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MSc Social Policy and Public Health

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Master's Thesis

'When you don't doubt, you don't use the benefit of the doubt': understanding barriers to asylum seeking with Post-Traumatic Stress Disorder in the Netherlands.

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Keywords: Asylum seekers, PTSD, Netherlands, IND, mental healthcare.

Abstract

Those seeking asylum are disproportionately affected by poor mental health, in particular often displaying symptoms of Post-Traumatic Stress Disorder (PTSD). Through content analysis of key legal and policy documents and conducting semi-structured interviews with professionals involved in supporting asylum seekers, this research analyses how those with symptoms of PTSD are accounted for by the *Immigration en Naturalisatiedienst (*IND), Non-Governmental Organisations (NGOs) and healthcare professionals during their asylum procedure in the Netherlands. Academically, this study aims to take an innovative stance on exploring asylum seekers' support throughout their procedure whilst experiencing trauma, by utilising data triangulation in combination with Fassin's (2013) and Legido-Quigley et al's (2019) theoretical frameworks. This will provide an in-depth, interdisciplinary insight into how the current system can be improved in order to better account for the challenges introduced by PTSD symptoms, thus providing enhanced support for asylum seekers throughout their procedure. The findings demonstrate that whilst there exists legislation and policy with which to guide support for those with PTSD, in practice this is hindered by structural constraints and differing approaches by the IND, NGOs and healthcare professionals. This results in significant power imbalances between professionals and asylum seekers, as well as amongst professionals. For future practice to reform, an individualised asylum procedure, stronger multilateral communication and training is needed in order to be able to better support traumatised asylum seekers through an extremely turbulent period.

Abbreviations

AIDA = Asylum Information Database

AS = Asylum Seeker

BoD = Benefit of the doubt

CEAS = Common European Asylum System

CJEU = Court of Justice of the European Union

DM = Decision Maker

EASO = European Asylum Support Office

ECHR = European Convention on Human Rights

ECRE = European Council on Refugees and Exiles

ECtHR = European Court of Human Rights

EU = European Union

GGZ = *Geestelijke Gezondheidzorg* (Mental healthcare)

IMMO = Netherlands Institute for Human Rights and Medical Assessment

IND = *Immigratie en Naturalisatie Dienst* (Immigration and Naturalisation Service)

IP = Istanbul Protocol

MLR = Medical-Legal Report

MS = Member State

OOP = Out-of-Procedure

PTSD = Post-Traumatic Stress Disorder

RSD = Refugee Status Determination

RZA = *Regeling Zorg Asielzoekers* (Healthcare Regulation for asylum seekers)

TFEU = Treaty of the Functioning of the European Union

UN = United Nations

UN CAT = United Nations Committee Against Torture

UNHCR = United Nations High Commissioner for Refugees

VoT = Victims of Torture

WI = Work Instruction

Introduction

In the Netherlands, credibility assessments play a significant role in refugee status determination (RSD). In 2019, 8,095 of the country's 22,533 applicants - 36% - were rejected (European Council on Refugees and Exiles (ECRE), 2020b). Despite the involvement of actors such as the *Immigratie en Naturalisatiedienst* (IND) (Immigration and Naturalisation Service) and Non-Governmental Organisation (NGO) and healthcare professionals who provide for those with Post-Traumatic Stress Disorder (PTSD), there remains a deficit in accommodating the impact of PTSD on cognitive functioning and consequently a failure of empathetic decision making. RSD professionals assume that applicants are aware of how to correctly apply for asylum and present the correct behaviour and language needed to assume credibility (Herlihy & Turner, 2013; Rogers, Fox & Herlihy, 2015), resulting in those with PTSD being at more risk of having their applications rejected than those without (Aarts et al., 2019). Additionally, cultural and language barriers in accessing mental health support, such as a lack of awareness of support or the perception of mental health issues as taboo, alongside the insecure legal status of living out-of-procedure (OOP) (Biswas et al., 2012), often results in receiving insufficient healthcare support (Hintjens, Siegmann & Staring, 2018; Legido-Quigley et al., 2019; Teunissen et al., 2015).

Thus, this mismatch invokes concerns about insufficient cross-cultural communication, empathy, and why decisions are based on assumptions about people's behaviour, intentions and motivation, given the severe consequences of PTSD (Herlihy & Turner, 2013; Kalin, 1986).

RSD professionals may have limited medical background or legal knowledge and consequently may misunderstand medical evidence and findings, resulting in misinterpretations of Medical-Legal Reports (MLRs), by regarding applicants' narratives as lacking evidence (Rossolatou, 2019; Pitman, 2010). This leads to many applications being rejected due to a perceived lack of credibility (Bruin, Reneman & Bloemen, 2006). A second factor which may contribute to asylum seekers being rejected is the political zeitgeist within society: right-wing governments are in general, far more likely to implement stricter immigration control and policies surrounding free movement (Van Prooijen, Krouwel & Emmer, 2018). Currently, the Dutch government - and therefore the IND - are governed by a centre right party, with the current Prime Minister, Mark Rutte, having a relatively conservative stance on refugee issues, calling for

a quota implementation and stricter border controls in future policy (London School of Economics, 2021).

Nevertheless, as an EU country, the Netherlands adheres to the Common European Asylum System (CEAS), as outlined by the Asylum Information Database (AIDA) (2021), which provides those seeking asylum with basic human rights (Grütters, Guild and De Groot, 2013). Those who have experienced certain traumas should be provided appropriate treatment, medical and psychological care (AIDA, 2017) under Article 25 of the Reception Conditions Directive (2013/33/EU), specifically through the Dutch Mental Healthcare Service (*Geestelijke Gezondheidszorg - GGZ*). AS with PTSD are also exempt from having to undergo the standardised credibility assessment, which lessens the initial burden of proof, given that complete accuracy can seldom be expected from those traumatised (United Nations Committee Against Torture (UN CAT), 2017). EU legislation guidelines also explore credibility assessments and offering the benefit of the doubt (EASO, 2018). In addition, the Office for the High Comissioner for Human Rights (OHCHR) (2004) and the International Association of Refugee Law Judges (IARLJ) (2010) provide guidelines for adhering to the Istanbul Protocol, an international mechanism used for Victims of Torture (VoT) during the asylum procedure.

Many actors are involved in supporting AS with PTSD throughout their asylum procedure in the Netherlands. The IND are responsible for the legal determination and processing of asylum applications, working in close cooperation with lawyers who represent the applicant in question. Non-governmental Organisations (NGOs), meanwhile, often support AS with PTSD in accessing support both during and outside of their procedure (AIDA, 2021). This may involve liaising with the IND, working with lawyers to prepare applications and making GP and psychological treatment referrals. Lastly, healthcare professionals often act as examiners within the procedure, investigating allegations of harm and torture and assessing these findings; and provide GP and psychological treatment (iMMO, 2018a).

Whilst it is clear that there are currently structures and frameworks in place to theoretically provide this population with protection and care, there remains a notable gap between law and practice left largely unaddressed, or treated with yet another legal rather than practical solution (Beirens, 2018). Therefore, there remains a need for multilateral collaboration between legal, policy and healthcare professionals (Chiarenza et al., 2019) in order to critically address the existing structural disparities in policies and procedures for AS with PTSD in being

disadvantaged in their asylum procedure. There is a wealth of grey literature concerning legislation (European Asylum Support Office (EASO), 2018; Grütters, Guild & De Groot, 2013; iMMO, 2017b) and the use of medical evidence in assessing credibility (Fassin & D'Halluin, 2005; Pitman, 2010; Wallace & Wylie, 2003) (see appendices section 3) due to the highly practical nature of this field. Within academia, the psychological impact of PTSD during the procedure (Rogers, Fox & Herlihy, 2015; Herlihy & Turner, 2013; Steel et al., 2009) and the impact of being rejected asylum (Mueller et al., 2010; Hintjens, Siegmann & Staring, 2018, Metselaar, 2017) have been well documented. However, to the best of the researcher's knowledge, there is little in academia to-date concerning the impact and governance of PTSD specifically upon asylum decisions and the interplay between law, NGO and healthcare provision in the Netherlands, which this study therefore seeks to contribute to academically.

Research aim

This research seeks to explore (a) a legal and policy analysis of IND actions; (b) interviews to ascertain NGO practice; and (c) analysis of healthcare professionals practice and policy through interviews and policy analysis.

