Practical Guide Series

Mental Health and Well-being of Applicants for International Protection

euaa
EUROPEAN UNION AGENCY FOR ASYLUM

PART 2

FOR THOSE WORKING IN THE FIRST LINE

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 II. Practical guide for implementing mental health and psychosocial support – for officers working in the first line

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]) 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; EASO, '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 second part of the guide?

This part targets **team leaders**, **coordinators** and **officers working in the first line** who provide mental health and psychosocial support in their respective context. The guide can also inform the work of **policymakers** working on integrating MHW as part of the support provision to applicants for international protection.

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 ([3]) 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 ([4]) 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.

([3]) EUAA, *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*, 2024.
([4]) EUAA, *Mental Health and Well-being of Applicants for International Protection – Part III. Toolbox supporting the implementation of mental health and psychosocial support*, 2024.

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
AI	artificial intelligence
APR	asylum procedure regulation – 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
EU+ countries	Member States of the European Union and the Schengen associated countries
EUAA	European Union Agency for Asylum
EUDA	European Union Drugs Agency
Fedasil	Agence fédérale pour l'accueil des demandeurs d'asile (the federal reception authority, Belgium)
GBV	gender-based violence
IASC	Inter-Agency Standing Committee
IFRC	International Federation of the Red Cross
IOM	International Organization for Migration
LGBTIQ	lesbian, gay, bisexual, intersex and queer
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
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
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 ([5]).'

Therefore, an **initial investment** by senior management in basic but holistic support provision requires focus on:

- selected **community-based interventions** for all applicants from the moment of arrival; and
- **focused and specialised care** to those in immediate need.
- Such an approach helps to avoid a crisis in the longer term. This is the focus of this part of the guidance.

A **multi- and interdisciplinary approach** 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 strengthen resilience. Such an approach will benefit those entering EU+ countries but also applicants awaiting the decision on their application, integrating into host communities or awaiting return. Reception and determining authorities and those working in the first line and partners also benefit from **a coordinated approach**. This approach ensures streamlined collaboration and communication, meaning goals set by an administration on mental health and well-being can be more efficiently met.

Lastly, those working in the first line can be affected by the stories and experiences shared by the applicants they work with. **Secondary** or **vicarious trauma** can occur in those working in the first line with applicants who might share their personal and traumatic accounts with them. The description of such disruptive or traumatic events and the continued exposure to this for those providing support over longer time periods can have an impact on the mental health and well-being of such officers. A robust staff welfare policy ([6]) and support package to avoid the risk of secondary trauma and/or burnout of employees working in the first line is therefore important.For more on terminology, refer to the glossary in Part I – Senior management.

The right to health is universal ([7]). This means that applicants have the right to be enabled to lead a healthy life, which consequently can support meaningful integration into the host community and allows them to contribute economically and socially. The same considerations apply when applicants are scheduled for return.

The **European Commission highlighted** the right to health for all in a communication on a comprehensive approach to mental health ([8]), which more generally discusses the **importance of awareness** that **better mental health** is both a **social and an economic imperative**.

The coinciding or accumulation of stressors throughout the entire migration process and all its critical stages can have a grave effect on the MHW of applicants. The critical stages include pre-departure, displacement, journey, post arrival and stay in the host country(ies), integration or return. These critical stages can influence and affect the protective and risk factors an applicant is exposed to. These stressors can compound the psychological effect of any disruptive or traumatic events pre-departure or in-transit.

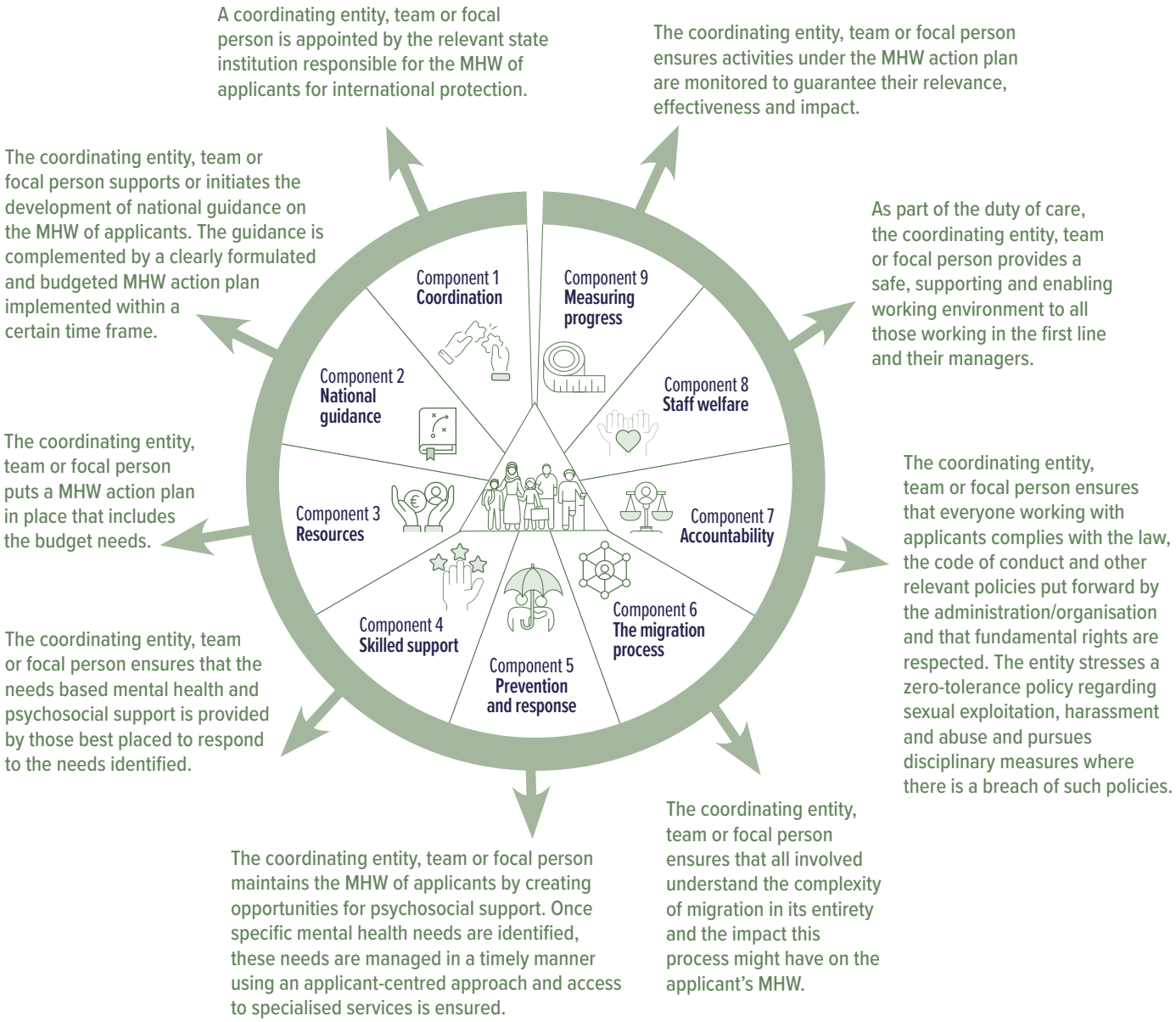
It is thus crucial to consider the **individual factors** and **social determinants**, such as the applicant's connectedness with family and community, safe accommodation or their economic situation and education. All these factors can affect health outcomes both positively and negatively.

([5]) World Health Organization (WHO), *Constitution of the World Health Organization*, p. 1, entered into force 1948.
([6]) Refer also to the EUAA's three-fold guidance on staff welfare: 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.
([7]) For more information refer to Office of the United Nations High Commissioner for Human Rights and WHO, *The Right to Health – Factsheet 31*, June 2008; UN Economic and Social Council, *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12)*, August 2000, which refers to accessibility, availability, acceptability and the quality of services.
([8]) European Commission, *A communication on a comprehensive approach to mental health,* June 2023.

About this guidance

Integrating the MHW of applicants into the asylum and reception system should be an integral part of a **national strategy** on health and mental health, where possible. It is most sustainable when implemented with the involvement of interdisciplinary actors. The overall framework proposed in Part I – Senior management to shape an MHW-informed asylum system as established is composed of **nine equally important interlinked components**.

Figure 1. At a glance: the nine components that shape an MHW-informed asylum system



Source: the EUAA

This part of the three-fold *EUAA Guidance on Mental Health and Well-being of Applicants for International Protection* provides officers working in the first line and their line managers particularly with suggestions on **what** and **how** to implement prevention activities and what needs-based response can be of benefit.

The proposals in this part complement the programming recommendations and suggestions made by other important actors in the field of international protection and particularly the guidelines on MHPSS by the Inter-Agency Standing Committee (IASC) ([9]).

Structure of this guidance

In each of the five chapters in this part, you will find a brief explanation on **what, when, why, where** and **how** the interventions and/or concepts can be implemented. This information is complemented by **promising practices** from 15 EU+ countries ([10]) which might be particularly interesting for those countries that wish to add relevant interventions into their existing mental health action plans.

This guide does **not** suggest replacing mechanisms already in place that are supporting applicants in relation to their health, mental health and overall well-being. Instead, this part complements existing efforts and provides additional ideas.

This part provides links to additional tools such as checklists to facilitate the implementation of MHPSS. These tools can be found in Part III – Toolbox.

Target group

The **target group** of this part includes (a) **officers working in the first line** who are in direct contact with applicants and (b) **specialists** implementing MHPSS activities including team leaders and coordinators of these interventions. The guide in particular targets the authorities responsible for the reception of applicants. This is the case because in many EU+ countries these are the authorities responsible for the roll out and implementation of the prevention and response activities. These authorities often implement these activities in collaboration with other actors such as civil society organisation.

However, the MHW of applicants needs to be considered during all critical stages of the asylum and reception pathway, from the point of arrival, during stay in reception up to integration and/or preparation for return. Therefore, ensure coordination and collaboration with different actors, particularly the health sector, as well as those responsible for registering applicants upon arrival at the EU external borders. This should be ensured throughout the entire asylum pathway for an effective approach to maintain the MHW of applicants.

([9]) IASC, *Guidelines on Mental health and Psychosocial Support in Emergency Settings*, 2007.
([10]) Austria, Belgium, Czech Republic, Finland, France, Greece, Germany, Hungary, Italy, Luxembourg, the Netherlands, Romania, Spain, Sweden, Switzerland in this part (16 in total). For more information from Finland, refer to Part I – Senior management).

Staff welfare

Working in the field of asylum and reception requires flexibility due to an oft-changing work context. Being able to handle a large workload and the ability to cope with difficult working conditions, including working with a population under high psychological distress, can be challenging. Team coordinators are therefore advised to put measures in place to ensure the **welfare of staff** ([11]).

Caring for those working in the first line can also include providing opportunities to attend various **training** sessions. Relevant topics include how to recognise signs of distress in oneself and others or how to de-escalate and handle a critical incident as effectively as possible. When a first-line officer finds themselves confronted with an applicant who is aggressive, agitated, or ready to engage in self-harm or suicide, employing de-escalation techniques can help ensure the safety of all involved. For more information on **staff welfare** related issues, refer to Part I – Senior management, Section '**Component 8.** Staff welfare'.

Mental health and well-being and related terminology

In the context of this guidance, **mental health** is understood to be an **integral part of health**. The term **well-being** is broader and interlinked with physical and mental health. It also depends also on factors such as the family set-up, the way a person is socialised and educated and their value system.

Psychological distress can be caused by different events and challenging life situations. Persistent stress such as a chronic medical condition, certain life events such as loss of a loved one and the neglect of emotional needs of a child by a parent can contribute to psychological stress. Similarly, prolonged and repeated exposure to disruptive and traumatic events such as sexual violence, political insecurity, war, conflict, violence, torture, detention, discrimination and abuse – which are experienced by many applicants in the context of asylum and are often experiences embedded in long-term poverty – can further contribute to psychological distress.

More generally, stress can trigger certain reactions in people. In the context of asylum, a person might react in a way that could be misunderstood by some as presenting with a psychiatric disorder. For example, applicants might develop symptoms which appear similar to those found in people suffering from depression. Their stress reaction however might simply be linked to the current circumstances in which they find themselves (e.g. densely populated quarters and poor living conditions). When not addressed, this accumulation of stress can lead to mental health disorders.

([11]) Refer also to the EUAA's three-fold guidance on staff welfare: 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.

Trauma ([12]) can be understood as a **psychological wound** and the result of persistent stress that has not been sufficiently addressed. It often comes with a sense of being overwhelmed or a feeling that a situation is bigger than the person can manage by themselves. Such events are often also experienced as life-threatening. People feel that they no longer have control in the moment.

Many applicants show remarkable resilience and manage to cope with the negative events they have witnessed, experienced and the post-arrival stressors they face. Always keep in mind that different people experience the same events with **various levels of psychological distress** – this is due to resilience and pre-dispositions, perceived support (including psychosocial), locus of control and similar.

Simply put, **resilience** is the ability to '**bounce back**'. It is 'the process and outcome of successfully adapting to difficult or challenging life experiences, especially through mental, emotional, and behavioral flexibility and adjustment to external and internal demands' ([13]). No matter the applicant's condition, it is important to support them as soon as possible to encourage them to realise their **own strength**. A broader continuum of care that promotes overall well-being is important. This guidance thus promotes an **integrated approach** to MHW and covers both interventions linked to **prevention** and needs-based **responses**.

([12]) Trauma comes from the Greek word 'wound'. Psychologist Renos Papadopoulos suggests that the word trauma could relate to what is left (e.g. memories) but also to what remains: Papadopoulos, R. K., 'Involuntary Dislocation: Home, trauma, resilience, and adversity-activated development', 1st edition, Routledge, 2021; refer also to EUAA, *Mental Health and Well-being of Applicants for International Protection – Part III. Toolbox supporting the implementation of mental health and psychosocial support*, 2024, Section 'Understanding Trauma'.

([13]) American Psychological Association, 'Resilience', APA website, accessed 12 August 2024.

Integrating the mental health and well-being of applicants into daily operations

Supporting the mental health and well-being of applicants is most effective once applicants in need of support receive **initial basic care** and support through a **human encounter** and are **timely identified**. Targeted activities such as a medical and vulnerability check (e.g. during initial screening activities) supported by follow up assessments can support identification. It is important to nurture MHW and to organise activities systematically.

'It is not good enough to just tell us that we are stressed. We want to be listened to and we want to get means to manage stress, techniques which help us get the worrisome and negative thoughts out of our heads – an applicant that participated in an EUAA consultation on the topic of MHW.'

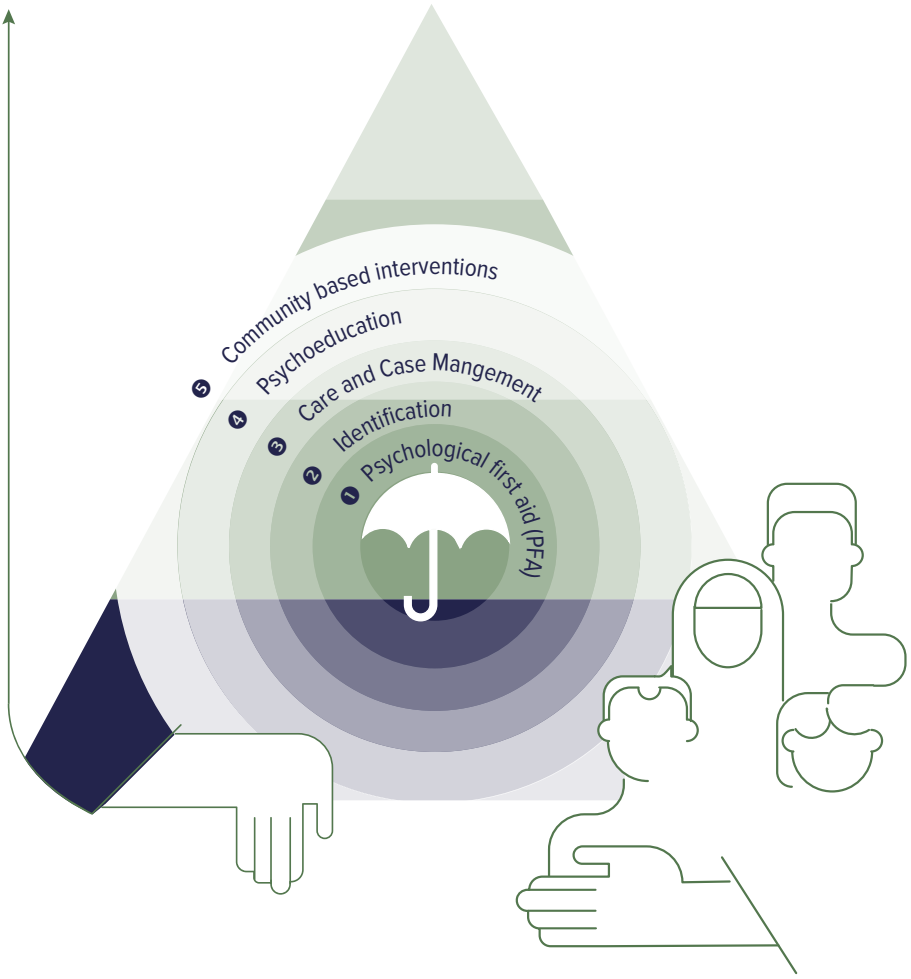
This can be done by rolling out psychological first aid (PFA) throughout the asylum and reception pathway, strengthening the mental health literacy of applicants through psychoeducation, involving applicants in the decisions affecting them, creating space for community-based interventions and ensuring access to care and case management for those with more serious conditions.

Once such activities are integrated as part of an MHW action plan, and where the activities are organised in a way that **complement and reinforce** one another, they can nurture self-disclosure, help in the early identification of concerns and avoid the risks of longer term or more complex conditions developing.

The Mental Health and Psychosocial Support (MHPSS) pyramid ([14]) and the four intervention levels introduced by the IASC have been taken into consideration within the interventions proposed as part of this guidance.

([14]) IASC, *Guidelines on Mental health and Psychosocial Support in Emergency Settings*, 2007, Figure 1, p. 12.

Figure 2. Five focus areas to promote an integrated approach to MHW of applicants



Source: the EUAA, adjusted from the IASC, *Guidelines on Mental health and Psychosocial Support in Emergency Settings*, 2007, p. 12 and UNICEF, *Understanding Community based MHPSS in humanitarian settings*, 2018, p. 15.

In summary, the systematic and efficient implementation of the five interventions on levels 1 and 2 will reduce the need for focused and specialised care (levels 3 and 4) for most applicants. Lastly, **psychological first aid** is a cross-cutting concept; **identification** of applicants in need is an ongoing effort and can apply to all levels of the MHPSS pyramid; **care and case management** corresponds to all levels of the MHPSS pyramid; **psychoeducation** is important throughout all four levels of the MHPSS pyramid; and **community-based interventions** are important in view of the prevention of concerns (levels 1 and 2) but can also be vital to support the treatment and recovery process (levels 3 and 4).

Considerations on age, gender and diversity

Before rolling out any of the MHPSS interventions proposed as part of this guidance, it is vital to consider the age, gender and diversity ([15]) of applicants and link these considerations with the imperatives of promoting gender equality, particularly empowering women and girls, and promoting the best interests of the child. 'Each person is unique. The differences between people, whether actual or perceived, can be defining characteristics that play a central role in determining an individual's opportunities, capacities, needs and vulnerability.' ([16]) Past and current violent and stressful experiences in applicants may 'have an impact on not only the individual, but also their family and more widely on communities and on society' ([17]).

Family relations might be affected by a change in behaviour of a family member. Parents might have lost the ability to provide a regular income to support their family (including those left behind), which can be exacerbated by hardship experienced in relation to finding paid work in the country of asylum. Investing therefore in activities which strengthen family unity, positive parenting and income generating activities can be important.

Gender roles often differ between the country of origin and the host country, which can have an influence on applicants' social expectations and ability to adapt and cope with these differences, which can be nurtured and supported by providing platforms for exchange at an early stage on values and laws to be followed in this regard. Gender roles are often challenged when the head of the family (often conceived as being male) is no longer able to support the family financially, resulting in women taking on this role and often becoming the sole breadwinners, which can create tension within families.

Children are at times forced to pick up **parenting roles**, such as taking care of younger siblings and supporting with other domestic chores. There are situations where children are asked to support their parents as interpreters, since they are often the only ones in the family able to communicate in the local language due to having been enrolled in school in the host country. This can bring them into situations where their parents ask them to interpret for them when relaying their experiences to services providers. This content may not be appropriate for the child to hear due to their age. While children are inherently resilient, their ability to cope will depend on the length of exposure to challenging situations and experiences of violence, the intensity of such experiences and the presence of an empathic support system in the host country.

Traumatic experiences such as **sexual violence** in the country of origin, during transit or in the host country have a serious impact on an individual no matter their age or gender. **Men** who are victims of sexual violence or sexual exploitation seem to struggle differently to women. Men often consider themselves not as victims but simply as weak or 'not man enough' to prevent the violence perpetrated against them. This can have a tremendous negative impact on their physical and mental state. Sexual violence in men can also lead

([15]) UNHCR, Age, Gender and Diversity Policy, 8 June 2011.
(16) UNHCR, *Age, Gender and Diversity Policy*, 8 June 2011, p.1.
([17]) Payne-James, J., Beynon, J., & Vieira, D. (Eds.), *Monitoring Detention, Custody, Torture and Ill-treatment: A Practical Approach to Prevention and Documentation*, 1st ed., CRC Press. 2017, https://doi.org/10.1201/9781315211459

to struggles with their sexual identity or lead to poor libido ([18]). Men seem even more likely to avoid airing experience of sexual violence, due to their strong feeling of guilt and shame and a culture or religion that does not encourage an open discourse around emotions, fear or general anxiety among men ([19]).

Women, on the other hand, are often confronted not only with the psychological impact of such violence and abuse but the cultural implication of having lost their virginity, the physical consequences such as unwanted pregnancy or no longer being able to get pregnant, or other negative affects related to their reproductive health. The **impact of dealing with sexually transmitted diseases is relevant for both men and women.** Applicants with **diverse sexual orientations, gender identities, gender expressions and sex characteristics (SOGIESC)** (20) might have faced threats and discrimination back home and might also now face them within the host community and reception facility where they are accommodated. A better understanding among those supporting in the first line on the ways applicants were socialised and educated back home depending on their gender – and how they therefore deal with trauma, loss, distress, and frustration – is important.

Family expectations of those who have been sent to Europe, which are often **young**, **single men**, can put severe pressure on these men on different levels (financial, emotional). The preparation for sending a family member on such a journey with the hope of them supporting those left behind is often tied to collecting excessive amounts of money by the family for months and even years pre-departure and paid to networks that claim to ensure a safe journey. Too often the networks arranging the journey however are part of criminal networks linked to smugglers and traffickers, who, in cases of loans to be repaid, put pressure on the person who has reached Europe and the family back home.

Given that Europe receives many young single men, targeted support to enable those to adapt to their **socialised concepts of masculinity** for example, which often relate to a sense of honour and patriarchal beliefs, can help to better integrate them in the daily routines of reception centres. These young, single men at times might also **feel disconnected from community life** since they are often placed separately or are not as well targeted by the activities run by the administration since they are not considered vulnerable. Therefore, supporting interactions with community members for this group should be an emphasis.

