Practical Guide Series

Mental Health and Well-being of Applicants for International Protection

euaa
EUROPEAN UNION AGENCY FOR ASYLUM

PART 3

FOR USE IN CONJUNCTION WITH PARTS I AND II

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 III. Toolbox for the implementation of mental health and psychosocial support

November 2024

About the toolbox

Why was this three-fold guide created?

The European Union Agency for Asylum (EUAA) gathered information on the needs of the EU Member States and the Schengen associated countries (EU+ countries) on the topic of mental health and well-being (MHW) of applicants for international protection. This three-fold guide is the outcome of this exercise and aims to support EU+ countries and their senior management in creating the foundation for an asylum system informed by considerations around MHW. It is also a support package aiming to facilitate the implementation of ongoing mental health and psychosocial support to those in need. The guide also touches upon related subjects such as critical incident management, staff welfare and drug use in reception ([1]).

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.

Who should use this toolbox?

Part III targets in particular **team leaders**, **coordinators** and **those working in the first line** who provide mental health and psychosocial support. It also targets **senior managers** who can find useful material to guide their actions towards building an MHW-informed asylum system.

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

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

How to use this guide.

The three parts of the EUAA guidance on MHW of applicants for international protection should 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 ([4]) focuses on the **interventions** that are crucial to maintaining the MHW of applicants for international protection. It covers **how** to operationalise interventions on mental health and psychosocial support and mainly targets **first-line officers** and their **team leaders**.
- **Part III** is a '**toolbox**' containing practical tools such as checklists, safeguarding considerations and questionnaires to support those **first-line officers** in providing mental health and psychosocial support.

How does this guide relate to national legislation and practice?

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

How does this guide relate to other EUAA tools?

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

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

([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 II. Practical guide for implementing mental health and psychosocial support – for officers working in the first line*, 2024.

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
CFSs	child-friendly spaces
EU+ countries	EU Member States and the Schengen associated countries
EUAA	European Union Agency for Asylum
GBV	gender-based violence
IASC	Inter-Agency Standing Committee
IOM	International Organization for Migration
MHPSS	mental health and psychosocial support
MHW	mental health and well-being
PFA	psychological first aid
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization

Introduction

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

'We think about the asylum procedure too much. Our future is at stake. Hope is infinite, but maybe … maybe we are waiting for nothing.'([5])

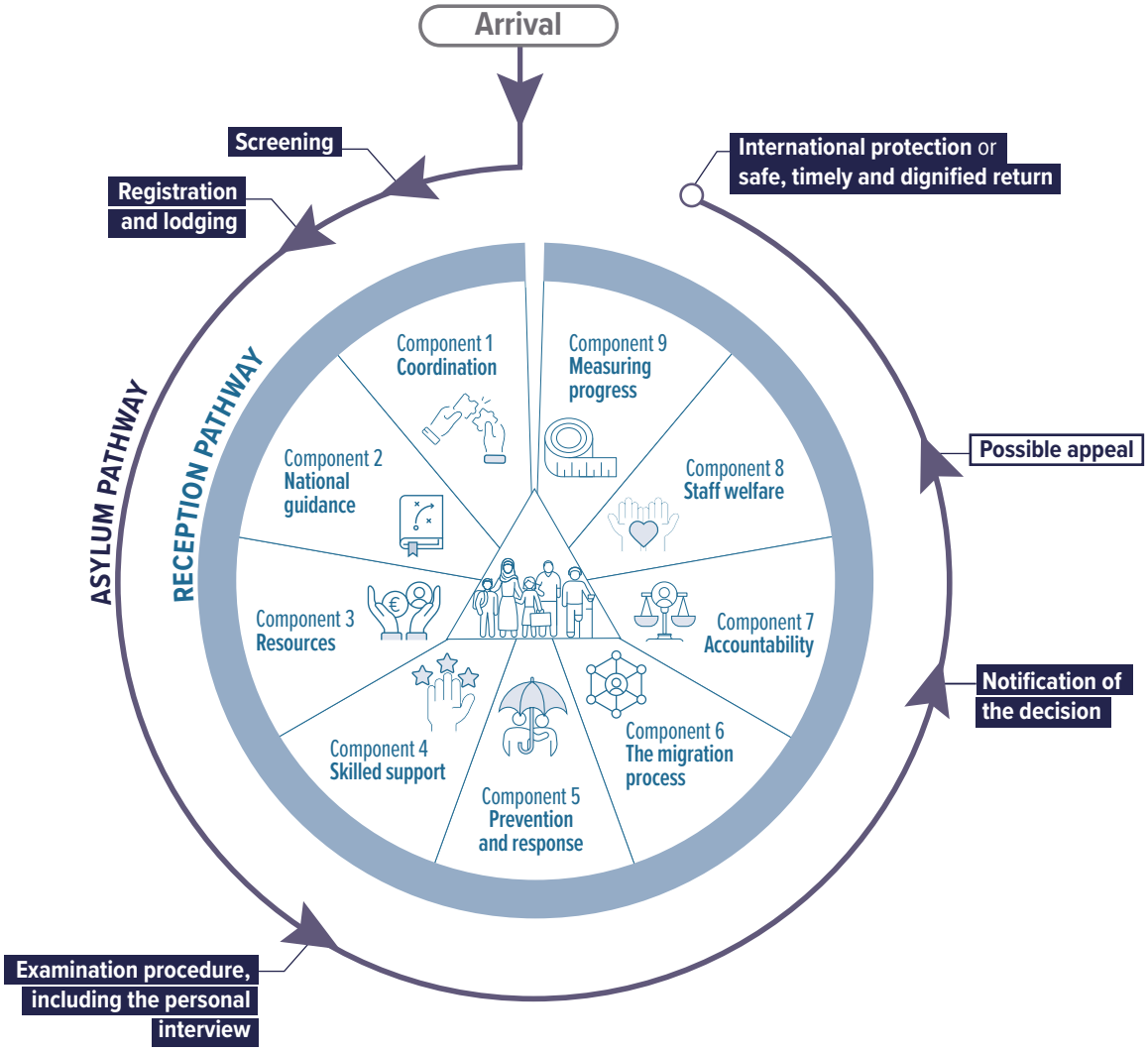
It is therefore important to integrate considerations on the mental health and well-being (MHW) of applicants throughout the entire asylum and reception pathway. These considerations should more generally be a fundamental part of a **national strategy** on health and mental health of a country, where possible and such an approach is most sustainable when organised through the involvement of interdisciplinary actors.

Consequently, the overall framework proposed as part of the **threefold EUAA guidance** to facilitate the shaping of an MHW-informed asylum system, as established in part I ([6]), suggests the equal importance attributed to the **nine interlinked components**.

([5]) A quotation from an applicant for international protection from Guinea, taken from the European Asylum Support Office (EASO), *Consultations with Applicants for International Protection on Mental Health A participatory approach – supported by Member State authorities*, December 2021.

([6]) 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.

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



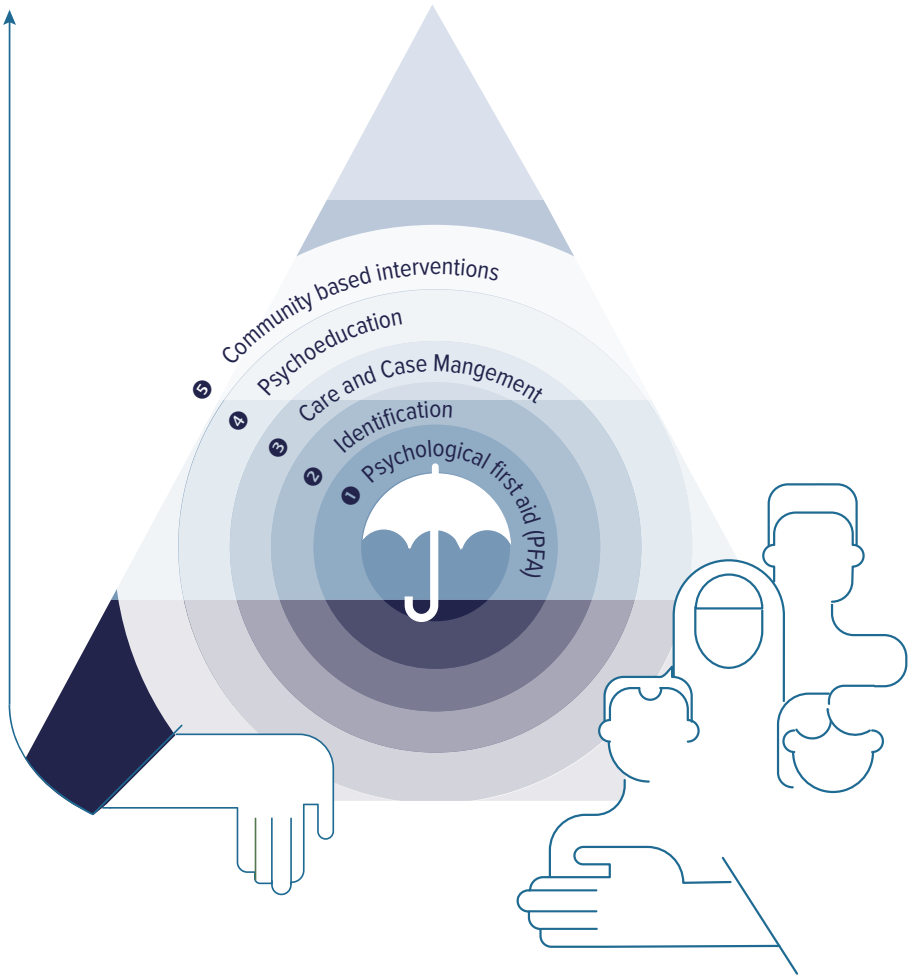
Source: the EUAA

If the relevant authority is better prepared for integrating considerations around MHW into its daily actions, the less likely it will be to observe immediate or long-term negative consequences in those seeking asylum. Part I – Senior management focuses on establishing a framework to shape an MHW-informed asylum system.
Part II – First-line officers focuses on:

- proposing **psychological first aid (PFA)** throughout the asylum and reception pathway as a cross-cutting concept;
- early and **timely identification** of needs and vulnerabilities;
- ensuring **access to care** accompanied by **case management**, where applicable;
- **psychoeducation** for the purpose of mental health literacy; and
- a **community-based approach**.

Once the administration systematically rolls out these proposed interventions, the MHW of applicants can be maintained and managed more easily.

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



Source: the EUAA, adjusted from the Inter-Agency Standing Committee (IASC), *Guidelines – Mental health and psychosocial support in emergency*, 2007 and the field test version by UNICEF, *Operational guidelines – Community-Based Mental Health and Psychosocial Support in Humanitarian Settings*, 2019, p. 15.

Part III of the guidance is a basic 'toolbox' and should **only be used in conjunction** with Part I – Senior management and Part II – First-line officers. The tools provided in Part III provide the means to put into practice the concepts elaborated in the first two parts and should not be seen as a standalone document. These tools aim to further support those working in the first line that are implementing mental health and psychosocial support (MHPSS) interventions.

Purpose and structure

This part of the guidance provides additional guidance on:

- ensuring **accountability** and the **do no harm principle**;
- acknowledging and creating awareness of the **complexity of migration** with a focus on the critical stages and the necessary protective measures;
- highlighting cross-cutting concepts such as **cultural competency**;
- ensuring that all those working in the first line have **a basic understanding of trauma**;
- focusing on the below when working with **vulnerable groups**:
  - the safe identification of needs including intersecting vulnerabilities;
  - engaging with child applicants;
  - applicants with a substance use problem;
  - dealing with suicidal behaviour in applicants;
- ensuring mental health literacy through **psychoeducation**;
- organising **community-based interventions**.

In this part, readers will also find checklists to support the meaningful coordination and roll out of the personal interview for those reception authorities closely collaborating with the determining authorities. It also provides basic input on how to measure the progress of MHPSS interventions.

1

The importance of accountability in the field of asylum and reception

When forming an MHW-informed asylum system, ensure that safeguards are in place to protect service users. Ensuring a do no harm approach is vital. This approach focuses on ensuring those providing support services are enabled and sufficiently knowledgeable to provide high quality assistance that is as safe as possible. Most importantly, it ensures that the assistance does not further harm or lead to additional risks for those receiving the support. Taking a do no harm approach requires understanding the working context. In-depth preparation and planning of the support helps to mitigate risks of harm triggered by intervening. Normally, do no harm is a topic found in the field of humanitarian aid operations. Nevertheless, such an approach can be equally important for working in the field of asylum and reception in Europe.

As detailed in Part I – Senior management of the EUAA guidance under **Component 9. Accountability,** accountability ([7]) safeguards service beneficiaries and protects first-line officers. It also protects the reputation of the services provided by the authority or organisation, which can otherwise be jeopardised. It requires that the authority and service provider acts responsibly and responds to the needs of service users where applicable. Accountability mechanisms, such as feedback and complaint mechanisms, should be in place even where services are outsourced. These mechanisms should be organised in a format and language that is accessible for the service users.

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

Establishing accountability mechanisms

In the context of this guidance, **feedback** is understood as any positive or negative statement about a service provided or the service provider. It may be expressed formally or informally and may or may not require a response. The purpose is to integrate the feedback received to improve services implemented.

A **complaint** on the contrary is understood as a grievance, 'an expression of dissatisfaction about the standards of service, [activity] or lack of such by [an authority / service provider] or its staff, volunteers or anybody directly involved in the delivery of its work. It is a criticism that expects a reply and would like things to be changed.' ([8])

Considerations when collecting feedback

The educational background or age of the applicants involved when gathering feedback will indicate if feedback can be collected in a written format of if questions are better posed by involving applicants in individual personal session or focus group discussions, for example.

Below is a sample of a written feedback format. The questions provided are guiding questions only and should be adjusted to the context.

([8]) CHS Alliance Guidance, *Managing complaints: A Best Practice Guide for Aid Organisations*, p. 5 and p. 36 'Glossary', 2023.

FEEDBACK ON PSYCHOSOCIAL SERVICES

Date: _____

Name of the person responding (optional): _____

Age of the person responding (optional): _____

Gender of the person responding (optional): _____

Location where data collection takes place (name of reception facility):

_____

Sample questions	 Very good	 Good	 Fair	 Poor	 Very poor
• How would you rate your overall satisfaction with the psychosocial support available from (*insert service or activity*) provided at/by (*insert location and/or service provider*)?	☐	☐	☐	☐	☐
• How would you rate the time allocated / timing of the services/activities provided? Do they fit your schedule or jeopardise participation in other activities?	☐	☐	☐	☐	☐
• How would you rate the announcement of activities/services in terms of clarity (*what is available, where, for whom and who to contact*) and inclusiveness (are there activities available for a diverse group of applicants)?	☐	☐	☐	☐	☐
Additional information					
• Was there a particular support/activity you found extremely useful? If yes, please share briefly what was helpful.					
• Would you recommend the activities/ services to other applicants? If yes/no, please indicate why.					
• Do you have any other recommendations on what could be improved or which services/activities would be useful in relation to the MHW of applicants?					

Source: the EUAA

The questions should link to the interventions in the MHW action plan. The applicants involved need to be informed of the purpose of the feedback exercise. The language should be simple and understandable by a diverse group of applicants taking age and literacy levels into account. The provision of feedback is voluntary.

Requesting feedback from children

Requests for feedback from children should be short and fun. The use of icons, emojis and images can help. Keep the language simple and ask only a few short and clearly formulated questions depending on the age of the children.

Feedback on psychosocial services

Introductory remark by the facilitator: we have just finished our joint activity for today. On this flipchart you can see 5 emoji faces. One is very happy, one is content, one is rather neutral, one is not so happy and one is very unhappy. It is important for us to hear from you and whether you enjoyed the activity (insert more information where relevant). Your opinion helps us to better understand how and in what format to organise our next meeting.

Before you leave, please answer the question: **'did you enjoy our activity today?'** by ticking the emoji that you think fits.

If you have specific suggestions you would like to add on what we can do better next time, let us know in person or write your suggestion on the flipchart below the emoji faces. In the same manner you can also share what you liked best today.

Considerations when establishing a complaint mechanism

What to keep in mind regarding complaint mechanisms

Clarify to staff, experts and volunteers working in the first line as well as applicants:

- ☐ what is considered feedback and/or a complaint;
- ☐ what is to be reported, how and to whom and which policies are relevant;
- ☐ when a complaint should be escalated (based on criteria), investigated and by whom.

Make information accessible to all staff, experts and volunteers working in the first line on how to escalate a complaint.

- ☐ Appoint a designated and trained focal person/team to follow up on complaints.
- ☐ Make applicants aware of focal persons/teams.
- ☐ Inform every applicant on what is acceptable/unacceptable behaviour and how to access the complaint mechanisms (for complaints against peers or against those acting in an official capacity).
- ☐ Make the feedback and complaint mechanisms accessible to a diverse group of applicants and do not only refer written/online measures.