These aims will be met by triangulating data from qualitative content analysis of jurisprudence, policy documents, and practices and semi-structured interviews, integrating legal, policy and healthcare fields underpinned by socio-anthropological theory. This will enable policy recommendations and seek to advance multidisciplinary connections within the field of the researcher's internship organisation, STIL. STIL supports people living undocumented, particularly rejected asylum seekers throughout their procedure. This will therefore directly benefit their clients, many of whom experience severe mental health difficulties, such as PTSD; and the professionals supporting them involved in the medical and legal fields. Additionally, by aiming to identify and overcome current obstacles in service provision, this research will also be beneficial in wider society and public health provision.

Theoretical framework

Alongside the asylum procedure having been explored within law, psychology, policy and medical academia, Fassin (2013) explores theoretical perspectives behind the procedure - specifically the categorical labelling of refugees through social-anthropological theory, in his work *The Precarious Truth of Asylum*. Truth can be contentious to determine, often viewed as a relation between propositions and the world (Fassin, 2013). Fassin's work explores the truth of asylum as twofold. With regards to the truth told by decision makers (DMs), this comprises two questions: can the account of the applicant be regarded as true? And if so, does it conform to the criteria previously defined as the truth of asylum? This refers to his definition of truth *making* (Fassin, 2013: 19). The applicants, meanwhile, are asked: are you telling us the truth about what happened to you (persecutions endured) and about what could happen were you to return to your country (risk of persecutions)? And secondly, are the statements in line with the Geneva Convention and corresponding jurisprudence? This essentially asks whether their narrative reflects reality (truth *telling*) and whether the reality conforms to the international norms (truth *matching*) of credibility criterion and the use of medical evidence (Fassin & D'Halluin, 2005).

However, these questions are difficult to answer without doubt and are open to interpretation. The coherence theory of truth notes that truth is a significant whole and thus a belief is true as part of a belief *system*, rather than because of its relation to facts (Fassin, 2013). This significant whole, in the case of AS, is more than just the narrative and documents; it includes the person and their authenticity. Therefore to obtain refugee status, the AS must display unquestionable signs of sincerity - all the more so as doubt is cast on veracity (Fassin, 2013). The more restrictive individual decisions are, the more conventional legal frameworks are followed, which results in the truth of asylum being articulated as a valued, scarce commodity, and the truthfulness of AS as being subject to mistrust (Fassin, 2013).

Moreover, not only is an AS' veracity and sincerity observed and judged, but equally, certain factors affecting their *access* to mental healthcare are also a relevant consideration, that may affect their ability to 'tell' the truth (Fassin, 2013). For instance, language barriers, the availability of interpreters (Kalin, 1986), professional norms (including discriminatory treatment and cultural competence), legal status and eligibility for insurance (Legido-Quigley et al., 2019)

may all affect access. This is demonstrated in Figure 1 below, elaborating upon migrants' healthcare-seeking practices in general, but is equally applicable to people seeking asylum.

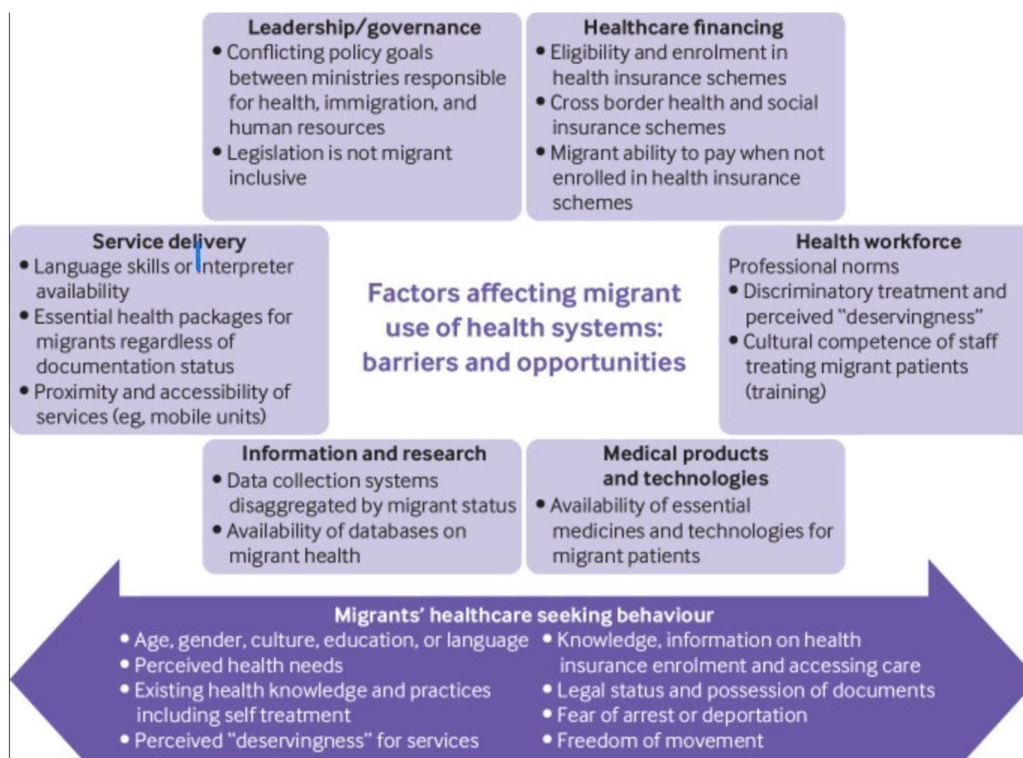

Figure 1: Factors affecting migrant use of health systems (Legido-Quigley et al., 2019).

Particularly pertinent factors include: language barriers and offering healthcare regardless of legal status; inclusive legislation and conflicting policy goals; and professional norms. PTSD acts as a double burden, itself imposing a barrier to accessing appropriate psychological support as symptoms may be psychosomatic or entirely physical and behaviour influencing the perception of credibility by decision makers (Rogers, Fox and Herlihy, 2015). AS may be unwilling to disclose their mental health difficulties because of fear of gossip in their communities, being shunned and other country-specific taboos (Teunissen et al., 2015). This group may also fear prosecution upon visiting their GP (particularly those undocumented), the financial burden of seeking care and discrimination (Hintjens, Siegmann & Staring, 2018). Those with severe PTSD may become stuck and lose access to previous rights if their application is rejected, worsening their condition (Mueller et al., 2010). This reinforces their liminality - living between the positions assigned by law, custom and convention (Turner, 1969) - and prevents them from being fully able to disclose their stories, prove their credibility and 'tell' the truth (Fassin, 2013). These factors will act as the basis of the methodology, with truth telling

and truth making overarching. This will seek to examine to what extent RSD professionals make the truth, and equally, how those with PTSD tell their truth, or stories and narratives, as demonstrated in Figure 2 below:

Truth making	**Truth telling**
Credibility	PTSD symptoms
Rejected AS	Burden of proof
Failed AS	Access to psychologist during procedure
Professional norms	Storytelling / narrative
Istanbul Protocol (IP)	Lack of knowledge / awareness of support
Medical-legal reports (MLRs)	Cultural barriers - mental health as taboo
Lack of evidence	Language barrier
Disbelieving	Insecure legal status
Availability of mental health support	Fear of arrest / deportation
Inclusive healthcare legislation	Proximity to healthcare services

Figure 2: Research codes as aligning with the theoretical factors (Fassin, 2013; Legido-Quigley et al., 2019).

Aligning with the theory and literature, these will seek to answer the research expectations, as explored below.

Research question

Given the detrimental impact experiencing PTSD symptoms can have upon physical and psychological functioning, this research seeks to (a) investigate whether and how AS' position is taken into account in Dutch national law, policy and practice and (b) explore the experiences of professionals and asylum seekers themselves. The research question will be as follows:

'How are AS displaying symptoms of PTSD accounted for by the IND, NGOs and healthcare professionals throughout their asylum procedure in the Netherlands?'

The research will explore the expectations in three sections, aligning with the theory and literature:

1. How AS with PTSD are accounted for in legislation, policy and in practice by actors in the procedure of asylum seeking.

This will seek to explore the interplay between the symptoms and limitations of PTSD, as explored in depth by Rogers, Fox and Herlihy (2015), current legislation in supporting them throughout the procedure (Bruin, Reneman and Bloemen, 2006; Haar et al., 2019; Wallace & Wylie. 2013) in contrast to the practical care and support offered, developing upon prior research considering the consistency of medical evidence and asylum decisions (Aarts et al., 2019) and the support given by legal and healthcare professionals (Biswas et al., 2012; Mueller et al., 2010; Pitman, 2010; Teunissen et al., 2015).

2. How the support available to AS is impacted by structural factors in provision.

Observing Legido-Quigley et al's (2019) framework, potential existing factors may present in cultural barriers such as differing norms and language barriers such as access to interpreters (Kalin, 1986; Kagan, 2003, Pitman, 2010), capacity, funding and time constraints, as Metselaar (2017) notes, and the impact these factors may have upon support provision.

