Mental health of applicants for international protection in Europe

Initial mapping report

July 2020
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<tr>
<td>AI</td>
<td>Asylum interview – referring in this document to the Personal interview</td>
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<tr>
<td>CEAS</td>
<td>Common European Asylum System</td>
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<tr>
<td>COVID-19</td>
<td>SARS-CoV-2 virus</td>
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<td>CSO</td>
<td>Civil Society Organisations</td>
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<td>Dublin III Regulation</td>
<td>Regulation (EU) No 604/2013 of the European Parliament and of the Council of 26 June 2013 establishing the criteria and mechanisms for determining the Member State responsible for examining an application for international protection lodged in one of the Member States by a third-country national or a stateless person (recast).</td>
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<td>EASO</td>
<td>European Asylum Support Office</td>
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<td>EU</td>
<td>European Union</td>
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<td>EU+ countries</td>
<td>Member States of the European Union plus Associated Countries</td>
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<td>FRA</td>
<td>European Union Agency for Fundamental Rights</td>
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<td>MoU</td>
<td>Memorandum of Understanding</td>
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<td>MS</td>
<td>Member States of the European Union</td>
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<td>NGO</td>
<td>non-governmental organisation</td>
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<td>SGBV</td>
<td>Sexual and gender-based violence</td>
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<td>SOP</td>
<td>Standard Operating Procedure</td>
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<td>S-R</td>
<td>Survey Reception</td>
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<td>S-AI</td>
<td>Survey Asylum interview</td>
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<td>QD</td>
<td>Directive 2011/95/EU of the European Parliament and of the Council of 13 December 2011 on standards for the qualification of third-country nationals or stateless persons as beneficiaries of international protection, for a uniform status for refugees or for persons eligible for subsidiary protection, and for the content of the protection granted (recast)</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<td>VEN</td>
<td>EASO Vulnerability Experts Network</td>
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Background

Statistics reveal a prevalence of mental health concerns not only in periods of conflict but also during peaceful times. Mental health concerns seem to be a global problem. Health systems worldwide are challenged with the consequences faced by a lack of investment in mental health. The WHO pointed this out already back in 2003. It mentioned that investment in mental health services will result in individuals and communities that are better able to cope with the stresses and conflicts that are part of everyday life, and who will therefore enjoy a better quality of life and better health.\(^1\)

According to the WHO\(^2\): Mental health and well-being are influenced not only by individual attributes but also by the social circumstances and the environment in which people find themselves. These determinants interact dynamically and may threaten or protect an individual’s mental state.

- Mental disorders are one of the most significant public health challenges in the WHO European Region, as they are the leading cause of disability.
- They are the third leading cause of overall disease burden (measured as disability-adjusted life years), after cardiovascular disease and cancers.
- The estimated prevalence of mental disorders in the WHO European Region in 2015 was 110 million, equivalent to 12% of the entire population.
- Inclusion of substance use disorders increases that number by 27 million (to 15%).
- Inclusion of neurological disorders such as dementia, epilepsy and headache disorders increases the total by more than 300 million, to 50%.

In terms of mental health in emergency situations, the WHO suggests that\(^3\):

- The prevalence of common mental disorders such as depression and anxiety is expected to more than double in a humanitarian crisis.
- Most people affected by emergencies will experience distress (e.g. feelings of anxiety and sadness, hopelessness, difficulty sleeping, fatigue, irritability or anger and/or aches and pains). This is normal and will improve over time for most people.
- Among people who have experienced war or other conflict in the previous 10 years, one in 11 (9%) will have a moderate or severe mental disorder.
- One person in five (22%) living in an area affected by conflict is estimated to have depression, anxiety, post-traumatic stress disorder, bipolar disorder or schizophrenia.
- Depression tends to be more common among women than men.
- Depression and anxiety are more common as people get older.

While data on population worldwide and in the European Union (EU) demonstrate that nobody is immune or safe from having a mental health concern at some point in their lives, applicants for international protection

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often appear more prone than host country citizens to present with mental health concerns. This is due to traumatic events\(^4\) many of the applicants have experienced.