Furthermore, **unaccompanied children**, primarily teenage boys, also form part of this group of people being sent to Europe. Among this group are also girls who might be exposed to different types of exploitation and abuse. **Peer pressure** to engage in activities that might be criminal is commonplace, particularly among male youths, who may see such activities as a means to generate an income. It is therefore crucial to provide a relatively ordinary life early on (accessing education, being involved in play with

([18]) Kiss, L., Quinlan-Davidson, M., Pasquero, L. et al. '*Male and LGBT survivors of sexual violence in conflict situations: a realist review of health interventions in low-and middle-income countries*', Confl Health 14, 11 , 26 February 2020.
([19]) The Humanium, '*Bacha Bazi – severe child abuse disguised as an Afghani custom*', 13 September 2022. It describes an Afghan tradition which has become distorted to now involve slavery and sexual abuse, in clear violation of the rights of children.
([20]) EUAA, *Practical guide on applicants with diverse sexual orientations, gender identities, gender expressions and sex characteristics – Reception*, 2024.

peers, access to leisure activities) to all applicants and particularly unaccompanied and separated children ([21]), to ease tension and strengthen resilience.

Investing in family reunification will be important, taking the best interests of the child into account. In addition, appoint a legal guardian to the children who have arrived without a caregiver ([22]) to ensure that their best interests are considered throughout the process. This is particularly important for those nearing the age of maturity as this caregiver can support in ensuring a relatively smooth transition into adulthood.
Ensuring that applicants living with a form of **disability** (e.g. those living with physical, psychological, cognitive, or hearing impairments ([23])) are provided with access to care and an appropriate opportunity to share their needs is important. This is particularly the case since this group might not have the means or capability to react quickly and reach out and ask for help due to their condition. This can make them vulnerable to violence, abuse and exploitation and should not be underestimated ([24]).

The **elderly** and their needs are also often overlooked in the context of asylum but are very important to consider. They might have seen their children die back home or on their way and might now be on their own or caring for grandchildren. They might be cognitively, physically, and emotionally affected by past experiences as well as age and might struggle with the adaptation to a new culture or language. Identifying those with specific needs, particularly those who arrived with dependants, is crucial. Keep in mind the different critical stages and the complexity of the migration process throughout your work. Ensure protective measures are in place throughout the asylum and reception pathway to allow for a comprehensive and meaningful services provision.

Refer to **Part I – Senior management**, Section ‘Component 6. The migration process’.

([21]) See a report from Belgium by K. Fournier, K. van Acker, D. Geldof, A. Heyerick, ‘Etre enfant en centre d’accueil’, 2023 (in French), which focuses on applicant children and families and how to support them their MHW.
([22]) For more information on how to support children in reception, refer to this policy brief by K. Fournier, K. van Acker, D. Geldof, ‘Strengthening Opportunities for Accompanied Children in Reception Centres’, 2022.
([23]) See guidance developed by Fedasil (the federal reception authority, Belgium), Doof Vlaanderenand and Fédération Francophone des Sourds de Belgique, *Guide – Accompagnement des demandeurs sourds & malentendants*, January 2022. The guidance is only available in French and covers general information about applicants living with hearing loss and the forms of communication used by such applicants. The guidance also provides practical and concrete information on the obstacles that these applicants may encounter during their journey, information on the use of interpreters and recommendations with which one can facilitate the interaction; *EUAA, Persons with disabilities in Asylum and Reception Systems*, 2024.
([24]) Global Protection Cluster, Gender-based Violence AoR, ‘Gender-based violence and disability inclusion fact sheet’, 2023.

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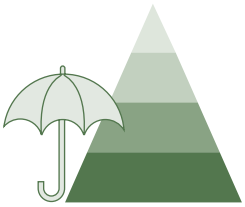
Psychological first aid



What is psychological first aid?

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. Anyone can provide PFA ([25]) at any stage, granted some basic training on how to read the signs of psychological distress has been provided.

Overall, **PFA** aims to identify and respond to people who find themselves in distress as soon as possible and guarantee their safety, promote calm, try to comfort them as much as possible in the given situation, check in with them and see what needs they may have to link them with relevant follow-up services.

([25]) IFRC Reference Centre for Psychosocial Support, *A guide to psychological first aid for Red Cross and Red Crescent Societies*, Copenhagen, 2018.

Table 1. Psychological first aid in a nutshell

PFA is...	PFA is not...
Providing non-intrusive, practical care and support	Something that only professionals can do
Assessing needs and concerns	Psychosocial counseling or psychotherapy
Helping people to address basic needs (food, shelter, medical treatment, information)	A detailed discussion of the event that caused the distress
Listening to people, but not pressuring them to talk	Asking someone to analyze what happened to them or to put time and events in order
Comforting people and helping them to feel calm	About pressuring people to tell you their feelings and reactions to an event
Helping people connect to information, services and social supports	Having all of the answers to questions or being able to provide all of the things someone needs

Source: Signpost, 'Psychological First Aid (PFA)', Signpost Global website, updated January 2024.

Why is psychological first aid useful?

PFA is a means of caring for those in need. PFA is a stepped process that simply organises basic, innate, helping skills. Particularly upon arrival, some initial feelings of being overwhelmed can be reduced by a kind gesture or word, some basic information on where to go and who to ask for help depending on the need, clarification on what will happen next and the simple acknowledgement that things are not always easy. Such a very basic, human approach can have a great positive impact and provides a feeling of being acknowledged as a fellow human being and taken seriously. PFA provides exactly that.

Applicants can do better over the long term if they:

- regain a sense of control by being able to help themselves;
- have access to social, physical and emotional support;
- feel safe, connected to others, calm and hopeful ([26]).

All the above can be facilitated by the implementation of PFA.

([26]) IFRC Reference Centre for Psychosocial Support, *A guide to psychological first aid for Red Cross and Red Crescent Societies*, Copenhagen, 2018.

When is psychological first aid best provided?

PFA aims 'at helping people who have been very recently affected by a crisis event'. PFA is therefore best implemented at first contact with people in severe distress. 'This is usually during or immediately after a disruptive event. However, it may sometimes be days or weeks after, depending on how long the event lasted and how severe it was' ([27]). Looking at the situation in Europe where applicants arrive and are often transferred from one location to another (e.g. from islands to the mainland), PFA can be seen to be of benefit at every step of the moves organised.

Who can benefit from psychological first aid?

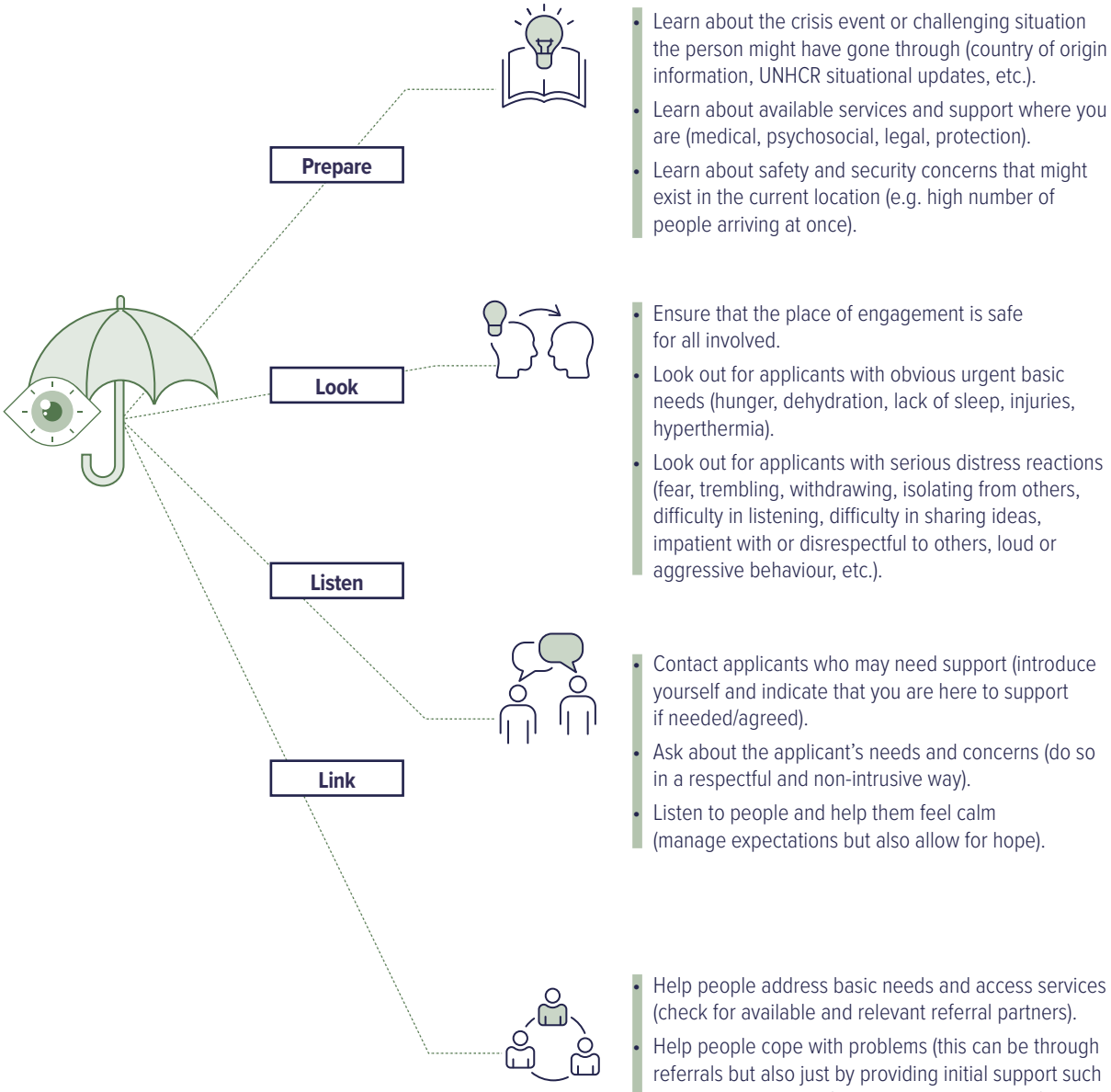
PFA is for 'people who have been recently exposed to a serious crisis event' and find themselves in severe distress. Both children and adults can benefit from this intervention. 'However, not everyone who experiences a crisis event will need or want PFA. Help should not be forced on people who resist it but those providing PFA should make themselves readily available to those who may want support ([28]).

How to roll out psychological first aid interventions and who to target

PFA is a set of helping skills that can be provided by professionals and volunteers with some basic training. When used in the humanitarian sector, there are four main steps: prepare, look, listen and link. In brief, these steps capture the importance of **observation** to identify those in need. It ensures **empathy**, by kindly and carefully **listening** so as to be able to **refer or link** the person to appropriate and **relevant follow-up** based on the main needs and potential vulnerabilities identified (e.g. finding family, getting medical attention).

([27]) WHO, *Psychological First Aid: Guide for field workers*, 2011, p.5.
([28]) WHO, *Psychological First Aid: Guide for field workers*, 2011, p.4.

Figure 3. The steps to take when implementing PFA



Source: the EUAA.

Promising practice and support material

The EUAA has an animation on PFA, which is complemented by instructions ([29]). It is designed to support those knowledgeable and already providing PFA in sharing the concept of PFA with newcomers, paraprofessionals or volunteers. The section on '**Distress and trauma**' and '**Explaining the five principles**' as part of the instructions explain in more detail how to ensure a meaningful roll-out of the concept of PFA.

Designated focal persons can provide and mainstream the PFA concept throughout the asylum and reception pathway. PFA as a concept is useful throughout all **four levels** of the MHPSS pyramid. PFA is often linked to the critical stage of **arrival** and once applicants are placed in initial reception centres. Officers working in the first line can therefore benefit from being knowledgeable on the concept of PFA.

Refer to material developed by other key stakeholders:

- Red Cross and Red Crescent Societies, ***A Guide to Psychological First Aid***, 2018.
- Save the Children, ***Save the Children Psychological First Aid Training Manual for Child Practitioners***, 2013 providing guidance on what to consider when working with minors.
- WHO, '**Psychological first aid: Guide for field workers**', 2 October 2011.

([29]) EUAA, '**Psychological First Aid Video**', YouTube, 2023 and the accompanying '**instructions**'.

2

Identification

What do we mean by identification and why is it important?

To be able to provide the relevant safeguards and protection, procedural guarantees, and other services appropriate to the vulnerabilities and/or special needs of applicants, an applicants must be first identified as in need. Once needs and intersecting vulnerabilities are identified, administrations are in a position to provide the appropriate needs-based response. Early needs-based response can also prevent a deterioration of conditions. The identification of vulnerable applicants and those with special needs is crucial and highlighted in the Pact on Migration and Asylum ([30]) and makes it therefore also a legal obligation.

([30]) European Commission, '[Pact on Migration and Asylum]', May 2024.

When to identify vulnerabilities and special needs?

The **initial detection** of medical conditions and other vulnerabilities **upon arrival** at the border, or when placed within an arrival/initial reception centre, through a **targeted exercise** (e.g. health and vulnerability checks), is central to flag those applicants with visible or diagnosed health and mental health conditions as to provide timely and a potentially lifesaving and needs-based response. Such an identification exercise is also vital to detect contagious disease and to avoid a public health crisis. While physical health conditions might be the focus for those conducting medical intakes during disembarkation or at the border, or when placed in initial reception centres, **preventing psychological distress** from worsening should be emphasised as well.

Administrations need to be aware that most of the special needs and vulnerabilities, and particularly mental health concerns and other **invisible vulnerabilities** applicants arrive with, might not be easily detected upon arrival. This can be for different reasons.

Depending on the vulnerability and need, applicants might:

- have a lack of insight into their condition (e.g. applicants with mental health conditions),
- experience shame and a feeling of guilt in sharing certain problems and experiences (e.g. particularly in cases of sexual violence);
- present with fear of repercussion against family members left behind (e.g. in the case of victims of torture);
- worry that the condition experienced could affect their application for international protection (e.g. substance abuse or a chronic disease such as an HIV infection);
- experience language barriers in the absence of knowledgeable interpreters;
- face psychological distress upon arrival after a traumatic journey; or
- distrust the authorities conducting the initial health and vulnerability checks.

All these elements may hinder an early disclosure of specific needs and vulnerabilities. The coordinating authority should thus emphasise to the first-line officers and those supporting at a later stage the importance of treating **identification** of vulnerabilities as an **ongoing effort** rather than a one-time off exercise taking place within a very limited period.

The below points will help facilitate the timely identification of needs, which ultimately positively affects the asylum procedure and helps applicants remain in reception:

- **clear** tools available to identify vulnerabilities, including invisible vulnerabilities, by integrating a number of meaningful indicators;
- brief those working in the first line on **how to use the tools** including their limitations (what cannot be identified);
- embed the initial medical and vulnerability checks and intake assessment exercises **into daily procedures** ensuring they are organised more than once to monitor the well-being of applicants;
- the **availability of sufficiently and well-trained and experienced specialists** including on migration to support such a process;
- relevant information material for applicants to **nurture self-disclosure** of specific needs and vulnerabilities.

How to detect health conditions and other vulnerabilities

In some countries, initial medical intakes also include questions on general vulnerabilities, including mental health conditions and treatment adherence, while in others they do not. When such questions are integrated as part of early identification of vulnerabilities, considerations might be given to:

- experiences of torture and other forms of violence (gender-based violence, family violence);
- mental health conditions including suicidal thoughts, physical and cognitive disabilities, age-relevant problems (e.g. in the case of elderly people, whether they are in a position to care for themselves); and
- addiction problems.

While most applicants might not be able to disclose such sensitive experiences upon arrival, at times applicants might be willing to share some information once a safe and trusting environment is created. It can help to clearly explain the reason this information is important to the authorities and if there is an expert with sufficient experience present to engage with applicants in an empathic and calm way.

Who identifies vulnerabilities and special needs?

An early detection of needs may be conducted by (a)first-line **officers** who may have only **limited knowledge of vulnerability**-related matters such as border guards, who are however important first-contact officers in this regard.

In addition, (b) the **community of applicants**, once equipped with some basic training (e.g. PFA), can also facilitate the process of early identification particularly once needs such as psychological distress are visible (e.g. a person is crying, very irritated, restless or confused) and the context allows for them to meaningfully flag needs in their peers to relevant officers.

Every administration should strive however to appoint (c) **officers specially trained** for the purpose of identification. These officers should be knowledgeable on health, vulnerability and protection-related matters (e.g. child protection, gender-based violence, victims of torture, trafficking in human beings). They should be instructed to support the two groups indicated under (a/b) and to see identification as an ongoing effort on their part.

Conduct a risk assessment ([31]) regarding specific needs and vulnerabilities with unaccompanied children ([32]) concerning trafficking in human beings ([33]) or the risks of abscondment ([34]). This also applies to the conduct of a needs assessment with applicants leaving reception for the purpose of integration and/or for those being prepared for return. The findings can indicate the relevant next steps to take to grant protection.

([31]) Refer to Section The case management process.
([32]) Refer to Section Unaccompanied children.
([33]) Asia Foundation, *Checklist to Identify Suspected Victims of Trafficking*, National Anti Human Trafficking Taskforce: Sri Lanka, 2021.
([34]) Fedasil, 'Preventing the disappearance of Mena', 25 May 2023.

What should follow the early detection of an applicant with special needs or vulnerabilities?

The assessment of special needs is a systematic evaluation of the situation of the applicant. A special needs and vulnerability assessment considers the complex intersection of vulnerabilities, risks and harm factors. It also highlights **protective factors** and the **resilience** of an individual and any social and/or family network on which the applicant may be able to rely on. A comprehensive and continuous assessment aims at understanding the vulnerabilities and special needs of the applicants and the ways in which they can holistically be addressed ([35]).

A vulnerability assessment may trigger a referral for further support in a case where direct support cannot be provided, which might include interventions targeting all four levels of the MHPSS pyramid. This ranges from the coverage of basic needs up to specialist treatment from an expert such as a psychiatrist for a mental health condition. This care and support is most effective when embedded in a case management process (see Section 3. Care and case management). This means a person attends to the needs of an applicant and coordinates respective services until the applicant is able to do so independently.

All officers working in the first line and who are in direct contact with applicants are to be enabled to conduct **referrals**. To do so, they require updated information on referral partners and their contact details to link those in need to the appropriate support services.

In summary. Vulnerabilities and special needs can emerge at any stage or may be identified at any stage of the asylum pathway. Both professionals and community members can detect the imminent needs. Identification can take place at any point in the four levels of the IASC MHPSS pyramid.

The identification of a specific need or vulnerability(ies) is not the end of the process. It can trigger processes that aim to take care of the specific need or vulnerability(ies) within a case management approach (see Section 3. Care and case management) and the necessary referrals can be made (refer to Figure 4 below). The figure below provides an example workflow on **early identification upon arrival** in a country and how the early identification links to the ongoing identification once an applicant has been placed in a more permanent reception facility.

Vulnerability in the context of this guidance is understood as a situation an applicant finds themself in due to age, gender and other personal factors. Some of these factors can relate to belonging to a specific minority group, specific health conditions or their experiences. These personal and environmental factors can also put applicants in a vulnerable situation at risk. It is vital to put the necessary measures, safeguards and guarantees in place to prevent harm, the deterioration of their condition or the emergence of new needs. For example, an applicant woman falls in a vulnerable group category due to her gender and the fact that women are more likely exposed to violence, abuse and exploitation. Therefore, choosing the appropriate accommodation is paramount to ensure her safety. Monitoring the situation of the applicant woman is then an ongoing effort to prevent (further) harm.

An applicant who has a specific need, on the other hand, can be but is not necessarily considered to be in a situation of vulnerability. A person who has a visual impairment might have the specific need for reading glasses provided by the reception authorities. Once the glasses are provided however the person can function and is no longer in need of additional support.

There is a difference between an immediate response to a need and a purposely delayed response. For those working in the first line, keep the urgency level of a response in mind. The detection of needs is continuous. A response will follow however depending on the urgency level of the need detected.

([35]) EUAA, *Special Needs and Vulnerability Assessment tool*, 2023.

Figure 4. Identification of specific needs and vulnerabilities for the purpose of service provision

Identification upon arrival ([36])

Where: arrival centre

When: immediate / first few days

What/why: to facilitate the detection of:

- infectious disease, tuberculosis (where applicable), vaccinations status and any other urgent medical and mental health conditions;
- physical disabilities/impairments which make living independently challenging or impossible;
- severe emotional/psychological distress;
- immediate needs for protection.

The identification of such concerns can trigger an immediate referral where applicable.

Who can be involved in the identification:

Specialised/experienced nurses (emergency/psychiatric/epidemiology) and for vulnerabilities social workers with expertise in child protection, trauma, gender-based violence, trafficking, etc.)

↓

Medical doctor / psychologist in-house for more in-depth follow up where applicable

↓

Referral to external service provision depending on the circumstances

How: by using medical and vulnerability check/intake/assessment tools.

Ongoing identification

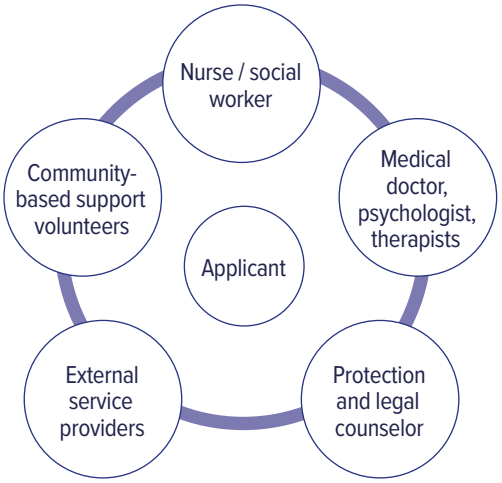
Where: more permanent reception facility

When: ongoing / when the need arises

What/why: to follow up on:

- existing medical, mental health and other specific needs;
- emerging medical and other needs;
- further assessing vulnerabilities identified upon arrival at the accommodation including any intersecting needs such as protection-related needs;
- ongoing efforts in identifying specific needs and vulnerabilities (e.g. those invisibles such as experiences of torture, trafficking in human beings, etc.);
- The issuing of a referral where applicable and organising appropriate care and case management where applicable.

Who can be involved in the identification:



How: by using medical and vulnerability intake/assessment tools and the creation of space to self-identify (e.g. safe spaces).

Information travels with the applicant considering privacy, data protection and consent

Source: the EUAA (adjusted from a workflow provided by Fedasil, Belgium)

([36]) The points in this section can also be of interest to the authorities responsible for the screening of third-country nationals.

Identification is to be understood as an **ongoing effort** and takes time. The identification of a vulnerable applicant can take place at any stage of the asylum pathway as well as by different actors interacting with the applicant (e.g. family members, teachers, social workers, medical personnel, reception officers). Therefore, it will be crucial to create a general awareness in the community of applicants and those supporting them as to who to contact when specific needs arise and how to access a comprehensive referral system which facilitates the appropriate and necessary care (for more information, refer to Section 3. Care and case management).

It is crucial to create a comfortable and **safe environment** for the applicants and ensure accessibility to **skilled officers** who are provided with the means and **time** to conduct meaningful vulnerability assessments. This ensures an applicant-centred approach during identification and compliance with fundamental rights obligations.

