Practical Guide Series

Mental Health and Well-being of Applicants for International Protection

euaa
EUROPEAN UNION AGENCY FOR ASYLUM

PART 1

FOR SENIOR MANAGEMENT

November 2024

On 19 January 2022, the European Asylum Support Office (EASO) became the European Union Agency for Asylum (EUAA). All references to EASO, EASO products and bodies should be understood as references to the EUAA.

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EUROPEAN UNION AGENCY FOR ASYLUM

Mental Health and Well-being of Applicants for International Protection

Part I. Shaping an asylum system informed by considerations for mental health and well-being – for senior management

November 2024

About the guide

Why was this three-fold guide created?

The European Union Agency for Asylum (EUAA) has recently invested in exchanging on the topic of the mental health and well-being (MHW) of applicants for international protection and on related subjects such as critical incident management, staff welfare and drug use in reception ([1]). The aim is to gather information on any potential needs of the EU Member States and the Schengen associated countries (EU+ countries) and to ensure the EUAA develops relevant support packages to address these needs. This includes support on how to improve the provision of psychosocial support to applicants. This guide aims to provide a tool for EU+ countries and their senior management to create the foundation for an asylum system informed by MHW in their respective countries and to facilitate ongoing mental health and psychosocial support to those in need.

How was this three-fold guide developed?

This guide was created with the support of several experts from across the EU, in Belgium (Fedasil), Germany (Psychosoziales Zentrum, St Johannis), Greece (Danish Refugee Council Greece) and Sweden (Swedish Migration Agency). The development was facilitated and coordinated by the EUAA's vulnerability team. Before the guidance was finalised, it was sent for consultation to a reference group consisting of experts from several organisations: the European Commission's Directorate-General for Health and Food Safety, the United Nations High Commissioner for Refugees, the International Organization for Migration and the International Federation of the Red Cross ([2]). Lastly, the guide was shared for review and the final approval by members of the EUAA Vulnerability Experts Network for adoption.

([1]) Refer to EASO, *Practical guide on the welfare of asylum and reception staff – Part I: Standards and policy*, 2021; EASO, *Practical guide on the welfare of asylum and reception staff – Part II: Staff welfare toolbox*, 2021; EASO, *Practical guide on the welfare of asylum and reception staff – Part III: Monitoring and evaluation*, 2021; EUAA, '*The importance of early identification of signs of stress*', YouTube, 22 September 2021; on critical incident management, refer to EUAA, *Critical incident management in the field of asylum and reception – A mapping of practices*, 2022; on collaboration with the EMCDDA on drug use in reception, refer to EMCDDA-EUAA, *Professionals working in reception centres in Europe: an overview of drug related challenges and support needs*, 2023.

([2]) Not all parts of this EUAA three-fold guidance necessarily align with the position of the members of the reference group.

Who should use this guide?

This first part of the guide targets **senior management** who can approve the implement mental health and psychosocial support in their respective context. While the guidance targets specifically those **authorities** within EU+ countries **responsible for the reception** of applicants for international protection, certain proposals in the guidance can also be relevant to an extent to the determining authorities, the health authorities or social services depending on the set up of support to applicants in the country. The guide can also inform the work of **policymakers** working on integrating MHW as part of the support provision to applicants and migrants more generally.

How to use this guide.

The three parts of the EUAA guidance on MHW of applicants for international protection should therefore be read in conjunction with one another.

- **Part I** sets the **framework** to shape an asylum system informed by MHW considerations. It therefore targets **senior management**.
- Part II focuses on the **interventions** that are crucial to maintaining the MHW of applicants for international protection. It covers **how** to operationalise interventions on mental health and psychosocial support and mainly targets **first-line officers** and their **team leaders**.
- Part III is a **'toolbox'** containing practical tools such as checklists, safeguarding considerations and questionnaires to support those **first-line officers** in providing mental health and psychosocial support.

The guidance uses recurring icons as detailed below.

Example.
Selected practical examples from the EU+ countries for a better understanding.

Considerations.
Highlights, additional items, safeguards and information and opportunities.

Additional resources and information.
Provides material that complements proposals and facilitates further learning on the topic covered in that chapter.

Animation or **video material.**
Provides animations or video material that allows for better understanding of the content and builds the capacity of those working in the first line.

Reminder and **actions to take.**
Leads to other relevant information within the guide to create an overall understanding or complement what is presented on the page.

How does this guide relate to national legislation and practice?

This is a soft convergence tool. It is not legally binding. It complements national strategies and interventions implemented in EU+ countries on MHW in the field of asylum.

How does this guide relate to other EUAA tools?

This three-fold guidance links to other efforts made and tools developed by the EUAA to mainstream vulnerability into all its activities including the support to EU+ countries and Member States in which the EUAA operates. This guidance complements the following EUAA products:

- Three pocketbooks on psychological distress accompanied by instructions:
  - EUAA, ***How can I support my child during difficult times?***, June 2023.
  - EUAA, ***How can I deal with situations in which my parents seem sad, worried, or angry?***, June 2023.
  - EUAA, ***How to handle situations when my friend or sibling is sad, angry or does dangerous things?***, June 2023.
- EUAA, '**Psychological First Aid Video**', YouTube, 26 June 2023 accompanied by **instructions**.
- European Asylum Support Office (EASO), ***Consultations with Applicants for International Protection on Mental Health A participatory approach – supported by Member State authorities***, December 2021.
- EASO, '**The importance of early identification of signs of stress**', YouTube, 22 September 2021.
- EASO, ***Mental health of applicants for international protection in Europe – Initial mapping report***, July 2020.

Other related products:

- EUAA, ***Guidance on sexual orientation, gender identity, gender expression and sex characteristics***, 2024.
- EUAA, ***Guidance on Vulnerability in Asylum and Reception – Operational standards and indicators***, May 2024, particularly p. 55.
- EUAA, ***Strategy on Vulnerability***, December 2023.
- EUAA, ***Lets Speak Asylum Portal***, July 2023.
- EUAA, ***Special Needs and Vulnerability Assessment Tool***, 2022.
- EUAA, ***Tool for the Identification of Persons with Special Needs***, 2016.

All EUAA practical tools are publicly available online on the EUAA website: **https://euaa.europa.eu/practical-tools-and-guides**. Refer also to the EUAA's training catalogue: **https://euaa.europa.eu/training-catalogue** for relevant training modules on the topic of vulnerability.

Contents

Abbreviations

Abbreviation	Definition
EU+ countries	Member States of the European Union and the Schengen associated countries
EUAA	European Union Agency for Asylum
Fedasil	Agence fédérale pour l'accueil des demandeurs d'asile (the federal reception authority, Belgium)
IASC	Inter-Agency Standing Committee
IOM	International Organization for Migration
MHPSS	mental health and psychosocial support
MHW	mental health and well-being
MoU	memorandum of understanding
NGO	non-governmental organisation
PFA	psychological first aid
PTSD	post-traumatic stress disorder
Refugee Convention	Convention Relating to the Status of Refugees (1951), as amended by its Protocol (1967) (referred to in EU asylum legislation and by the Court of Justice of the European Union as the Geneva Convention)
RCD (2024)	reception conditions directive — Directive (EU) 2024/1346 of the European Parliament and of the Council of 14 May 2024 laying down standards for the reception of applicants for international protection
SEAH	sexual exploitation, abuse and harassment
Screening regulation	screening regulation – Regulation (EU) 2024/1356 of the European Parliament and of the Council of 14 May 2024 introducing the screening of third-country nationals at the external borders and amending Regulations (EC) No 767/2008, (EU) 2017/2226, (EU) 2018/1240 and (EU) 2019/817
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization

Introduction

'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity ([3]).'

To maintain the mental health and well-being (MHW) of applicants for international protection a focus on **prevention** is required. Care for both physical and mental health does not need to be expensive but demands a systematic and integrated approach of mental health and psychosocial support services (MHPSS). An investment in skilled support from an early stage and a physical safe space to provide meaningful services will be important.

In the context of asylum, it is crucial to **identify** the immediate needs of applicants in a timely manner. This ensures an **appropriate** and **needs-based response** as well as one that is human and dignified from the responding officers who can engage with empathy and without prejudice regarding age, gender or culture.

The conditions that applicants for international protection present with once in Europe are often **natural reactions**, such as feeling anxious, hopeless or restless, **to the abnormal events** they have experienced. This can be the result of witnessing or experiencing violence, being uprooted, the loss of loved ones, exploitation, abuse, torture and inhuman and degrading treatment or punishment, detention, lengthy stays in transit countries and difficult and often dangerous journeys.

Many of the **psychological distress** factors applicants face must be addressed as a preventative measure to avoid a mental health crisis requiring psychiatric treatment. This is important since the provision of psychiatric treatment, which is provided when a situation escalates, cannot be the answer to what are most often social problems. Focusing on preventative practices can also be **more cost efficient** and can reduce mental healthcare expenditure.

An **initial investment** by senior management in basic but holistic support provision that focuses on:

- **direct tailored support** to those in immediate need of care **from an early point** in the asylum pathway; and
- **community-based interventions** for **all** applicants

A **multi- and interdisciplinary approach** offered throughout the asylum and reception pathway (arrival, stay in reception, continuation of integration and inclusion or preparation for return) is key to ensure prevention and to strengthen resilience. Such an approach will benefit not only those entering Member States of the European Union and the Schengen associated countries (EU+ countries), but also those awaiting their decision, those being integrated into host communities or persons awaiting their return.

([3]) WHO, *Constitution of the World Health Organization*, 2010, p. 1.

In addition, the reception and determining authorities and those working in the first line and partner organisations of those working in first contact positions also benefit from such a **coordinated approach**, since the collaboration and communication is improved and streamlined, leading to an easier achievement of the overall MHW goals set by an administration.

Purpose and structure

This first part of the guidance sets the **framework** to shape an asylum system informed by MHW considerations. It proposes **9 components** of equal importance, for consideration by those responsible to approve the integration of the mental health and well-being of applicants into daily operations.

The right to health is universal ([4]). This means that applicants have the right to be enabled to lead a healthy life, which consequently can support meaningful integration into host communities and allows them to contribute economically and socially. The right to health is also to be considered for persons scheduled for return.

The **European Commission highlighted** the right to health for all in a communication on a comprehensive approach to mental health ([5]), which more generally discusses the **importance of awareness** that **better mental health** is both a **social and an economic imperative**.

Consequently, the European Commission put forward, among other things, an initiative that will allocate a budget to support the role of stakeholders in promoting mental health in communities focusing on **vulnerable groups, including children, young people and migrant/refugee populations**.

Suggestions on **actions to take** under each of the components and how to measure progress on setting up such a framework are made under Chapter 2. Action and progress followed by the annexes where readers can find additional checklists and information referred to underneath the various components.

This guidance does not propose to replace existing and functioning mechanisms in supporting applicants in relation to their health, mental health and overall well-being. The objective rather is to complement such efforts.

Added value

The three interlinked parts of the guidance *Mental Health and Well-being of Applicants for International Protection* aim to complement programming recommendations and suggestions made by other important actors in the field of international protection and mental health and psychosocial support (MHPSS).

([4]) For more information refer to Office of the United Nations High Commissioner for Human Rights and WHO, *The Right to Health – Factsheet 31*, 2008; UN Economic and Social Council, *CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12)*, E/C.12/2000/4, 11 August 2000 which refers to accessibility, availability, acceptability and quality of services.

([5]) Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions on a comprehensive approach to mental health, COM(2023) 298 final 7.6.2023.

This three-fold guidance builds synergies with existing global, regional and local efforts such as:

- the communication by the European Commission on a comprehensive approach to mental health ([6]) and the Action Plan on Integration and Inclusion 2021-2027 ([7]);
- the European mental health action plan of the World Health Organization (WHO) ([8]), which comprises seven objectives and the European Commission's investment under the EU4health programme 2021-2027 ([9]), which also includes considerations on MHPSS.
- the sustainable development agenda and in particular the sustainable development goal 3 on good health and well-being ([10]) which refers to mental health for all in several places and entails a commitment to tackle the issue globally, including in Europe;
- the work by the Inter-Agency Standing Committee (IASC) ([11]) and the International Red Cross Red Crescent Movement on MHPSS ([12]), and the core principles formulated in these but also those of other important actors in the field of international protection and humanitarian aid.
- to link with wider, global efforts under the UNHCR's Global Compact on Refugees ([13]), which aims to commit and contribute resources and expertise to expand and enhance the quality of national systems to provide effective access to support including to applicants regarding health and mental healthcare and the newly adapted UN resolution on mental health and psychosocial support ([14]) which specifically refers to migrants and refugees;
- material made available on the topic by the European Migration Network ([15]), non-governmental organisations and EU+ country authorities themselves, which have already developed relevant interventions.

Finally, recommendations made by applicants for international protection and refugees ([16]) who have been consulted during the development process of this guidance, havebeen integrated as well the views of experts from EU+ countries working on the topic ([17]), and more specifically first-line officers working for the reception and determining authorities.

For further guidance regarding healthcare and MHPSS, consult:

- Intergovernmental Consultations (IGC) on Migration, *Asylum and Refugees, Supporting the Mental Health of Refugees and Asylum Seekers: A Toolkit for IGC States*, September 2021.
- International Organization for Migration (IOM), *Manual on community-based mental health and psychosocial support in emergencies and displacement – second edition*, 2021.
- International Federation of the Red Cross, *Mental Health Matters*, 2019.
- Sphere Association, *Humanitarian Charter and Minimum Standards in Humanitarian Response*, 2018 edition.
- WHO, *Mental health promotion and mental health care in refugees and migrants Technical guidance*, 2018.
- United Nations High Commissioner for Refugees (UNHCR), *Assessing Mental Health and Psychosocial Needs and Resources – Toolkit for humanitarian settings*, 2012.

([6]) Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions on a comprehensive approach to mental health, COM(2023) 298 final 7.6.2023.
([7]) Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions Action plan on Integration and Inclusion 2021-2027 {SWD(2020) 290 final} 24.11.2020 COM(2020) 758 final.
([8]) WHO-Europe, *European Framework For Action On Mental Health 2021–2025*, 2022.
([9]) European Commission, EU4Health programme 2021-2027 – a vision for a healthier European Union.
([10]) WHO, 'Targets of Sustainable Development Goal 3'
([11]) IASC, *Guideline Mental Health And Psychosocial Support In Emergency Settings – IASC Reference Group on Mental Health And Psychosocial Support in Emergency Settings*, 2007.
([12]) IFRC Psychosocial Centre, *The International RCRC Movement Framework*.
([13]) United Nations General Assembly, *Global Compact for Safe, Orderly and Regular Migration* (A/RES/73/195), 11 January 2019.
([14]) United Nations General Assembly, *Mental health and psychosocial support* (A/RES/77/300), 3 July 2023.
([15]) European Migration Network, 'EMN inform: Mapping of mental health policies for third-country national migrants', 4 July 2022.
([16]) EASO, *Consultations with Applicants for International Protection on Mental Health A participatory approach – supported by Member State authorities*, December 2021.
([17]) EUAA, *Mental health of applicants for international protection in Europe – Initial mapping report*, July 2020.

Terminology

In the context of this guidance, **mental health** is understood as an **integral part of health**. The term **well-being** is broader and very much interlinked with physical and mental health. It also depends on factors such as the family set-up, the way a person is socialised and educated and their value system, for example. Such factors can, on the one hand, take a protective role and mitigate dangers of a person feeling unwell or becoming sick or, on the other hand, constitute a risk. The well-being of a person can be captured as how content, comfortable and happy they are in their life. Well-being also influences how someone copes with stressful, disruptive and even traumatic situations and how resilient they are and continue to be.

Hence, a broader continuum of care that promotes overall well-being is important. This can be organised by creating a setting which allows the consideration of individual factors. Social determinants, such as connectedness with family and community, safe accommodation, or the economic situation of an applicant and education, will be extremely important from an early stage, since these can affect health outcomes both positively and negatively. Thus, this guidance promotes **integrated approach to MHW**. It captures first and foremost, interventions linked to prevention but also touches upon needs-based response, such as different forms of psychotherapy including psychiatric treatments such as medication, when needed.