Conflict-related violence coupled with ongoing stressors related to flight and displacement can affect a person’s wellbeing\(^5\). There is no such thing as a general response to traumatic events as some service providers would hope. However, somatic presentations such as headaches, non-specific pains or discomfort in the torso and limbs, dizziness, weakness, and fatigue are central to the subjective experience and are central to the subjective experience and manifestations of distress wrought by war and its upheavals worldwide\(^6\). Mental health problems in applicants for international protection are, however, not only linked to conflict, war, and persecution. Mental health problems can also be closely related to poor social support in the country of asylum\(^7\). Long waiting times for decisions on applications for international protection and placement in detention facilities increase the risk of prolonged problems or developing mental health concerns. The weight of events experienced in the country of origin, during transit, or in the country of asylum, all can have a long-lasting impact. However, mental health falls on a continuum and should be seen as a flexible condition therefore. Mental health is ongoing and fluid throughout the human lifespan. All of us can potentially be negatively impacted by certain life events (loss of a loved one, divorce, trauma etc) in the way we feel, act and present ourselves. All of us however can and will recover. When applicants present with mental health concerns, timely and relevant support can improve wellbeing. It is important to stress that the reactions of applicants for international protection in most cases are normal reactions to abnormal events.

While most applicants for international protection in Europe have shown remarkable resiliency, research findings also tell us that around half of the applicants and refugees arriving in Europe are experiencing psychological distress mainly resulting from traumatic experiences\(^8\). As many as half of those arriving could be suffering from post-traumatic problems, including post-traumatic stress disorder (PTSD). While this can be true, according to the Leuven Institute of Criminology, post-traumatic consequences are often overlooked, simply because most first-line workers are not aware of them and/or do not have enough expertise to identify such applicants. Stigma surrounding mental health concerns might be an additional barrier for applicants in need from reaching out.

\(^4\) See Healthline, Traumatic Events, 2020 (last accessed June 2020): ‘A traumatic event is normally referred to when talking about a critical incident that caused physical, emotional, spiritual, or psychological harm. Therefore, the person might feel threatened, anxious, or frightened or is trying to deny the event.’

\(^5\) According to the EASO Country of Origin Information Reports, mental illness is widespread in some of the key countries producing refugees in Europe such as Afghanistan, Iraq or Nigeria, due to years of exposure to war, conflict, violence and trauma. At the same time mental health infrastructures and specialists in these countries are limited while people enduring mental issues are stigmatised. Various sources point that half of Afghan’s population and up to one fifth of Iraq’s population face mental health problems while in Nigeria one out of seven persons will have serious mental illnesses and one in four will have some form of mental disorder. EASO, COI Report Afghanistan: key socio-economic indicators, April 2019, p. 49; EASO, COI Report Iraq: key socio-economic indicators, February 2019, p. 78; 79; EASO, COI Report Nigeria: key socio-economic indicators, November 2018, p. 50.


\(^8\) See work conducted by Leuven Institute of Criminology (KU Leuven) and partners since 2017: Research project: post-traumatic integration – low-level psychosocial support and intervention for refugees, 2017.
1. Introduction

The EASO Vulnerability Experts Network (VEN) identified mental health in asylum as a priority for 2020. VEN members stated that first-line officers face challenges when working with applicants that present with mental health concerns. Anecdotes of aggressive behaviour by applicants against themselves (self-harm), towards other residents in reception centres and verbal aggression towards case officers during interviews were shared during group sessions in last year’s VEN annual conference. Signs of depression, withdrawal and anxiety in applicants were mentioned. These signs were exhibited particularly by those who have been in Europe for months and even years without a decision, or those who have filed a subsequent application. Concerns around the credibility of content shared during interview by these applicants were also seen as challenging by some members of the network.