3. How the power relationships between AS and professionals influence truth telling and making (Fassin, 2013).

This will be explored in credibility and burden of proof indicators, as explored by Grütters, Guild and de Groot (2013) and the consideration (such as medical evidence) of these by legal professionals (Aarts et al., 2019; Fassin & D'Halluin, 2005) in determining their power relationship to AS. It will also explore power dynamics amongst healthcare professionals as Pitman (2010) and Wallace & Wylie (2003) observe, and amongst professionals themselves.

Methodology

Research Design

The research design took a qualitative approach to data collection, in order to explore the support provided for AS with PTSD by the IND, NGOs and healthcare professionals and scrutinise the structures and procedures in this field (Given, 2008). The data triangulation of documents and semi-structured interviews collected a broad and varied reach of data (Saunders, Lewis and Thornhill, 2009) and corroborated the respective findings.

Utilising an inductive approach, conventional content analysis of 17 key legal, policy and practice documents aimed to allow new insights to emerge, developing upon the existing limited literature available (Hsieh & Shannon, 2005). Following this, three semi-structured interviews were then conducted with experts in the field to deepen understanding (Boeije, 2009). The aforementioned literature and theoretical framework are elaborated upon and operationalised in section three of the appendices, which forms the basis for the code tree (appendices section one) with which the data collection adheres to as a guide. This also acted as a basis for the interview topic guide (appendices section four), alongside answering the research question and resultant expectations (Mason, 2002).

Sampling and Data Collection Instruments

Documents

The documents to be analysed were selected by browsing existing case law in the European Asylum Law Database (EDAL) and European Case Law Identifier (ECLI) in the Netherlands, as well as utilising Google Scholar and Utrecht University's subscriptions to journals such as RefWorks, WorldCat and other academic search engines, as well as the researcher's access to VluchtWeb during her internship at STIL, who work in close cooperation with *VluchtelingenWerk*, the Dutch Council for Refugees. The keywords 'credibility', 'burden of proof' 'PTSD', 'rejected', 'undocumented', 'asylum seekers', 'Istanbul Protocol' and 'medical-legal reports' were used in the search. As the data collection instrument, the documents were chosen on the basis of their link to these key codes, the theoretical framework and literature, comprising of research looking into the effects of PTSD during the procedure, with regards to:

the decisions made by courts; the consideration of medical evidence during the procedure; and the limitations PTSD can incur, as well as current policy and legislation guidelines for this population. A comprehensive list of the 17 documents is given in the appendices in section two.

Interviews

Interview participants were recruited using a snowball sampling approach, initially utilising the researcher's existing networks at her internship organisation, STIL. The main inclusion criterion was for participants to be experts and professionals involved in supporting AS. Given the ethical considerations of interviewing AS with PTSD, professionals exclusively were interviewed. Due to time constraints and the detailed nature of interviewing, three interviews lasting on average 45 minutes were conducted with participants, as detailed below:

Participant number	Background	Organisation
1	Medical doctor and researcher	Health expertise organisation
2	Medical worker	Advocacy NGO
3	Social-legal worker	Advocacy NGO

Table 2: details of interview participants.

Data Management

Before each interview, ethical approval and informed consent was obtained in the form of oral or written consent, composed by the researcher. This detailed information regarding data storage, management, alongside the anonymisation of each participant's details, adhering to confidentiality regulations and is attached in the appendices.

The interviews were recorded using an audio recorder from Utrecht University, anonymised using a numerical code linked to each participant's name and contact details.

All documents, each interview recording and transcript were stored on the YoDa server, only accessible by the researcher and her supervisor. The participant information details were stored on the FSS server.

Data Analysis

Both the interviews and content analysis were done by manual coding, allowing for a rigorous examination of the documents and deeper reflexivity than when using electronic coding (Lofland, 1971). Axis and then selective coding sought to identify connections between the codes and categories, reassembling the fractured data in order to form coherent links for the emergent analysis (Boeije, 2009). This revealed the aforementioned constructed codes (Figure 1), as well as new codes, as is demonstrated in the elaboration of the code tree in the appendices (section one).

Content analysis of case law was applied and, as described by Fassin's (2013) theory, truth telling and truth making will act as overarching themes. This sought to examine to what extent RSD professionals tell the truth, and equally, how those with PTSD 'make' their truth, or stories and narratives, by noting AS' presentation of their factual circumstances as well as judges' decision making. The documents consisted of UN CAT, European Court of Human Rights (ECtHR), Court of Justice of the European Union (CJEU) and Dutch national and regional case law.

Meanwhile, the content analysis of policy documents and practices utilised the same methods as the analysis of the legal documents, but observed the social context in which the discourse arised (Jørgensen & Phillips, 2002), by exploring the prevalence of certain factors in hindering AS access to support during the decision process and potential structural issues in service provision. Again using a micro perspective, it aimed to explore whether AS are accounted for in policy and legislation, and whether there remain unequal power relationships between AS and professionals. This links the legal frameworks with policy and healthcare considerations, aligning with Legido-Quigley et al's (2019) theory of structural factors affecting AS' experiences of support, which are operationalised in the appendices in section three.

The interviews were transcribed and analysed in the same format as the documents using the aforementioned codes (Figure 2). This aimed to explore in-depth the support of AS in

practice, in particular the expectations that the limitations of PTSD are adjusted for during their procedure, the existing power imbalances and structural factors. The interviews tested what the researcher had discovered from the document analysis and whether these themes also appeared in the interviews.

Several paramount sub-themes were identified as aligning with the constructed codes as noted from the theoretical framework. Primarily, inclusive policy legislation and cultural and language barriers, detailing the IND procedure; the availability of MLRs and capacity of NGOs to produce these; and the treatment of those OOP, the impact of PTSD symptoms upon storytelling and AS' narrative, alongside the principle of the benefit of the doubt. Additionally, new codes also arose, as elaborated upon in the subsequent discussion.

Results

Based on a meticulous exploration into key legal and policy documents and interviews with professionals involved in supporting AS, this research met with expectations: firstly, that AS with PTSD are accounted for in legislation, policy and practice, reflected in current provision throughout the procedure. Secondly, even so, this good practice is hindered by the existence of structural constraints, both within NGOs and healthcare and from cultural barriers. Thirdly, this creates unequal power relationships between AS and professionals involved in their support, catalysed by the inherent sensitivity of the decisions. The main themes arising under the expectations are outlined in Table 2 below:

Expectation	**Main themes**
1, Accounted for in legislation, policy and practice	Asylum procedure Legislation and policy Provision: - Adjustments and medical evidence - Cultural competence
2, Structural factors	NGO bottlenecks: MLR capacity Healthcare bottlenecks: differing approaches AS bottlenecks: cultural barriers
3, Power relationships	Power of the IND - Disregarding MLRs - Benefit of the doubt Healthcare professionals' power Power between professionals

Table 3: Expectations and main themes of the findings.

Expectation 1: AS with PTSD are accounted for in legislation, policy and practice

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From the document analysis it was evident that AS with PTSD are indeed accounted for by the IND, NGOs and healthcare professionals. This occurs in a) legislation and policy in order to guide those working with AS, which provides b) a baseline with which to adhere to during the procedure and c) for particular provisions to be made. These include particular adjustments and medical evidence, underpinned by cultural competence and awareness by professionals.

The asylum procedure

The journey to receiving a decision begins after the AS arrives in the Netherlands, when each applicant is granted a rest and preparation period of at least 6 days (AIDA, 2021). This allows preparation time (for instance collating facts and evidence as well as medical claims) before the initial IND interview and the hear and decide interview as conducted by the *Forensisch Medisch Maatschappij Utrecht* (FMMU), the Forensic Medical Company Utrecht. This determines whether there are any adjustments to be made during the interview as a result of physical or psychological disturbances that may impede the applicant's ability to be able to consistently tell their story during the interview (iMMO, 2018a). After the rest and preparation period, the actual procedure starts. The first day begins with a verification interview, then preparing, undergoing and corrections of the second interview; the intention to reject the application, the lawyer's perspective, and finally, the decision of the IND. This occurs over eight days, aside from when more time is needed to assess the application when an extended procedure is followed (AIDA, 2021).

