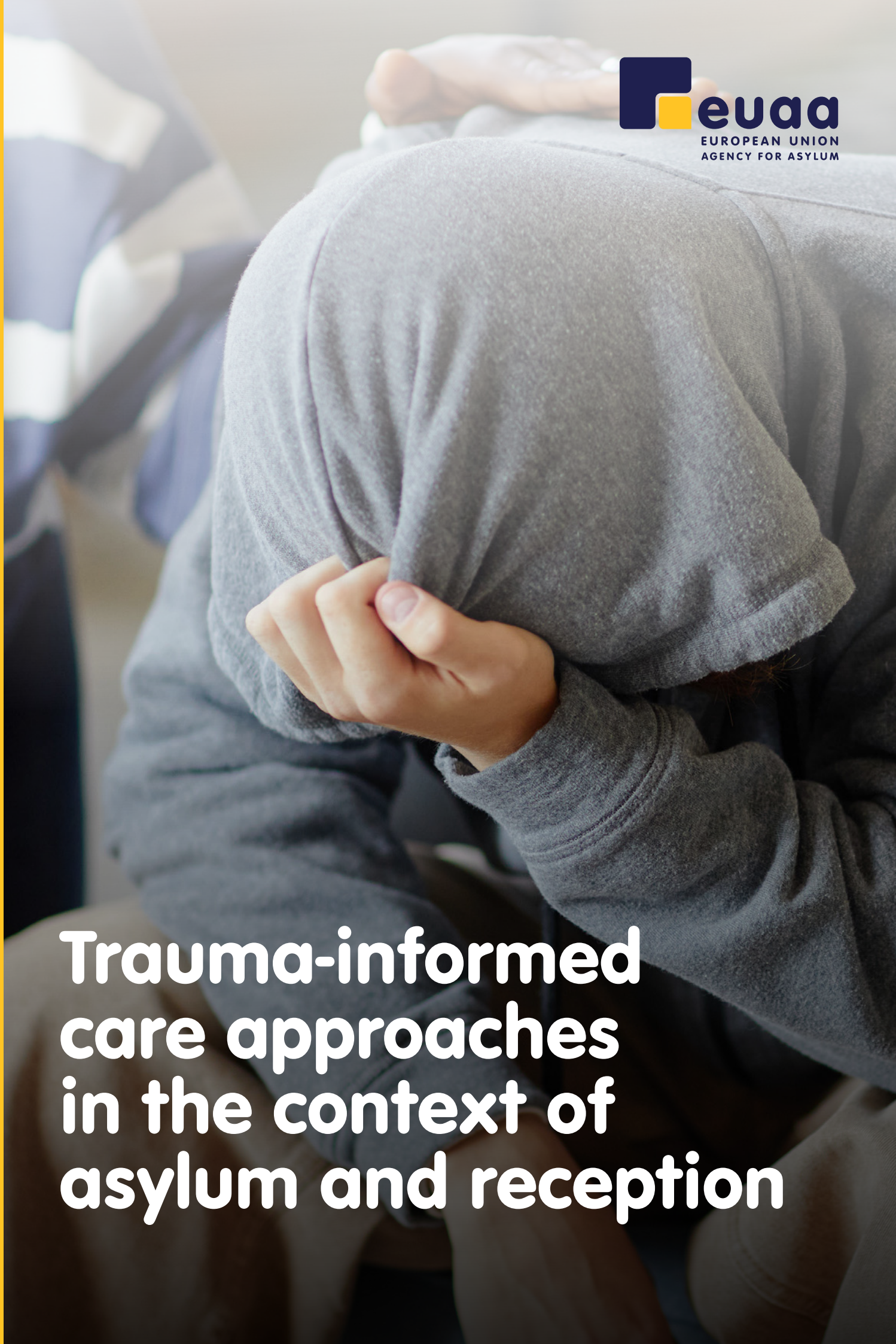
Mapping Report



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AGENCY FOR ASYLUM

Trauma-informed care approaches in the context of asylum and reception

October 2026

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A mapping report capturing findings from across Europe

October 2026

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

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List of abbreviations

Abbreviation	Definition
COA	Central Agency for the Reception of Asylum Seekers
CSO	civil-society organisation
EU	European Union
EU+ countries	EU Member States plus Iceland, Liechtenstein, Norway and Switzerland
EUAA	European Union Agency for Asylum
FGM	female genital mutilation
GBV	gender-based violence
IPAS	International Protection Accommodation Services
IPSN	Identification of Psychological Support Needs
LGBTIQ+	lesbian, gay, bisexual, transgender, intersex, queer, plus
NGO	non-governmental organisation
SOP	standard operating procedure
TiC	trauma-informed care
UAM	unaccompanied minor asylum seeker
UDI	Norwegian Directorate of Immigration

Executive summary

The topic of trauma-informed care (TiC) in asylum and reception systems was identified as one of the key priorities during the 2025 annual conference of the European Union Agency for Asylum (EUAA) Vulnerability Experts Network. In response, the EUAA vulnerability team developed and circulated a survey in March 2026 across three networks – the EUAA Asylum Processes Network, the EUAA Network of Reception Authorities and the EUAA Vulnerability Experts Network – and this mapping report presents the analysis of the findings.

The results indicate that trauma-informed principles such as the importance of trust, safety, participation, multidisciplinary cooperation and referral mechanisms are increasingly recognised and partially operationalised across European asylum and reception systems. At the same time, implementation remains uneven and, in many countries, continues to rely heavily on local initiatives, civil-society organisations (CSOs) and individual staff capacity and motivation rather than on comprehensive national frameworks and formalised procedures.

The participation profile in the survey showed a slightly stronger engagement from reception authorities and CSOs than from asylum authorities. This may suggest that TiC is currently more associated with **reception**, support provision and well-being functions than with asylum procedures, where the integration of trauma-sensitive approaches may still be developing, particularly in areas such as the **personal interview** and credibility assessment.

Respondents highlighted that visible needs and potential challenging behaviour by asylum seekers, including depression, social withdrawal, isolation, lack of cooperation, aggression, self-harm or suicidal behaviour, may be consequences of overlooked needs. Substance use, including the misuse of prescription medication, may also occur within this broader context. These difficulties, according to experts, are often linked not only to adverse or traumatic experiences in countries of origin and along migration routes, but also to post-arrival stressors, such as prolonged asylum procedures, uncertainty, family separation, overcrowded accommodation, inactivity and limited access to timely and appropriate support.

A key finding is the broad recognition that the identification of vulnerabilities and needs related to trauma, comorbidities and mental health conditions is a continuous, trust-based process that cannot be captured through a single screening or assessment exercise. While initial checks and assessments tend to prioritise acute health concerns and severe distress, trauma-related symptoms, psychosomatic complaints and more subtle manifestations of vulnerability often emerge at a later stage and only through repeated interactions, observation and trust building over time.

The findings underline the importance of a systemic and multisectoral approach that combines early identification with timely access to mental health and psychosocial support, effective communication and referral pathways, and attention to applicants' practical and social needs.

Respondents also emphasised the importance of meaningful opportunities for participation, social connection, education, employment and future planning as protective factors that support resilience and well-being.

Furthermore, particular attention should be paid to events that may trigger re-traumatisation, such as personal interviews, detention, transfers and decisions affecting an applicant's legal status. Preparing staff and services to respond appropriately before, during and after such events is essential to ensuring effective support and safeguarding applicants' well-being.

These findings have important implications in the context of the pact on migration and asylum, which strengthens requirements related to early identification and protection while simultaneously introducing accelerated procedural timelines. Balancing procedural efficiency with person-centred and trauma-informed approaches will remain a key challenge, particularly in systems facing large numbers of arrivals.

While implementing trauma-informed approaches may initially require additional investment in training, coordination and organisational adaptation, the findings suggest that such approaches can strengthen early identification, improve communication and cooperation, support staff well-being and reduce the risk of re-traumatisation and crises. Complementing the vulnerability frameworks used in most European Union Member States, which focus primarily on **what needs to be done**, with a TiC approach, which also considers **how services are provided**, can therefore be beneficial.

A trauma-informed perspective may also encourage a shift in focus: rather than concentrating solely on how early identification can be organised more effectively, it also invites consideration of how asylum and reception systems can be designed to provide a safe and supportive environment for people whose needs have not yet been identified or for people who have not yet disclosed them.

Ultimately, ensuring that mechanisms for identifying and assessing specific needs are well integrated and functioning is essential not only to meet legal obligations, but also to build asylum and reception systems that are fair, humane and responsive to the realities applicants face.

1. Terminology

The working definition by the European Union Agency for Asylum (EUAA) defines **vulnerability** as follows: '[a] vulnerable applicant for international protection is one whose ability to understand and effectively present their case or fully participate in the asylum process, and/or capacity to benefit from reception conditions is limited due to their individual circumstances' and is closely linked to that given in the Asylum Procedure Regulation ([1]).

In the EUAA guide *Mental health and well-being of applicants for international protection* ([2]), vulnerability is presented as a situation in which an applicant has an increased risk of harm or reduced ability to cope, due to personal characteristics, experiences or circumstances that affect their mental health and well-being. In that sense, vulnerability is not a 'fixed' category, but rather a context-dependent, multifactorial and dynamic category; certain factors may be protective for some but put others in a vulnerable position.

Health is understood as a state of complete physical, **mental and social well-being** and not merely as the absence of disease or infirmity, according to the World Health Organization. It includes a person's emotional, psychological and social well-being. The term 'well-being' is broad and very much interlinked with physical and mental health.

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

The EUAA guide *Mental health and well-being of applicants for international protection* highlights the importance of differentiating between **distress and disorder**. While distress may be situational and transient, disorder involves clinically significant, persistent symptoms and may be formally diagnosed. Rather than immediately defaulting to strict psychiatric definitions, first-line protocols should allow for the recognition of psychological distress arising from the triple-trauma paradigm: trauma experienced in the country of origin, during the migration journey and upon arrival.

Trauma can be understood as a natural response to abnormal events. It may be seen as a psychological wound and the result of persistent stress that has not been sufficiently addressed. It often comes with a sense of being overwhelmed or a feeling that a situation is

([1]) Asylum Procedure Regulation, Article 3 (14): '"applicant in need of special procedural guarantees" means an applicant whose ability to benefit from the rights and comply with the obligations provided for in this Regulation is limited due to individual circumstances, such as specific vulnerabilities'.

([2]) For more information refer to pp. 7, 10 and 44 in Part I of the threefold guidance.

bigger than the person can manage by themselves. Such events are often also experienced as life-threatening, as people feel that they no longer have control in the moment.

Last, if certain symptoms or specific behaviours persist over a specified period of time, a professional assessment is recommended. If a medical report is provided indicating a psychiatric diagnosis, then this should, of course, also be taken into consideration.

Overall, a **trauma-informed care (TiC) approach** recognises that trauma may affect a person's well-being and functioning, while acknowledging that everyone responds to traumatic experiences differently. It aims to provide care in a way that promotes safety, trust and empowerment, while minimising the risk of re-traumatisation for everyone also those not yet identified.

TiC is grounded in safety, trust and transparency, predictability, choice and empowerment, collaboration and participation, cultural sensitivity and the avoidance of re-traumatisation.

These **principles** can be operationalised through multidisciplinary cooperation, trained and supported staff, appropriate identification and referral mechanisms, coordinated services, safe environments and meaningful feedback mechanisms. In the findings of the survey, which form the base for this mapping report, the concept of TiC is not consistently used or defined. Some systems focus primarily on recognising vulnerable people and providing specific care but without clearly defining how care should be delivered in a trauma-informed or survivor-centred manner.

2. Purpose

This mapping report aims to support European Union (EU) Member States in strengthening the integration of trauma-informed care (TIC) into their asylum and reception systems. It provides an overview of existing approaches, practices and challenges, with a view to informing further development and implementation, particularly in Member States where TIC has not yet been systematically integrated into asylum and reception procedures.

The report may also support authorities during the initial implementation of the Pact on Migration and Asylum by highlighting approaches to the early identification of applicants experiencing distress or affected by trauma, and to responding to their needs in a timely and appropriate manner, in line with applicable obligations under the Pact.

A more systematic approach to TIC can help authorities recognise distress and support needs at an earlier stage, facilitate timely referrals and strengthen cooperation between relevant actors, including first-line officers. This can help prevent situations from escalating and create conditions in which applicants can access appropriate support and participate more meaningfully in asylum procedures, including where their needs have not previously been identified.

3. Participation

A total of **47 submissions** were received from 25 countries (24 EU+ countries ([3]) and Serbia).

Contributions ([4]) were provided by the:

- participating **reception authorities**, covering Belgium, Bulgaria, Croatia, Czechia, Germany, Iceland, Ireland, Italy, Lithuania, Luxembourg, the Netherlands, Norway, Portugal, Serbia, Slovakia, Slovenia, Spain and Sweden;
- participating **asylum authorities**, covering Austria, Cyprus, Denmark, Estonia, France, Germany, Greece, Luxembourg, Norway, Slovakia and Spain;
- participating **civil-society organisations (CSOs)**, covering Belgium, Bulgaria, Finland, Germany, Luxembourg, the Netherlands, Spain and Sweden;
- one **expert** appointed by the authorities (from a legal and specialist service unit in Finland).

Overall, the submissions reflect a diverse range of operational, institutional and civil-society perspectives from across Europe, allowing for a comprehensive analysis and reflection.

([3]) EU+ countries are the EU Member States plus Iceland, Liechtenstein, Norway and Switzerland.

([4]) Several countries contributed more than one submission.

4. Overview of findings

The following sections present the key findings of the survey. Responses were received from national contact persons from the EUAA Network of Reception Authorities, the EUAA Asylum Processes Network and the EUAA Vulnerability Experts Network.

4.1. Structural and policy framework

The responses show a strong general awareness of TiC principles ([5]) across European asylum and reception systems, but with major differences in how explicitly these principles are embedded, implemented and monitored.

Several countries apply TiC principles in practice without explicitly using the term 'trauma-informed care' in legislation or policy. Respondents indicated that such principles are instead framed under vulnerability or are indirectly embedded (e.g. through the implementation of vulnerability assessments, support provision to victims of sexual and gender-based violence (GBV), child safeguarding efforts, anti-trafficking mechanisms and referral pathways, to name a few). In some settings, TiC is explicitly referenced for people affected by psychological distress, domestic violence, forced marriage, female genital mutilation (FGM), trafficking and other forms of severe vulnerability.

The integration of TiC seems to thrive where guidelines exist, training on TiC is systematically provided to first-line officers ([6]), a clear referral pathway exists and inter-agency cooperation is nurtured, including during case management. Dedicated funding for TiC activities and political will to integrate such an approach more systematically were pointed out as crucial by respondents.

Systems that heavily rely on short-term funded projects implemented by CSOs and non-governmental organisations (NGOs) benefit in the short term, but risk inconsistent implementation and uneven and interrupted services provision during different steps of the asylum and reception pathway, which reduce their long-term impact. Twenty countries indicated having a 'partially structured' approach in terms of the integration of TiC principles into their daily work. For more information refer to Annex 1. EU+ country examples.

Ensuring an atmosphere of **safety** and **trust** was pointed out by respondents as the most important prerequisite, as it relates to TiC and the 'do no harm' principle. Currently, TiC across the EU+ countries remains more practice driven than policy driven. Implementation is largely driven by individual professional competence, motivation and experience, rather than by structured organisational requirements. Consequently, the quality and consistency of trauma-

([5]) Principles such as safety, collaboration, empowerment, trust and cultural sensitivity; see also 'Terminology' for more information.

([6]) Training was recommended across key positions, such as reception officers, security personnel, border and immigration officers, those conducting personal interviews, interpreters and guardians.

informed approaches can differ significantly depending on location, staffing levels, training exposure and local organisational culture.

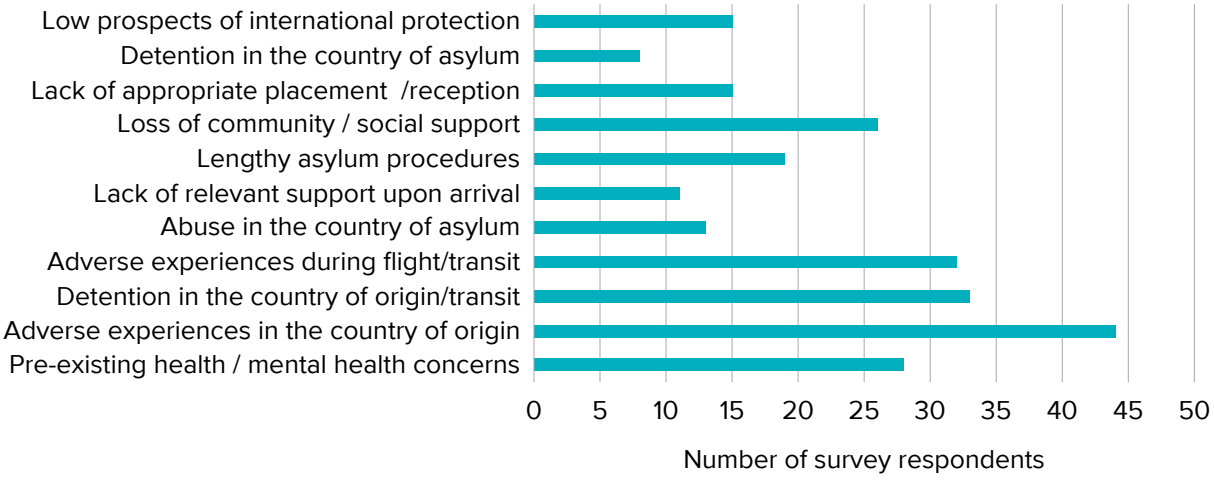
Last, respondents pointed out that there is not always an understanding of what TiC actually means. In addition, some respondents suggested that the concepts of vulnerability and specific needs in relation to physical health, mental health and psychosocial well-being are not always clearly understood either. Not having a joint understanding of these terms may trigger challenges linked to establishing a consistent approach to direct services provision, providing training for professionals and measuring the implementation of a TiC approach in some Member States.

4.2. Reasons for psychological distress

There are instances where the symptoms or behaviours observed in applicants by first-line professionals are interpreted simply as signs of a 'difficult' applicant or a lack of willingness to cooperate with the authorities and comply with obligations. However, respondents emphasised the importance of looking beyond such assumptions and considering the potential underlying causes of the observed behaviours and symptoms.