Once a **preventative approach** is taken and considerations around the MHW of applicants for international protection are considered, **risks linked to poor health**, reduced daily functioning or protection-related dangers (e.g. self-harm), are likely to be **reduced**.

The approach presented in this part of the guidance provides managers of relevant administrations with the **structural framework to ensure that the MHW of applicants** can be maintained and/or improved. It suggests interventions aimed at guiding those working in the first line to manage the health and well-being of applicants where applicable and provides considerations for setting up a system whereby applicants themselves are enabled to help themselves. Such an approach can be taken and implemented by Member State authorities when interlinking with public services such as health, educational services and civil society organisations, UN bodies and international non-governmental organisations to support.

Refer to Annex 1. Glossary for information on terminology linked to MHW.

Legal framework

Access to healthcare is a fundamental right. Article 23 of the Geneva Convention Relating to the Status of Refugees (Refugee Convention) ([18]) lays down that refugees should have the same treatment with respect to public relief and assistance as is accorded to their nationals' ([19]). Access to healthcare is similarly enshrined in Article 35 of the Charter of Fundamental Rights of the European Union (EU Charter) ([20]) guiding all Member States. The right to healthcare is also embedded in the Pact on Migration and Asylum ([21]).

([18]) UN General Assembly, Convention relating to the status of refugees, Geneva, 28 July 1951, United Nations, Treaty Series, vol. 189, p. 137, and *Protocol Relating to the Status of Refugees*, 31 January 1967, United Nations, Treaty Series, vol. 606, p. 267 (referred to in EU asylum legislation and by the CJEU as 'the Geneva Convention').
([19]) refer to *UNICEF Advocacy brief on health: Crisis in Europe*
([20]) European Union, Charter of Fundamental Rights of the European Union, 26 October 2012, 2012/C 326/02.
([21]) European Commission, Migration and Home Affairs, 'Pact on Migration and Asylum – A common EU system to manage migration', 21 May 2024.

In addition to the EU Charter, the United Nations Convention on the Rights on the Child ([22]) including the principle of best interests of the child are highlighted in the Pact on Migration and Asylum.

The Pact on Migration and Asylum, which entered into force in June 2024, aims to manage and normalise migration for the long term, providing certainty, clarity and decent conditions for people arriving in the EU. It is composed of several legal instruments. While the obligations by applicants for international protection throughout the asylum pathway have increased as part of the Pact, the guarantees to safeguard the fundamental rights of persons seeking international protection are highlighted throughout the legal framework.

Care and support to applicants in distress and those with mental health concerns can only be provided once a need has been identified. Therefore, timely identification and addressing specific needs, including mental health support, is crucial. References to identification (Regulation (EU) 2024/1352 (screening regulation)) ([23]), procedural guarantees (Regulation (EU) 2024/1348 (asylum procedure regulation)) ([24]) and support provisions (Directive (EU) 2024/1346 (RCD (2024)) ([25])) in the new legal instruments of the Pact are listed below.

Screening regulation

Articles 5 and 7 require compulsory pre-entry screenings of third-country nationals at the external border and within the territory. The screening is linked to identity and security, health and vulnerability. The identification of needs linked to health and vulnerability are conducted to facilitate a referral to the appropriate procedure (Article 1(b) and in accordance with Article 18).

Article 8(3) stipulates: 'the screening shall be carried out without delay and in any case completed within seven days from the apprehension…' ([26]).

Article 12(3) screening regulation refers to:

- timely and adequate support in view of physical and mental health; and
- access to emergency healthcare and essential treatment of illness ([27]); and
- the involvement of qualified and specialised personnel ([28]).

([22]) UN General Assembly, Convention on the Rights of the Child, United Nations, Treaty Series, vol. 1577, p. 3, 20 November 1989.
([23]) Regulation (EU) 2024/1356 of the European Parliament and of the Council of 14 May 2024 introducing the screening of third-country nationals at the external borders and amending Regulations (EC) No 767/2008, (EU) 2017/2226, (EU) 2018/1240 and (EU) 2019/817 PE/20/2024/REV/1 (OJ L, 2024/1356, 22.5.2024).
([24]) Regulation (EU) 2024/1348 of the European Parliament and of the Council of 14 May 2024 establishing a common procedure for international protection in the Union and repealing Directive 2013/32/EU (OJ L, 2024/1348, 22.5.2024).
([25]) Directive (EU) 2024/1346 of the European Parliament and of the Council of 14 May 2024 laying down standards for the reception of applicants for international protection (OJ L, 2024/1346, 22.5.2024).
([26]) The screening regulation stipulates seven days at the external EU border or three days if the third-country national is apprehended on EU territory (Article 8(4) screening regulation).
([27]) Recital 38 screening regulation states:
Particular attention should be paid to individuals with vulnerabilities, such as pregnant women, elderly persons, single-parent families, persons with an immediately identifiable physical or mental disability, persons visibly having suffered psychological or physical trauma and unaccompanied minors.
These categories also include anyone who may be 'stateless person, vulnerable or a victim of torture or other inhuman or degrading treatment, or have special [reception or procedural] needs' (Article 12(3)).
([28]) While health checks are to be conducted by vetted medical personnel, for the purpose of vulnerability checks,the screening authorities may be assisted by non-governmental organisations (Article 12(3)).

The **importance of documentation** of findings relating to **health and vulnerability** are laid down in Article 17(3). This article also refers to the importance of **cross checking and involving** the person screened for any corrections to be made: 'the person of concern shall have the possibility to indicated incorrect information' before the form is transmitted to the relevant authorities referred to in Article 18(1)-(4).

Further, Article 11(2), points (b) and (c) refer to the importance of **information provision** including on voluntary departure, relocation and solidarity mechanisms. In the case of information provision to **minors**, information should be provided in a child friendly and age-appropriate manner (Article 11(3) and Article 12(4) and Article 13(3)). Article 11(3) also lays down that **cultural mediation services** may be arranged **to facilitate access to the asylum procedure**.

Article 13 indicates additional guarantees for minors and lays down that the **best interests of the child** must **always** be a primary consideration in accordance with Article 24(2) EU Charter. Article 13(2) refers to the importance of ensuring that during the screening, '**the minor shall be accompanied** by, where present, an adult family member' (emphasis added). Article 13(3) stipulates that in case of **unaccompanied children**, a person is to be provisionally appointed to act as a representative. Article 13(4) requires that this person must act independently and is not involved directly in the screening. Child protection authorities should, wherever necessary, be **closely involved** in the screening to ensure that the best interests of the child are duly taken into account throughout the screening (recital 25).

Those conducting the health and vulnerability checks during the screening are required to have the **necessary expertise** (Article 12(3)). The screening regulation also requires those working in the first line to: **report any situation of vulnerabilities** observed or reported to them, should respect human dignity and privacy, and should refrain from any form of discrimination (recitals 37 and 38, emphasis added).

The regulation also emphasises the need for **close cooperation** between the competent national authorities (those responsible for the asylum procedure, the reception of applicants, public health and, where applicable, those carrying out return procedures) (recital 24).

Regulation (EU) 2024/1348 (asylum procedure regulation)

The asylum procedure regulation highlights the need to ensure special procedural guarantees for vulnerable groups. The regulation refers to 'age, gender, sexual orientation, gender identity, disability, serious physical or mental illness or disorders, including when these are a consequence of torture, rape or other serious forms of psychological, physical, sexual or gender-based violence' (recital 17). The importance of availability of **well-trained and relevant** staff is also mentioned (recital 18).

Article 34(3) indicates that 'authorities shall have the possibility to seek advice, whenever necessary, from experts on issues, such as medical, cultural, religious, **mental health**, and child-related or gender issues. Where necessary, they may submit queries to the Asylum Agency in accordance with Article 10(2), point (b), of Regulation (EU) **2021/2303**.'

Lastly, Article 53(2)(d) states that, 'Member States shall not apply or shall cease to apply the border procedure at any stage of the procedure where there are relevant medical reasons for not applying the border procedure **including mental health reasons**'.

RCD (2024)

Article 19(2) requires Member States to ensure that applicants receive healthcare. It requires 'an adequate standard of living for applicants, which guarantees their subsistence, protects their physical and mental health and respects their rights including under the [EU] Charter'.

The RCD (2024) lays down the following requirements:

- 'necessary health care shall be of adequate quality and include, at least, emergency care, essential treatment of illnesses, including of serious mental disorders, and sexual and reproductive health care which is essential in addressing a serious physical condition' (Article 22(1)).
- Applicants have the right to rehabilitation and assistive medical devices, 'where needed for medical reasons', including mental health care Article 22(3).
- The importance of assessing special reception needs including referrals to appropriate medical practitioner or psychologists for further assessment (Article 25(2), point (c).
- Regarding detention: 'Where the detention of applicants with special reception needs would put their physical and mental health at serious risk, those applicants shall not be detained.' (Article 13(1)). '[M]inors shall, as a rule, not be detained.' (Article 13(2)) and ensuring the best interests of the child is an overarching principle.
- In cases of concerns linked to public health, a medical screening might be required (Article 15).

- While this guidance focuses on **applicants for international protection**, the MHW of refugees from Ukraine with temporary protection granted in accordance with Council Directive 2001/55/EC ([29]) is equally important and to be considered. The council directive, which offers protection to refugees from Ukraine, indicates in Articles 13(2) and 13(4) that:
- *The Member States shall make provision for persons enjoying temporary protection to receive … medical care. Without prejudice to paragraph 4, the assistance necessary for medical care shall include at least emergency care and essential treatment of illness.*
- And that '[t]he Member States shall provide necessary medical or other assistance to persons enjoying temporary protection who have special needs'.

([29]) Council Directive 2001/55/EC of 20 July 2001 on minimum standards for giving temporary protection in the event of a mass influx of displaced persons and on measures promoting a balance of efforts between Member States in receiving such persons and bearing the consequences thereof (OJ L 212, 07/08/2001).

1

Shaping a mental health and well-being informed asylum system

This chapter targets the relevant state institutions and senior management responsible for approving the implementation of a MHW-informed approach within the field of asylum as well as **senior management** working in the context of reception. This chapter presents nine **interlinked components**, all of which are equally important for facilitating the creation of an MHW-informed asylum system.

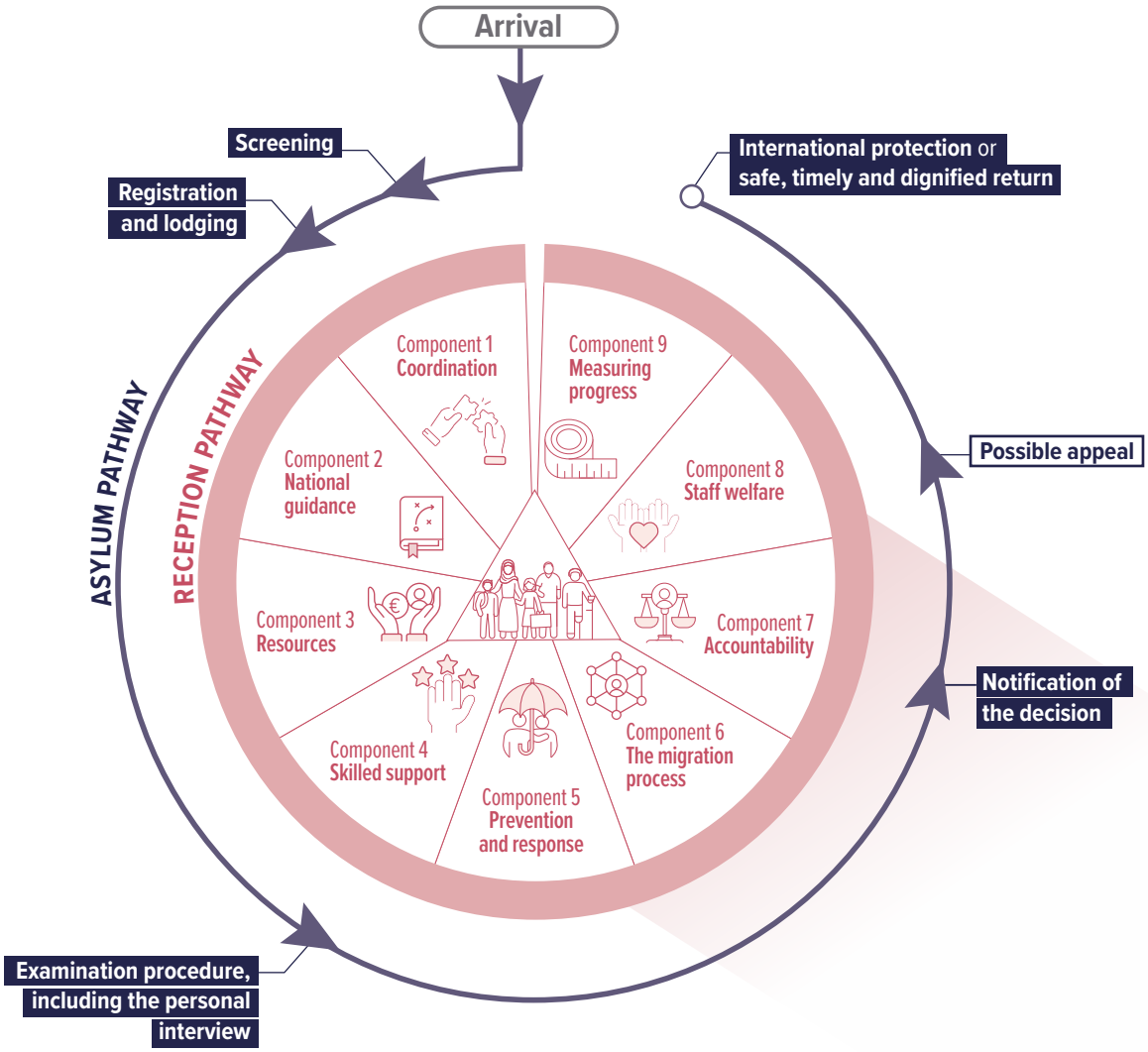
'When exploring the health of refugees and migrants, it is the social determinants of health rather than diseases or medical conditions themselves that explain most of their poor health outcomes ([30]).'

While the overall framework mainly affects the work of those organising the reception of applicants, considerations for the MHW of applicants will be needed throughout all critical stages of the asylum and reception pathway (see figure 1 below). In practice, this means the applicant's MHW needs to be considered from the point of arrival, during stay in reception and during the transition to becoming integrated into the host community and/or prepared for return.

A lack of preparedness or otherwise delayed or poor psychosocial and health support, particularly upon arrival, might otherwise lead to a risk of prolonged concerns.

([30]) WHO, *World report on the health of refugees and migrants*, 2022, p. 42.

Figure 1. Shaping an MHW-informed asylum system.

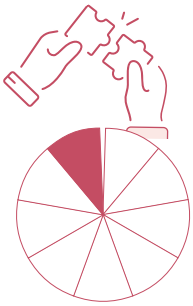


Source: the EUAA

The **nine components** introduced as part of this guidance stem from recommendations made by EUAA network members from EU+ countries and international actors. The components are supported and complemented by examples from EU+ countries ([31]). Generally, integrating the MHW of applicants into the asylum and reception systems should be an integral part, where feasible, of a national strategy on health and mental health.

Considerations around MHPSS should, where possible, not only be considered as part of reception and asylum but also embedded where possible into other programming activities. This can include those activities delivered in the context of healthcare provision, education and the social protection context more generally. This will ensure an interdisciplinary approach to supporting those seeking international protection and will meaningfully combine expertise across different fields for sustainable action.

([31]) Examples from Belgium, Germany, the Netherlands, Finland and Sweden are cited in this part while examples from Austria, Czechia, Greece, France, Hungary, Luxembourg, Italy, Romania, Spain and Switzerland are cited in Part II – First-line officers.



Component 1 | Coordination

A coordinating entity, team or focal person is appointed by the relevant state institution responsible for the MHW of applicants for international protection.

It is recommended that a coordinating entity, team or focal person best placed to manage MHW-related activities within the reception context is appointed by the relevant state institution / senior management. This entity, team or focal person is consequently responsible for supporting the development and/or the update of national guidance focusing on maintaining the MHW of applicants for international protection throughout the asylum and reception pathway.