Legislation and policy

Throughout the asylum procedure, there exists legislation and policies adhered to by the IND specifically for those experiencing trauma. The Istanbul Protocol (IP) acts as a global framework, used in practice during medical examinations for Victims of Torture (VoT) in order to assess medical findings alongside the consistency of an applicant's story (OHCHR, 2004). Elaborating upon the use of the IP, the International Association of Refugee Law Judges (IARLJ) offers guidelines on how MLRs should be used and the fact that they can provide possible explanations for inconsistencies (IARLJ, n.d.). Article 18 of the Procedures Directive

(PD) clarifies the use of medical evidence specifically, when to request and conduct an examination in order to use it as evidence from the IND's perspective if they have doubts concerning credibility (2017b). The subsequent MLR is then adjusted to all other circumstances of the case, culminating in the decision (Arq Psychotrauma Expert Group, 2016).

These provisions are also translated into national legislation as IND Work Instructions (WI) (IND, 2021). These cover psychological problems specifically affecting the interviews and examinations; the need for interpreters, taking breaks as well as provision of psychological treatment services, as well as suspending deportation for those who are extremely ill (AIDA, 2014).

Whilst current legislation and policy provides a basis for good practice, there remains a discrepancy in the translation of these frameworks into practice, alongside a significant requirement upon professionals involved to make significant moral decisions. The IND must identify psychological limitations amongst AS, deciding whether the hearing can go ahead (despite not being medically trained) (IND, 2021); whilst healthcare professionals must remain neutral in their assessments of AS in composing their findings in order to present to the IND.

Furthermore, the extent to which PTSD is taken into account in the asylum procedure was found to be variable. This appeared in the scholarship, detailing the use of medical evidence and the need for cultural competence.

Provision for those with PTSD:

Adjustments and medical evidence

The above legislation is translated into current practice, particularly within legal adjustments made during the procedure. These include taking frequent breaks during interviews if needed, ensuring that as much as possible interpreters are offered in the applicant's native language (IMMO, 2018b); family members may attend; a lawyer being present; leniency from the IND officer on small inconsistencies and possible postponement of the interview to a later date (AIDA, 2021).

Another important aspect of provision for those with PTSD is medical evidence, such as examinations conducted by medical professionals, which seek to identify the onset of symptoms and must be conducted in a timely and appropriate manner, considered by the IND if a positive MLR could in any way lead to an asylum permit (iMMO, 2018b). Also considered are explanations of significant psychological effects; medical documents explaining distress or supporting that a return to the country of origin would lead to persecution/serious harm; and the explanations of AS (Arq Psychotrauma Expert Group, 2016).

Whilst the adjustments and medical evidence provision demonstrates appropriate support, the findings also revealed the IND often requests second medical examinations conducted by their contracted forensic institutes in procedures where iMMO had already delivered an MLR (iMMO, 2018b). This brings into question the level of trust between the IND and iMMO. Additionally, this support is of little use without being underpinned by cultural competence, as will be explored next.

Cultural competence during the procedure

Particularly important aspects of cultural awareness during the procedure, as highlighted by the literature, involve access to and the suitability of interpreters and sufficient awareness amongst GPs and examiners.

Interviewers using interpreters must ensure they speak in the applicant's most suitable language and dialect. However, GPs may often be unwilling to provide interpreters given the expense, furthering the language barrier, creating longer consultations and significant communication problems (Verhoeven, 2016). Medical examiners must be conscious of interference, whereby information may be distorted through translation (iMMO 2017b); allow sufficient time and be sensitive to exhaustion and the need to take breaks. Establishing trust and rapport with the patient is paramount in being sensitive and empathetic to the trauma they have incurred, whilst remaining objective in their clinical assessment (Bloemen & Mellink, 2008). Ultimately, intercultural competence requires knowledge, appropriate attitudes and ensuring communication styles use non-verbal cues and body language, in order to communicate in a style suitable for the AS (iMMO, 2017b).

Thus, cultural relativity is essential when working with AS: what is expected in one person's culture may not be in another, particularly in Westernised societies which can have contrasting norms to AS' countries of origin. This therefore appears an obstacle for AS in the procedure, who must adhere to Westernised concepts of time, lies and truths (UNHCR, 2013).

Whilst there demonstrably exists some level of cultural awareness and the behaviours needed to work with traumatised AS, the cultural disparities between Western and non-western notions and concepts hinder the effectiveness of this provision.

It is evident that clear legislation and policies exist to guide professionals involved in supporting AS with PTSD throughout their procedure. This is translated into appropriate provision, such as adjustments, medical evidence and underpinned by cultural competence. Nevertheless, there remain complexities within both legal and healthcare provision. The IND are required to identify psychological problems, despite not being medically trained; GPs are often reluctant to provide interpreters; and the IND appear to sometimes doubt the iMMO's provision of medical examinations. Further structural constraints affecting the provision of support for those with PTSD will be explored in the subsequent expectation.

Expectation 2: Structural factors impacting AS' access to support

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Whilst PTSD is accounted for in legislation and policy and to some extent in practice, the support AS receive is hindered by structural constraints. These appear as bottlenecks, amongst NGOs with capacity constraints in producing MLRs, and amongst healthcare professionals, whose differing approaches and professional norms result in insufficient communication and a lack of continuity in care. Amongst AS themselves, cultural and language barriers appeared most significant.

NGO bottlenecks: MLR capacity

Requests for MLRs by the IND are rare (around 10 per year), and therefore AS are required to independently arrange these (around 100 per year((iMMO, 2018b; Reneman, 2018b). The capacity problems amongst NGOs in dealing with these results in financing by private donors, with volunteer health professionals executing the examinations (Scruggs et al., 2016).

This results in iMMO rejecting around 20% of requests, determining which MLRs to accept based upon the AS' country of origin, medical signs and symptoms, as well as legal obstacles to an MLRs value (Arq Psychotrauma Expert Group, 2016). Additionally, iMMO must shorten the examinations and their reporting of them - which take on average 5 hours to conduct and 27 days to compose the subsequent MLR (iMMO, 2017a).

Ultimately, these capacity constraints result in long waiting lists for MLRs, prolonging decision making for AS and additional costs for courts (iMMO, 2018b). For those with PTSD, prolonging their uncertainty of whether they will be granted the right to stay in the Netherlands may only intensify their symptoms.

Healthcare bottlenecks: Differing approaches

Healthcare professionals can have differing approaches, resulting in insufficient communication and lacking continuity in care. This was apparent in an interview, whereby the professional noted that a lack of follow up of treatment commonly occurs in cases when AS are rejected, must leave the AZC and become OOP. AZC doctors frequently do not follow up on subsequent treatment or that they are registered with a GP, even in the case of needing intensive psychological support. Thus, it is left to NGOs to ensure the person in question is supported, referring their medical file from the AZC to the *huisarts* (GP) and liaising with psychologists:

> *'They are transferred from one AZC to another, so there is never a doctor-patient confidence in their relationship… Sometimes they get treatment in the AZC, and sometimes they get referred to someone else, and it is the responsibility from the doctor in that AZC to see that that treatment is prolonged… that's the fear, if you treat someone yet you don't follow up after the AZC'*
>
> - *Participant 3, Advocacy NGO*

This lack of continuity of care and a lack of trust in doctor-patient relationships can be exacerbated by lengthy waiting times, alongside unstable living conditions resulting in not being able to start treatment:

‘Nationwide, the waiting lists for mental healthcare in the Netherlands are terrible… after so many months of waiting, you then get the intake, and they say, well, we cannot really help - you do not have a stable house? It is not any use to have this trajectory!’

- *Participant 2, Advocacy NGO*

In reality, AS commonly receive better and more efficient treatment living OOP, as they are then able to access more stable shelter (than living in an AZC) and thus receive a diagnosis and begin psychological treatment:

‘They get out of the procedure - if they have shelter, it’s more steady and they can go to their doctor and get a full diagnosis... [OOP treatment is] more efficient and I think also sometimes better, because in the procedure the COA helps you with medical problems and they tend to keep the help within the AZC and that’s not correct, because you’re entitled to a free choice of your doctor, so I think that COA should also refer to psychiatrists and psychologists outside of the centre, but they don’t, or seldom’

- *Participant 3, Advocacy NGO*

OOP AS are entitled to basic healthcare coverage and shelter, which puts them in a more stable position to begin psychological treatment - juxtaposing with their legal fragility. Nevertheless, the lack of follow up and free choice given by healthcare professionals demonstrates a clear barrier to AS receiving support.