Design the formats to lodge a complaint to cater for a diverse target group and ensure the following mechanisms simultaneously as a minimum: complaint box, email address, contact number/hotline, personal focal person.

- ☐ Clarify the applicant's rights and obligations in a given context.
- ☐ Ensure it is possible to submit anonymous complaints.

This is particularly important for vulnerable groups. While it might not be possible to investigate certain complaints due to a lack of information, there might be situations where complaints are raised against a specific person by several people anonymously. It should still be possible to allow actions by the appointed focal person/team to follow up on complaints.

- ☐ Acknowledge the complaint. Record and report the complaint.
- ☐ Inform the complainant (where possible) about the next steps.

If more information is needed to clarify the context and contact information is available, this is organised through the focal person/team. In these situations, **confidentiality** must be respected.

- ☐ The issue is either resolved by a mediation (if minor) or escalated through the established system, depending on the type of complaint.

The team responsible for assessing complaints decides if an investigation is needed or if the matter can be resolved without an investigation. An escalation of the complaint and administrative investigations are normally required where there has been a breach of the code of conduct or other policies.

- ☐ Appoint an independent team in the event of an investigation.
- ☐ Formulate a workplan on how to conduct the investigation, draw up a list of who will be interviewed and formulate a timeline.

The victim, if known to the investigating team, is always the first to be interviewed. The subject of concern should be the last person to be interviewed.

- ☐ In a situation where a **criminal act** was committed (e.g. rape), involve the relevant authorities (law enforcement) as soon as possible to handle the situation. Always ensure the safety of the victim.
- ☐ Once an administrative investigation has been concluded, formulate a report of the findings and share it with the senior management of the entity requesting the investigation.
- ☐ A decision is issued and the take the necessary steps to address the complaint (e.g. dismissal) and implement the necessary changes to avoid similar incidents (e.g. increased awareness and training on the code of conduct, strengthening selection procedures/background checks).
- ☐ In the event of a malicious complaint or a complaint unsupported by evidence, the information should still be recorded and a follow up should be organised accordingly.
- ☐ Ensure the **safety** of those involved, particularly the complainant and/or victim, throughout the process.
- ☐ Ensure the safety of those receiving complaints and those investigating them throughout the procedure.

Sample of minimum information requested as part of a complaint mechanism in written format

- Name of complainant or the person submitting a complaint on behalf of the complainant.
- If the complainant is represented by another person/organisation, the complainant has consented to the information being shared.
- Contact details (phone/email/address) of the complainant so that they can be contacted if needed to clarify certain information and/or to provide protection.
- Leave space for the complainant to describe the incident, including:
  - a description of the person accused;
  - the location of the incident;
  - when the incident took place (date/time)
  - details of what happened.
- Note down if there was more than one incident. For example, if a previous complaint was submitted, include details on when this complaint was submitted, to whom and what steps were taken.
- If available, ask the complainant and/or representative to provide supporting information (e.g. a copy of a communication such as an email). Retrieving or sharing this information should only be done if doing so would not put the complainant/representative in danger.

The entity collecting this information needs to clearly articulate how and when a follow-up can be expected. Confidentiality is guaranteed throughout the procedure and the complainant or representative needs to be assured that information is only being shared with other stakeholders with the consent of the complainant where needed.

A sample of a self-assessment form on accountability for an administration

#	Question	Strongly agree	Agree	Somewhat agree	Do not agree	Not sure
1	Does the administration have a well-disseminated information policy?	☐	☐	☐	☐	☐
2	Does the administration inform the applicant community regularly about their rights and entitlements by taking age/gender/language into consideration?	☐	☐	☐	☐	☐
3	Does the administration inform applicants about the standards the staff working for the authorities, including volunteers/experts, have set themselves (code of conduct)?	☐	☐	☐	☐	☐
4	Does the administration clearly inform applicants on the services available to them (by whom, where, when and for how long)?	☐	☐	☐	☐	☐
5	Does the administration invite feedback and make sure a diverse group of applicants (adults, children, older people, those living with an impairment/ disability) know how to provide it?	☐	☐	☐	☐	☐
6	Does the administration provide different formats to provide feedback (e.g. written, verbally, anonymous)?	☐	☐	☐	☐	☐
7	Does the administration have a clear, formal and transparent system in place to handle complaints and concerns from applicants?	☐	☐	☐	☐	☐
8	Does the administration have a clear, formal and transparent system in place to handle complaints and concerns from employees?	☐	☐	☐	☐	☐
9	Does the administration complaint mechanism specify how and within which time frame a complaint will be processed and how the complainant can receive feedback?	☐	☐	☐	☐	☐
10	Are there clear procedures in place to address allegations of abuse? Does the administration have the expertise to investigate allegations of abuse, including sexual abuse and corruption in a safe manner for both applicants and employees?	☐	☐	☐	☐	☐

Source: Adapted from World Vision, *Complaint and Response Mechanisms*, Food Programming and Management Group, World Vision International, First edition, 2009, pp. 42-43.

- CHS Alliance Guidance, ***Managing complaints: A Best Practice Guide for Aid Organisations***, 2023.
- UNHCR, ***Accountability to Affected People (AAP)***, last updated 12 June 2024.
- International Federation of the Red Cross (IFRC), ***Applying better programming initiative – Do no harm***, 2016.
- IASC, ***Guidelines – Inter-Agency Community-Based Complaints Mechanisms: Protection against Sexual Exploitation and Abuse,*** April 2016.

2

The complexity of migration

As elaborated in the other two parts of the guidance, the complexity of migration, the adverse events experienced by those arriving in Europe and the experiences in the host countries can affect the mental health and well-being of a person positively and negatively.

The migration process is complex and not a linear path ([9]). It encompasses different critical stages which come with challenges and opportunities. The experiences of applicants back home, during displacement, transit and during arrival followed by the critical stages linked to the asylum and reception pathway (registration, initial reception, stay in reception, integration or return and the re-integration there) can all play a critical role. Every applicant is unique and reacts to adversity in different ways.
This is also due to resilience.

([9]) Refer to Part I – Senior management, Component 6: the complexity of migration.

The critical stages and protective measures

Stage 1: arrival

Upon arrival it is crucial to immediately **provide for an applicant's first basic needs**. This will mitigate risks of a potential physical and mental health crisis and creates a sense of safety and security in the person. This initial provision of support applies regardless of whether a person arrived irregularly at the border, during a high influx situation, through disembarkation, by search and rescue mission or in the context of a transfer, including resettlement ([10]) or relocation ([11]).

Detention/quarantine measures, where those newly arrived are placed in initial closed reception facilities for the purpose of gathering information on their identity and health status for the purpose of public health and security, should be for the **shortest time possible**. Such measures should be complemented by health and psychosocial support options. This is particularly important for shipwreck survivors and children no matter their age or whether they are accompanied. Shipwreck survivors and children should, where possible, not be detained to effectively address any psychological distress/trauma experienced.

Placement in detention is a **last resort** as it can have a negative impact ([12]) on the MHW of a person no matter the circumstances. The detention of children can never be seen as being their best interests. If a person stays in a closed facility, the purpose (e.g. verification of identify, health and security measures, conduct of vulnerability checks) should be communicated clearly, including the importance of self-disclosure of vulnerabilities and needs.

Provide officers working in the first line (including law enforcement and registration officers) with regularly **updated** and simple **referral information**, which should include as a minimum:

- the contact details and names of relevant organisations;
- the types of services offered;
- location(s) to access these services;
- opening hours.

Ensure that first-contact officers have been introduced to the concept PFA ([13]). For more information on how to facilitate the timely identification of those in need, refer to Part II – First-line officers, Section 'Psychological first aid'.

Additional capacity building on the topic of MHPSS is of benefit (refer to Part I – Senior management, Annex 4. Resources for building capacity on mental health and psychosocial support.

([10]) 'Member States are encouraged to design dedicated and effective integration and social inclusion programmes for resettled persons that take into account vulnerability in particular'. Commission Recommendation (EU) 2020/1364 of 23 September 2020 on legal pathways to protection in the EU: promoting resettlement, humanitarian admission and other complementary pathways (OJ L 317, 01/10/2020), point 9.
([11]) European Commission, *Relocation: EU solidarity in practice*, Migration and Home Affairs website: 'Relocation puts core priorities of EU's migration policy into action - caring for vulnerable people and promoting their well-being.'
([12]) World Health Organization (WHO), *Immigration detention is harmful to health – alternatives to detention should be used*, 2022.
([13]) EUAA, 'Psychological First Aid Video', YouTube, 26 June 2023 accompanied by instructions.

Primary healthcare and **MHPSS** services are in place and accessible to all arriving. Strategically, these services should be:

- embedded and organised through an insurance scheme; or
- other national practices and
- last for the first 12 months of an applicant's stay/residence in that country.

These efforts reduce the bureaucratic workload and minimises the impact on service providers. It ensures applicants have access to care when needed without disruption. After an initial period and depending on the legal status acquired in the meantime, EU Member States and the Schengen associated countries (EU+ countries) might issue electronic health cards or similar.

If a person is returned to their country of origin, the entitlement to healthcare services ceases.

Provide **food**, **water** and basic non-food items such as **clothes** and **sanitary items** particularly for women or those applicants arriving with babies where needed.

At this stage, provide basic but **relevant** and **age-appropriate** information. Information can include where they are, how long they will stay and for what purpose. The information should include tentative next steps, depending on the personal circumstances of the person (including on access to asylum or on the procedure itself, where applicable).

Depending on the context, **information on voluntary return** might be beneficial to some. Collaborating with other stakeholders to provide such information is important.

Generally, it is recommended to use **different formats** and communication **channels** (animations, applications, printed materials, information provision by a focal person) in the main languages of applicants arriving ([14]) to provide this information. Basic information on how to access care and other relevant services (e.g. access to longer-term accommodation, etc.) might also be touched upon.
Explaining certain procedures in the mother tongue of the applicant helps provide a sense of safety. The strategic **use of colours and pictograms** linked to certain procedures that repeat in different settings in the host country can help the applicant understand different parts of the procedures.

This approach is useful for certain people that might find it difficult otherwise to grasp information (e.g. an illiterate population, children, those living with cognitive disabilities) as well as those not yet able to communicate in the local language or those in severe distress.

([14]) EUAA, *Lets Speak Asylum*, Portal, which has plenty of reference materials for information providers and professionals designing communication and information provision activities in the field of asylum and reception.

Ensure the **appropriate** and **safe initial reception** for those arriving. Initial reception centres are often characterised by dense living conditions. The number of people hosted in such centres, which can be found at the external borders, should not jeopardise the standards of living conditions ([15]). This is particularly important where concerning unaccompanied minors ([16]) and children generally.

This stage of the asylum and reception pathway already creates opportunities for those arriving to **connect with family and friends**. This includes family tracing ([17]) and **family reunification**, where relevant. This should be prioritised particularly when it comes to unaccompanied minors. It is important to inform applicants to share if family members are already present in any of the EU+ countries as they may potentially be reunified with them. In the absence of family, minors are to be appointed a **legal representative/guardian** in a timely manner.

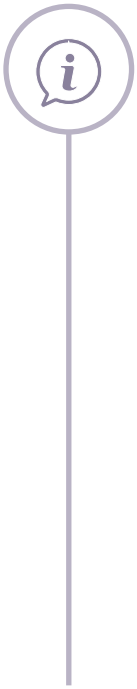
Stage 2: stay in reception

Once an applicant has entered the reception system more permanently, including those resettled or relocated, additional provisions are beneficial to maintain MHW. The daily or regular ([18]) presence of certain professionals such as social workers and child protection specialists, (psychiatric) nurses, psychologists, general practitioners and lawyers or legal counsellors and mentors for children, can strengthen resilience of applicants.

The accessibility of these professionals can often be sufficient to create a sense of calm. Community involvement and opportunities for applicants to exchange and meet each other can also help maintaining the MHW of applicants. Keep in mind the protective and risk factors (see Figure 3). For more information on the benefits of community-based support, refer to Part II – First-line officers.

Senior management should keep in mind the potential outcomes and risks if certain support is not provided. This can affect the well-being of applicants and potentially the overall implementation of support provided by first-line officers.

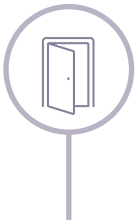
([15]) European Union Agency for Fundamental Rights, *Initial Reception Facilities at External Borders: Fundamental rights issues to consider*, 2021. It identifies 12 points for protection-sensitive and fundamental rights-compliant planning and design of initial reception facilities; EASO, *Guidance on Reception Conditions: operational standards and indicators*, September 2016.
([16]) ChildMove project, *The impact of flight experiences on the mental health of unaccompanied minors on the move*, Ghent University, 2022, particularly the recommendations on p. 28.
([17]) ICRC, *Safety tips for families*, 2022.
([18]) While certain support staff work on site at reception facilities and are accessible on a daily basis, others might rotate and provide their services on specific days or via online consultation or upon request.



Provide **all** applicants with **information** on the healthcare providers available and where and when they can be accessed. Applicants need to be aware that in most countries specialised care is often only possible following a referral by a general practitioner.
The available services should accommodate the diverse needs of applicants (age, gender, other specific needs they might have).

In addition, information on how certain processes work in reception including house rules can help in rebuilding the confidence of applicants and ease tension. First-line officers involved in information provision can and are advised to share relevant information on mental health with the applicant community. Inform the applicants about their general rights and obligations during their stay in reception, the next steps in the asylum procedure, how to access legal advice, including how to appeal (e.g. on an age assessment procedure for child applicants ([19])) and information on voluntary return where applicable. Uaccompanied children close to the age of maturity need to be prepared for the responsibilities they will face once they turn 18 and are considered adults. Put them in contract with organisations facilitating this transition phase in collaboration with their guardian. Refer to the EUAA's Let's Speak Asylum Portal to support meaningful information provision to applicants.

A **(psychiatric) nurse or doctor** is available onsite (or through regular organised mobile support). This can create an important link between those providing daily psychosocial support services and more specialised services. The availability of a nurse and/or doctor can increase awareness of mental health literacy and support the **ongoing identification** of applicants with more serious needs and vulnerabilities in a timely manner for tailored and specialised support. For more information on identification, focused and specialised care and psychoeducation for the purpose of mental health literacy refer to Part II – First-line officers.



Maintain an **open-door policy** on certain days where applicants can access first-line officers, such as reception officers, social workers, psychologist and child protection to encourage those in need to seek help. Some applicants might find it difficult to make appointments and stick to them, including in situations where an applicant might face partner or family violence. In such situations, it is crucial to have the opportunity to visit these professionals without an appointment to reach out for help.

The provision of **food** should to the extent possible include the staple foods of the nationalities in the reception facility or otherwise provide applicants with the opportunity to cook for themselves. Ensure the provision of basic non-food items such as **clothes, hygiene products (at least some times) and cooking utensiles** (including for single men) or otherwise provide allowances to cover these needs, particularly during the period where an applicant is not yet able to work. Further, access to information on how to access employment is important.

([19]) EUAA, All you need to know about age assessment, 2022.

Safe and appropriate more permanent placement of applicants. Refer to EASO, *Guidance on Reception Conditions: Operational standards and indicators*, September 2016 and EASO, *Guidance on Reception Conditions for Unaccompanied Children: Operational standards and indicators*, December 2018.

Create opportunities to **connect with family and friends**. This also should include efforts of family tracing and family reunification where relevant and particularly for unaccompanied children. Nurturing the involvement of the applicant community in regular activities creates agency.

Daily routines and activities can strengthen MHW and can also prepare someone for smoother integration into the host community. Activities can cover an introduction into the host countries culture and traditions, language courses, educational opportunities and preparation for employment. A new set of skills can also be useful if a person voluntarily decides to return home since may facilitate their reintegration. Further, schooling for children, leisure and sports are important activities to provide. A secondary benefit of such activities may be an earlier outflow of those granted status from reception, since people connect with the host community while they are waiting for the decision.

While MHPSS is important to strengthen resilience, information on the asylum procedure ([20]) or the asylum claim is also vital. Organise regular time slots, where possible, where applicants have access to legal counsellors visiting the reception centre and inform those in need on legal matters.

Stage 3: legal status and continuation of integration or the preparation for return

Meaningful **integration** is a process and not a 'stage' or 'point in time'. Often it is associated with the moment an applicant moves out of reception, lives independently and has acquired legal status. The preparation for integration will therefore need to start as early as possible and already from the moment the applicant is placed in reception (pre-integration).

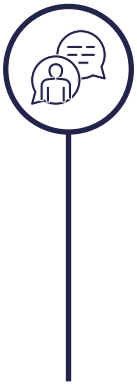
Strengthen knowledge of the host country's **culture** while the applicant is in reception**.** Involve them in **educational and employment opportunities**, the way of life such as the behaviour towards and interactions with one another, leisure activities and **language** courses to support the integration process.