As a first step in responding to the VEN request, EASO developed a survey that included two separate questionnaires. The survey took into account the informal discussions during the last annual conference and VEN meeting (29th of Oct 2019). One questionnaire focused on potential mental health concerns of applicants in reception facilities and the related challenges for professionals. The second questionnaire focused on challenges arising during the personal interview for professional and applicants alike.

The purpose of the survey was to gain a better understanding on:

- the major mental health concerns applicants present and which are the main vulnerable groups according to first-line officers in reception as well as case officers;
- the way the work of first-line officers in reception and during the personal interview is affected by mental health conditions of applicants;
- the needs to be addressed by authorities and organisations working in the context of asylum to ensure professional, timely and continuous identification, response to and prevention of mental health concerns of applicants.

Up to now, EASO and its various networks have not yet worked specifically on the topic of mental health of applicants for international protection. As a first step, EASO is sharing this initial mapping report with the networks (VEN, the EASO Network of Reception Authorities and Asylum Processes Network), all of which participated in this survey as a base for follow-up and identification of additional areas for support.

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9 See both questionnaires (reception and asylum interview) in full in Annex I.
10 As per Articles 21 and 22 RCD.


**1.1 Approach and methodology**

This initial mapping report is a presentation of information received from Member States of the European Union and Associated Countries (EU+ countries) and their representatives. It is important to note that the survey was designed for first-line officers working in both reception facilities and as case officers, and not necessarily for professionals working on mental health only. The term mental health was open to interpretation in a broad sense. In addition, the survey approaches the issue of mental health concerns through the lens of psychological distress rather than psychiatric disorder per se. Mental health is an integral part of health. Good mental health is related to physical, mental and psychological wellbeing.

On a global level, the WHO defines mental health as:

... a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community' ... ‘Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.  

While on a European level, the definition of mental health proposed by the European Commission in its report *The State of Mental Health in the European Union* refers to:

Positive mental health relates to well-being and the ability to cope with adversity. Negative mental health comprises both psychological distress, which refers to the presence of symptoms (mainly depression or anxiety), and diagnosis of psychiatric disorders ...

The interpretation of vulnerability in the framework of the Common European Asylum System (CEAS) involves the designation of vulnerable groups including applicants of international protection with mental health problems. A non-exhaustive list of categories of **vulnerable applicants** can be found in Article 20(3)

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Qualification Directive (QD)\textsuperscript{13} as well as in Article 21 Reception Conditions Directive (RCD)\textsuperscript{14}. The CEAS also refers to the concepts of ‘special needs’ and ‘special reception needs’ providing for assessment of the need for special procedural guarantees on behalf of the applicant, following the making of the application (Article 24 Asylum Procedures Directive (APD))\textsuperscript{15}. While reference to mental disorders is made in both directives, it is important to acknowledge that when mental health concerns were discussed in the survey, EASO did not refer exclusively to persons presenting with a mental health disorder certified by a clinician\textsuperscript{16}.

In the survey, respondents were encouraged to refer also to persons whose mental health state might have been impacted by critical and traumatic\textsuperscript{17} events. For example, people that have been subjected to torture or other serious forms of violence (e.g. rape and other forms of gender-based violence). It is important that applicants for international protection and those of them that may present mental health concerns are seen in their complexity regarding their life and the situations in which they find themselves. In our conceptualisation of the survey and description of the findings, we avoid approaching signs of distress in applicants as pathology as they are a rather normal response to situations of adversity. In addition to that, not all people who experience a potential traumatic event will show symptoms. Protective factors do play a role as well.

As already indicated, two slightly different questionnaires\textsuperscript{18} were developed for the purpose of mapping the main concerns for applicants according to first-line officers, in terms of mental health concerns and how to potentially address them. Both questionnaires were constructed along six categories: general information on participation; understanding of mental health; identification of applicants with mental health concerns; response to the needs identified; and prevention, monitoring and good practices.

One limitation of the survey relates to the absence of the voices of the applicants themselves. Their own perception of what mental health means, origins of concerns, their consequences and how to address such concerns in their view is missing. The survey analysis is based solely on the experience and perspective of first-line staff in the domains of asylum and reception. Adding a further survey focusing on the perspective of applicants therefore would complete the overall picture\textsuperscript{19}.