AS’ bottlenecks: Cultural barriers

Amongst AS themselves, structural bottlenecks present as cultural barriers (including language, as was explored earlier in the need for interpreters throughout the procedure). Often waiting until crisis point to seek help, many AS’ trauma symptoms worsen the longer they delay support from NGOs:

‘Our clients come to us with a problem that is so bad, and so many of them didn’t realise there even were possibilities from medical healthcare. Their situation is already so much worse…

people may already have been living in these situations for a year, before it gets so bad that they must come to us in a crisis'

- *Participant 2, Advocacy NGO*

One such reason for not seeking help sooner may be the perceived stigmatisation of mental health, or a lack of awareness surrounding mental health:

'Many are afraid to ask for help, because they feel ashamed, think they can manage without help; they are afraid of the stigma of mental health treatment… Syrians followed for 4 or 5 years… 8 or 9% have treatment with a psychiatrist or psychologist, whereas 40% have mental health problems'

- *Participant 1, Health expertise organisation*

These cultural barriers therefore notably undermine access to treatment - which consequently impacts upon the ability of AS to 'tell' their truth throughout their procedure (Fassin, 2013), when hindered by the cognitive and behavioural impacts of PTSD.

It is clear that there are a multitude of structural factors impeding current support. Ultimately, there are numerous inconsistencies: in MLR capacity amongst NGOs (iMMO, 2017b), and within treatment from healthcare providers. This variability in care alongside the cultural barriers experienced by AS results in sporadic support and them slipping under the radar. This contributes to the impact of disparities in power felt between AS and the professionals supporting them, as will be explored in the last expectation.

Expectation 3: Power imbalances between AS and professionals

The culmination of legislation being translated into only partially effective provision, alongside structural constraints present amongst NGOs, healthcare professionals and AS themselves and the automatic hierarchy involved in governance processes, catalyses unequal power relationships between AS and the IND and healthcare professionals. This became evident upon analysing case law and in conversations with interviewees, whereby in their assumption of distrust, the IND disregard the importance of medical evidence and do not offer the benefit of the doubt. Additionally, disparities in the willingness of healthcare professionals to

treat AS contribute to a lack of trust and ultimately, inequalities. Between legal and healthcare professionals, there also appears conflict in treatment not interfering with the legal procedure.

The power of the IND: **Disregarding MLRs**

Despite the existence of supportive frameworks, the IND appear to often disregard MLRs in their judgements, even where conducted by reputable organisations such as the UNHCR and Amnesty International. In one case, it was discovered that if an MLR is given in a subsequent application, it is disregarded by courts due to the fact it is not considered as new evidence and thus there is seen to be no reason for submitting one at a later stage (H.A. & G.H. Vs the Netherlands, 2018). The court also deemed a lack of credibility in the iMMO report, stating there were inconsistencies in the Claimant's statements and allegations of torture. The Complainant thus noted procedural obstacles, in the consistent refusal of the court to consider iMMO reports, and that the excessively restrictive approach failed to properly examine whether there would be a violation of Article 3 ECHR if deported.

A further UN CAT case suggests again the dismissal of the credibility of torture, and thus having no basis to apply PTSD as grounds for admission (S.S. Vs. The Netherlands, 2003). However, Amnesty International's medical examination report noted the Claimant's permanent suffering from past experiences, increased sensitivity, being overly anxious, concentration problems and insomnia as being typical symptoms of PTSD. Nevertheless, the Court failed to consider the examination, even though reports are made only in a small number of cases, and gave its decision before receiving medical advice.

It is clear that the dismissive attitude of the IND with respect to medical evidence clearly demonstrates the significant power held by those in charge over AS with PTSD. In the latter case, the applicant faced removal to Sri Lanka, demonstrating that the IND disregard the impact of negative decisions upon AS who are already extremely vulnerable.

The benefit of the doubt?

Despite the principle of the benefit of the doubt (BoD) being explicit in Dutch legislation of Article 4 of the Qualification Directive (QD) (UNHCR, 2013) and as elaborated upon in section three of the appendices: 'it has to be seen if the Alien can be given the benefit of the doubt'

(UNHCR, 2013: 226), decision makers (DMs) rarely explicitly refer to it in written decisions - as was also evident in the case law examined. Yet, it is widely known that traumatic experiences and the onset of symptoms of PTSD significantly impede AS' ability to tell their story consistently and as such, those with PTSD should be given the BoD. However, the extent to which this given by the IND is questionable:

> *'Because they [AS] are traumatised, it's more difficult for them to tell their story and to convince the IND what happened in the past… it influences your state of mind, your memories… it is very difficult to convince the judges, the Raad van State, because they act like* it's psychology, it's not law, *so they don't take it into account'*
>
> *'[AS] are always inclined to cooperate with the IND, the lengths they go to to answer questions'*
>
> - *Participant 3, Advocacy NGO*

The requirement upon AS to prove their credibility means that they are extremely willing to cooperate - potentially anxious to 'tell' their truths. In contrast, decision makers (DMs) view the boundaries between law and the psychological impacts of PTSD as fixed, unable to merge. As another participant identified, whilst the IND do make some adaptations, their 'black and white' thinking obscures the limitations PTSD can cause:

> *'The IND [have made interview] adaptations… for example more regular pauses - which means that the impairments are no longer there! They can be switched out by the adaptations, and that's not the way it works! Do some adaptation to get the best interview, but some of the impairments are still in place'*
>
> *'The awareness [of the IND] is superficial and not in-depth: it is built into a legal framework which is always black or white. Yes, you have the right; no, you don't have the right; yes, you have impairments, no you don't! We know in real life there are these grey areas of intensity, and that is where most of the problems lie… there is little education on the mechanisms of how memory functions'*
>
> - *Participant 1, Healthcare disparities organisation*

This implies that in their assumption of distrust, the IND do not fully comprehend nor perhaps realise the detrimental impact that symptoms of PTSD have upon AS' ability to present their story coherently and consistently, demonstrating that their truth 'making', as posed by Fassin (2013), may not consider the full picture nor allow the BoD to be given:

> *'I think that in the IND they don't doubt their own judgement. So it means that when you don't doubt, you don't use the benefit of the doubt!... They easily take this position of distrust, then you are less open for other assumptions, for doubts… [the IND] don't make use of scientific knowledge in this field. So that's why people with mental health disturbances are judged in the same way as those without'*
>
> - *Participant 1, Healthcare disparities organisation*

This tunnel vision held by the IND may result in predetermined negative assumptions, threatening their ability to remain impartial and objective DMs. It is therefore evident how this may cause little leniency when assessing the credibility of those with PTSD, resulting in the rejection of many applications as is evident in the analysis of case law.

The questions posed in the operationalizing of these concepts: Can the account of the applicant be regarded as true? Does it conform to the previous criterion (truth making)? Are statements made by AS about endured and risk of persecutions true and in line with jurisprudence (truth telling)? - are in practice extremely complex and cannot be objectively determined. However, the interpretations of the truth - made by DMs and told by AS, results in significant power play which is inherent in governance.

Healthcare professionals' power

Differential power relationships were also apparent between healthcare professionals and AS, as was apparent in the exploration of the structural factors present in healthcare support. Furthermore, access to support can be variable, with variations in the quality of medical advice and capacity of GPs to treat OOP AS:

'The quality of the medical advice is not very high… because they examine 10,000 AS, so you cannot have an in-depth examination for this many people'

- *Participant 1, Health expertise organisation*

'Difficulty in communicating with the client - you are dependable on the goodwill of the doctor… I've seen a lot of doctors who struggle receiving patients without documents in their clinics… our clients may be very difficult to treat: language problems, cultural… psychosomatic complaints, you need somebody to check they are taking medication properly, especially with psychiatric [problems].'

- *Participant 2, Advocacy NGO*

The disparities in approaches and communication, as explored earlier, clearly result in disparities in treatment, which combined with a lack of awareness of cultural relativity, further the power imbalance between healthcare professionals and AS. This can be assumed to be furthered by the requirement upon doctors to give medical examinations and MLRs which contribute to the power of decision making.

Power relationships between professionals

Finally, the interviews also identified power relationships between professionals. From healthcare providers' perspectives, working with legal professionals can somewhat hinder AS treatment (and vice versa):

'In mental healthcare… working with lawyers firstly interferes with treatment, and… with the legal procedure. It creates all kinds of mistrust in treatment and procedures. So in both sides there is a lot of conflict'

'*It's not only a question of communication, but also of policy, awareness and knowledge… [the IND's] main policy [is] the idea that they can do this on their own, with their own legal framework, without input from others. And the input is only when they are pushed to it'.*

- *Participant 1, Health expertise organisation*

The power relationships amongst professionals evidently create some frustration and can be assumed to create difficulties in the differing approaches and disparities in communication.

To summarise, it is evident that the inherent hierarchy between institutions and decision makers and AS creates significant strains upon the procedure that are already likely felt by those who have experienced significant trauma. From the literature and interviews, it was clear that this may be intensified by the aforementioned structural factors and the responsibility placed upon professionals to make such influential decisions.