However, and particularly in transit countries or large EU Member States and the Schengen associated countries (EU+ countries) where identification might be **centralised**, authorities might only have **one opportunity** to engage with an applicant. Therefore, it is highly recommended that the teams supporting upon arrival in different contexts are **well equipped** in terms of **expertise**, have **sufficient time**, have an enabling working environment and access to further specialists where needed. This will help ensure the effective early identification of needs.
Generally, vulnerabilities can be flagged by first-line officers with different levels of expertise relating to vulnerability and protection needs. There are varying ways to detect and identify vulnerabilities, for example:

- The applicant already self-identifies.
- A medical doctor, mental health professional and/or vulnerability officer poses some targeted questions to gain insight into certain medical vulnerabilities and protection needs.
- Through documents or evidence provided by the applicant or family members certifying a vulnerability or its indicators.
- The vulnerability is visible (e.g. advanced pregnancy or a visible physical disability, being an unaccompanied child or elderly person, unusual behaviour).
- Through psychological first aid provided by trained support to all applicants at different stages of the asylum and reception pathway (see Section 1. Psychological first aid). The trained support (those working/supporting in the first line) have a basic knowledge of indicators of psychological distress.

The tools for officers working in the first line **with limited or no knowledge on vulnerability and special needs** (e.g. immigration police), who are in any case expected to support with identification during high influx, are relatively easy to administer. Such tools can facilitate the 'flagging' of special needs. Note, however, that many of the vulnerabilities that applicants arrive with are invisible. This indicates that the better trained the officers are that are working in the first line using these simple tools at the border or during high influx/turnover, the more likely some of the invisible vulnerabilities will be detected earlier. This can include identifying potential victims of torture and people who may have experienced sexual violence. Therefore, it is crucial to build the capacity of all involved.

Find a list of useful training options and capacity building exercises in Part I – Senior management, 'Annex 4. Resources for building capacity on mental health and psychosocial support'.

For additional information relating to **cultural sensitivity** and **enablers of good mental health** refer to Part III – Toolbox.

For more information on the topic of **disability**, refer to the EUAA, *Persons with disabilities in Asylum and Reception Systems*, 2024 and EUAA, *Safeguards for asylum applicants with disabilities*, Fact Sheet EUAA/IAS/2022/14, November 2022.

Promising practice and support material

Tools. Identification

Early detection of vulnerabilities and special needs

- EUAA, *Identification of Persons with Special Needs tool*, 2016. This tool targets first-line officers with no or little knowledge on vulnerability and helps them to learn about vulnerability indicators and the next steps are required to ensure the safety and protection of the person served.
- Caritas International, *Towards fair treatment of refugees*, December 2017 (in French).
- Screening Tool for Asylum-seeker and Refugee Mental Health, **STAR-MH**, Star-MH website, 2024 'is a brief and simple 9-item mental health screening tool developed for use by non-mental health trained workers to identify likely PTSD [post-traumatic stress disorder] and major depressive disorder in their asylum seeking or new refugee clients.'
- Pathways to Wellness, '**Refugee Health Screener - 15 (RHS-15)**', 2012 to support the screening of people for emotional distress and mental health. Note this checklist is not intended for use in refugee populations.
- UNHCR, International Detention Coalition and the Oak Foundation, *Vulnerability Screening Tool*, 2016.

In-depth assessment of vulnerabilities and special needs including mental health

- EUAA, *Special Needs and Vulnerability Assessment tool*, 2022. This tool supports specialised staff in assessing special needs in a structured way and to identify appropriate actions to take in the applicant's interests.
- WHO, *Assessing mental health and psychosocial needs and resources: toolkit for humanitarian settings*, 2012.
- United Nations Population Fund, *Guidelines for the provision of remote psychosocial support services for GBV survivors*, 2021 is designed to support service providers once a possible risk of suicide is evident (e.g. negative intrusive thoughts, suicidal thoughts, feelings of despair or risky behaviour).
- Fedasil (Belgium), Doof Vlaanderenand and Fédération Francophone des Sourds de Belgique, *Guide – Accompagnement des demandeurs sourds & malentendants*, January 2022 (in French). This guide helps to identify deaf and people who are hard-of-hearing and helps to understand their communication preferences. Deaf and people who are hard-of-hearing applying for international protection are often overlooked.

Some countries will apply the PFA concept to support in identifying specific needs and vulnerabilities. Other administrations use self-assessment mechanisms including questionnaires as part of the identification. The latter can be particularly useful in situations where a high number of applicants have arrived and therefore a timely identification of those with mental health needs might be otherwise jeopardised. Self-assessment mechanisms, while useful in certain circumstances to flag concerns, should not be seen as the only format to use to identify applicants in need. These mechanisms are limited and can risk excluding certain groups or applicants (e.g. people who are illiterate and/or children).

France

The Questionnaire Santé Mentale (mental health questionnaire) is used by the Office for Immigration and Integration as part of their Rendez-vous santé (health meeting). The tool is understood as a working tool and can be updated. This assessment is conducted on a voluntary basis only. Those who join receive an orientation on the purpose in a language they understand. Minors are exempt. The questionnaire is available in 36 languages. The questionnaire conforms to practices in the psychiatric field (limited to different pre-existing psychiatric diagnoses) and is adapted to different general medical screening procedures.

Main benefits: reduces pressure on first-line officers when many new arrivals need to be screened. Officers with no background in psychiatry are able to flag certain concerns as a minimum. The findings can highlight which applicants might need to be prioritised for a follow up.

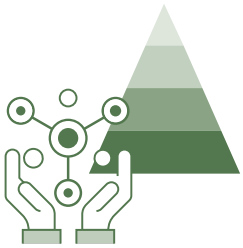
Generally, answers are linked to a colour scheme (green – not linked to a psychiatric diagnosis; amber – requiring consultation only if the condition is affecting the daily functioning of the applicant; red – implies a high risk of serious mental health condition.) For those flagged as red, the IT system automatically prints a referral letter for the consulting psychiatrist where applicable. To comply with confidentiality obligations, the referral letter only indicates a need for a consultation. Data entered into the system is anonymised and complies with the general data protection regulation.

Refer to Part III – Toolbox, Section 'Checklists, questionnaires and other tools'.

In some instances, it might be advised to re-consider national practices linked to sharing on applicants in need. This might be also relevant on the way consent by applicants is obtained to share such information for example in case of a needed referral. Information normally is only shared on a 'need-to-know' as to ensure a smooth, safe and meaningful referral and follow up. Age, gender and diversity are cross-cutting considerations.

- For general information on how to approach the topic of vulnerability also refer to the EUAA, *Strategy on Vulnerability*, 2024, Section '4.2. Identification, prevention, and response'.
- International Organization for Migration (IOM), *Determinants of migration vulnerability*, Part 1, 2020.
- Part III – Toolbox, Section. 'Identification of vulnerabilities and special needs'.

3



Care and case management

This section focuses on the **access to care**, the **case management** process in which care is embedded and **care and case management for specifically vulnerable applicants** and underserved groups.

Access to care

Caring for the needs of applicants will require a need to have been identified. Consequently, a mix of support could be offered. This can include financial support as well as practical support, for example facilitating access to certain services provided by experts (e.g. medical professionals), interpretation services and informal support provided by community members. The format of the support will differ depending on the context and the needs identified. In some settings, a stronger focus on mobile support options might be required to see those that are otherwise harder to reach. This can be in the form of mobile support teams visiting reception facilities on specific days or social workers conducting home visits in an urban context. Emphasis on coordination between entities is important.

What does care in the context of this guidance mean?

Depending on the problem at hand and other factors (e.g. age, history of health/mental health, educational background), some applicants might need more support than others. As with any population, there will be individuals with complex needs who will require access to various services including focused and specialised care.

The aim is that applicants under psychological distress are empowered through the care they receive, formal (targeted support) or informal (community-based interventions/support provided by family members) and depending on their needs. The care will help them to manage their own daily lives as independently as possible. Once a need or intersecting needs have been identified and assessed, if they cannot be immediately addressed by a respective officer, a referral and case management process is triggered to ensure relevant response or care.

This requires the availability of an established **referral system composed of different partners** able to provide meaningful support. At a minimum, this includes basic health care, protection (including social services, shelter, law enforcement), community lead initiatives on psychosocial support, education/employment and legal counselling.

It is strongly advised to adopt a holistic approach to mental health covering **informal** (community-led psychosocial support efforts) and **formal support** mechanisms (as part of focused and specialised care).

The coordinating entity in a given country/context responsible for managing the implementation of MHPSS interventions should make sure that a **multidisciplinary team of service providers** is available. These providers should cover, at a minimum, health, protection and the educational sector. Their services should form part of an established referral mechanism. The mapping and strengthening of community-led initiatives relating to psychosocial support within a given context is also crucial.

The case management process

What are the benefits of case management?

Case management enables the timely and systematic addressing of the needs of applicants through either direct assistance or referrals ([37]). While the overall objective of case management is to improve the autonomy and independent functioning of the applicants, remember that every applicant possesses varying capabilities and resilience to achieve such a goal. Standard operating procedures can support in fostering quality, consistency and coordination of assistance. Response services should always be based on the needs of applicants.

Case management is a cross-cutting intervention. It is relevant for applicants presenting with varied and intersecting vulnerabilities including those under psychological distress or those with a diagnosed mental health condition. Applicants presenting with distress or mental health conditions often feel anxious and too overwhelmed to act by themselves.

([37]) 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.

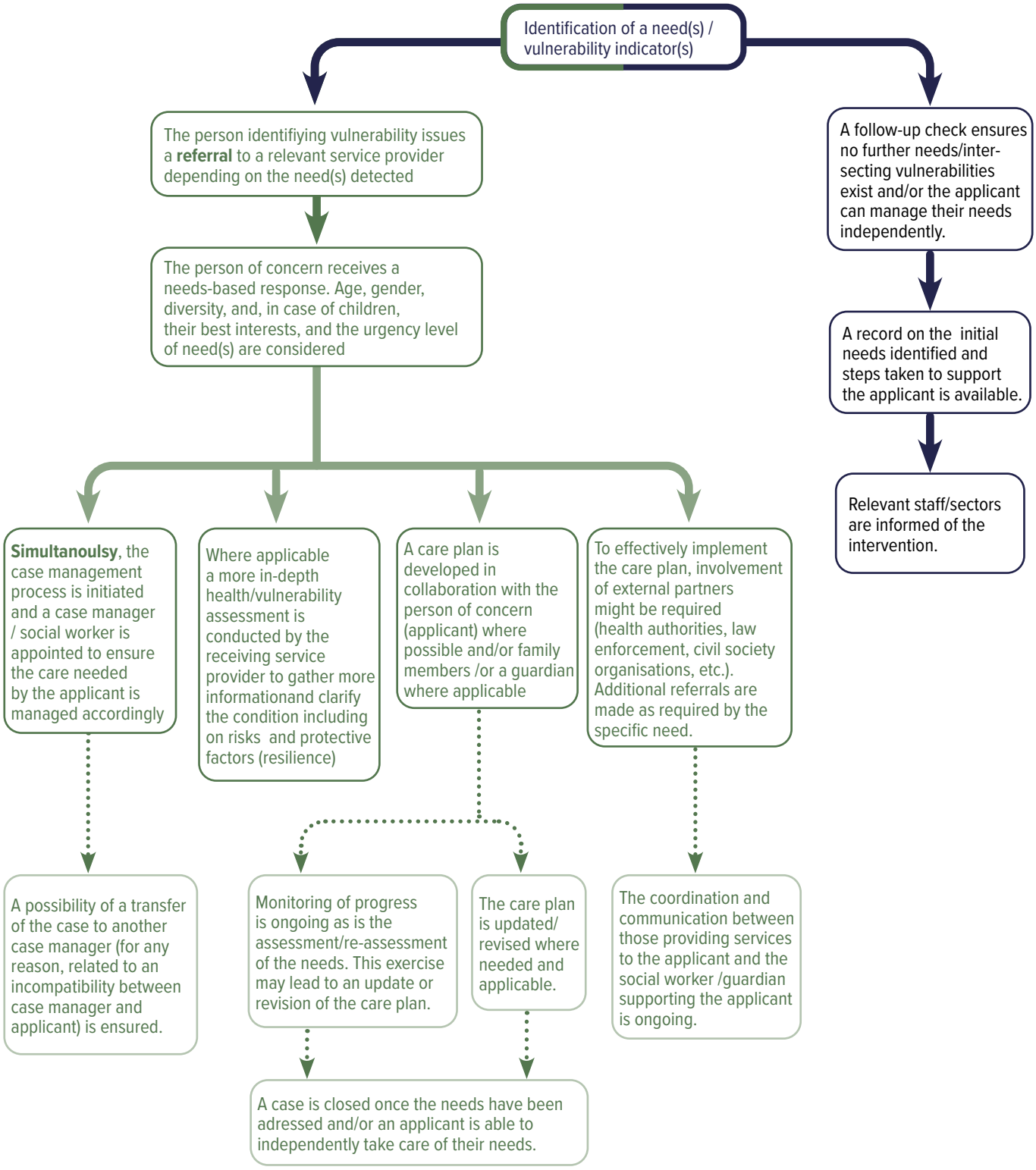
They may perceive themselves as not being in control or simply do not possess any insight into their condition. Being joint by a case manager/social worker in charge of supporting them through the process of services provision can ease feelings of anxiety and be beneficial for this group of applicants. Depending on the local context, the needs and circumstances of the applicant, different delivery models can be implemented and/or combined:

- the **individual care model** assigns dedicated case officers (appointed by the reception authorities) to applicants, fostering trust but potentially requiring significant resources;
- in the **community-based care model**, case manager/social worker are embedded in migrant communities, allowing direct access to the population and better knowledge of the available services;
- **outreach/mobile models** involve case managers meeting applicants at their residences or convenient locations, which is suitable when beneficiaries cannot or do not want to visit a migrant centre;
- **remote case management** via phone or the internet (e.g. to facilitate regular follow-up in a context where applicants are hard to reach or human resources are limited therefore making it difficult to arrange regular follow-ups in person);
- **identification** of persons with specific needs;
- conducting a **risk assessment** to assess which approach/service is in the **best interests** of the applicant, by also ensuring the **safety** of the case manager;
- analysis on the potential outcome(s) if the services are not provided;
- to ensure the **care is accessed**/received;
- **involving** the applicants and/or family in the planning of care;
- **monitoring** and **evaluation** of such care;
- the **adjustment of the care plan** following the results of the monitoring and evaluation, where applicable.

How to roll out case management

Case management is normally carried out at the level of the individual applicant. This means that when officers working in first line are determining their direct role, it is essential to recognise that each applicant has varying levels of capacity to function independently. Establishing a strong and trustworthy relationship with each applicant is crucial as it allows for a more accurate assessment of their abilities. After assessing the applicant's skills and abilities and other protective factors, a care plan is formulated accordingly. The care plan builds around the evaluation of the applicant's attributes to promote increased independence and self-direction, taking the views of the applicant into consideration. This approach nurtures agency and can contribute to better MHW.

Figure 5. A summary of the case management process

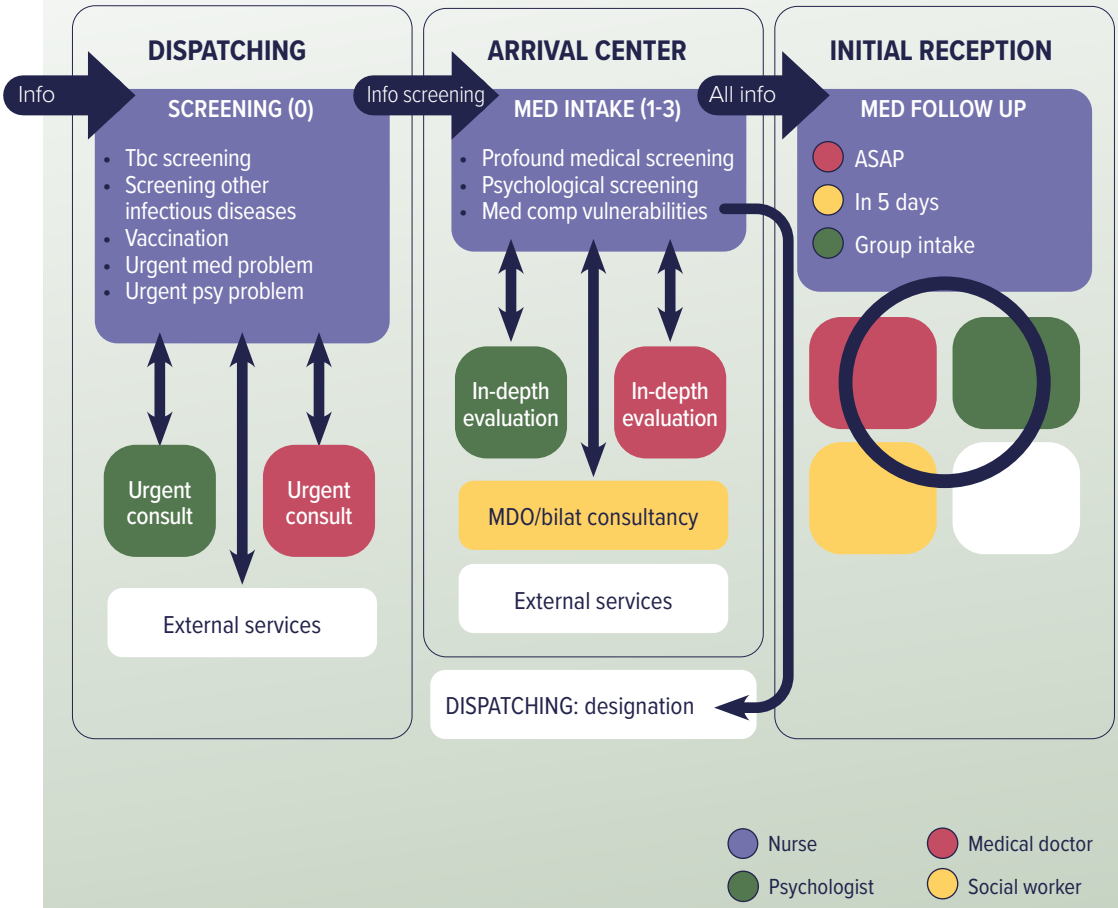


Source: the EUAA

Every EU+ country has a slightly different format to organise the identification of applicants with specific needs and vulnerabilities and their follow-up. The format and follow-up might also depend on the stage of the asylum and reception pathway.

Belgium, Fedasil

Below is a simple visualisation of a phased **workflow** and the professionals involved **upon arrival**, **initial reception** and during the **stay in reception**. The timelines for interventions (upon arrival day 0; day 1-3; day 5) are indicated as well as the entities with whom to liaise depending on the situation.



Developing a care plan requires the following components.

- **Values.** Each client is unique and has their own set of goals and values. Align interventions with the client's value system to effectively work towards achieving their objectives.
- **Cognition and attitude.** Consider the client's state of mind, including perceptions, reasoning, judgements, mindset and attitudes. An accurate assessment of the client's cognition will lead to a more appropriate intervention plan.
- **Skills.** Evaluate how well the client can utilise their cognitive and behavioural skills to function independently.
- **Ability and willingness to accept help.** Assess the client's readiness to accept your assistance in achieving the goals outlined in the resettlement plan. Understanding their willingness to seek help is crucial for effective intervention.

Who is managing the case?

Case management is normally provided by skilled support such as by social workers and reception officers with a background in mental health, vulnerability and/or protection. Throughout this process, the staff member should seek assistance and support from supervisors. Keep an open communication channel with colleagues and, to an extent, the applicant themself. Case conferences to facilitate the case management process can further support those supporting applicants in need.

Why is assessing risks important as part of a case management process?

'Case managers should conduct regular assessments to identify any risks to the security, safety and well-being of vulnerable migrants and the risks inherent to accessing and/or not accessing services.' ([38]) These assessments should be carried out with the active involvement of the vulnerable applicant. If any risks are identified, appropriate strategies to mitigate them should be implemented. The risks can link to the mental health state of an applicant but also other intersecting vulnerabilities, for example being a survivor of sexual violence or intimate partner violence, retaliation from human traffickers, self-neglect or self-harm. These identified risks and mitigation strategies should be integrated into the care plan.

➡ **The risk assessment includes:** the classification of the urgency and priority of action, the mapping of available services, the development and implementation of care plans and coordination with service providers. Depending on the quantity and severity of identified needs, the risk level can be categorised in relation to the need for action.

([38]) IOM, *Protection and Assistance for Migrants Vulnerable to Violence, Exploitation and Abuse: Individual Case Management – Part 2*, 2020.

Table 2. Risk assessment and urgency level in the case management process

Risk level	Parameter	Intervention	Practical examples
High risk: urgent follow-up needed	One specific need, which requires immediate action. More than three specific needs, requiring action soon.	A situation of serious and immediate risk to personal safety demands urgent immediate intervention / immediate access to emergency / psychiatric care. Daily follow-up is needed to ensure immediate action is taken.	A female applicant who has self-disclosed that she is **pregnant** as a result of **sexual violence** and presents with **suicidal thoughts / risk of suicide**. An applicant with s**eizure-like symptoms** (unconsciousness, fainting, sudden convulsions) of **unexplained origin**. An applicant with **acute self-harming tendencies** and **maladaptive use of medication** or who is **dangerous to others**, with **psychotic symptoms** (including 'threat' symptomatology – feeling persecuted and threatened). An elderly applicant who is **disoriented** and exhibits **self-harming behaviour**, potentially indicating **dementia**. An applicant presenting with **hallucinations** and **delusions**, potentially indicating a **psychotic disorder** (or substance abuse).
Medium risk: follow-up needed	One or two specific needs, requiring action soon.	The possibility of a significant risk to personal safety, requiring interventions within a maximum of seven days. Weekly follow-up required to ensure mitigation of imminent risks.	An applicant feeling **very frustrated** (e.g. due to a long wait for their legal status / papers to work still pending, presents with low motivation to do anything; evidence that the applicant has **started drinking** more often and is constantly **quarrelling** with roommates. An applicant with a **recurring persistent headache** and **maladaptive substance usage**.
Low risk: no case management needed	No specific need selected.	In cases in which there is no risk to personal safety, information regarding relevant services and counselling should still be provided promptly within two weeks if an intervention is required to address specific needs and decrease vulnerability.	Parents approaching the social worker in a reception centre and sharing that they would like to learn more about good parenting since they have noted some tension with their teenage child and that their behaviour has changed (more withdrawn, does not go to school sometimes, etc.). A single, male applicant states that it is too noisy in the accommodation, which is why he cannot sleep and has become increasingly tired and apathetic.

Source: the EUAA

During service provision, those managing cases are responsible to monitor the progress of the care plan. For this purpose, open regular communication with the applicant is essential to allow for an adjustment to the care plan where required. Methods for soliciting feedback may include 'questionnaires, comment boxes, online forms, focus group discussions, formal consultations, or conversations between the [applicant] and case managers or supervisor' ([39]).

([39]) IOM, *Protection and Assistance for Migrants Vulnerable to Violence, Exploitation and Abuse: Individual Case Management – Part 2*, 2020.

The case planning process should begin in a timely manner and ensure the completion of a vulnerability/needs/best interest assessment as soon as possible. However, if there are urgent situations with a high level of risk, take immediate intervention. The assessment-based care plan should include the specific and achievable goals (without creating unrealistic expectations), selection of specific actions to address the identified risks and needs (including immediate-, short-, medium- and long-term steps) and when the measures will be implemented and by whom.

As part of the case management process, the best interests of the child ([40]) need to be considered. The best interest's procedure specific to children at risk need to be formulated and these procedures require relevant and safe standard operating procedures ([41]).