\textsuperscript{13} Directive 2011/95/EU of the European Parliament and of the Council of 13 December 2011 on standards for the qualification of third-country nationals or stateless persons as beneficiaries of international protection, for a uniform status for refugees or for persons eligible for subsidiary protection, and for the content of the protection granted (recast).
\textsuperscript{15} For more information, refer to section 1.2. Legal Framework.
\textsuperscript{16} Clinical classification tools often used are the DSM-5 and the ICD-9. DSM–5 is an evidence-based manual to help clinicians when diagnosing mental disorders (developed by the American Psychiatric Association (APA), United States). The ICD-9 is a list of codes intended for the classification of diseases, developed by the WHO, a global health agency.
\textsuperscript{17} Trauma means that an individual has experienced, witnessed or been confronted with an event or events that involve actual or threatened death or injury or a threat to the physical integrity of others. This includes exposure to war-related violence, sexual assault, torture, incarceration, genocide and the threat of personal injury and annihilation. For further information also see: https://www.apa.org/topics/trauma/
\textsuperscript{18} See Annex I.
\textsuperscript{19} Additional research was also one key priority identified in a report published by the WHO on Europe: Mental health promotion and mental health care in refugees and migrants; 2018; https://www.euro.who.int/__data/assets/pdf_file/0004/386563/mental-health-eng.pdf
1.2 Legal Framework

Reference is made in the CEAS to applicants with special needs and vulnerable groups, including applicants for international protection with mental health problems. Reference is also made as to how to safeguard such applicants.

A non-exhaustive list of categories of vulnerable applicants can be found in Article 20(3) QD as well as in Article 21 RCD:

*Member States shall take into account the specific situation of vulnerable persons such as minors, unaccompanied minors, disabled people, elderly people, pregnant women, single parents with minor children, victims of human trafficking, persons with mental disorders and persons who have been subjected to torture, rape or other serious forms of psychological, physical or sexual violence*.20

As part of the more general provisions of access to healthcare, the CEAS grants access to mental health care. Articles 17(2) and (3) RCD oblige Member States to grant applicants the right to material reception conditions that guarantee their subsistence and protect their physical and mental health. Article 19 RCD stipulates that Member States must provide the necessary healthcare, including, emergency care and essential treatment of illnesses and of serious mental problems as a minimum. Under Article 19, applicants who have special reception needs have a right to ‘appropriate mental health care’, where needed. Concerning children, Article 23(4) RCD requires that Member States ensure that appropriate mental health care is developed, and qualified counselling is provided when needed.

Further, Article 22 RCD requires Member States to assess whether vulnerable persons have special reception needs. If this is the case, authorities are expected to react appropriately to the applicants’ needs, even if these needs appear at a later stage in the process. Similarly, Article 24 APD obliges Member States to assess whether the applicant has special procedural needs in a reasonable timeframe after an application for international protection has been made. If this is the case, needs must be considered and adequate support guaranteed.

Article 25(1) RCD also indicates that Member States must in particular ensure that persons who have been subjected to torture, rape or otherwise serious acts of violence receive the necessary response, which includes not only medical but also psychological care and treatment. The relevant response is also highlighted in Article 9(1) Victims’ Rights Directive (2012/29/EU)21, which indicates the need by Member States to provide victims with information, advice, and support.

Lastly, in both Article 4(3) APD and Article 25(2) RCD, Member States are required to ensure that their staff working with applicants are able to provide professional support to applicants (reference is made in particular to interviewing and/or working with torture victims).

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20 Article 21 RCD refers also to victims of female genital mutilation.

2. Survey participation and key findings

This is a first step taken by EASO to learn from EU+ country authorities and civil society organisations (CSOs) some of the challenges and good practices regarding the topic of mental health and applicants for international protection. The findings compile input received from three of EASOs networks: Reception; Asylum Processes; and the VEN. These findings will facilitate the planning of the next steps for EASO support in collaboration with the three networks.