There was broad agreement that adverse experiences in the country of origin, such as exposure to prolonged insecurity, war and conflict, family violence or similar events, are among the main reasons why applicants experience psychological distress (Figure 1). It was also stressed that such distress often results from the cumulative impact of multiple adverse experiences encountered throughout the migration process (including during the journey and after arrival in the host country).

Figure 1. Reasons for distress according to respondents to the survey



Source: EUAA, TiC survey, 2026.

When psychological distress remains unrecognised and unaddressed over an extended period, and applicants are exposed to additional stressors in the country of asylum, it may

worsen and only become visible over time. According to first-line officers, this may manifest through:

- signs of depression and anxiety;
- aggressive behaviour towards family members, other applicants or staff;
- withdrawal and social isolation;
- self-harm, including suicide attempts;
- substance use or the misuse of prescription medication.

Any of the above behaviours might reduce an applicant's ability to cooperate with the authorities. Participants also highlighted that some applicants experience severe sleep disturbances. Some are unable to fall asleep, while others struggle to remain asleep. Although trauma-related experiences can be an important contributing factor, at times, **overcrowded living conditions** can also significantly affect sleep and may be a main cause. As a result, some applicants may go for days or even weeks without sufficient sleep, further undermining their mental health and overall well-being. Limited access to mental health, psychosocial and other appropriate and timely support may leave individuals with few available healthy coping mechanisms or sources of assistance.

In this context, it was mentioned that some applicants may use substances as coping mechanisms to deal with insomnia and anxiety. Substance misuse may exacerbate existing psychological vulnerabilities. Patterns of substance use may include alcohol and cannabis, as well as the misuse of prescription medicines such as pregabalin and benzodiazepines. The most frequently cited **stress factors** mentioned while in the **host country** were:

- uncertainty regarding the outcome of the asylum procedure and generally the future and what it will hold;
- long waiting times with little chance of meaningful activities;
- missing and being worried about family members left behind or separated from them;
- lack of adequate housing;
- frustration about displacement and being an 'asylum seeker';
- lack of languages skills;
- minimal prospects for a smooth long-term integration option.

Among **younger applicants**, including **minors**, the need for a sense to belong, acceptance and social connection may also contribute to vulnerability, particularly where positive forms of support and meaningful participation are limited.

A recurring theme across responses was the interaction between stressor factors along the migration spectrum (country of origin, journey, host country). While applicants may arrive with significant trauma histories, distress is often aggravated by prolonged uncertainty, unstable living conditions, repeated transfers, social isolation and barriers to integration.

Several respondents stressed that uncertainty about the future, family separation, financial insecurity, inability to work, lack of meaningful daily activities and fear for relatives left behind all contribute significantly to psychological deterioration over time.

Several respondents also highlighted barriers linked to stigma, lack of trust, low mental health literacy and cultural differences in understanding psychological symptoms. Some noted that trauma may be expressed through somatic complaints or behavioural changes rather than direct verbal disclosure.

Respondents also pointed out areas that may **nurture self-disclosure**, such as:

- the creation of a safe and predictable environment, including safe spaces (for women and children), with access to trained staff and where applicants can speak out (i.e. repeated but non-intrusive opportunities to speak);
- information on and an explanation of the asylum procedure, reception and how confidentiality is ensured;
- the presence of trained and trusted interpreters and cultural mediators (trauma-informed communication);
- the presence of a support person (including family members), where possible;
- the organisation of group psychoeducation sessions;
- efforts to allow disclosure to happen at the applicant's own pace.

For more information, refer to Annex 1 'Member State examples', specifically Annex 1.3 'What works to nurture self-disclosure and limitations'.

Last, it is also important to recognise that psychological distress is expressed differently from person to person and can also be influenced by cultural background, gender and age. Similar manifestations of distress may have different implications or lead to different outcomes for different individuals.

4.3. The process of identification and assessment

Looking at the responses received, most EU+ countries currently use a **vulnerability framework** ([7]), which is a structured approach used to:

- observe and identify;
- assess and understand;
- respond, for example through referrals.

([7]) Also refer to the EUAA's approach to vulnerability.

Such a framework is seen to support authorities in identifying applicants who may have specific reception or procedural needs and in assessing the nature and severity of such needs. It also helps to facilitate referrals, relevant support provision and follow-up, which can be organised when needed. It emerged that many of those responding ([8]) strongly emphasise the importance of a multistage and/or ongoing process; this multisectoral approach to identifying specific needs should be based on trust and relationship building.

Respondents commonly agreed that an **initial health and vulnerability screening** can capture **visible needs** and readily identifiable mental-health- and health-related indicators, such as:

- immediate and obvious risks (serious illness/injury), including those shared by the applicant;
- urgent medical needs (e.g. seizures, diabetic emergencies, high-risk pregnancies);
- clear indications of trafficking, sexual violence, abuse and/or torture;
- severe and obvious signs of distress (e.g. disorientation, self-harm);
- obvious needs linked to age (e.g. for older people (above 65) or unaccompanied minors).

It was repeatedly highlighted that the **less visible behavioural and emotional indicators** (e.g. withdrawal or emotional numbness, which might be consequences of experiences of sexual violence or abuse, prolonged discrimination and abuse, and mental health concerns or other impairments) are only identified or disclosed when:

- trust with officers and staff has been established;
- an applicant experiences a sense of stability;
- an applicant becomes visible (acts out, shows challenging behaviour).

Once an applicant is placed in more **permanent reception**, responsible officers may emphasise relationship building, trust development, and behavioural and social observation to identify underlying issues, vulnerabilities and needs in more depth.

Should officers, after a specialised assessment or due to ongoing observations, identify needs that cannot be addressed in the context of reception, referrals to multidisciplinary actors are expected (where accessible). These actors will then conduct further specialised assessments (e.g. psychological, psychiatric or medico-legal assessments). Most respondents highlighted the need for a protocol for referring individuals identified as having or who have disclosed severe psychological distress or mental health concerns (including substance use).

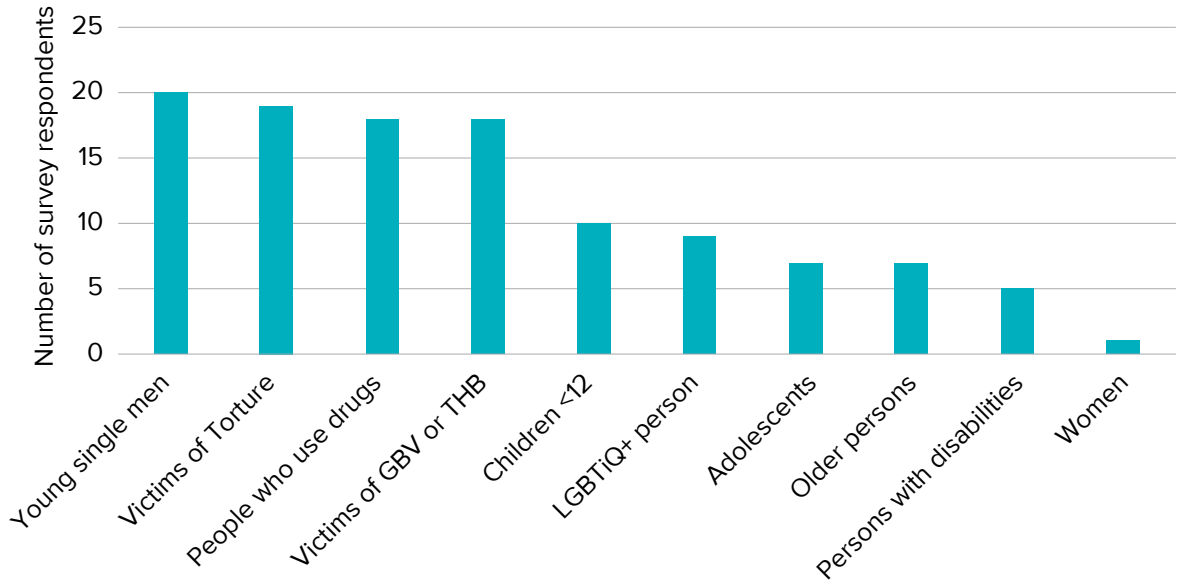
Respondents also emphasised that, rather than focusing solely on predefined categories of people, such as children or victims of trafficking, the identification of vulnerabilities should consider the **interaction between a person's individual circumstances and experiences and the context in which they currently find themselves**. This includes relevant **social**

([8]) Countries such as Ireland, Italy, Luxembourg, the Netherlands, Norway and Slovenia emphasised this layered approach.

determinants of health, as these factors can influence health outcomes and mental health and well-being, both positively and negatively.

Respondents also highlighted that early identification may be hindered not only by the often invisible nature of vulnerabilities, but also by factors related to age, gender and intersecting characteristics, such as race and disability, which can influence how needs are expressed, recognised and disclosed (Figure 2).

Figure 2. Applicants at risk of not having their needs assessed in a timely manner



NB: LGBTiQ+, lesbian, gay, bisexual, transgender, intersex, queer (or questioning), and + represents additional identities; THB, trafficking in human beings; GBV, gender-based violence.
Source: EUAA, TiC survey, 2026.

Respondents indicated that **young single men** are in most Member States not seen as 'vulnerable' per se, and their needs are therefore likely to be overlooked. In addition, **unaccompanied** and **accompanied younger children** (under the age of 12), among others, often fall through the cracks because the tools used to identify needs in children do not fully capture indicators of distress, trauma, violence and abuse.

Experts shared the following details.

Young single men are frequently impacted by societal stereotypes suggesting that they should be more emotionally resilient than others or that they may cope better with adverse experiences. This pressure often leads to young men concealing their struggles, fearing that disclosing psychological needs will be perceived as a sign of weakness. Initial assessments using the Identification of Psychological Support Needs (IPSN) tool – combined with an environment free of prejudice – have proved effective in uncovering 'hidden' topics, which then serve as critical points for further (including clinical) referral.

Identifying specific psychological issues in **young children** (under the age of 12) is often difficult due to their developmental stage and limited verbal skills. Additionally, parental reporting can be influenced by social stigma or cultural prejudice, leading to the unintentional masking of a child's distress. For instance, a three-year-old boy showing subtle developmental challenges highlights this systemic gap; while clinical indicators suggest a need for assessment, a lack of local specialists hinders a referral. In such cases, psychosocial support focuses on enhancing parental coping mechanisms and caregiving skills.

For **victims of torture**, disclosing experiences of torture is exceptionally difficult without a high level of established trust. This reluctance is often compounded by deep-seated feelings of inadequacy and shame and the fear of being judged. However, by providing a warm, safe environment and building strong rapport, practitioners can help survivors feel secure. Integrating a support network – including lawyers, mental health professionals and trusted individuals – significantly improves their functional performance and readiness to engage in further recovery steps.

Difficulties arise for **individuals with disabilities, LGBTIQ+ persons, and those who have experienced severe abuse**, as they may be reluctant to disclose personal characteristics, vulnerabilities or trauma. This often stems from feelings of fear, stigma or mistrust, especially given the limited time to build trust with asylum service staff. As a result, their needs may be identified later in the process rather than at the initial stages.

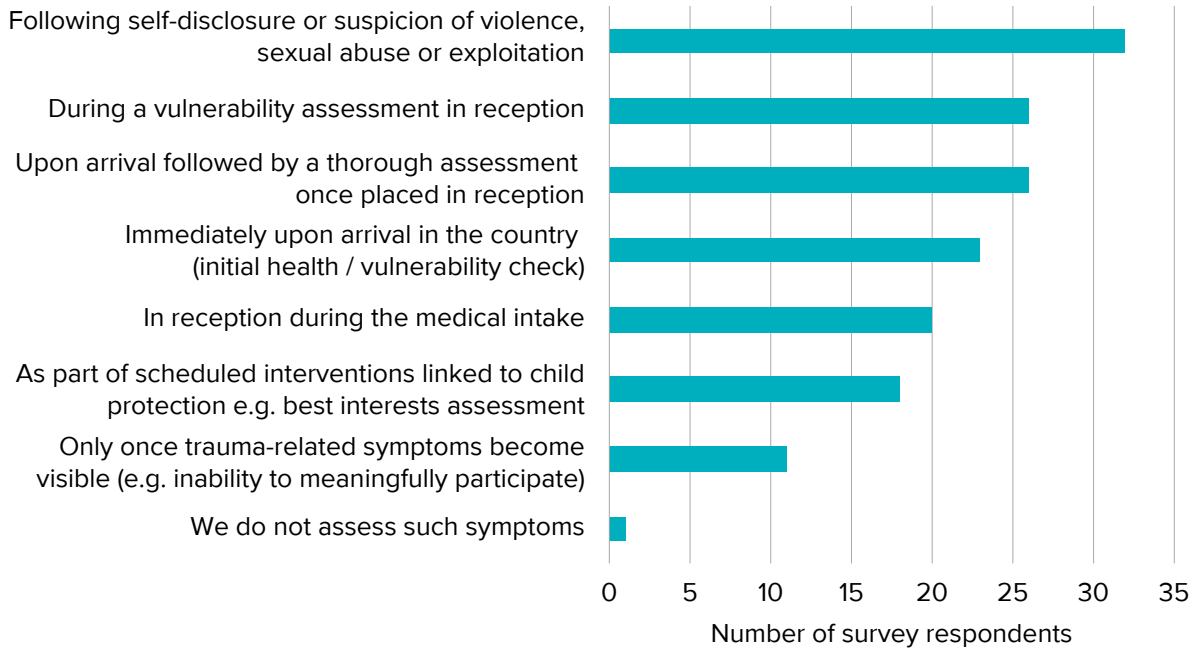
In addition, personality may play a role according to respondents, and the **more silent and less demanding** applicants might be overlooked. This might be further exacerbated: applicants demanding and requiring a large amount of attention and time can stretch the capacity of first-line officers, while those who are quieter and less demanding might mistakenly be considered to be 'well'.

See Section 4.5 'Applicants with specific needs' for more information on certain categories of vulnerability.

4.3.1. Context of identification

Respondents indicated that **applicants are checked** for trauma exposure or trauma-related symptoms **mainly following self-disclosure**, followed by a scheduled vulnerability assessment in the context of reception. Only a few experts noted that indicators linked to trauma, exploitation or violence are not assessed (Figure 3).

Figure 3. When are applicants checked for trauma exposure?



Source: EUAA, TiC survey, 2026.

Since invisible vulnerabilities or needs are often not disclosed by those arriving (e.g. due to a lack of trust in the authorities, not being aware of the importance of sharing needs, or feelings of shame, guilt or similar), most respondents acknowledged that **identifying** vulnerabilities, including trauma-related symptoms, should be organised as an **ongoing process that builds on relations** rather than a one-time screening event.

Otherwise, operational tensions may emerge, since those working in the arrival context are given the challenging task of identifying specific needs and vulnerabilities within a tight time frame, while the persons arriving may not be ready, informed or cooperative. Respondents also pointed out that in the context of arrival at the border or during search and rescue missions different types of officers, for instance immigration police, may be expected to identify immediate needs while having limited expertise and lacking the necessary skills and training to do so.

4.3.2. Barriers to self-disclosure of specific needs and vulnerabilities

Respondents highlighted structural and practical barriers to early identification. Reliance on self-disclosure (refer to Figure 3) was one of the barriers identified. Upon arrival, individuals are often in 'survival mode' and therefore not mentally and emotionally ready to disclose adverse experiences. Disclosure may be possible once a **sense of safety and stability** has been established. This is when symptoms tend to emerge, as applicants begin to feel 'ready' to share more information about themselves or their dependants and a baseline of trust has been built with officers.

Barriers to self-disclosure shared were, among others:

- lack of trust in authorities more generally;
- lack of self-awareness;
- general anxiety and fear, for example that disclosure may negatively affect the person's application (for international protection) or jeopardise the safety of family back home;
- the fear that information might be used to separate family members or inform intelligence services back home;
- shame and stigma surrounding the violence experienced (e.g. sexual violence);
- time pressure during arrival procedures;
- lack of privacy in overcrowded **reception settings** and during large-scale arrivals;
- frequent transfers disrupting continuity of care;
- limited availability of specialised services, especially in rural areas;
- language and cultural barriers and the shortage of interpreters and cultural mediators.

Some practical examples shared by respondents suggested that applicants from certain African countries may be reluctant to disclose mental health needs due to fears about subsequent interventions. These concerns were linked to previous negative experiences with mental health services in their countries of origin, including psychiatric wards, as well as with traditional forms of intervention.

It was also indicated that some applicants have never enjoyed a situation of 'being cared for' and are not used to receiving support. In addition, sharing needs may be perceived as 'weakness', particularly among the male population.

Personality was also pointed out as an important factor. Many applicants are simply quiet people who wish to integrate without attracting any attention, meaning that their needs are easily overlooked.

Last, certain people arrive from countries or regions where conflict, insecurity and violence are part of their 'upbringing' and they might not be aware that what they have experienced constitutes a violation of their rights.

During arrivals and in situations where applicants may not have disclosed needs, officers with some basic training may still manage to read signs of distress such as:

- withdrawal and isolation;
- lack of cooperation;
- sleeping difficulties;
- irritability;

- somatic complaints;
- substance use or misuse of prescription drugs;
- inconsistent, changing behaviour.