Summary

These findings have revealed that whilst AS experiencing symptoms of PTSD are supported by policy, legislation and to some extent in practice, there remains a number of structural factors. NGO capacity constraints, differing healthcare approaches and cultural barriers experienced by AS limit the effectiveness of current service provision. These are both exacerbated by and result in power imbalances between actors in the system and those seeking asylum. To an extent, the IND overlook medical evidence, whilst healthcare professionals' have limited capacity. Additionally, disparities in communication between professionals can cause friction in their attempts to act in the best interests of AS with PTSD. The subsequent discussion will therefore explore strategies and recommendations with which to improve this field.

Discussion

Research question and expectations

‘How are AS displaying symptoms of PTSD accounted for by the IND, NGOs and healthcare professionals throughout their asylum procedure in the Netherlands?’ is answered in the observation that AS are accounted for in legislation, policy, and in practice by the IND, NGOs and healthcare professionals, with provisions made for those with PTSD. However, it emerged that these do not entirely account for the limitations PTSD symptoms create, with support hindered by a multitude of NGO and healthcare organization structural constraints. The culmination of these factors result in significant power imbalances between AS and legal and healthcare professionals.

Alignment with previous research, theoretical framework and other noteworthy findings

These findings appeared representative of existing literature and theory. Whilst current legislation and policy offers a starting point of good practice, the extent to which these guidelines are implemented can vary, as Haar et al. (2019) and Wallace & Wylie (2003) note. As Pitman (2010) identifies, medical evidence such as MLRs are paramount in providing support towards decision making. Nevertheless, the way in which this is managed in practice can cause conflict, aligning with the constraints felt by healthcare practitioners, such as a lack of time and capacity (Hintjens, Siegmann & Staring, 2018; Teunissen et al., 2015); and by legal professionals, who must seek to remain impartial and objective in their decision making (Metselaar, 2017).

As Rogers, Fox and Herlihy (2015) recall, symptoms detrimentally impact both behaviour and cognitive functioning, with the inability to recall peripheral details and non-verbal behaviour derailing applicants’ credibility. However, cross-cultural miscommunication clouds this observation (Kalin, 1986), with the cultural relativity of what are considered lies, truths and time differing between Western and non-Western cultures and thus posing the notion of credibility as subjective to the decision maker. This reinforces the cultural and language barriers, such as perceiving mental health as taboo and thus stigmatised, variable access to interpreters and a lack of intercultural training amongst professionals, as confirmed by Legido-Quigley et al’s (2019) framework.

The requirement upon healthcare professionals to provide medical evidence in the form of MLRs results in a significant influence in power in being able to contribute to such significant decisions (Pitman, 2010). This moral burden of having to make life-changing decisions can be onerous, having to juggle their moral duty in the best interests of the patient and adhering to official legislation. Equally, the requirements upon decision makers to observe credibility indicators combined with compassion fatigue and time constraints also poses difficulties (Metselaar, 2017). Therefore, it is clear that the power imbalances between legal and healthcare professionals are not without complexities and the ethics of responsibility (Fassin & D'Halluin, 2005). For instance, in GPs testifying that an applicant has undergone such treatment, this grants more power to the expert than to the applicant and in cases deemed not credible, this therefore creates to some extent, degrees of truth, or at least of proof. Thus, Fassin's (2013) notions of truth telling and making can be defined as interpretations of the truth, rather than rigidly defined categories.

Other noteworthy findings include the importance of the early identification of symptoms, as moderate symptoms may go unnoticed even after AS' initial IND interview. There remains differing professional norms and approaches, such as the use of different screening instruments, diagnostic classifications (OHCHR, 2004) and in prescribing medication. Time constraints also lead to PTSD diagnosis inconsistencies and identifying symptoms, corroborating Teunissen et al's (2015) research.

Finally, the treatment of OOPs corroborated Biswas et al's (2012) and Hintjens, Siegmann and Staring's (2018) research, discovering that they often receive more efficient treatment than those in procedure. Other best practices included iMMO's training for legal professionals and decision makers to identify medical signs and symptoms behind requesting an MLR, as well as torture's impact on AS' cognitive functions (iMMO, 2017b) and medical examiner training (Arq Psychotrauma Expert Group, 2016). There are examples of effective NGO and healthcare provider communication, such as between ASKV, an organisation in Amsterdam which provides support to undocumented asylum seekers, MOO (a shelter for asylum seekers with severe illnesses) and Equator Foundation, which provides specialised psychological care. Moreover, the *horen en beslissen* (hear and decide) medical advice

developed in the past 10 years was a result of pressure and lobbying by professionals involved in supporting AS.

Future beneficial research may consider: the impact of moderate psychological symptoms upon the procedure; the extent of and implications behind a lack of communication and continuity of care amongst AS; the impact of this upon receiving or being rejected refugee status; and the extent to which these constraints further power relationships. A multidisciplinary perspective could broaden this field, combining anthropology, law, social policy and public health.

Strengths and limitations

The internal validity posed one limitation of the research, given the sample size of the methodology. Initially focusing upon content analysis, after identifying the lack of research describing lived experience in policy and legislation, semi-structured interviews were conducted. The resulting 17 documents analysed proved fruitful in offering context to practices in supporting those with PTSD, analysing manifest and latent content by adhering to the coding and operationalisation. Given the filtering of the data according to the appropriateness to the research question and that it was already produced, it was relatively high in validity.

Developing upon the content analysis, initially 10 interviews aimed to be conducted. Upon attempting to recruit participants and given time constraints however, this was not feasible. Initially aiming to interview AS at STIL, the researcher discovered in practice that many were too ill to be able to ethically participate. The IND were also contacted but did not respond, which resulted in the three participants working in support services. Nevertheless, by observing the IND's policies and the challenges experienced by professionals involved in decision making, the research strove to remain neutral and objective.

Given the detailed nature of the semi-structured interviews, the resultant three interviews offered a rigorous insight into the challenges, bottlenecks and good practices, in order to answer the research question and develop future policy recommendations.

With respect to the external validity of the research, it may be generalisable in other EU countries and amongst AS with other mental illnesses or disabilities. However, academia has

previously little studied continuity of care amongst AS with PTSD, given the specificity of this theme within practice. Additionally, there is little focus upon moderate psychological symptoms (as opposed to PTSD), whilst the examples of best practice were only identifiable upon close research of this field.

The ecological validity of the study was high, given the ability to transfer concepts from legal and clinical policy to practice, ensuring appropriate support for AS with PTSD. The field of the researcher's intern work presented a particular insight into the lived experiences of those OOP, with failed AS experiencing severe trauma. This therefore provided the researcher with detailed knowledge of this field prior to and during conducting her research. Nevertheless, Fassin's (2013) theory of truth telling and making proved difficult to adhere to in practice, given the complexities of cultural relativity and determining truths amongst AS. This was dealt with by noting the operalisation of these concepts and the key themes as interpretations of the truth, given the subjectivity of this field.

Research Implications

Recommendations for policy and intervention practice

Given the strengths and limitations of this study, the resulting findings have varying implications for theory, policy and interventions. These gaps may be addressed by policy recommendations with which to improve support and discussion amongst actors in this field. The lack of an individualised procedure, significant gaps in communication and knowledge distribution between support providers suggest that an overhaul of the current system would do much to alter these current deficiencies.

In order to address this in practice, it would be of value to implement a relatively long-term multilateral project from 2022 to 2027. The main aim would be to adapt the procedure to applicants' individual needs and improve communication and overall support, with the objectives as follows:

1. Six monthly meetings to discuss individual case progress, positive outcomes of cases and obstacles identified in providing support.

2. An individual asylum procedure, involving:
    A) Delayed starting times in the beginning of each procedure
    B) Sufficient, individualised adjustments made dependent upon identified limitations
    C) A full medical and psychological assessment before the beginning of one's procedure. This will allow diagnoses to be made and thus for applicant's to receive sufficient, tailored support throughout, ensuring they feel safe and supported by professionals.

3. Yearly training for all professionals involved in support and decision making, both old and new (current) professionals. This would involve legal and healthcare workers, and those working for NGOs in supporting AS having experienced or currently experiencing trauma. This would seek to build upon the iMMO's previous training, exploring whether this has been translated into current practice.

Figure 2: Policy recommendations for professionals involved in supporting AS with PTSD.

This multilateral project would not only aim to foster greater trust both of and within the IND, regarding offering the benefit of the doubt during credibility assessments, but also seek to reduce the current backlog of asylum applications faced by the IND, and hopefully reduce the number of asylum seekers living out-of-procedure.