Depending on the context and in-house capacity, they will liaise and collaborate with different actors providing MHPSS. They might also be partially responsible for the direct implementation of certain activities. The mapping of relevant MHPSS service providers and documenting the relevant contacts / referral persons is important to initiate effective and efficient communication and collaboration and access to services.

Ideally, the entity, team or focal person supports the coordination of the MHW-related psychosocial activities implemented across different governmental organisations such as health, social welfare and security and law enforcement services where possible. This must be done in an appropriate, professional and safe manner for both applicants and those providing support to ensure a high-quality impact and sustainable service provision.

Depending on the national set up, it will be important to promote MHW within the different governmental organisations engaging with applicants to create links for support, ensuring collaboration and avoiding duplication of efforts.

All those involved in implementing MHPSS, such as governmental partners, civil society organisations and international organisations, could sign a memorandum of understanding (MoU) that:

- clarifies the roles, responsibilities and limitations to their involvement within a specific time frame and the location out of which services are provided; and
- includes an agreement on potential payments to be made for services conducted, where applicable ([32]).

Where possible, establish a formal working agreement with all relevant MHPSS partners.

([32]) It will be important to ensure that it is clearly laid out who covers the costs of services provided to applicants for international protection. This is important not only when linked to other public services accessed but also when engaging private companies to provide the services.

Establish communication channels between the Reception authorities, MHPSS partners and the determining authorities ([33]) to allow for the safe and relevant sharing of information regarding applicants. This is only applicable where deemed necessary to ensure the applicant's procedural guarantees. Any transfer of data must ensure the confidentiality of the data shared and only be shared with the consent of the applicant.

Those in charge of coordination will focus on a harmonisation of activities related to the MHW of applicants, starting from the point of their arrival, during the stay in reception and during the phase out from reception. It is advised to connect the efforts with those actors supporting the integration of applicants into the host community or during their preparation for return, to ensure a smooth transition and continuation of services. This is particularly important when it comes to applicants that are chronically sick or unaccompanied minors close to the age of maturity.

Having one authority appointed to coordinate MHW-related activities makes it easier to streamline communication and to provide a more effective case management system overall. Such a system can include the timely referrals to relevant partners and prevent deterioration of conditions.

The **responsibility** to appoint a coordinating entity, team or focal person to manage the MHW interventions in a country, region or accommodation centre depends on the national context.

([33]) This can be particularly important when it comes to reducing the risk of critical incidents. In some cases, critical incidents can be avoided if case officers are aware of the relevant information regarding applicants before the personal interview. Depending on the purpose of the communication and the type of information shared, the consent of the applicant might be required. Generally, information is shared in accordance with the national regulations on sharing information (and Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data, and repealing Directive 95/46/EC (General Data Protection Regulation), (OJ L 119, 4.5.2016)), and only the information relevant for the examination of the claim and guaranteeing procedural guarantees is shared. See also the EUAA, *Critical Incident Management in the Field of Asylum and Reception*, June 2022.

Finland

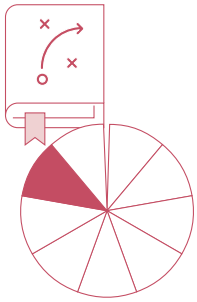
The **Finnish Immigration Service (Migri)** steers and plans the content of activities relevant to mental health within reception. An instruction targeting relevant staff was the outcome of a project funded by the EU's Asylum and Migration and Integration Fund. Below is a summary of crucial points highlighted in the instructions on mental health formulated by the Finnish Immigration Service.

- A broad and holistic view on how to ensure mental health, the instructions include working instructions on how to manage mental health and prevent a deterioration of concerns.
- Mental health work is not only specialised care but structured into interrelated principles, structures, activities, services and practices. It is a continuum of elements that do not necessarily carry a mental health work label (e.g. community-based activities) all the way up to extremely specialised care practices).
- There is a discrepancy between the needs of applicants and what is available related to mental health and psychosocial support services. Both more specialised services and investment in less intensive and everyday practices are needed.
- One element that is particularly important for the mental health of applicants is support for those activities that they undertake themselves to maintain and promote mental well-being. Such own initiatives should be fostered, promoted and even required.
- The stepped care model ([34]) is a good way to plan and structure activities, practices and goals (for more information, consult Part II – First-line officers.

In many EU+ countries, the **responsibility** for coordinating activities related to MHW in the context of asylum and organising collaboration might be best placed with the **reception authorities**. Depending on the national set up, it is advised to establish a close collaboration with the health authorities. Open and clear communication channels with the **determining authorities** are advised to ensure an effective exchange on the needs of applicants for a smooth examination of the asylum claim for those in need of procedural guarantees. The applicant will need to consent to the exchange of such information.

([34]) National Health Service (United Kingdom), *Stepped Care Model*, Bradford District Care – NHS Foundation Trust, 2015.

Component 2 | National guidance



The coordinating entity, team or focal person supports or initiates the development of national guidance on the MHW of applicants. The guidance is complemented by a clearly formulated and budgeted MHW action plan implemented within a certain time frame.

Systematically acknowledging that the MHW of applicants matters positively demonstrates a Member State's respect for and obligations towards upholding an applicant's fundamental rights. Having clearly formulated **national guidance** on MHW, where possible complemented by a budgeted **action plan**, is vital.
In some EU+ countries, such national guidance applies to all citizens including migrants, refugees and applicants. In others, national guidance addressing the needs of the health and MHW of applicants for international protection is formulated separately. Several EU+ countries already have a national mental health strategy ([35]) or guidance for migrants in place. No matter the approach, it is important that such guidance is available and accessible to all staff in contact with applicants.

The following steps can be beneficial particularly for those countries that do not yet have such guidance available.

↪ Step 1.

Formulating a national guidance on MHW which includes the:

- **aims, objectives** and the approach to address the MHW needs of applicants;
- **relationship** between the national mental health guidelines and other strategies if available;
- the **coordination** between all relevant partners including other governmental departments on how communication is organised and structured (health, law enforcement, social services and education);
- development of an **action plan** complementing and operationalising the national guidance for a specific period (e.g. annual).

([35]) See European Migration Network, *Mapping of mental health policies for third-country national migrants*. Countries with reference to a strategy on mental health at the national level: Estonia, Ireland, Greece, Spain, Italy, Malta, the Netherlands, Austria, Slovenia and Finland.

↪ Step 2.

The action plan developed clearly refers to the following points:

- Designing and launching MHPSS also with the **meaningful participation** of the applicant community. The participation considers their cultural and educational backgrounds, age, gender and diversity as part of a needs assessment on services to be provided.
- The importance of focusing on **preventative measures** to maintain MHW such as through psychosocial support involving the applicant community, psychoeducation and the early **identification** of applicants in a vulnerable position.
- Allowing for a **needs-based response** by providing ongoing systematic opportunities for vulnerability assessments, referrals, coordination and case management.
- Clarity on who is **responsible** for coordinating the respective intervention(s) and who is in charge of providing the services including when and where. Specify if interventions are ongoing or a one-time response only and if they are linked to a specific step in the asylum and reception pathway (e.g. only upon arrival, during stay in reception, during preparation for integration or return);
- The ongoing assessments identifying the needs of staff linked to:
  - training and capacity building;
  - interventions to support the welfare of staff;
- as well as the resources needed to:
  - implement the proposed MHPSS;
  - the human resources needed to conduct these tasks.
- **Realistic minimum targets** to support the effective implementation of MHPSS and the involvement of a **multidisciplinary** team (e.g. reception and child protection officers, social workers, health professionals such as general practitioners, nurses, psychiatrists, psychologists. It could also include legal counsellors, guardians and interpreters who have a certain level of mental health literacy).

The coordinating entity, team or focal person is **responsible** for ensuring the development of such national guidance and the MHW action plan.

Sweden

'It's about life' is the name of the proposal for a new national **strategy** ([36]) for mental health and suicide prevention in Sweden. In addition to the vision, the strategy contains four overarching goals that are followed up and guide the work: (1) improved mental health in the entire population; (2) fewer lives lost to suicide; (3) reduced inequality and (4) reduced negative consequences due to psychiatric conditions.

The proposed framework aims to simplify the process for all actors to prioritise and plan new efforts around mental health and suicide prevention. It aims to **strengthen work** that is already being carried out to **harmonise** towards common goals **over 10 years**.

The strategy includes both promotional and preventative measures, to create the conditions for good MHW as far as possible and to prevent mental illness from occurring. In addition, care and treatment are included, as are efforts to improve the living conditions of people living with various psychiatric conditions and ways to ensure their meaningful participation in society.

The strategy also contains proposals for a coherent follow-up system which has been lacking before and now provides increased opportunities for learning. Mental health impacts the whole of society, especially migrants since they are one of the largest groups represented in the statistics of mental illness and suicide.

The Swedish Migration Agency, healthcare organisations and the municipalities that are important keyholders are jointly aiming to lower the numbers of mental illness, suicide attempts including suicides among migrants.

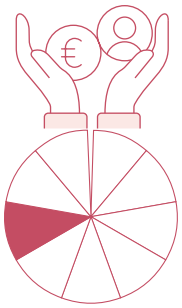
Strong collaboration with the health sector to promote basic healthcare services is crucial. Basic healthcare should be free of charge or chargeable at the same rates to the local population as well as to applicants, including those who just arrived on EU territory and might not yet have their paperwork finalised ([37]). This can reduce bottlenecks in service provision.

The opportunities created for applicants to access such care might encourage preventative medical check-ups by applicants. This is particularly important when it comes to pregnant women and their unborn babies and reproductive health as well as for applicants with mental health concerns. Such visits can help to mitigate the risks of health conditions potentially manifesting, which can then be costly for the state.

Basic healthcare provision needs to be linked to targeted awareness raising on the psychological needs of applicants and refugees to health professionals, the importance of cultural sensitivity and availability of cultural, gender and age-appropriate **interpretation** services. Since seeking the support of a psychologist or psychiatrist might be linked to stigmatisation, psychoeducation and mental health literacy is crucial for all involved. **Finding the right words** when addressing psychological distress or mental health problems and promoting the relevant support is crucial.

([36]) The Public Health Agency of Sweden and the National Board of Health and Welfare have proposed a strategy for mental health and suicide prevention called 'It's all about life'. For more information, consult https://www.folkhalsomyndigheten.se/livsvillkor-levnadsvanor/psykisk-halsa-och-suicidprevention/nationell-strategi/

([37]) Having access to free services (e.g. through a special insurance card issued upon arrival or medical treatment vouchers) for longer periods (minimum of 1 year) will not only reduce the bureaucratic burden on applicants (to prolong certain entitlements every few months) and on stakeholders referring to or providing health services (by not having to issue new insurance cards in short cycles) but can also accommodate waiting times for the follow-up of potentially more specific health needs an applicant might have and can be covered therefore.



Component 3 | Resources

The coordinating entity, team or focal person puts a MHW action plan in place that includes the budget needs.

The allocation of the necessary budget for the implementation of the action plan on MHW is approved by the financial and human resources teams and integrated into the overall annual budgets by the coordinating entity, team or focal person. This is then submitted to the relevant ministry for a final overall approval of the budget.

It is important that all activities, such as case management and non-operational costs are considered including space, logistics, specialists, training and additional staff. Vet all practitioners providing MHPSS before they implement their interventions. The services provided need to be relevant to the needs of applicants and the financing of specialised support services is approved.

The coordinating entity, team or focal person is **responsible** for ensuring the approval of the action plan including a budget allocation for human resources. The MHW action plan is developed in close collaboration with the finance and human resources teams within the authority.

Belgium

The budget of Fedasil (the federal reception authority, Belgium) is essentially made up of a federal allocation. There are also contributions from EU funds. The budget covers different types of expenses such as employee salaries; operating costs including, among others, medical costs for applicants; subsidies to finance the reception of applicants in other structures, even voluntary return; and expenses relating to projects financed by the European fund.

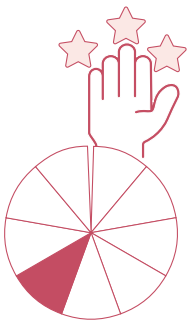
Governments should commit a certain budget to allow asylum and reception authorities to integrate MHW interventions in a comprehensive and meaningful way. Some funding can be requested also through financial support provided as part of ongoing calls such as the EU's Asylum, Migration and Integration Fund ([38]).

An applicant for international protection is entitled to material assistance as soon as they have submitted their application for international protection. Material assistance is provided in a reception structure. Fedasil will designate a community or individual reception structure for the applicant in need of assistance. Material assistance consists for example of accommodation, meals, clothing, access to legal aid, interpretation, voluntary return programme, daily allowance and the **medical, social and psychological support**.

Medical assistance or support is the medical care and assistance listed in the Institut national d'assurance maladie-invalidité (INAMI) nomenclature.

At a micro-level (reception structures), there is a yearly budget per reception centre for the implementation of psychosocial activities. The **advantage** of this is that the budget enables reception teams to set up specific activities that meet the real needs of the residents of the reception facility. One **challenge** is that each year, budgets must be reviewed based on the overall allocated budget.

([38]) Commission Implementing Decision of 23.11.2022 on the financing of components of the Thematic Facility under the Asylum, Migration and Integration Fund and adoption of the Work Programme for 2023, 2024 and 2025 C(2022) 8340 final, 23.11.2022.



Component 4 | Skilled support

The coordinating entity, team or focal person ensures that the needs-based mental health and psychosocial support is provided by those best placed to respond to the needs identified.

Those working in reception in EU+ countries, often with a background in social work, likely already have a proficient level of mental health literacy and the skills to identify applicants with specific needs including those related to mental health and trauma.

However, awareness is a cross-cutting concept that involves authorities, senior managers, first-line officers and other stakeholders concerned with the MHW of applicants. MHW are connected to various aspects of the daily lives and experiences of the applicants, including culture, social context and past/present experiences.

Therefore, additional training and psychoeducation on these topics should be accessible to all staff, including refresher sessions on the topic as to build their capacity. Refer to Annex 4. Building capacity on mental health and psychosocial support.

Generally, officers working in the first line should have the following awareness, skills and mental health literacy ([39]):

- the ability to recognise general distress in applicants and to observe basic indicators of other underlying vulnerabilities or special needs (including signs of psychiatric disorders) and how to organise referrals; a basic knowledge of psychological first aid (PFA) can help in identifying these signs ([40]);
- basic knowledge about causes, risk and protective factors related to mental health and how to nurture resilience;
- basic knowledge on self-help interventions to be shared with applicants and some which can also be used by staff working first line to reduce their own stress level;
- basic knowledge on how to help applicants to access support services;
- how and what to share in terms of additional information regarding mental health for the applicant in need but also where to proactively search for information for oneself to continue learning and developing certain skills.

First-line officers working in the context of arrival (e.g. registration officers, disembarkation) and those working in detention will also need to know how to maintain well-being and prevent mental health concerns from deteriorating. This can be done by responding adequately and/or by conducting referrals where necessary to those who can provide the relevant intervention ([41]).

([39]) International Journal of Environmental Research and Public Health, 'Mental health literacy: it is now time to put knowledge into practice', 2022, Vol. 19, No 12, p. 7030.
([40]) EUAA, Psychological First Aid Video, YouTube, 2023 and the accompanying instructions.
([41]) Refer also to the IASC, *MHPSS minimum service package*, 2024 and particular Activity 3.2: Orient frontline workers and community leaders in basic psychosocial support skills.

Other professionals supporting the authorities responsible for reception, such as staff of civil society organisations, the police and legal officers should be aware of how to provide referrals. They should be aware of what should be done to support vulnerable groups with suitable accommodation, where applicable, and how to ensure care and confidentiality.

The accessibility and placement of specialised social workers (such as those with additional knowledge on substance use, suicide prevention and trauma) as well as psychiatric nurses and general practitioners working in reception centres can be seen as an added value. This can help with the early detection of concerns and to prevent more serious mental health problems or other health issues arising. In a situation where general practitioners, psychiatric nurses or specialised social workers cannot be permanently placed in a reception centre, selecting specific days and times for them to be present and having a mobile approach to their service delivery can be an option. Once their availability is clearly communicated to the applicants, such a mobile approach can be of great benefit.