This chapter starts out with a general overview about participation in the survey, followed by a review of key findings. A more in-depth analysis is presented in the following chapters, which looks into reception and the personal interview findings separately. Each section is introduced with a quote shared by respondents of this survey.

2.1 General information on participation

A total of 25 countries participated in the survey, 22 of which are EU Members States. Contributions were also received from Norway, Serbia and Switzerland. Some countries provided more than one submission. A total of 91 submissions were received from reception and asylum authorities as well as CSOs.

Figure 2. Submissions by EU+ country (S-R Q 1.1; S-AI Q1.1)
Out of 91 respondents, the majority (62) work in reception facilities, and 29 work in the context of the personal interviews. Out of the total (91 respondents) 41 are employed by asylum authorities.

After analysing the 91 submissions from the respondent 25 countries, the following areas emerged for consideration.

1. Resources (including sufficient human resources)
2. National coordination, networking and collaboration
3. Expertise of professionals involved in service provision
4. Availability and access to prevention and response mechanisms
5. Information provision and public awareness on mental health and how it links to the context of asylum
6. Data collection, monitoring and evaluation

All six areas are crucial to have a system in place that safeguards applicants with special needs and in particular those presenting with mental health concerns.

2.2 Roles, responsibilities and exposure to applicants with mental health concerns

In terms of roles and responsibilities, 63 % of all respondents were first-line professionals. 53 % of those working for reception authorities were reception officers or specialists (e.g. psychologists, nurses, etc.). 83 % of those whose work includes conducting the personal interview were either case officers or legal aid officers/child psychologists. For reception, 35 % of respondents had managerial roles compared to 24 % of respondents answering the asylum interview questionnaire. Three respondents reported working on policy, in relation to reception.

The majority (76 %) of professionals working with applicants in the personal interview and in reception facilities confirmed that they regularly meet and work with applicants with mental health concerns. Professionals working in reception facilities by the nature of their work see applicants more regularly. This was also reflected in the findings. The frequency of exposure for those working in reception authorities was reported to be higher than respondents working in other areas, with 40 % among them engaging with 4-10 applicants with mental health concerns and 27 % seeing more than 10 applicants with mental health concerns monthly.
In terms of training, 56% of the respondents (36 from reception authorities and 15 working with applicants in the personal interview) reported to have participated in training courses that focused in one way or another on dealing with applicants with mental health concerns.

The main training topics mentioned included:

- general training modules on vulnerability;
- specific training modules, for example courses on how to deal with suicidal thoughts of applicants, PTSD, and anxiety;
- the EASO module on trafficking in human beings.

Guidelines developed specifically for working with vulnerable applicants were mentioned as valuable resources as well by some. This includes the Guidelines for the protection and improvement of mental health of refugees, asylum seekers and migrants (PIN - Psychosocial Innovation Network).

For more information see the Psychosocial Innovation Network: [https://psychosocialinnovation.net/en/projects/](https://psychosocialinnovation.net/en/projects/) (last accessed June 2020).
### 2.3 Perceived sources of mental health concerns of applicants and common signs

As indicated, survey participants included a variety of staff working directly with applicants on a regular basis. The responses below, while significant, are opinions and observations of reception and asylum support staff. The opinions and observations is not feedback received exclusively from trained and specialised mental health professionals.

**The three leading sources for mental health concerns in applicants according to the respondents, in order of prevalence are:**

1. **traumatic experiences in the country of origin** (insecurity, conflict and war) (76 responses out of 91);
2. **pre-existing health conditions** (45 responses out of 91);
3. **lengthy asylum procedures** in the country of asylum (43 responses out of 91)

![Figure 5. Potential sources of mental health concerns of applicants according to first-line workers (S-R, Q 2.9; S-AI Q 2.6)](image)

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25 A recent FRA study on good practices and challenges in the integration of young refugees in the EU (based on 190 interviews with experts and 163 interviews with people in need of international protection) identifies the main factors negatively impacting the mental health of applicants. The study points to lengthy procedures together with poor reception conditions and the need to repeatedly tell one’s story at different stages. (FRA, *Integration of Young Refugees in the EU: Good Practices and Challenges*, 2019, pp. 77-80.)
The three most common signs of mental health concerns observed by respondents are:

1. general sign of anxiety (64 responses out of 91);
2. substance abuse (alcohol and other substances) (49 responses out of 91);
3. lack of concentration (45 responses out of 91).