Support **independent living** arrangements for example by providing information and guidance on how to open a bank account, the importance of insurance (e.g. for a car, health), why pension benefits are important, etc.

([20]) For an example, refer to CGVRS Asylum in Belgium, *Asylum Procedure*, asyluminbelgium website, accessed 21 August 2024.

Pursue family reunification where possible and provide opportunities for an applicant to **socially connect** with their own community members and the host community.

Where person are confronted with a **negative decision**, the notification of such a decision should be delivered in a sensitive manner, with the use of an interpreter where needed. Provide a full explanation of the consequences of the decision and the next steps including the possibility of **appeal respectively return** to the country of origin. This is also relevant for those signing up to voluntary return to their home countries.



Provide legal counselling to support in cases in which an applicant intends to appeal and provision of **psychological counselling** to guide those people denied asylum in how best to prepare mentally for a return are equally important. This phase, similar to the arrival phase, is extremely sensitive.

Some applicants scheduled for return might feel devasted by the realisation that they have gone through so many difficult situations hoping to start a new life only to be returned to a place they left because they did not see a healthy future there. Organise sessions with a professional counsellor to prepare the applicants on an individual or group basis to nurture better cooperation with those organisations facilitating the return.

Ensure access to **healthcare** in the period between receipt of the negative decision and the scheduled return. Liaise with organisations responsible for return activities, including voluntary return, such as the International Organization for Migration (IOM) to help ensure the right information is shared.

Provide **all** returnees with the relevant information on their home country / country of return regarding safety, security, health situation, accommodation, circumstances of or around arrival and humanitarian and/or other support actors on the ground. Refer to IOM Ireland's guidance on supporting the preparation for return ([21]) as well as the tools for reintegration counselling ([22]).

([21]) IOM Ireland, *Preparation for Return*, 2015.
([22]) IOM, *Reintegration Counselling: A Psychosocial Approach*, 2020.

Protective and risk factors

Authorities should be competent to identify the **protective** and **risk factors** applicants for international protection might carry and face. These factors can interlink with individual factors such as age, gender or overall health. While some factors might be protective for some, they might be risk factors for others (e.g. presence of family). Certain protective or risk factors might accompany the person throughout the migration process while others might only appear at a later stage or disappear completely. The non-exhaustive list below provides some examples of such protective and risk factors. Remember that the different critical stages and factors are interlinked throughout.

Figure 3. Protective and risk factors throughout the migration process

PROTECTIVE FACTORS

PAST Pre-departure	• High level of education • Good financial conditions in home country • Family and community support, social network
RECENT PAST Forced displacement and journey	• Direct route • Experienced support during displacement • Family and community support • Personal and political situation in the country of departure • Faith
NOW Arrival and stay in the host country(ies)	• Timely identification / vulnerability assessments to detect intersecting needs • Sense of safety • Access to primary healthcare and MHPSS • Support in family tracing • Measures to reduce language barriers • Effective/efficient asylum procedure • Psychoeducation • Access to daily/meaningful routines (e.g. leisure education, employment) • Stable/appropriate accommodation • Transfers kept to a minimum
NEAR FUTURE Integration or return	• Support in family reunification • Opportunities to safely practice cultural beliefs, (non-harmful) rituals and social practices • Sense of being and belonging • Ethnic density • High level of education • Access to the labour market / educational opportunities • Better English proficiency and self-sufficiency

RISK FACTORS		
	PAST Pre-departure	• Exposure to disruptive as well as life threatening events (such as gender-based violence (GBV), torture and other events beyond your control • Poverty • A history of health / mental health problems • Female gender • Separation of families/community • Substance abuse • Ethnic minority
	RECENT PAST Forced displacement and journey	• Exposure to disruptive as well as life threatening events (such as gender-based violence (GBV), torture and other events beyond your control • Situation in transit countries or long, dangerous migration routes • Detention and longer stay than anticipate in a third country • Separation from family members • Unaccompanied child • Victim of human trafficking • Living with a disability • Female gender • Old/very young age (child) • Deprivation of basic rights • Disability • Substance abuse
	NOW Arrival and stay in the host country(ies)	• Food insecurity • Separation of families/community • Unaccompanied child • Loss of loved ones • Lack of access to needs-based support • Inappropriate living conditions (e.g. in camps) or homelessness • Lengthy asylum procedure and uncertainty of the outcome • Substance abuse • Xenophobia and racism in the host country • Chronic health condition / disabilities
	NEAR FUTURE Integration or return	• Fear of deportation • Loss of job or social role / unemployment • Homelessness • Detention • Family conflict • Discrimination / victimisation • Anti-immigrant sentiment in the host country • Social isolation / downward social mobility • Disability or poor physical/mental health: chronic diseases • Substance abuse • Experienced disruptive events • Family at risk in country of origin / loss of loved ones / ongoing war in country of origin

3

Cultural sensitivity and competency

Cultural sensitivity is always important but particularly so when working with persons in a vulnerable situation. In the case of applicants for international protection, the different cultures add yet another layer of complexity that requires heightened cultural sensitivity. Due to its importance, cultural sensitivity and competence, in the form of specially tailored questions on culturally sensitive topics, can be streamlined into the selection procedure for first-line officers. In addition, staff already in post can be trained on the topic. Where possible, this training should be accessible to all staff, no matter their role, including volunteers.

The involvement of trained interpreters in reception as well as during the personal interview is crucial. Involving cultural mediators can also be of added value. Follow the below tips to further support meaningful engagement with applicants.

Nurturing cultural competency

Cultural competency

Identify cultural patterns

- ☐ Observe and acknowledge gender roles/norms and what they might mean in terms of engagement.
- ☐ Familiarise yourself with the local traditions and practices of the applicants.
- ☐ Avoid stereotypes and approach applicants as individuals.

Avoid assumptions

- ☐ Clarify and confirm the narrative shared by the applicant.
- ☐ Be open and flexible when engaging.
- ☐ Be aware and control your own potential stereotypes and biases.
- ☐ Acknowledge any intersecting needs a person might have since they might not be obvious.

Break power dynamics

- ☐ Refrain from adopting a 'saviour approach'. Acknowledge and point out the applicant's strengths to support their self-efficiency and help them realise their own strengths.

Practice cross-cultural communication

- ☐ Use active listening.
- ☐ Be aware of both your own and the person's non-verbal communication (e.g. body language, eye contact, clothing).
- ☐ Promote learning from and with colleagues such as cultural mediators, guardians and interpreters.

Observations/comments.

Tips and reminders for current and incoming staff and volunteers when engaging with applicants during the implementation of mental health and psychosocial support

Tips for current and incoming staff and volunteers

Space and time

- ☐ Provide applicants with some privacy and allow them time to settle in before approaching them with questions and support offers.
- ☐ For applicants that immediately want to talk and receive information, share what is relevant in a variety of formats depending on their needs, the topic and the context (e.g. leaflets, animations, group meetings, information sessions).

Mindful use of words

- ☐ Certain words might make applicants feel uncomfortable depending on their cultural and educational background.

> Referring an applicant to a psychiatrist or psychologist when they express worry, anxiety or similar could be understood as you considering them 'crazy'. Psychiatric and psychological support is still linked to stigmatisation in many countries including in Europe. Explain to applicants that in Europe there are specialised professionals that can help when a person is feeling stressed and overwhelmed.

Active listening

- ☐ Make the effort to listen to what seems most important to the applicant at that point of the asylum procedure.

> While applicants might face psychological distress, some of their worries might be addressed by simply listening to their concerns, which can help them feel reassured and calmer.

Routines and predictability

- ☐ Ensure a clear structure and framework for applicants. Inform applicants of the basic rules in their accommodation and inform them as to what will happen in the coming days regarding the asylum procedure or in reception.

Empathy

- ☐ Try to stay calm and where needed put yourself in the position of the applicant to better grasp their thoughts and feelings.

> Most applicants appreciate simply having someone listen and being taken seriously. Be professional and aware of those applicants for whom you might not be the best support person due to personal bias. Step back if you realise that being empathic in a given scenario is a challenge. Be transparent and professional and suggest to your line management, where applicable, if you consider there is a colleague who might be better placed to support.

Giving it a name

- ☐ Give certain symptoms a name to relieve a person of any uncertainty, though be careful not to 'label' applicants with conditions.

> For example, in a case of someone presenting with severe anxiety, including symptoms such as circular thinking patterns, the inability to sleep, eat or concentrate, it can be helpful to talk openly with the person about these signs. Explain that these symptoms are natural for people who have gone through a lot and with the right support and/or treatment these symptoms can be managed. Applicants may realise that they feel 'different' now when compared to how they felt before certain event(s) took place. Acknowledging this fact can be helpful while being reassured that their condition can change with the relevant support.

Human engagement

- ☐ Treat all applicants with respect and dignity. Listen to the applicants and provide them with the opportunity to make some basic choices in decisions affecting them.

> Focus on the applicant's own resources by asking them about any coping mechanisms they used in the past to cope with similar symptoms or feelings. Self-determination is vital since having a sense of control is empowering and gives agency.

Acknowledging diversity

- ☐ Be aware that every person is different and use an applicant-centred approach.

> Remember that the way a person reacts can be influenced by several factors including their age, gender, upbringing, educational background or social support. These factors can also intersect.

Perspective

- ☐ Be realistic on the services that can be offered and who can deliver them to manage expectations.

4

Understanding trauma

Many of the persons arriving in Europe have experienced disruptive and even traumatic events. This does not necessarily mean that such events will have a lasting impact. The way someone copes with negative and traumatic experiences can differ significantly to another person. The way a person reacts also depends on the support they received when needed.

The possible impact of trauma is briefly explained in this chapter. As with a physical injury, psychological wounds also need time to heal and the individual affected needs time to learn how to cope with the experiences. While some of the scars (physical and/or psychological) might last forever, timely and effective support from professionals and/or the loving care of family and community members can help someone move on with life and not suffer from a permanent mental health condition. Timely access to the support of social networks (family and friends) can be crucial to ensure the effective management of adverse reactions to trauma (such as resorting to substance use or self-harm).

Psychological wounds, as with physical wounds, can, however, also ‘re-open’ when triggered. The triggers are often linked to our **five senses**.

Certain scents, sounds, taste, images, atmospheres or behaviours might trigger a person to remember a disruptive or traumatic situation.

Our five senses

Vision

Hearing

Smell

Taste

Touch

Examples

- **Vision**. The outfit or a physical trait of the officer conducting the personal interview might remind the applicant of a person who was harmful towards them in the past.
- **Hearing**. Fireworks as part of celebrations can remind an applicant of a situation of combat.
- **Smell**. The smell of a person or a room might trigger negative memories/physical reactions since they are automatically linked to a certain disruptive event.
- **Taste**. A meal using a typical herb from home brings the person back to a specific situation in the past.
- **Touch**. The surface of the table in the room where the personal interview takes place feels 'sleek and cold' like the table in a room in which the applicant was investigated in the past.

Random individual or combined factors might trigger a person to be drawn back to a specific moment of crisis. Emotional reactions might be the case to such sensory experiences. The affected applicant is not only reminded of the incident but the body and the brain might react instinctively. In this way, though the triggers themselves are often harmless, they cause the body of the applicant potentially to react as if they are again in a situation of danger.

In addition to the above, witnessing a similar trauma can set off symptoms. This includes scenes from a television show, film or a news report. Returning to a location where a traumatic event took place or if the location shows similarities to such a place can also be a trigger.

Though the senses can trigger memories of negative experiences, they can also remind a person of positive ones. Therefore, be attentive also to what comforts the applicant and makes them feel safe.

Our senses are always on alert. While normally they help us to sense danger and consequently help us to protect us, they can, when linked to negative events also lead to unwanted reactions and affect the way our brain functions. They can also drive us to fight, flee or freeze in a given situation. The personal interview is one of the most important moments in the lives of many applicants. Distress and nervousness may further impact the ability of some to always fully collaborate and engage.

Explaining fight, flight or freeze

Reacting to situations that create stress or anxiety by either fighting a given situation or person (fight), avoiding a situation (flight) or by staying in place and waiting until the 'threat' is over (freeze) is natural. The way people respond to a certain situation however also has to do with the way they were brought up, exposure to similar situations as well as support experienced in the past, culture and the empathy and understanding shown by the first-line officer engaging with them.

What is the stress response of fight, flight and freeze?

Scenario

A person was attacked by a dog at the age of 14 leaving the person with a scar on one leg. One day, as the person is walking, another dog of the same breed walks towards them. The dog is on a lead but the owners seem to be struggling to control the dog. This situation can constitute a potential 'trigger'. It creates an alert and can lead to different reactions in persons who have experienced a dog attack.

POSSIBLE REACTIONS

Flight

The person decides to avoid the dog owner and the dog by crossing to the other side of the street.

Freeze

The person immediately stops walking, stands still and tenses while waiting for the dog and owner to pass.

Fight

The person confronts the dog owner. They tell them that breed of dog is dangerous and therefore they should keep the dog tightly on the lead while the dog owner might benefit from dog training.

The reactions and the way the body responds to the emotions caused by such a situation might be faster than the thoughts linked to them. The reactions might also depend on the support and follow up received after the initial incident took place, which in this case is the attack by the dog as a 14-year-old boy.

In the context of the asylum procedure, the stress and anxiety levels experienced by an applicant affected by disruptive events including trauma might be especially high. This is due to the accumulation of trauma and additional post-arrival stressors. Some might respond therefore with either a fight, flight or freeze reaction in a situation that they might perceive as decreasing their chances of 'survival' in a threatening situation, for example a question posed during the personal asylum interview might trigger such a sensation and reduce the ability of the applicant therefore to engage meaningfully.

As a reaction to this accumulated trauma, an applicant might be late or even miss an appointment or behave aggressively towards the case officer when asked certain questions. Others might simply be unable to collaborate and contribute coherently or meaningfully to the interview as they are unable to recall situations or are not even able to speak. For more information, refer to Section Considering trauma during the personal interview.

How the brain might react

Depending on the **life stages** (age) of a person and the **length** and **intensity** (frequency) of the disruptive or traumatic event, there might be different challenges and effects on the brain.

Cases of chronic distress and the presence of trigger(s) can lead to a situation where the brain shuts down and a person can no longer properly function. In a situation where reactions to certain triggers persist, mental health professionals might indicate that a person is suffering from **post-traumatic stress disorder**. Some of the symptoms first-line officers might observe can include ([23]):

- recurrent, intrusive distressing memories;
- dreams about the traumatic event(s) and inability to fall or stay asleep;
- 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);
- concentration problems.

If a first-line officer suspects that an applicant might be severely affected by trauma, a referral to a **mental health professional should follow**. This includes referrals to clinical psychologists and psychiatrists to provide the relevant specialised support to the applicant and potentially also formulate a diagnosis ([24]) where applicable. Inform the applicant on the support options available and how to access them and that these reactions might be reactions to events experienced and once looked at can be managed. Before making a referral, ensure you have obtained the applicant's consent.

([23]) This list is adapted from the four symptom clusters identified by the American Psychiatric Association when diagnosing post-traumatic stress disorder. See American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, DSM-5, 2013.

([24]) EUAA, *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*, Section 'Applicants presenting with a mental health disorder'.