Cultural sensitivity and competency are crucial for all those working in the first line. Providing culturally-sensitive support is a key commitment for first-line officers. Commitment to cultural sensitivity is important in all activities throughout the asylum pathway and should be considered during the recruitment of first-line officers. Accepting and respecting difference and paying the necessary attention to specific dynamics is important.

the Netherlands

The cultural interview as practised in the Netherlands is one example of how to nurture cultural competency when providing support to applicants for international protection ([42]). This is a tool to stimulate conversation and consists of several questions about one's cultural background and allows the officer to connect with the applicant's perception of the world. The cultural interview can be used by (mental) health professionals and in current diagnostic intake procedures ([43]) including in the context of reception.

For other relevant topics in terms of building the capacity of first line officers refer to Annex 4. Building capacity on mental health and psychosocial support.

([42]) Pharos, *The Cultural Interview – Infosheet*, October 2018.
([43]) See Al Tamimi, Y., *Identification of asylum seekers with special reception and procedural needs in the Dutch asylum procedure*; Bloemen 2020; Bloemen et al., 2018; van Willigen, 2009.

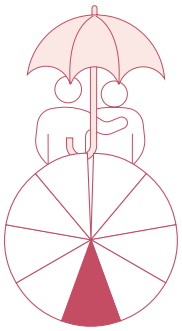
The exposure to people from diverse backgrounds working in the field of asylum and reception can be exciting, rewarding and challenging. To ensure professionalism, staff should not only understand their own culture and engage in self-assessment but also acknowledge and appreciate cultural and behavioural differences. An informed understanding of similarities and differences helps prevent certain mental health concerns from manifesting. It can also help with the more effective management of critical incidents.

Lastly, in the context of asylum where trauma might have accumulated for some applicants, those working first line need to be aware of how to provide trauma-informed care ([44]). Awareness of trauma-informed care is also important for those officers supporting the screening of third-country nationals as part of the identification, security, medical and vulnerability checks and for case officers working with applicants for international protection in the context of the personal interview.

Management is **responsible** for selecting, vetting and identifying staff and experts in collaboration with human resources and the training department(s), where applicable.

Keep in mind that while psychological distress might be experienced by many applicants arriving in Europe, few will fall into the category of individuals presenting with a mental disorder such as depression or post-traumatic stress disorders (PTSD). Many applicants will cope with the adversity experienced once the relevant MHPSS is available.

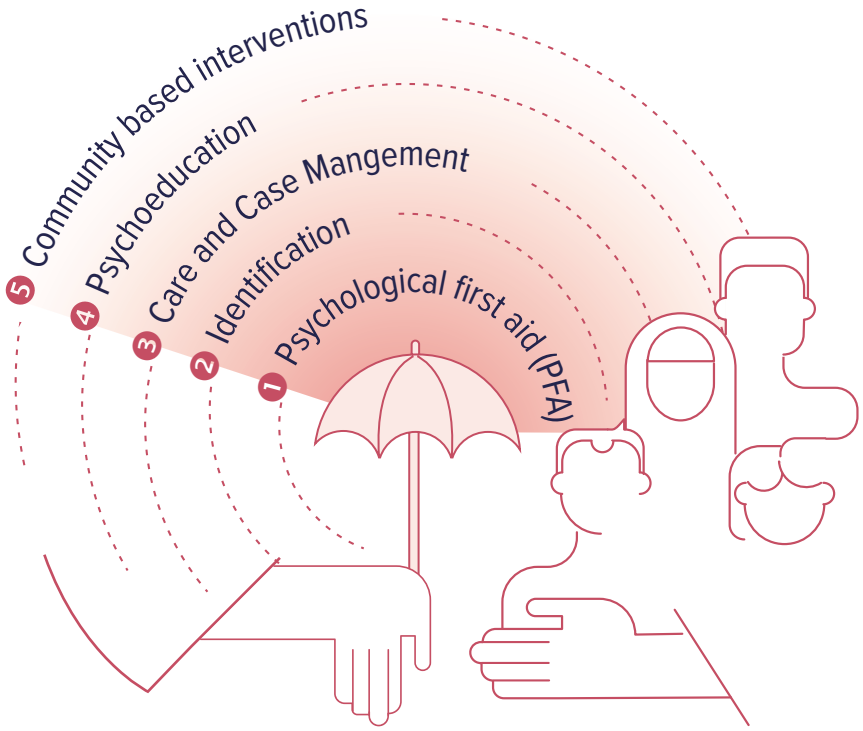
([44]) For more information, consult the EUAA, *Mental Health and Well-being of Applicants for International Protection – Part III. Toolbox for the implementation of mental health and psychosocial support*, 2024.



Component 5 | Prevention and response

The coordinating entity, team or focal person maintains the MHW of applicants by creating opportunities for psychosocial support. Once specific mental health needs are identified, these needs are managed in a timely manner using an applicant-centred approach and access to specialised services is ensured.

This component forms the core of an MHW-informed asylum system. Ensuring the **five focus areas** listed below are integrated into the daily processes of an administration will nurture the MHW of applicants, prevent ill-health, mitigate the risks of mental health disorders from manifesting and, if they do emerge, will facilitate the management of such disorders effectively. An in-depth explanation on how to operationalise these five areas is provided in Part II – First-line officers.



❶ Psychological first aid

The coordinating entity, team or focal person ensures that at each stage of the asylum and reception pathway specialised support (e.g. focal persons) is available to implement the PFA approach ([45]).

This is important since vulnerabilities and needs can emerge along the asylum/reception pathway and first-line officers might find themselves in a situation that requires them to identify and respond to these needs. PFA can facilitate the timely identification of those in need, provide some basic comfort and support and ensure that those in need are referred to the relevant support.

PFA is a useful approach and cuts across all stages of the asylum and reception pathway as well as all four levels of the MHPSS pyramid (refer to Figure 2).

❷ Identification

The **identification** of needs must start at the earliest point possible i.e. at the point of arrival either at the external border or at the initial reception centre during medical and vulnerability checks. At the same time, identification must be an **ongoing effort** since vulnerabilities and special needs can emerge at any time and/or can be disclosed by the applicant at a later stage of the asylum and reception pathway. Those coordinating the identification of vulnerabilities and special needs are to ensure that all applicants receive the opportunity to be identified as someone in need of support when and where relevant.

The identification should take place through different means and by taking age, gender and diversity into account, including:

- an initial medical/vulnerability detection exercise upon arrival conducted by qualified and trained professionals including child protection specialists;
- the administering of self-assessment tools;
- through PFA and psychosocial support and community interaction during their stay in reception, etc.

An early identification of concerns helps to prevent the deterioration of conditions and facilitates the addressing of health and protection needs related to the concerns identified. It also facilitates the work of the authorities since the development of serious conditions can be avoided.

❸ Care and case management

Providing the relevant care is important from the point of arrival to cater for basic and immediate needs. Intersecting and invisible vulnerabilities (which might not become obvious until a later stage of the asylum/reception pathway) must not be overlooked. Focused, and specialised services (psychologists, psychiatrists, child protection specialists, etc.) should be made accessible from the point of arrival. For this purpose, a referral system that includes multidisciplinary specialists is fundamental. Applicants in need of longer-term support are to be embedded in an applicant-centred case management process. This will also require assessing the impact of such services on the MHW of applicants.

([45]) Consult Part II – First-line officers; the EUAA, *Psychological First Aid Video*, YouTube, 2023 and the accompanying instructions.

4 Psychoeducation

Ongoing psychoeducational activities to strengthen the mental health literacy of all staff is important to ensure an effective form of prevention of mental health problems. This ensures that all those supporting applicants throughout the asylum and reception pathway, including even the applicants themselves, are knowledgeable on mental health literacy.

Integrating psychoeducation into daily operations will support the prevention of mental health concerns. It may potentially also prevent other intersecting vulnerabilities in the longer-term and it allows for a timely response for those in need of care and specialised support. Once awareness is created on why mental health is important and how to maintain it, applicants are empowered and informed on where to get help and how to care for themselves. In this way, applicants may be more able to care for others (dependants and other community members) in distress.

5 Community-based applies throughout interventions

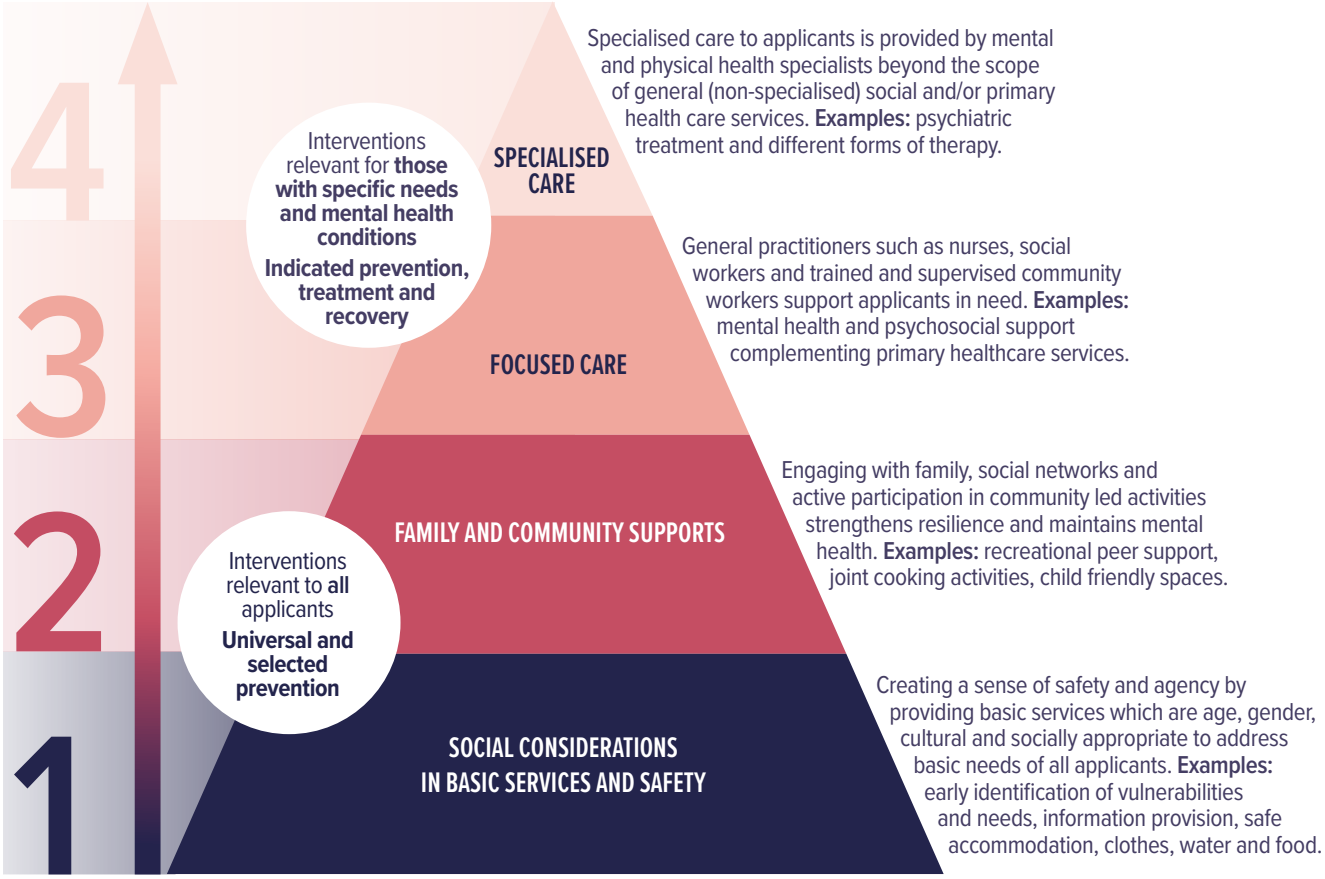
Involving applicants in the design and implementation of certain interventions after providing some basic training (e.g. through information provision, psychoeducational activities and peer to peer support) and building their capacity on mental health and psychosocial support can benefit both the authorities in case of situations of tight human resources and applicants. Involving applicants can nurture a sense of empowerment and agency as members of the community and it helps strengthens their resilience. Further, being supported by members of the community can, in some contexts, help some applicants to overcome their distrust of the authorities and seek help.

To maintain MHW, it is crucial to encourage applicants to interact socially with each other and members of the host community. Another important aspect is to support applicants with family reunification procedures, where possible and applicable. Similarly, help applicants establish routines such as through preparation for employment and activities related to education, leisure and language learning.

Defining the scope of prevention

The approach presented in this three-fold guidance has a strong emphasis on prevention, closely following the logic of the MHPSS pyramid from the IASC, which is broadly used by actors working in the humanitarian field. The approach focuses on interventions which fit particularly into the first three levels of the pyramid.

Figure 2. Promoting an integrated approach to mental health and well-being by focusing on prevention and a continuum of care for those in need.



Source: the EUAA, adjusted from IASC, *Guideline Mental Health And Psychosocial Support In Emergency Settings – IASC Reference Group on Mental Health And Psychosocial Support in Emergency Settings*, 2007 and United Nations Children's Fund, *Operational guidelines on community based mental health and psychosocial support in humanitarian settings: Three-tiered support for children and families (field test version)*, New York, UNICEF, 2018, p. 15.

Senior management should ensure that the MHPSS as coordinated by the appointed body fits into the four levels of the MHPSS pyramid (Figure 4). Once all applicants have equal access from an early stage of the asylum and reception pathway to the activities under levels 1, 2 and 3 of the MHPSS pyramid, only a few applicants and those identified with very specific needs will require longer-term focus or specialised care.

Universal prevention can help to flag concerns early. Mental health literacy enables applicants and first-line officers to pro-actively maintain MHW by engaging in a healthy lifestyle, for example through regular physical exercise. It also ensures access to care such as voluntary health and vulnerability checks and assessments. At times it might be relevant to simply ban certain activities which might put the health of applicants at risk (e.g. banning smoking or drinking in common areas).

Selective prevention tries to support a population at risk so that they receive the necessary attention. In the context of asylum, many applicants present with psychological distress for varying reasons linked to their challenging experiences and insecurity linked to their legal status. An early identification of those in severe distress is important as is the availability of community-based support to nurture connectedness.

Indicated prevention focuses on individualised support after needs have been assessed. A vulnerability assessment may recommend that an applicant could benefit from focused support such as group counselling sessions or specialised accommodation to cope with psychological distress ([46]).

Prevention and care

- In **Germany**, the Bridges project ([47]) reaches out to children, adolescents and young adults. The approach suggests that singing and making music together in a group strengthens the sense of community, mental well-being and resilience, social interaction and mutual respect. (For more examples, consult Part II – First-line officers.)
- In **Belgium**, the KU Leuven has established a day treatment for applicants for international protection and refugees called 'Day program for young refugees' ([48]). The offer is tailored to what young applicants need to stabilise their symptoms and process trauma and loss. Eligibility requires legal residence status in the asylum procedure or with a recognition status such as an unaccompanied minor or a young refugee residing in Belgium with family members.

Applicants often leave their home countries due to violence, persecution and human rights abuses. The journey to a new country can be stressful and traumatic at times. These experiences can cause mental health problems, including depression, anxiety disorders such as PTSD and other psychological problems for some applicants. Such problems can often be managed with interventions provided on the first three levels of the MHPSS pyramid (creating a sense of safety, ensuring community-based support is possible and involvement in psychosocial support activities, which might be placed on Level 3). Only once such mental health problems persist, **specialised support** and **treatment** might be needed and must be available and accessible.

([46]) For more information on a public health approach also consult Dr Audrey Begun, *Theories and Biological Basis of Substance Misuse, Part 1. Module 6 – Chapter 2. Prevention and the Continuum of Care*, 1994.
([47]) The Bridges project website is available here: https://bridgesmusik.com/en/uber-uns/
([48]) The KU Leuven webpage for 'Day program for young refugees' is available here: https://www.upckuleuven.be/nl/campus-kortenberg/dagprogramma-jonge-vluchtelingen

Even then, community-based support can be as important as psychotherapy and/or pharmacological therapy, depending on the circumstances. Therefore, a holistic and multidisciplinary but applicant-centred approach is recommended.

The coordinating entity, team or focal person is **responsible** for implementing the interventions in collaboration with skilled support from specialists. This support can also include the applicant community, where applicable, and professionals with a specific specialisation (e.g. child psychologists, psychiatrists, etc).