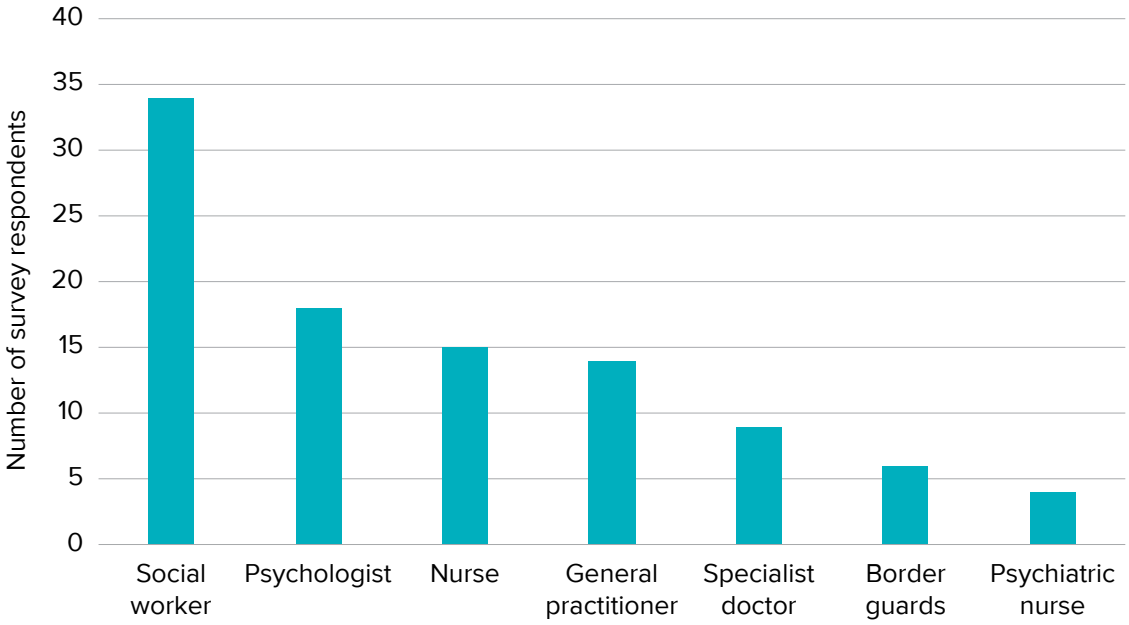
Articulating such observations and discussing these with the applicant can help shed light on underlying issues and needs that may require and benefit from a response.

Finally, **trust building** was consistently identified as the **single most important factor** enabling disclosure.

4.3.3. Identification of specific needs

Social workers represent the highest share of those identifying applicants with needs in the reception context, followed by psychologists and nurses (Figure 4).

Figure 4. Who identifies specific needs?



Source: EUAA, TiC survey, 2026.

The **daily presence** of social workers in many reception facilities allows for observation and relational continuity with applicants. This consistency creates a situation where social workers can more easily engage with applicants, fostering a **relationship of trust**. Hence, the identification of trauma or related needs often depends on social workers, although other care providers including educators, reception staff and volunteers were also mentioned by some respondents.

Note that **identification is not diagnosis**; identifying these needs or vulnerabilities in a person may require specialised support and ongoing follow-up.

According to respondents, a huge burden of responsibility is often placed on a single profession, namely social workers, in the context of identification. This can lead to feelings of being overwhelmed, particularly when social workers:

- may not have the necessary training (yet);
- are not enabled to refer to specialists;
- lack support from their employers (staff well-being).

In addition, inconsistencies in the identification process and in the definition of their role may create confusion for social workers, their colleagues and the applicants. Furthermore, it was indicated that, due to workforce shortages and limited access to qualified clinical professionals in some countries, including psychologists and psychiatrists, social workers are at times required to carry out certain assessments that would ordinarily involve or benefit from specialised clinical expertise.

Finally, it was stressed that all professionals working with applicants, such as educators, intercultural mediators and lawyers, may, in their position, be able to identify potential support needs through their interactions. It is important therefore that they receive basic training on trauma and psychological first aid, be aware of referral pathways and know how to connect applicants with the appropriate professionals, to ensure that applicants' needs are properly identified and addressed once they arise.

4.3.4. Tools supporting identification

While respondents indicated that tools such as checklists and questionnaires exist and are used to conduct initial checks and intake procedures to identify specific needs, there was a consensus that they often lack cultural appropriateness. It was also highlighted that low contextual validity and literacy barriers further challenge their use. In addition, some respondents pointed out that these tools often fail to account for age or gender, meaning that questions are often adjusted informally by those organising the checks.

The tools used to conduct initial checks and intake procedures focus on the following areas (in the order of importance reported by respondents):

- severe distress,
- depression and anxiety,
- severe mental health disorders,
- substance-related problems,
- sleeping difficulties,
- trauma-related symptoms and somatic complaints without an identifiable medical cause,
- child-specific indicators, such as signs of regression.

Interestingly, according to respondents, **child-specific indicators** (particularly for children under the age of 12) were **less frequently included**; hence, child trauma detection remains underdeveloped in many systems.

Children under the age of 12 are generally more likely to be accompanied by a parent or other caregiver and may therefore receive less direct attention from authorities, with greater reliance placed on the accompanying adult to identify or communicate the child's needs. This reliance may, however, be problematic where parents or caregivers are themselves traumatised, distressed or otherwise have limited capacity to recognise and communicate signs of trauma in the child. This could further contribute to the under-identification of child-specific trauma indicators in this age group.

It was also emphasised by some that, while certain systems systematically assess physical and mental health concerns, others rely on referrals to healthcare services or professional observation rather than formal screening tools.

The importance of recognising less visible and more subtle indicators of trauma and vulnerability, such as withdrawal, reluctance to disclose information, communication difficulties, emotional numbness, shame, self-blame, sudden mood changes and disruptive behaviours, was stressed, particularly since, in some countries, health assessments do not systematically include screening for trauma, post-traumatic stress disorder or psychological distress.

The **lack of standardised tools** that are culturally sensitive and age and gender appropriate was also pointed out by some respondents.

Respondents noted that there are relatively few checklists or questionnaires adapted to people arriving from Africa. They also highlighted that some people arriving in the country may have limited mental health literacy. According to respondents, many of the tools currently used have been developed based on research involving predominantly **white male populations**, which may therefore limit their cultural, linguistic and contextual appropriateness for some groups.

Some **tools** used to support the identification of needs listed by respondents were:

- the EUAA IPSN tool;
- the Assessment System for Children and Adolescents (Application, Scoring and Interpretation Manual);
- escala de Evaluación Global de Estrés Postraumático ([9]);
- the International Trauma Questionnaire;
- other national self-assessment tools.

([9]) In Spanish only.

4.3.5. Capacity, training and technology

Difficulties in identifying needs at an early stage may be due to gaps in training or a lack of refresher training for first-line staff. The feedback received by respondents stresses that there is a considerable difference in the availability and accessibility of trauma-informed training across asylum and reception systems and among their staff.

Gaps in training

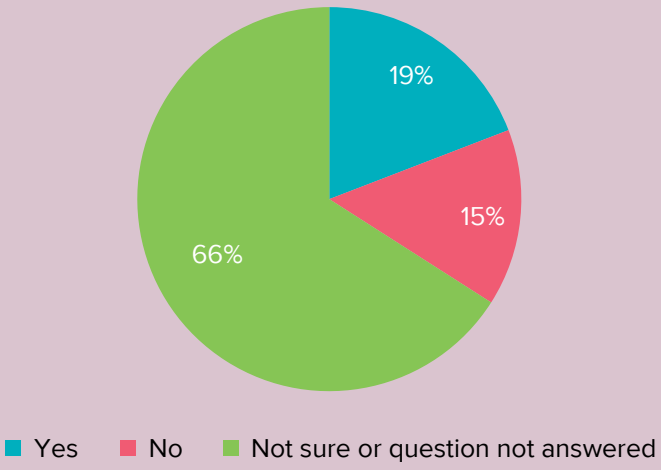
It was pointed out that the visibility of training structures across institutions and professional groups differs and certain groups of officers are often 'overlooked' and do not benefit from such training. Feedback received seems to indicate that training on TiC approaches is more likely to be available for:

- asylum case officers;
- reception staff;
- psychologists;
- social workers;
- medical personnel;
- specialised vulnerability officers.

However, training is less likely for (Figure 5):

- immigration officers and border guards;
- security personnel;
- interpreters;
- external contractors.

Figure 5. Awareness of access to training extended to first-contact officers (e.g. immigration, police, security personnel)



Source: EUAA, TiC survey, 2026.

Many respondents emphasised that TiC is not limited to formal interviews or vulnerability assessments. Applicants interact daily with security personnel, interpreters, transport staff, healthcare workers and administrative personnel. Border guards are often the first and in certain instances the only professionals some applicants may interact with.

This uncertainty regarding the accessibility of such training for these colleagues can be seen as significant, as it may suggest limited coordination and transparency between different parts of the asylum and reception system and relevant partners (immigration). A lack of trauma awareness among any of these actors may increase distress, reinforce mistrust or contribute to re-traumatisation for applicants.

Therefore, respondents highlighted a need to involve first-contact officers, including immigration officers or border guards, more systematically. Otherwise, trauma-informed approaches may remain concentrated among specialised professionals rather than being integrated across the entire reception and asylum system, including upon arrival, jeopardising continuity of care and increasing the risk of deterioration of conditions.

Respondents emphasised the importance of safety, predictability and trust building to nurture calm and collaboration, particularly for applicants with 'hidden' vulnerabilities (e.g. those with mental health concerns, LGBTIQ+ persons, victims of GBV as well as single men).

The absence of comprehensive training risks undermining efforts linked to TiC and contributes to the inconsistent identification of needs, especially among groups already described as frequently overlooked.

Respondents pointed out that employers must equip first-line officers with essential training. Useful topics highlighted were recognising basic vulnerability indicators, TiC, organising referrals, psychological first aid, 'do no harm protocols', suicide prevention and de-escalation techniques.

Finally, at the border, where a focus on security persists, the environment may unintentionally produce fear, mistrust or even re-traumatisation if staff are not trained or knowledgeable on how to de-escalate distress and communicate calmly, respectfully and patiently.

(a) Staff well-being

The responses also suggest that trauma-informed competence is not static but requires continuous reinforcement. Some respondents referred to staff turnover and operational pressures as barriers, meaning that, even where training exists, maintaining institutional expertise remains difficult. Respondents also raised concerns about staff turnover linked to burnout. High caseloads, insufficient staffing and limited opportunities for supervision are reasons for staff to potentially change jobs or experience poor health.

See Annex 1.5 'Staff well-being' for more information regarding practices linked to maintaining staff welfare and well-being.

(b) Technology

Responses indicate that the use of new technologies in asylum and reception contexts remains relatively limited and cautious across participating countries.

It was mentioned that such tools should be used on a **case-by-case basis only** and only **after** needs have been assessed and are evident as specific vulnerabilities and needs may provide a reason not to use such tools. Safeguards to complement the use of such tools and digital literacy were also stressed as being important. Respondents mentioned the use of remote interviews and interpretation, telehealth or telepsychiatry, digital healthcare consultations, AI-supported translation tools and multilingual information platforms.

As for **remote interviews**, several benefits were noted.

- They might benefit those who feel safer in familiar surrounding (e.g. the reception centre they stay in) or those with limited physical capabilities.
- They remove the need for applicants to organise lengthy and stressful travel.
- Applicants may experience improved access to trained case officers relevant to their situations through such interviews (e.g. those familiar with certain vulnerabilities, such as victims of torture), that is officers who might not be available in remote parts of certain countries.
- Similarly, such interviews were also seen as helpful in the context of accessing healthcare, particularly in countries where specialists are available only in urban areas, or where online psychosocial support with culturally competent professionals is the only method for regular contact, while making support more economically feasible.

Respondents also pointed out the importance of giving applicants a choice, noting that remote interviews should only be organised where the applicant feels comfortable and where their vulnerabilities have been appropriately considered in advance.

Concerns raised regarding remote interviews were that:

- building trust is more difficult through screens;
- The setting and location may not always provide sufficient privacy for applicants to share relevant information, including sensitive details, with specialists or ensure their safety.
- emotional clues may be harder to identify or misunderstood;
- communication barriers may increase;
- vulnerable applicants may experience greater emotional distance or stress.

Several respondents specifically stated, for example, that remote interviewing should be avoided or discouraged in cases involving trauma and severe vulnerability. This set up can be also challenging for children who might be not familiar with video communication and

for those who might suffer from previously unidentified physical impairments, such as mild hearing loss, which makes communication challenging.

As for **AI and translation tools**, a smaller number of respondents described the use of AI-supported translation tools or digital multilingual communication systems as positive. These technologies were viewed as beneficial only when used to:

- reduce immediate communication barriers in the absence of trained interpreters as to swiftly provide information in multiple languages;
- support emotional disclosure in situations where applicants might feel uncomfortable sharing their emotions and needs with multiple people simultaneously (e.g. due to feelings of shame).

Respondents expressed serious caution or scepticism regarding AI use, including concerns that:

- over-reliance on technology may weaken human interaction;
- inaccuracies may affect sensitive communication;
- emotional nuance may be lost;
- ethical safeguards remain underdeveloped.

One response explicitly advocated limiting AI use in asylum settings.

New technology

Current use appears relatively cautious, responses suggest that familiarity with remote interviewing has increased since the COVID-19 pandemic. Respondents also reported growing use of multilingual digital tools and some experimentation with AI-supported communication. The expansion of telehealth practices was also mentioned, particularly in situations where specialised support would otherwise be unavailable.

Simultaneously, respondents consistently emphasised that technological innovation should not compromise:

- trust;
- empathy;
- confidentiality;
- relational safety;
- individualised assessment.

This reflects a broader finding throughout the survey: TiC is understood primarily as a **relational and human-centred approach**, which **technology** may support but **cannot replace**.

The findings clearly suggest that, while digital tools may improve in some instances accessibility and responsiveness, they are not viewed as substitutes for human, relational and trauma-informed engagement. This is particularly relevant given that psychological distress among applicants is often linked to loss of social networks, communication barriers and consequently isolation and withdrawal.

Creating opportunities for **human contact, community interaction** and meaningful **social connection** therefore plays a crucial role in maintaining well-being ([10]).

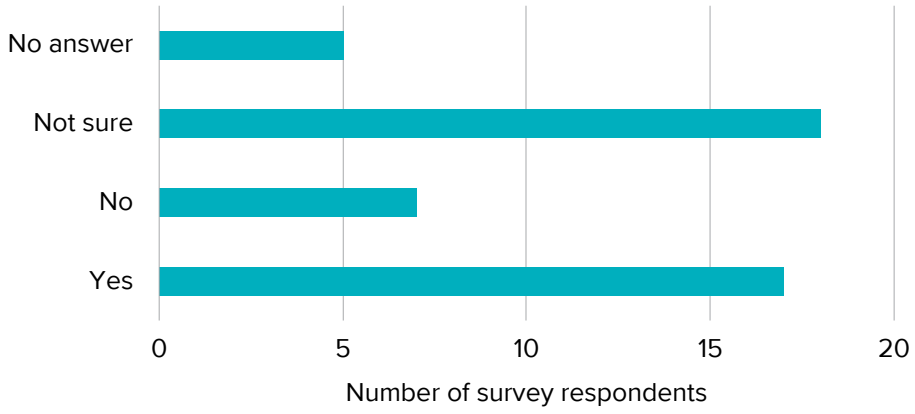
4.3.6. Complaint mechanism

In the mapping survey, participants were asked about the accessibility of complaint mechanisms, as these processes form a part of TiC approaches. Most respondents indicated that complaint mechanisms exist for:

- complaints against other applicants;
- dissatisfaction with services;
- complaints regarding staff behaviour.

When asked if the existing mechanisms are accessible and adjusted to the needs of children or applicants with specific needs, the answers were less clear. While some participants indicated yes, others were not sure or decided not to answer (Figure 6).

Figure 6. Access to adjusted complaint mechanisms for children and those with specific needs



Source: EUAA, TiC survey, 2026.

In terms of available channels and mechanisms for submitting or addressing complaints, respondents mentioned:

([10]) Also refer to the EUAA threefold guidance *Mental health and well-being of applicants for international protection*, Part II (2024), and specifically the section on community-based interventions (p. 73).

- complaint mailboxes;
- digital complaint systems;
- formal written complaints;
- escalation of complaints to management;
- independent complaint offices;
- informal resolution through communication with staff.

Examples

Adjusted mechanisms for vulnerable ([11]) groups include individual visits to reception centres during assessments, during which conversations with minors take place to ensure that staff are meeting the requirements for adequate care. These conversations follow a structured protocol and include questions about the child's daily life at the centre, whether the child feels safe and receives the necessary support and whether they have access to leisure activities, among other topics. Dietary offers, access to education and health services are also discussed during these conversations.

It was emphasised that also informal resolution mechanisms remain important because certain issues, depending on their nature and severity, can be resolved directly through communication rather than escalating into formal complaints.

4.3.7. Promising approaches in the context of identification

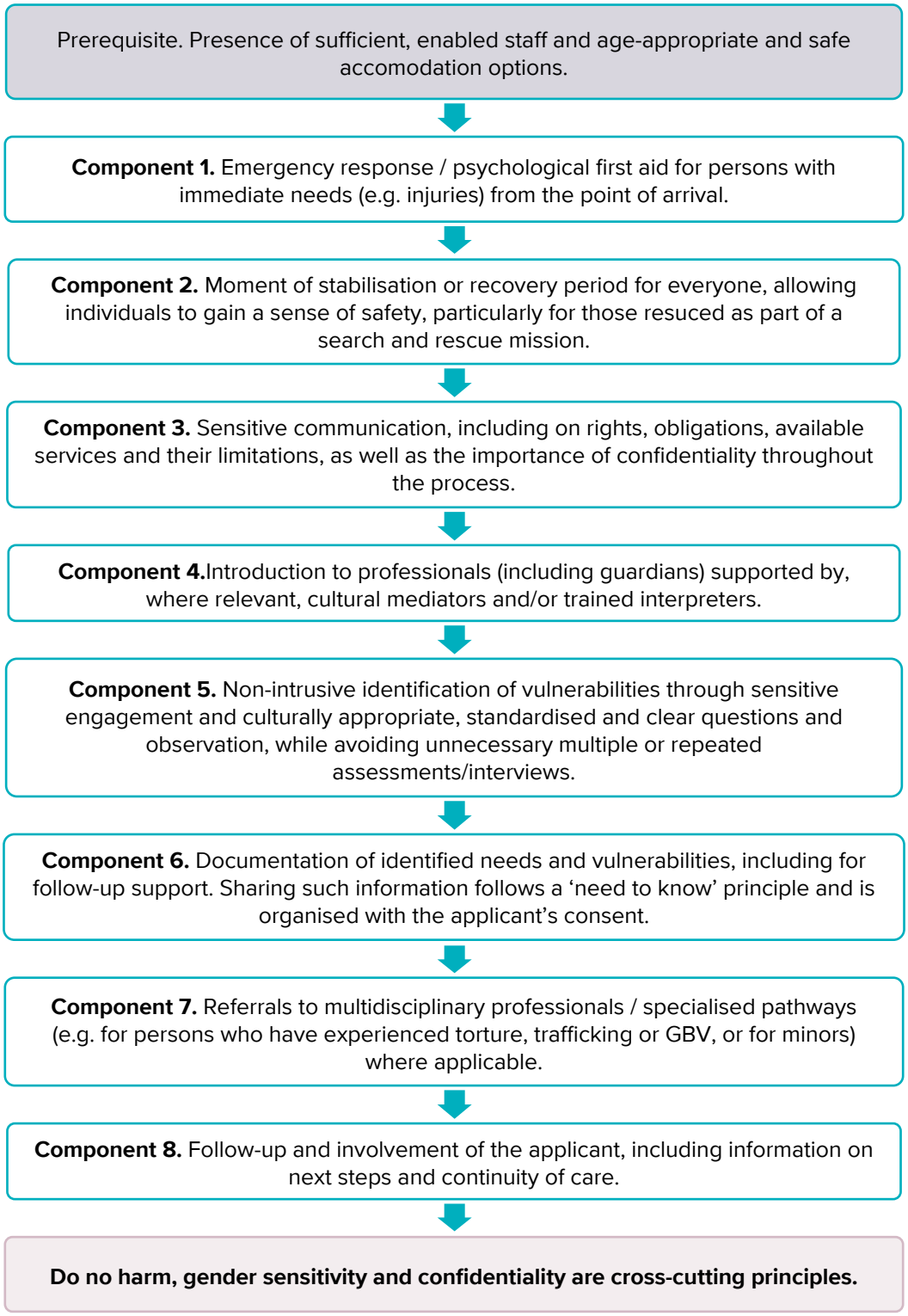
Respondents provided insight on how trauma-informed principles are applied during initial checks, disembarkation and first-reception procedures, including search and rescue, and how the risk of re-traumatisation is avoided (for more practices, also refer to Annex 1 'Member State examples' and its sub-annexes, particularly Annex 1.4 'Trauma-informed principles in practice').

