pdf [ accessed 12 June 2017].

- iMMO, Newsletter 10 December 2016, http://www.stichtingimmo.nl/wp-content/uploads/2016/12/iMMO-nieuwsbrief-nr-23.html

- iMMO, *Toelichting Inspanningsverklaring kostenvergoeding iMMO*, http://www.stichtingimmo.nl/wp-content/uploads/2016/02/Toelichting-Inspanningsverklaring.pdf

- IND, *Asylum Trends, Monthly Report on Asylum Applications in The Netherlands and Europe*, January 2016, https://ind.nl/en/Documents/AT_January_2016.pdf [accessed 9 June 2017]

- IND, *Asylum Trends, Monthly Report on Asylum Applications in The Netherlands and Europe*, January 2017, https://ind.nl/en/Documents/AT_January_2017.pdf [accessed 9 June 2017]

- IND, *Before your asylum procedure begins*, August 2015, https://ind.nl/Documents/RVT_Engels.pdf [accessed 9 June 2017]

- IND, Instruction 2010/13, https://ind.nl/Documents/WI_2010-13.pdf [accessed 9 June 2017]

- IND, Instruction 2014/5, https://ind.nl/Documents/WI_2014-5.pdf [accessed 27 September 2017]

- IND, Instruction 2014/10, https://ind.nl/Documents/WI_2014_10.pdf [accessed 27 September 2017].

- IND, Instruction 2015/8, http://cmr.jur.ru.nl/cmr/tbv/tbv13/15/wi.2015.08.pdf [accessed 20 June 2017]

- IND, Instruction 2017/1, https://ind.nl/Documents/WI_2017-1.pdf [accessed 9 June 2017]

- IND, Jaarverslag 2016, http://cdn.instantmagazine.com/upload/2392/ind_jaarverslag_2016.d1ec3734061a.pdf [accessed 27 September 2017]

- IND, Onderzoek naar rol iMMO rapportage in asielzaken, versie 0.1, November 2016

- IND and FMMU, *Protocol IND en FMMU-Advies*, 5 November 2015, available at www.vluchtweb.nl.

- IND, NFI and NIFP, *Procesbeschrijving FMOA*, versie 2.0, 27 October 2015.

- Inspectie voor de Gezondheidszorg, Brief aan ketenpartners, naar aanleiding van bezoeken 2016, 13 October 2016, https://www.igz.nl/zoeken/document.aspx?doc=Brief+aan+ketenpartners+over+medische+zorg+aan+asielzoekers&docid=10499

- Format Zorgplan crisisopvang asielzoekers, www.ggdghorkennisnet.nl/?file=25862&m=1449143724&action=file.download [accessed 9 June 2017]

- GGD Nederland and Menzis COA Administratie, *Protocol OGGZ*, www.rzasielzoekers.nl/dynamic/media/28/documents/oggz/Protocol_OGGZ.PDF

- Menzis COA Administratie, *Convenant GGZ voor asielzoekers*, October 2015, https://www.rzasielzoekers.nl/dynamic/media/28/documents/overige_documenten/MCA%20Convenant%20GGZ.pdf [accessed 9 June 2017]

- Menzis COA Administratie, *Algemene Inkoopvoorwaarden Zorg Menzis COA Administratie B.V. versie 1.0*, 2015 https://www.rzasielzoekers.nl/dynamic/media/28/documents/Formulieren%20-%20Nieuwe%20versie/Algemene_Inkoopvoorwaarden_MCA_2015_concept_versie_voor_website.pdf [accessed 9 June 2017]

- Ministerie van Veiligheid en Justitie, *Rapportage Vreemdelingenketen*, Periode januari-juni 2017, https://www.rijksoverheid.nl/documenten/rapporten/2017/09/08/rapportage-vreemdelingenketen-periode-januari-juni-2017 [accessed 26 September 2017]

- Ministerie van Veiligheid en Justitie, Rapportage Vreemdelingenketen, Periode januari-december 2016, March 2017, file:///C:/Users/mreneman/Downloads/LR98004_vreemdelingenketen_2016_V5.pdf [accessed 10 July 2017]

- Ministerie van Veiligheid en Justitie, *Kerncijfers Asiel en Migratie*, December 2016**,** https://www.rijksoverheid.nl/documenten/publicaties/2017/01/23/kerncijfers-asiel-en-migratie-december-2016

- Ministerie van Veiligheid en Justitie, *Handreiking uitwisseling medische informatie in de vreemdelingenketen*, May 2016, https://ind.nl/Documents/handreiking-uitwisseling-medische-informatie-in-de-vreemdelingenketen[1].pdf [accessed 9 June 2017]

- MediFirst, IND and Vereniging van Indicerende en adviserende Artsen, *Protocol Medisch Advies Horen en Beslissen*, November 2013

- Nederlands Forensisch Instituut, *De reeks waarschijnlijkheidstermen van het NFI en het Bayesiaanse model voor interpretatie van bewijs*, October 2014, https://www.forensischinstituut.nl/binaries/Vakbijlage%20waarschijnlijkheidstermen_tcm35-56319.pdf [accessed 11 September 2017]

- NHG/LHV, NHG/LHV-Standpunt, Het (ondersteunend) team in de huisartsenvoorziening, June 2011, https://www.nhg.org/sites/default/files/content/nhg_org/uploads/toekomstvisie_-_nhg-lhv-standpunt._het_ondersteunend_team_in_de_huisartsenvoorziening_juni_2011_.pdf [accessed 27 September 2017].