The coordination with a multidisciplinary team should involve the health authorities and social services, law enforcement, and where applicable, the educational/employment sector. Clear communication can facilitate streamlined and effective support. For example, in the context of education, teachers are faced with children with a migration background. It is therefore important to systematically involve teachers and educators including kindergarten teachers so they better understand the needs and challenges applicants might face.

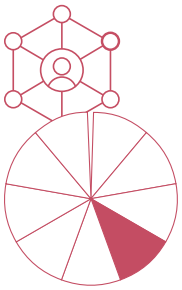
This will help to organise clearer communication and facilitate relevant referrals where needed to allow for a needs-based response. The same is true for medical personnel who provide services to applicants for international protection in different settings or those working with law enforcement.

Lastly, do not underestimate the importance of giving applicants a certain level of control in decisions being made during the asylum pathway. Ensuring that applicants are free to an extent to plan and control their day-to-day life can sustain hope. While transparency is vital to avoid false hope, realistic optimism ([49]) can nurture resilience.

Prevention can be nurtured through a community-based approach. Several international actors have developed guidance on how to involve community effectively in the design, development of programs but also as part of support services.

- IASC, *Community-Based Approaches to MHPSS Programmes: A Guidance Note*, 2019.
- IOM and USAid, *Manual on Community-Based Mental Health and Psychosocial Support in Emergencies And Displacement – Second Edition*, 2021.
- UNHCR, *A Community-based Approach in UNHCR Operations*, 2008.
- Joint Action on Mental Health and Well-being, *Towards community - based and socially inclusive mental health care, situation analysis and recommendations for action*, 2015.
- WHO, *Guidance on community mental health services: Promoting person-centred and rights based approaches*, 2021.

([49]) Consult also John Hudson *The survival triangle*, 27 June 2019.



Component 6 | The migration process

The coordinating entity, team or focal person ensures that all involved understand the complexity of migration in its entirety and the impact this process might have on the applicant's MHW.

The coordinating entity, team or focal person underlines that all involved should be aware that the migration process is complex. It is not a linear path but has numerous critical stages that come with challenges and opportunities. The experiences of applicants in their home countries, during displacement, transit and arrival followed by the critical stages of the asylum and reception pathway (registration, initial reception, stay in reception, integration or return and re-integration) can all play a critical role. Every applicant is unique and reacts to adversity in different ways.

The critical stages experienced by applicants entail protective and risk factors that staff working with applicants need to be aware of. These factors can combine with individual factors such as the age, gender or general health condition of a person. Some of these factors, for example the presence of family, might be protective for some while a risk factors for others. Some protective or risk factors might accompany the person throughout the migration process, whereas others might appear at a later stage only or disappear.

To maintain the applicant's strong MHW:

- address the basic needs of those arriving;
- ensure access to basic health and mental healthcare including psychosocial support;
- place the applicant in a safe and dignified initial reception centre upon arrival;
- engage with empathy;
- provide information on the next steps;
- explain how the authorities can support in tracing family members or communicate with them.

During the stay in reception, applicants should be supported to transition slowly towards integrating into the host community where possible. This can be done by involving them in language courses as early as possible and creating an atmosphere that encourages interactions with the host community. Provide access to leisure activities (e.g. joining local sport clubs), provide educational and employment opportunities or help the applicant prepare for such opportunities. A basic daily structure coupled with opportunities to understand the host country culture can be empowering. Mentorship programmes and peer support are useful tools. Ensure that applicants receive the relevant information taking into consideration their age, gender and the diversity on services available to them and how to access such opportunities. This will facilitate integration once a positive decision is received on their asylum application.

In the event of a negative decision on the asylum application, it is important to liaise with the organisations responsible for return activities, including voluntary return, such as the IOM to ensure that the right information is shared. A return should be organised in a timely, respectful and dignified manner.

Service providers working with applicants in the first line are **responsible** for implementing the support interventions.

Belgium

At the **Arrival Centre in Petit-Château, Brussels** ([50]), Fedasil works with newly-arrived applicants arrival by strategically using colours, pictograms and the language of applicants to facilitate a smoother workflow.

At the first stage in the arrival path, newly arrived applicants are registered and fingerprinted in the yellow zone.

Fedasil first-line officers check whether an applicant is entitled to reception during the examination of the application for international protection. This task is carried out by the immigration department following Fedasil's instructions. If the applicant is the entitled to reception, Fedasil will temporarily offer reception at the centre. After a brief stay, applicants are transferred to a reception facility which is best suited to their situation.

Social screening is organised in green rooms which can be complemented by a medical screening and/or vulnerability screening.

([50]) Information about the Fedasil Arrival Centre in Petit-Château is available here: https://www.fedasilinfo.be/en/welcome-arrival-centre and an information hub for applicants is available in many languages here: https://www.fedasilinfo.be/en/landingspage

The detention of applicants upon arrival, while waiting for the examination of their claim or when scheduled for return is a last resort and should only be applied only in the absence of viable alternatives. If considered, detention should last for the shortest time possible and only with certain guarantees in place ([51]). Detention can have a negative impact on someone's MHW no matter the circumstances ([52]). The detention of children can never be seen as being in their best interests.

During stay in reception and where applicable, services should always allow for recovery, rehabilitation and reintegration. All interventions are to be designed in an applicant-centred and culturally sensitive manner, taking the personal circumstances of the applicant (age, gender, disabilities, diversity, educational background, etc.) into consideration. This includes consideration for any experiences prior to arrival in the host country.

Staff providing services need to have a basic understanding of the psychological needs of applicants and refugees regardless of whether the interventions are provided within a reception facility context or if applicants live independently. Past experiences and present grievances, once disclosed, should be considered when developing a care plan. To do so, the workforce engaging with applicants will need to have the necessary skills and knowledge, including an awareness of the country-of-origin information where applicable to ensure a 'do no harm' approach.

In terms of those awaiting return, some authorities use the tools developed by IOM, such as IOM Ireland, *Preparation for Return*, 2015 and IOM, *Reintegration Counselling: A Psychosocial Approach*, 2020

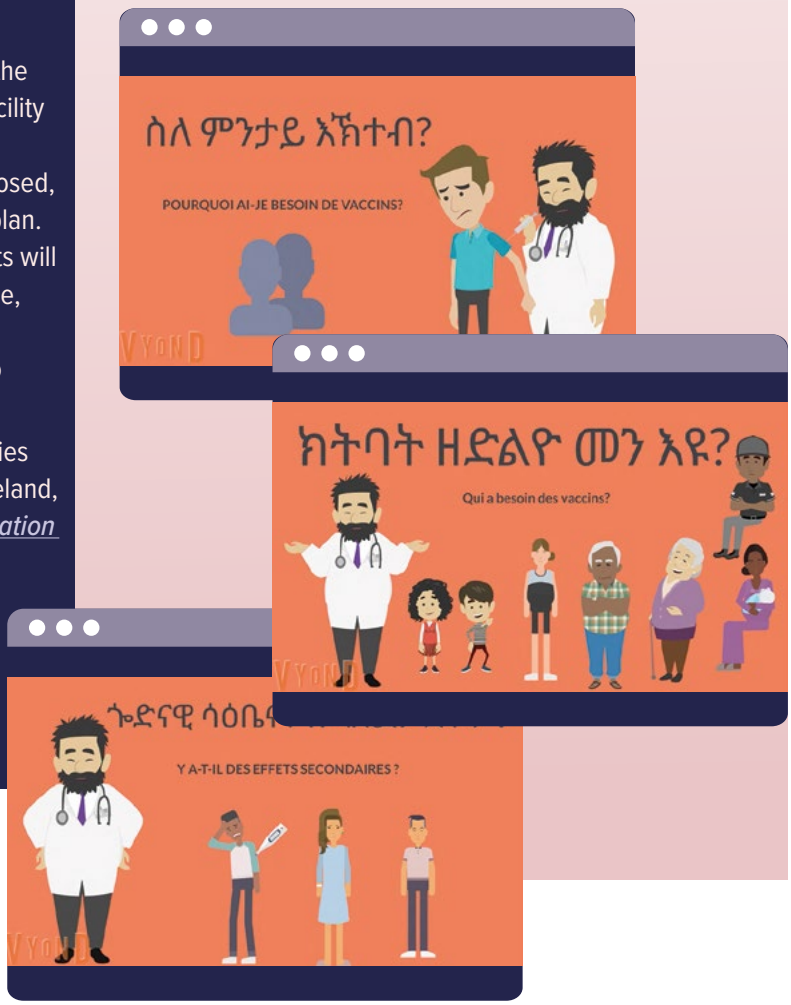
In addition, consult the EUAA, *Mental Health and Well-being of Applicants for International Protection – Part III* ... Section: Complexity of migration', 2024.

The applicants can also **watch animations explaining the medical procedures** (e.g. vaccination) they are expected to undergo. The videos are shown in the language of the applicant and explain why the medical procedure is important, what will happen exactly, who will undergo the procedure and any potential side effects or consequences.

These brief videos have received positive feedback, since hearing a familiar language at this very critical point in time (arrival) creates some calm and sense of safety.

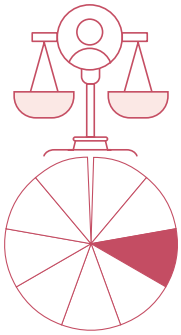
In the orange zone, applicants are allocated a reception place, mostly in the arrival centre itself and are provided with other relevant information.

Generally, the transition from yellow to green to orange is facilitated by the presence of staff and security on site and supported by icons that illustrate what to expect in a specific zone. The use of colours and icons also helps applicants with little to no literacy and ensures applicants access the next stage in the workflow.



([51]) Recitals 26, 29, 31, 33, 40 and Article 10 RCD (2024).
([52]) WHO, 'Immigration detention is harmful to health – alternatives to detention should be used', 4 May 2022

Component 7 | Accountability



Commitment, integrity, respect, non-discrimination, transparency, impartiality and equality are some of the core principles promoted by administrations to ensure a fair and fundamental rights-based engagement for applicants and staff.

The coordinating entity, team or focal person ensures that everyone working with applicants complies with the law, the code of conduct and other relevant policies put forward by the administration/organisation and that fundamental rights are respected. The entity stresses a zero-tolerance policy regarding sexual exploitation, harassment and abuse and pursues disciplinary measures where there is a breach of such policies.

The team or person appointed to coordinate the MHW activities is therefore responsible for stressing that all those working to implement the MHW action plan comply with these principles. It is crucial for the coordinating entity, team or focal person to set a good example and to ensure conduct meets the highest professional standards. This is also important particularly when working with minors. The best interests of the child should be the primary consideration and this throughout the entire asylum/reception pathway.

The coordinating entity, team or focal person is responsible for ensuring that all staff in contact with applicants are aware of, comply with and have signed the code of conduct and ethics and other relevant policies (e.g. on sexual exploitation, abuse and harassment (SEAH), child protection, inclusion and diversity, etc.). A collaboration with other departments, particularly human resources is important. The MHW activity coordinators emphasise the importance of safeguarding all applicants and that all those supporting the roll out of interventions are aware and responsible for recognising, recording and reporting any breaches.

Accountability ([53]) safeguards service beneficiaries and protects first-line officers. It also protects the reputation of the services provided by the authority or organisation, which can otherwise be jeopardised. Accountability mechanisms, feedback and complaint mechanisms should be in place even where services are outsourced. These mechanisms should be organised in a format and language that is appropriate for the service users.

The below points need to be clearly communicated to all those working first line:

- how to organise and respond to feedback and complaints;
- how to report/document potential incidents and to whom;

([53]) In addition, consult UNHCR, *Accountability to Affected People (AAP)*, last updated 12th June 2024 indicating: Accountability refers to the responsible use of power (resources, decision making) by humanitarian actors, combined with effective and quality programming that recognizes a community's dignity, capacity, and ability to be independent.

Feedback is any positive or negative statement of opinion about someone or something, i.e. an opinion shared for information. It may be expressed formally or informally and may or may not require a response.

A **complaint** ([54]) is a grievance, an expression of dissatisfaction about the standards of service, activity or lack of such by a respective authority / services provider or its staff, volunteers or anybody directly involved in the service delivery. It is a criticism that expects a reply and potentially follow-up action to amend the situation.

The senior management of the coordinating entity, team or focal person is first and foremost **responsible** for ensuring accountability and that all the relevant policies are in place, together with human resources ([55]). However, every single staff member, consultant and volunteer has a role to play to ensure accountability towards service users.

It important to be aware that carers and those involved daily in supporting applicants can be affected by **power dynamics** of the professional relationship between them and the applicant. Carers and those supporting applicants can unintentionally harm applicants by putting them in a position where they feel powerless or helpless. This can also lead to pathologising the conditions of applicants in the longer term. Hence, those providing care have to use their position responsibly.

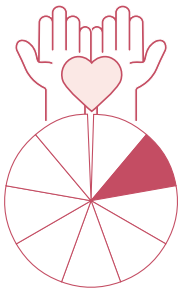
Further, access to family, friends and services including counselling during the COVID-19 pandemic through technology was experienced as extremely useful for many. Remote support has also since then increased in the field of Asylum and Reception. The use of technology clearly has many advantages in terms of reach and reduction of costs, but it also has its limits. A human encounter and direct service provision, where possible, should not be replaced by a pure focus on technology. In-person **human encounters** and **connectedness are key pillars** for ensuring strong MHW.

For more information on ensuring a do no harm approach consult Part III – Toolbox, Section: Accountability and for promising practices for online support provision and Part II – First-line officers, Section: Internet-based therapy.

([54]) Refer to the CHS Alliance Guidance, *Managing complaints: A Best Practice Guide for Aid Organisations*, p. 36 Glossary, 2023

([55]) The human resources department(s) can also include training on ethical behaviour in the mandatory training package within an administration. See University of Texas at Austin, *Behavioral Ethics – Ethics Defined*, YouTube, Texas McCombs School of Business, 2017.

Component 8 | Staff welfare



Working in the field of asylum and reception can be fulfilling but it requires flexibility to adapt to different realities ([56]). Those working in the first line are exposed to an ever-evolving work context. Being able to handle a large workload and cope with challenging cases (e.g. cases of severe psychological distress), potential crises triggered by critical incidents ([57]), a lack of resources and the political sensitivities around the topic of migration can take a toll on the MHW of first-line officers.

As part of the duty of care, the coordinating entity, team or focal person provides a safe, supportive and enabling working environment to all those working in the first line and their managers.

The MHW of staff needs can be supported through:

- a selection process that considers skills and the ability to conduct tasks in a professional manner;
- ongoing capacity building;
- regular encounters between line managers and their teams to learn about the immediate needs;
- providing access to a comprehensive staff welfare package to ensure preventative support and support in times of crisis.

Further, clarity on the terms of reference of the job, the responsibilities and duties can increase job satisfaction. This creates a sense of preparedness and can reduce cases of burnout amongst staff working in the first line.

Senior management in close collaboration with the coordinating entity, team or focal person, human resources and the safety and security department are **responsible** for the well-being of staff members ([58]).

([56]) For example, an officer working day shifts might observe different needs in an applicant to officers working with the same applicant during the night. The night officer might observe, for example, that the applicant is unable to sleep due to nightmares.
([57]) For more information, consult the EUAA, *Critical Incident Management in the Field of Asylum and Reception*, June 2022.
([58]) EASO, European Union Agency for Law Enforcement Cooperation, European Border and Coast Guard Agency, *Occupational Health and Safety Deployment Information*, 2020.

While first-line officers are encouraged to ensure that they take care of themselves by taking regular breaks at work, regularly engaging in activities not linked to work (hobbies, sports, further education, etc.), taking all leave days and having regular preventative medical check-ups, they should also look out for one another.

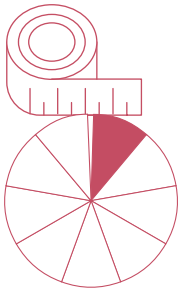
Employers should ensure that certain support activities are embedded within the overall framework of support provided as part of the national guidance on MHW, which should also refer to staff needs and support for these needs. The strategy should therefore refer to a staff welfare support package, including activities for capacity building and internal mobility.