Figure 2. In a nutshell – how the brain works when in severe distress

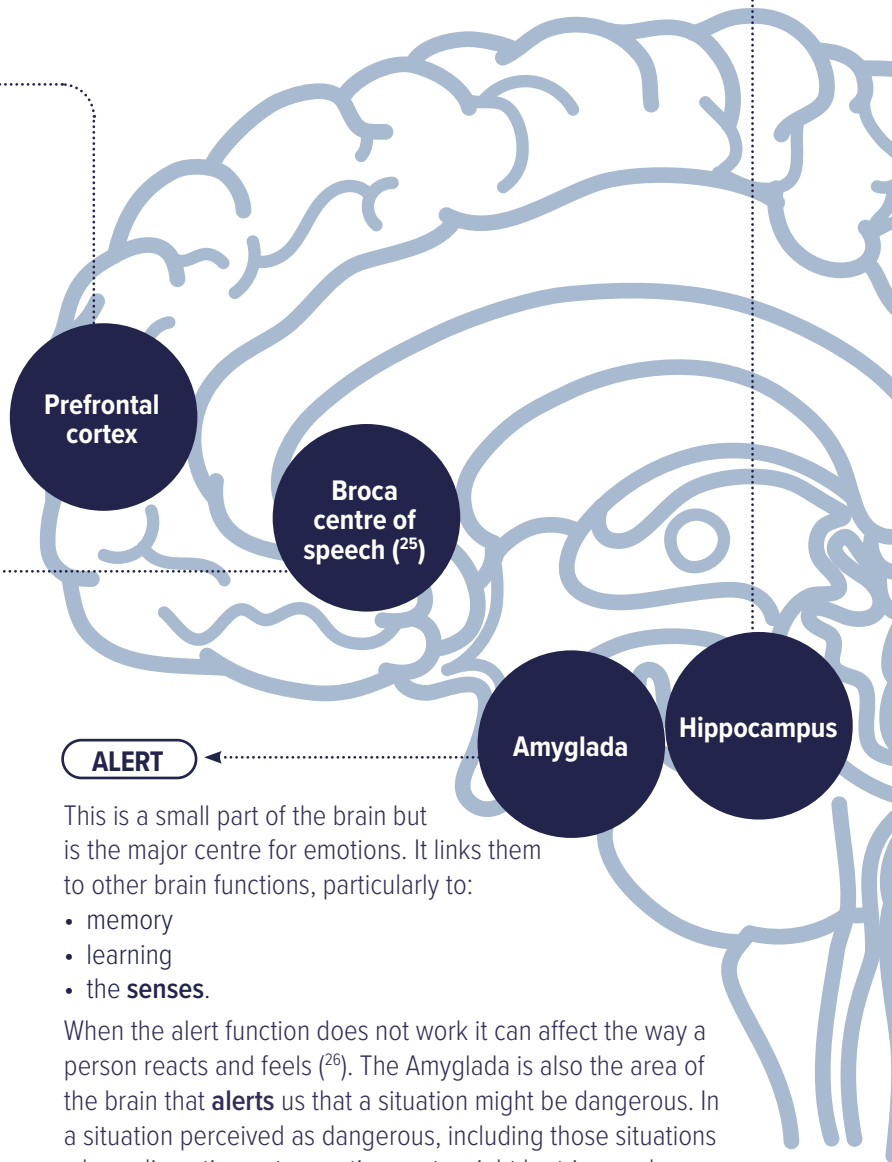
MEMORIES

This part of the brain oversees memories. It is here that the brain stores things that are interesting and meaningful to us. It is also here that the brain stores memories of difficult or violent situations. After disruptive and traumatic events, this part of the brain can either decide not to be able to recall certain memories or when triggered it will bring the person back to that situation. Certain **memories** might be lost (temporarily or long term) and depending on the intensity of the trigger, a person might not be able to function as usual for as long as they find themselves in severe distress or confronted with that specific trigger.

The **memory stored** in a situation of stress might **not be accessible** to the person. In a situation such as the personal interview, this inability to recall the incident may be detrimental to their ability to express what they have experienced and their need for protection.

IMPULSES

Impulses are normally regulated by norms and social values. Severe distress can lead to a situation where our **impulses** might not be regulated as usual. This can also affect the ability to concentrate and focus. For example, a person who is normally calm, patient and polite, might present as very irritated and impatient when confronted with a trigger. They may even act aggressively.



COMMUNICATION

The ability and means of **communication** might be affected for those in severe distress. This person might not find the right words to explain what happened or starts stuttering seemingly for no apparent reason. During the **personal interview**, an inexperienced case officer with limited knowledge on how psychological distress and trauma can affect the brain might question the credibility of an applicant who is suddenly struggling to find the right words or who seems to recall events in an incoherent manner.

ALERT

This is a small part of the brain but is the major centre for emotions. It links them to other brain functions, particularly to:

- memory
- learning
- the **senses**.

When the alert function does not work it can affect the way a person reacts and feels ([26]). The Amyglada is also the area of the brain that **alerts** us that a situation might be dangerous. In a situation perceived as dangerous, including those situations where disruptive or traumatic events might be triggered, our brain alerts us by using the **fight, flight or freeze** reaction.

Source: This figure draws inspiration from the Trauma Company, a knowledge centre for trauma-sensitive support based in the Netherlands and founded in 2018.

([25]) M. Crank and P.T. Fox, 'Broca's Area', *Encyclopedia of the Human Brain*, ed. V.S. Ramachandran, *Academic Press*, Vol 1, 2002, pp. 569-586.
([26]) Cleveland Clinic, 'Amygdala', Cleveland Clinic medically reviewed website, reviewed on 4 November 2023.
([27]) M. G. Quirke, *Intergenerational Trauma: Recognize These Signs & Symptoms*, accessed 21 August 2024.

As a case officer conducting the personal interview, be mindful if an applicant seems not to remember or avoids answering certain questions but instead reacts physically (e.g. increased nervousness or sweating). The applicant might find themself in a situation of distress. In this moment, the person might by unable to fully and meaningfully participate in the interview. In a moment like this, allow the applicant to take a break, encourage them to drink water and check first with the applicant to confirm that the interview can continue.

When **working with children**, keep in mind that in addition to their own experiences, the experiences of their parents or family members might affect the child's resilience and can affect a child's behaviour and MHW. This is referred to as generational trauma ([27]) and might be important to consider during the personal interview. It is therefore recommended that the same case officer, who has received basic training on trauma, is assigned to the whole family. This will allow the case officer to understand these dynamics and to ensure the relevant guarantees are in place such as pausing the interview and making a referral to focused and specialised care where needed.

What is trauma-informed care?

Trauma informed care shifts the focus from 'what is wrong with the applicant' to 'what happened to the applicant?'. The approach is applicant-centred and those on the receiving end of such an approach, such as survivors of trauma, experience it as more empowering ([28]). First-line officers using a trauma-informed approach allows for more time to be allocated to a person. It ensures more listening and learning on the part of the first-line officer on what is important for the applicant to share. This allows officers working in reception but also those working with the determining authorities to have a more comprehensive picture on what needs an applicant might have and what support (reception conditions, procedural guarantees) might be most effective.

Below a brief overview what trauma-informed care can mean in the context of asylum and reception:

([28]) Center for Health Care Strategies: Trauma-Informed Care, Implementation Resource Center, 'What is Trauma Informed Care?' accessed 21 August 2024.

Main principles of a trauma-informed approach

Safety

- ☐ Ensure the physical and psychological safety of all applicants including during the personal interview.

Empowerment, collaboration and support

- ☐ Focus on the applicant's own resources. Educate them with skills that will help them calm themselves down and provide them with opportunities to connect with other affected applicants (peer support).

Trust and transparency

- ☐ Allow time to build rapport to ensure trust and be transparent with the decision that will be made at the end of the procedure; explain the applicant's obligations and the limitations of your support.

Culture, gender, and other personal factors

- ☐ Consider the gender, age and other personal factors the applicant presents with in your engagement and planning of reception conditions and procedural guarantees.

A trauma-informed approach:

- recognises the impact trauma can have but not must have; every person reacts different to traumatic experiences;
- ensures a 'do no harm' approach and reflects on the potential impact of your involvement and what and how you interact or your decision not to act;
- ensures sufficient time is available to first-line officers to recognise the needs of applicants and respond adequately;
- ensures those in contact with applicants have a basic level of mental health literacy and are sufficiently supported in their daily work (staff welfare).

It is important that case officers conducting the **personal interview** have a basic understanding of trauma and how it can affect an individual. It is crucial to take time to build rapport, show empathy, allow for silence and not display a judgemental or authoritative attitude. It is advised to have access to colleagues who are specialised in interviewing applicants in psychological distress and/or a list of internal and external referral partners for those applicants with more complex needs.

When working with applicants who are presumed to be victims of torture, and particularly interesting for those officers in the determining authorities, refer to work by the Center of Victims of Torture, '**Designing a trauma-informed Asylum system in the United States**', updated 19 July 2023.

5

Working with vulnerable applicants

To be able to meaningfully support applicants in need, they must first be identified as being in need and/or in a vulnerable situation.

Identification of vulnerabilities and special needs

Practitioners often see the identification of applicants in need as challenging. Some considerations to facilitate the identification of such applicants are provided below.

Identification

- ☐ The initial medical and vulnerability detection exercises (checks) target **all new arrivals** as a first step.

  > This ensures that vulnerabilities and special needs are identified at any stage of the asylum/reception pathway and a follow-up for the immediate concerns can be organised in a timely fashion.

- ☐ Medical and vulnerability intakes/checks upon arrival **complement one another.** If only a medical check is conducted upon arrival, this check has vulnerability- and protection-related indicators integrated into them at a minimum.
- ☐ **Identification is an ongoing process.** Conduct further assessments to reevaluate the needs when necessary.
- ☐ The medical and vulnerability intake is conducted by a sufficient number of **experienced** and **well-trained professionals** with experience working with migrants.

  > Since some applicants might only be in touch with a first-line officer (medical/vulnerability officer) at the point of arrival, it is crucial that these experts have the experience they need to be more likely to flag specific needs and intersecting vulnerabilities and particularly those that are hard to identify. 'Invisible' vulnerabilities can be, for example victims of human trafficking, torture or sexual violence, someone belonging to a minority group (SOGIESC) or presenting with mental health problems. Having experienced staff appointed at the critical stage of arrival can help to mitigate problems occurring at a later stage.

↳ **Supporting self-identification / self-disclosure** by applicants

- ☐ Organise information sessions with cultural mediators for applicants on the importance of sharing their concerns and to ensure they have access to support and special guarantees and know about their rights.
- ☐ Highlight that normally first-line officers will request consent from applicants before further support services / referrals are organised. Stress that confidentiality is always respected.
- ☐ The **child's best interests** is a primary consideration in all decision-making processes.
- ☐ In the case of child applicants, **child protection experts** are involved as early as possible to ensure the **best interests determination** regarding the child's situation. A risk assessment is conducted as soon as possible, where applicable, to reduce the risk of abduction.
- ☐ In a situation of high influx, the first-line officers could be supported by paraprofessionals with basic training on how to **implement PFA** to support the initial identification of those visibly in distress.
- ☐ Exhibit **cultural sensitivity and competency** at the point of arrival and when conducting initial intakes to ease the tension of those arriving.

- ☐ Simultaneously, upon arrival applicants should receive **basic information on the purpose of the identification exercise**.

  Knowledge about why an identification of vulnerabilities and special needs is carried out will help to reduce anxiety in the newly arrived and increase willingness to collaborate including nurture self-disclosure.

- ☐ When identification exercises are organised, **referrals and meaningful follow-up** are instrumental.

  Information on available services is up-to-date and made available to those conducting the initial intakes and vulnerability assessments later on.

- ☐ When the identification has a referral as an outcome, the **applicant being referred is made aware** of the next steps and **consent** is ensured. **Confidentially** in the process is vital.

- ☐ During a vulnerability assessment, focus is not only on the negative effects but an **applicant's strength, resilience** ([29]) and **protective factors**.

  This will help to ensure the most effective and relevant support.

- ☐ The authorities supporting in situations of disembarkation **closely coordinate** their efforts with the efforts of **search and rescue teams** ([30]).

  This ensures that relevant medical and mental health services are available for those already identified as being in need following the pre-arrival screenings conducted on rescue vessels, for example.

Engaging with child applicants

No matter the activities organised with and for children, their **best interests** remain a primary consideration. Ensure that the activities for children are planned in a safe and meaningful manner. When working with children, be mindful of the **language** used, the location (i.e. the space) and the '**what**' (i.e. the topics covered) when implementing interventions. The '**who**' will the people implementing such activities and the timing, i.e. the '**when**', will need to be thoroughly considered.

Below are some general considerations to facilitate the work of officers engaging with children.

([29]) IOM, *Psychosocial support after adversity: a systematic approach*, 2020; Caritas International, *Vulnérabilités Vers un traitement juste des réfugiés vulnérables*, 2017 (in French).

([30]) Legal framework – **pre-arrival**: Regulation (EU) No 656/2014 of the European Parliament and of the Council of 15 May 2014 establishing rules for the surveillance of the external sea borders in the context of operational cooperation coordinated by the European Agency for the Management of Operational Cooperation at the External Borders of the Member States of the European Union (OJ L 189/93). Article 4(4) states that:
the participating units shall address the special needs of children, including unaccompanied minors, victims of trafficking in human beings, persons in need of urgent medical assistance, disabled persons, persons in need of international protection and other persons in a particularly vulnerable situation.

Tips when working with children ([31])

- ☐ Be adaptable and responsive. Listen closely to their needs and preferences, modifying activities when necessary. Be open to their suggestions for improvements and recognise what engages and interests them. Embrace flexibility and adaptability.
- ☐ Facilitate opportunities for children to connect with one another and build relationships. Encourage communication and teamwork to foster stronger bonds with peers and staff. Support children in maintaining connections with siblings or other meaningful relationships.
- ☐ Schedule activities at consistent times and communicate in a child-friendly manner.

  > Children generally benefit from having structure, consistency and routines particularly during or after a crisis. Such support can provide comfort and stability to deal with difficult experiences and help to adapt to the numerous changes. Set healthy boundaries.

- ☐ Focus on children's strengths and the positive influences in their lives. Encourage self-reflection on their abilities, problem-solving skills and support networks. Create a positive atmosphere, demonstrating that, even in challenging circumstances, positive experiences and enjoyment are possible.
- ☐ Allow them to be creative. Foster connections to their cultural heritage while also introducing them to new, helpful traditions in their host country. Mentorship programmes where peers support one another can be helpful.
- ☐ When working with unaccompanied children, provide them with the relevant psychoeducation and use appropriate language. Children may experience overwhelming feelings due to the stressors they face. It can be helpful for them to understand these emotions. Psychoeducation involves providing basic information about mental health to address stigma and encourage openness to seeking help if needed.
- ☐ Reassure children that many of their reactions are natural in their situation. Offer age-appropriate and concise information. Use everyday language instead of clinical terms, unless in a clinical setting. It is crucial to provide accurate information that you know to be true.
- ☐ Be ready to engage in constructive and open discussions when children raise sensitive topics. Help them manage discomfort, provide accurate information, connect them to relevant resources, seek support when needed and take appropriate action if children disclose experiences of violence, exploitation or abuse.
- ☐ Respond to children's issues in a non-judgemental manner, respecting their religious, cultural and political beliefs. Identify and address taboo or difficult subjects, practice navigating uncomfortable discussions through role play, and avoid lecturing, preaching, withholding information or expressing discriminatory views.

([31]) 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 self-help tools targeting applicant parents, children and their friends who might face psychological distress are complemented by instructions for first-line officers.

- ☐ While providing opportunities for self-expression, be mindful of potential risks to children. Consider the safety and appropriateness of discussing certain topics in mixed-gender or mixed-age groups. Avoid situations that may cause distress or harm.
- ☐ Provide accurate information about the place children stay and the overall process they are going through. Create an atmosphere for questions. Provide truthful answers since false expectations or broken promises can erode trust and cause distress. Depending on the age, sensitive information including sexual and reproductive health, gender roles and social or political issues might need to be considered.
- ☐ Support adolescents in accessing resources and support them in connecting with their social support networks including through online services when necessary. At the same time, inform them about the risk the internet might pose (cyber abuse, cyberbullying, etc.).
- ☐ Recognise that children, particularly adolescents, are able to take charge of their lives and make decisions that shape their paths. Provide opportunities for children to take on leadership roles and responsibilities, respecting their readiness and preferences (e.g. which activity to engage in), introduce big sister/brother initiatives (mentorship programmes ([32])) and allow them to take the lead with slightly younger peers.
- ☐ Create an inclusive environment, where no child is left behind or discriminated against based on their identity or background. Adapt activities to ensure equal participation for everyone (age, gender and diversity considerations).
- ☐ Take the time to listen to children, allowing them to share their experiences, ideas and challenges. Children have valuable insights into their own needs and interests. Collaborate with them to develop activities and services that are engaging and beneficial for them. Create a safe space for them to discuss issues of importance to them.
- ☐ Involve the caregivers and parents in the process where considered to be in the best interests of the child, or the guardian if the child is unaccompanied.

([32]) Such peer support programmes seem to have a 'positive impact of the interventions on young refugees' lives in terms of mental health benefits, coping with life difficulties, or gaining access to valuable resources'. F. Barbaresos, N. Georgiou, F. Vasilopoulos, C. Papathanasiou, 'Peer support groups and peer mentoring in refugee adolescents and young adults: A literature review', *Global Journal of Community Psychology Practice*, Vol 14, Issue 2, 2023.

How and what to share with children

Tools. Sharing information with children

Child-friendly information is also, and maybe above all, information provided to help the child with their questions and worries (i.e. it is not only for the professional's purposes).
This means looking at things from the child's perspective and making a list of answers to their questions. Children might need answers to questions such as:

- Where am I?
- How long will I stay here?
- Will I be transferred? And if so, when?
- Who will take care of me and what are the procedures for making my stay official in this country?
- When can I go to school?
- How can I talk to my family?

Preparing answers to such questions will create a sense of calm in the child. Children might also want to find their own answers to some more general questions they might have about themselves, their identity, the emotions they are experiencing in this new country.

Nidos has developed several tools to support unaccompanied minors including a booklet guiding diary entries ([33]). In addition to ongoing psychosocial support by specialised officers working with children and youths using tools as diaries can be beneficial. The diary entries might however trigger emotions so it is important to provide access to support.