Generally, the findings indicate, as mentioned, that self-disclosure of needs and vulnerabilities is more likely when applicants feel **safe**, **respected** and **not pressured** to disclose traumatic experiences immediately. Gradual engagement, clear communication, the accessibility and continuity of personnel and a non-judgemental environment were repeatedly described as essential.

Several countries also highlighted the importance of **practical stabilisation measures**, such as providing safe accommodation, food, rest and access to communication with family members before conducting an assessment. **Communication with family members or any other close support person** throughout the asylum and reception pathway is seen as a key stabilising factor. Find a summary of stabilising factors below (Figure 7).

([11]) Examples shared by Norway and Sweden.

Figure 7. Core components for stabilising and supporting easier and more timely identification of needs



Although some EU+ countries reported difficulties in accessing specialised professionals, particularly psychiatrists, the survey findings indicate that respondents generally do not view trauma and vulnerability identification as solely a medical exercise.

As indicated, the emphasis by respondents was very much placed on multidisciplinary and complementary approaches that support:

- creating safe spaces for disclosure;
- ensuring the continuity of care;
- reducing over-medicalisation;
- avoiding the pathologisation of trauma-related reactions and mental health symptoms presented by applicants.

Areas for improvement

The responses indicate that efforts are made by authorities to create stronger and more coordinated systems that allow for early identification and avoid re-traumatisation. However, as discussed in previous sections, a notable gap remains between policy and practice. The main reasons mentioned for why certain efforts are not consistently applied were:

- staff shortages and lack of specialised staff;
- time pressure and unrealistic deadlines;
- insufficient and overcrowded reception facilities;
- the lack of organised coordination between different stakeholders and authorities (asylum, reception, immigration, health).

The fact that some European countries refer almost everything to the medical system while others rely heavily on non-clinical actors creates inconsistencies in thresholds, competences and follow-up quality (continuity of care). The lack of professionals to provide such care in some countries may also lead to over-medicalisation due to the absence of mental health and psychosocial care services.

It was mentioned that systems that share vulnerability findings directly with asylum authorities may create a situation of reduced trust, fear of disclosure and confusion between care and control functions.

4.3.8. Effective measures to support vulnerable applicants

Some respondents indicated certain measures that they perceived as useful when working with applicants who may be severally traumatised but have not yet been identified.

Examples shared on effective measures as they relate to TiC

Respondents from **Belgium** indicated that non-verbal therapies, art therapy, the 'tapping technique' and body-focused or stress management therapies can be useful when working with applicants as part of support provision. Simple exercises can be provided to help clients ground themselves and release stress. During interviews, taking regular breaks to practice these exercises – potentially with a psychologist present – can help calm an applicant and support stress regulation.

Respondents from **Slovenia** mentioned that one simple, effective practice is maintaining continuous daily contact between applicants and social workers, which allows for trust building and the gradual identification of vulnerabilities. Rather than relying on one-time assessments, this approach enables individuals to disclose sensitive experiences over time at their own pace.

This is particularly important in cases of trauma, where immediate disclosure is often not possible. Through consistent presence and a non-judgemental approach, relationship building is possible and applicants are more likely to share their needs, allowing for more accurate identification and appropriate support. This approach works because it creates a sense of safety and predictability, which is essential for TiC.

Respondents from the **Netherlands** shared that intercultural mediation is important and is integrated into a trauma-informed approach; such guidance is also accessible to guardians. Intercultural mediators can effectively help identify trauma, encourage young people to come forward and help them understand the purpose of mental health services and where and how to access them. These efforts are essential in making existing interventions more culturally responsive.

Respondents from **Spain** shared that understanding and maintaining a non-judgemental approach towards the applicant is key. This ensures that both the support provider and the environment are perceived as safe and friendly. Transparency and clarity regarding the decisions to be made, the involvement of the applicant and possible future actions are equally important and help to build trust from the outset. Knowing the population one works with is also crucial. For example, when working with nationals from certain African countries who may have lower literacy levels, using stories can be an effective and meaningful way to communicate. Consequently, psychoeducation is vital.

4.4. Consent and availability of follow-up services

Generally, respondents highlighted the importance of obtaining applicants' consent before referring those with specific needs to specialised services or sharing relevant information. Consent was presented as a central principle, reflecting participating experts' strong commitment to confidentiality, medical ethics and data protection, and respect for applicants' autonomy.

Only a small minority of respondents considered that identification mechanisms are adequately matched by timely follow-up services, as most respondents indicated that this is 'not always' the case. This may reflect a significant implementation gap across many asylum and reception systems. Respondents repeatedly referred to shortages of specialised mental health professionals, long waiting lists, insufficient interpretation services and uneven geographical access to care.

4.5. Applicants with specific needs

This section provides a brief overview of four specific groups of vulnerable applicants for whom TiC is considered: asylum-seeking children, victims of torture, victims of GBV and applicants with substance use problems.

4.5.1. Asylum-seeking children

The survey findings indicate that children's mental health needs are often underestimated through the asylum and reception pathway. Effective support depends on early identification, child-sensitive procedures and stable relationships. Even in situations where children arrive unaccompanied, maintaining regular contact with their parents is highly beneficial, as is providing a predictable environment and coordinated, multidisciplinary care, although these elements are not sufficiently integrated in some countries.

Respondents mentioned that **younger children (under the age of 12)** are among the groups most likely to be identified late or overlooked, particularly when arriving with family members. Respondents note that children's psychological distress is frequently hidden because:

- symptoms may appear as behavioural problems rather than verbalised problems or concerns;
- children often struggle to articulate traumatic experiences;
- adults (staff and parents) tend to prioritise physical safety over emotional well-being during the first stages of reception;
- trust and disclosure take time to develop.

First response for children across the participating countries emphasises:

- safe shelter;

- food and water;
- contact with family members;
- medical care;
- emotional stabilisation and, where possible, predictable routines;
- age-appropriate information.

Several respondents stress that in the first phase professionals avoid extensive questioning about traumatic events and instead prioritise **psychological first aid** and immediate protection.

Guardians or **representatives** ([12]) were seen as **important** for guiding and explaining asylum- and reception-related requirements and entitlements and also advocating for the child's needs and ambitions throughout the asylum and reception pathway.

Respondents pointed out that children are especially **vulnerable to re-traumatisation**, particularly during the **personal interview** (Figure 8) and:

- accelerated procedures, where there might not be sufficient time to identify or address children's needs;
- transfers between reception centres;
- repeated questioning;
- introductions to new professionals;
- in the exceptional situation where an authority may consider the **detention** of a specific child, the decision will need to be based on a documented outcome assessment.

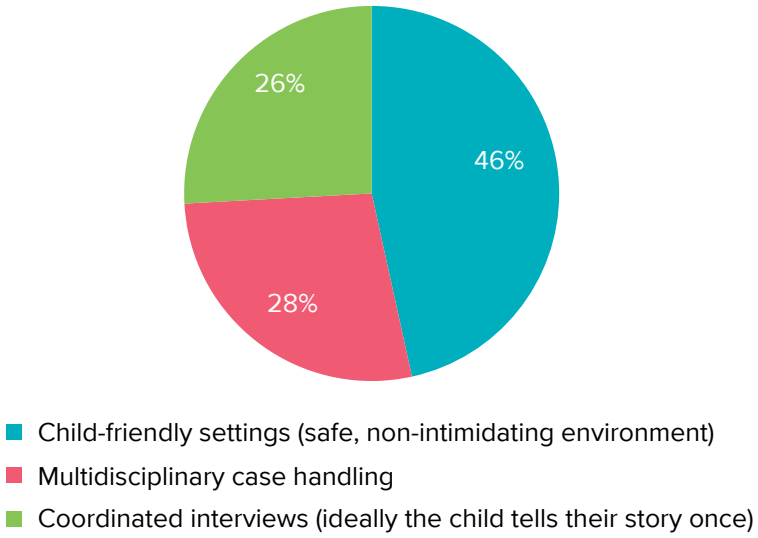
The importance of sharing information appropriately so that the child does not have to repeat traumatic experiences was stressed.

Measures proposed to reduce such risks include:

- limiting the number of interviews;
- assigning the same case officer and guardian to the asylum-seeking child throughout all processes;
- ensuring that officers are knowledgeable about **child-friendly interviewing methods** and interpreters are trained on trauma;
- preparing a setting for strong coordination among a diverse group of persons supporting the child, such as their parents (where present), psychologists, healthcare providers, social workers, guardians, teachers, lawyers and others;
- providing the opportunity to attend school and engage in meaningful activities, which helps children maintain or gain emotional stability.

([12]) For the purpose of this mapping report, the term 'guardian' is used.

Figure 8. Trauma-informed procedures for children



Source: EUAA, TiC survey, 2026.

Respondents shared that, while many children may initially show signs of psychological distress, symptoms often decrease once they experience safety, stability and the necessary social support. Therefore, as with adult applicants, early assessments should distinguish between temporary distress caused by displacement and more severe psychological conditions requiring specialised intervention.

Examples shared on supporting children

Respondents from **Norway** shared that an earmarked state budget fund has been provided for capacity building at reception centres for unaccompanied minor asylum seekers (UAMs) since 2017. Among other initiatives, this fund has been used to purchase services from the Regional Resource Centres on Violence, Traumatic Stress and Suicide Prevention to implement the capacity development programme 'a good temporary home' in UAM reception centres. The programme targets all staff members. Its overall goal is to support high-quality, trauma-informed and relationship-based care for UAMs, in line with existing guidelines.

The learning objectives are to:

- develop competence, values and attitudes, and apply simple methodological tools that enable good, trauma-informed, relationship-based care;
- strengthen knowledge of child welfare and refugee-related issues;
- maintain a focus on coping and everyday strengths, recognising young people's achievements and contributions;
- support minors in dealing with daily challenges, their unresolved life situations and their hopes for the future;

- contribute to ensuring that minors encounter safe, caring adults who are sensitive to their needs.

The programme is adapted locally to the needs of each reception centre and includes a two-day course on basic trauma understanding, followed by four sessions (eight days in total) with all staff.

In addition, two follow-up days are offered once the programme is completed. One of the sessions involves the active participation of the UAMs at the centre. In this session, minors and staff work together. UAMs develop their individual **mind maps**, present them to the group and receive feedback from both staff members and other minors.

The Norwegian Directorate of Immigration (UDI) has also entered into supplementary agreements with 11 ordinary reception centres for asylum seekers accommodating minors arriving with an accompanying person aged 18 or older. Staff at these centres have completed a lighter version of the 'a good temporary home' training. The regional resource centres have additionally developed a guide to TiC and relationship-based care for use by staff in reception centres.

In addition to other measures, **Ireland** has ensured that asylum-seeking children are supported by a designated lead for child safeguarding, who is a trained social worker with vast experience in the area of children and families.

4.5.2. Victims of torture

Across countries ([13]), respondents described broadly similar approaches when signs of torture or other inhuman or degrading treatment are identified. In most cases, applicants are referred to specialised medical, psychological, psychiatric or psychosocial services, often involving multidisciplinary cooperation between reception authorities, healthcare providers and NGOs. Identification is generally viewed as the starting point for access to specialised services, and efforts should therefore not end there.

A strong common principle across responses is that information sharing and any follow-up actions are generally based on the informed consent of the applicant. Many countries emphasised confidentiality, professional secrecy and compliance with data protection standards.

In several countries, medico-legal documentation may be prepared by specialised professionals and used to support the application (for international protection), particularly regarding vulnerability assessments, procedural safeguards or credibility assessments ([14]). Such reports are often prepared in accordance with the Istanbul Protocol or equivalent

([13]) See Annex 1.2 'Victims of torture'.

([14]) Also refer to EUAA, *Victims of Torture – Identification, support and examination of claims*, 2023.

national guidance. However, respondents also noted uneven availability of specialised services and medico-legal expertise, particularly outside urban areas.

Countries differ substantially with regard to how important medico-legal reports are. For example, in France, medical certificates are generally not required except for in FGM cases. In Italy, however, medico-legal reports are used to support vulnerability and credibility assessments, while in Serbia such reports are considered critical evidence.

Some country respondents ([15]) described information flowing to asylum authorities, while others stressed maintaining a separation between healthcare and asylum procedures. For example, a CSO in Luxembourg noted that whether an applicant uses a medical report is entirely their choice.

The purpose of documentation seems to also differ depending on the country. Some countries present medico-legal reports primarily as evidence for asylum (e.g. Italy and Serbia), while others present them mainly as a tool for adapting procedures (e.g. France).

Furthermore, respondents highlighted the importance of avoiding repeated retelling of traumatic experiences, particularly for victims of torture. Several countries described phased approaches in which only initial indicators are identified at first contact, while detailed assessments are postponed until trust has been established and the applicant is emotionally stable.

A holistic approach to support provision was stressed. Therefore, in addition to healthcare and psychosocial support, some countries established referral pathways linked to anti-trafficking mechanisms, child protection services and, in limited cases and subject to applicant consent, **war crime investigation units** (e.g. Denmark, Estonia and Finland).

Despite the existence of procedures in many contexts, respondents repeatedly pointed to significant gaps in access to specialised torture rehabilitation services, long waiting lists, shortages of qualified professionals and geographical disparities in service availability.

4.5.3. Applicants and gender-based violence

The information received indicates that responses to GBV, including sexual violence and related protection risks, are present across several asylum and reception systems, but their level of institutionalisation varies. Some countries have explicit policies, protocols and standard operating procedures (SOPs) for preventing and responding to GBV, while in others relevant measures are embedded within broader vulnerability frameworks or are delivered primarily through CSOs, international organisations and their funded projects. Hence, in some countries, responses to GBV remain strongly dependent on project-based funding rather than being mainstreamed into the routine work of authorities. As a result, the identification of and response to GBV-related needs rely heavily on the expertise and capacity of external organisations.

([15]) See Croatia, Finland, Germany, Italy and Serbia.

It appears that the overall approach to supporting victims of violence is increasingly aligned with TiC. Specifically, it points towards individual vulnerability assessments, specialised support and multidisciplinary referrals, compared with other vulnerability categories where this is less the case. This approach creates an opportunity to identify GBV and other violence-related risks early, although its effectiveness depends heavily on staff capacity, trust and safe disclosure mechanisms. Where formal SOPs exist, cases of sexual violence or GBV can trigger coordinated responses between reception staff, NGOs, government authorities, health services and other specialised actors.

Respondents indicated that measures or services are available for:

- domestic violence;
- forced marriage;
- FGM;
- sexual violence;
- GBV;
- trafficking in human beings.

Reception and social work staff may identify vulnerability and violence-related risks through individual assessments, case files and personalised support plans. It was also pointed out that in some systems the response to sexual violence and GBV is organised holistically, similar to the support provided to victims of torture (see Section 4.5.2 'Victims of torture'). The involvement of specific NGOs, certain ministries (those responsible for social welfare and family affairs, child protection or similar) and mental health and psychiatric support services was stressed as important, as was the need for coordination with actors organising protective shelters, where relevant.

Depending on the circumstances, cooperation with anti-trafficking units may be considered essential. Finally, respondents pointed out the need for staff training on vulnerability, trauma, mental health and related issues.

A major challenge pointed out by respondents is that trauma-informed and GBV-related approaches are not consistently and systematically integrated into national asylum and reception systems. In addition, there is no single comprehensive national guideline on TiC or a fully integrated GBV response framework. Relevant measures are therefore often spread across different laws, protocols, SOPs, projects and organisations. This can make the overall system difficult for staff and survivors to navigate.

Furthermore, only a small number of respondents indicated the presence of monitoring indicators within their asylum and reception systems related to GBV. This may indicate room for improvement in monitoring systems, specifically regarding:

- the number and types of GBV cases identified;
- the referrals made and outcomes documented;

- access to specialised services;
- the quality and timeliness of responses;
- survivor satisfaction and safety throughout the process.

Finally, safe disclosure mechanisms, survivor-centred interviewing, confidentiality and protection from retaliation, for example, are topics that may need additional focus.

4.5.4. Applicants and substance use

Analysis of the feedback received suggests that substance use is strongly understood as a potential comorbidity associated with psychological distress, trauma and other mental health difficulties. Experiences during the migration process appear to play an important role in this regard.

Respondents did not identify pre-existing problematic substance use as a significant concern. Rather, the feedback suggests that problematic substance use may develop or increase because of challenging circumstances following arrival in an EU+ country. Participants reported neither specific nor heightened concerns regarding increased crime rates or violence linked to drug use (or selling) within the reception context.