Conclusion

This research has provided a unique insight into the support offered to AS with PTSD throughout their procedure in the Netherlands. Detailed content analysis and semi-structured interviews revealed that AS are supported by the IND, NGOs and healthcare professionals. Bridging the gap between academia and practice, it identified that despite positive steps in current legal and medical frameworks in governing the asylum procedure, this fails to be implemented in practice given the lack of capacity, capability and resources and results in the persistence of exceptional power differences by those involved in the asylum process. The

complexities of making such instrumental decisions, however, are not without a moral burden. Reinforcing Legido-Quigley et al's (2019) framework, these conclusions can be assumed as interpretations of the truth, developing upon Fassin’s (2013) theory. In order to dismantle the current obstacles in support throughout the procedure, future reform therefore requires a more tailored asylum procedure, better multidisciplinary communication and training in order to translate this support into culturally sensitive and appropriate practice.

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APPENDICES

1. CODE TREE

Bold = overarching themes

- = new codes

Truth making

Credibility

- Indicators
- Criteria
- Assumption of distrust
- Benefit of the doubt
- Cultural relativity

Rejected / Failed AS

- OOPs
- Access to healthcare

Professional norms

- Legal frameworks
- Policy guidelines
- Practice

Istanbul Protocol

- Global use
- State implementation
- Future improvements

MLRs

- Requests
- Medical examinations as evidence
    - Conducting

        - Using as proof
    - Capacity

Lack of evidence

- Burden of proof

Disbelieving

- IND
- UN CAT case law

Availability of mental health support

- Continuity of care
- During medical examinations
- Throughout procedure

Inclusive healthcare legislation

- Current policy
- Procedural guidelines
- OOPs
- Continuity of care

Truth telling

PTSD symptoms

- Onset
- Categorisations
- Behaviour
- Cognitive functioning

Burden of proof

- Benefit of the doubt

Access to psychologist during procedure

Storytelling / narrative

- Requirement to coherently and consistently tell story

Lack of knowledge / awareness of support

- Support by NGOs
- Support during AZC
- Timing of offering support

Cultural barriers

- Mental health as taboo
- Relativity of Westernised concepts (time, lies and truths)
- Cultural competence by GPs and examiners

Language barrier

- Access to interpreters

Insecure legal status

- OOPs

Fear of arrest / deportation

- Article 64 - suspension of deportation based on medical grounds

Proximity to healthcare services

- Often only access to internal doctors inside AZCs
- Continuity of care

2. DOCUMENT LIST

Legal cases:

1. H.A. And G.H. Vs the Netherlands (2018).
2. S.S. v. The Netherlands (2003)
3. Anonymous vs. Rechtbank Den Haag (2019).
4. Anonymous vs. Rechtbank Den Haag (2020)

Policy and practice documents:

1. IARLJ (n.d.)
2. Medical examination (IMMO, 2017a)
3. Bevreemdingwekkend (iMMO, 2014)
4. Verhoeven (2016)
5. Arq Psychotrauma Expert Group (2016)
6. IND WerkInstructies (2021)
7. Directive 2013/32/EU
8. UN OHCHR (2004)
9. Hidden evidence of torture (IMMO, 2018)
10. Bloemen en Mellink (2008)
11. AIDA (2021): Netherlands' procedure
12. Zorginstituut Nederland (2020)
13. UNHCR (2013)

3. **OPERATIONALISATION OF THEORETICAL CONCEPTS**

Theme	Concept and corresponding source	Topic	Sub-topic	Source operationalisation
Truth telling	AS applicants are asked: are you telling us the truth about what happened to you (persecutions	The limitations that PTSD symptoms can cause during the procedure. Symptoms may be physical; psychological or psychosomatic (see other	Psychological symptoms of PTSD (Rogers, Fox & Herlihy, 2015) (Herlihy & Turner, 2013) - e.g. - Re-experiencing the trauma - Avoidance and emotional numbing	Fassin (2013) conducted anthropological fieldwork with MLR organisations in France, which involved discussing PTSD and observing symptoms. Rogers, Fox & Herlihy (2015); Herlihy & Turner

	endured) and about what could happen were you to return to your country (risk of persecutions)? And secondly, are the statements in line with the Geneva Convention and corresponding jurisprudence? (Fassin, 2013).	literature).	- Avoidance of any thought/place/person that arouses a recollection of the trauma - Profound emotional constriction - Profound personal detachment and social withdrawal - Inability to recall an important aspect of the trauma - Hyperarousal - Difficulty falling/staying asleep - Irratibility - Difficulty concentrating - Hypervigilance; exaggerated startled response - Generalised anxiety - Shortness of breath, sweating, dry mouth or dizziness and gastrointestinal distress	(2013): Presented in signalling of / screening for symptoms: often using DSM-IV or ICD-10, the latter of which distinguishes between acute, chronic and delayed PTSD, depending on the timing of the appearance of complaints.

		Burden of proof: The requirement upon asylum seekers to ally to the burden of proof - proving their credibility and symptoms of PTSD / impact these have during their interview, hearings and medical examinations	(EASO, 2018) Whilst Article 4(5) of the Procedures Directive does not specifically refer to a burden of proof, it does state that Member States may consider it the duty of the applicant to 'substantiate' the application. The EASO do note that reference to a BoP is not necessarily a helpful concept when eliciting the meaning of the duty to substantiate an application. Additionally, paragraph 204 of the UNHCR (n.d.) handbook states that the burden of proof is given only when 'all available evidence has been obtained and checked and when the examiner is satisfied as to the	Article 4(1) QD (recast) does not refer to there being a burden of proof on the applicant, only that Member States may consider it the duty of the applicant to 'substantiate' the application (EASO, 2018). Grütters, Guild & De Groot (2013) define (under QD) credibility as involving: internal consistency (within the statements and other evidence); external consistency (between statements and external evidence); impossibility (whether alleged facts are impossible to believe); plausibility (whether 'facts' are able to be believed); in the round (totality of all findings); sufficiency of detail; timeliness of the claim (late submission of statements and evidence may negatively affect credibility); personal involvement (claimant

			applicant's general credibility. The applicant's statements must be coherent and plausible, and must not run counter to generally known facts.	must be personally involved in the story or evidence).
		Access to psychological support during procedure	When is a psychologist present? Who provides support?	The iMMO are a national organisation supporting AS experiencing psychological limitations during their procedure, by conducting medical examinations (AIDA, 2021).

		Storytelling / narrative	Whether PTSD symptoms hinder one’s ability to coherently retell their story	The effects PTSD presents upon one’s memory and cognitive functioning are wide ranging. As Herlihy & Turner, (2013) note, autobiographical memory guides behaviour in the present, giving examples of key events that developed morals and emotional responses, and help to explain the decisions made about life directions, updating and developing in light of new understandings and experiences. They note a chasm of understanding between the demands of memory made by the asylum system (for reliable, legal evidence) and the psychological process, which is flexible (: 52).
		Lack of knowledge / awareness of support	When AS are aware of where and how to access support	As Legido-Quigley et al (2019) note, asylum seekers may lack the required knowledge and

				information in accessing care.

		Cultural barriers - MH as taboo	Whether AS perceive mental health as taboo or stigmatised, and thus are less likely to report symptoms of trauma or access help. 1. Manner of expression 2. Interpreter 3. Cultural relativity of notions and concepts 4. Perceptions of time 5. Cultural relativity of lies and truths	In their study, Kalin (1986) explores the cultural barriers affecting AS' credibility during asylum hearings. The manner of speaking, such as those who speak more clearly and indicatively (voice quality and speech style) often results in more successful applications. Interpreters also act as a mediator between cultures; which may work to an AS advantage (if they translate the cultural concepts of words); or to their disadvantage, if they are fearful or intimidated by the interpreter if they suspect them of working against them. Cultural relativity of notions and concepts refers to the fact that words are culture bound: what is understood of

				one expression in one culture may be very different in another culture. Perceptions of time also differ between Western and non-Western cultures, such as a Muslim calendar; therefore the insistence of DMs in rejecteing contradictory statements concerning the time and duration of events poses an issue. Lies and truths are also culturally relative: lies may be an attempt to meet the expectations of DMs, or act as a way out of a dilemma created by the values of two 'legal levels'. For instance, the sub cultural duty to keep political activities secret and the requirement of asylum law to disclose all relevant facts. In some Middle Eastern societies, what s considered 'lying' in the

				West is an inherent and fundamental part of social life (Kalin, 1986: 237-238).