Applicants supported through case management:
should be aware of the principles of case management and any standards or codes of conduct for case managers. Case managers suspected of unprofessional conduct or of flouting the principles of assistance should be investigated and disciplinary action taken in accordance with local laws, licencing boards and the child protection policies of the organization concerned. ([42])

Procedures must be established for vulnerable applicants to report any misconduct by case managers, including incidents of sexual exploitation and abuse, in an anonymous and confidential manner to ensure that this does not affect their care and support ([43]). Refer to the nine components introduced in **Part I – Senior management**, 'Component 7. Accountability' and 'Component 8. Staff welfare'.

In summary. An integrated approach to the MHW of applicants for international protection requires that an authority creates an environment:

- where applicants can be identified in a timely manner and receive the relevant needs-based response and care provided by appropriate skilled support person(s);
- that allows community-based interventions by ensuring community members acquire the necessary mental health literacy through psychoeducation, have the agency to organise their lives as independently as possible and pro-actively seeks to prevent distress and mental health concerns.

Refer to **Figure 2. Five focus areas to promote an integrated approach to MHW of applicants**.

([40]) EASO, *Practical Guide on the Best Interests of the Child in the Asylum Procedure*, 2019.
([41]) UNHCR, *Standard Operating Procedures for the Implementation of Best Interests Procedure for Children at Risk (BIP SOPs)*, 2018.
([42]) IOM, *Protection and Assistance for Migrants Vulnerable to Violence, Exploitation and Abuse: Individual Case Management – Part 2*, 2020, p.37.
([43]) IOM, *Protection and Assistance for Migrants Vulnerable to Violence, Exploitation and Abuse: Individual Case Management – Part 2*, 2020, p.37.

Promising practices and support material

"According to the EU Charter of fundamental rights, everyone has the right of access to preventive healthcare and the right to benefit from medical treatment under the conditions established by national laws and practices. According to the European Pillar of Social rights, everyone has the right to timely access to affordable, preventive, and curative healthcare of good quality ([44])".

This **guidance promotes preventative measures** such as the **early identification** of needs and vulnerabilities and the provision of support in a timely manner. This includes in particular support through **psychoeducation** in combination with **community-based care services**. Nevertheless, there might be situations where also focused and specialised care will need to be considered and complement such services as to prevent further deterioration of a situation or to support the managing of a mental health condition.

Unaccompanied children

Meeting children's needs is crucial for their psychosocial well-being, especially in a situation of crises that disrupt their lives. **Community-based care** and support for unaccompanied children ([45]) is eminent since commonly children arriving in Europe experience a range of challenges and circumstances.

- They often lack consistent caregivers, leading to disruption in attachment.
- Loss and grief are common, including the deaths of loved ones, being separated from caregivers and the breakdown of family and community.
- Trusting appointed caregivers and/or guardians might be difficult due to their past disruptive experiences.
- Uncertainty about the future adds to their emotional burden.
- Some might have spent years trying reach Europe and have not had the opportunity to attend formal education They may have only had a few years' schooling and consequently lack opportunities for further education.
- Language barriers, communication difficulties and cultural differences pose challenges.
- Existing psychosocial and mental health issues may worsen due to their circumstances.
- They may fear deportation.
- Despite potentially years of separation, they may maintain a strong connection and commitment to their parents and family. Some might feel the need to financially support their family back home including to cover any depts accumulated to support the child's journey.

([44]) 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 Brussels, 7.6.2023 COM(2023) 298 final, p. 3.
([45]) This section was inspired by UNICEF, *Best practices for working with unaccompanied migrant children in humanitarian contexts: A guide for staff and volunteers in the United States*, UNICEF Programme Group, October 2017.

Despite these challenges, unaccompanied children demonstrate remarkable independence and resilience, each child possessing unique strengths that have helped them thus far. Their connection with family and friends back home or religious faith may be a source of comfort and strength and should be nurtured.

What are the signs that a child might need more attention and care?

Below is a list of common signs of distress that child and adolescent applicants might show which can indicate that in addition to community-based care (level 2 of the MHPSS pyramid), **focused care** (level 3) and at times **specialised care** (level 4) might be needed to maintain and/or manage their mental health and well-being.

Common signs of distress among child and adolescent applicants	
Emotional	The emotional experiences that children and adolescents may experience include intense grief, feelings of guilt or regret, overwhelming emotions, hopelessness, persistent sadness, anger, irritability, anxiety, panic and erratic mood changes. Other common emotions may include fear, numbness, detachment, depression, sadness and fluctuating emotional states. Acknowledge and address these emotions in order to support individuals in coping with their feelings effectively.
Behavioural	Children and adolescents may exhibit various behavioural changes and reactions, including withdrawal, emotional numbness, loss of interest in activities, bedwetting, excessive crying, clinginess or independence, aggressive behaviour, rejection of rules, self-harm, defiance of authority figures and engagement in risky behaviours such as substance misuse. These behaviours can indicate underlying emotional struggles, self-destructive feelings or attempts to assert independence. Address these behaviours with appropriate support and interventions to ensure the well-being and safety of the individuals involved.
Physical	Children and adolescents affected by challenging circumstances may experience symptoms such as fatigue, disrupted sleep, heightened alertness, physical discomfort (such as aches and pains), increased heart rate and changes in appetite or eating habits. These symptoms can be indicative of heightened stress levels and emotional distress. It is crucial to recognise and address these physical manifestations of stress to support the well-being and overall health of the individuals involved.
Cognitive	Children and adolescents who have experienced challenging situations may have symptoms such as 'intrusive thoughts or memories of distressing events, nightmares, difficulty concentrating, easily confused or disorientated, poor memory'. They may also undergo a 'shift in view of world, philosophy, religious beliefs, loss of faith'. Additionally, they may display a 'preoccupation with violence, death and killing (including suicide)' ([46]). These psychological and cognitive changes highlight the significant impact of traumatic experiences on their mental well-being and require sensitive and appropriate support and intervention.

([46]) UNICEF, *Best Practices for Working with Unaccompanied Migrant Children in Humanitarian Contexts A Guide for Staff and Volunteers in the United States*, UNICEF Programme Group, October 2017, p.23.

Communicating with children in distress as part of the support provided

When communicating with children in distress, it is crucial to approach them with care and sensitivity, recognising their vulnerability both physically and emotionally. Some key tips for effective communication include the following ([47]).

- **Respect their boundaries.** Do not pressure children to discuss topics they are uncomfortable with or force them to talk. Respect their decision if they refuse to share or need more time to do so.
- **Treat them with respect.** Give children the same level of respect and honesty as you would with adults. Avoid making unrealistic promises.
- **Be sensitive.** Use a caring tone of voice and simple language that children can easily understand.
- **Give your full attention.** Dedicate your full attention to the child when communicating, showing them that you are present and attentive.
- **Encourage self-expression.** Provide opportunities for children to express themselves but avoid pressuring them to relive negative experiences if they are not willing to share.
- **Encourage meaningful participation.** Create opportunities for children to share their views and opinions including on issues concerning them. This nurtures self-esteem and can empower children to speak out on topics of importance to them.
- **Listen and reassure.** Supportively listen to children and assure them that their reactions are normal. Validate their feelings of fear, confusion, anger or guilt.
- **Be patient.** Understand that expressions of frustration or anger may not be directed at you personally and be patient with their emotions.
- **Promote inclusivity.** Maintain communication free from stereotypes, treating all children with equal respect and consideration.
- **Observe and identify distress.** Pay attention to persistent signs of distress or concerning behaviour that may require specialised support.
- **Age and cultural appropriateness.** Pay attention to the age of the child you are engaging with.Some might appear very mature for their age. This does not mean they do not need the emotional age-appropriate response. Simultaneously, the engagement will need to take the cultural background of the child equally into consideration.

([47]) This list was inspired by UNICEF, *Best practices for working with unaccompanied migrant children in humanitarian contexts: A guide for staff and volunteers in the United States*, UNICEF Programme Group, October 2017, p.25.

Three key elements ([48]) to promote the **well-being of children** by officers working in the first line (levels 1 and 2 of the MHPSS pyramid).

- **Sense of safety.** Children need to feel secure and protected, both physically and emotionally, in their relationships and environment. Creating a warm and safe environment (place where they are accommodated) can help instil a sense of safety for children and adolescents in care.
- **Stability and routines.** Providing predictability and consistency in their social, emotional and physical environments is important. Being a consistent and caring presence can help children develop trust. Establishing and maintaining a routine can also contribute to their sense of stability. Children should have on person of trust they can be in contact with (e.g. a guardian). Children should not be moved on several occasions within a host country whenever possible but should be placed early on in a more permanent living situation.
- **Nurturing.** Caregivers play a crucial role in meeting the needs of children sensitively and consistently. Actively listening and responding to each child's unique needs are essential. Creating opportunities for play, art and free expression can foster a nurturing environment.

In addition to the three key elements above, pay attention to **non-verbal communication**. Children might communicate about their emotional distress through means other than talking and airing concerns. Paying attention to their drawings, for example, which may represent their fears. Keep in mind that the **health and well-being of children** is multilayered. It concerns:

> ***emotional well-being:*** *positive, happy, calm, peaceful, interested in life,* ***social well-being:*** *to the ability to engage and participate combined with a personal sense of value and belonging; and* ***functioning well-being:*** *the capacity to develop skills and knowledge that help a person make positive decisions and respond to life challenges* ([49]).

Acknowledging these needs, including the importance of access to education (including the accessibility of accelerated learning programmes for those with gaps in their formal education) and social interactions, for example by establishing child-friendly spaces for children and peers of the same age, is crucial for children's overall well-being and development. This awareness is not only important for first-line officers in reception supporting children but also their caregivers, foster parents and teachers ([50]). All these professionals should be included in awareness-raising activities and reminded of the specific needs of children. All involved should be aware of how to ensure the best interests of the child to be able to support the children to achieve the best of their abilities in the given situation.

([48]) These three key elements are adapted from UNICEF, *Best practices for working with unaccompanied migrant children in humanitarian contexts: A guide for staff and volunteers in the United States*, UNICEF Programme Group, October 2017, p.26.
([49]) UNHCR and Luxembourg Aid & Development, *Designing safe digital mental health and psycho-social support (MHPSS)*, 2023, p.8.
([50]) In addition, see European Commission, 'The Girl Who Kept Her Eyes Open – A book for children', 14 November 2023, supporting teachers in engaging with applicant children in the educational setting to address challenges they might face. This booklet was developed for Ukrainian children but could be adjusted.

For more information on psychological distress in children, teenagers and parents and how to deal with it, refer to the EUAA's threefold pocket guides and accompanying 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.

These pocket guides have been developed in form of 'self-help' tools. For use during group awareness raising sessions on the topic of psychological distress, refer to EUAA, ***Rolling Out Psychoeducational Material on Psychological Distress to Parents and Children – Instructions for First Line Officers Working in Reception***, 2023.

For more information on how to support children during the reception pathway, refer to **Part III – Toolbox**, Section 'Engaging with child applicants'.

Applicants presenting with a mental health disorder

In the context of reception, the following conditions are often highlighted by those working in the first line as being difficult to handle: applicants who seem depressed, extremely anxious or who might abuse substances. It is good practice for officers working in the first line to have the basic mental health literacy and an awareness of basic indicators which can suggest a potential psychiatric disorder such as depression, PTSD or a substance use disorder. Remember however that a condition is considered a 'disorder' only following a diagnosis by a psychiatrist. This type of disorder needs to be monitored by the relevant specialised care. Below are some common signs and symptoms, which once noted in applicants, should trigger a referral to a specialist to conduct a medical assessment.

Mental health disorders	Common signs and symptoms
Post-traumatic stress disorder (PTSD)	Recurrent, intrusive distressing memories; dreams related to the traumatic event(s) ([51]); dissociative reactions (e.g. flashbacks); prolonged psychological distress; physiological reactions; avoidance of distressing memories, thoughts or feelings; inability to remember important aspects of the traumatic event(s); persistent negative emotional state (e.g. fear, horror, anger, guilt or shame); diminished interest in participating in activities; inability to experience positive emotions; concentration problems; self-destructive behaviour; hypervigilance; irritable behaviour; sleep disturbance.
A mood disorder like depression	Depressed mood; diminished interest in most/all activities; significant weight loss/gain; insomnia/ hypersomnia; psychomotor retardation; fatigue or loss of energy; feelings of worthlessness or excessive guilt; problems concentrating or indecisiveness; recurrent thoughts of death; suicidal ideation, planning or attempts.
A psychotic disorder including types of Schizophrenia e.g. paranoid, disorganised or catatonic	Psychotic symptoms like (paranoid) delusions and hallucinations (e.g. hearing voices); disorganised speech; grossly disorganised or catatonic behaviour ([52]); negative symptoms (e.g. affective flattening).
Bipolar disorder or related psychiatric disorders	'Bipolar and related disorders are episodic mood disorders defined by the occurrence of manic, mixed or hypomanic episodes or symptoms. These typically alternate over the course of these disorders with depressive episodes or periods of depressive symptoms.' ([53]) 'Bipolar symptoms during a manic phase may include: • feeling incredibly 'high' or euphoric; • delusions of self-importance; • high levels of creativity, energy and activity; • getting much less sleep or no sleep; • poor appetite and weight loss; • racing thoughts, racing speech, talking over people; • highly irritable, impatient or aggressive; • inappropriate sexual activity or risk-taking; • dressing more colourfully and being less inhibited; • impulsiveness and making poor choices in spending or business; • grand and unrealistic plans; • poor concentration, easily distracted; • delusions, hallucinations.' ([54])
Substance use related disorders	• Consumption of substances in larger amounts and over a longer period of time than intended. • Persistent desire to cut down or regulate use / unsuccessful attempts to stop. • Time needed to recover from obtaining or using substances. • Cravings and desire to use the substance. • Impaired ability to fulfil major obligations at work, school and home. • Social or interpersonal problems due to substance use. • Withdrawal from recreational, social or occupational activities. • Use of substances in physically unsafe environments and continuation of substance use despite knowledge that it may cause problems. **Tolerance:** increasingly higher doses are needed to achieve the desired effect. Withdrawal: withdrawal symptoms might appear. **Note:** substance use-related disorders can be the abuse of alcohol, cannabis, heroin, cocaine, opioids, amphetamines, etc.

Source: Adapted from the American Psychiatric Association, ***Diagnostic and Statistical Manual of Mental Disorders***, 5th edition (DSM-5).

([51]) EUAA, *Mental Health and Well-being of Applicants for International Protection – Part III. Toolbox for the implementation of mental health and psychosocial support*, 2024, Section 'Understanding Trauma'.
([52]) Royal College of Psychiatrists, definition of 'catatonia', April 2022.
([53]) WHO, *Clinical descriptions and diagnostic requirements for ICD-11 mental, behavioural and neurodevelopmental disorders*, 2024.
([54]) Gordon Private Hospital, 'Bipolar Disorder – Mental health treatment for Bipolar Disorder in Sydney', Gordon private website, 2024.

Once these signs are noted or there is a suspicion that something is 'not right', the involvement of a mental health specialist and a **referral is highly recommended**. An in-depth assessment by a mental health professional can clarify if a psychiatric disorder exists or if the symptoms are rather an emotional stress reaction. The applicant will need support in both instances but the type of support will differ.

What MHPSS interventions can be useful for applicants with mental health disorders?

Community-based care interventions (level 2 of the MHPSS pyramid) are of great benefit to all applicants and should be provided for all. They are also useful for people with a diagnosed psychiatric disorder. The activities detailed in this section and particularly those linked to creative arts, cooking and sports can support applicants in managing certain conditions. Engaging those with mild depression in such regular activities can boost their confidence and helps them to better organise their days.

Creating spaces to **connect with others** supports the strengthening of MHW more generally and reduces the risk of developing negative coping mechanisms such as self-harm and the abuse of substances. Adopt a holistic psychosocial support package for this group of applicants, which can also include strengthening families such as through re-establishing family links. Supporting youths and adults with the development of their social skills to improve interpersonal interactions to better support their connectedness to the community is crucial.

Focused care (level 3 of the MHPSS pyramid): individual and/or group counselling sessions and therapeutic support can be beneficial, particularly when it comes to conditions such as PTSD, depression and substance use disorders. Complement this care with psychoeducation to help applicants understand why maintaining their mental health is important and the benefits of certain support services.

Specialised care (level 4 of the MHPSS pyramid): different types of psychotherapeutic interventions can support the management of a condition. In the case of PTSD, trauma-focused cognitive behavioural therapy, testimonial therapy and narrative exposure therapy as well as different types of medication (e.g. antidepressants, anxiolytics) or combinations of a certain psychotherapy and medication might be recommended.

the Netherlands

In 2016, the Resilience project ([55]) was initiated by Nidos and the National Trauma Center called ARQ Centrum'45 ([56]), founded in 2007 and supports those impacted in coping with stress alongside traumatic experiences. Initially focused on Eritrean youths, the project later expanded to include Syrian and Afghan youths. A distinctive feature of the intervention is its outreach nature, where a therapist, along with an intercultural mediator, visits the young person. The meeting takes place at a location chosen by the young person, often at their residence, leveraging the advantage of the therapist having good connections with those in the immediate living environment of the young individual, such as a youth guardian and residential counsellor. To assist the young individuals, intercultural mediators were recruited and trained in the interventions that were crucial for the successful roll out and support to the therapists.

Belgium

The University of Leuven has established a possibility for applicants for international protection and refugees to receive day treatment referred to as Trauma-care for refugee youth ([57]).

At the request of Fedasil, Red Cross-Flanders opened a Center for Intensive Counselling of Asylum Seekers in the buildings of the reception centre in Sint-Niklaas for this target group. A maximum of 40 residents can stay there for 3 months. The Red Cross in Wallonia also provides intensive support for people with mild mental health problems. The maximum capacity is 40 places for families or single men/women. For 3 months, renewable 1 time.

The POZAH ([58]) project helps adult applicants with severe psychiatric problems who therefore need specific and specialised treatment and care. It is a collaboration between Psychiatric Hospital Sint-Alexius and Fedasil. The goal is maximum integration into society. They are supported with a multidisciplinary team of psychiatrists, psychologists, social assistants, case managers, interpreters, nurses and experts by experience.

([55]) Nidos (guardianship for refugees, the Netherlands), 'Resilience Project', NidosinEurope website, accessed 16 August 2024.
([56]) ARQ National Trauma Center, 'The Organisation', ARQ website, accessed 16 August 2024.
([57]) University Psychiatric Center KU Leuven, 'Info for referrers – Trauma care for refugee youth', upckuleuven website, accessed 16 August 2024.
([58]) L. Claus , M. Schouler-Ocak , M. H Braakman, B. Sabbe 1, G. Van Beuren, S. van den Ameele, 'Unlocking asylum seekers' voices: protocol of a mixed-method clinical study on the use of the cultural formulation interview with asylum seekers in Belgium', Front Psychiatry, 14: 1156803, 2023.

Applicants presenting with a psychotic disorder such as Schizophrenia

It is important to consider the cultural and ethnic backgrounds of service users when the applicant is suffering from a mental health disorder(s). The expression of symptoms 'may vary and be shaped by common cultural idioms, cultural histories or personal histories that are prominent in identity formation and expressed as grandiose ideas or beliefs' ([59]).
A change in mood is differently expressed in different cultures. At times somatic symptoms are declared to describe however emotional distress including 'low' mood. Depending on the culture the use of symptoms and words can differ. The reason to not share that one feels depressed and potentially might need support but rather uses physical explanations to explain a condition might be due to fear of stigmatisation.

Lastly, insight into the condition might be an issue as is stigmatisation. Reflect on terminology to use when touching upon mental health that referring to seeing a psychologist or psychiatrists might be seen as being considered 'crazy' and can impact the working relationship between the officer working first line and the applicant in need of support.

For more information on trauma-informed treatment refer to the Centre d'expertise sur le bien-être et l'état de santé physique des réfugiés et des demandeurs d'asile (CERDA, Centre for Expertise on the Well-Being and Physical Health of Refugees and Asylum Seekers) ([60]).

Vulnerable applicants and the abuse of substances

'Substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs' ([61]) and gambling and gaming. According to the 2022 European Drug Report (EUDA, formerly the European Monitoring Centre for Drugs and Drug Addiction) ([62]), drug availability and use remain at high levels across the EU.

While substance use is a wider problem, including within European society, it also appears to be a problem for some applicants for international protection. A recent joint study between the EUAA and EMCDDA ([63]) found consensus that substance use (disorders) among applicants upon arrival is generally lower compared to host populations. This may reflect substance use behaviour in their countries of origin. However, applicants seem to be more vulnerable once they have arrived in Europe to substance misuse as a way of negative coping mechanism in response to the complexity of migration and the issues they experience. It may be used to cope with experiences of trauma, unemployment, poverty, loss of family and social support. The availability of

([59]) WHO, *Clinical descriptions and diagnostic requirements for ICD-11 mental, behavioural and neurodevelopmental disorders*, 2024, p.237; 'T. Stompe et al, who examined groups of patients diagnosed with Schizophrenia in the same data set later used by Bauer et al. Using discriminant analysis, they argued that between 15 % and 30 % of the psychotic symptomatology examined in their study was culture dependent, 16 % for hallucinations specifically.' T. Stompe et al, 'Culture and Hallucinations: Overview and Future Directions', Schizophr Bull, June 2014.
([60]) CERDA, *Working with refugees, a trauma informed approach*, 2022.
([61]) WHO, 'Health topics, substance abuse', WHO – African Region website, accessed 12 August 2024.
([62]) EUDA, *European Drug Report 2022: Trends and Developments*, 2022.
([63]) EUAA and EMCDDA, *Professionals working in reception centres in Europe: an overview of drug-related challenges and support needs*, 2023.

substances may increase use over time, since different substances are easily accessible in Europe compared to the countries of origin of applicants.

Substance use has multiple implications for the affected applicants, posing harm to their mental and physical health, negatively affecting their social interactions and connectedness and bringing isolation and stigma. It can also negatively affect their families and the community. The impact of post-arrival stressors in relation to starting to use substances seems still to be underestimated. There is a **strong correlation between trauma and substance use**. Starting with 'self-medication' due to feelings of grief and loss, shame and guilt can be seen as a form of negative coping.

Young, single men are especially vulnerable to engaging in substance use activities as are unaccompanied minors who often feel hopeless and isolated over an extended period, experience extreme boredom due to a lack of activities or peers they could reach out to. They often consequently face social problems, which leads to further isolation. Experts participating in the study conducted by the EUAA and EUDA noted that an open drug scene at times exists close to camp settings, which makes access to illicit substances even easier.

the Netherlands – motivational sessions during Ramadan

For Muslim youths, Ramadan is a period of fasting and a time to be patient, humble and spiritual, maintaining pure thoughts and taking time to reflect. During this period, no alcohol is consumed and no drugs are used. This makes it a suitable time to discuss the function and role that substance uses plays in the lives of many young people. During the Ramadan period therefore, young people gather weekly for discussions. The sessions take place at the end of the day and conclude with an Iftar (the meal that traditionally breaks the fast after sunset). The goal of these sessions is to strengthen internal motivation for potential behaviour change by:

- raising awareness of their own talents, ambitions, and goals;
- exploring their own values;
- becoming aware of the discrepancy between their current behaviour and their ultimate ambitions.

After the last session, there is an opportunity for those interested among the youths to embark on an individual journey. The programme is initiated by Nidos (National Guardianship institution for Unaccompanied Minors) and is carried out in collaboration with the Dutch central agency for the reception of asylum seekers.

Officers working with applicants in the first line can benefit from additional training, such as in motivational interviewing and solution-focused working to help them interact meaningfully with applicants.