The main reasons reported for using substances were linked to the purposes of:

- numbing traumatic memories;
- managing anxiety and psychological distress;
- coping with sleep disturbances and insomnia;
- maintaining daily functioning;
- seeking peer acceptance and a sense of belonging, predominantly among younger, male applicants.

While this highlights the importance of addressing substance use within broader trauma-informed and mental health support frameworks, rather than treating it solely as a separate or behavioural issue, ensuring access to addiction specialists remains crucial once such needs are identified; however, respondents reported that this is not always possible in some countries.

Drugs indicated by respondents

Alcohol is the most commonly reported substance, followed by cannabis/weed.

Prescription and other psychoactive medications (e.g. pregabalin (Lyrica)) feature prominently and benzodiazepines are also frequently reported, including diazepam, lorazepam and clonazepam (Rivotril), and also other sedatives and sleep medications.

Other medications reported include antidepressants, sleeping pills and antipsychotic medication. Examples include zolpidem (Sanval), quetiapine and various sedatives, with some responses referring specifically to medication prescribed through psychiatric care and others leading in some instances to misuse of prescribed medication.

A range of illicit and controlled substances were also reported. These include cocaine, heroin, methadone and α-pyrrolidinovalerophenone (alpha-PVP).

Patterns of use appear to be highly individual. It was noted that the choice of substance can vary considerably, with applicants using both legal substances (e.g. alcohol and prescription medication) and illicit drugs in an effort to regulate distress or maintain functioning.

Compared with GBV, sexual violence and trafficking, substance use receives very limited explicit attention according to the information provided. This may indicate that it is not yet systematically addressed within asylum and reception policies. While respondents rarely mentioned specific access to dedicated addiction services, systematic screening or similar harm reduction services, they pointed out the crucial need for a holistic approach and strengthened cooperation between reception staff, NGOs and health professionals, such as addiction specialists.

The responses also highlight the importance of accessible mental health and psychosocial support, including the availability of medical teams covering both physical and mental health in reception centres, alongside psychosocial support, sports, leisure and creative activities.

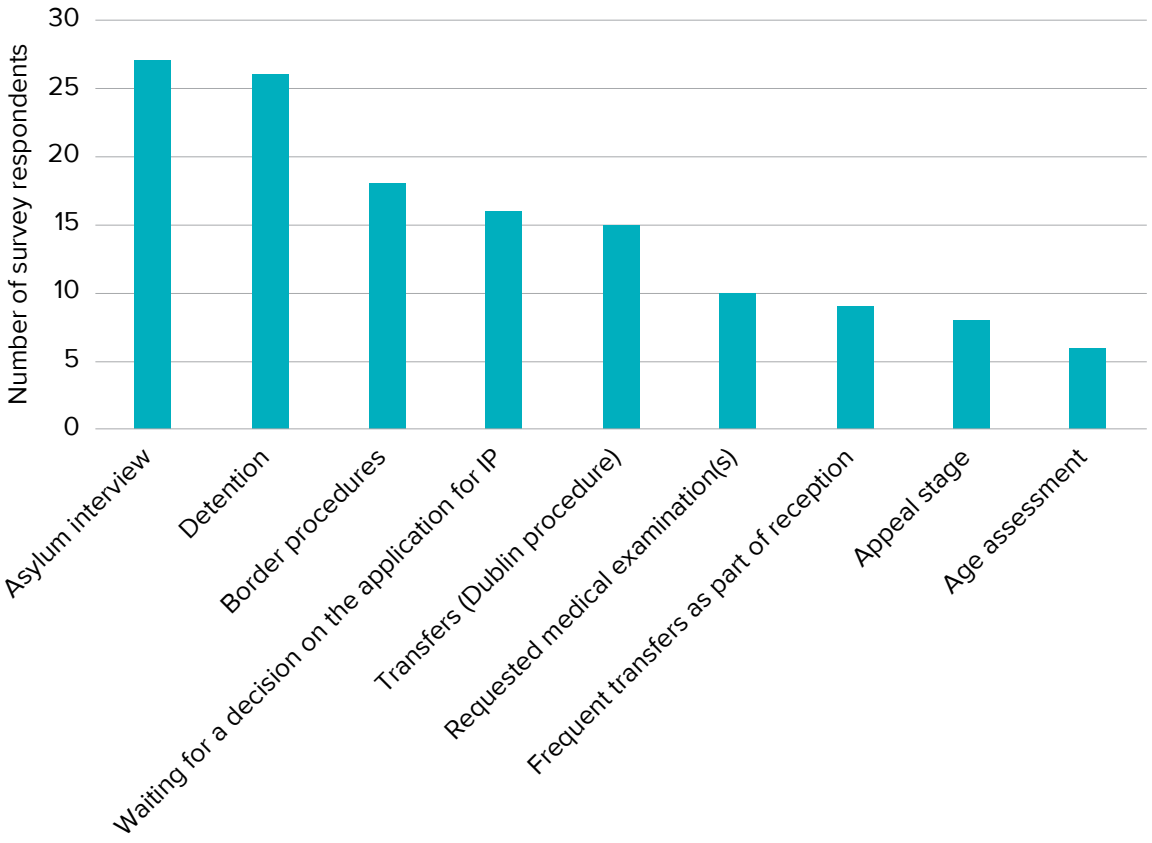
Finaly, training needs were pointed out by respondents; although topics linked to addiction are included in some training, requirements vary by staff role. This can create an inconsistent capacity to identify and respond to substance-use-related needs. Addressing how training needs link with mental health concerns may therefore be of benefit.

5. The asylum and reception pathway and risks of re-traumatisation

Respondents indicated that there are specific stages along the asylum and reception pathway where the risk of re-traumatisation is higher than at other times. Enabling first-line workers and preparing administrative systems during these stages can help create an environment that mitigates such risks.

In particular, the **personal interview** and **detention** were identified as contexts in which applicants are more likely to experience **heightened psychological distress** and may present with more serious mental health concerns if not supported accordingly (Figure 9).

Figure 9. Stages of the procedure and potential for re-traumatisation



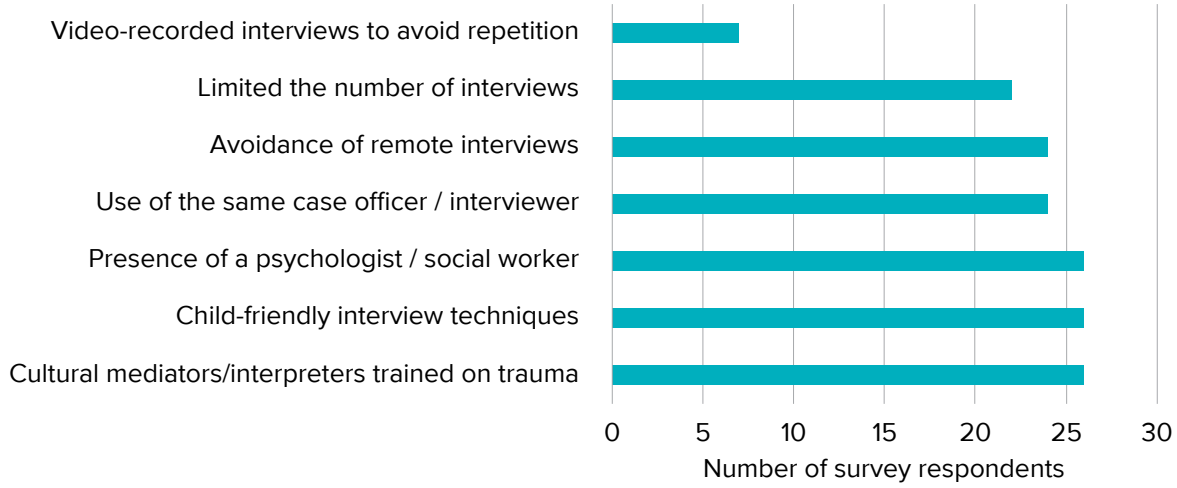
Source: EUAA, TiC survey, 2026.

Almost all respondents agreed that the **involvement of well-trained cultural mediators** and **interpreters** alongside access to **psychologists** or **social workers can support** applicants throughout the asylum and reception pathway, particularly during the **personal interview** or time spent in **detention**.

5.1. The personal interview

Having support persons present during the interview, such as cultural mediators and trained interpreters on trauma, was seen as essential for relieving distress. As for children, it was highlighted that **child-friendly interview techniques** are critical to create an atmosphere of comfort. Using the same **case officers** to hold the interview, should interviews be scheduled on more than one occasion, and **avoiding remote interviews** were also stressed as important to mitigate the risks of re-traumatisation (Figure 10).

Figure 10. Measures to safeguard applicants



Source: EUAA, TiC survey, 2026.

Additional practices mentioned included:

- better coordination and information sharing between professionals;
- gender-sensitive staffing arrangements;
- efforts to allow applicants time to stabilise before interviews;
- prior psychoeducation and legal information;
- use of audio-recordings to reduce interruptions and repeated retelling;
- focus on the importance of continuity, predictability and respectful communication throughout procedures;
- preparation and short opportunities before, during and after the interview to access **counselling support**.

Safeguards and data protection

Several countries clearly distinguish **care and support functions**, such as referring applicants to specialised services, identifying support needs or assessing appropriate accommodations, from **asylum-related decision-making functions**, such as assessing the protection claim or examining the credibility and consistency of an applicant's account.

This separation can help safeguard confidentiality and ensure that information disclosed in a care or support context is not automatically treated as evidence in the asylum procedure. Clinical and other sensitive information should be appropriately protected, with access limited to those who have a legitimate need to know.

At the same time, data protection and confidentiality should not become barriers to safeguarding or appropriate support. Effective trauma-informed systems require **clear protocols** for when and how relevant information can be shared lawfully, proportionately and securely between actors.

Where possible, applicants should be informed about what information may be shared, with whom and for what purpose, and their consent should be sought where appropriate. However, where consent is not required or cannot reasonably be obtained and there is another valid legal basis for sharing information – for example, where necessary to fulfil safeguarding or other legal obligations – this should be clearly understood by staff.

The objective is therefore to achieve an appropriate balance: **protecting applicants' privacy and autonomy while ensuring that relevant information does not remain siloed in a way that prevents authorities and service providers from responding to identified needs or risks**.

Clear roles, referral pathways, information-sharing protocols and staff guidance are essential to avoid a situation in which concerns are identified but no actor feels responsible, able or authorised to take action and address such needs.

5.2. Trauma-informed principles in practice

Respondents were invited to share information on how trauma-informed principles, such as safety, trust and transparency, predictability, choice and empowerment, collaboration and participation, cultural sensitivity and avoiding re-traumatisation, are applied in their daily work.

It was stressed that TiC starts with reducing uncertainty. Most respondents emphasised that **predictability is the foundation of psychological safety**. Respondents mentioned the importance of:

- explaining procedures, timelines and next steps;

- providing information on rights and available support;
- creating a calm, respectful environment;
- building trust from the first contact.

Respondents were also clear that **ensuring the autonomy of applicants and giving them choices** is crucial to maintain and manage well-being. Applicants are seen as active participants rather than passive recipients. In this regard, respondents mentioned the following elements to consider:

- explaining why sensitive questions are being asked;
- seeking consent before making referrals;
- involving applicants as much as possible in decisions that impact them;
- checking for understanding;
- allowing applicants to add information (e.g. during the personal interview);
- ensuring informed consent, particularly before sharing information or making referrals.

In terms of **collaboration, multidisciplinary approach and referrals**, almost every participating country mentioned collaborating with psychologists, psychiatrists, social workers, healthcare providers, NGOs and legal advisers. They also reported using established referral pathways for:

- mental health concerns;
- child protection;
- psychosocial support;
- victims of trafficking;
- victims of GBV;
- legal support.

This is one of the most consistently reported components across countries.

Respondents indicated that a shift in focus is needed and that trauma-informed work requires **adapting procedures** rather than expecting applicants to adapt. Some examples shared in this regard concerning the **personal interview** ([16]) were:

- allowing breaks, conducting several shorter interviews or postponing interviews;
- adapting the interview pace;
- avoiding unnecessary repetition and considering the emotional state of the applicant being interviewed;
- referring the person once concerns are noted, before continuing with the interview.

([16]) Mentioned by Cyprus, France, Germany, Greece, Lithuania, Slovenia and the EU-based umbrella CSO.

To create **trust**, respondents indicated the importance of **taking time** with the applicant, listening to them, communicating respectfully and 'seeing' the applicant for the person they are. Empathy and consistency throughout the engagement and contact was also stressed.

Rather than focusing only on procedures, respondents recognise that **relationships** themselves **are part of TiC** ([17]).

Highlights shared

TiC is much broader than a few selected guarantees or adjustments during the **personal interview** or **time spent in reception** ([18]). Respondents indicated that these practices should be integrated into the organisation of daily interactions and case management and into the structure of collaboration and coordination.

Rather than simply providing information, many respondents described the communication itself as an intervention ([19]) that communication was, in a way, therapeutic. They highlighted:

- using clear language;
- avoiding administrative jargon;
- speaking calmly;
- avoiding overwhelming applicants with too much information;
- cross-checking understanding;
- explaining limitations or reasons for potential delays.

There was also an understanding that TiC is not only about identifying trauma but also preventing procedural harm ([20]). For more practices, refer to Annex 1.4. 'Trauma-informed principles in practice'.

Aspects that seemed to be less of a focus or were only sporadically mentioned but still relevant when discussing TiC were:

- monitoring or evaluation of trauma-informed practice (not mentioned);
- trauma-informed service design informed by the lived experiences ([21]) of applicants and people who have navigated reception and asylum procedures (not mentioned);
- routine supervision or reflective practice (largely absent);
- strength-based or resilience-focused approaches (rarely mentioned);

([17]) Belgium (CSO), Croatia, France, Germany, Norway, Slovenia and Sweden particularly stressed trust building.

([18]) This broader understanding appears in feedback provided by Belgium, Germany, Luxembourg, the Netherlands and Slovenia.

([19]) This emphasis appears particularly strong in Germany, Greece, Lithuania and Norway, and also the CSOs.

([20]) Pointed out particularly by Greece, Lithuania, Serbia and Slovenia, and also CSOs.

([21]) Lived experience refers to understanding and knowledge gained through a person's own direct experiences.

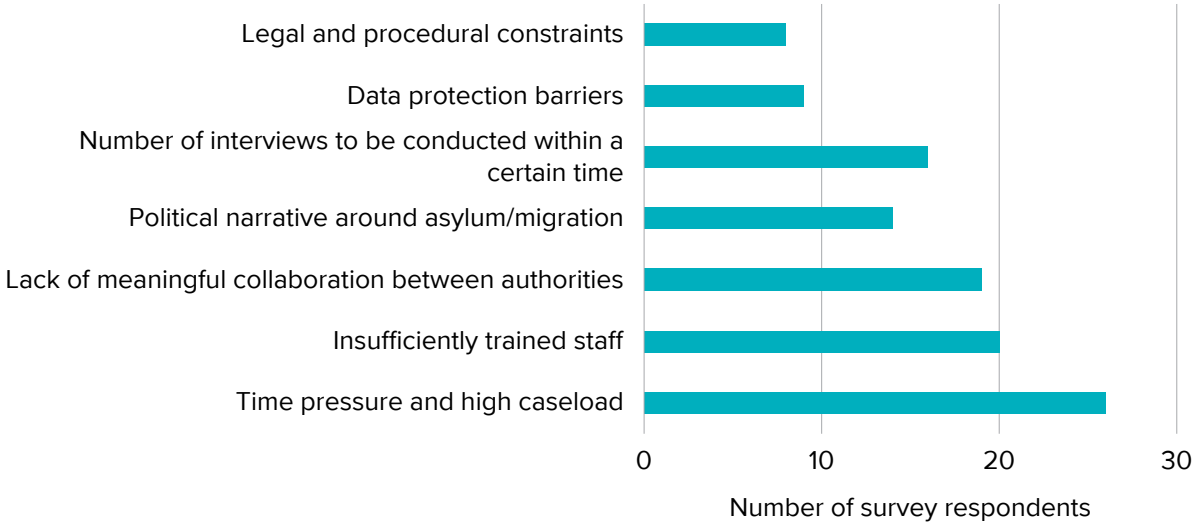
- staff well-being and secondary trauma support (limited mentions);
- cultural humility beyond interpreter arrangements (limited mentions).

When it comes to cultural humility, this is an approach based on openness, self-reflection and respect; therefore, it is crucial that professionals recognise they cannot assume they fully understand an individual's cultural background or experiences. Cultural humility also involves being aware of one's own assumptions and biases, listening to the individual's perspective and recognising that experiences and expressions of trauma, distress, safety and trust may differ across individuals and cultural contexts.

5.2.1. Challenges and dilemmas

Respondents shared some of the main challenges they noted regarding the implementation of TiC within their national asylum and reception contexts. High workload and time pressure ranked the highest (Figure 11).

Figure 11. Main challenges linked to rolling out TiC



Source: EUAA, TiC survey, 2026.

In addition, participants mentioned the following challenges.

- Burnout among staff and interpreters was noted, alongside a lack of free case supervision with a psychologist and insufficient psychological support within the service.
- There is an absence of a safe childcare space or play area for children during interviews with their parents or guardians.
- There is a lack of a structured support framework for applicants regarding housing, language learning, skills profiling and integration into the labour market.

- Limited access to timely psychological support and the absence of early-stage mental health assessments represent significant barriers and delay appropriate identification and support.
- Short lengths of stay in arrival centres make it difficult to identify applicants who have experienced trauma. Because not everyone can be identified in time, trauma-informed principles must be applied across various settings and by multiple actors, regardless of whether an individual applicant has been formally identified as having experienced trauma.
- Short stays in ordinary reception centres may similarly hinder the assessment and follow-up of trauma for applicants who are settled rapidly, such as Ukrainians granted collective protection.
- Unpredictable lengths of stay can make it difficult for reception and asylum staff to plan effectively if they must rely on external authorities to assess needs or initiate therapy and other treatment.

5.2.2. Monitoring and feedback

The survey findings suggest that requesting feedback from applicants – specifically regarding safety, respect and understanding procedures – is not systematically organised in most countries and could be improved. According to respondents, feedback, including the expression of certain needs or fears, is shared by applicants with first-line officers present in reception, but only on an ad hoc or informal basis.