Child-friendly spaces and safe spaces for women and girls

Working side by side with community structures such as safe spaces for women/girls, child friend spaces, local/host **community centres**/organisations and informal education and learning centres, can enhance the reach of mental health interventions, as these structures can serve as entry points for mental health services and can be experienced as less stigmatising than mental health facilities, especially for the more vulnerable groups ([34]).

The purpose of child friendly spaces

Child-friendly spaces (CFSs) can be defined as:

> *places designed and operated in a participatory manner, where children can be provided with a safe environment, where integrated programming including play, recreation, education, health, and psychosocial support can be delivered and/or information about services/supports is provided ([35]).*

([33]) Nidos, Levensboek, 2015, (in Dutch).
([34]) Borja Jr., A., Khondaker, R., Durant, J. and Ochoa, B., 'Child-centred, cross-sectoral mental health and psychosocial support interventions in the Rohingya response: a field report by Save the Children', *Intervention*, 2019, Vol. 17, pp. 231–237.
([35]) UNICEF, *A Practical Guide for Developing Child Friendly Spaces*, 2008.

The main objectives of CFSs are:

- to mobilise 'communities around the protection and well-being of all children, including highly vulnerable children';
- to 'provide opportunities for children to play, acquire contextually relevant skills and receive social support';
- to 'offer intersectoral support for all children in the realisation of their rights' ([36]).

One of the strengths of a CFS is 'its capacity to serve children of all ages' ([37]). In general, the four main age groups that CFSs may serve are ([38])

- babies/toddlers;
- preschool children (under 6 years);
- school-aged children (ages 6 to 12);
- adolescents (ages 13 to 18).

The needs and activities and the requirements and set-up of the CFSs are different for each age group ([39]).

Key principles when setting up a child-friendly space ([40])

Principle 1. CFSs are secure and 'safe' environments for children
All involved actors (i.e. government, donors, international organisations, non-governmental organisations) should commit to ensuring that this principle is followed by:

a. including CFSs in the original design of camps / reception centres;
b. providing 'a quick and efficient support system and response for the safety of children' ([41]);
c. creating 'an environment for children to protect them from violence, exploitation and abuse' ([42]); and
d. creating a system/workflow to identify high-risk children.

Principle 2. CFSs provide a stimulating and supportive environment for children
A supportive environment entails a 'i) wide range of appropriate activities and programmes; ii) a physical environment to facilitate the activities and programmes; iii) encouraging, supportive and sensitive staff.' ([43]) 'Child and community participation in the selection of activities will enhance the supportive nature of the CFS. Staff should be aware of and practice a child-centred active learning approach. Children should be allowed to establish bonds and interact socially as much as possible.' ([44])

([36]) Global Education Cluster, Inter-agency Network for Education in Emergencies, IASC, Global Protection Cluster, *Guidelines for Child Friendly Spaces in Emergencies*, 2011, p.2.
([37]) UNICEF, *A Practical Guide for Developing Child Friendly Spaces*, 2008, p.43.
([38]) Ibid.
([39]) IFRC and World Vision, *Operational guidance for child friendly space in humanitarian Settings*, 2021.
([40]) The principles of child-friendly spaces have been taken from UNICEF, *A Practical Guide for Developing Child Friendly Spaces*, 2008, pp. 9-14.
([41]) Ibid, p.10.
([42]) Ibid.
([43]) Ibid.
([44]) UNICEF, *A Practical Guide for Developing Child Friendly Spaces*, 2008, p.10.

Principle 3. CFSs are built on existing structures and capacities within a community
Successful programming builds on and integrates existing capacities and structures of communities, civil society and governmental organisations. It is a matter of using and applying existing, available resources, services and daily routines of families. Understanding the lives of the families and children in the community, their existing coping mechanisms and how they perceive and pursue their livelihoods under unknown circumstances is essential to develop meaningful support.

Principle 4. CFSs use a fully participatory approach in terms of design and implementation
By involving families and children, expert knowledge is obtained through them directly, which can determine what would or would not be relevant. 'Participation will help to avoid challenges and misunderstandings in the long term.' ([45]) The applicant community is empowered, might feel a stronger sense of ownership and a sense of control, which can also support the sustainability of interventions.

Principle 5. CFSs provide or support integrated services and programmes
'The three most involved sectors of a CFS are education, protection and health (however, CFSs are not limited to these sectors alone and provide opportunities for engaging different sectors, i.e. water and sanitation). Activities that are integrated into wider systems ... tend to reach more people, carry less potential stigma and are usually more sustainable.' ([46]) They provide more coordinated referral systems and wider access to services and information.

Principle 6. CFSs are inclusive and non-discriminatory
'An inclusive process and a non-discriminatory approach ensures that all children regardless of their class, gender, abilities, language, ethnicity, sexual orientation, religion, nationality have equal access to CFS.' ([47]) Safe spaces for women and girls should have the following characteristics ([48]).

- **Context tailored.** The specific context variables, such as needs assessment findings, community dynamics and experiences and capacities of staff and implementing organisations, and of course context limitations, should be taken into consideration. This can also mean that where there are many single women with small children and depending on the activities, childcare might be provided and/or a context created where the small children can join the mother without significant disruption to other group participants.
- **Women and girl-led.** Women and girls must be consulted and their input should be included from the outset in decisions related to all the phases of the programme: design, implementation and monitoring. This is an essential step to support them through a process of empowerment. It ensures that safe spaces are always responsive and accountable to the needs of their members. Within such spaces for women and girls having same sex support (e.g. interpreters) is advised.

([45]) UNICEF, *A Practical Guide for Developing Child Friendly Spaces*, 2008, p.11.
([46]) Ibid based on the IASC, *Guidelines – Mental health and psychosocial support in emergency*, 2007.
([47]) Ibid, p.13.
([48]) United Nations Population Fund, Murfet, T., *Women and Girls' Safe Spaces*, Training manual – facilitators' guide, 2007.

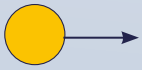
- **Community informed.** Key stakeholders in the community, such as community leaders, should be engaged from the outset of planning a women and girls' safe space. This will secure community support and consequently facilitate greater and safer access for women and adolescent girls. Ensure that community leaders are selected by taking gender and diversity into consideration (e.g. male community leaders could jeopardise in some context the active participation of female applicants and make them feel less at ease to speak about certain topics).
- **Psychosocial support activities for children.** The involvement of children in regular communal activities can nurture well-being and create opportunities to connect with peers, make friends, have fun and to forget their personal challenges for a time. Different forms of psychosocial support activities can help to support the mental health and well-being of child applicants. The type of activity to choose depends on the setting and context in which the child or children find themselves and the facilitators available.
- Generally, activities organised with and for children should focus on prevention and maintaining their mental health and well-being and nurture community participation. This approach will strengthen the children's resilience. For children in distress, it can provide ways to address these experiences in a safe and meaningful way with peers and/or professionals.
- To ensure a **do no harm approach**, first-line officers working with accompanied and unaccompanied children should select activities according to the children's needs and in line with the officers' expertise. Depending on the level of experience or knowledge of the facilitators, psychosocial activities can be grouped into those activities requiring facilitators with basic skills or background in psychology, child protection and social work and separately group those activities that require a high level of expertise.

Examples

The below examples have been taken from a toolkit developed for applicant children on psychosocial support activities as part of ongoing EUAA operational support:

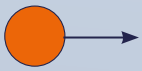
Green dot activities

Activities indicated with a **green dot** can be implemented by a variety of first-line **officers** including those **with little experience or knowledge** on vulnerability or psychosocial support. A minimum level of mental health literacy however would be recommended (refer to the EUAA animation for lay counsellors on the topic ([49])). The activities in green mainly cover leisure, play and recreational activities. They can be implemented in safe spaces created for children within a reception facility and/or outside in nature where possible.



Yellow dot activities

Activities indicated with a **yellow dot** are recommended to be implemented by **skilled officers** such as those officers working in reception with a background in social work, child protection and/or vulnerability. These activities are more tailored to the potential needs of children placed in reception and they might trigger memories and emotions. Skilled officers are better equipped to safely support children to cope with such emotions should they arise and can organise any necessary relevant follow--up (including referrals).



Orange dot activities

Activities indicated with an **orange dot** should also be implemented by **skilled officers with additional expertise** in social work, psychology and trauma-informed care or similar. This is important because the activities might trigger disruptive memories. These activities can require engaging more intensely with a child in distress and may require the subsequent organisation of a needs-based response.

([49]) EUAA, 'Psychological First Aid Video', YouTube, 26 June 2023 accompanied by instructions.

Considerations when organising group activities with children

The facilitators need to prepare for the interventions before choosing an activity and inviting the children. Below is a non-exhaustive list of tips on how to roll out psychosocial support activities with child applicants in a safe and meaningful manner.

Preparation

- Consider the children in the reception facility (age, gender, family composition, nationalities, cultural background, identified skills, hobbies and interests) and select the activities accordingly.
- Inform the children about the purpose of the activity.
- Ensure that parents/guardians are aware of the purpose of the activity and have provided consent for the child to join in.
- Schedule the activity at a time that it does not compete with other commitments (educational/language courses).
- Depending on the location and children, consider whether to group the children in a homogenous or mixed group. Consider the age and diversity of the children and ensure the activity is accessible for any child living with a disability ([50]).
- The activity timetable should be visible in common spaces and communicated to the parents or caregivers as well as to the children.
- All children in the reception facility should have equal opportunities to participate and benefit from the activities.
- Though certain activities can be spontaneous, plan most of the activities on a weekly or bi-weekly basis for a stronger positive impact and higher participation.
- Include/adjust activities according to the interests and age of the children residing at the reception facility and pro-actively involve them in the planning.

Location and set up ([51])

- Where possible, use a child-friendly / comfortable space or room.
- Ensure the safe spaces are accessible for children of different ages including for those who might have specific needs (e.g. wheelchair users).
- If possible, ensure there are bathrooms close to the location particularly when involving smaller children.
- Choose locations with natural lighting, where possible.

([50]) EUAA, *Persons with disabilities in the Asylum and Reception System*, 2024.
([51]) In addition, refer to Section Child-friendly spaces and safe spaces for women and girls.

Language and interpretation

- Facilitators should either speak the language of the participating children and/or be supported by an interpreter and/or where available cultural mediator. The interpreter should be aware of the purpose of the activities and be given a chance to de-brief with the facilitator(s) after the activities, where needed.
- The language used by both facilitators and interpreters must always be age appropriate, simple and clear.
- Speak gently. This is not an authoritative setting. Language and engagement should be empathic, fun and child-friendly

What facilitators should remember during implementation

- Invite participants to come up with some basic group rules (or the rules already formulated by participants of a previous activity can be shared with new group members) to ensure a smooth and respectful conduct of activities.
  - Example rules include arriving on time, allowing everyone to speak, respecting everyone's opinion, being kind to one another and not using phones during the activity.
- Facilitate activities in a way that encourages communication, exchange and teamwork between peers.
- Always focus on the children's strengths and the positive influences (protective factors) in their lives.
- Encourage self-reflection on their abilities, problem-solving skills and support networks inside and outside the group.
- Create a positive atmosphere, demonstrating that, even in challenging circumstances, positive experiences and enjoyment is possible, encouraged and nothing to feel guilty about ([52]).
- Allow for sad/silent moments if they arise as this is also a natural experience.
- Allow children to bring their own ideas on how to organise certain parts of the activities where applicable (e.g. their variations for games, artwork and questions).

Group size

- The age of the participants and the size of the group size will deciding the number of facilitators needed. However, avoid groups exceeding 10 children. A personal encounter with each of the children should be always possible. Smaller groups are also easier to coordinate.
- In some circumstances (such as green dot activities), interpreters and/or applicant community representatives might join in to support the efforts in collaboration with first-line officers working in the reception authorities
- In certain settings, activities might be community-led (e.g. green dot activities).

([52]) Some children who have experienced disruptive events and/or lost loved ones might feel guilty enjoying themselves while knowing that family have died or had to stay behind in insecure and difficult circumstances.

Community participation

- Integrate other residents, including parents, where applicable, to help facilitate the activities (e.g. a trip to the park).
- The involvement of community members can strengthen a sense of purpose and belonging in those volunteering. Further, strengthening skills by involving applicants can also be useful to nurture self-help skills. On rare occasions, creating a pool of paraprofessionals in this way could even be useful if human resources in the facility are scarce at one point.

Safeguards

- Remind new incoming group members that personal concerns are better shared in individual meetings with the facilitators before or after the activities.
- Clarify that the activities are not group counselling sessions. In situations where children might want to share personal concerns and problems, it is advised to 'park' the discussion sensitively and in a respectful manner and indicate that the facilitator will come back to the concern raised however after the activity has ended. If the child has already started sharing, the facilitator will need to be sensitive on how to integrate the comments and to ensure that the child is safeguarded, confidentiality is ensured as much as possible and that the other children are aware of the importance of being kind and care for one another including when peers face challenging situations.
- Provide any children seemingly struggling with immediate support and follow up. This support should be provided outside of the group setting, where possible, to allow for confidentiality.
- Participation is always voluntary. Children should be free to opt out at any time in the of the activity for example in case they feel uncomfortable.
- Facilitators should pay attention throughout the activities to any expressions of discomfort in the participating children. Even though the activities proposed in the green and yellow dot categories are low risk when it comes to triggering memories of disruptive events or even traumatic experiences, facilitators should recognise signs and intervene timely. Facilitators should arrange for follow up support where applicable.
- Depending on the nature of the group, the gender of the facilitator(s) and interpreters might be important and may need adjusting (e.g. all girl groups should not be facilitated by sole male facilitators and vice versa).
- Depending on the background of the children (age, faith, ethnicity/nationality) and topics touched upon, homogenous groups might be better suited.
- Facilitators will benefit from having some basic information of the participating children (how they arrived, family composition, experiences of psychological distress, etc.) in advance of the activities. This information can be useful to safely steer discussions within the group and to reduce the risk of tension and discomfort.
- Observe group dynamics particularly with a view to preventing bullying between peers.
- Breathing and relaxation exercises, while often useful including for children, will need to be done in an organised way and by people with the relevant experiences only.

An example green dot activity

EXCURSION INTO NATURE

Purpose and objective of the activity in brief

This activity brings children outside to explore their surroundings. The children are taken out into the fresh air and engage with peers in a 'nature-themed' field trip.

Benefits: this creative, guided trip encourages play in nature outside of the place of residence. The trip fosters sensory exploration and collaboration between peers, creativity and team spirit and contributes to general mental health and well-being.

Materials and other resources needed

- Paper/cloth bags to gather the objects collected
- Wipes for smaller children
- Appropriate clothes, depending on the weather and time of the year
- Drinking water and snacks depending on the duration

Number of participants and time needed

- 10 children (maximum)
- Around 2 hours (depending on the group size and location)

Facilitators

- At least one first-line officer familiar to the children, preferably a social worker assigned to a reception facility
- At least one volunteer/paraprofessional supporting the first-line officer, which could be a member of the applicant community
- An interpreter (where needed)

Suggested flow of this activity

- **Introduction (approximately 10 minutes):** a quick round of introduction of all children and facilitators. The children are given a brief overview of what is planned and how long it will take.
- **Details (5 minutes):** the assignment for the children is to collect natural objects such as pinecones, flowers, sticks, pebbles/stones and leaves, depending on the location while ensuring respect for the local flora and fauna.
- **Excursion (45 minutes):** the children are put in small groups depending on the number of children and will explore the area. They will collect objects while discussing with their groupmates the shapes, textures and colours of the items they collect and what they could be used for.
- **Showing the treasures (30 minutes):** form a circle at the site (park/outdoor location/ or reception facility), preferably outdoor if the weather permits and ask the children to group the objects based on size, texture and colour. Encourage the children to explore the objects through touch and smell. Ask what they could be used for, for example using a leaf to wipe a table, a stick for fishing, grass to feed animals, creating artwork. Encourage them to be creative.

- **Discussing the next step / follow-up activity (30min):** objects that the children and facilitators collect can be used as crafts for follow-up activities. Ask the children if they have any ideas on how to use these objects in another activity (e.g. building something with the items collected).
- **Examples**
  - Use the pinecones, stones and sticks to create different animals and even paint the stones. The group can collectively create a zoo out of their creations.
  - Use the leaves to create artwork/collages and organise a child-led exhibition for all residents at the reception facility.
  - After the excursion, the group can discuss the importance of keeping the environment clean for children in the future to do similar activities and find parks, trees, grass and flowers when they go for walks.
  - If the children agree on a follow up activity, the facilitator will keep the collected items until the group meets again.

Age group

- This activity can be organised with different age groups.
  - When organised with smaller children, less objects will be collected and more time will be given to explore, sense and discuss colours and shapes (4–8 years).
  - When organised with older children (8 and above), place the objects collected in a bag and children have to pick an item with their eyes closed. The child can hold it in their hand and describe the object to the rest of the group while guessing what they have picked.