Coordination with local care facilities (drug rehabilitation services) and the availability of interpreters and cultural mediators with the necessary cultural competence can facilitate the engagement with those in need. Investment in developing short-term intervention programmes is particularly useful when engaging with unaccompanied minors who might present with a substance use problem. Such programmes seem particularly promising when based on cognitive behavioural therapy, motivational interviewing and solution-focused therapy.

- The EUDA toolkit brings together useful tools and resources for anyone involved in shaping decisions, opinions and policies in Europe regarding the science-based prevention of substance use ([64]). In particular, the toolkit states 'Prevention has more to do with positive child and adolescent development rather than with talking adolescents out of drugs.'
- The Council of Europe handbook ([65]), which aims to provide 'practitioners with the insight and resources they need to adequately treat and respond to the needs of refugees, migrants and IDPs [internally displaced people] in the context of substance use disorders.' Refer particularly to Chapter 4 on prevention.
- The work on strong families first by the United Nations Office on Drugs and Crime and the University of Manchester ([66]), which focuses on support to those affected and their parents.
- The Flemish centre of expertise for alcohol, illegal drugs, psychoactive medication, gambling and gaming (VAD) ([67]), which has produced several important tools to support in the work on substance use.
- Part III – Toolbox, Section 'Vulnerable applicants and substance abuse'.

Lastly, the approach to substance use by the senior management of a respective reception facility is crucial. There is a difference between approaching the topic of substance use by reducing the risks of those being hosted to engage in such behaviour and ensuring a strong and integrated MHPSS package for their support or by simply indicating that drugs are not allowed in a respective reception setting and introducing a sanction system. While in certain situations of individual and/or collective danger where limits will need to be set, in most situations a needs-based, applicant-centred approach with responses adapted to the affected person is vital.

([64]) EUDA, 'Prevention toolkit', updated 28 March 2023.
([65]) Council of Europe, *Intercultural Responses to drug-related challenges for refugees, migrants and IDPS Handbook for professionals working in the field of addictions with refugees, migrants, and internally displaced persons*, 2022.
([66]) United Nations Office on Drugs and Crime and the University of Manchester, *Caring for your child in crisis situations*, 2020.
([67]) Flemish Centre of Expertise on Alcohol and Other Drugs (VAD), 'Working on alcohol and drugs with asylum seekers and refugees', 7 March 2019 (in Dutch).

Victims of torture

Torture and other forms of inhuman and degrading treatment and punishment is often associated by those working in the first line with severe physical pain and visible injuries. However, psychological torture and abuse such as humiliation, sleep deprivation, exposure to mock and real executions and other horrendous acts leave emotional scars. If the effects of such torture and abuse are not addressed through rehabilitative care, they can have a long-term impact on the physical and mental health and well-being of victims. The aftermath of torture not only affect the physical and mental health of the victims but can also play a role in how their family members feel. The impact can lead to negative coping in both the individual and the family and can limit their potential to recover.

The table below provides a summary of some of the potential signs and impact of torture on individuals ([68]).

Common signs in victims of torture	
Psychological	Symptoms such as flashbacks, nightmares, anxiety, insomnia, fatigue, diminished self-esteem, and survivor guilt; psychiatric disorders such as depression and PTSD. Particularly important in the context of sexual torture, forced nudity severely affects mental health since an individual is never as vulnerable and helpless as when naked. Threats of loss of masculinity and the subsequent loss of respect in society can trigger anxiety. The risks of pregnancy or the fear of the social stigma around the loss of virginity can also be paramount for women ([69]).
Social and behavioural	• challenges in social interactions • disruptions in marital and family relationships • inability to trust • withdrawal
Physical	Signs include 'scars, headaches, musculoskeletal pains, foot pains, hearing loss, dental pain, visual problems, abdominal pains, cardiovascular/respiratory problems, sexual difficulties, chronic disability, injuries to ligaments, neurological damage' ([70]) and sexually transmitted diseases.
Cognitive	intrusive thoughts or memories of the act of torture, difficulty concentrating, confusion, disorientation and poor or loss of memory.

([68]) The Center for Victims of Torture, 'Effects of torture', 25 August 2023.
([69]) Office of the Special Representative and Co-ordinator for Combating Trafficking in Human Beings, *Trafficking in Human Beings Amounting to Torture and other Forms of Ill-treatment*, Occasional paper series, no 5, 2013.
([70]) The Center for Victims of Torture, 'Effects of torture', 25 August 2023.

Organising support for victims of torture

A mapping report compiled by the EUAA on victims of torture ([71]) suggests that applicants and victims of torture tend to disclose their experiences and needs relatively late, if at all. The disclosure often only takes place at the time of the personal interview as part of the asylum procedure.

Psychoeducation and the timely and relevant **information provision** on how to access specialised services, including rehabilitation, is important. Furthermore, a human and empathic approach during the examination procedure, including during the personal interview, can increase the ability and willingness of victims to come forward.

C**reate several moments during the asylum pathway** for potential victims of torture to speak out including upon arrival. Therefore, asking questions that could indicate experiences of torture in an initial medical detection exercise can be helpful.

While pharmacological treatment, physical rehabilitation services and psychotherapy through **specialised care** (level 4 of the MHPSS pyramid) can be helpful for victims, **testimonial therapy** (levels 2-3), a brief intervention designed to improve well-being in victims of torture and organised violence, has also shown promising results. This therapy allows victims to share their stories while receiving psychotherapeutic and community-based support. Refer to the Section Examples of support interventions.

Examples of specialised medical interventions for **victims of torture with chronic pain** and other specific forms of pain, are rheumatological and neurological care with different forms of pain management and rehabilitation programmes. The effectiveness of such support provided is even more obvious once guaranteed that a **combined treatment** (specialised care and community-based support) effort is ensured.

Information to applicants and presumed victims of torture on the possibility of taking part in a **medico-legal-forensic assessment** (level 4 of the MHPSS pyramid) linked to the experience of torture if relevant for the examination of their asylum claim is also important and their right. Confidentiality and empathy in handling such applicants is crucial. For more information, refer to the revised **Istanbul Protocol** ([72]).

Appointing trained focal persons specialised on the topic of torture within an administration to support the timely and relevant follow up of specific need's victims might be beneficial. This is the case for both reception settings and it is also relevant for the determining authorities in the context of the personal interview.

([71]) EUAA, *Victims of torture, Identification, support and examination of claims*, March 2023.
([72]) United Nations Human Rights Office of the High Commissioner, *Istanbul Protocol*, Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Professional training series No. 8/Rev. 2, 2022.

Applicants seeking **rheumatological care** ([73]) often present with spinal pain and it has been observed that many of them have a history of torture. Resolving emotional issues is crucial before addressing physical goals in their rehabilitation.

Psychologically based rehabilitation programmes including **relaxation techniques** have shown **positive outcomes** in treating persistent pain, improving function and reducing distress and anxiety. Providing a holistic approach to rehabilitation is crucial also to reduce the risk of self-medication (e.g. using Tramadol) the problematic usage of which has been noted by experts in some EU+ countries. Where applicable, involving family members of a victim of torture can help to strengthen family ties, reduce stigmatisation and nurture healing. While medical support accompanied by MHPSS to victims of torture is crucial on their journey to recovery, accountability and justice is equally important to support their rehabilitation.

Important considerations linked to children

Torture is often discussed in the context of adult applicants for international protection but children can also be affected. This can either be experienced directly when torture has been inflicted on them or indirectly when being forced to witness such acts inflicted against family members. Torture can have a disruptive effect on children's developmental process not only psychologically and emotionally but also physically and socially. The impact and reactions can differ depending on the child's age, cognitive skills, supportive environment and the length of the exposure.

Children may not exhibit having memories of torture, however, they might exhibit signs of anxiety, irritability or of feeling on guard. Children also may develop PTSD symptoms similarly to adults. Adolescents may face trouble managing emotions and thoughts and present with behavioural and relational problems. However, they also may regress ([74]) to previous developmental levels and lose previously acquired skills (i.e. presenting with enuresis).

Children that exhibit alarming symptoms indicating that they have been victims of torture directly or indirectly should be referred to specialised support, assessed and treated by trained mental health professionals. Where possible trusted family members should be involved in the process and supported through parenting consultations. Interventions should be initiated as early as possible to avoid further development of the effects of trauma and enhance the resilience of the child ([75]).

- European Network of Rehabilitation Centres for Survivors of Torture, ***Refugee survivors of torture in Europe – Towards positive public policy and health outcomes***, 2018.
- EUAA, ***Victims of torture, Identification, support and examination of claims***, March 2023.
- European Migration Network ad-hoc query, ***Practices and challenges in identifying victims of torture and ill-treatment in the context of international and temporary protection***, 2023
- For more insight on a holistic support provision to victims of torture, refer to the International Rehabilitation Council for Torture Victims, ***Strategy 2022-2025***, 2021.

([73]) Frank, A. O., De Souza, L. H. and Frank, C. A., 'Neck pain and disability: a cross-sectional survey of the demographic and clinical characteristics of neck pain seen in a rheumatology clinic', International Journal of Clinical Practice, Vol. 59, pp. 173–182, 2005.
([74]) UNICEF, *Psychological First Aid for children, adolescents and families experiencing trauma – Guide for First Responders*, 2021.
([75]) United Nations Human Rights Office of the High Commissioner, *How can children survive torture?*, 2016.

Applicants with suicidal thoughts

Certain research ([76]) has used the term 'lethal hopelessness' to describe 'the increased suicide risk in [applicants] due to a combination of limited access to mainstream services, financial support, culturally safe healthcare, and working rights' ([77]). They propose a public health approach to address distress and suicidality in asylum seekers, emphasising immediate support from mental health professionals and where applicable facilitate successful resettlement. Suicide and self-harm are also prevalent in applicants for international protection and other third-country nationals waiting for deportation. To mitigate the risk of self-harm and including due to suicidal ideation, it is beneficial to conduct a screening of the risks of suicide.

What are some of the warning signs linked to suicidal thoughts?

Those working with applicants in the first line should pay attention to the following warning signs presented in a non-exhaustive list.

Warning signs that may indicate suicidal tendencies

- **Talking about suicide** and statements such as 'I'm going to kill myself', 'I wish I were dead' or 'I wish I hadn't been born' can be indicators that the applicant might plan to hurt themself. Indication of a wish to die should be taken seriously.
- **Losing hope** regarding their situation (waiting for a decision on their application for international protection) and increased willingness to use substances (mainly alcohol/cannabis).
- **Hoarding** pills, storing shaving blades, showing interest in other weapons (knives, guns, etc.) and trying to get hold of such things.
- **Withdrawal and distancing** from friends, family and other social contacts and stopping engaging in hobbies, etc.
- Increase in **mood swings**, extreme highs and lows and engagement in risky behaviour and general self-harm tendencies.
- **Preoccupation with death**, dying and/or violence.
- **Changes in eating and sleep pattern** such as a loss of appetite and a general lack of sleep.
- Talking about **formulating a will** or selling / giving away the little belongings one might have.
- **Changing** their way of engaging with others and changing personality.
- Saying that **soon nobody will have to bother** taking care of them and saying goodbye to family and friends ([78]).

([76]) (N. G. Procter, A.M. Kenny, H. Eaton, C. Grech: 'Lethal hopelessness: Understanding and responding to asylum seeker distress and mental deterioration', 2017.
([77]) F. Laughton, 'About Suicide Screening, Referral, and Imminent Harm in Washington State, 3 units (325)', 2024, p. 13 citing Ingram J, Lyford B, McAtamney A, et al. (2022). Preventing suicide in refugees and asylum seekers: a rapid literature review examining the role of suicide prevention training for health and support staff. Int J Ment Health Syst 16, 24.
([78]) Adjusted from information provided by the Mayo Clinic, 'Suicide: What to do when someone is thinking about suicide', 12 August 2023.

Organising support for applicant with suicidal thoughts

As a general point, evidence indicates that **early intervention practices** can help **prevent mental illness and suicide** among applicants ([79]).

Therefore, involving **all** applicants as soon as possible strategically along the asylum and reception pathway in community-based activities (refer to the chapter **Examples of community-based support interventions** as part of this guidance and level 2 of the MHPSS pyramid) can nurture resilience. To reduce psychological stress in applicants and the risk of suicide, provide applicants with **information** on services available to them but also on topics which can make their life in the new setting clearer such as information on the local culture, values and ways to behave in a respective host country etc. Cultural competency is relevant for applicants to feel more ready and comfortable to initiate an integration process and adjust to their new context.

Simultaneously, **officers working in the first line** are also to be enabled and equipped to:

- identify some of the warning signs (see above),
- have the ability to provide psychological first aid.
- provide accurate information on where to refer applicants in need of support
- and access to information on referral partners which can ensure more focused or specialised support (level 3–4 of the MHPSS pyramid) to an applicant in crisis

Further, important:

- Suicide prevention training has shown promise in improving the ability to understand, identify and manage suicidality in applicants experiencing suicidal thoughts or psychological distress ([80]).
- Gatekeeper training ([81]), is integral to comprehensive approaches to suicide prevention and has proven effective in other population groups.
- The presence of trained specialists in suicide prevention ([82]) interventions can reduce suicidality in distressed individuals. Such training should focus on cultural appropriateness, the use of interpreting services and the benefits of incorporating cultural or spiritual services and groups alongside mainstream medical and psychological services to effectively address suicide prevention.
- The use of sensitive language and cultural competency by support staff will be important.
- Incorporating actual case studies and role play into suicide prevention training for health staff working with applicants can enhance their confidence and capacity to address suicidal distress. The presence of health workers in reception facilities and other support staff interacting closely with applicants can support the prevention of incidents through early recognition of signs of suicidality.
- While it is crucial to prepare first-line officers for critical incidents ([83]) and how to manage such incidents including suicide, creating an awareness of the fact that not all applicants who might be suicidal can be 'saved' and the importance of being realistic can reduce stress in those working on the first line.

- UNHCR, ***Planning for prevention and risk mitigation of suicide in refugee settings***, field testing version, 2023.
- IASC, ***Addressing Suicide in Humanitarian Settings***, 2022.
- For more information on applicants and the risk of suicide, refer to **Part III – Toolbox**.

([79]) Robinson, J., 'Early intervention and suicide prevention', *Early Intervention in Psychiatry*, 2008, Vol. 2, No 3, pp. 119–211; Weine, S. M., 'Developing preventive mental health interventions for refugee families in resettlement', Family Process, 2011, Vol. 50, No 3, pp. 410–430.
([80]) M. Ferguson et al, 'Suicide prevention training – improving the attitudes and confidence of rural Australian health and human service professionals', National Libera of Medicine, 2018.
([81]) BMC Psychiatry, 'Brief gatekeeper training for suicide prevention in an ethnic minority population: a controlled intervention', 2016, Vol. 16, pp. 1–9.
([82]) Ingram, J., Lyford, B., McAtamney, A. et al. 'Preventing suicide in refugees and asylum seekers: a rapid literature review examining the role of suicide prevention training for health and support staff', Int J Ment Health Syst 16, 24, 2022.
([83]) EUAA, *Critical Incident Management in Asylum and Reception*, 2022.

Applicants and gender-based violence

The WHO estimates that 'worldwide, nearly 1 in 3, or 30%, of women have been subjected to physical and/or sexual violence by an intimate partner or non-partner sexual violence or both' ([84]). It is not only women at risk; children and individuals with diverse SOGIESC, men or those living with a physical or cognitive disability can also be at risk.

The IASC defines gender-based violence (GBV) as:

> *an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (i.e. gender) differences between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty. These acts can occur in public or in private.* ([85])

GBV is a general problem, but, in a context of war, prolonged insecurity, natural disaster, forced displacement, affected populations are at an elevated risk. However, applicants for international protection with an unclear legal status, dependency due to lack of financial means, language skills or existing special needs might put certain groups of applicants in a disadvantaged position.

The five main interrelated types of GBV ([86]) are physical, psychological, sexual, socioeconomic and verbal (including hate speech).

Impact of the different types of GBV on an individual	
Psychological	Symptoms such as anxiety, flashbacks/nightmares, extreme feelings of guilt and shame and suicidality Psychiatric disorders such as depression, PTSD and alcohol and drug abuse.
Social and Behavioural	• disruptions in marital and family relationships and/or being isolated from the family/ community particularly when a woman becomes pregnant through rape; the loss of virginity can be an additional reason why survivors are ostracised; • forced marriage to the person who perpetrated the sexual violence which can lead to a continuation of domestic violence experienced upon arrival in Europe; • inability to trust; • promiscuity; • self-harm; • withdrawal.
Physical	Unwanted pregnancies, complications from unsafe abortions, female sexual arousal disorder or male impotence and sexually transmitted infections, including HIV but also impact on the neurological, gastrointestinal, muscular, urinary, and reproductive systems can be a consequence, eating disorders, self-harm (cutting).
Cognitive	Difficulty concentrating, confusion and poor or loss of memory.
Concern linked to victims of trafficking in human beings	• secrecy and reluctancy to talk about themselves or their needs due to fear of repercussion; • strong dependency on certain people, unwilling to make their own decisions; • presence of or attempts to hide gang tattoos; • owning expensive items such as mobile phones or clothes; • child applicants might pretend to be older than they are.

([84]) WHO, 'Key facts', 2024.
([85]) IASC, *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action Camp Coordination and Camp Management Food Security and Agriculture Reducing risk, promoting resilience and aiding recovery*, Global Protection Cluster, 2015, p.5.
([86]) Council of Europe, 'Types of gender-based violence', COE international website, accessed 30 August 2024.

Organising support for applicants who have experienced GBV

Disclosure of experiences of GBV, particularly when violated by family members or partners and when sexual violence has been perpetrated, will take time. Investing and allowing for time will be crucial in building rapport and to build trust.

For some applicants, the violence, exploitation and abuse experienced back home might have been the reason to leave and seek refuge in Europe. These experiences might be the main component of their application for international protection. Psychological support to cope with such past experiences might be essential for some. Others might have experienced acts of GBV during transit and/or in the host countries which will also require attention and support. It may require different interventions (e.g. a person who has been raped within a reception facility will require immediate medical follow-up and the involvement of law enforcement).

Those working in the first line appointed to focus on the area of GBV should familiarise themselves with information regarding the countries of origin and transit of the populations they are working with. This will help to understand if in that country(ies):

- sexual and GBV is common;
- violence due to armed conflict is widespread.

This can help in asking more targeted questions and supporting the applicant in a sensitive manner. Such an approach may be more effective even at an early stage of the asylum pathway. This knowledge can also be relevant to provide support from those working with the determining authorities ([87]).

When interpretation services are needed, providing a choice is always good practice, irrespective of the vulnerability or potential special need but particularly vital when experiences of sexual violence is suspected.

Additional points to consider

- **Psychoeducation** and the relevant information provision on the importance of disclosure to ensure relevant medical care and psychological care can be provided is crucial. Particularly when a sexual violation has been committed in the host country and the victim could still benefit from post exposure prophylaxis or the morning after pill to avoid pregnancy, both of which are to be administered within 72 hours after the violation took place).
- A human and victims/survivor- centred approach ([88]) ensuring confidentiality aids the willingness by those affected to speak out.
- **Medical attention** by a specialist to examine potential physical and psychiatric consequences (e.g. gynaecologist, paediatrician, urologist, psychiatrist or clinical psychologist) and depending on the need and context, individual psychotherapy (level 4, MHPSS pyramid) might be required in holistically supporting those who have suffered sexual violence.
- **Group counselling sessions** (level 3 of the MHPSS) can help survivors realise they are not alone with such experiences and that there is room for hope that one can move forward after such an experience.
- **Community-led efforts** (level 2 of the MHPSS pyramid) such as relaxation exercises or creative activities can support recovery.
- **Creating safe spaces** ([89]) ([90]) for women and girls to meet, exchange, connect and receive counselling where needed.
- Connecting victims/survivors with **legal advice/services**.
- Ensuring access to **protective shelter or** a safe house when needed, which can accommodate the needs of different groups of survivors of GBV (single women, women with children, applicants with diverse SOGIESC).

The guiding principles in the work with GBV survivors are respect, non-discrimination, self-determination and dignity, confidentiality, safety and security. Well-trained police officers who might be involved in supporting GBV survivors are important. Trust in the authorities and particularly in police might can be a concern for victims/survivors ([91]).
Refer to the IASC guidelines for more information on for integrating interventions on GBV in humanitarian action ([92]).

([87]) Court of Justice of the European Union, judgment of 20 April 2023, *WS v Intervyuirasht organ na Darzhavna agentsia za bezhantsite pri Ministerskia savet, third party: Predstavitelstvo na Varhovnia komisar na Organizatsiyata na obedinenite natsii za bezhantsite v Bulgaria*, Case C621/21, EU:C:2023:314.
([88]) IASC, *Definition & Principles of a Victim/Survivor Centered Approach*, 2023.
([89]) EUAA, *Mental Health and Well-being of Applicants for International Protection – Part III. Toolbox supporting the implementation of mental health and psychosocial support*, 2024, Sections 'Working with vulnerable applicants' and 'Child-friendly spaces and safe spaces for women and girls'.
([90]) EUAA, *Protecting women and girls in the asylum procedure*, Fact Sheet 24, June 2024.
([91]) European Union Agency for Fundamental Rights, *Underpinning victims' rights*, February 2023.
([92]) IASC, *Guidelines on integrating Gender Based Violence Interventions in Humanitarian Action*, 2015.

Belgium

It is estimated that 58 % of female migrants arriving in Europe and about 38 % male migrants have experienced violence ([93]). It is therefore important to adopt an integrated and holistic approach ranging from the detection of the needs to the service delivery with meaningful case management in place. The care may include forensic, medical and psychological care. A project was designed and implemented to promote inclusive holistic care for migrant victims of sexual violence (INHeRE).

The INHeRE project ([94]) linked to the International Centre for Reproductive Health Belgium (ICRH Belgium), which is a multidisciplinary research institute within Ghent University, has produced the following useful tools ([95]).

Sweden

The Swedish Migration Agency is part of the collaboration forum called National Method Support against Prostitution and Human Trafficking ([96]), which is coordinated by the Swedish Gender Equality Agency. Method support is a strategic resource for the development and streamlining of collaboration to counteract human trafficking. Some examples are human trafficking for sexual purposes, the removal of organs, war service, forced labour or other activities that place people in a vulnerable situation. The collaborating authorities are the Swedish Gender Equality Agency, Swedish Migration Agency, Swedish Police Authority, municipal social services and the Swedish Prosecution Authority.

([93]) International Centre for Reproductive Health Belgium, *Inclusive Holistic Care for Migrant victims of sexual violence*, 1 November 2019 – 31 October 2021.

([94]) The INHeRE project was implemented between 1 November 2019 – 31 October 2021. The project developed several tools to support those working in the first line in providing care. This included care for applicants that had been trafficked, those with diverse SOGIESC and victims of sexual violence. ICRH Belgium, 'Inclusive Holistic Care for Migrant victims of sexual violence (INHeRE)', ICRHB website, accessed 10 September 2024.

([95]) Refer to S. Lamonaca, K. Vanhoutte, L. Linthout, L. De Schrijver, V. Clarke, R. Correia, I. Keygnaert, *Good practice tool for police hearings with migrant, applicant for international protection, refugee (MAR), trafficked, and LGBT+ victims of sexual violence*, 2021; I. Keygnaert, L. Linthout, *Triage Tool for identification, care and referral of victims of sexual violence at European asylum reception and accommodation initiatives*, 2021; A. Verelst, N. Szelei, V. Clarke, O. Boychenko, L. Linthout, I. Keygnaert, *Safe reporting framework for migrant victims of sexual violence*, 2021 ; PAG ASA, payoke, SÜRYA, *You are staying in Belgium, you do not have the Belgian nationality and you find yourself in one or more of these situations*, 2009, which provides information to presumed victims of trafficking in human beings; *PAG-ASA*, a civil society organisation support victims of THB particularly the section on victim support.