Examples shared on monitoring and feedback

Respondents from **Belgium** indicated that a survey on the quality of reception is carried out among residents of the centres; safety and quality of care are covered in the survey.

Respondents from **Ireland** mentioned that all applicants who seek accommodation from the International Protection Accommodation Services (IPAS) are provided with an email address. They are encouraged to contact the reception authorities if they feel disrespected or unheard in their place of accommodation. IPAS operates an electronic help desk, which is reviewed by staff within IPAS. IPAS has a customer services team that visits centres to hear directly from residents regarding their concerns, and they notify relevant teams where follow-up is required. On occasions where a recurring pattern of complaints about centre management staff is notable, IPAS holds a multiteam clinic at the centre. Based on these interactions, an action plan is developed to address the issues, followed by a subsequent clinic to assess improvements.

While there was limited feedback on formal mechanisms for gathering applicant feedback regarding support services, some countries indicated that regular reviews of **personal interviews** and decisions are conducted to, for example, assess staff performance, reinforce good practices and ensure fair and proper case management.

5.2.3. Trauma-informed care and the implementation of the pact on migration and asylum

Almost all respondents indicated that the pact on migration and asylum presents opportunities to strengthen the asylum system while improving existing mechanisms linked to identification, support and referrals. Such potential improvements were particularly pointed out as important in ensuring earlier and more systematic identification of vulnerabilities and for improving timely access to specialised support services.

However, respondents also pointed out that, while having a mechanism in place is important, it is equally critical to have trained professionals in the field who understand the importance of early identification and will ensure that there is a coordinated approach to services provision and access to follow-up services (respondents pointed out a current lack of psychiatrists, psychotherapists and interpreters). Simultaneously, those providing the follow-up services should be better involved and informed in certain cases, particularly in instances where the applicant is disagreeing with certain treatment.

The pact introduces certain safeguards, guarantees and protection measures for vulnerable groups (particularly asylum seeking children), two mandatory opportunities to identify applicants for international protection are indicated: first, during the screening phase (vulnerability and health screening, pursuant to Article 12 of the Screening Regulation) and, second, through a vulnerability / best interest assessment (Article 25 of the Reception Condition Directive and Article 20 of the Asylum Procedure Regulation), to be conducted within 30 days of registration.

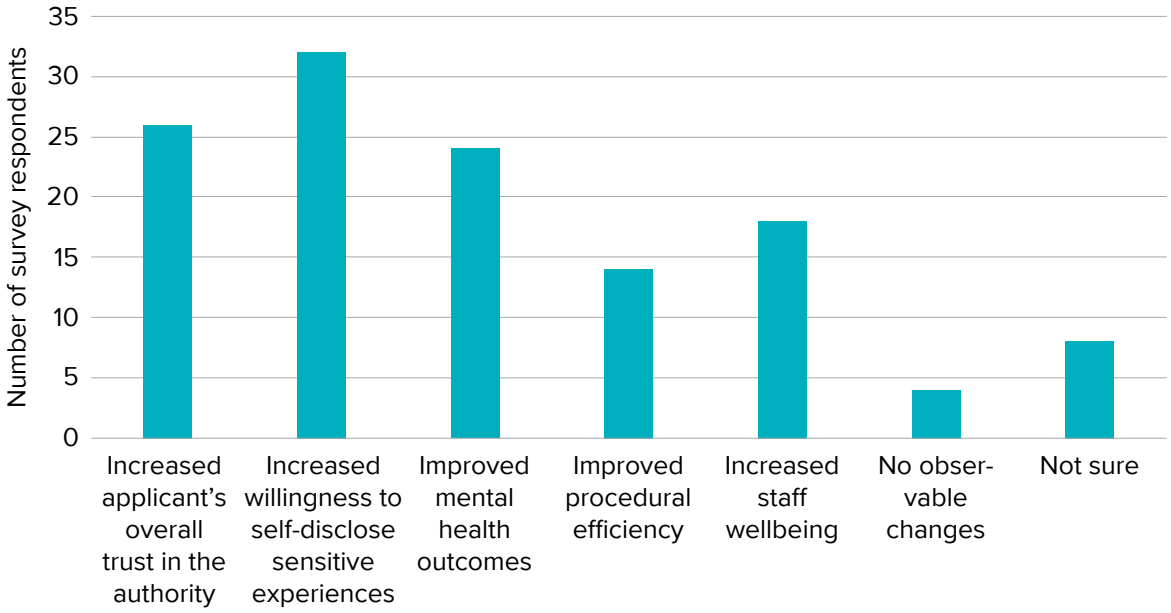
At the same time, however, the pact also promotes accelerated procedures and shorter procedural timelines. Given that existing mechanisms already face challenges in identifying psychological distress and other less visible needs, increased pressure for speed may further challenge authorities' capacity to identify and respond appropriately to such needs. This creates a tension between the objective of ensuring effective safeguards and the need to process applications within increasingly compressed timelines.

6. Trauma-informed care works

Respondents were invited as part of the survey to share:

- their experience regarding the positive impacts observed following the introduction of trauma-informed practices (Figure 12);
- direct feedback received from applicants during their daily work, showing how TiC has helped strengthen resilience, maintain well-being and manage mental health despite difficult circumstances.

Figure 12. Positive impacts observed following the introduction of TiC



Source: EUAA, TiC survey, 2026.

Respondents indicated that implementing a trauma-informed approach can increase an applicant's willingness to self-disclose and nurtures trust in interactions with the authorities. Interestingly, such an approach seems not only to benefit applicants but also to increase staff well-being. Below are statements shared by respondents indicating increased trust or empowerment as a result of the TiC approach taken.

Quotations

- ‘You’re the first person I’m telling this to.’
- ‘A woman who had been attending psychological counselling sessions for more than two years participated in her personal interview. She explained that, when talking to the asylum case officer, she imagined herself talking to the psychologist instead, which helped her open up to the officer about difficult parts of her life. Although she did not receive a positive decision, her overall self-confidence had increased, enabling her to approach the interview with greater confidence and experience less symptoms of secondary trauma afterwards.’
- ‘If you told me during the day that it was night outside, I would trust you.’
- ‘If I were to name a tornado, I would name it Miša, because if I were a land you would be the only one who could shake me.’
- ‘In several cases, people have told me, “I trust you”, or have specifically asked to speak with me first to share a concern or problem. I remember one particular case in which a female applicant sought me out in the office (I am male) to express concerns about pain in her groin. It turned out to be a urinary infection. I was surprised that she approached me first rather than the other staff members who worked directly with her, all of whom were women.’
- ‘I know that you are here to help me.’
- ‘When I saw the Red Cross logo, I knew I was in good hands.’

Finally, one respondent shared that:

‘I feel I must invest more time in developing my trauma-informed care skills and knowledge. I’m looking forward to do so in the near future. This survey has been eye-opening, meaning helping me to acknowledge how overlooked this particular issue is in my daily working environment and how I do it unconsciously but still would like to do it in a much more conscious and informed way.’

7. Discussion and conclusion

Small changes, like improving safety and privacy, or offering relevant mental health and psychosocial support at the right time, can make a big difference in how people cope with such a difficult period in their lives.

(Quotation by an expert working in the context of reception)

Overall, the work conducted by the EUAA on the mental health and well-being of applicants for international protection, together with the findings of this mapping exercise, indicates that TiC is increasingly recognised within asylum and reception systems. However, its implementation remains uneven and is often dependent on individual professional commitment, local initiatives and available expertise rather than being systematically embedded across organisations and procedures.

A central pattern emerging from the consultation is the tension between:

- individual professional commitment and systemic limitations;
- trauma-sensitive approaches and procedural pressures;
- emerging good practices and limited institutional standardisation.

At the same time, the responses demonstrate considerable readiness for stronger cooperation, the exchange of practices and capacity building. This provides a strong foundation for further work on harmonised training approaches, operational guidance, multidisciplinary cooperation, child-sensitive and survivor-centred procedures, safeguarding against re-traumatisation, and improved monitoring and organisational support.

7.1. From vulnerability identification to trauma-informed systems

Most countries participating in the mapping exercise reported using a vulnerability framework. Vulnerability frameworks and trauma-informed approaches are complementary, but they serve different purposes. Vulnerability assessments focus on identifying applicants with specific needs and determining the safeguards, guarantees and support required. A trauma-informed approach broadens this perspective by considering how trauma may affect behaviour, communication, trust and engagement, and by seeking to ensure that services, procedures and environments are delivered in ways that promote safety and reduce the risk of re-traumatisation.

In this sense, a trauma-informed approach does not replace vulnerability assessments. Rather, it strengthens the context in which they take place. The shift is therefore not only from asking ‘What are this person’s needs, and what safeguards or support do they require?’, but also to

asking 'What experiences may be influencing this person's behaviour and interactions, and how can the system respond in a supportive way?'

Importantly, adopting a trauma-informed approach does not necessarily require entirely new structures or procedures. In many cases, it may require a shift in **how** existing procedures, services and interactions are delivered, alongside targeted organisational adjustments.

Based on the responses received, a trauma-informed approach can support authorities in:

- identifying vulnerabilities and specific needs earlier and more effectively;
- strengthening case management and referral pathways;
- improving trust and cooperation between applicants and authorities;
- reducing the risk of re-traumatisation;
- promoting safer and more supportive reception environments including those whose needs have not yet been identified; and
- supporting staff well-being and professional resilience.

Ultimately, this can contribute to asylum and reception systems that are more responsive, fair and effective.

7.2. Considerations for implementation

Embedding trauma-informed principles may initially require additional time, training, coordination and organisational adaptation. However, responses to this mapping exercise suggest that these investments can strengthen trust and cooperation, facilitate earlier identification of needs, reduce the risk of crises and repeated interventions, and support staff well-being.

Several considerations are relevant.

- **Balancing procedural timelines with trust building.** Trust and disclosure often develop gradually. Creating repeated, non-intrusive opportunities and physical spaces for interaction, particularly following arrival can facilitate the identification of needs and improve engagement throughout the asylum process. Where appropriate, the involvement of family members and/or a support person may also be helpful. Importantly, applicants should have opportunities to approach staff outside scheduled appointments and speak with someone when they feel ready, without pressure to disclose information before they are comfortable doing so.
- **Adapting interviewing and assessment practices.** Understanding how trauma may affect memory, communication and disclosure can support more effective interviews while contributing to fair and informed decision-making ([22]).

([22]) Refer also to EUAA, *Mental health and well-being of applicants for international protection: Part III – Toolbox for the implementation of mental health and psychosocial support*, 2024, particularly p. 31.

- **Recognising invisible or hidden vulnerabilities.** Particular attention may be required for groups whose vulnerabilities are less visible, including children, young single men and applicants who may be reluctant or unable to disclose their experiences. Continuous observation and trust building can help ensure that needs are identified over time. This is important because children and young single men can be vulnerable in very different ways, and both can be missed by approaches that depend too heavily on visible vulnerability or immediate self-disclosure.
- **Addressing substance use and behavioural difficulties through a supportive lens.** Understanding substance use and certain behaviours as potential coping responses to adverse experiences can support responses that combine safety considerations with appropriate support and referral pathways.
- **Supporting staff well-being and professional capacity.** Staff working with trauma and vulnerability require appropriate training, supervision and organisational support to reduce stress and the risk of burnout and to strengthen professional resilience. A more holistic institutional approach to training – where trauma-informed principles extend beyond social workers, psychologists or case officers to include all actors interacting with applicants – seems relevant. Furthermore, consideration should be given to organisational and staffing conditions, including adequate staffing levels, manageable caseloads and, where appropriate, reduced or more flexible working hours for professionals regularly exposed to highly demanding or traumatic cases. Such measures could help mitigate fatigue and secondary traumatic stress, while supporting professionals' capacity to maintain consistent, trauma-sensitive and high-quality engagement with individuals ([23]).
- **Investing in organisational adaptation.** Targeted adjustments to procedures, communication and inter-agency cooperation can strengthen coordination and case management and reduce the likelihood of crises, re-traumatisation and repeated interventions.
- **Promoting cultural sensitivity and reducing stigma.** Awareness of different understandings of trauma, including psychological distress, mental health concerns, gender roles and help-seeking behaviour, can strengthen communication, trust and engagement.
- **Combining universal and targeted approaches.** A trauma-informed approach provides a preventive, system-wide perspective, while vulnerability assessments remain essential to ensure that applicants with specific needs receive appropriate support and procedural safeguards. Integrating trauma-informed principles into the mechanisms for identifying specific needs established under the pact on migration and asylum can therefore strengthen both the implementation of these safeguards and the overall functioning of asylum and reception systems.

A trauma-informed approach should not be viewed as an additional burden on asylum and reception systems, but as an investment in their effectiveness and sustainability.

([23]) Also refer to the EUAA threefold guidance on the welfare of asylum and reception staff: Part I, Part II and Part III.

While implementation may initially require additional resources and organisational effort, embedding trauma-informed principles can support the earlier identification of needs, improve cooperation between applicants and authorities, reduce the risk of critical incidents and re-traumatisation, and strengthen the well-being of both applicants and staff.

Ultimately, TiC offers an opportunity to ensure that **how** asylum and reception systems operate is as responsive to applicants' needs as **what** safeguards and services those systems provide.

To conclude, the EUAA vulnerability team remains committed to supporting EU+ countries interested in integrating TiC into their practices in the years to come. For more information on the work by the EUAA vulnerability team on the topic of TiC or to provide comments and feedback on this publication, please contact: vulnerablegroups@euaa.europe.eu.

Annex 1. EU+ country examples

As part of the survey, participating countries were invited to share their trauma-informed practices, including details about related challenges and opportunities.

Not all countries responded to every question or thematic area and therefore not all countries are listed under each heading. Furthermore, in some countries, authorities are supported by CSOs, and their input has been integrated. Responses were provided not only by the relevant authorities but also by international organisations and/or CSOs in the following countries: Belgium, Bulgaria, Germany, Luxembourg, the Netherlands, Finland and Sweden.

Below is a collection of the overall practices shared, by thematic area.

Annex 1.1. Multidisciplinary approaches

Belgium

Belgium indicates a strong commitment to:

- preparing first-line officers;
- institutional training.

Finland

Finland provides examples of embedding principles without 'explicit terminology'. Its approach stresses the importance of safety and trust, while making reference to structured e-learning development and mental health guidance.

Other effective elements highlighted by participants include:

- standardised assessments;
- specialised focal points;
- individual case plans;
- priority procedures.

In terms of child-centred and guardianship approaches it was pointed out that strong elements are:

- the best interest principle;
- relationship-based care;
- empowerment-oriented methodology;
- adapted communication.

When it comes to safety- and trust-oriented reception environments, Member States consistently emphasised the importance of:

- calmness;
- predictability;
- relational trust;
- dignity;
- community orientation.

Italy

The ***Handbook for the identification, referral and care of persons living with vulnerabilities entering Italy and within the protection and reception system*** ([24]) reflects several TiC principles in practice. It was drafted through a multi-agency collaboration, involving the Ministry of the Interior (various departments), the Ministry of Health, the tax and customs police, the coast guard, the Office of the United Nations High Commissioner for Refugees, International Organization for Migration, the United Nations Children's Fund, the EUAA, the European Border and Coast Guard Agency, the European Union Agency for Law Enforcement Cooperation and other national and international partners. Its entire approach is interinstitutional, aligning directly with the trauma-informed approach principle of shared decision-making and cooperation. It focuses on providing immediate protection, early identification of vulnerabilities and access to appropriate services for people arriving in Italy. It outlines detailed procedures for detecting psychological, physical and trauma-related vulnerabilities, particularly for newly arrived migrants. This operational emphasis creates safe environments and ensures the physical and psychological security of individuals. The document establishes uniform procedures, standardised referral mechanisms and coordinated practices among all actors in the reception system: police, health services, the Italian reception and integration system, United Nations agencies, NGOs and others. By formalising clear responsibilities and predictable steps, the handbook fosters transparent processes that help build trust, a core of the trauma-informed approach. Empowerment appears indirectly in the emphasis on timely referral to competent services, supporting individuals' recovery and autonomy. Cultural sensitivity is reflected in the involvement of international agencies specialising in migrant protection and in the adaptation of procedures to diverse cultural backgrounds.

In addition, in 2017, the Italian Ministry of Health issued national guidelines ([25]) titled, adopted by the ministerial decree of 3 April 2017. They require multidisciplinary assessment involving psychiatry, psychology and cultural mediation; evidence-based and trauma-focused clinical pathways; and standardised procedures for rehabilitation

([24]) Italian Ministry of the Interior, *Handbook for the identification, referral and care of persons living with vulnerabilities entering Italy and within the protection and reception system*, 2023.

([25]) Guidelines: '*Linee guida per l'assistenza, la riabilitazione e il trattamento dei disturbi psichici dei rifugiati e delle persone che hanno subito torture, stupri o altre forme gravi di violenza*', 2017

and treatment. The guidelines are applicable to refugees, subsidiary protection holders and asylum seekers with histories of severe violence, and function as Italy's core national standard for conducting psychological and psychiatric assessments of vulnerable applicants (for international protection).

The Netherlands – Central Agency for the Reception of Asylum Seekers

The Central Agency for the Reception of Asylum Seekers (COA) provides high-quality guidance to residents, empowering and enabling them to be self-reliant in an unfamiliar environment. In this way, they can take responsibility for their own future early on and contribute to society. For residents whose asylum applications are unsuccessful, guidance si provided as it relates to return processes.

COA's mission, vision and core values are reflected in national, regional and local policies and working methods. The methodology used by Nidos for guardianship is based on TiC principles. The child is seen as an individual, and the methodology is based on the child's needs. Principles such as safety, empowerment, collaboration, trust and cultural sensitivity are mainstreamed in the methodology and all policies and guidance that are used.

Slovenia

Slovenia integrated TiC principles into asylum law without using TiC terminology directly.

Elements include:

- individual assessments;
- adapted reception conditions;
- prioritisation of vulnerable cases;
- safeguards for minors;
- culturally sensitive interviews.

Furthermore, **Czechia, Spain, Italy and Slovenia** emphasised the importance of avoiding repeated trauma narratives, while **Italy, the Netherlands and Finland** seem to prioritise a stabilisation-first approach (safety, rest, predictability) before entering into detailed questioning. **Spain, Italy, Luxembourg and Slovenia** pointed out the value of a holistic and integrated approach that integrates social, legal, psychological and medical care, and **Italy, Luxembourg and Serbia** specifically pointed out the importance of using a 'do no harm' approach and following through with psychological first aid.