Consult the EASO, *Practical guide on the welfare of asylum and reception staff* – Part I: Standards and policy, Part II: Staff welfare toolbox and Part III: Monitoring and evaluation, 2021. Part II presents practices from Member States including Belgium and the Netherlands and Part II, **Section 5. Self-care** presents exercises for officers working in the first line.

EUAA, 'The importance of early identification of signs of stress', YouTube, 22 September 2021, which was developed to promote the well-being of staff members.

Allowing staff and first line officers to consciously set healthy boundaries at work is crucial as not to create a situation of prolonged stress. Some first line officers might be overwhelmed with feelings of guilt of not being able to do enough or become a victim of the applicant through the use of 'emotional blackmail' in terms of a constant need to be available and/or to support. Acknowledging such instances is possible when authorities have a solid staff welfare support system in place that allows for first-line staff to access regular peer-to-peer support sessions, reflective practice sessions, case supervision or similar which also reduces the risk of burnout.

Component 9 | Measuring progress



The coordinating entity, team or focal person ensures activities under the MHW action plan are monitored to guarantee their relevance, effectiveness and impact.

Measuring the progress of interventions and evaluating their impact including the effectiveness of collaboration between the different critical stakeholders are a main focus. Basic data on the specific MHW needs of applicants should be regularly collected through needs assessments. Such data supports the adjustment of activities where needed. Without this information, authorities cannot make decisions on what to prioritise or what to omit.

For example, the types of services contacted and the number of referrals over a certain period can be analysed to assess if the vetted service providers in the referral system are sufficient or whether new concerns regarding the applicant community have emerged.

The coordinating entity, team or focal person in collaboration with the service provides and the internal monitoring and evaluation team are **responsible** for measuring progress.

The below can help to provide a basic oversight.

1. Collecting data
   - types of cases i.e. the main concerns applicants present with over a certain period or in a certain context, for example in a reception facility, region or nationwide, including the level of urgency;
   - data collected segregated by age and gender (e.g. which services are needed for minors in comparison to other age groups);
   - types of services accessed (formal versus informal);
   - main recipients of referrals (which collaboration partners and organisations are mainly engaged and receive most of the referrals);
   - trends in terms of critical stage (is there a moment along the asylum/reception pathway where more referrals/needs emerge then at other moments);
   - understanding the cultural appropriateness of services including feedback from applicants so as to guide the authorities on what works and what does not and why);
   - appropriate budget allocation for a well-functioning and effective case management and referral system).
2. Analysis of data
   - The data collected facilitates an assessment of the impact of activities and if the services and the collaboration partners have led to a situation where:
   - MHW levels are stable;
   - the risk of deterioration of existing conditions was mitigated;
   - a decrease in crisis/critical incidents in which applicants are involved has been observed.

For more information on an overall approach to measure progress, see Chapter 2. Action and progress.

IASC

Refer also to the IASC framework ([59]) to monitor and evaluate progress relating to MHPSS, the IFRC, Psychosocial Centre ([60]) and the Mental Health Innovation Network ([61])

By measuring progress, senior management can ensure better support is available to the MHW intervention coordinators. This means field teams will be better prepared to conduct their duties with the utmost professionalism. This will positively affect the final target group i.e. applicants for international protection.

([59]) IASC, *Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings*: With means of verification (Version 2.0), 2021.
([60]) IFRC, 'Webinar: MHPSS Assessments', 2023, addressing the assessment of Mental Health & Psychosocial Support needs.
([61]) IASC MHPSS MSP, *Mental health and psychosocial support minimum support package*, 2022, Section 2.2 Develop and implement a monitoring and evaluation (M&E) system, which provides additional references to monitoring and evaluation frameworks to consider.

2

Action and progress

‘Mental health is a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community … Mental health is more than the absence of mental disorders. It exists on a complex continuum, which is experienced differently from one person to the next, with varying degrees of difficulty and distress and potentially very different social and clinical outcomes ([62]).’

Chapter 1 presents **nine** equally important **components** to support the shaping of an asylum system informed by MHW considerations. Each component introduces practices and activities to implement the component. These activities, linked to a set of **indicators**, will facilitate the measuring of progress.

The authority must ensure the necessary framework within which these **nine components** can be established. Hence, the coordinating entity, team or focal person is invited to adjust the propositions made in this guidance to fit their own national and/or local context including adapting the language of the indicators. It is advised however that the indicators are **SMART** (specific, measurable, attainable, relevant, time-bound) to provide valuable information.

([62]) WHO, ‘Mental Health’, 17 June 2022.

Why and how to report progress

Vulnerabilities and special needs can be noted at any point in the asylum and reception pathway and will require documentation. Documentation of needs is critical to ensure that the person in need can be channelled towards the appropriate procedure (e.g. during the screening exercise and the medical/vulnerabilities checks) as well as to the relevant support services (e.g. during stay in reception).

The findings should however also be compiled to inform and potentially facilitate the readjustment of the MHW action plan developed by an authority, where needed. Documenting lessons learnt on what does and does not support the MHW of applicants is crucial. Such learning will enable those coordinating MHPSS to improve their planning including in terms of cost-effective investments to support applicants and help the reception authorities in reaching their overall objectives within a specific timeframe.

When looking into measuring progress, the below items should be highlighted:

- which of the MHPSS interventions seem to reach a large number of people and have a positive impact on their MHW, i.e. success stories;
- the new and emerging needs taking age, gender and diversity into account;
- challenges and/or gaps regarding intersecting vulnerabilities;
- any safety and protection concerns for applicants and those working in the first line;
- to what extent applicants been involved in the design and implementation of interventions.

For more information regarding different interventions linked to response and prevention (component 5), consult **Part II – First-line officers**.

How to collect data and feedback?

Data can be collected via different means. Consider gathering feedback from service users as well as those coordinating and implementing the services. The coordinating entity, team or focal person should ensure that cross-cutting concepts, such as cultural competency, or protective/risk factors, etc. are streamlined during the implementation. For more information on how to collect important data, consult the EUAA, ***Mental Health and Well-being of Applicants for International Protection – Part III. Toolbox for the implementation of mental health and psychosocial support***, 2024.

Reporting on activities

It is recommended to regularly fill out activity reporting templates regarding the MHW interventions. Such templates should cover, at a minimum:

- collecting data on how many applicants identified as vulnerable have also show signs of psychological distress and/or other intersecting vulnerabilities over a certain period;
- disaggregated data on age, gender and diversity;
- the number of referrals conducted to partners and the types of support received (formal / specialised care / psychosocial support activities).

In an initial reception centre, where applicants normally only stay for short periods, a weekly recording of information might be logical. In a facility providing longer-term accommodation, monthly or quarterly recording might be sufficient. It can be helpful to separately record information concerning a specific group of vulnerable applicants (children, the elderly, those living with disabilities, etc.) to compare certain needs, repeated visits, etc. The information gathered feeds into a quarterly/biannual/annual report (depending on the context).

To allow for the documentation of intersecting vulnerabilities, first-line officers might aim to capture the following points over a specific period:

- main target groups in need of follow-up support;
- main referral partners contacted (health, employment, rehabilitation, social services, protection, law enforcement, child protection, etc.);
- any gaps identified (e.g. referral partners / service providers / information provision, etc.);
- summary of main needs/challenges;
- any other observations/needs/comments.

Collecting feedback from applicants

Receiving direct feedback from applicants using services is important. Feedback mechanisms are part of the daily reality of many areas of life (doctor appointments, private sector as part of customer satisfaction measures, etc.). In the field of asylum, feedback from service users can be a useful tool for the authorities to learn what is well received and therefore should be continued and where budget, time and efforts might need to be shifted or reorganised.

The formats to request feedback can differ depending on the number of applicants to reach, their age, literacy levels, capacity of staff and the time available. Formats can include focus group discussions, feedback forms for individual or joint feedback and encouraging applicants to simply use emoji answers to share their satisfaction level, for example as part of online forms to fill in, if appropriate in the context. For more information on how to collect feedback from applicants, consult EUAA, ***Mental Health and Well-being of Applicants for International Protection – Part III. Toolbox for the implementation of mental health and psychosocial support***, 2024.

Voluntary participation

All activities used to support data collection and reporting are voluntary for applicants. This is particularly important for feedback collection exercises to ensure these activities do not unrealistically raise expectations (e.g. remuneration due to participation, information collected to be used for the asylum procedure, etc.).

Senior management, in collaboration with the coordinating entity, team or focal person, can take the nine components proposed in this guidance and:

- translate them into a **set of standards** reflecting their own reality on the ground;
- translate the **actions** into **quality benchmarks**;
- link the quality benchmarks with **SMART indicators** to facilitate progress monitoring.

Generally, progress is best measured over a certain time and by:

- establishing a baseline at day one of implementing the MHW action plan;
- conducting a midterm check-in halfway through the programme;
- conducting an end-of-programme evaluation.

Progress can be measured during different time periods, for example quarterly, semi-annually or annually. This depends on the capacity of the authority and the activities themselves. It can also depend on how these activities are phased in the MHW action plan and the duration of each intervention.

The findings of such an analysis can enhance service provision and improve the quality of services generally. In the long-term, it may improve efficiency where the activities are more effective when integrated over a longer period rather than following a pure project funding approach or ad-hoc interventions. This could jeopardise the continuity of and can lead to a high staff turnover, which can disrupt the important work of the administration. The feedback from MHPSS service users is important to allow for culturally appropriate and meaningful interventions.

- Sphere Association, *Humanitarian Charter and Minimum Standards in Humanitarian Response*, 2018 edition, p. 380.
- IASC, *A Common Monitoring and Evaluation Framework for Field test version - Mental Health and Psychosocial Support in Emergency Settings*, 2017.
- IASC, *Guideline Mental Health And Psychosocial Support In Emergency Settings – IASC Reference Group on Mental Health And Psychosocial Support in Emergency Settings*, 2007.

Annex 1. Glossary

Term	Definition	Source(s)
Access to healthcare	In the context of international protection, the entitlement of a third-country national or stateless person, to use personal health services, and at least receive emergency care and essential treatment for illnesses and of serious mental disorders, in a timely manner.	EUAA glossary: IATE ID: 3620627
Accompanied child	A child who arrives in a Member State accompanied by parent(s), or an adult who is considered responsible for the child according to the law or the practice of the Member State concerned and remains accompanied after entering the territory of the Member State.	EUAA glossary: IATE ID: 3591901
Accompanying adult	An adult who appears with a child before the authorities, but who is not the adult responsible for the child whether by law or by the practice of the Member State concerned.	EUAA glossary: IATE ID: 3591902
Age assessment	A process by which asylum or migration authorities seek to estimate the chronological age or age range of an applicant to determine whether the applicant is a child or an adult.	EUAA glossary: IATE ID: 3591903
Applicant of international protection	A third-country national or stateless person who has made an application for international protection in respect of which a final decision has not yet been taken.	Article 2(d) Directive 2013/32/EU ([63])
Applicant with special needs	An applicant whose ability to benefit from the rights and comply with the obligations is limited due to individual circumstances.	Article 2(d) Directive 2013/32/EU ([64])
Best interests assessment (BIA)	An activity consisting of evaluating and balancing all the elements necessary to make a decision in a specific situation for a specific child or group of children.	EUAA glossary of terms: IATE ID: 3591905
Caregiver	In the context of migration, any adult person or any organisation in charge of the daily care of a child, in the absence of the child's parents.	EUAA glossary of terms: IATE ID: 3591914
Case Management	An initial approach that provides protection and assistance to individuals with complex needs, requiring access to various services and enables the needs to be addressed in a timely and systematic manner through direct assistance or referrals.	IOM, 'Case Management'

([63]) 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), (OJ L 180/60, 29.6.2013).
([64]) 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), (OJ L 180/60, 29.6.2013).

Term	Definition	Source(s)
Community based approach	An approach to mental health and psychosocial support that works with the community of applicants in partnership throughout the programme delivery. These approaches are based on the understanding that communities can be drivers for their own care and change. Such an approach should continue throughout the whole asylum and reception pathway.	IASC, *IASC Community-based Approaches to MHPSS programmes: A guidance note*, 17 January 2019; UNHCR, Division of International Protection Services, *UNHCR Manual on a Community Based Approach in UNHCR Operations*, UNHCR, March 2008; IOM, *IOM Manual on Community-Based Mental Health and Psychosocial Support in Emergencies and Displacement*, 2021.
Consent	Any freely given, specific, informed and unambiguous indication of individual's wishes by which they, by a statement or by a clear affirmative action, signify agreement to the proposed action.	EUAA operational definition based on recital 32 of Regulation (EU) 2016/679 ([65])
Gender-based violence	An umbrella term for any harmful act that is perpetrated against a person's will and is based on socially ascribed differences (i.e. gender) between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion and denial of resources, opportunities of services, forced marriage and other deprivations of liberty. These acts can occur in public or in private.	IASC, *IASC Guidelines for Integrating GBV Interventions in Humanitarian Action*, 2015.
First-line	Reception resources, workers or facilities, which are acting or are used to provide immediate support to third-country nationals and stateless persons at the border or in transit zones or in arrival centres.	EUAA glossary of terms: IATE ID: **34985**
Guardian	A legally appointed person to act on behalf of a child, in the absence of parents, with responsibility for the custody of the child and for safeguarding the child's best interests and general well-being.	EUAA glossary of terms: IATE ID: **3591900**
Mental health literacy	The ability to recognise mental health problems and the knowledge and understanding about risk factors and causes, self-help interventions and how to seek appropriate support.	EUAA working definition used for the purpose of this guide based on A. F. Jorm, *Mental health literacy: Public knowledge and beliefs about mental disorders*, British Journal of Psychiatry, 177(5):396-401, 2000.
Mental health and psychosocial support (MHPSS)	A composite term used to describe any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder.	IASC, *Guideline Mental Health And Psychosocial Support In Emergency Settings – IASC Reference Group on Mental Health And Psychosocial Support in Emergency Settings*, 2007, p. 16.