- NIFP, *Handreiking Rapporteurs NIFP, Forensisch Medisch Onderzoek Asiel (FMOA)*, Pilot version, Augustus 2016

- NOVA, letter to the State Secretary Security and Justice of 9 January 2014 concerning the implementation of the Procedures Directive and Reception Conditions Directive, https://zoek.officielebekendmakingen.nl/blg-415319 [accessed 9 June 2017]

- NRC, *IND stuurt 300 tijdelijke krachten weg*, 22 August 2016, https://www.nrc.nl/nieuws/2016/08/22/ind-neemt-afscheid-van-300-tijdelijke-krachten-a1517424

- Pharos, *Factsheet Eritrese Vluchtelingen*, June 2016, http://www.pharos.nl/documents/doc/factsheet_eritrese_vluchtelingen.pdf [accessed 11 September 2017]

- Pharos and ASKV, *Are you are suffering from concentration problems, nightmares, anxiety or depression?*, http://www.pharos.nl/documents/doc/webshop/brochure_3_als-u-last-heeft-van_engels.pdf [accessed 9 June 2017]

- Pharos and ASKV, *Long-term stress-related symptoms and what you can do about them*, http://www.pharos.nl/documents/doc/webshop/brochure_2_langdurige-stressklachten_engels.pdf [accessed 9 June 2017]

- Pharos and ASKV, *Where can you get help for your mental problems?,* http://www.pharos.nl/documents/doc/webshop/brochure_1_waar-kunt-u-hulp-vinden_engels.pdf [accessed 9 June 2017]

- Regeling Zorg Asielzoekers 2016, https://www.rzasielzoekers.nl/dynamic/media/28/documents/Regeling_Zorg_Asielzoekers/Regeling%20Zorg%20Asielzoekers%202016.pdf

- Regeling Zorg Asielzoekers 2017, https://rzasielzoekers.nl/dynamic/media/28/documents/RZA_regeling_2017.pdf [accessed 12 June 2017]

- Regeling Zorg Asielzoekers 2017, Bijlage 5, Noodhulp Tandheelkunde 2017, https://www.rzasielzoekers.nl/dynamic/media/28/documents/rzaenbijlagen/Bijlage%205%20Noodhulplijst%20Tandheelkunde%202017.pdf

- State Secretary of Security and Justice, Letter explaining asylum seekers about the reception conditions and the waiting times in the asylum procedure, November 2015, https://www.rijksoverheid.nl/documenten/brieven/2015/10/19/brief-van-de-staatssecretaris-van-veiligheid-en-justitie-aan-asielzoekers [accessed 9 June 2017]

- State Secretary of Security and Justice, *Asylum application in the Netherlands*, February 2017, https://www.rijksoverheid.nl/onderwerpen/asielbeleid/documenten/brieven/2016/02/18/brief-van-de-staatssecretaris-van-veiligheid-en-justitie-aan-asielzoekers-aan-de-grens-engels [accessed 23 June 2017]

- VluchtelingenWerk Nederland, letter to the Ministry of Security and Justice of 23 January 2014 with regard to the Consultation on the implementation of the Procedures Directive and Reception Conditions Directive, https://zoek.officielebekendmakingen.nl/blg-415324 [accessed 9 June 2017]

- VVD, CDA, D66 en ChristenUnie, *Regeerakkoord 2017-2021, Vertrouwen in de Toekomst*, 10 October 2017, https://www.kabinetsformatie2017.nl/documenten/publicaties/2017/10/10/regeerakkoord-vertrouwen-in-de-toekomst [12 October 2017]

- UN Committee against Torture, *General Comment nr. 3, Implementation of article 14 by States parties*, 19 November 2012, http://www2.ohchr.org/english/bodies/cat/docs/GC/CAT-C-GC-3_en.pdf [accessed 9 June 2017]

- UN Committee against Torture, *Concluding observations on the combined fifth and sixth periodic reports of the Netherlands*, adopted by the Committee at its fiftieth session (6-31 May 2013), CAT/C/NLD/5-6, https://www.johannes-wier.nl/wp/wp-content/uploads/2014/02/Concluding-observations-CAT-21-6-2013.pdf [accessed 9 June 2017]