		Language barrier	Access to interpreters	A particular cultural barrier is that of language, which although as Kalin (1986) notes can be overcome with the use of interpreters, access to these can be variable, with the suitability differing. In addition, the availability and funding for interpreters varies by organisation (MacFarlane et al., 2020).
		Insecure legal status	Whether the insecurity of AS' legal status impacts the onset / diagnosis of trauma-related disorders	The invisibility of those living out-of-procedure (OOP), results in them existing invisibly, which may further their reluctance in seeking support (Hintjens, Siegmann and Staring, 2018); worsening AS' mental health in the meantime (Mueller et al, 2010).
		Fear of arrest / deportation	Reluctance by AS to disclose parts of their story to the IND, therefore hindering the consistency of	Those living OOP and thus undocumented often live in constant fear of deportation and detention (Hintjens,

			their story - due to fear of being deported or found to be lying.	Siegmann and Staring, 2018). Whilst these are rejected asylum seekers, they still exist in the asylum process when appealing against their negative decision and making subsequent applications.
		Proximity to healthcare services	How accessible are healthcare services for AS? During staying in an AZC? After?	During staying in an AZC, applicants have access to doctors and psychologists within the reception centre, but outside of AZCs (e.g. as an OOP) applicant's must seek healthcare through the GP they are registered with/referral from GP to psychological treatment. The proximity of these services to where they are staying varies depending upon capacity/waiting lists of different services (AIDA, 2021) Biswas et al (2012) (Legido-Quigley et al, 2019).
Truth making	Fassin (2013): can	Credibility	To what extent are AS required to prove	Grütters, Guild & De Groot (2013) note the

	the account of the applicant be regarded as true? And if so, does it conform to the criteria previously defined as the truth of asylum?		their credibility, beyond reasonable doubt, in the asylum procedure?	basic criteria and standards of good practice when assessing credibility. Article 4.1-4.5 QD notes the duty of applicants to present their own applications; assessed on an individual basis. The basic criteria are: internal and external consistency; impossibility; plausibility; in the round; sufficiency of detail; timeliness of the claim and personal involvement (Kagan, 2003).
		Failed/rejected AS	These are known as ‘out-of-proceedure’, or OOPs. What healthcare and legal opportunities to they have?	See previous code (fear of arrest / deportation) in access to healthcare for OOPs and alternative legal options (Biswas et al, 2012).
		Professional norms	To what extent do professionals involved in supporting AS with PTSD adhere to norms and regulations?	Biswas et al (2012) and Aarts et al (2019) note healthcare professionals’ support for AS; legal policy and guidelines are studied by Rossolatou (2019); Bruin, Reneman & Bloemen (2006).

				Metselaar (2017) notes the norms adhered to by decision makers and the extent to which these values influence decisions.
		Istanbul Protocol	The usage of the IP throughout the asylum procedure	The IP has been studied in detail, firstly laid out by OHCHR (2004), with recommendations in its utilisation studied by Rossolatou (2019) and Wallace and Wylie (2013).
		Medical-legal reports (MLRs)	The use of MLRs during the asylum procedure to act as evidence for AS' applications	Pitman (2010) notes the use of MLRs as evidence, considering the practical and ethical challenges; whilst Fassin and D'Halluin (2005) explore the impact of medical evidence, along with Wallace and Wylie (2013).
		Lack of evidence	This refers to the requirement to ally to the burden of proof by the AS.	Whilst there is not explicitly a burden of proof upon the applicant, MS consider it the duty of the applicant to substantiate the application (EASO,

				2018).
		Disbelieving	Disbelief by the IND of the coherency, consistency and thus credibility of AS' stories.	Herlihy, Fox & Rogers (2015) note blurred boundaries between deception and anxiety, which often present as similar behavioural displays; combined with time constraints and compassion fatigue by decision makers. As Metselaar (2017) observes, confirmation bias, belief perseverance and cognitive dissonance may create tunnel vision, predetermined negative assumptions and threaten their ability to remain impartial, fair and objective.
		Availability of mental health support	Whether mental health support is provided without question throughout the procedure, or only in cases whereby psychological disorders/symptoms are suspected.	AS are provided basic healthcare under the Regeling Medische zorg Asielzoekers (RMA), including psychologist consultants and inpatient treatment. Several organisations specialise in the treatment of AS with psychological

				problems (AIDA, 2021). Hintjens, Siegmann and Staring (2018) note OOPs access to basic healthcare; alongside Biswas et al (2012); and Teunissen et al (2015).
		Inclusive healthcare legislation	Whether current healthcare policy and legislation provides for AS with PTSD.	Biswas et al (2012); Herlihy and Turner (2013; 2015); EASO (2018); UN CAT (2017) explore current healthcare legislation for traumatised AS.

4. **Expert interview topic list**

1. Role of the organisation
2. Experience of the field / supporting AS with PTSD
3. Main bottlenecks / obstacles
4. Credibility weighting in their procedure / interviews
5. Assumption of allying to the burden of proof / giving AS benefit of the doubt
6. Access to psychological / medical support
7. How to improve the current system
8. Whether medical-legal reports / examinations are used in the procedure

9. Adaptations / exemptions for those with PTSD

10. Improving cross-collaboration / communication with services

11. IND’s assumption of distrust

12. Improving decision making - how the organisation can be more responsive

5. INFORMATION LETTER AND CONSENT FORM

Information Letter

Subject information for participation in social scientific research, MSc Social Policy and Public Health at Utrecht University

24th April 2021

Introduction

Through this letter we would like to ask your permission to participate in a research conducted as part of a Master's thesis at the University of Utrecht studying the procedures asylum seekers in the Netherlands have to follow.

The purpose of this research is to investigate the position of asylum seekers with PTSD within law, policy and practice. In order to receive the best possible answers for this research, it depends on interviews with both experts involved in supporting and those seeking asylum.

The interviews are expected to last for around 45 minutes and will be loosely structured by the researcher whilst allowing you as the participant to contribute your own thoughts and opinions.

By participating in this research you will be able to contribute to future development of supporting those seeking asylum with PTSD in their asylum procedure and accessing appropriate psychological support.

However, whilst this research aims to remain as unobtrusive as possible, due to the sensitive nature of the topic, it may result in some questions being somewhat difficult to answer. If this is the case, participants are free to withdraw their answers and/or pause or stop the interview at any time. For any further queries, please contact the independent contact person and complaints officer as detailed below.

Confidentiality of data processing

This research requires us to collect a number of personal data from you. We need this information to be able to answer the research question properly by providing some background details into the characteristics of those seeking asylum with PTSD, and/or to be able to approach you for follow-up questions.

The data will be treated confidentially and stored anonymously and therefore will not be traceable to the individuals concerned. The data will be stored in a data package including each participant's informed consent forms; the audio recording of each interview; alongside the files used for data analysis, on a secure server, YoDa (Your Data) Storage, as approved by the Faculty of Social and Behavioural Sciences, Utrecht University. The recordings and transcripts will be identified using a numerical code linked to each participant's name and contact details, for verification purposes if required. Only the researcher, her supervisor and thesis coordinator will have access to the data package.

Your data will be stored for 10 years after internal publication of the thesis, according to the appropriate VSNU (*Vereniging van universiteiten* - association of universities in the Netherlands) guidelines. You can read more information about privacy on the website of the Personal Data Authority:

https://autoriteitpersoonsgegevens.nl/nl/onderwerpen/avg-europese-privacywetgeving

Voluntary participation

Participation in this study is voluntary. You can discontinue the examination at any time, without giving a reason and without any adverse consequences for you. The data collected so far will be used for the research, unless you explicitly indicate that you do not want this.

Independent contact person and complaints officer

If you have questions or comments about the study, you can contact John de Wit - J.d.wit@uu.nl

If you have an official complaint about the investigation, you can send an e-mail to the complaints officer via Klachtenfunctionaris-fetcsocwet@uu.nl

Contact details of the Data Protection Officer

Www.UU.nl/en/organisation/data-protection-officer

Contact details of the Principal investigator

Sophie Colebourne
0633360619, s.colebourne@students.UU.nl

If, after reading this information letter, you decide to take part in the research, please sign the enclosed reply strip and hand it to the researcher.

Kind regards,

Sophie Colebourne

Statement of consent:

I herewith declare to have read the information letter concerning research by Sophie Colebourne, as part of her thesis written for the MSc in Social Policy and Public Health at Utrecht University, and to agree to participate in the research.

This means that I agree with:

1. Participation in the research

2. Collect my contact details

3. Collection of special personal data, namely: asylum participants' country of origin, gender, age and how long they have lived in the Netherlands for.

Name: ________________________________

Date: ____________________________________

Signature: ______________________________________