Variations

- Teaching the words for the collected objects can encourage knowledge of the local language.
- The facilitator can guide them to classify the collected objects based on size, colour, shape and texture. The facilitator can also encourage the children to explore the elements through touch and smell and use counting games to see which objects are more frequently collected than others or if there are any rare objects.
- For children living with a disability, focusing on shapes, size or smell can encourage meaningful engagement.
- The objects could be also used for older children as a basis for a fantasy story. They can attribute superpowers to the objects and in pairs create a story to share with the rest of the group when they meet again.

Other considerations and safeguards

- The children need to confirm that they understand the need to stay together. This is particularly important when the group visits a park outside of the reception environment.
- The parents/caregivers give their consent for their children to join the activity.
- Where seen as useful and depending on the size of the group, having some parents/caregivers join in can nurture community participation.
- For smaller children, facilitators need to make sure the children do not try to put the collected objects in their mouths.

For reporting purposes: additional comments/observations from the facilitator during the session

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_____

_____

An example yellow dot activity

Creating and telling a story

Purpose and objective in brief

This activity brings children together to work on a project. Afterwards the children can read out their stories to the others.

Benefits: this activity enhances the spirit of working in teams, allows for creativity, curiosity and aims and creating a joint 'product' with peers.

Materials and resources needed

- Whiteboard/chalkboard/notebooks
- Markers, chalk, pens and pencils
- Drawing paper and colouring materials (optional)
- Drinking water and snacks depending on the duration

Number of participants and time needed

- 10 children (maximum)
- Around 2 hours (depending on the group size and location)

Facilitators

- At least one first-line officer familiar to the children, preferably a social worker assigned to a reception facility
- At least one volunteer/paraprofessional supporting the first-line officer, which could be a member of the applicant community
- An interpreter (where needed)

Suggested flow of this activity

- **Introduction (approximately 10 minutes):** a quick round of introduction of all children and facilitators. The children are given a brief overview of what is planned and how long it will take.
- **Introduction and setting the tone (5 minutes):** depending on the age of the children and their literacy levels, the facilitator will decide which format is most suitable for the participants. They can create a story through writing, drawing, sharing it verbally or by coming up with some scenes and acting them out.

- They can choose their own groups if there are many children participating and they are old enough (e.g. 2-4 children in one group). If the group is smaller or has younger children, this can be an activity for the whole group guided by the facilitator. In both scenarios, encourage the children to use their imagination. All children can and should share their ideas. There are no right or wrong ideas to build this story.

- **Starting the story (5 minutes):** the facilitators will provide the groups with a few introduction lines to encourage the children to use their imagination to start their stories. For example:
  - 'Once upon a time there was a young girl/boy who was very curious. She/he loved learning new things and...'.
  - 'In a big and wonderful city there lived a woman/man with two cats. The cats were called Mimi and Meme. One day...'.
  - 'It was the weekend and it was finally raining. The flowers, trees and fields needed the water to grow. Two farmers, Mr and Ms Smith, looked out of the window and were happy to see the rain. However, one family member was not so happy because...'.

  Facilitators are invited to find their own beginnings.
- **Creating characters (10 minutes):** invite the children to collectively create characters for the story. Discuss key details such as names, appearances, personalities and their roles and actions. Encourage each child to contribute at their ideas.
- **Developing the plot (20 minutes):** facilitate a discussion on the plot if the group is composed of younger children. Prompt the children to share their ideas for events, challenges to overcome and adventures that the characters might encounter. You or a designated helper will write down the ideas on the board. If the group is composed of older children and able to write, they can write their ideas in their respective groups. The facilitators can check in with the groups to see if there are any questions.
- **Connecting ideas (10 minutes):** help the children connect and weave their ideas into a cohesive storyline. Ask questions such as 'How can character X and character Y work together to overcome this challenge?' or 'Is there a funny or adventurous twist to add to make this story even more exciting?"
- **Visual elements (15 minutes, optional):** if desired, provide drawing paper and colouring materials. Encourage the children to draw scenes or characters from the story as it unfolds. These visuals can enhance the collaborative experience.
- **Writing the story (15 minutes):** once the storyline is developed, work together to organise the events into a narrative. Write the story on the board as it is being discussed. Encourage the children to contribute and edit as needed.
- **Reading and sharing (15 minutes – if sufficient time is available):** once the story is written down, read it aloud as a group. This allows children to see their ideas come to life and appreciate the collaborative effort. If the stories are not yet finalised – this can be an exercise to finish the story together until the next time the group meets, and the stories are being presented. Schedule the next activity shortly after the first activity (maximum of one week afterwards).

- Reflection and conclusion (10 minutes): gather the children together to reflect on the activity:
  - How did it feel to create a story together?
  - What were their favourite parts of the story or stories heard?

Age group

- This activity can be organised with different age groups. When organised with younger children, the children can explain what happens in the story and the facilitator will write it down, while the children can focus on drawing pictures depicting their stories. The facilitator can read the story and the children's drawings can be taped on the wall so children can see them.

Variation

- Depending on the context, the stories can be collected, typed up and compiled together with the drawings in a small story book which can be made available to other applicant children arriving to the reception centre.
- The stories can be translated into a play or the drawings can be shared with applicants in the centre in the form of an exhibition.

Other considerations and safeguards

- Facilitators will carefully but clearly instruct group members at the beginning and during the process that the story can be action oriented or an adventure story but cannot include brutal and violent scenes. If the facilitators realises that the story telling goes into such a direction, the facilitator will gently help the team to redirect their narrative by adding ideas if needed, on how to lead the content on a more positive and constructive path.
- With smaller children try to tell the story but avoid writing contents since not all might be on the same level in terms of literacy.

For reporting purposes: additional comments/observations from the facilitator during the session

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An example orange dot activity

Purpose and objective of the activity in brief

This activity brings children together to share a little bit about themselves with their peers, such as what they like or dislike, their hobbies, dreams and hopes.

Benefits: this activity encourages children to disclose certain personal things in a safe space while guided by a skilled reception staff member. This can help children observe similarities with others, for example shared interests or similar experiences. This can create a sense of not being alone.

Materials and resources needed

- Coloured cardboard
- Markers
- Magazines, newspaper sheets
- Watercolours, crayons
- Glitter
- Glue, scissors
- Drinking water and snacks depending on the duration

Number of participants and time needed

- 10 children (maximum)
- Around 2 hours (depending on the group size and location)

Facilitators

- A first-line officer assigned to the reception facility with expertise in social work, psychology, trauma-informed care or similar who is familiar to the children
- At least one social worker supporting the first-line officer
- An interpreter (where needed)

Suggested flow of this activity

- **Introduction (approximately 10 minutes):** a quick round of introduction of all children and facilitators. The children are given a brief overview of what is planned and how long it will take.
- **Setting the scene (10 minutes):** the activity is to create a poster that should focus on what the children think represents them best. Explain that each child will receive a big piece of paper – they can choose the colour (where possible) – and will:
  - divide the paper into three equal parts;
  - draw or paste three objects or images that represent them best in the first section;
  - draw or paste three things that they like in general in the second section;
  - draw or paste three things they dislike in the third section of the paper.

- **Poster making (30 minutes):** allow the children to express themselves artistically by creating posters that represent them and by using the material made available to them (drawing, writing or cutting out items from newspapers).
- **Poster exposition (15 minutes):** once the posters are completed, each child places their poster on the table or the facilitator sticks them to a wall for the children to look at them. Each child is then invited to explain what is on their poster.
- **Find the similarities (10 minutes):** encourage each child/teenager to find a poster created by another participant with similarities to their own poster (e.g. pizza, dislike getting up early in the morning).
- **Closure and reflection (10 minutes):** summarise the discussion points by focusing on the similarities between the children.

Age group

- This activity can be organised with different age groups. When organised with smaller children, they might need support from the facilitators in creating their posters.

Variation

- The children are asked to draw themselves in the centre of the paper and depict around them:
  - one thing they like to do, a hobby or skill (e.g. I am good at singing);
  - something they like about the way they look (e.g. I like the colour of my eyes);
  - something they like about the way other people relate to them (e.g. I like it when people talk calmly and kindly to me).

Other considerations and safeguards

- Help younger children when using scissors.
- When children feel shy to share things they like about themselves or that they do not have anything 'special' to share about themselves (in terms of looks or skills), facilitators should encourage them and point out things, for example you have a beautiful smile, I like your hairstyle, you are really funny, you are a great runner.

For reporting purposes: additional comments/observations from the facilitator during the session

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Vulnerable applicants and substance abuse

In recognition of the growing complexities around drug use, the EU drugs strategy 2021–2025 ([53]) puts forward several priorities relevant for addressing drug use with applicants for international protection in the EU. To **prevent, raise awareness** and facilitate **access to treatment and care** services (priorities 5 and 6 of the strategy), the strategy considers addressing several areas, such as:

- 'prevention interventions and strategies for target groups and environments to increase resilience and strengthen life skills and healthy life choices;
- prevention interventions for young people and other vulnerable groups;
- provide, implement and, where needed, increase the availability of evidence-based early intervention measures;
- voluntary access to treatment and care services' ([54]);
- peer work, identification and remedy in relation to barriers to accessing treatment;
- reducing stigma;
- 'treatment and care addressing the specific needs of women;
- models of care that are appropriate for groups with special care needs' ([55]).

For risk- and harm-reduction interventions for people who use drugs (priority 7), the strategy focuses on the areas of reduction of 'the prevalence and incidence of drug-related infectious diseases and other negative health and social outcomes' ([56]). It also focuses on prevention of overdoses and drug-related deaths; promotion of civil society participation; and alternatives to coercive sanctions.

Motivational interviewing and solution focused working

Motivational interviewing ([57]) is a technique that has been specifically developed to help motivate ambivalent people to change their behaviour. Addiction is all about doubt and ambivalence; motivational interviewing helps people move towards change in positive, healthy ways.

'Motivation to change varies from person to person, from one situation to another, and over time. Some of us are unwilling, others are unable to change, and many are not fully ready.' ([58]) People can resist if they feel they are being judged or if they feel they are being forced. Motivational interviewing helps dealing with resistance and from there in strengthening motivation and commitment to a goal such as sobriety.
It is also a helpful tool in strengthening self-worth and self-esteem; both are necessary elements in motivation.

([53]) Council of the European Union, General Secretariat, *EU drugs strategy 2021–2025*, 2021.
([54]) Ibid, strategic priority 5, p.20.
([55]) Ibid, strategic priority 6, p. 22.
([56]) Ibid, strategic priority 7, p.26.
([57]) Miller W.R., et al, *Understanding Motivational Interviewing*, 2019.
([58]) Beata Souders, '17 Motivational Interviewing Questions and Skills', Positive Psychology website, Scientifically reviewed by Maike Neuhaus Ph.D., 5 Nov 2019, accessed 30 September at https://positivepsychology.com/motivational-interviewing/.

Motivational interviewing tries to shift the focus from what is clinically wrong, in a manner similar to positive psychology, to the promotion of well-being and the creation of a satisfying life filled with meaning, engagement, positive relationships and accomplishment.

Most people are ambivalent to change. They are not fully motivated but usually express both sides: ‘I need to get high to keep me going every day’ to ‘I love how drugs make me feel’. Or otherwise: ‘I’ll do better at school if I quit smoking weed’ to ‘I have to cut down. I need all the money to send to my parents”.

Motivational interviewing defines core skills as trying to understand and act according to what is being said against change (sustain talk) and in favour of change (change talk) and, where appropriate, encouraging movement away from sustain talk toward change talk. Training intermediaries and staff has proven effective in promoting motivation among young people in different settings.

Mitigating the risks of substance use

Mitigating the risks of substance use in applicants

- ☐ Focus on a **holistic psychosocial support** package for applicants, which can include:
  - strengthening families as a whole but also involving parents in discussions around positive discipline and parenting skills;
  - allowing the applicant community to be involved in topics relevant to them (depending on their age, gender and diversity) such as how to prevent/respond to bullying in schools, how to take care of oneself with a healthy lifestyle and sufficient exercise;
  - providing psychoeducation on how to manage stress and increase mental health literacy;
  - sharing information on employment and educational opportunities, which often reduces the risk of feeling hopeless among applicants once they can access such activities.
- ☐ Offer **community-based psychosocial activities** and joint planning of the activities such as sports, arts and theatre for youths and adults.

  > These fun activities will allow for meaningful engagement and distraction from daily worries linked to their waiting times, legal status and lack of financial means.
- ☐ Offer refresher sessions on rules in the accommodation, including what behaviour is acceptable and what is not. Such rules should include the following.
  - The prohibition of dealing/selling drugs and the consequences for doing so.
  - Information on how to raise concerns or complaints on protection-related issues. The use of such complaints and response mechanisms are organised in a safe and confidential manner.
  - Include activities linked to substance use in and around the centre.
- ☐ Ensure awareness raising materials ([59]) containing content on certain services (social/health), including recognition of risk signs are available to staff.
- ☐ **Invest in small-scale reception facilities**, particularly where concerning unaccompanied minors, placed closer to big towns to ensure access to specialised healthcare and protection services, where needed, but also to enable interactions with the local community ([60]).
- ☐ Provide **accessible services** and recognise the importance of qualified experts supporting those with a substance use problems.
- ☐ Make **information material** available on how to access certain services (social/health), including where to seek help for family members of someone with a substance use problem, available in different languages.
- ☐ Regarding unaccompanied children close to maturity, provide guidance on autonomous living (e.g. how to rent a room or apartment or find a job) to facilitate the transition into adulthood and mitigate risks of feeling overwhelmed.

([59]) VAD (the Flemish centre of expertise on alcohol and other drugs), 'Introducing VAD', webpage available at https://vad.be/francais-english/, accessed 24 September 2024. The website provides materials for professionals and informative and sensitising material tailored to people, parents and children of users.

([60]) Single male applicants are often accommodated in separate centres which isolate them from the larger community. The lack of access to community members and their support might however increase a risk of ill-health. Being involved in community activities can support their mental health and well-being.

6

Community-based interventions

This chapter builds on Chapter 5. Community-based interventions in Part II – First-line officers, by introducing community radio initiatives and additional considerations on cooking together as well as preparation for employment.

Community radio

Engaging applicants in the design and development of content on the topic of health, mental health and other needs nurtures learning and awareness. Certain mediums of communication developed through group meetings or community radio programmes have proven useful tools to inform applicants. In the case of radio programmes, it allows applicants to connect with the broader community of refugees in a host country. **Community radio** is a clear-cut community support activity and **level 2 on the MHPSS pyramid**.

Communicating to share, connect and learn

- An EU-funded, **EU wide** project promoting community communication called: Comm Unity ([61]).
- Radio programmes organised by refugees for refugees from **Germany**: the Refugee Radio Network ([62]) hopes to provide space for the voices of those who had to flee, to inform and inspire others.
- RadioMobile Paris ([63]) is an open and mobile group established by artists and nurses working for the GHU (Groupe Hospitalier Universitaire) **France**, Paris. The team offers a space to vulnerable people including migrants to create, share based on improvisation and music to strengthen resilience.

Evidence-based **cooking interventions** have frequently been used to improve cooking skills and the nutritional and health status of specific population and patient groups. They have also been used for the cognitive and physical development in rehabilitation and occupational therapy of patients including those with psychiatric disorders ([64]). Although the available studies on psychosocial benefits of cooking interventions are few and recent, they indicate that participation in such communal culinary activities can result in ([65]):

- improved confidence, self-esteem and self-reliance, as people feel less dependent on charitable resources;
- increased socialising and social skills;
- when mixed groups cook together, learning about the 'other' community, including the host community, can nurture a better understanding each other;
- a sense of belonging;
- the establishment of social bonds and networks providing access to social and emotional support;
- significant improvement in psychological well-being.

([61]) Comm Unity, 'Welcome to COMM UNITY', Community radio project.eu website, accessed 21 August 2024, available at https://communityradioproject.eu/.
([62]) RRN, Refugee Radio Network.net website, accessed 21 August 2024, available at https://www.refugeeradionetwork.net/.
([63]) RMP, Radio Mobile Paris.com website, accessed 21 August 2024, available at https://www.radiomobileparis.com/.
([64]) Grasser, L. R., Al-Saghir, H., Wanna, C., Spinei, J. and Javanbakht, A., 'Moving through the trauma: dance/movement therapy as a somatic-based intervention for addressing trauma and stress among Syrian refugee children', *Journal of the American Academy of Child and Adolescent Psychiatry*, 2019, Vol. 58, No 11, pp. 1124–1126.
([65]) Refer to Farmer, N., Touchton-Leonard, K. and Ross, A., 'Psychosocial benefits of cooking interventions: a systematic review', *Health Education & Behavior*, 2018; and Iacovoum M. et al., 'Social health and nutrition impacts of community kitchens: a systematic review', *Public Health Nutrition*, 2013.