Annex 1.2. Victims of torture

Belgium

While medico-legal reporting may be proposed, it is often limited (e.g. to a very short report) due to a lack of means. Referrals to entities for investigation are generally not made.

Bulgaria

When signs of torture or other forms of inhuman or degrading treatment are identified during medical or vulnerability assessments, applicants may be referred to specialised medical, psychological or social support services. Such support is often provided through cooperation between reception facilities managed by the State Agency for Refugees, healthcare providers and NGOs.

With the consent of the applicant, medical or psychological findings may be documented and used to support the asylum procedure, including as part of medico-legal documentation, where available. In certain cases, applicants may also be referred to specialised organisations providing rehabilitation for torture survivors or legal assistance. However, the availability of specialised medico-legal documentation and systematic referral mechanisms may vary depending on the reception facility and the presence of partner organisations.

Croatia

In cases where signs of torture or other inhuman treatment have been identified, the applicant is referred to an expert (psychiatrist or psychologist) for further treatment. With the applicant's consent, information about these signs is forwarded to decision-makers, but only if the applicant's behaviour or experiences could negatively affect the conduct and outcome of their interview.

Cyprus

If an officer notices signs of torture, they can refer the applicant to the medical and mental health services for further support. However, this is only done with the consent of the applicant.

Denmark

When signs of torture are detected, the applicant is referred to a doctor for subsequent referral to a psychologist or psychiatrist. Evaluations from treatment processes are often forwarded to authorities so that they can be included in the processing of the case. In some cases, referrals to war crime investigation units or other authorities are carried out.

Estonia

The applicant is offered the opportunity to receive free psychological assistance (e.g. see a psychologist); however, this information is generally not used for follow-up. In the case of war crimes, the applicant is referred to a war crime investigation unit only if they consent to this referral.

Finland

Applicants have access to a medical doctor and therapy as required. The medico-legal report is shared with the asylum authority with the consent of the applicant. Currently, Finland does not have existing experience of or procedures for handling cases involving war crimes. **Spain**

In Spain, the applicant receives coordinated support from a psychologist, lawyer and social worker, with each acting strictly within their professional scope: psychological care addresses emotional and trauma-related needs; legal assistance ensures rights protection and preparation of all asylum documentation; and social work covers practical support and access to services. When required, the applicant is referred to external specialised entities for medico-legal reports to strengthen the asylum claim.

France

If signs of torture or inhuman treatment are identified, the asylum seeker may, at the end of the personal interview, be referred to a doctor or a mental health professional using the referral brochure made available to protection officers.

However, a medical certificate is never a prerequisite for the examination of an application (for international protection) by the Office français de protection des réfugiés et apatrides, except in cases where FGM is suspected. In such cases, the applicant will be referred to a forensic medical unit for a medical examination, which is necessary for the processing of the application. In other cases, when a medical certificate is provided by the asylum seeker, this allows the application (for international protection) procedure to be adapted – for example, by enabling the presence of a mental health professional during the interview or by postponing the applicant's appointment date. It also ensures other actors are informed of the alleged ill-treatment and the applicant's ability to describe the events, which are factors taken into account during the examination of the application.

Furthermore, if the alleged perpetrator of torture or inhuman treatment is present in France, the office may report the matter to the relevant authorities.

Germany

Support includes referral to counselling, establishing contact with specialised services and, if necessary, the provision of initial medical assistance via emergency departments, violence protection clinics or on-site paramedics.

The availability of support is dependent on the federal state and proximity to urban centres. Generally, connecting applicants to specialised treatment for torture victims is extremely difficult, and virtually impossible in rural areas. The few specialised services available have long waiting lists.

Such information is forwarded to the competent federal office for migration with the applicant's consent. This office will carry out the necessary verifications. Social services can provide details of contact points to the person concerned and support them with appointments if necessary.

Greece

Depending on the indications identified, the applicant and presumed victim of torture is referred to specialised professionals within public services or NGOs, so that any reports or certificates issued may be used in the examination of their asylum case, and to ensure they receive specialised assistance and support.

Iceland

Applicants are supported by general practitioners, nurses, psychologists, social workers and support staff, and are provided with the best housing available. Information may be shared with legal representatives in the reception country if it is considered beneficial.

Ireland

Applicants are advised to attend a general practitioner to request a referral to an appropriate service when the assessment officer receives information that the applicant has experienced torture or inhuman treatment in their country of origin. The specialist service can make an independent decision regarding any follow-up required by the applicant, including a medico-legal report.

Italy

When signs of torture or other inhuman or degrading treatment are identified during checks, intake or early assessments, the applicant is promptly referred to specialised health, psychosocial and protection services within the national health service and the reception system.

Support includes:

- medical care;
- psychological and psychiatric assistance;

- social support and protection measures, in line with the Ministry of Health guidelines on assistance to victims of torture and violence (2017) ([26]) and Società Italiana di Leadership e Management in Medicina (SIMM) recommendations.

The person is informed, in a language they understand, about available services, rights and possible procedural safeguards (e.g. special procedural guarantees in the asylum procedure). Any further assessment is conducted by qualified and trained professionals, avoiding repeated or unnecessary recounting of traumatic experiences.

With the informed consent of the applicant, findings may be documented through medico-legal and/or psychosocial reports, which can be used to support the application (for international protection), particularly to substantiate vulnerability, credibility assessments and the need for procedural adaptations.

Such documentation is shared with asylum decision-makers only in summary or certification form, respecting professional secrecy, data minimisation and General Data Protection Regulation principles.

Consent-based referrals may also be made to specialised NGOs, rehabilitation centres or anti-violence services for longer-term support and recovery.

Lithuania

When signs of torture or inhuman treatment are identified, the applicant is supported through a trauma-informed approach, ensuring emotional safety, confidentiality and respect. Immediate psychological support is provided, focusing on stabilisation and the person's current needs.

With the informed consent of the applicant, relevant information may be used for follow-up actions, such as referral for specialised mental health care or medico-legal documentation to support the asylum procedure. Where appropriate, the person may also be referred to organisations that document human rights violations.

The applicant is always informed about the purpose of sharing such information, and their autonomy and choice are respected at all stages.

Luxembourg

Where there are signs of torture or inhuman treatment, the approach focuses on protecting and informing the individual. Identification may take place during reception or through actors on the ground (National Reception Office, NGOs and medical staff). The individual is referred to specialist services (medical care, psychological support, social support).

([26]) Guidelines: '*Linee guida per l'assistenza, la riabilitazione e il trattamento dei disturbi psichici dei rifugiati e delle persone che hanno subito torture, stupri o altre forme gravi di violenza*', 2017

Any use of the information (e.g. medical certificates) is made solely with the applicant's informed consent. Where relevant, and always with the applicant's consent, referral to competent services (legal or international) may be considered.

Asylum authorities indicated that the evaluation of special procedural guarantees is governed by Article 19 of the amended Asylum Law of 18 December 2015. This applies to international protection applicants based on factors such as age, sex, sexual orientation, sexual identity, disability, serious illness, mental disorders, or status as a victim of torture, rape or other serious violence (e.g. FGM). If signs of torture or inhuman treatment have been identified and the ministry confirms the need for special guarantees, the applicant is granted adequate support, a suitable interview framework and sufficient time to prepare their application. Interviews for vulnerable persons can be adapted – for example, several breaks are permitted, the interview may be postponed depending on the state of the person or, in some cases, the applicant may be permitted to submit their statement in writing. In addition, applicants are entitled to have any signs of torture examined by a doctor, if necessary.

Luxembourg – *feedback by CSO*

If a case involves an identified torture victim, the CSO refers the person to a medical doctor who can prepare an appropriate report if the person wishes. The applicant is free to use this report in their claim, but this information is not provided to or requested by the CSO.

The Netherlands

Young people are informed verbally by their guardian of why sharing information relevant to their asylum procedure is important, as this information can be used in the event of an appeal.

Norway

UDI has, among other things, developed a guideline (UDI 2024–011) that defines torture, and provides an overview of Norway's obligations towards asylum seekers who have been subjected to torture and builds on a review report by FAFO ([27]). This guideline is intended to assist case managers in assessing allegations of torture within applications for protection. It also provides an overview of how an applicant's exposure to torture can affect the asylum procedure and their reception conditions.

Portugal

There is a specialised team that identifies and deals with applicants who are presumed victims of torture or victims of human trafficking.

([27]) Fafo, *A review of Norway's obligations, with recommendations for practice*, 2021

Serbia

1. Support for identified victims

When signs of torture or inhuman treatment are identified, beneficiaries (asylum seekers, migrants) in the centres in Serbia are entitled to the following support.

- **Medical and psychological care.** Victims receive specialised psychiatric and psychotherapeutic services focused on healing and preventing re-traumatisation. This begins within the centres (where general practitioners, nurses and psychologists work as a team) and extends to state health centres, mental health departments and specialised NGOs, such as the International Aid Network and the Psychosocial Innovation Network.
- **Legal aid.** NGOs provide free legal representation to ensure that the applicant's vulnerability is officially recognised throughout the asylum process.

2. Use of information and consent

The use of sensitive information for follow-up is strictly governed by the beneficiaries' informed consent.

With the applicant's consent, specialised medical and psychological reports are drafted following the Istanbul Protocol. These reports serve as critical evidence to support the asylum claim by documenting the physical and psychological consequences of torture.

There are also SOPs for interacting with suspected victims of human trafficking. These protocols clearly outline the mandatory steps for reporting suspected cases. Upon receiving a report, the Centre for Protection of Victims of Human Trafficking required to initiate the identification procedure immediately, and no later than 24 hours from the initial notification.

Slovenia

When signs of torture or inhuman treatment are identified, applicants are approached in a sensitive and non-intrusive manner, respecting their pace and willingness to disclose. Immediate support is provided through social work and individuals are referred to appropriate services, including psychiatric and medical support.

Cases are addressed through multidisciplinary cooperation, and specific procedures (e.g. SOPs or anti-trafficking mechanisms) are activated where relevant to ensure coordinated and appropriate intervention.

Any further use or sharing of information is strictly based on the informed consent of the applicant and in line with data protection and confidentiality standards. Where appropriate, applicants are informed about the possibility of medico-legal documentation or other forms of support relevant to their asylum procedure.

Sweden – *feedback by CSO*

Although the initial health assessment rarely identifies signs that a person is a presumed victim of torture (because it does not systematically screen for trauma), if a healthcare professional notices indicators during general questioning, the person can be referred to the regional healthcare system for further assessment ('care that cannot wait'). They may also be referred to specialised services, such as the Swedish Red Cross treatment centres if available locally. Any sharing of information for medico-legal purposes occurs only with explicit consent, based on Swedish confidentiality rules.

Annex 1.3. What works to nurture self-disclosure and limitations

Belgium

What works well in reception is taking time and listening actively. It is important to ask sensitive questions (e.g. about sexual violence, sleeping problems) so that applicants know they can ask for help if they experience difficulties. Otherwise, they might not know it is possible to get help. Group sessions about sleeping difficulties, FGM and sexual health, for instance, can also help to open up discussions, and reasons to look for help can be addressed during these sessions.

Bulgaria

Early identification of severe psychological distress is supported by basic medical screening and vulnerability assessments conducted in reception facilities, and also cooperation with social workers, healthcare providers and NGOs. Interpreters and cultural mediators can also facilitate communication and help applicants' express concerns about their well-being. In some cases, trust-building interactions with social workers or NGO staff encourage applicants to disclose experiences of trauma or distress.

However, several challenges remain. Severe distress or trauma-related symptoms may not be immediately visible, and applicants may hesitate to disclose sensitive experiences due to fear, stigma, lack of trust or uncertainty about how the information will be used in the asylum procedure. Limited time during initial intake procedures, language barriers and the availability of specialised mental health professionals may also affect early identification. As a result, some cases of psychological distress are identified later during the reception period rather than immediately upon arrival.

Cyprus

During the vulnerability assessment, vulnerability officers try to provide a safe environment and offer support in order to make the applicant feel welcomed and safe to express what happened to them.

One of the main limitations in identifying severe psychological distress at an early stage is that applicants may not be able to disclose their history due to not feeling protected. Furthermore, individuals may not know that what happened to them could be considered trauma require follow-up care.

Czechia

A limitation is the willingness and capacity of the health sector (psychiatric care) to take in applicants for international protection and provide them with support. Furthermore, those applicants who undergo psychiatric assessments and are prescribed medication often tend to be unwilling to adhere to their prescribed treatment.

Estonia

The main limitation mentioned was that in a new, stressful situation (e.g. at the border, at the airport, upon arrival at the reception centre), the applicant is not yet ready to open up and therefore it is difficult to identify severe psychological distress.

France

The benefits of early identification include better support for asylum seekers during the asylum procedure. It allows them to provide documents (particularly medical documents) that facilitate the examination of their application (for international protection). In addition, having already started psychological care helps applicants articulate their experiences during the personal interview.

Obstacles to early identification include a lack of financial resources (which often results in a shortage of interpreters) and the fact that some asylum seekers may not follow the 'standard' pathway upon arrival (e.g. applicants in the Dublin ([28]) procedure). Furthermore, a lack of psychological availability presents a significant barrier: individuals struggling for their physical survival due to, for example, a lack of housing or food are not mentally able to focus on anything beyond survival.

Germany

In general, it was noted that it helps to take the person seriously and convey a high level of attention. It is helpful to explain positively that no one is obliged to share anything, but that symptoms need to be established in order for the most specialised/appropriate support or assistance to be provided. A high level of transparency and an initial trust gesture often also helps, as does explaining that information from the conversation cannot be shared without the person's consent.

([28]) This mapping report was formulated before application of the pact on migration and asylum and the application of the Asylum Migration Management Regulation (AMMR).

Immediately upon arrival, people are often exhausted, disoriented and uncertain. Some individuals fear state structures, are unable to assess the existing services and organisations or cannot anticipate the potentially adverse effects of not disclosing personal information regarding trauma. Some parents may fear that they may have their children taken away if they report emotional distress or mental instability. They also may believe that psychological distress could impact their application (for international protection) negatively. Some individuals indicate fear of foreign intelligence services using their information. Furthermore, applicants and certain staff may lack knowledge about mental health issues and, not least, the fact that symptoms sometimes only emerge after some time, when people find peace in a calmer environment.

Greece

Effective practices include the use of trained first-line staff, structured procedures for vulnerability identification and cooperation with public and NGO services, all of which support the early detection of psychological distress. Main limitations include language barriers, limited time during initial stages and the fact that applicants may not immediately disclose sensitive information due to fear or trauma. Efforts to encourage self-disclosure include providing a safe and respectful environment and using interpreters and trauma-informed communication approaches.

Iceland

While the EUAA Special Needs and Vulnerability Assessment ([29]) tool is used soon after an applicant's arrival, it is often better to delay the assessment to allow the applicant time to settle into their new surroundings.

Ireland

Early identification of needs, timely referral to appropriate services and prompt access to support can help to reduce psychological distress. Applicants are encouraged to disclose any mental health needs during the vulnerability assessment and are provided with information regarding support services and referral pathways. If an applicant presents with acute distress, they are referred to on-site health professionals who, depending on the severity of need, may refer the applicant to the accident and emergency department of the local hospital.

Italy

Early identification benefits from the presence of trained first-line staff, including health professionals, social workers, personnel from international and European agencies, NGOs and cultural mediators, particularly during disembarkation and first reception. Use of non-intrusive observation, psychological first aid and basic vulnerability screening allows early recognition of acute distress without requiring the disclosure of traumatic events.

([29]) Refer to the EUAA online Special Needs and Vulnerability Assessment tool for more information.

Multidisciplinary teamwork and referral pathways within the national health service facilitate timely access to specialised care when warning signs are detected. Continuity of support in small-scale or community-based reception settings also favours trust building.

Key challenges include time pressure and emergency conditions upon arrival, high caseloads, overcrowded facilities and frequent transfers, all of which hinder continuity and follow-up. Severe psychological distress may be masked by shock, exhaustion or cultural expressions of suffering, making early detection difficult. Language barriers, fear of authorities, stigma around mental health and concern that disclosure could negatively affect the asylum procedure further limit self-disclosure. In some contexts, the availability of specialised mental health services is uneven across territories.

Specific efforts include creating safe, predictable and non-coercive environments; using cultural mediators; providing clear information about rights, confidentiality and the separation between care and asylum decision-making; and avoiding repeated or immediate detailed questioning. Trust is fostered through using gradual engagement, ensuring the consistency of personnel, using gender- and child-sensitive approaches and offering support proactively rather than waiting for explicit requests. Self-disclosure is encouraged over time rather than expected at arrival.

Lithuania

What works well in identifying severe psychological distress at an early stage is the use of a trauma-informed approach, by ensuring attentive listening, observing non-verbal cues and creating a safe and respectful environment. Building trust, even briefly, helps individuals feel more comfortable expressing their distress.

However, several limitations exist. At the early stages (e.g. upon arrival), individuals are often in survival mode and may feel unsafe, distrust authorities or experience language barriers, which makes disclosure difficult. Time constraints and a lack of continuity of care can also limit proper assessment. To nurture self-disclosure, efforts are made to ensure clear communication, for example using interpreters when needed and having a non-judgemental attitude. Giving individuals time and focusing on immediate needs rather than detailed trauma narratives also supports gradual disclosure over time.

Luxembourg

Trauma-informed practice is paramount, and that is why staff are trained in psychological first aid (among other relevant mental health topics, such as suicide risk evaluation). Access to trained staff is crucial to detecting psychological distress as soon as possible, identifying needs and then guaranteeing safe and need-based referrals. Self-disclosure is only possible if the person can trust the process and the staff involved; that is why trained and supervised staff are needed. The person in distress is offered a safe space to share without any pressure and given safe referral pathways. Obstacles to identification include a lack of access to specialised staff (psychologists, psychiatric nurses) and/or trained staff (in mental

health and psychosocial support) within reception centres (first reception centre or long-term accommodation), feelings of stigma surrounding mental health issues, and also low mental health and health literacy, among other obstacles.

In the context of reception, the presence of trained staff, access to interpreters and effective coordination and collaboration between different services facilitate the early identification of vulnerabilities.