([96]) Swedish Migration Agency, 'Collaboration against crime', last updated 14 June 2021.

Trafficking in human beings

While trafficking in human beings can affect anyone, it is a gender-specific phenomenon ([97]) ([98]) and women, men and children are trafficked for different purpose. The main victims are still women ([99]) and girls. They are trafficked mainly for the purpose of sexual abuse and exploitation and domestic servitude. Men are trafficked more for the purpose of forced labour or criminal activities ([100]).

When an officer working in the first line suspects that an applicant has been victimised, liaising with protection agencies and relevant stakeholders is required, while always ensuring the safety and protection of the victim. If the victim consents to the referral to the anti-trafficking unit of the police, they may be assisted by the officers working in the first line. Trafficking of human beings is a serious crime that abuses people's fundamental rights and dignity.

Officers working in the first line can assist in the timely identification of potential victims of trafficking and raising awareness to reduce the risk of others falling victim to trafficking, including to e-trafficking ([101]). Expanding knowledge in the fields of criminology, human trafficking and cybersecurity can further empower officers to effectively combat these modern-day challenges.

Different actors, institutional and non-institutional, are involved in different ways in the identification process and they contribute best case scenarios in a **multi-agency** and **multi-sectoral perspective** ([102]) to the protection of victims of trafficking. This is from the stage of first entry or tracking in the territory, together with the initial measures of protection of the person, also to ensure their personal safety. The identification of trafficked persons is a single process, consisting of multiple actions and generally carried out by different subjects, aimed at the gradual emergence of relevant elements/indicators. It can be divided into two stages ([103]):

- early/preliminary identification, aimed at an initial analysis of the circumstances that may reasonably lead one to believe that the person concerned is a victim of trafficking or is at risk of becoming one;
- formal identification, carried out by qualified and authorised persons, which aims to establish whether the person is a victim of trafficking.

It is crucial to emphasise that being a victim of trafficking does not negate an individual's right to seek asylum. A victim of trafficking may have a valid claim for asylum. Non-EU nationals are granted a reflection period ([104]) to recover and to escape the influence of the perpetrators of the offences. Providing a reflection period to recover while having access to health and mental health services and receiving the relevant information and legal counselling to make an informed decision is important and a legal obligation. Generally, the collaboration between different government entities and institutions to counteract crimes such as trafficking in human beings is important.

([97]) Council of Europe, 'Physical violence', COE international website, accessed 10 September 2024.
([98]) European Union: Council of the European Union, 'Council Framework Decision 2002/629/JHA on preventing and combating trafficking in human beings', July 2002.
([99]) Eurostat, 'Prevalence of females involved in trafficking of human beings', 2015 – 2022, 24 January 2024.
([100]) Eurostat, '10.093 registered victims of human trafficking in 2022', 24 January 2024.
([101]) UNODC, *Good Use and Abuse: The Role of Technology in Human Trafficking*, 2021.
([102]) EUAA, *Victims of human trafficking in asylum and reception*, Situational Update, Issue No 21, August 2024.
([103]) Danish Refugee Council under the Free2Link project: 'Operational tools for prevention and early identification of potential victims of e-trafficking', 30 November 2020.
([104]) 'European Commission' on reflection period.

GBV

- EUAA IPSN online tool ([105]) can support to learn more about special needs linked to several vulnerable groups including those who might have been subject to sexual violence but also victims of trafficking in human-beings, among others.
- UNHCR has invested a lot of time and efforts in ensuring the necessary guidance and resources for GBV specialists as well as those with little knowledge ([106]).
- The IASC has invested in the development of training modules on GBV ([107]).
- IOM work addressing GBV in crisis situations ([108]).
- Refer to the Global Protection Cluster, and their animation ([109]) to introduce the 16 Interagency Minimum Standards for GBV in Emergencies Programming.
- Refer to standards developed by the WHO, Center for Disease Control, the United States of America's President's Emergency Plan for AIDS Relief, Johns Hopkins Program for International Education in Gynecology and Obstetrics ([110]).
- On the topic of female genital mutilation, refer to Fedasil (Belgium) and their efforts to assess such risks and how to best organise the relevant referrals. Strategies Concertees, 'Checklist à faire avant de saisir un service spécialisé (liste non exhaustive)', 2023, available at **https://www.strategiesconcertees-mgf.be/wp-content/uploads/2023_DE%CC%81TECTOME%CC%80TRE_FR.pdf**

Trafficking in human beings

- European Commission and its strategy ([111]) against the trafficking of human beings, which promotes a holistic response to the crime, while also highlighting the gender dimension and the importance to pay attention to women and minors
- See the EU Anti-Trafficking Directive ([112]) which set's common rules on how to support and protect survivors of trafficking in human beings
- United Nation Office on Drugs and Crime (UNODC) ([113]) and their Global Programme Against trafficking in human beings.
- IOM, and their work on the identification of victim of trafficking ([114]).

In addition, refer to the following publications:

- The e-learning modules on trafficking and e-trafficking by a project called Free2Link ([115])
- See the Federal Migration Center (myria) and their multidisciplinary approach on fighting trafficking in human beings ([116]).

For more information on MHPSS and related topics, also refer to **Part I – Senior management**, 'Annex 4. Building capacity on topics linked to mental health and psychosocial support'.

([105]) EUAA, *Identification of Persons with Special Needs tool*, 2016.
([106]) UNHCR, *Gender Equality Toolkit*, 2020.
([107]) Refer to the website of the IASC
([108]) IOM, Department of Operations and Emergencies, *Institutional Framework for addressing gender-based violence in crisis situations*, 2018.
([109]) IASC, animation 'Introducing the 16 Inter-Agency Minimum Standards for GBV in Emergencies Programming', 2021.
([110]) Jhpiego, the U.S. Centers for Disease Control and Prevention and the WHO, *Gender-based violence facilitation guide, Standards for the provision of high-quality post-violence care in health facilities*, 2022.
([111]) European Commission, *Communication from the Commission to the European Parliament, the Council, The European Economic and Social Committee of the Regions on the Strategy on Combatting Trafficking in Human Beings*, 2021-2025, Brussels, 14.4.2021 COM(2021) 171 final.
([112]) Directive 2011/36/EU of the European Parliament and of the Council of the 5 April 2011 on preventing and combating trafficking in human beings and protecting its victims, and replacing Council Framework Decision 2002/629/JHA, (OJ L 101/1, 15.4.2011).
([113]) UNODC, *Human trafficking indicators*, 2008; *Toolkit to Combat Trafficking in Persons*, 2006, *section of reflection period for more information and indicators of trafficking*, Tool 6.4.
([114]) IOM, *Screening interview form of the International Organization for Migration for the identification of victims of trafficking*, 2008.
([115]) Project Free2Link is funded by the European Union's Rights, Equality and Citizenship Programme (2014-2020) of the European Commission. The project is available at https://free2link.eu/about-the-project/.
([116]) Belgium has adopted a multidisciplinary approach, see Myria – Federal Migration Centre, 'A multidisciplinary approach', https://www.myria.be/en/traff-and-smuggling/a-multidisciplinary-approach.

Applicants with diverse SOGIESC

It is important to point out diverse SOGIESC do not constitute a vulnerability or a special need *per se*. However, LGBTIQ applicants might have specific needs stemming from their SOGIESC. For instance, they may have suffered isolation in their community back home and this may have left them vulnerable to violence and exploitation during transit. Such vulnerability may persist in the host country if support is not provided in a timely manner.

Applicants with diverse SOGIESC might be reluctant to disclose their diverse SOGIESC during the registration process. It is therefore paramount to stress that privacy and confidentiality is ensured throughout the procedure. Applicants with diverse SOGIESC might have faced specific and challenging situations, for example: have left countries where consensual same-sex relations are criminalised; have engaged in transactional sexual activities to make a living; have been exposed to violence and exploitation. Some LGBTIQ applicants might be wary to reveal their SOGIESC to staff upon arrival but also later during stay in reception, due to fear of stigmatisation, discrimination and abuse. As a result, they may abstain from seeking services.

Against this background, it is vital that officers working in the first line have general awareness of the challenges associated with this group of applicants. The authorities should be able to provide them with safe access to counselling and peer support, for example by resorting to LGBTI- specialised outreach volunteers, specialised civil society organisations (level 3 of the MHPSS pyramid) as well to ensure access to specialised care (level 4 of the MHPSS pyramid) ([117]).

First-line officers themselves may have their own prejudice towards certain minority groups. For example, some might have a misconception that LGBTIQ persons have some mental health problems. Therefore, it is essential to train staff and interpreters on the topic of applicants belonging to a minority group, e.g. applicants with diverse SOGIESC.

Refer also to the EUAA, ***Practical guide on applicants with diverse sexual orientations, gender identities, gender expressions and sex characteristics – Reception***, 2024.

How to support access to specialised care for applicants with divers SOGIESC

Some applicants with diverse SOGIESC might face psychological distress due to experiences of abuse, homophobia or transphobia. Years of discrimination and abuse can lead to an increased likelihood of mental health concerns and a need for focused and specialised care. Others might have intersecting vulnerabilities and also be in need of medical care.

([117]) UNHCR, *Need to Know Guidance: Working with lesbian, gay, bisexual, transgender, intersex and queer persons in forced displacement,* 2021.

Signs of distress and needs of applicants with diverse SOGIESC	
Emotional	They might have faced and still be facing psychological distress due to experiences of abuse, social isolation and homophobia/transphobia. Some might have been exposed to attempts of 'retraining' on part of their families and communities. This might have led them to question their SOGIESC. As a result, the spectrum of their emotions might include anger, irritability, high stress level, anxiety, signs of depression, panic, mood changes and feelings of guilt. It is important to acknowledge and address these emotions to support individuals in coping with their feelings effectively.
Behavioural and social	Some applicants might engage in risky behaviours, e.g. substance misuse/abuse, promiscuity, self-harm such as cutting and suicide attempts and social isolation. These types of behaviour can indicate their emotional struggles and it is important to address them with the appropriate support. Homelessness and poverty can also be signals of such distress.
Physical	Examples of physical signs of distress include change in sleep patterns, potential eating disorders (lack in appetite or overeating/obesity), sexual transmitted infections e.g. HIV infection or cervical cancer resulting from human papillomavirus infection. For those who have started a hormone therapy, additional challenges might arise, which need to be considered by those providing support. It is crucial to recognise and address these physical manifestations of stress to support the well-being and overall health of the individuals ([118]).

Providing support to applicants with diverse SOGIESC

The referral system in place should ensure access to healthcare providers knowledgeable of the psychological and potential health needs of this group of applicants.

LGBTIQ-sensitive medical care could include e.g. transgender transitional care, surgery and hormone therapy as well as **LGBTIQ-sensitive forensic care** for victims of sexual violence. Both should be accessible by LGBTIQ applicants (level 4 of the MHPSS Pyramid).

While LGBTIQ applicants are not a special needs group **per se**, they can be at heightened risk of human trafficking and sexual exploitation. **Accommodation in protective shelters** and/or coordination with anti-trafficking units and medical and mental health and psychosocial support services might be advised for the purpose of protection, including of their mental health.

Refer applicants who self-identify as LGBTIQ to specialised civil society organisations who provide **psychosocial support** to persons with diverse SOGIESC, or to provide them with **information** about such organisations (levels 2-3 of the MHPSS Pyramid).

- EUAA Guidance on SOGIESC:
  - *Practical guide on applicants with diverse sexual orientations, gender identities, gender expressions and sex characteristics – Information note*, 2024.
  - *Practical guide on applicants with diverse sexual orientations, gender identities, gender expressions and sex characteristics – Reception*, 2024.
  - *Practical guide on applicants with diverse sexual orientations, gender identities, gender expressions and sex characteristics – Cross-cutting elements*, 2024.
  - *Practical guide on applicants with diverse sexual orientations, gender identities, gender expressions and sex characteristics – Examination of the asylum procedure*, 2024.
- EUAA, *Applicants with diverse SOGIESC*, training module information, 2023.
- UNHCR, *Working with Lesbian, Gay, Bisexual, Transgender, Intersex and Queer Persons in Forced Displacement*, 2021.
- The Open Society Foundation and Negative/Positive, 'Born Julius and Julia', is a comic developed for youths about SOGIESC. The story details the difficulties an intersex person can face and why the person might have had to leave their country.

([118]) B. Bass and H. Nagy, 'Cultural Competence in the Care of LGBTQ Patients', National Library of Medicine, last updated 13 November 2023.

Psychological needs of applicants placed in detention

Applicants in EU+ countries might be detained by the authorities for different reasons. They might be detained for a certain period to verify their identity or nationality, as part of the return process or of a transnational-transfer procedure, or due to security considerations. No matter the context, detention is a last resort and should be as short as possible. While detention is often organised outside of reception, there are countries where reception authorities do provide support services to those in closed facilities.

What makes detention so critical is that, depending on the personal situation, the situation in the country of origin and the migration route taken, persons arriving in Europe have often experienced detention pre-arrival. Being in a closed facility following an experience of detention can have a devastating impact on the individual's MHW. Healthcare in detention centres must therefore be provided. The mental health situation of the persons in closed facilities must be continuously assessed. Proactively take measures to minimise the negative impact that detention can have on MHW.

The impact of detention on the MHW of applicants	
Adults	• Sense of hopelessness. • Increased feelings of lack of control, which can lead to anxiety and depression. • Change in sleep pattern. • Low frustration tolerance, self-harm tendencies and verbal/physical aggression towards others. • Restlessness, inability to concentrate. • Suicidal ideas. • Neglect in personal hygiene and/or lack of opportunity to take care of personal hygiene, which can impact the well-being of a person.
Organising support for those detained	
Adults	• Examine applicants placed in detention upon arrival to determine their physical and mental health and thereby ascertain whether the person requires treatment for mental health concerns and/or illness. If vulnerabilities are identified, alternatives to detention are recommended. • Train all staff in contact with detainees to recognise basic signs of psychological distress and mental illness. • Provide applicants in detention with the opportunity to be informed on their asylum application on a regular basis, including expected timelines. • Provide access to both somatic and psychiatric care when needed, also for preventative purposes. • Guarantee platforms to safely communicate with other detainees, and family or friends residing outside of the detention facility. • Provide low-threshold community psychosocial support to strengthen resilience and involve detainees in daily activities. • Make those in detention feel seen and heard as individuals by all staff. • Give the detainees the opportunity to go outside in the fresh air daily. • Ensure access to critical stakeholders such as UNHCR, legal service providers or other NGOs providing mental health services.

Detention and MHW

Children, and particularly unaccompanied and separated children, should in principle not be detained for immigration-related purposes, irrespective of their legal/migratory status or that of their parents.

The detention of children can never be seen in their best interests ([119]). The impact of detention on children is devasting on their psychological and physical well-being. It can undermine their cognitive development, create risk of developing depression and an anxiety disorder, and lead to insomnia and nightmares, including bedwetting. Alternatives for detention, such as family-based alternative care options or other suitable care arrangements or engagement-based alternatives are therefore to be organised whenever possible. Also refer to the European Court of Human rights (ECHR) ([120]) and the Advocacy Series by the United Nations Task Force on Children Deprived of Liberty ([121]).

Generally, while under **Article 5(1), point (f) of the European Convention on Human Rights** it is possible to detain a person for the purpose of deportation and or to prevent illegal entry, the need to support detainees to prevent ill health are to be addressed in a timely fashion. Simultaneously information on the timeline of detention is to be provided.

The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment considers that 'the **prolonged detention** of a person under aliens' legislation, **without a time limit** and with **unclear prospects for release**, could easily be considered to amount to **inhuman treatment**' ([122]).

In addition, refer to the MHPSS minimum service package, a checklist for an effective emergency response. See also Section **4.2. Provide mental health and psychosocial support to persons deprived of their liberty** on how to provide MHPSS to those deprived of their liberty.

([119]) EUAA, *Detention of Applicants for International Protection in the context of the Common European Asylum System – Judicial analysis*, 2019; European Court of Human Rights, judgment of 5 April 2011, *Rahimi v Greece*, Application No 8687/08; European Court of Human Rights, judgment of 19 January 2010, *Muskhadzhiyeva and others v Belgium*, Application No 41442/07; ECtHR, 2006, *Mubilanzila Mayeka and Kaniki Mitunga v Belgium*; European Court of Human Rights , 2012, *Popov v France*, paragraphs 91 and 119. UNHCR's position is that detention is never in the best interests of the child and that effective alternative care arrangements should be provided. This is in accordance with similar positions issued by the UN Committee on the Rights of the Child and the UN Special Rapporteur on Torture. See UNHCR, *UNHCR's position regarding the detention of refugee and migrant children in the migration context*, Division of International Protection, January 2017.

([120]) European Court of Human Rights, *Unaccompanied migrant minors detention*, Factsheet, February 2024.

([121]) United Nations Task Force on Children Deprived of Liberty, *End Immigration Detention of Children*, Advocacy Brief, 2024.

([122]) European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, *Immigration Detention*, March 2017, p. 2 (emphasis added).

Internet-based therapy

Different digital formats of care such as internet-based therapy have emerged as a potential solution to address the urgent problem of limited accessibility of care to those in need, including asylum seekers and refugees. Many individuals exposed to disruptive and traumatic events do not receive timely evidence-based treatments due to various barriers (e.g. lack of availability of specialists, language barriers). However, telehealth methods that use modern technology can help overcome some of these barriers and provide accessible care.

Internet-based treatment focuses on training aspects and self-help and can help reduce stigmatisation associated with seeking care. **Digital interventions** that **also include human support** contribute not only to more regular use and a lower dropout rate, but also to a greater reduction in symptoms compared with those without human support. Digital interventions are complementary to direct human encounter, not a replacement.

Switzerland

Sui SRK is a Swiss Red Cross application ([123]) for refugees in Switzerland. It is free of charge, in various languages and combines support (S), unaided self-help (U) and information (I). It provides anonymous access to psychological and psychosocial support for asylum seekers and refugees, with and without mental health conditions, who are exposed to post-arrival stressors. The main objective is an improvement of their quality of life and well-being.

The **app targets** asylum seekers and refugees aged 15 years and older living in Switzerland, regardless of residence status, with a focus on those with low educational levels. The Sui app has the following characteristics.

- **User-centred design.** Bottom-up development.
- **Evidence-based.** The intervention is based on psychoeducational content and exercises that have been successfully applied with the target group in analogous settings.
- **Safety.** High priority is given to data protection and data security.
- **Flexibility.** The digital service can be implemented as self-guided, as a stand-alone intervention and as a guided service.
- **Scalability.** The intervention is scalable for different target groups and contexts in and outside of Switzerland since the content and structure of the platform are separated.

The app was built on existing software from the Freie Universität Berlin and contains nine modules with information about Switzerland (e.g. asylum procedure, residence status, family reunification, housing, healthcare system, work/education). These informative modules are linked to low-threshold psychoeducational content and psychological exercises (stress, audio exercises, sleep, chronic pain, resources and emotion regulation). Users can also receive in-app and on-demand support via chat by non-specialist peer guides, who themselves have a migration background and speak the same language as the user.

([123]) Swiss Red Cross, 'Sui SRK app', available at https://www.migesplus.ch/en/sui.

The use of artificial intelligence in the field of health and well-being

What is artificial intelligence?

The International Business Machines defines artificial intelligence (AI) as follows.

'AI leverages computers and machines to mimic the problem-solving and decision-making capabilities of the human mind.' ([124])

According to a high-level experts group working for the European Commission, AI refers to systems – either purely software-based or combined with hardware that are:

> *designed by humans that, given a complex goal, act in the physical or digital world by perceiving their environment through data acquisition, interpreting the collected structured or unstructured data, reasoning on the knowledge derived from this data and deciding the best action(s) to take … to achieve the given goal* ([125]).

AI has found its way into our daily lives (education, housing, online services recommendations, etc.). AI system applications have also become more visible in the field of migration and refugee and asylum management. Some examples are (a) biometric identification (automated fingerprint and face recognition), (b) emotion detection, (c) algorithmic risk assessment and (d) AI tools for migration monitoring, analysis and forecasting ([126]).

What are the benefits and limitations of AI in the area of health?

The use of AI technology is more and more discussed in the area of health. Some considered AI useful when it comes to identifying or assessing mental health concerns. Certain providers claim that they 'can now detect depression just by listening to someone speak a few sentences' and to their surprise, 'the language or the words spoken aren't as important as *how*' the person speaks ([127]). Other research projects focus on screenings of different biomarkers that are collected and analysed to predict mental health concerns before the person is even aware ([128]), or on the roll-out of AI with a focus on suicide prevention– as in the project STOP ([129]). Another example is the Woebot App ([130]), which focuses on mental health support to adolescents. The application claims 'to replicate the way clinicians move through a session, using great conversational design and the familiar modality of smartphones to enable teens to engage'.

([124]) See the definition of AI at IBM, 'What is artificial intelligence?', updated 16 August 2024.
([125]) European Commission, *A definition of AI: Main capabilities and scientific disciplines – Definition developed for the purpose of the deliverables of the High-Level Expert Group on AI*, Brussels, 18 December 2018.
([126]) European Parliamentary Research Service, *Artificial intelligence at EU borders*, Overview of applications and key issues, 2021.
([127]) G. Kesar, Forbes magazine, 'AI Can Now Detect Depression From Your Voice, And It's Twice As Accurate As Human Practitioners', 2021.
([128]) Eurnoews, 'Scientists are using fitness trackers and AI to detect depression with '80% accuracy', 22 October 2022.
([129]) S. Mariscal, 'How AI and mental health combined could prevent depression', 2021.
([130]) The app is available at https://woebothealth.com/.

There are however also voices who are critical about the use of AI for mental health support. They suggest that 'the urgency of the crisis doesn't mean that we want a lower-quality solution, or that we want a solution that doesn't work' ([131]).

AI as a useful tool in relation to mental healthcare centres around the three main factors.

- The lack of access to and availability of mental health professionals (in terms of distance).
- The lack, in some cases, of consistent quality care that is affordable to most people in need.
- The fact that the individuals and their families impacted by mental health concerns are still stigmatised, potentially within their own family or society. Some people feel more comfortable talking to a machine since the attention received is less likely to exhibit bias or discrimination in the way a human might.

While some might suggest that having a psychotherapy chatbot for vulnerable people is better than having no form of therapy at all, there is a real concern that some countries will be 'satisfied' with this service and reduce the number of mental health professionals deployed in the future. Such an approach can change the framing of mental health support for refugees, so the new minimum standard becomes the offering of psychotherapy chatbots, potentially preventing some refugees from getting more substantive support, while clarity on the actual effectiveness of this support is still to be evaluated.

It is important to keep in mind that some mental health concerns applicants present with might have been triggered by a **lack of human encounter** during pre-arrival detention ([132]) or other disruptive and traumatic events experienced throughout the migration process. Human encounter is completely missing if there is a pure focus on technology. Making technology more humanlike in terms of appearance to overcome such concerns may not hold ([133]).

As to stigmatisation, awareness and psychoeducation can support reducing the risk of stigma more generally and consequently reduce the need to resort to chatbots.

AI might have advantages particularly when it comes to psychological distress and needs emerging in a situation where there is a lack of actual human services. Access to family, friends and services during the COVID-19 pandemic by using technology was extremely useful for many.