Preparing applicants already at the point of their stay in reception **for the labour market** can facilitate smoother integration into the host community once a legal status is granted. It can also support their mental health and well-being, since they are involved in meaningful activities, which can be useful if they stay in the host country and potentially even if they return to their home country.

A briefing by the EU Parliament on the labour market integration of applicants and refugees ([66]) states:

> *EU law envisages access to employment for refugees as soon as they are granted refugee status, or for asylum-seekers at the latest within nine months of lodging an asylum application … To ensure that migrants' skills will match the future EU labour market and fill its gaps, focus should be turned to facilitating the proper recognition of their qualifications, as well as to upgrading their education and skills as needed. The EU supports Member States' integration efforts through its EU action plan on integration and inclusion.*

According to the European Centre for the Development of Vocational Training ([67]), vocational education and training programmes can help migrants connect more easily with the labour market and find jobs matching their skills and qualifications.

Support to applicants can entail:

- identifying useful skills that match the local labour market and the labour market in the country of origin, which can also facilitate a smoother voluntary return once the security situations allows;
- to learn how to participate and prepare for job interviews; and/or
- help draft CVs.

([66]) European Parliament, *Labour market integration of asylums seekers and refugees*, Briefing paper, 2022.
([67]) European Centre for the Development of Vocational Training, *Vocational Education and training; Bridging refugee and employer needs*, Briefing Note, 2017.

7

Rolling out psychoeducation

Consider the following when implementing psychoeducation activities.

- Platforms are provided for a diverse group of applicants to safely share their worries.
- Make relevant information available on a variety of support services (health, mental healthcare, protection, social services, legal counselling, education, employment, independent housing).
- Share knowledge on structured problem-solving techniques.
- For applicants who stay for a significant period in reception, refresher sessions are available to provide additional, more in-depth education where needed.
- Safeguards are put in place to ensure a **do no harm approach** during psychoeducation.
- Psychoeducation is available from the point of arrival in different formats (in person, reading material, animations, etc.) and adjusted to the literacy level of a diverse group of people.
- Access to more specific modules of psychoeducation for those in greater distress are made available throughout the asylum pathway.

Tips on how to implement psychoeducation

Implementing psychoeducation

- ☐ Psychoeducation is available in different formats from the point of arrival (in-person, reading materials, animations, etc.).
- ☐ Ensure access to specific modules of psychoeducation throughout the asylum pathway for those in greater distress.
- ☐ Provide support to applicants to understand the overwhelming feelings that naturally arise from the many stressors they face. Acknowledge that people may experience changes in sleep and eating habits or be quickly irritated.
- ☐ Reassure people of the normality of many of these reactions and provide simple ways to cope with distress and negative feelings.
- ☐ Provide platforms for a diverse group of applicants to safely share their worries.
- ☐ Introduce 'the concept of talking with others – e.g. friends, religious figures, or a counsellor as a way to releasing pent up emotions and stress. Useful analogies can be to get things 'off one's chest' or a pressure cooker valve 'letting off steam', rather than 'bottling things up''. ([68])
- ☐ Explain that 'counselling may not suit everyone, but that it may help provide strategies to reduce further build up of emotional stress, strengthen emotion regulation, and increase social connectivity, can be a useful strategy.' ([69])
- ☐ Ensure the relevant information on support services is available.
- ☐ To reduce potential stigma, explain that 'counselling, may increase the likelihood of the individual accepting a referral in the future.' ([70])

  > Counselling may be normalised by framing it as a problem-solving process which can improve coping strategies. In addition, it is a confidential space to release 'emotional pressure' independent of family and community relationships.

- ☐ Share knowledge on **structured problem-solving techniques**.
- ☐ Identify and challenge 'negative core beliefs using simple cognitive behavioural therapy strategies' ([71]).
- ☐ Use technology such as mobile phone applications, where useful ([72]).
- ☐ Provide refresher sessions for applicants who stay for a significant period in reception to provide additional, and more in-depth information where needed.
- ☐ Acknowledge the different challenges applicants face throughout the asylum trajectory (pre-interview, waiting for decision, trauma experiences, possible negative asylum decision).

  > Psychoeducation is not a one-time intervention; it is ongoing in nature.

([68]) Australasian Society for Infectious Diseases and Refugee Health Network of Australia, *Recommendations for comprehensive post-arrival health assessment for people from refugee-like backgrounds*, 2nd edition, 2016, p.143.
([69]) Australasian Society for Infectious Diseases and Refugee Health Network of Australia, *Recommendations for comprehensive post-arrival health assessment for people from refugee-like backgrounds*, 2nd edition, 2016, p.143.
([70]) Ibid.
([71]) Cognitive behavioural therapy should only be applied by staff with the relevant expertise. Ibid.
([72]) Ibid.

Safeguarding applicants during psychoeducational activities

Safeguards when implementing psychoeducation

- ☐ Find a quiet place to speak without distraction.
- ☐ Provide the information in a language that applicants can understand.
- ☐ Be mindful about the use of certain words because mentions of a psychologist or psychiatrist could be misunderstood (e.g. someone might misinterpret needing to see a psychologist as being considered 'crazy').
- ☐ Speak slowly and use simple language when communicating health information.
- ☐ Consider the age, gender and diversity of the applicant community engaged in information provision and psychoeducation.
- ☐ If children are targeted with certain activities linked to psychoeducation, consider involving the parents depending on the topic and context.

  > Parents are generally more open to allowing their children to engage once they are informed and acknowledged.

- ☐ Show a human approach and allow for applicants to settle. This will nurture more openness in residents.
- ☐ Some applicants might come from countries where health information is not provided regularly, therefore keep in mind that information should be repeated to give every applicant a chance to follow the instructions and understand at their own pace.
- ☐ See who is in the room when providing training or information and awareness-raising sessions. The cultural backgrounds can suggest what information is shared and how.
- ☐ Visuals such as photos or symbols can help, in conjunction with other contents provided.
- ☐ Clarify that training sessions are safe spaces to learn and what is discussed in the group stays in the group. Highlight the confidentiality of the discussions.
- ☐ Explain that these sessions are there to ask and clarify what is not clear, where more knowledge is needed but also experiences applicants bring to the table. The group is learning together and therefore questions are welcome.
- ☐ Employ 'teach back', 'show me' and 'ask–tell–ask' methods ([73]) when teaching new skills to correct inaccurate information and evaluate where there might be some gaps to be addressed in a follow-up session.
- ☐ Request verbal confirmation from participating applicants by using closed-ended questions that can be easily answered with 'yes' or 'no'. and, where applicable, to allow for narrative to further evaluate the actual understanding of content delivered by allowing the applicant to provide examples.
- ☐ Schedule regular follow-up sessions where certain content can be clarified, if needed.

([73]) Agency of Health Care, Research and Quality, Health Literacy Universal Precautions Toolkit, 3rd Edition, Teach me back method: Tool 5, available at https://www.ahrq.gov/health-literacy/improve/precautions/tool5.html, accessed 21 August 2024. 'It is important to confirm that you have explained things in a manner your patients understand. The teach-back method is a way of checking understanding by asking patients to state in their own words what they need to know or do about their health. The related show-me method allows you to confirm that patients are able to follow specific instructions'.

8

Checklists, questionnaires and other tools

Applicants with suicidal behaviour

There are situations where applicants might air desperation and even a wish to die. Suicidal thoughts and expressions should always be taken seriously. The applicant should be supported by an officer with the relevant skills and expertise to do so.

Dealing with suicidal behaviour

Applicant-centred approach

Discussing suicidal thoughts requires an individualised approach. Suicidal ideation should always be addressed, but how it is discussed depends on factors such as culture, religion, and the level of trust. In some faiths, such as Islam, for example, suicide may not be accepted or may be considered taboo. These factors can be explored together with the individual. Simply talking about suicidal thoughts can already help reduce the intensity of such thoughts. It is crucial to listen attentively to people without passing judgement, as many individuals feel ashamed of their thoughts.

Take affected applicants seriously

Always take signs of suicidal behaviour seriously, regardless of how they are expressed, even if it appears to involve manipulation.

Ask questions

When serious signs of suicidal behaviour are present, ask very specific questions about suicide plans. Inquire about the person's plan and the way they intend to say goodbye. The more concrete the plans for suicide, the closer someone may be to attempting it. If the plans are concrete, seek expert help immediately.

Change in sleeping pattern

Many people with suicidal thoughts experience severe sleep problems.
Vital exhaustion brings suicide closer. Adequate rest is crucial, so inquire about their sleep and rest. Discuss how they can improve their sleep quality and help establish a good day-night routine.

Living arrangements

People with suicidal thoughts often find sleeping alone uncomfortable. Discuss this and explore whether arrangements can be made, such as sharing a room.

Daily routines

Ensure there are daytime activities, both individually and, if possible, in group settings.

Develop a safety plan

In the case of identified suicidal behaviour, create a safety plan. Try to involve others in the safety plan in consultation with the individual (mentor, other residents, etc.).

Regular check-ins

Organising (additional) attention, similar to creating a safety plan, often has a positive impact. It is crucial to have people who regularly show concern for the individual and check on their well-being. Genuine active attention is essential, such as having a cup of tea together, visiting before bedtime (coach and fellow residents) and checking in each morning. Include family, even if they are abroad.

Faith

In conversations with a religious individual, incorporate their faith. This can be supportive and provide the strength to persevere.

Risk of suicide screening tool – an adjusted questionnaire used by the Swedish Migration Agency in detention

This questionnaire ([74]) can be used in connection with registration at the detention unit and on other occasions when needed and in cases of suspected suicidal thoughts. The questions deal with areas that, each and in combination, indicate a potential suicide risk.

([74]) This is an adjusted sample of a questionnaire used by the Swedish Migration Agency for applicants placed in detention.

Questions 6-9 are highlighted as particularly strong risk indicators. A 'yes' to any of these questions must **always** lead to a further in-depth assessment of the persons needs as to be able to design an appropriate response/identify the main need for action. If a 'yes' was indicated under these questions, it is always the responsibility of the officer to inform the team leader/manager on duty who has been designated to make a situational assessment.

The questionnaire is part of the arrival interview. You can only proceed once each question is asked. The questionnaire is electronically available. The original document is saved in the persons file and a copy is given to the nurse appointed to the detention facility. The importance of confidentiality once handed over to the nurse is highlighted officially. The handing over of file to the nurse again is registered.

Detainee's name _____ Dossier number_____

Detention unit _____ Completed by: _____ Date and time _____

↳ **Observation** by the expert screening the person: is the detainee visibly under the influence of alcohol or drugs? ☐ **Yes** ☐ **No**

If yes, the professional tries to find out which drug(s).

Questions posed directly to the person after a brief introduction and explanation of why these questions are posed (i.e. to ascertain the physical safety of the person questioned)

1. Are you taking any medicines prescribed by a doctor? ☐ **Yes** ☐ **No**
If yes, which medicines are you currently taking and for what purpose?
Note. The officer checks if the medicine mentioned requires a prescription.

2. Have you taken alcohol in the last two weeks? ☐ **Yes** ☐ **No**
If yes – follow up question: How often do you drink alcohol?
When was the last time you drank alcohol and how much?

3. Have you taken any (other) drugs in the last two weeks? ☐ **Yes** ☐ **No**
If yes: What kind of drugs? When was the last time and how much?

4. Have you ever been treated for depression? ☐ **Yes** ☐ **No**
Note: The officer checks if the person understands the term depression or otherwise supports with explaining the term in simple words (e.g. do you feel hopeless, frustrated, sad, anxious, 'empty', not motivated to do anything, sleeping constantly/not being able to sleep)

5. Have you been treated because you were feeling bad emotionally in some other way? ☐ **Yes** ☐ **No**
If yes: Can you briefly explain?
Have you ever been diagnosed with a psychiatric disorder: ☐ **Yes** ☐ **No**

6. Have you ever tried to take your life? ☐ **Yes** ☐ **No**
If yes: Can you share with me how you tried to take your life?
Note. If no, go to question 13.

7. Have you tried to take your life in the last 12 months? ☐ **Yes** ☐ **No**
If no, move to question 11.

8. Have you tried to take your life within the last month? ☐ Yes ☐ No
If no, move to question 11.

9. Have you tried to take your life in the last few days? ☐ Yes ☐ No

10. Did any attempt result in you having to go to hospital? ☐ Yes ☐ No

11. Did any attempt result in you being admitted to hospital? ☐ Yes ☐ No

12. Current assessment ladder:

- Have you felt recently that life is not worth living, that you would be rather dead? ☐ Yes ☐ No
- Have you had thoughts about taking your life recently? ☐ Yes ☐ No
- When was the last time you had such thoughts? _____

13. Did you also think about how you could end your life? ☐ Yes ☐ No

If the answer to some of the questions are YES, the officers continues with:

14. Would you like to have more information on some of the topics we briefly discussed today (e.g. suicidal thoughts, substance use, stress managemen techniques, your mental health/worries?) ☐ Yes ☐ No

15. I note from the way you answered the questions today that you seem to be under stress. I will try to see if a colleague can come to see you soon and to talk to you in more details.

Note. This proposal is made by the officer only if as indicated the person questioned indicated several times YES during the process and if there is a professional available to follow up as soon as possible.

Closing. The officer closes the meeting by saying goodbye and providing any other information to the person where applicable.

Observation by the officer:

16. Is there any information about a risk of suicide in previous documentation? ☐ Yes ☐ No
If yes: What measures were taken? Was a care plan developed?

Follow up

- **Step 1.** If the person answered **YES to questions 6-9**, a follow up assessment is scheduled as soon as possible. Depending on the individual's condition, the person (also refer to question 15) is informed about the potential follow-up by a colleague shortly. If the person indicated **YES to question 13** and mentioned ways on how to attempts suicide, a follow-up assessment is a priority. The person should not be left alone. Where possible, a relative or acquainted can stay with the person. If a staff member is unsure on how to approach an applicant in crisis, they can always reach out to experienced colleagues for advice.
- **Step 2.** The nurse on duty is informed as is the team leader/line manager. Depending on the severity of suicidal thoughts of the person, the location where the person is to be placed should be checked discretely for any means/tools that could be used in a suicide attempt (e.g. sharp objects, pills, ropes, laces).
- **Step 3.** Until a follow up is possible, a nurse and/or first-line officer should regularly check on the person. If there are information materials available that are useful for the applicant, they are shared at this point.
- Generally, involving persons placed in detention in regular activities for the purpose of staying active but also for 'distraction' purposes (granted they do not pose a risk to others) is beneficial to prevent thoughts around self-harm. Specialised support in dealing with the present stressful situation (such as being in detention) should be available.

  The importance of a written protocol regarding the risk of suicide/suicidal ideation in detention (referring also to the steps beyond identification) should be available and tailored to the needs, context and resources of each country. This protocol should include clear steps to follow and the appointment of focal points after a risk of suicidal ideation was identified.

Self-assessment tools to indicate mental health concerns

Self-assessment tools shared with applicants can be beneficial to the authorities. Such tools can especially support those working in the first line during situations of high workload and/or high influx of population. Depending on the design, such tools can bring attention to certain basic indicators of vulnerability that help even those with little knowledge of the issues at hand. The detection of the indicators can be rated and support decision to take as next steps. These self-assessment tools should however not be seen as the only way to identify and assess needs in applicants. They should be accompanied by a personal encounter to cross-check statements made by the applicants and particularly those applicants flagged as in need.

A self-assessment tool focusing on mental health – adjusted questionnaire from the Office for Immigration and Integration, 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) and still in a testing phase. Applicants can engage in a self-assessment on a voluntary basis. Minors, applicants who are not literate or those who do not want to fill in the form are exempted.

The questionnaire is available in 36 languages and distributed and collected by medical staff only. The questionnaire conforms to practices in the psychiatric field (limited to various pre-existing psychiatric diagnoses) and is further adaptable to different general screening procedures.

A self-assessment can reduce pressure on first-line officers when a large number of new arrivals need to be screened at a specific entry point / reception centre. The self-assessment also enables officers with no background in psychiatry to flag certain concerns as a minimum. The findings can highlight which applicants might need to be prioritised and need to see a professional for follow-up.

The questionnaire is only shared with the applicant's agreement following a brief orientation. The questionnaire is accompanied by written information explaining that the participation is voluntary, that confidentiality is granted and that filling out the questionnaire does not affect the processing of the asylum application. The information is stored safely (for several years) and can be retrieved if an applicant requests access. Data entered into the system is anonymised and complies with the general data protection regulation.

The 22 items of the questionnaire are based on a colour scheme,

green – not linked to a psychiatric diagnosis;

amber – requiring consultation only if the condition is affecting the applicant's daily functioning;

red – implies a high risk of serious mental health condition.