Limitations/barriers include under-reporting due to fear, mistrust or trauma, and linguistic and cultural barriers. Symptoms may also emerge at a later stage.

To encourage self-disclosure, efforts are made to build trust through clear information on rights, regular and non-intrusive interviews, and ongoing support. Trauma-informed approaches and consistent support staff gradually encourage the expression of needs.

The Netherlands

The main role of the guardian is to establish trust and provide the young person with information, as it is important for young people to know that mental health services are there to support them.

As for the main limitations, language and cultural barriers are stressed, as is the feeling of shame, a lack of understanding of the role of the guardian and a lack of understanding of how mental health services can be helpful.

Portugal

Timing is important in relation to identification. For example, registering an application or requesting accommodation are not the best times to evaluate specific needs, as these are already stressful situations.

Serbia

Effective practices include the following.

- **24/7 monitoring and early identification.** Officers from the Commissariat for Refugees and Migration are present in the centre 24/7. Their constant presence allows them to observe signs of distress and raise a ‘red flag’ when necessary. Staff are specifically trained to identify psychological suffering and follow established referral pathways to specialised services.
- **Systematic screening.** Upon admission, the IPSN tool is used for every individual, with all findings documented and maintained in official records.
- **Mental health and psychosocial support teams.** Specialised NGOs operate directly in the centres. Their presence facilitates the identification of distress at an early stage.

- **Cultural mediators.** The use of trained translators who understand the cultural nuances of distress (e.g. how trauma is expressed somatically rather than verbally) serves as an effective bridge for early detection.
- **Multisectoral cooperation.** The established referral pathway between the Commissariat for Refugees and Migration and mental health institutions and also NGOs ensures that, once 'red flags' are spotted, clinical help is relatively accessible.

The main limitations and obstacles identified are as follows.

- **The 'transit mentality'.** Many individuals view Serbia as a transit country. They often suppress symptoms or hide distress to avoid being 'stuck' in a medical or legal process that might delay their journey.
- **Shortage of cultural mediators.** Due to budget constraints, there is a shortage of cultural mediators, particularly for certain languages.
- **Geographical disparity in healthcare.** A critical challenge is the acute shortage of specialised medical services in smaller municipalities. Access to paediatric specialists, such as child physiatrists, is severely limited outside major urban centres, causing significant delays to diagnosis and therapy.
- **Accounting for the migration journey.** Current diagnostic practices sometimes fail to adequately account for the migrant experience, which is inherently traumatic. Challenges arise when clinical assessments treat symptoms in isolation, without considering the cumulative trauma of displacement, loss and the journey itself.
- **Need for culturally sensitive intervention.** Effective treatment for these vulnerable groups requires specialists who can distinguish between developmental/psychological disorders and complex post-traumatic stress disorder or trauma-related responses specific to refugees. The shortage of such specialised expertise in local health centres remains a critical barrier to providing holistic care.

Slovakia

First the person must feel safe in the new environment and create a relationship of trust with the professionals from the reception centre. Exchange of information, relevant training, etc., can be helpful in this regard. What works quickly is determining if any indicators are already visible and considering how the person's current situation might reveal immediate needs.

Slovenia

Early identification of psychological distress is supported by continuous daily contact between applicants and staff, particularly social workers, which enables trust building and observation over time. A person-centred and flexible approach allows for the gradual disclosure of needs, rather than relying solely on one-time assessments. Multidisciplinary cooperation and specific procedures (e.g. SOPs, anti-trafficking mechanisms) further support the identification of vulnerabilities.

However, there are important limitations. There is no systematic or early-stage access to psychological assessment, and support is typically limited to later referrals (e.g. psychiatric services), which may delay the identification of trauma-related needs.

Identification also often depends on self-disclosure, which may be hindered by fear, mistrust, stigma or cultural and language barriers. In addition, limited and inconsistent availability of qualified interpreters can affect communication and the accurate identification of vulnerabilities.

Efforts to nurture self-disclosure include building a relationship of trust, ensuring a safe and non-judgemental environment, providing clear information about rights and available support and maintaining a consistent presence of staff.

Spain

The main limitation occurs during large-scale arrivals along the coast. In these scenarios, it is not possible to carry out proper initial identification of vulnerabilities or referrals due to the limited number of places available within the reception system.

As a good practice, NGOs take into account the initial vulnerability report prepared by the Red Cross for the initial interview. In cases of large-scale arrivals where vulnerabilities could not be identified at the outset, the NGO conducts an initial interview, taking into consideration the limited information that may have been collected beforehand in order to identify additional vulnerabilities.

It is important to review every prior report in order to identify vulnerability. A first interview is a must. In some cases, several sessions are needed in order to assess properly the impact of trauma. Communication with colleagues involved in the applicant's process is necessary in order to exchange information and views. An effective approach is to combine trust building with psychoeducation through group workshops; this allows the applicant to increase their trust in the team, while enabling the team to detect certain needs. A noted limitation is that applicants prioritise 'survival' and adaptation to the new context over engaging in deep trauma work. Consequently, providing a safe and stable environment is effective, as this allows applicants to gradually open up when they feel ready.

Sweden

Effective practices include deploying well-informed case officers with knowledge of and training in how to communicate effectively and remain attentive to vulnerability indicators when meeting with applicants.

Additional information – EU-based umbrella CSO

Early identification of severe psychological distress has improved through screening tools, trained front-line staff and multidisciplinary cooperation, which help flag visible

vulnerabilities upon arrival. The presence of interpreters and specialised NGOs also supports more accurate and sensitive identification.

However, important limitations remain. Time pressure in arrival contexts, high caseloads and limited specialised staff often reduce screening to basic assessments. Psychological distress is not always immediately visible, and trauma may manifest later. In addition, fear, mistrust, stigma or a lack of information may prevent individuals from disclosing their needs early on.

In relation to nurturing self-disclosure, some practices have proved effective: providing clear and repeated information in accessible formats; ensuring a safe, confidential and non-judgemental environment; using trained cultural mediators; and adopting a phased approach where trust is built over time. Continuous follow-up, rather than one-off screening, is key to enabling individuals to share their experiences when they feel ready.

Annex 1.4. Trauma-informed principles in practice

Croatia

It was stated that applicants are reassured of their safety to alleviate fears of re-traumatisation, while clarifying that the purpose of support is rehabilitation and recovery.

Denmark

Denmark indicated using the **STROF pedagogical methodology**, creating predictable daily structures and routines for children: S – structure (establishing clear, consistent routines), T – time (sufficient time allocated for activities), R – routines (creating predictable patterns, such as specific slots for naps/snacks), O – organisation (arranging the physical environment to facilitate learning) and F – focus (intentional attention paid to the child by an adult present). It is used particularly in the context of early childhood education for supporting emotional security, development and well-being.

France

France notes that applicants may be accompanied by a trusted third person during interviews, a practice that aligns closely with trauma-informed principles.

Germany

A representative of one of the federal states responsible for the reception of asylum seekers shared an example of how protected spaces for confidential conversations are provided, organised and safeguarded, namely by:

- maintaining a low noise level,

- ensuring a high level of privacy,
- requiring staff to maintain appropriate body posture and appropriate interpersonal distance,
- emphasising the avoidance of administrative language.

They also mentioned walks through the reception centres with residents so that they can express wishes and needs informally. This relational approach is unique among the responses.

Greece

Many countries noted that they explain procedures. Greece explicitly stated that interviewers explain **why** sensitive questions are necessary before asking them. This is an example of promoting transparency and reducing distress. Greece also stated that interviewers avoid asking for excessive details about traumatic experiences.

Iceland

Iceland informs applicants in advance of how the organisation's phone number will appear before calling them and outlines the information they will receive along the way. Although seemingly small, this process reduces anxiety and uncertainty and reflects thoughtful, trauma-informed communication.

Lithuania

Lithuania highlighted the importance of explaining delays or procedural changes in advance, noting that uncertainty itself increases distress – a simple but powerful practice.

The Netherlands

The Dutch approach focuses on the importance of relationship building with guardians, child-friendly explanations and consistency in keeping agreements.

Norway

Norway highlighted the importance of asking applicants what they are comfortable with. This practice recognises that the characteristics of the interpreter may influence disclosure and psychological safety.

Serbia

Women- and girl-friendly spaces, including those catering for mothers and their babies ('baby corners'), were established to facilitate the disclosure of potential GBV.

Serbia reported group sessions focusing on psychoeducation, explaining that 'It is natural to feel abnormal after certain events.'

Slovenia

Slovenia noted that avoiding repeated disclosure is important; therefore, the coordination of support was pointed out as vital to creating a trauma-informed system.

Spain

Spain highlighted the importance of training staff in accordance with their specific roles and responsibilities, reinforcing the principle that TiC is a whole-system responsibility.

Annex 1.5. Staff well-being

Belgium

Webinars and training sessions are organised on themes linked to staff wellbeing. Staff support is provided through several key initiatives, including training for all reception centre personnel (such as first aid), structured case intervision, and direct access to counsellor teams at the central office. Additionally, the regular rotation of staff across different reception centres helps prevent burnout and ensures shared expertise.

Cyprus

At present, support is mainly provided through informal discussions within teams and supervision by line managers, particularly following difficult cases or interviews involving vulnerable applicants.

Denmark

Employees participate in regular supervision groups and have access to individual psychological support when needed.

Finland

Coaching/supervision is arranged when needed. Occupational health services, including access to an occupational psychologist, are available to staff. In reception, teamwork and defusing are an integral part of daily work. There is also regular training for the staff.

France

Case officers have access to psychological support. Training is regularly organised on trauma-related topics, and each year a week is dedicated to workplace well-being.

Germany

The federal office offers supervision to case-makers. The aim of supervision is to help participants discuss and reflect on issues arising in their day-to-day professional lives, and also to better process difficult experiences, problems and conflicts.

A representative of one of the federal states responsible for the reception of asylum seekers indicated that documented sports activities can be credited as up to one hour of working time per week. One can also participate in life-situation coaching with a contract partner and benefit from supervision.

Iceland

Counselling is offered up to four times a year.

Ireland

Management can play a key role in supporting staff and preventing burnout in IPAS centres by creating a supportive and safe work environment. Centre managers should be offered regular check-ins and supervision by senior management. The centre managers should have space to debrief, especially after dealing with challenging situations. The centre managers also need to have clarity about their roles and responsibilities, and there should be clear escalation pathways. The centre management staff should have access to regular training and peer support. Preventing burnout and supporting staff well-being is not about a single initiative but ensuring that there are clear and consistent staff-centred approaches in place.

Italy

In the reception of applicants for international protection, management supports staff well-being through organisational, supervisory and preventive measures aiming to reduce exposure to chronic stress and secondary trauma.

Key measures include clear role definitions and procedures, multidisciplinary teamwork, and regular coordination meetings to share responsibility for complex cases and avoid individual overburdening. Where possible, management promotes task rotation, reasonable caseloads and a balanced allocation of high-impact situations (e.g. victims of torture, violence or severe distress).

Staff well-being is supported through regular supervision (individual or group), peer-support mechanisms and opportunities for structured debriefing, especially following critical incidents or emotionally demanding cases. Training on trauma-informed approaches, recognition of secondary traumatic stress and self-care strategies is encouraged, in line with national guidance and sector standards.

Management also fosters a supportive organisational culture, where psychological strain is recognised as an occupational risk, and staff are encouraged to seek support without

stigma. Access to occupational health or psychological support services is facilitated when needed, and rest periods, leave and recovery time are respected.

Overall, staff well-being is treated as a core component of quality reception management, recognising that protecting professionals from burnout and secondary trauma is essential to ensure **c**ontinuity, professionalism and humane treatment of applicants.

Lithuania

Management supports staff well-being and helps prevent burnout and secondary traumatic stress through a combination of training, supervision and well-being initiatives.

Regular training is provided on topics such as burnout prevention and maintaining a healthy work–life balance. In addition, staff have opportunities to discuss workload and emotional well-being with supervisors, which helps to monitor stress levels and adjust responsibilities when needed. There is also a strong emphasis on encouraging employees to take time for themselves and maintain personal boundaries.

For example, once a month, relaxation sessions are organised for staff, focusing on stress reduction and body awareness, helping employees release tension and reconnect with their physical and emotional state.

Luxembourg

The psychosocial service of the public service in Luxembourg provides support to ensure the well-being of officers in contact with applicants for international protection.

The Luxembourg Red Cross also has two staff psychologists dedicated to staff well-being. These two psychologists can be contacted to discuss traumatic events at work or concerning staff's personal life. LRC provides psychological first aid training to all staff members and offers resilience workshops and salutogenesis training, among other training related to mental health and psychosocial support.

Norway

UDI requires that the managers at the reception centres ensure that their employees receive external supervision/guidance regularly to address specific challenges associated with working at the reception centres. This supervision must comprise 20 hours per year as a minimum, divided into at least four separate sessions.

Serbia

To support staff well-being, some employees participate in burnout prevention and resilience trainings as part of other training on child protection and GBV. In addition, through a UN Multi-Partner Trust Fund Office project, a 'Migration and public health' training module was developed, which includes the topic of burnout prevention.

Slovenia

Some initiatives have been introduced, such as a working group on workplace well-being, which has provided staff with guidance, exercises and general recommendations.

Social workers (reception staff) have access to regular supervision, which is organised on a monthly basis. Management staff also have access to coaching under similar conditions.

Spain

There is a phone line to request psychological support if needed. Most of the actions are done informally. Staff also have access to interdisciplinary team supervision, clinical supervision, emotional debriefing sessions and technical supervision from the central office.

These countries **Bulgaria, Czechia, Estonia, Spain and the Netherlands** indicated that group and individual sessions are organised when it comes to 'team care' and supervision, respectively.

Additional information – EU-based umbrella CSO

Management supports staff well-being and prevents burnout or secondary traumatic stress through a combination of organisational culture, structured support mechanisms and practical safeguards.

This includes promoting a supportive and open work environment where staff can discuss challenges without stigma and providing regular supervision and debriefing sessions, particularly for those exposed to traumatic content. Access to psychosocial support services, including counselling where needed, is also ensured. Workload management is a key component, with efforts made to monitor caseloads, prioritise tasks and encourage reasonable working hours, alongside flexible working arrangements where possible. Training on self-care, resilience and trauma-informed practices is provided to help staff recognise and manage stress. Concrete examples include structured team check-ins, peer support systems and guidance for managers on identifying early signs of burnout. Encouraging regular breaks and annual leave and fostering a culture of mutual support further contribute to staff well-being.

Annex 2. Additional reading and tools

Annex 2.1. Publications shared by respondents to the survey (EU+ countries)

Italy

- Italian Ministry of the Interior, Office of the United Nations High Commissioner for Refugees and United Nations Children's Fund, *La mitigazione del rischio di violenza di genere e i meccanismi di tutela di persone minorenni nel sistema di accoglienza – Nota tecnica e strumenti operativi*, 2024.
- Italian Ministry of the Interior, *Handbook for the identification, referral and care of persons living with vulnerabilities entering Italy and within the protection and reception system*, 2023.
- Department of Civil Protection, Office of the United Nations High Commissioner for Refugees and United Nations Children's Fund, *La mitigazione del rischio di violenza di genere e i meccanismi di tutela di persone minorenni nel sistema di accoglienza diffusa – Guida pratica e strumenti operativi*, 2023.
- Ministry of Labour and Social Policies, *Piano di azione nazionale per l'attuazione della Garanzia Infanzia (PANGI)*, 2022.
- Italian government, Decreto del Presidente del Consiglio dei ministri 24 Novembre 2017, Gazzetta Ufficiale website, 2018.

Annex 2.2. EUAA materials and tools

Mental health and well-being

EUAA mapping report and consultation.

- EASO, *Consultations with applicants for international protection on mental health: A participatory approach supported by Member State authorities and civil society*, 2021.
- EASO, *Mental health of applicants for international protection in Europe – Initial mapping report*, 2020.

Threefold EUAA guidance on the mental health of applicants for international protection.

- EUAA, *Mental health and well-being of applicants for international protection: Part I – For senior management*, 2024, sets the framework to shape an asylum system informed by mental health and well-being.

- EUAA, *Mental health and well-being of applicants for international protection: Part II – For those working in the first line*, 2024, focuses on the interventions.
- EUAA, *Mental health and well-being of applicants for international protection: Part III – Toolbox for the implementation of mental health and psychosocial support*, 2024, is a toolbox containing practical tools.

EUAA tool on psychological first aid (published 2023).

- EUAA, 'Psychological first aid video', YouTube website, 26 June 2023.
- EUAA, *The EUAA animation on psychological first aid as an awareness raising tool: Instructions for professionals on how to use the animation to educate on the concept of PFA*, 2023.

Substance use response

- EUAA, *Guidelines for group discussions on substance use prevention with adolescent boy applicants in reception: To be used in conjunction with the EUAA animation 'Everywhere there is life'*, 2025, was developed for reception professionals to facilitate discussions in conjunction with the EUAA animation.
- EUAA, 'EUAA prevention of substance use EN', YouTube website, 13 December 2024, focuses on substance use prevention and is designed to support adolescent applicants in staying resilient throughout the reception pathway.
- European Monitoring Centre for Drugs and Drug Addiction and EUAA, *Professionals Working in Reception Centres in Europe: An overview of drug-related challenges and support needs*, 2023.

Victims of torture

- EUAA, *Victims of Torture: Identification, support and examination of claims – Mapping report*, 2023.

Staff welfare

- EASO, *Practical guide on the welfare of asylum and reception staff: Part I – Standards and policy*, 2021.
- EASO, *Practical guide on the welfare of asylum and reception staff: Part II – Staff welfare toolbox*, 2021.
- EASO, *Practical guide on the welfare of asylum and reception staff: Part III – Monitoring and evaluation*, 2021.
- EASO, 'The importance of early identification of signs of stress', YouTube website, 22 September 2021.

Applicants with diverse sexual orientations, gender identities, gender expressions and sex characteristics

- EUAA, '*Practical Guide on applicants with diverse sexual orientations, gender identities, gender expressions and sex characteristics*', 2024, comprises three standalone yet complementary and interlinked parts.

Remote interviews

- EUAA, *Guidance on Remote Interviews*, 2025.

Standards and indicators

- EUAA, *Operational standards and indicators on reception including vulnerability-related aspects*, 2026.
- EUAA, *Operational Standards and Indicators on the Asylum Procedure*, 2025.

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