However, a human encounter cannot and should not be replaced by a pure focus on technology in a broader sense ([134]). The impact that isolation may have on individuals and their mental health should be remembered. Let us think of the COVID19 pandemic as a recent example Actual physical **human encounter** and **connectedness are key pillars** when it comes to the mental health and well-being of anyone, including applicants.

([131]) G. Brown, *The problem with mental health bots*', 2022.
([132]) Derluyn, I., Orsini, G., Adeyinka, S., Behrendt, M., Rota, M., Uzureau, O., & Lietaert, I. and the childmove project, *The impact of flight experiences on the mental health of unaccompanied minors on the move*, 2022. The report covers interviews with unaccompanied minors on the move regarding their MHW.
([133]) N. Meyer, M. Hammerschmidt, W. Weiger, 'AI and the Vulnerable', 2022.
([134]) UNHCR, *Designing Safe Digital Mental Health and Psycho–Social Support (MHPSS for Displaced and Stateless Adolescents*, 2023.

As indicated in the section on community (refer to Community-based interventions) in the majority of case, simple and cost-effective platforms for applicants to communicate and exchange (e.g. child-friendly spaces or safe spaces for women and girls), combined with daily routine and basic psychosocial support, can support MHW and reduce the risk of deterioration of conditions, thus making **AI systems redundant**. Finally, it will be crucial to assess case by case if AI can be the right technology to support a vulnerable population/person for a certain period. When using AI, the authorities should bear in mind the following basic considerations ([135]).

- Weigh the benefits against the risks. In general, avoid AI if possible and instead strengthen community-based support initiatives.
- Use AI systems that are contextually based.
- Include local communities in the planned AI initiatives to create better understanding on why they are used.
- Implement algorithmic auditing systems.

The lack of clear safeguards linked to rolling out AI and the potential (ab)use of personal and health information shared online may be devastating for certain vulnerable groups such as applicants for international protection arriving in Europe.

([135]) The Digital Humanitarian Network and a report by J. Wright and A. Verity called, 'Artificial Intelligence Principles for Vulnerable Populations in Humanitarian Contexts', 2020.

4

Psychoeducation

What is psychoeducation?

Education entails that a person 'learns' what was shared and is enabled to use the information shared and knowledge gained. Psychoeducation (like health education) therefore means **learning, understanding and being aware** what can negatively impact one's MHW and how to strengthen resilience. It also aids understanding of how one's body, mind and emotions can be impacted due to different strains or stressors and can provide some simple self-help techniques (e.g. relaxation exercises to reduce a sense of stress).

Why to roll out psychoeducational activities?

Generally, the better informed and knowledgeable a person is, the more likely it is that they will be able to make healthy decisions and successfully deal with adverse situations. This is true also for applicants. Psychoeducation gives applicants access to information on a given theme, such as sleep, stress or similar. At the same time, it supports in translating techniques and information received into actions to address and to deal with their problem. Psychoeducation strengthens the mental health literacy of a person.

Mental health literacy refers to the ability to:

- recognise mental health problems;
- have knowledge and understanding about risk factors and causes;
- have knowledge about self-help interventions;
- have knowledge and understanding about professional help available and how to access it;
- have attitudes that assist with recognition and appropriate help-seeking;
- know how to seek appropriate mental health information ([136]).

Applicants may have been exposed to many stressors in their country of origin, during their journey (e.g. violence, separation from loved ones) or at different stages of their asylum and reception pathway (e.g. loss of social support, discrimination). Having access to accurate and reliable information about MHW from the moment of arrival, tailored to individual needs, can support mental health literacy and constitutes a preventative measure.

Who rolls out psychoeducational activities?

Psychoeducation can be provided by officers working in the first line, who understand the basic needs and potential effects of prolonged psychological distress (and trauma) on mental health and well-being. These professionals can recognise some of the signs (137), respond appropriately to applicants experiencing mental health issues, provide empathic and non-judgemental support, refer the person to mental health professionals if needed and link with care and case management where applicable (for more information, refer to Section Access to care).

Who can benefit from psychoeducation?

Psychoeducation is useful for anyone. For applicants, psychoeducation can be particularly important as they may be experiencing mental health challenges related to their experiences of forced displacement, trauma and resettlement. By providing applicants with:

- culturally sensitive,
- linguistically appropriate
- and evidence-based information about mental health,

officers working in the first line can help them understand their experiences and consequently better manage their MHW. It can also help to reduce stigma around mental health conditions and interlinked vulnerabilities and encourage applicants to seek the appropriate support they need. As a consequence, psychoeducation can encourage self-disclosure.

([136]) Jorm, A.F., et al., '"Mental health literacy": a survey of the public's ability to recognise mental disorders and their beliefs about the effectiveness of treatment', Med J Aust,166(4), 1997, p. 182-6; Canberra Health Literacy Club, 'Mental health literacy', accessed 12 September 2024.

Ensuring basic psychoeducation for officers working for the administrations in different capacities, but also for lay counsellors and the applicant community, can create broader awareness on how to prevent mental health concerns and nurture well-being.

How to enable officers in rolling out psychoeducation effectively

Additional skills and knowledge will benefit those rolling out MHPSS ([138]), officers providing information on health- / mental health-related topics and those engaged in psychoeducation, all will need some. Officers working in the first line should be trained on the topics below.

- **Initial support** and how to identify basic needs and mental health concerns; referral to appropriate resources; cultural sensitivity; and trauma-informed care. Providing **initial support** may include education and resources directly to applicants to help them better understand and manage their own MHW (see the promising practices below), as well as active listening, the ability to proceed with a crisis intervention ([139]) and managing referrals to appropriate services. Referral mechanisms should be part of an internal protocol of the organisation.
- Recognising **basic signs and symptoms** of mental health concerns, such as anxiety, depression and psychosis, to help to identify applicants who may need mental health support. Knowledge on applicants' referral to appropriate formal and informal support, such as counsellors or community organisations, is also important (also refer to Section Applicants presenting with a mental health disorder).
- **Cultural sensitivity** ([140]) is crucial to ensure reliable support to the applicants and to understand how cultural factors may impact mental health.
- **Trauma-informed care** ([141]) with dos and don'ts to recognise the impact of traumatic experiences on mental health and to create a safe and empowering environment for individuals seeking care.
- **Consideration of intersectionality of vulnerabilities** is important, for example on how mental health can intersect with a substance use problem.

Strengthening the capacity of first-line officers through training is important ([142]).

([137]) EUAA, 'Psychological First Aid Video', YouTube, 2023 and the accompanying *instructions*.
([138]) IASC, *Mental health and psychosocial support minimum service package*, 2022.
([139]) EASO, *Practical guide on the welfare of asylum and reception staff – Part III: Monitoring and evaluation*, 2021, Section '3.3. Critical incident management' and annexes 9–12.
([140]) For more information, refer to EUAA, *Mental Health and Well-being of Applicants for International Protection – Part III. Toolbox supporting the implementation of mental health and psychosocial support*, 2024, Section cultural competency.
([141]) The principles of trauma-informed care include promoting physical and psychological safety of applicants, to emphasise the importance of relationships and the need for time to build trust, provision of peer support and the collaboration between the potentially impacted applicant, their family and the first-line officer. Nurturing agency and promoting intersectionality is vital. Also refer to Chapter 2 of: Miller, K. K., Brown, C. R., Shramko, M. and Svetaz, M. V., 'Applying trauma-informed practices to the care of refugee and immigrant youth: 10 clinical pearls', Children (Basel), 2019, Vol. 6, No 8, p. 94.
([142]) For a list of training courses and capacity building options, refer to EUAA, *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*, 2024, Annex 5. .

Mental health literacy is an important consideration. Psychoeducation is therefore to be considered throughout **all four levels** of the MHPSS pyramid. When applicants with specific needs are identified during psychoeducational activities (e.g. applicants with a substance use problem), they are to be referred to internal/external resources, including specialised support where applicable (level 4 of the MHPSS pyramid). Normally this is with the consent of the applicant as long they do not pose a danger to themself or others.

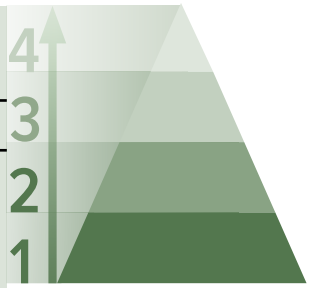
Applicants with specific mental health and psychosocial needs might be identified during psychoeducational activities as well. To avoid premature referrals for treatment, use a stepped care approach ([143]). This approach ensures that the mental healthcare provided matches the real needs of the applicant, as identified by a vulnerability and/or special need assessment. The care provided can cover the full spectrum of interventions such as:

- self-help,
- low-intensity interventions such as community support measures or digital psychosocial support,
- focussed specialist care.

This approach promotes an applicant centred care and adopts the principle of using the least intensive treatment option with a focus on the applicants' actual needs. Needs can change. If this is the case, any measures and treatment put in place will need to change accordingly.

In addition, refer to **Part III – Toolbox**, Section 'Rolling out psychoeducation'.

([143]) Australian Government on Primary Health Alliance, *What is mental health stepped care? Mental Health Factsheet*, 2020.



Promising practice and support material

Psychoeducational activities can be implemented at all levels of the MHPSS pyramid. To ensure prevention or mitigating the risks of deterioration of a condition, providing meaningful psychoeducational activities at levels 1 and 2 are to be considered.

Applicants facing psychological distress can benefit from psychoeducation. Different formats can be used. See the **three such formats** below as an example.

A. **Group psychoeducation.** Trained officers provide information about mental health conditions, treatment options and the available resources in a group setting. These sessions can be held in person or online and can be tailored to specific populations or concerns identified. The applicant community can also be trained and pro-actively involved in organising peer-to-peer psychoeducational activities, e.g. through regular meetings in community centres.

B. **One-on-one psychoeducational.** First-line officers who are trained in counselling can work with individuals with mental health concerns one-on-one to provide support and referrals to additional services focusing on certain needs. As part of such counselling sessions psychoeducation can take place to help applicants to better cope with their situation.

C. **Self-help products for applicants.** Officers working in the first line and the applicant community can provide printed materials, such as brochures, leaflets or fact sheets, that provide information about mental health conditions, treatment options (including online tools) but also how to prevent conditions from worsening or emerging in the first place.

The material can also be distributed during group (A) and individual (B) psychoeducation sessions. Material should include where relevant intersecting concerns such as substance use and self-medication, suicidal thoughts, experiences of sexual abuse or diverse SOGIESC, stress reduction and relaxation techniques. Depending on the context, techniques introduced in the information material can be jointly practiced and discussed (in group / individually) for a better understanding.

Example A: group psychoeducation efforts

Mindfit ([144]) is an intervention rolled out in the Netherlands that focuses on psychoeducation at an early stage and aims at strengthening mental health and psychosocial skills and to empower participants. The sessions are interactive and pay attention to skills, such as the ability to recognise (signs of) mental health problems and learning to deal with stress.

Mind-Spring ([145]) is a psychoeducational group programme by and for asylum seekers and refugees that is presented in the participants' native language. It is always run by a trainer who has a refugee or immigrant background. The programme is not curative but rather preventative. Examples of topics discussed include natural reaction to an abnormal situation, stress, stress symptoms and the vicious cycle how to cope/deal with stress, loss and mourning etc. In this regard also refer to a charity based in the United Kingdom called **Oasis** ([146]), whose main emphasis is among others to support the integration of refugees and asylum seekers. In addition, refer to the manual created by the Danish Refugee Council focusing on MindSpring ([147]).

([144]) The mindfit.nl, accessed 10 September 2024.
([145]) ARQ is a Netherlands-based National Psycho-trauma Centre that aims to help people, organisations and societies to minimise the psychosocial impact of traumatic events. Refer in particular to ARQ, 'Mind Spring – Preventative intervention for and by refugees', 2004-ongoing (in Dutch).
([146]) For more on preventative psychoeducational group activities, see OasisCardiff, 'Mind-Spring', accessed 19 August 2024.
([147]) Danish Refugee Council, *Manual – MindSpring for Young Adults, Group activities for and with refugee young adults: a preventative health resource*, 2021.

Example B: one-on-one psychoeducation efforts

The **ALIN** project (workshop – language – inclusion – new technologies) (Luxembourg) 'targets beneficiaries of international protection who are experiencing psychological distress and survivors of human trafficking. The project proposes activities that can help people who are traumatised to avoid self-destructive thinking patterns, enhance creativity and re-establish self-esteem' ([148]).
De Kracht van Gedachten vluchtelingen ([149]) ('the power of thoughts') is a four-meeting module based on rational emotive therapy. The person becomes aware of the influence of (negative) thoughts on their own mood and learns to think more healthily. By thinking more realistically, the person feels stronger and can cope better with problems.

Example C: self-help products for applicants

The **EUAA** self-help tools for parents, children and peer support ([150]) comprises three pocketbooks directly targeting applicants. They provide tips and reminders on how to recognise psychological distress and best support parents, children and friends who find themselves in such a situation. The pocketbooks are complemented by instructions for first-line officers on how to use the pocket series during awareness raising sessions as part of individual or group support.
Self-help for survivors of trauma: a very efficient relaxation method (5 minutes) for self-help until professional care is available called the **trauma tapping technique** ([151]).
Breathing and relaxation exercises ([152]) can meet specific needs by reducing physiological activation. They can help applicants with high levels of anxiety.
Support in coping with intrusive thoughts and intense emotional reactions by using **relaxation tools** ([153]) in different languages.
Sanadak ([154]) is an interactive self-help intervention for people with refugee experience. It is an Arabic-language, mobile-optimised website that can be used on any smartphone.
Self-care strategies ([155]) by IOM, mainly targeting male Syrian applicants in Germany.
The **self-help tool on poor sleep and worries** ([156]) can be used by affected people themselves and can support applicants to understand why distress can impact physical and mental health and well-being. It focuses on sleep patterns (poor sleep) and how to address the problem.

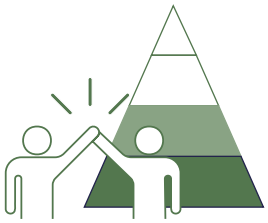
the Netherlands

The bamboo project ([157]) is a mental healthcare prevention programme for asylum seekers. Asylum seekers learn how to enhance their own resilience, recognise stress and psychological issues, and understand how to seek help from a professional. The program **does not focus on the treatment of trauma**, mental disorders, or underlying problems, but aims to increase factors such as personal strengths, positive emotions, positive relations and self-esteem.

([148]) Red Cross Europe, 'Healing by doing – promoting mental health among beneficiaries of international protection', accessed 19 August 2024.
([149]) GGNet, 'About GGnet', accessed 19 August 2024.
([150]) EUAA, Instructions for First Line Officers Working in Reception on Rolling out Psychoeducational Material on *Psychological Distress to Parents and Children*, 2023.
([151]) Self-help for trauma, 'Benefits of Self Tapping', accessed 19 August 2024.
([152]) Care4refugees provides breathing exercises available at https://www.care4refugees.com/relax.html.
([153]) Group for the Abolition of Female Sexual Mutilation (Belgium), 'A relaxation tool', accessed 19 August 2024.
([154]) The Sanadak ('I'll call you') application is available in English, Arabic and German at https://www.sanadak.de/.
([155]) IOM, *Self-Care Handbook for Syrian Men in Germany*, 2021. The handbook is based on the experiences of Syrian men living in Germany, supplemented by the perspectives of sisters, mothers, wives and daughters.
([156]) Agentschap, Integratie and Inburgering, *Poor Sleep, worry and Stress – A guide for people with a migration background*, September 2019.
([157]) GZA (Asylum Seeker Healthcare), 'Bamboo project', Gzasielzoekers website, 1 January 2020-ongoing.

5

Community-based interventions



What are community and a community-based approach?

'What makes community a unique form of human systems is the **diversity** of its composite elements' ([158]). Communities are not stable constructs as they continuously evolve. The people forming communities in the context of migration carry a richness of differences and similarities in terms of experiences, 'gender, sociocultural background, physical and mental ability, ethnicity, language and religion/faith' ([159]). All these elements can be seen as a **resource** to support the MHW of community members. A community-based approach refers to the involvement of community members, in different formats and with different aims.

A **community-based approach** is a participatory and inclusive way of **working in partnership** with the applicant community during **all** stages of the asylum and reception pathway and in **all** the phases of a programme: needs assessment, identification of the problems and the goals, prioritisation, design, implementation, monitoring and evaluation. The involvement and participation can be pro-active, meaning that community members are involved in the planning, designing of activities and might initiate as well as lead activities which they deem useful to them. Community members can also join the activities planned, developed and offered to them by the authorities in collaboration with different partners.

([158]) IOM and USAID, *Manual on community-based mental health and psychosocial support in emergencies and displacement*, 2nd edition, 2022, p.323.
([159]) Bedson, J. and Abramowitz, S., 'UNICEF minimum quality standards and indicators for community engagement', 2020, p.6.

Why is a community-based approach useful to mental health and well-being?

Adopting a community-based approach brings a wide range of benefits. It can help communities to independently 'prevent social problems and to deal directly with those that do arise' ([160]), including responding to certain concerns in a cultural appropriate way instead of counting only on external actors such as services provided by the authorities.

Adopting a community-based approach can therefore nurture the following.

Community empowerment: a process by which people re-gain control over their lives and that can foster collective efficacy ([161]).

Sense of community: it acts positively as a determinant of physical and mental health and is 'an attitude of bonding, or mutual trust and belonging, with other members of one's group or locale' ([162]) and a sense of not being alone. As such it can help prevent increased distress, poor psychological functioning and mental health illness. Finally, social connection can offer individuals social and psychological support ([163]).

Further, a **sense of community** and enhanced **community relationships** can act as a **protective factor** for people already dealing with mental health illness, as they ([164]):

- provide emotional warmth and connectedness;
- contribute to the person's feeling of being a member who influences their community and is influenced by it;
- help the person cover their physical and psychological needs through existing resources (e.g. traditions celebrated, community leaders).

A community-based approach also nurtures the **participation of community members**, which can support the successful delivery, uptake and reach of programmes focusing on MHW. Community participation is more likely to restore a sense of ownership in the applicants ([165]) and to exert influence in decision-making processes affecting their lives. As such, it allows community members to be the agents of their own development and to fulfil their own potential. This approach allows for an increased understanding of the sociocultural context. At the same time, it can reduce coordination needs from the side of the authorities and, in the long term, also reduce needs in terms of human and financial resources, since certain activities are stronger when they are community-led.

([160]) Bedson, J. and Abramowitz, S., 'UNICEF minimum quality standards and indicators for community engagement', 2020, p.9.
([161]) WHO, 'Health promotion', Track 1: Community empowerment, accessed 2 September 2024.
([162]) D. Offutt, 'Reviving the Rules, Roles, and Rituals Of Resiliency', Theses and Dissertations, Curriculum and Instruction. 32, 2020, p.60, https://uknowledge.uky.edu/edc_etds/32; McMillan, D. W. and Chavis, D. M., 'Sense of community: a definition and theory', Journal of Community Psychology, 1986, Vol. 14, No 1, pp. 6–23.
([163]) Kim, E. S. and Kawachi, I., 'Perceived neighbourhood social cohesion and preventive healthcare use', American Journal of Preventive Medicine, 2017, Vol. 53, No 2, pp. 35–40.
([164]) Terry, R., Townley, G., Brusilovskiy, E. and Salzer, M. S., 'The influence of sense of community on the relationship between community participation and mental health for individuals with serious mental illnesses', American Journal of Community Psychology, 2019, Vol. 47, No 1, pp. 163–175.
([165]) UNICEF, *Community-based mental health and psychosocial support in humanitarian settings: Three-tiered support for children and families*, 2020.

Magnifying the resources that already exist in a community brings the resilience and agency of the community to the forefront. This increases the prospects of sustainability of any intervention and opens to community ownership of the improvements achieved. The direct involvement of community members in activities that enable them to learn new skills also provides a sense of 'normality': applicants are engaged in caring for themselves and others as they used to do before they were forced to flee.

How to roll out or enhance a community-based approach

A **community-based approach** mainly links to the **levels 1 and 2 of the MHPSS** pyramid. It requires understanding and consideration of: community and gender dynamics; protection risks; resources and strengths of the community, including knowledge on applicants belonging to a certain cultural, social and educational group (e.g. the less represented and the most vulnerable) and members who might be agents for change; how to build on the existing capacities, skills and resources of applicants to maintain MHW in a cultural-, age- and gender-appropriate way. To be able to roll out a community-based approach a genuine interaction with the community is required.

Community-based support interventions can also play a crucial role in the treatment and recovery of applicants in need of focused and specialised care (**levels 3 and 4** of the MHPSS pyramid). Refer to Section Promising practice and support material.

- Include the community from the earliest possible point of an intervention and programme (e.g. needs assessment).
- Identify and analyse the needs and priorities of the community, as perceived by its members, in depth. Decision-making regarding interventions should be based on holistic and evidence-based data.
- The design and implementation of interventions should be directly related to the needs, expectations and preferred outcomes of the community.
- Tailor interventions to the characteristics of every context. This includes resources and context-related limitations.
- Failure to include all the groups that reside within a community and to consider their particular situations and needs may result in further discrimination and social exclusion. This, in turn, may increase the vulnerability of specific groups and lead to their exploitation. Therefore, all the different community groups should be represented in all phases of an intervention. Pay attention to the representation of vulnerable groups in particular.
- Involving the local/hosting communities in tailored activities nurtures integration and a better understanding of one another and reduces potential stigmatisation.
- Community-based approaches and inspiring practices mostly focus on stay in reception and the integration process. However, examples of a community-based approach also exist in the return phase ([167]).

Who is the target of a community-based approach?

This approach places a particular focus on vulnerable people ([166]) such as the elderly, people living with disabilities, unaccompanied children, women, people with mental health problems but also under-represented or marginalised groups and those who do not have equal access to care and/or are hard to reach.

The needs of vulnerable, marginalised and underrepresented groups often overlap with the needs of the overall community. Different approaches to reach each community should coexist and be enhanced by any approach targeting the wider community.

([166]) Not every person that has specific needs are vulnerable. A person living with a physical disability might require the use of a wheelchair. Once provided with a wheelchair, the person is therefore mobile and the need is addressed. Conversely, an elderly person might have age-related needs and may be generally more vulnerable though not yet exhibit a particular special need.

([167]) IOM, *Voluntary Return and Reintegration: Community-Based Approaches*, 2018.

Promising practice and support material

Active participation of the applicant community in programme design

To allow for the meaningful roll out of MHPSS activities, ask for the views of applicants on their needs and how to address them. Work on the topic of mental health requires that the occurrence of any potential stigma is addressed carefully.

Community involvement and needs assessment

Assessing the situation. Those working in the first line organise **focus group discussions**, where applicable, with **diverse** groups of applicants to understand the following points.