The IT system automatically prints a referral letter for the consulting psychiatrist. To comply with confidentiality, the referral letter only indicates a need for a consultation.

Mental health questionnaire (Office for Immigration and Integration, France) ([75])

'Instructions: In this program, we help people with all their problems, not just their addictions. This commitment includes helping people with emotional problems. Our staff is ready to help you to deal with any emotional problems you may have, but we can do this only if we are aware of the problems. Any information you provide to us on this form will be kept in strict confidence. It will not be released to any outside person or agency without your permission. If you do not know how to answer these questions, ask the staff member giving you this form for guidance. Please note, each item refers to your entire life history, not just your current situation, this is why each question begins –"Have you ever...".' ([76])

([75]) This questionnaire used by the Office for Immigration and Integration, France, to facilitate the self-assessments of applicants with potential MHW concerns is based on the Mental Health Screening Form III developed by Forensic Counselor, *Guidelines for Using the Mental Health Screening Form III*, 2000 (questions 1 to 17) and Johns Hopkins Medicine, *CAGE Substance Abuse Screening Tool*, 2010 (questions 18 to 21).

([76]) Mental Health Screening Form III developed by Forensic Counselor, *Guidelines for Using the Mental Health Screening Form III*, 2000.

Sex: ☐ **male** ☐ **female** ☐ **transgender**

Year of birth: _____

Nationality: _____

Country of birth: _____

Do you agree to fill out this medical symptoms questionnaire? ☐ **Yes** ☐ **No**

Do you agree to keep this anonymous medical symptoms questionnaire in your file? ☐ **Yes** ☐ **No**

Nr	Question	Please tick Yes/No
1	Have you ever talked to a psychiatrist, psychologist, therapist, social worker or counsellor about an emotional problem?	☐ Yes ☐ No
2	Have you ever felt you needed help with your emotional problems, or have you had people tell you that you should get help for your emotional problems?	☐ Yes ☐ No
3	Have you ever been advised to take medication for anxiety, depression, hearing voices, or for any other emotional problem?	☐ Yes ☐ No
4	Have you ever been seen in a psychiatric emergency room or been hospitalised for psychiatric reasons?	☐ Yes ☐ No
5	Have you ever heard voices no one else could hear or seen objects or things which others could not see?	☐ Yes ☐ No
6a	Have you ever been depressed for weeks at a time, lost interest or pleasure in most activities, had trouble concentrating and making decisions, or thought about killing yourself?	☐ Yes ☐ No
6b	Did you ever attempt to kill yourself?	☐ Yes ☐ No
7	Have you ever had nightmares or flashbacks as a result of being involved in some traumatic/terrible event? For example, warfare, gang fights, fire, domestic violence, rape, incest, car accident, being shot or stabbed?	☐ Yes ☐ No
8	Have you ever experienced any strong fears? For example, of heights, insects, animals, dirt, attending social events, being in a crowd, being alone, being in places where it may be hard to escape or get help?	☐ Yes ☐ No
9	Have you ever given in to an aggressive urge or impulse, on more than one occasion, that resulted in serious harm to others or led to the destruction of property?	☐ Yes ☐ No
10	Have you ever felt that people had something against you, without them necessarily saying so, or that someone or some group may be trying to influence your thoughts or behaviour?	☐ Yes ☐ No
11	Have you ever experienced any emotional problems associated with your sexual interests, your sexual activities, or your choice of sexual partner?	☐ Yes ☐ No
12	Was there ever a period in your life when you spent a lot of time thinking and worrying about gaining weight, becoming fat, or controlling your eating? For example, by repeatedly dieting or fasting, engaging in much exercise to compensate for binge eating, taking enemas, or forcing yourself to throw up?	☐ Yes ☐ No
13	Have you ever had a period of time when you were so full of energy and your ideas came very rapidly, when you talked nearly non-stop, when you quickly from one activity to another, when you needed little sleep, and believed you could do almost anything?	☐ Yes ☐ No

Nr	Question	Please tick Yes/No
14	Have you ever had spells or attacks when you suddenly felt anxious, frightened, uneasy to the extent that you began sweating, your heart began to beat rapidly, you were shaking or trembling, your stomach was upset, you felt dizzy or unsteady, as if you would faint?	☐ Yes ☐ No
15	Have you ever had a persistent, lasting thought or impulse to do something over and over that caused you considerable distress and interfered with normal routines, work, or your social relations? Examples would include repeatedly counting things, checking and rechecking on things you had done, washing and rewashing your hands, praying, or maintaining a very rigid schedule of daily activities from which you could not deviate?	☐ Yes ☐ No
16	Have you ever lost considerable sums of money through gambling or had problems at work, in school, with your family and friends as a result of your gambling?	☐ Yes ☐ No
17	Have you ever been told by teachers, guidance counsellors, or others that you have a special learning problem?	☐ Yes ☐ No
18	Have you ever felt that you ought to cut down on your drinking or drug use?	☐ Yes ☐ No
19	Have people annoyed you by criticising your drinking or drug use?	☐ Yes ☐ No
20	Have you ever felt bad or guilty about your drinking or drug use?	☐ Yes ☐ No
21	Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?	☐ Yes ☐ No

The **name / identification number** of the officer supporting the intervention: _____

Comments / observations by the first-line officer leading this support intervention:

Considering trauma during the personal interview

Even though this guidance targets the reception authorities and first-line officers working in reception, some considerations are provided below for those EU+ countries in charge of both reception and the asylum procedure.

Tips for case officers ([77])

Preparatory activities

- ☐ Provide relevant training to those conducting interviews including interpreters such as 'how to interview vulnerable applicants'. Appoint specialised case officers with additional training on vulnerabilities, protection and mental health.
- ☐ Ensure structured communication between the reception and determining authorities for the purpose of information sharing and coordination granted the confidentiality is not jeopardised and the applicant provided informed consent.
- ☐ Study the case file including relevant country of origin information.
- ☐ Communicate where relevant certain needs of the applicant with the interpreter if already known and applicable.

Logistics

- ☐ Ensure applicants do not wait too long in the waiting area for their interview.
- ☐ As with all applicants but even more so with those clearly vulnerable, create a positive and relaxed atmosphere in the interview room.

Conducive environment

- ☐ Build rapport make time for a welcoming introduction, display a neutral and positive attitude, avoid displaying signs of authority.

> Showing authority could be particularly counterproductive when it comes to victims of torture and applicants who suffered abuse at the hands of authorities or militias and this might lead to severe mistrust.

Information and purpose of the interview

- ☐ Explain the process, time, reaffirm confidentiality, the purpose of taking notes and that the applicant can ask questions whenever needed or if something is unclear.

Time

- ☐ Leave space for free narrative and use open-ended questions which may support the applicant in disclosing information on past experiences.
- ☐ Allow for silence.
- ☐ Do not shy away from acknowledging indications of violence and/or abuse and ask contextual questions.
- ☐ Propose a short break if applicants show signs of detachment, lack of concentration or similar.

([77]) In addition, refer to Section Understanding trauma.

- ☐ Ask gently for clarification in a situation where the applicant seems to provide incoherent information. Be careful to avoid the implication that the applicant has failed to articulate themselves properly.

↳ **Additional evidence**

- ☐ Inform and guide the applicant about the possibility to bring forward new elements of their claim at every step of the process.

↳ **Flexibility**

- ☐ Assess the situation and flow of the interview throughout and, if applicable, reschedule or postpone the interview if required for the applicants to stabilise.
- ☐ Consider adding a support person as indicated by the applicant (outside/inside the interview room).

↳ **Closure**

- ☐ Properly close the interview including allowing room for questions.
- ☐ Conduct a referral to follow-up services if the interview triggered additional distress in the applicant.

↳ **Post-preparation**

- ☐ Inform the applicant about the outcome of the interview in a timely and empathic manner.
- ☐ Provide the option to access legal and psychological counselling when informed of the decision.

> This should be organised in collaboration with the reception authorities when applicants are notified of a negative decision.

Tips for case officer coordinators

Enabling those who examine the application for international protection

- ☐ Ensure case officers receive information on potential vulnerabilities, where possible, including on severe psychological distress of those scheduled for the personal asylum interview.
- ☐ Case officers are provided with basic training to identify some key indicators on psychological distress and/or trauma.
- ☐ Managers and team coordinators ensure sufficient time for case officers to prepare and conduct a meaningful personal interview.

  > Preparation might include time to request and receive relevant information such as information on the applicant's current health status to ensure the procedural safeguards can be put in place as appropriate.

- ☐ Where possible, create a pool of specialised case officers who have the necessary expertise on different types of vulnerabilities (e.g. mental health, victims of torture, trafficking in human beings, children) and can support when the need arises.
- ☐ The relevant authorities allow the applicant time to gather the relevant evidence/information to substantiate aspects relating to mental health and to receive immediate support when needed.
- ☐ Clear and simple communication channels between the determining and the reception authorities (and potentially other partners) are in place to enable, where needed and granted the applicant provides the consent, the sharing of information which can support the work of those examining the application for international protection.
- ☐ Managers and team coordinators, while ensuring a swift follow up on applications received
- ☐ The interview should not be scheduled too close to the initial arrival.

  > Particularly very vulnerable applicants might need time to stabilise first, understand their rights and obligations so they can be physically and mentally prepared and enabled to engage meaningfully in the procedure.

- ☐ Provide applicants with an opportunity to meet their case officer before their personal interview, where resources allow. When children are involved, ensure caregivers are involved as long as it is in the best interests of the child and allow for guardians to support in cases of unaccompanied children.

  > This can create a sense of familiarity with the person examining the claim as well as the room set up, which can help those in severe psychological distress. The same applies for the elderly or those living with disabilities. Being aware of who and what to expect makes people feel more comfortable. Consequently, it reduces their stress levels and can increase their level of collaboration.

If this is not possible due to logistical challenges, time constraints or a lack of human resources, ensure that relevant information is provided to the applicant on the personal interview in a way that takes their personal circumstances into account. This includes information provision before the interview and at the beginning of the interview to ensure that the applicant knows what will happen next and what is expected from them. This also includes making sure the applicant is aware that disclosing certain vulnerabilities including psychological distress and/or a mental health condition, if relevant, are important to mention during the personal interview.

- ☐ Where possible, allow the applicant to have a person of trust (e.g. legal counsellor, social workers/psychologist or other) join the personal interview.

  This can create a sense of calm in persons facing severe psychological distress. The presence of a family member outside the interview room who can remain on the premises might also have a comforting impact.

- ☐ Those working in the first line have access to updated contact information of those providing support services to applicants in distress.

  Creating the knowledge in case officers on who to contact and when will allow for meaningful referrals where a need arises. Support service can include psychological support and can be combined with legal advice and legal counselling.

- ☐ Remind the case officer to avoid displaying any controversial items (such as religious/political symbols) and that they are dressed appropriately (wear moderate clothes and avoid uniforms) to create a sense of comfort and trust.
- ☐ Train the case officers on how to organise and execute the personal interview to appear less formal (avoid an interrogative style or an exam-like situation) and use child-friendly language where applicable to minimise the applicant's nerves and stress levels.
- ☐ Involve the case officer in regular training and re-fresher sessions on topics such as cultural competency, PFA, trauma-informed care and similar. Such training is also important for interpreters.
- ☐ Training topics should also focus on how to gather relevant information to substantiate an applicant's application.

  Such information could relate to how their mental health may affect their statements and even be related to the need of international protection (e.g. due to stigma related to mental health and psychiatric support in their country of origin).

- ☐ Ensure a balance of genders between the case officer and the interpreter.

  The gender of the applicant should be considered when it comes to assigning a case officers and interpreter, particularly when sexual violence is an element of the claim.

- ☐ Allow for the timely processing and prioritisation of claims lodged by persons with identified special needs, including children and applicants approaching adulthood.

9

Considerations when measuring progress

The focus of the EUAA guidance on the mental health is not on the monitoring and evaluation of the proposed interventions. However, certain considerations are briefly discussed in Part I – Senior management under **Component 9: Measuring progress** and in **Annex 3.** Measuring progress of the same part, which should be read in conjunction with the below.

Considerations when measuring cross-cutting concepts such as the below.

Cultural competency	Stage of implementation
☐ Gender roles/norms, stereotypes and biases among the applicant community and first-line officers in contact with applicants are part of awareness-raising and training sessions offered to both. > The training sessions aim to reduce the risks of discrimination against certain groups, increase self-awareness of own biases and improve ability to support with a better understanding of other cultures and traditional practices ([78]). ☐ Measures to reduce discrimination and racism among the applicant community, first-line officers and the host community are proactively promoted.	☐ Not started ☐ In progress ☐ Completed ☐ Not applicable in the current set-up

([78]) While understanding the culture and traditions are important to ensure a meaningful and respectful interaction, harmful traditional practices such as female genital mutilation and cutting must not be accepted. Such practices need to be addressed in a careful and sensitive manner.

Risk and protective factors	Stage of implementation
☐ An applicant-centred approach is implemented throughout the asylum pathway and allows for needs-based, tailored support provision by acknowledging the individual characteristics of applicants where possible. > This can be individual factors such as age, gender or health status. It can also include family or relationship-related factors such as family cohesion/structure, influence of certain family members or community and societal factors including education and employment. Some of these might be identified as protective factors while others might be considered risk factors depending on the context and the applicant's reality. Such factors also interlink with the critical stages and the complexity of the migration process (refer to component 4). ☐ Those supporting applicants as part of a case management process are encouraged and enabled to participate in regular case conferences to provide meaningful and holistic long-term support which is reflected in the care plan (potential adjustments made in the interests of the applicant) and a plan to ensure staff welfare. ☐ Interventions proposed as part of the MHW action plan integrate activities organised with/by the applicant community, focusing on appropriate cultural beliefs, rituals and social practices.	☐ Not started ☐ In progress ☐ Completed ☐ Not applicable in the current set-up
Psychological first aid	**Stage of implementation**
☐ Depending on the context and location, a number of trained PFA providers (focal persons) are appointed. ☐ Staff implementing PFA have the basic skills to do so, including knowledge of indicators of psychological distress and they are aware of the important safeguards to consider relating to age, gender and diversity. ☐ Updated referral information is available to PFA providers. ☐ The concept of PFA is introduced to interested/selected applicants who can support with its implementation. ☐ Selected officers working in the first line with the determining authorities take part in PFA training sessions.	☐ Not started ☐ In progress ☐ Completed ☐ Not applicable in the current set-up

Early detection and a special needs and vulnerability assessment	Stage of implementation
❑ First-line officers and those professionals conducting initial detection exercises to identify vulnerability indicators or medical and mental health concerns are aware on the necessary follow-up actions (referral). ❑ Officers and professionals conducting a vulnerability assessment have the necessary skills to do so and are aware of the complexity of migration and the importance of acknowledging risk and protective factors such as own resources of applicants to strengthen their resilience. ❑ Officers conducting a more in-depth assessment on specific needs and vulnerability ensure that the identified applicants are referred to the relevant services based on clear criteria linked to specified levels of urgency. ❑ Updated referral information is available, including instructions for developing a care plan and how to initiate case management.	☐ Not started ☐ In progress ☐ Completed ☐ Not applicable in the current set-up
Case management ([79])	**Stage of implementation**
❑ Case managers regularly assess risks to the security, safety and well-being of vulnerable applicants, as well as the risks associated with accessing or not accessing services. ❑ Case managers are offered regular case conferences to facilitate the coordination of service providers and address complex cases. ❑ The best interests of the child is considered throughout all actions. Ensure the active involvement of the child's parents/ caregivers/guardians where in the best interests of the child.	☐ Not started ☐ In progress ☐ Completed ☐ Not applicable in the current set-up

([79]) EUAA, Part II – First-line officers, Section '3. Care and Case Management'.

Ethical work conduct and zero tolerance to sexual exploitation, abuse and harassment	Stage of implementation
☐ Create awareness of the importance of the code of conduct including the principles of engagement among all employees, consultants, temporary experts, interpreters and volunteers at regular intervals. ☐ All employees, consultants, temporary experts, interpreters and volunteers sign the code of conduct and other relevant policies. All are aware of disciplinary measures in case of a breach. **Examples of such policies** ✓ Preventing sexual harassment in the workplace policy ✓ Preventing sexual exploitation and abuse policy towards applicants for international protection ✓ Child protection policy ✓ Preventing forced labour and human trafficking policy ✓ Anti-fraud and anti-corruption policy ☐ Establish an accountability mechanism to report breaches of the code of conduct or other policies that can be used for reporting by a diverse group of applicants. ☐ Staff and staff of implementing partner organisations have a sound knowledge on how to access such accountability mechanisms. ☐ When several partners operate in a specific context, formulate an agreement on how to streamline complaints from applicants for international protection to ensure a confidential, safe and timely follow up.	☐ Not started ☐ In progress ☐ Completed ☐ Not applicable in the current set-up

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