([65]) Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data, and repealing Directive 95/46/EC (General Data Protection Regulation) (OJ L 119, 4.5.2016)

Term	Definition	Source(s)
Needs-based response	The actions taken to reduce the risk of symptoms deteriorating or to manage the symptoms. The response reflects the individual needs of the applicant by focusing on support for the applicant's physical and mental health and psychosocial support.	EUAA working definition used for the purpose of this guide
Prevention	A measure that maintains the mental health and well-being of applicants for international protection as well as providing timely relevant support to reduce the risk of deterioration of conditions.	EUAA working definition used for the purpose of this guide
Psychoeducation	Similarly to health education, it aims to learn and understand what can positively and negatively impact one's mental health and well-being and how to strengthen resiliency.	EUAA working definition used for the purpose of this guide
Post-traumatic stress disorder (PTSD)	A psychiatric disorder which arises as a delayed or protracted response to a stressful event or situation (of either brief or long duration) of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone.	European Society for Traumatic Stress Studies, ***Post-traumatic Stress Disorder***
Psychological first aid	A direct response and set of actions to help someon in distress.	IFRC, ***A Guide to Psychological First Aid***, 2018.
Reception	In the context of the Common European Asylum System, the full set of measures and processes implemented to ensure that applicants for international protection benefit from their rights in the Reception Conditions Directive, namely have an adequate standard of living, and have their material, healthcare and psychosocial needs, and any potential special reception needs and vulnerabilities, identified and addressed, from the moment of making the application until a final decision is made.	EUAA glossary of terms: IATE ID: **3591884**
Reception conditions	1. **Material reception conditions** means the reception conditions that include housing, food, clothing and **personal hygiene products** provided in kind, as financial allowances, in vouchers, or as a combination thereof, as well as a daily expenses allowance; 2. Member States shall ensure that material reception conditions **and health care received** provide an adequate standard of living for applicants, which guarantees their subsistence, protects their physical and mental health and **respects their rights under the Charter**. Member States shall ensure that the adequate standard of living referred to in the first subparagraph is met in the specific situation of applicants with special reception needs as well as in relation to the situation of persons who are in detention. 3. Reception conditions need to be adapted to the specific situation of minors and their **special reception needs**, whether unaccompanied or within families, with due regard to their security, **including security against sexual and gender-based violence,** physical and emotional care and need to be provided in a manner that encourages their general development.	1. Article 2(7) RCD (2024) 2. recital 39 RCD (2024) 3. Article 19(2) RCD (2024)

Term	Definition	Source(s)
Reception worker	A practitioner, such as social workers, education and healthcare staff, registration officers, interpreters, facility managers, administration, or coordination staff, etc. who is in direct contact with applicants for international protection in a reception context, regardless of whether their employer is a governmental or non-governmental organisation, a private contractor, or a local authority.	EUAA glossary of terms: IATE ID: 3620639
Referral	The act of directing someone to a different place or person for information, help, or action.	Cambridge English dictionary
Referral mechanism	Cooperative frameworks aimed at identifying, protecting, and assisting a vulnerable person or a person with special needs through the timely referral to the adequate support and involving relevant public authorities and civil society organisations.	EUAA glossary of terms: IATE ID: 3591886
Referral procedure	A procedure by which persons in need of international protection and persons in a vulnerable situation benefit from a referral to specialised bodies and services for adequate support.	EUAA glossary of terms: IATE ID: 3620603
Relative	In the framework of Regulation (EU) No 604/2013, the applicant's adult aunt or uncle or grandparent who is present in the territory of a Member State, regardless of whether the applicant was born in or out of wedlock or adopted as defined under national law.	Article 2(h) Regulation (EU) No 604/2013 ([66])
Representative	A person or organisation appointed by competent bodies to assist and represent an unaccompanied child in the international protection procedure, with a view to ensuring the best interests of the child and exercising legal capacity for the child where necessary.	EUAA glossary of terms: IATE ID: 3591890
Re-victimisation / secondary victimisation	When a victim suffers further harm not as a direct result of the criminal act but due to the manner in which institutions and other individuals deal with the victim. It may be caused, for instance, by repeated exposure of the victim to the perpetrator, repeated interrogation about the same facts, the use of inappropriate language or insensitive comments made by all those who come into contact with victims.	Council of Europe (2006), Recommendation Rec (2006)8 of the Committee of Ministers to member states on assistance to crime victims
Separated children	Children who have been separated from both parents, or from their previous legal or customary primary caregiver, but not necessarily from other relatives. These may, therefore, include children accompanied by other adult family members.	UN Committee on the Rights of the Child (CRC), *General comment No. 6 (2005): Treatment of Unaccompanied and Separated Children Outside their Country of Origin*, CRC/GC/2005/6, 1 September 2005; UNHCR, UNICEF, *Safe & Sound: What States can do to ensure respect for the best interests of unaccompanied and separated children in Europe*, October 2014.

([66]) Regulation (EU) 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).

Term	Definition	Source(s)
Service provider	A professional, organisation or individual who can adequately address one or more vulnerabilities or special needs identified in an applicant for international protection.	EUAA working definition used for the purpose of this guide
Sexual orientation, gender identity and expression and sex characteristics (SOGIESC)	Sexual orientation refers to each person's capacity for profound emotional, affectional and sexual attraction to, and intimate and sexual relations with, individuals of a different gender or the same gender or more than one gender. Gender identity is understood to refer to each person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth, including the personal sense of the body and other expressions of gender, including dress, speech and mannerisms. Gender expression refers to people's manifestation of their gender identity, and the one that is perceived by others. Sex characteristics refers to a person's chromosomes, anatomy, hormonal structure and reproductive organs. Persons born with sex characteristics that are either female and male at the same time or not quite female or male or neither female or male are classified as intersex, however they may identify as intersex persons, male, female, trans persons, or other.	EUAA Training Curriculum Glossary
Special procedural guarantee	A support measure put in place in order to create the conditions that allow international protection applicants with special needs to benefit from all their rights and comply with all the obligations throughout the duration of the asylum procedure.	EUAA glossary of terms: IATE ID: 3591894
Special procedural need	Individual circumstances specific to an applicant for international protection, requiring adapted support measures to ensure fairness and efficiency throughout the asylum procedure.	EUAA glossary of terms: IATE ID: 3620616
Specialised support	Support provided by a specialised professional (e.g. psychiatrist, psychotherapist, paediatrician, etc.).	EUAA working definition used for the purpose of this guide
Trafficking in human beings (THB)	The recruitment, transportation, transfer, harbouring or reception of persons, including the exchange or transfer of control over those persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation in this context includes, as a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, including begging, slavery, or practices similar to slavery, servitude, or the exploitation of criminal activities, or the removal of organs.	Article 2 Directive 2011/36/EU ([67])
Trauma	A psychological wound.	Counselling directory, 'Trauma and Traumatic Wounds', March 2013

([67]) Directive 2011/36/EU of the European Parliament and of the Council of 5 April 2011 on preventing and combating trafficking in human beings and protecting its victims (OJ L 101, 15.4.2011).

Term	Definition	Source(s)
Unaccompanied child/minor	A child/minor who arrives in the territory of the Member States unaccompanied by an adult responsible for them whether by law or by the practice of the Member State concerned, and for as long as they are not effectively taken into the care of such a person/adult. It includes a child/minor who is left unaccompanied after they have entered the territory of the Member State.	Article 2(e) Directive 2013/33/EU ([68]); Article 2(m) Directive 2013/32/EU ([69]); Article 2(l) Directive 2011/95/EU ([70]); Article 2(j) Regulation (EU) No 604/2013 ([71]); Article 2(f) Council Directive 2003/86/EC ([72]); UNHCR, UNICEF, ***Safe & Sound: What States can do to ensure respect for the best interests of unaccompanied and separated children in Europe***, October 2014, p. 22.
Vulnerability	In the context of migration and international protection, a characteristic or situation of a person or group of persons in need of special reception conditions and/or additional procedural guarantees, which may also affect their qualification for international protection.	EUAA glossary of terms: IATE ID: **3591898**
Vulnerable applicant	Applicant for international protection whose ability to understand and effectively present their case or fully participate in the asylum process, and/or capacity to benefit from reception conditions is limited due to their individual circumstances.	EUAA glossary of terms: IATE ID: **3535936**
Vulnerability assessment	A specific examination of an applicant for international protection for the purpose of identifying any need for special reception conditions and/or procedural guarantees and referring them to the appropriate authorities for adequate support.	EUAA glossary of terms: IATE ID: **3620636**

([68]) Directive 2013/33/EU of the European Parliament and of the Council of 26 June 2013 laying down standards for the reception of applicants for international protection (recast), (OJ L 180, 29.6.2013).
([69]) 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), (OJ L 180/60, 29.6.2013).
([70]) 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 (recast) (OJ L 337, 20.12.2011).
([71]) Regulation (EU) 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).
([72]) Council Directive 2003/86/EC of 22 September 2003 on the right to family reunification (OJ L 251, 3.10.2003).

Annex 2. Actions to take ([73])

A coordinating entity (team/focal person) is appointed by the relevant state institution responsible for the MHW of applicant for international protection in a given context.

- The relevant state institution appoints the entity responsible for coordinating the activities linked to the MHW of applicants.
- Announce the establishment of the coordinating entity, team or focal person to collaboration partners and other relevant interdisciplinary actors.
- Formulate MoUs / standard operating procedures to guide the coordination of all relevant actors involved in providing the MHPSS services.

The coordinating entity, team or focal person supports or initiates the development of national guidance on the MHW of applicants. The guidance is complemented by a clearly formulated and budgeted MHW action plan implemented within a certain time frame.

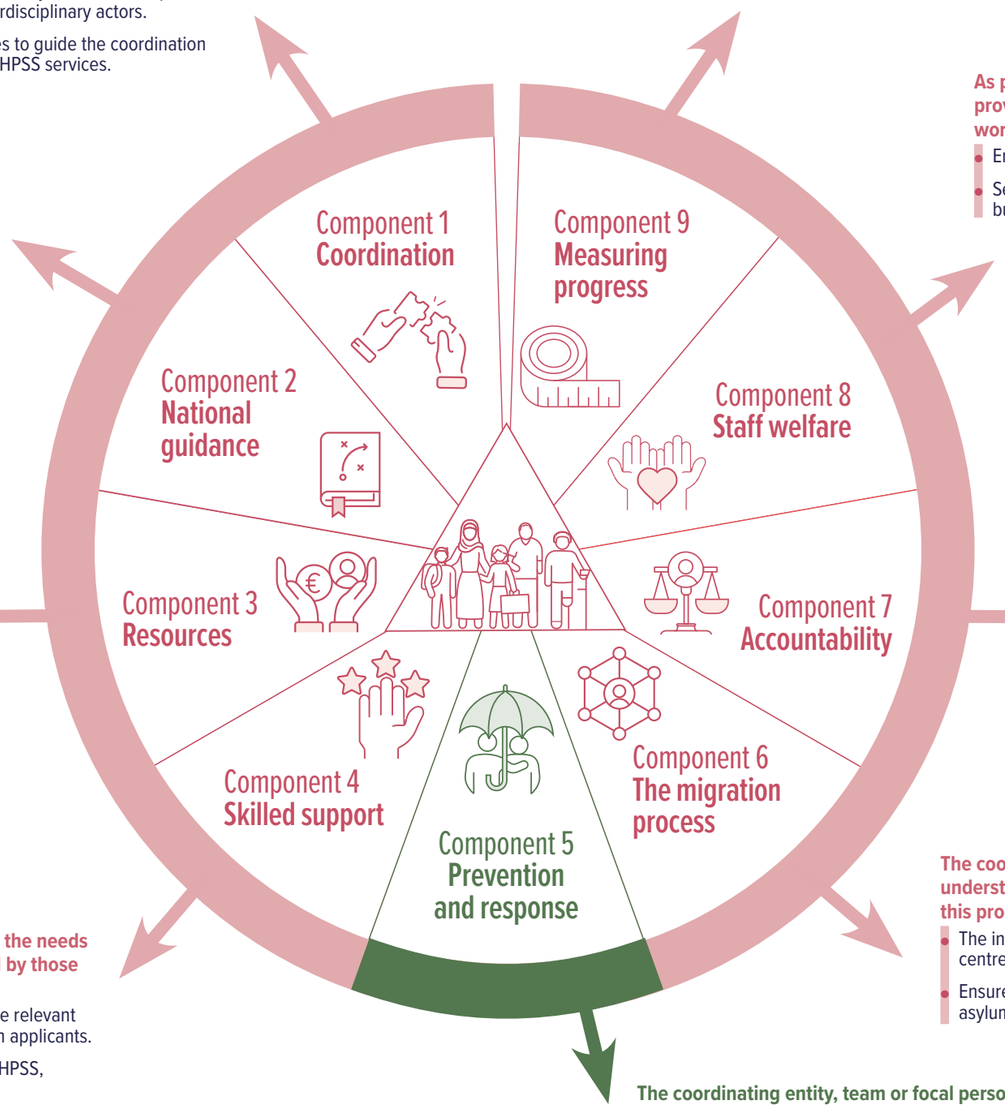
- Formulate national guidance complemented by an MHW action plan in collaboration with a multidisciplinary team of internal and/or external professionals (social workers, nurses, doctors, psychiatrists, psychologists, etc.). The MHW action plan complements any existing health and protection action plans.
- The MHW action plan considers the views of the applicant community regarding their psychosocial needs and cultural appropriateness.
- The relevant authority approves the MHW action plan.
- The national guidance lays down the importance of skilled support to implement MHPSS, which is reflected in the MHW action plan.

The coordinating entity, team or focal person puts a MHW action plan in place that includes the budget needs.

- Clearly allocate budget requirements in the MHW action plan in collaboration with the relevant financial authority.
- The budget breakdown covers the entire time frame of the MHW action plan and includes direct ([74]) and indirect ([75]) costs.

The coordinating entity, team or focal person ensures that the needs based mental health and psychosocial support is provided by those best placed to respond to the needs identified.

- Provide those working in the first line with the basic knowledge relevant for their line of work to best support in maintaining the MHW in applicants.
- Job descriptions / terms of reference require knowledge on MHPSS, cultural competency and accountability.
- Create an enabling environment that values the well-being of staff to ensure professionalism.



The coordinating entity, team or focal person ensures activities under the MHW action plan are monitored to guarantee their relevance, effectiveness and impact.

- Develop a framework to measure improved MHW in applicants.
- Feed the lessons learnt during review into an update of the MHW action plan.

As part of the duty of care, the coordinating entity, team or focal person provides a safe, supporting and enabling working environment to all those working in the first line and their managers.

- Ensure access to activities linked to staff well-being.
- Select key support (e.g. stress teams psychologist, etc. ([76])) to mitigate risks of burnout in the employees including after a critical incident.

The coordinating entity, team or focal person ensures that everyone working with applicants complies with the law, the code of conduct and other relevant policies put forward by the administration/organisation and that fundamental rights are respected. The entity stresses a zero-tolerance policy regarding sexual exploitation, harassment and abuse and pursues disciplinary measures where there is a breach of such policies.

- Ensure the code of conduct and other relevant policies (e.g. on SEAH) are accessible and all those supporting applicants, including all staff and newcomers, consultants, experts and volunteers are aware of the policies. Communicate a zero tolerance on SEAH.
- Establish a complaint mechanism connected to a response mechanism that is accessible to a diverse group of applicants from the point of arrival until integration and/or return.

The coordinating entity, team or focal person ensures that all involved understand the complexity of migration in its entirety and the impact this process might have on the applicant's MHW.

- The interventions are safe, culture-, age- and gender-appropriate and applicant-centred. They take protective and risk factors relevant to the person into account.
- Ensure that the MHPSS interventions are implemented throughout the entire asylum pathway including upon arrival at external borders.

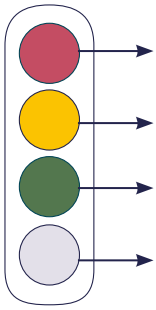
The coordinating entity, team or focal person maintains the MHW of applicants by creating opportunities for psychosocial support. Once specific mental health needs are identified, these needs are managed in a timely manner using an applicant-centred approach and access to specialised services is ensured.

- Ensure the early identification of needs and vulnerabilities of applicants no matter the context by using different means.
- Promote a community-based approach throughout the asylum/reception pathway
- Create specific spaces and/or channels with relevant partners to implement psychosocial support activities. These activities are educational, leisure and work-related and provide a sense of safety.
- Establish a functioning case management system which ensures access to specialised care to those with specific needs.
- Systematically organise the provision of basic services, community-based support interventions and specialised care as part of the MHW action plan so that these activities reinforce one another.

([73]) The proposed actions are the responsibility of the coordinating entity, team or focal person unless otherwise stated.
([74]) Such as the actual activities
([75]) Such as office space, salaries etc
([76]) EASO, *Practical guide on the welfare of asylum and reception staff – Part I: Standards and policy*, October 2021; EASO, *Practical guide on the welfare of asylum and reception staff – Part II: Staff welfare toolbox*,October 2021; EASO, *Practical guide on the welfare of asylum and reception staff – Part III: Monitoring and evaluation*, October 2021.

Annex 3. Measuring progress

The example below provides **four options** to rate progress. The traffic light approach is a simple way to easily identify those areas which might need further consideration and/or investment.



This action has not yet been considered / implemented / is still pending.

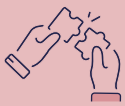
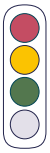
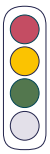
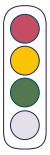
The action has partially been addressed / has started.

The action has been completed / successfully implemented / achieved as indicated in the MHW action plan.

Not sure / unclear.

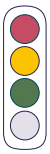
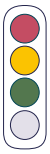
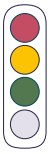
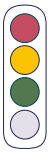
The grey colour indicates a situation where there is no clarity (yet) whether an action has been implemented or not. By using a checklist such as the example below, which will need to be adjusted to the needs and reality of the EU+ country rolling out the interventions, an overall picture will emerge on where progress has been made and which areas might need a stronger focus.