Sample questions	Safeguards and steps to take
• What are the main needs linked to mental health and well-being? • What are the priorities of those affected (e.g. persons in distress)? • What are the current coping strategies and capacities of applicants in the given setting? • Which of the current services are deemed useful and might need to be expanded? What seems less of use and why? • Are there any other potential or emerging risk factors not yet addressed? • Are there members of the applicant community with the interests/skills to implement a certain support activity themselves?	• The purpose of the focus group discussions should be communicated in advance to ensure informed participation based on consent (especially for children and their caregivers). This will reduce the risk of discomfort since some might believe that the discussion could influence the outcome of the asylum procedure. • Homogenous group composition is advised, taking gender, age, nationality, cultural/religious background and family composition into consideration to allow for an open discussion. • Applicants in severe distress or facing any other serious physical or mental condition during the time of the consultations **should not** be involved; this is to reduce the risk of triggering discomfort. ◻ The consultations should therefore involve the applicants who have been perceived as not living with an acute or serious mental health problem by the first line teams assigned to them. • The availability of after care (psychosocial follow-up) should be granted if the content discussed in the focus group discussions triggers negative emotions. • When including applicants below the age of 18, involve a child protection specialist and ensure the consent of parents/caregivers. • The organisers of the focus group discussions keep track of the total number of participants as well as data on gender, average age, educational background, nationalities (including statelessness) and family composition.

Prioritisation. The first-line officers who gather the information analyse the findings and see which of the issues might need prioritisation and why. Analysis is linked to the following questions.

- What type of service provision seems most relevant according to the discussions?
- Which group(s) is/are to be prioritised / mainly in need?
- Any suggestions in terms of timeframe?
- Any suggestions in terms of format of activities to be rolled out to address the needs/challenge(s) identified (e.g. in person, in a group/individual setting, online, printed material, community activities etc.)?
- What are the existing or potentially emerging risks that the group(s) shared? Any suggestions for preventive action(s) with respect to these risks or actions to reduce them?

Delivery of interventions

- Consider the **safest**, most realistic and most relevant intervention(s) with highest impact for the larger applicant community and integrate the activities/needs pointed out by the applicants. Check if community-based support is accessible, psychoeducation activities are rolled out, focused and/or specialised care is being provided and if there are services providers identified (protection, social services, legal counselling, law enforcement etc.) to receive referrals when needed.

Considerations should also include:

- cost effectiveness;
- the availability of skilled support in the given context;
- timeframe available to roll out the activity;
- knowledge on how to access specialised care (incl. other somatic medical professionals) for those in serious need.

Feedback and learning

- The first-line officers collect feedback from the community on the services and integrate any lessons learnt into the design of an updated MHW action plan.

A **community-based approach** does not only involve applicants but, where applicable, it also **pro-actively** aims to involve the **host community and refugee population**. This approach can lead to better mutual understanding and reduce potential stigmatisation.

Also refer to a policy paper by UNHCR called: Understanding community-based protection ([168]) in this context and the work by the WHO on community mental health ([169]) Guidance on community mental health services. Also refer to the comprehensive manual developed by IOM in collaboration with USAID on community based mental health support. ([170])

Examples of community based support interventions

Community spaces

It is crucial to create opportunities and platforms for applicants to participate safely in leisure, educational or psychosocial activities ([171]). Those supporting first line might also collaborate with the applicant community in developing mental health sensitisation and mobilisation strategies in such spaces created for exchange to further nurture and increase the accessibility and reach of those applicants in need.

As applicants being actively involved and gaining agency also increases the ability to protect oneself and others in adverse situation and support and informed decision-making process.

Creating safe spaces for applicants

Child-friendly spaces such as those established by the Danish Refugee Council (DRC) in Greece, 'address the protection and psychosocial needs of children aged 6-17 years old, and to support younger children in the context of humanitarian crises. The child-friendly spaces provide a temporary and safe environment in which children may find some degree of normalcy and with access to expertise to support their psychosocial and cognitive well-being in situations of extreme adversity.' ([172])

Blue dots ([173]) is an initiative by UNICEF in collaboration with UNHCR that addresses mainly Ukrainian refugees. Blue dots are **safe spaces** in strategic locations and provide practical support and information to children and families. Child-friendly spaces aim at offering a welcoming space for children to rest, play and simply be a child. The idea is to provide care (services and information) in a location that is easy to access by those in need.
People in Need is a **Czech** NGO that organises **child-friendly spaces** for children aged 4-16 ([174]). It also holds sessions at schools to inform about these child-friendly spaces that are open to all children free of charge.

([168]) UNHCR, *Understanding Community based Protection*, Protection policy paper, 2016.
([169]) WHO, *Guidance on community mental health services*, Promoting person-centred and rights-based approaches, 2021.
([170]) IOM and USAID, *Manual on community-based mental health and psychosocial support in emergencies and displacement*, 2nd edition, 2022.
([171]) For more information on child-friendly spaces, or safe spaces for women, refer to EUAA, *Mental Health and Well-being of Applicants for International Protection – Part III. Toolbox supporting the implementation of mental health and psychosocial support*, 2024.
([172]) Danish Refugee Council, 'Greece: Need for spaces that are child-friendly and safe', 16 June 2023.
([173]) UNICEF, 'What are the Blue Dots Hubs?', accessed 10 September 2024.
([174]) For more information on the NGO People in Need, visit European Commission, European Civil Protection and Humanitarian Aid Operations, 'Armenia: Finding a safe space to play, learn and heal', 10 February 2022.

Mentorship and peer support

Involving **volunteers** as mentors or peer counsellors is a meaningful low-threshold support with a very human and positive angle. Therefore, focusing on involving applicants in service provision or as **mentors**, after they have received some basic training, can encourage **peer support** and maintain, nurture and promote MHW in the community.

Mentorship, peer support, psychosocial support

The **Mentorship Project** ([175]) in **Greece** is a pilot project (initiated by the Special Secretariat for the Protection of Unaccompanied Minors with the support of the EUAA) that aims to provide guidance and empowerment to unaccompanied children through a network of trained mentors, based on peer-to-peer support. The Mentorship network consists of former unaccompanied minors and refugees who have been in the Greek educational system and who faced similar difficulties and challenges.

References

- Ministry of Migration and Asylum (Greece), ***National Strategy for the Protection of Unaccompanied Minors***, 17 January 2022.
- EUAA, '**Mentorship project – providing guidance and empowerment to UAMs in Greece (long version)**', YouTube, 2 August 2022 and Thema, '**Ministry of Migration: Video by the Mentors Group for teaching Greek to children from third countries**', 4 January 2024.

Re-Generations ([176]) is a project in **Italy, Spain and Greece** that aims to enhance social integration of new third-country nationals and to promote exchange between new third-country nationals and hosting community. The project is based on the idea of mentorship as well as empowerment and collaboration between young refugees and migrants (aged 18-23, also former unaccompanied minors) and country citizens/volunteers ([177]).

Problem management plus (PM+) ([178]) is a **low-intensity psychological intervention** for adults and adolescents over 16 with depression, anxiety or stress, living in communities affected by adversity. It is a **five-session programme** that integrates aspects of cognitive behavioural therapy. It focuses on teaching skills to deal with both emotional and practical problems. The innovative value of this intervention is that it can be delivered by a wide range of people, in the form of **peer support** (e.g. provided by lay helpers who are part of the applicant community who have received a basic introduction on PFA). It therefore includes people without formal counselling or mental healthcare training.

In **Greece**, PM+ is being implemented by EPAPSY (the Association for Regional Development and Mental Health) ([179]) on behalf of UNHCR. EPAPSY has trained refugees forming a Community Psychosocial Workforce and use Management Plus (PM+), provide PFA, and Peer Support in the language of those arriving. They are supervised by psychologists or social workers and as act as a link between the different refugee communities and the professional service providers. Ukrainian refugee population also benefits from the interventions.

The project 'Stichting Nieuw Thuis Rotterdam' ([180]) supports Syrian refugees and their families in Rotterdam with housing and integration and uses the PM+ method.

([175]) European Commission, European Website on Integration, 'The Mentoring Project: supporting unaccompanied children in Greece', project date 1 July 2021.
([176]) Defence Children International Italy, 'Re-generations: Mentoring for young people who have just turned 18', project duration December 2018 – May 2022; the webpage of the Association for the Social Support of Youth, is available at https://arsis.gr/en/home/.
([177]) Irabor, E., 'Social Mentoring Practices In Italy: An introduction to the project regeneration', European Mentoring Summit 2022, May 2022.
([178]) World Health Organization, 'Problem management plus (PM+): individual psychological help for adults impaired by distress in communities exposed to adversity', WHO generic field-trial version 1.1., 1 January 2018.
([179]) EPAPSY, the Association for Regional Development and Mental Health, 'Community Based Intervention for Mental Health Care of Asylum-seekers and Refugees in Greece', accessed 19 August 2024.
([180]) Scaling up psychological interventions with Syrian refugees, STRENGTHS, 'Training Syrian refugees in delivering PM+', 23 May 2018.

Creative and art-based activities

Participation in creative art therapies and activities, which are to be led by therapists, can help displaced people to maintain their cultural identity, especially when they feel some of it has been lost or is at odds with their new culture. Arts, music, dance and theatre can also provide opportunities for people to externalise negative feelings and trauma as to access emotions. It can help people to reconnect with their body. Creative and art-based activities such as music workshops, rock contests or intercultural choirs are part of interventions rolled out under level 2 or the IASC MHPSS pyramid. Level 3 and 4 focus on creative means used as part of counselling sessions and when art, dance or music therapy a used for symptom-reduction or treatment purposes. Recreational and creative activities are particularly useful when working with children.

Theatre

Cantieri Meticci is a 'well-established cultural association in Bologna, Italy, which has been running for over a decade. It works to promote intercultural exchange and dialogue, community development and active participation of migrants and refugees in local life. It does so through art, particularly theatre.' ([181])
Theatrical group Caritas Hellas ([182]) supported the integration of refugees in **Greece** through acting.

Music and Dance

Music and dancing initiatives in several EU+ countries are rolled out **outside** the professional psychotherapeutic context and seem to have a great impact on the lives of refugees and local communities.

- In Frankfurt, **Germany**, the Bridges project ([183]) reaches 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.
- In Lesbos, **Greece**, Cantalaloun ([184]) is a multicultural choir initiative that was created to provide access to polyphonic lessons to all people independent of religion, language and music skills. The teaching is in Greek and English, and the approach includes teaching methods that include non-verbal communication such as 'body percussion'.
- In **France**, OUI 2 ([185]) tries to nurture personal, human and social development through dance and by putting words into motion. It also provides access to vulnerable populations to cultural institutions, including the opera house (Paris), which applicants for international protection might otherwise hardly have the opportunity to visit.

However, there are also initiatives that use music, dance and movement **therapy** to work with applicants for international protection and refugees with traumatic experiences, which seem also positively received by those participating.

- Mateneen (Together) is a music therapy project for and with young refugees and asylum seekers in **Luxembourg**. The project aims to 'reduce the stress and anxieties linked to what asylum seekers face, including the dangerous conditions of their migration journeys, the loss of their linguistic, cultural and material reference points and the distance from their family.' ([186])
- In Berlin, **Germany**, the Berlin Center for the Treatment of Torture Victims ([187]) has included art therapies including music and movement therapy in the day centre services for victims of torture.
- Creathera international ([188]), **Belgium**, offers music therapy sessions to stimulate children and help them connect with themselves and their peers.

([181]) European Commission, European Website on Integration, 'Cantieri Meticci: The Refugee Theatre Company', project date 1 January 2013.
([182]) Global Compact on Refugees, 'Acting Project: theatre and refugee integration in Greece', project duration November 2017 – March 2019.
([183]) Bridges Musik, 'Bridges project – About us', 2024.
([184]) Cantalaloun, 'Cantalaloun', accessed 19 August 2024, https://www.cantalaloun.org/.
([185]) Opera de Paris, '*OUI#2*', accessed 19 August 2024, https://play.operadeparis.fr/en/p/o-u-i-2.
([186]) European Commission, 'Luxembourg: Music therapy for refugees', European Website on Integration; C. Schmartz, A. Majerus, 'Mateneen [Together] – a music therapy project for and with young refugees and asylum seekers in Luxembourg', 2020.
([187]) Zentrum Überleben (Center for the treatment of torture victims), 'Creative-, Music- and Movement-Therapies', Überleben website, accessed 19 August 2024.
([188]) Creathera international, 'Empowermokent and Connection through creative and Therapeutic Projects', accessed 10 September 2024.

Painting

Redpencil Europe, Brussels, **Belgium**, 'by engaging in the creative process, individuals can regain control over an uncontrollable situation, while learning to express themselves' ([189]) through arts. Children might particularly benefit from activities linked to art therapy.

Other interventions

The EUAA has compiled psychosocial support activities for child applicants as part of their operational support to Member Sates. The activities aim at strengthening the resilience of applicants and are rolled out by skilled support staff with different knowledge on vulnerability.

For more details, refer to Part III – Toolbox, Section on **Engaging with child applicants**.

Cooking and eating together

Food connects people and gives room to celebrate faith-based holidays or other traditions. Preparing food and eating together not only allows people to spend time together and exchange on different topics, but also to learn about another person's culture by eating their food. Cooking and eating together is a form of communication and provides a sense of normality to the people sharing a meal. The cooking process becomes an occasion for exchanging knowledge and cultural customs and creating memories around culinary production ([190]).

The people who have arrived in EU+ countries might have experienced lack of food in the past. Therefore, preparing and eating together might be an even more precious activity proving that experiencing hunger is no longer the case. **Cooking** is a clear-cut community support activity on **level 2 of the MHPSS pyramid.**

Cooking and eating together

Über den Tellerrand (looking beyond your plate) ([191]), in **Germany** and **Austria**, runs a variety of projects aimed at the integration and social participation of people with refugee experience through means of 'encounters' that enable relationships and opportunities for exchange and mutual learning. The projects include group activities, mentoring activities and tandem activities that involve pairs of refugees and local families.

The communal cooking with communal gardening projects implemented by Pervolarides (Gardeners) ([192]), **Greece**, have the main purpose of promoting social solidarity and sustainability.

In Zurich, **Switzerland**, the Social Gastronomy Movement is coordinated by Cuisine Sans Frontières ([193]) in collaboration with the cooperative die Cuisine and financially supported by the SV Foundation.

([189]) Red Pencil Humanitarian mission, 'What is creative arts therapy', Redpencil website, accessed 20 August 2024.
([190]) Marovelli, B. 'Cooking and Eating Together in London: Food sharing initiatives as collective spaces of encounter', Geoforum, 2019.
([191]) Ueber den Tellerand, 'Make the world a better plate', Ueber den Tellerand website, accessed 19 August 2024.
([192]) The Greek Project, 'Links: People who care passionately about Greece – About us', Greekproject website, accessed 19 August 2024.
([193]) *Cuisine sans frontieres*, accessed 19 August 2024, https://cuisinesansfrontieres.ch/en/.

Sports

Similarly to the arts, sports and games are universal activities and can connect, empower, protect and improve the physical and mental health of people, particularly children and youth. Physical exercise and practising a sport has been linked to increased levels of self-esteem, general self-efficacy, and body satisfaction. It is considered as a protective factor for mental health problems such as depression and anxiety ([194]). Additional positive social effects have been found especially in children and adolescents participating in team sports. These effects include lower social anxiety, lower social isolation, peer support and social connectedness ([195]). **Sports is a clear-cut community support activity on level 2 of the MHPSS pyramid**.

Sports and games – different projects implemented in Europe

- Football: a glue that binds in Europe ([196]) (**Germany**, **Italy**, **UK**)
- Welcome through football ([197]), in **Greece**, is a project for refugee children and youth that promotes teamwork, communication skills, socialisation, and interaction with the host community.
- Rewins 2.0 ([198]) includes refugee girls and women in sports and encourages social inclusion and a sense of belonging. It also promotes equal opportunities in sports and education insofar as it targets to women and girls from all cultural and social backgrounds. Similar projects are rolled out in the Netherlands ([199]) and Denmark ([200]).
- Keeping children safe in sports ([201]), a project by Terres des Hommes (**Greece**, **Hungary** and **Romania**), aims at promoting child protection policies in sports environments.
- The Belgian Cricket Federation ([202]) (**Belgium**) promotes integration of refugees and asylum seekers into local cricket clubs, with a focus on the participation of minors.
- The **Royal Belgian Football Association** ([203]) promotes and encourages the inclusion at local level of refugees and asylum seekers through football.

([194]) Eather N. et al. 'The impact of sports participation on mental health and social outcomes in adults: a systematic review and the 'Mental Health through Sport' conceptual model', Syst Rev. Jun 21;12(1):102, 2023.
([195]) Eime RM. et al. 'A systematic review of the psychological and social benefits of participation in sport for children and adolescents: informing development of a conceptual model of health through sport', Int J Behav Nutr Phys Act., 10:98, 15 August 2013.
([196]) UNHCR and Goal Click, 'Football: a glue that binds in Europe', accessed 20 August 2024.
([197]) UNHCR, 'Colorful football balls come to life bringing smiles to refugee children', 14 July 2022.
([198]) Farenet, 'Our work – EU projects', accessed 20 August 2024.
([199]) Farenet, 'Our work – refugees and football', accessed 20 August 2024.
([200]) GirlPower, https://www.girlpowerorg.com/, accessed 20 August 2024.
([201]) Terre des hommes project, 'Keeping children safe in sports' project, accessed 20 August 2024
([202]) Cricket Belgium, *Fedasil Cricket Project*, accessed 19 August 2024, https://cricket-belgium.com/fedasil-project/.
([203]) Kraainem Football, 'We Welcome Young Refugees', accessed 20 August 2024.

Vocational training and preparation for employment

Involvement in regular meaningful daily activities as well as developing new skills or building on existing ones promotes mental health, showcases strengths, increases resilience, and nurtures self-esteem. The ability to contribute to the host community enhances further independency, integration and acceptance. Applicants can proactively contribute to the local social welfare system instead of staying dependent on financial allowances.

Informing applicants at an early stage of the reception pathway on what is realistic to achieve in the host country (e.g. types of jobs accessible) and what to expect once a work permit is obtained, eases psychological distress and anxiety. Consequently, it can create hope and help to stay hopeful during stressful times and periods of transition.

Preparation for employment

Polaris 14 ([204]) is a **French** association that provides professional support and guidance to asylum seekers and beneficiaries of international protection on how to **prepare for work/employment**. The Socio-Professional Workshop Programme provides participants with a structured approach to defining and constructing their professional projects, enhances presentation skills and links with potential future employers.

Among other topics, Tent partnership for Refugees focused on exploring whether companies can draw benefit from hiring refugees. A study conducted in **Germany** analysed 'the experiences of 100 mid-sized and large German companies that have hired refugees' ([205]). The findings were extremely positive and indicated that 88 % of companies would hire refugees in the future again. The research report provides guidance for companies on how to best integrate refugees.

Social inclusion, integration and affordable housing

Reception centres are often densely populated and not always close to amenities such as schools or workplaces. At times, they are set up without previous discussions with the surrounding host communities, which can create tension. In addition, applicants can hardly afford independent accommodation, which means that they often lived in shared facilities.

Applicants who have private accommodation without a regular rental contract might face challenges in accessing employment opportunities, social services or health care since they might fail to produce the necessary paperwork (rental documentation). With regard to MHW, recent studies have indicated that anxiety and depression was more prevalent among children and adults facing housing insecurity and homelessness. A similar negative impact was also observed with regard to family well-being, school access/attendance and health.

([204]) Polaris (France), accessed 20 August 2024, https://polaris14.org/.
([205]) Tent (Germany), 'From a Refugee Crisis to a Job Engine, An Analysis of German Businesses' Experience in Refugee Integration', May 2022.

Research confirms not only that appropriate housing is a crucial indicator for successful integration, but also that 'addressing housing as a social determinant is relevant for improving health and reducing disparities' ([206]), including in the asylum seeker population.

Accommodation, independent living arrangements and timely integration

Housing in the **Netherlands** has been a challenge for many years, and young people / students are one of the social groups facing great difficulty in finding **affordable housing**. Startblok ([207]) was launched in 2016 as an innovative solution for the increased influx of asylum seekers and the lack of affordable housing for young adults from the Netherlands. It is an ongoing project.

CURANT ([208]) is a project from **Belgium**, designed to offer accommodation and support services for the education, training, employment, housing and mental health needs of young refugees through a 'cohousing/mentoring system' with young Belgian adults, and case management. The project was based on the creation of a **buddy system** ([209]).

In **France**, the Cinq Toits (Paris) ([210]) refers to a **housing project** promoting the integration of migrants and 'is designed to provide exiled and **vulnerable people** not only with a house but also with a place to heal, to meet and interact with local actors to eventually acquire their place in the society' ([211]).

Still in **France**, HUDA ([212]) provides **emergency accommodation** for asylum seekers with identified vulnerabilities, including persons with diverse SOGIESC. HUDA stands for united habitat for diversity and autonomy.

([206]) B. Dudek, S. Razum, Systematic Review, Public Health Rev., 'Psychosocial Attributes of Housing and Their Relationship With Health Among Refugee and Asylum-Seeking Populations in High-Income Countries, 4 May 2023.
([207]) Startblok Zenhagen (the Netherlands), 'What is Startblok'.
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Annex 1. A summary of the enablers of good mental health and well-being

Basic requirements upon arrival

- Psychological first aid (PFA) and basic knowledge on how to observe and judge a situation, look and listen to **identify** person(s) in need and link/refer the person(s) to needs-based response including initial medical/ vulnerability checks or a follow-up assessment.
- Appropriate initial placement ([213]) and where possible not in a close facility.
- Access to initial medical and social care.
- Provision of food and non-food items such as clothes, hygiene items, cooking utensils (including to single male applicants) etc.
- Equality (considering age, gender and other factors along the process).
- Access to relevant information at this stage (e.g. available services/ entitlements, next steps in the procedure, how to access legal advice, support related to family tracing ([214]) ([215]), information on family re-unification etc.).
- Ensuring access to the relevant procedure (incl. other forms of protection e.g. in cases of trafficking in human beings).

Once placed in a more permanent accommodation

- Psychological First Aid (PFA) and basic knowledge on how to observe, look and listen to **identify** persons in need and link/refer them to needs-based response. Identification is an ongoing process.
- Needs-based reception. Refer to the EUAA Guidance on Reception Conditions ([216]) and the EUAA Guidance for unaccompanied children ([217]) and where applicable preparation for independent housing.
- Importance of providing psychoeducation to all applicants.
- Ongoing formal and informal care and support and case management offered to all applicants where needed.
- Promote access to social networks, community-based support interventions and allow applicants to connect with family and community members.
- Access to community activities such as play, arts, sports and cooking can nurture well-being and connect people.
- Access to opportunities for personal development e.g. vocational training and preparation for employment related activities.

([213]) This refers to safe and appropriate accommodation taking into account the personal circumstances of the person arriving.
([214]) ICRC, *Safety Tips for Families*, 2022.
([215]) EASO, *Practical Guide on Family Tracing*, March 2016.

Integration or the timely preparation for a dignified and safe return

Psychological First Aid (PFA) is an ongoing process and provides basic knowledge on how to observe, look and listen to **identify** persons in need, and link/refer them to a needs-based response (medical, psychosocial, legal, protection).

In-depth person-centred **needs** and **risk assessment** (psychosocial/health/mental health needs) to be conducted to ensure effective processing of the case and support to the individual during transition periods (both integration and preparation for return). This is particularly important when children are involved (best interests of the child principle).

Integration: participation in psychoeducational activities can support integration into the host community. Information provision on support available after leaving the reception facility is important.

Return: psychoeducation can also be important for those scheduled for return to better cope with unwanted feelings of distress during the preparation for return procedure. Support the preparation for return ([218]) and tools to support reintegration counselling ([219]).
Basic information on what services are available in the country of return is important. The timely and pro-active linking with organisations supporting voluntary return (e.g. IOM).

([216]) EUAA, *Guidance on Reception, Operational standards and indicators*, May 2024; EASO, *Guidance on reception conditions: operational standards and indicators*, September 2016.
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