Table 4. Implementation checklist

Measuring the overall progress in establishing an asylum system informed by MHW considerations			
 **COMPONENT 1. Coordination** A coordinating entity, team or focal person is appointed by the relevant state institution responsible for the MHW of applicants for international protection.			
Action	**Indicators**	√	**Observations and comments**
1. The relevant state institution appoints the entity responsible for coordinating the activities linked to the MHW of applicants for international protection.	**1a.** An agreement is available confirming the appointed entity and describes its mandate endorsed by the relevant state institution **1.b** Terms of reference for coordinating team members are in place.		
2. Announce the establishment of the coordinating entity, team or focal person to collaboration partners and other relevant interdisciplinary actors.	**2a.** Online and printed materials are made available for internal/external use creating awareness of the benefits, roles and responsibilities of the coordinating entity, team or focal person. **2b.** Number of information sessions held, outreach activities or contacts made with the relevant interdisciplinary partners (e.g. law enforcement, health, asylum determining authorities) to explain the roles and responsibilities of the coordinating entity, team or focal person. **2c.** Percentage of stakeholders/collaboration partners who are aware of the roles and responsibilities of the coordinating entity, team or focal person.		
4. Formulate MoUs / standard operating procedures to guide the coordination of all relevant actors involved in providing the MHPSS services.	**4a.** A list of all internal/external partners to roll out MHPSS interventions including for the purpose of referral and case management is available. **4b.** Standard operating procedures / MoUs are available to frame the collaboration, including a referral mechanism.		

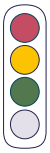
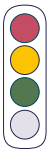
COMPONENT 2. National guidance

The coordinating entity, team or focal person supports or initiates the development of national guidance on the MHW of applicants. The guidance is complemented by a clearly formulated and budgeted MHW action plan implemented within a certain time frame.

Action	Indicators	√	Observations and comments
1. Formulate national guidance complemented by an MHW action plan in collaboration with a multidisciplinary team of internal and/or external professionals (social workers, nurses, doctors, psychiatrists, psychologists, etc.). The MHW action plan complements any existing health and protection action plans.	**1a.** A multidisciplinary team is appointed to support the development process. **1b.** National guidance and MHW action plan are available. **1c.** The MHW action plan is integrated into the overall planning of the authority.		
2. The MHW action plan considers the views of the applicant community regarding their psychosocial needs and cultural appropriateness.	**2a.** Number of focus group discussions with applicants on their psychosocial needs. **2b.** The feedback received by a diverse group of applicants is analysed and reflected in the MHW action plan.		
3. The relevant authority approves the MHW action plan.	**3a.** The MHW action plan is signed by the relevant entity.		
4. The national guidance lays down the importance of skilled support to implement MHPSS, which is reflected in the MHW action plan.	**4a.** The MHW action plan includes capacity building activities on MHPSS.		

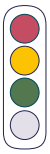
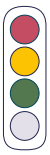
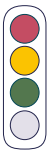
COMPONENT 3. Resources

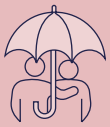
The coordinating entity, team or focal person puts a MHW action plan in place that includes the budget needs.

Action	Indicators	√	Observations and comments
1. Clearly allocate budget requirements in the MHW action plan in collaboration with the relevant financial authority.	**1a.** An MHW action plan is available with clear budget allocation.		
2. The budget breakdown covers the entire time frame of the MHW action plan and includes direct and indirect costs.	**2a.** The budget covers interventions linked to prevention and response (MHPSS) and their coordination. **2b.** The budget covers indirect costs (e.g. office space, if applicable). **2c.** The budget covers human resources needs such as the coordination/payment of specialised care. **2d.** The budget covers activities to build capacity on MHPSS.		

COMPONENT 4. Skilled support

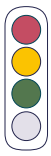
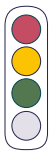
The coordinating entity, team or focal person ensures that the needs based mental health and psychosocial support is provided by those best placed to respond to the needs identified.

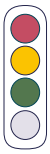
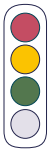
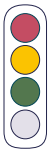
Action	Indicators	√	Observations and comments
1. Provide those working in the first line with the basic knowledge relevant for their line of work to best support in maintaining the MHW in applicants.	**1a.** The percentage of those working in the first line who participated in a needs assessment exercise on awareness of mental health literacy. **1b.** Number of awareness raising sessions conducted per asylum/reception facility on MHW. **1c.** Percentage of all officers working in the first line who attended this training. **1d.** Number of MHW topics covered (e.g. identification, cultural competency, complexity of migration, psychological first aid, importance of community-based support, case management). 2e. Tailored material on psychoeducation for those working in the first line is accessible.		
2. Job descriptions / terms of reference require knowledge on MHPSS, cultural competency and accountability.	**1a.** Internal experts have access to training to increase their knowledge on MHPSS. **1b.** External experts are vetted on their knowledge of MHPSS.		
3. Create an enabling environment that values the well-being of staff to ensure professionalism.	**3a.** Confidential staff welfare support teams or focal persons are available. **3b.** Number of technical supervision meetings / case conferences to support the processing of applicants between staff/collaboration partners. **3c.** Regular integrated meetings with line managers.		

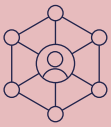


COMPONENT 5. Prevention and response

The coordinating entity, team or focal person maintains the MHW of applicants by creating opportunities for psychosocial support. Once specific mental health needs are identified, these needs are managed in a timely manner using an applicant-centred approach and access to specialised services is ensured.

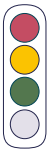
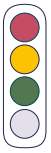
Action	Indicators	√	Observations and comments
1. Ensure the early identification of needs and vulnerabilities of applicants no matter the context by using different means.	**1a.** Share of the overall number of applicants detected as in need during a certain time frame. **1b.** Information boards display information on what MHPSS is available and how to access help at any stage (arrival, stay in reception, till integration/return) **1c.** The concept of PFA is introduced to all first contact officers		
2. Promote a community-based approach throughout the asylum/ reception pathway	**2a.** Number of community meetings held to discuss (new emerging) MHW needs and the effectiveness of interventions. **2b.** Number of psychoeducational sessions organised with applicants. **2c.** Number of applicants trained on the concept of psychological first aid and basic counselling skills. **2d.** Number of community-led psychoeducational activities.		

3. Create specific spaces and/or channels with relevant partners to implement psychosocial support activities. These activities are educational, leisure and work-related and provide a sense of safety.	**3a.** Child friendly spaces offering psychosocial support are in place in facilities hosting children. **3b.** Safe spaces for women and girls are in place. **3c.** Number of opportunities for applicants to connect with others including the host community through social and educational activities. **3d.** Partners (associations, civil society organisations) are selected according to the needs identified within the community of applicants.		
4. Establish a functioning case management system which ensures access to specialised care to those with specific needs.	**4a.** Number of psychoeducational group or individual activities organised on topics identified as important (e.g. anxiety, substance use, suicidal thoughts, etc.). **4b.** Number of applicants identified with specific needs have a case manager appointed to support. **4c.** Number of applicants with identified mental health concerns/conditions take part in community-based activities. **4d.** Number of applicants with identified mental health concerns/conditions report a reduction of symptoms over a given time period during or after during care.		
5. Systematically organise the provision of basic services, community-based support interventions and specialised care as part of the MHW action plan so that these activities reinforce one another.	**5a.** The MHW action plan integrates activities linked to basic services delivery, community-based support provision, focused and specialised care.		



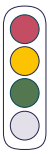
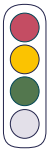
COMPONENT 6. The migration process

The coordinating entity, team or focal person ensures that all involved understand the complexity of migration in its entirety and the impact this process might have on the applicant's MHW.

Action	Indicators	✓	Observations and comments
1. The interventions are safe, culture-, age- and gender-appropriate and applicant-centred. They take protective and risk factors relevant to the person into account.	**1a.** Number of information sessions for first-line officers on understanding the complexity of the migration process, risk and protective factors and consequently the psychological needs of applicants.		
2. Ensure that the MHPSS interventions are implemented throughout the entire asylum pathway including upon arrival at external borders.	**2a.** Availability of skilled support at the external borders and/or initial arrival centre including on psychological first aid. **2b.** Information material accessible in different formats/ languages on interventions to expect as part of the procedure and how to access health, mental healthcare. **2c.** Number of special needs and vulnerability assessments conducted. **2d.** Number of referrals of applicants identified as in need (vulnerable/with specific needs).		

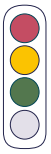
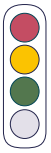
COMPONENT 7. Accountability

The coordinating entity, team or focal person ensures that everyone working with applicants complies with the law, the code of conduct and other relevant policies put forward by the administration/organisation and that fundamental rights are respected. The entity stresses a zero-tolerance policy regarding sexual exploitation, harassment and abuse and pursues disciplinary measures where there is a breach of such policies.

Action	Indicators	√	Observations and comments
1. Ensure the code of conduct and other relevant policies (e.g. on SEAH) are accessible and all those supporting applicants, including all staff and newcomers, consultants, experts and volunteers are aware of the policies. Communicate a zero tolerance on SEAH.	**1a.** Number of awareness-raising session to applicants on the Complaint mechanism **1b.** Number of employees (including consultants, volunteers, etc.) who have attended (an) awareness-raising session(s) **1c.** Number of employees who sign the code of conduct and other relevant policies.		
2. Establish a complaint mechanism connected to a response mechanism that is accessible to a diverse group of applicants from the point of arrival until integration and/or return.	**2a.** All reception facilities are equipped with complaints mechanisms in different formats to allow for meaningful responses from a diverse group of complainants. **2b.** Applicants are regularly informed on how to access the complaints mechanism and what can be reported. **2c.** Reports on complaints received and how they were solved are available and accessible and used by the relevant authorities for learning and preventing further incidents.		

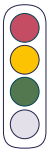
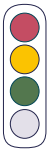
COMPONENT 8. Staff welfare

As part of the duty of care, the coordinating entity, team or focal person provides a safe, supporting and enabling working environment to all those working in the first line and their managers.

Action	Indicators	√	Observations and comments
1. Ensure access to activities linked to staff well-being.	**1a.** Individual and group support is available to those working in the first line (such as case conferences, counselling, etc.) **1b.** Share of staff members out of all staff who take part in staff welfare services		
2. Select key support (e.g. stress teams, psychologist, etc.) to mitigate risks of burnout in the employees including after a critical incident.	**2a.** A team providing support during a crisis (e.g. critical incidents) is in place. **2b.** Share of staff who have accessed this crisis team over a certain period. **2c.** Number of staff as a share of all relevant staff enrolled in staff welfare support activities.		

COMPONENT 9. Measuring progress

The coordinating entity, team or focal person ensures activities under the MHW action plan are monitored to guarantee their relevance, effectiveness and impact.

Action	Indicators	√	Observations and comments
1. Develop a framework to measure improved MHW in applicants.	**1c.** Tools or interventions (feedback) are available to measure a potential change in the well-being in applicants over a certain period. **1b.** A focal person(s)/team to document is selected. **1c.** Feedback from applicants of their increased ability to cope with psychological distress after participating in MHPSS is collected anonymously.		
2. Feed the lessons learnt during review into an update of the MHW action plan.	**2a.** Briefs (per year) held to senior management of the coordinating entity recommending adjustments to MHW interventions.		

Annex 4. Resources for building capacity on mental health and psychosocial support

Training, coaching and capacity building	
Topic	**Brief description of the resource and reference**
Interviewing vulnerable persons	The EUAA, *Interviewing Vulnerable Persons* module provides insight to first contact officers on how to engage with applicants with vulnerabilities and specific needs.
Conflict management	The EUAA, *Conflict management and mediation in reception – level A* module. The EUAA *Conflict management and mediation in reception – level B* module is under development and will be launched in 2024/2025.
Mental health, stress and trauma	The *Post-traumatic integration (PTI) e-Platform* is a training environment that provides access to a wide range of materials focused on supporting the continuing professional development of refugee educators and youth workers to deal with an increasing number of refugees/applicants with a variety of psychological, emotional and behavioural difficulties. This project is co-funded by the EU Erasmus+ Programme.
	The EUAA *Reception of Vulnerable persons: identification of vulnerability and provision of initial support, (Block A)* module is running in the 'old' version. The restructured version 2.0 will be launched soon. The EUAA *Reception of Vulnerable persons: assessment and design of interventions (Block B)* module is running in the 'old' version. The restructured version 2.0 will be launched soon. Further EUAA training modules on health, safety and security will be launched in 2025.
	Karolinska Institute, Sweden runs a training course aimed at people in the humanity professions, for example, staff in social services, schools, police, prison service and fire department, individual and family members, disability and elderly care, ambulance staff, district nurses and the voluntary sector and the public. The training requires in-person presence and attendance against payment. The focus is on *Mental Health First Aid* (MHFA).
Mental health and psychosocial support	The IOM runs a course at the ecampus that aims to facilitate MHPSS managers and experts involved in designing, implementing, monitoring and evaluating community-based MHPSS programmes, projects and activities in contexts impacted by emergencies and displacement within humanitarian responses. The course is online available and free of charge. IOM, *Community-Based Mental Health and Psychosocial Support in Emergencies and Displacement.* WHO runs an online orientation course to strengthen the competencies of health sector actors working in emergencies to establish, support and scale up MHPSS in countries. WHO, *Introducing mental health and psychosocial support in emergencies.* The IASC has an MHPSS minimum Service Package website which has consolidated all MHPSS guidance and checklists. Refer in particular to the section 4.2. on *MHPSS for persons deprived of their liberty*. The EUAA training module on health, safety and security in reception is forthcoming.

Psychological first aid	Kaya is the global learning platform of the Humanitarian Leadership Academy. Refer to the website of the Humanitarian Leadership Academy which is available here: https://www.humanitarianleadershipacademy.org/ EUAA animation on psychological first aid accompanied by instructions on how to use the animation. The animation aims to introduce psychological first aid to professionals including new staff and/or volunteers and the applicant community. EUAA, 'Psychological First Aid Video', YouTube, 2023 and the accompanying instructions.
Cultural competency	This book aims to assists mental health professionals in gaining a better understanding of the factors that may influence their interventions on the ground. It provides recommendations for the improvement and enrichment of services provided to persons from different ethnic and cultural backgrounds. Refer to: Delia Saldaña, Ph.D., 'Cultural Competence: A practical guide for mental health professionals', *Hogg Foundation for Mental Health*, 2010 available in English and Greek.
Ethics and integrity	The introductory EUAA, ***Introduction to ethical and professional standards*** module
Staff welfare and care and safeguarding related topics	Kaya is the global learning platform of the Humanitarian Leadership Academy. Refer to the Humanitarian Leadership academy DisasterReady was launched in 2013 with a simple but powerful mission: to better prepare humanitarian and development professionals for the critical work they do by providing high-quality, relevant online learning resources at no cost, including on: ***staff care and safeguarding***. The introductory EUAA ***Professional well-being*** module targets Asylum and Reception practitioners.
Introduction to vulnerability	The EUAA ***Introduction to vulnerability*** covers all types of vulnerability and contains a part on mental health.
Monitoring and evaluation of MHPSS	The IASC tool to support the common monitoring and evaluation framework for mental health and psychosocial support in emergency settings. Refer to the IASC, ***Guidance on mental health and psychosocial support in emergencies, evaluation and monitoring – monitoring and evaluation with means of verification: version 2.0***, September 2021.
Introduction to gender-based violence	The purpose of the IASC online training: Guidelines for Integrating Gender-based Violence Interventions in Humanitarian Action is, which is available on their website: https://gbvguidelines.org/en/capacity-building/iasc-gbv-guidelines-introduction/, is to introduce the guidance to those working in the first line and those wanting to know more to ensure a smooth roll out.
Preventing self-harm/suicide	The Pan American Health Organisation (PHAO) and their virtual campus for public health provides opportunities to strengthen capacity on the topic of self-harm and suicide with the aim to empower primary healthcare providers. The training named: ***Preventing Self-harm/suicide: Empowering Primary Health Care providers***, creates awareness on the topic of suicide prevention.
Substance use	The Flemish Centre of expertise on Alcohol and other drugs offers several online training courses and education on alcohol, illegal drugs, psychoactive medication, gambling and gaming.
Sexual orientation, gender identity and expression and sex characteristics	The EUAA ***applicants with divers Sexual orientation, gender identity and expression and sex characteristics*** module supports Asylum and Reception practitioners to be more aware of the needs of such applicants and how to support.
Trafficking in human beings	The EUAA ***Trafficking in Human Beings module*** prepare officers who come in contact with victims or potential victims of human trafficking with the knowledge and skills required to detect and handle signs of human trafficking and to prepare and conduct a personal interview with a victim or potential victim of human trafficking.

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