Some of the multiple choice signs indicated in the lists slightly differed across the two questionnaires depending on the context (reception or personal interview). The reason for this is that reception officers usually have the chance to see applicants more than once, even if only for short time. Case officers, on the other hand, see applicants potentially only once, though they have the opportunity to engage in a lengthy interview with applicants.

Figure 6. Observation of signs by reception and personal interview professionals (S-R Q 2.3; S-AI Q 2.3)
Traumatic experiences endured by applicants are often a combination of many factors. This can include loss of loved ones, loss of property, violence experienced or witnessed back home, pain inflicted by others in the form of torture or threats of such acts, as well as gender-based violence to name just a few. These events translate in many cases into the symptoms observed by respondents and are indicated in Figure 6. Respondents stated also that age, gender, cultural, religious and educational background can play a significant role on whether applicants choose to air their mental health concerns with others.

2.4 Main challenges raised by first-line workers in their daily engagement with applicants with mental health concerns

Most respondents identified the lack of time available with applicants as a main challenge. It was also stated that some applicants are not yet ready to disclose their experiences or mental health concerns, and some might never be ready. This can have a negative impact not only on their mental health, but also on their application for international protection. Consciously or unconsciously hiding mental health concerns is often a consequence and a way to cope with negative experiences, while culture, family and religion can also constitute other factors why applicants do not come forward. Further, timely processing of cases, reducing bureaucracy without jeopardising quality, and ensuring applicants are not forced to live for years in a state of limbo regarding their status will need to be a focus. This should be in combination with efforts to ensure that all applicants - including those who find themselves in accelerated procedures - are being provided with the psychosocial and legal support needed. Provision of adequate living conditions is important. Further, respondents saw access to communication with family and community as crucial to strengthen resilience in applicants. Lastly, detention (including pre-transfer detention under the Dublin III Regulation) should only be used as a last resort and should be avoided for children.

A summary of comments raised by respondents were:

- The current focus is on keeping applicants going, and not necessarily to heal and help them. More time and flexible access is needed, including to those who find themselves in accelerated procedures and/or detention.
- Sometimes it is difficult to know when a story is false, or an applicant is genuinely unable to share their story due to trauma.
- How can case officers set boundaries and improve handling very emotional content shared during the personal interview?
- Some staff might need to be reminded of their obligation to ensure a respectful and dignified working approach towards applicants.
- Provision of training courses on mental health concerns of applicants to be extended to interpreters.
- Training on asylum to specialists such as medical professionals who are potentially needed to issue medical statements for further processing of applications

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26 Refer to the following chapters on reception and personal interview for more details.
27 Regulation (EU) No 604/2013 of the European Parliament and of the Council of 26 June 2013 establishing the criteria and mechanisms for determining the Member State responsible for examining an application for international protection lodged in one of the Member States by a third-country national or a stateless person (recast).
2.5 Relevance of the survey

Approximately 73% stated that the effort of this survey in gathering more information on mental health concerns of applicants for international protection in the personal interview and reception was useful and relevant. Another 23% were not sure, and less than 1% (1 person only) did not see any relevance for such an attempt.
3. Mental health of applicants and reception

“Reception is so much more than just a bed!”

Summary

While reception facilities across Europe are overall trying their best to accommodate the needs of all applicants in their facilities, there seems to be anecdotal evidence that some facilities are stretched in terms of human resources and funds to cater for applicants in need. Most EU+ countries indicated to have a somewhat functioning system in place when it comes to identification, assessment, referral, specialised support and case management of applicants with special needs such as those presenting with mental health concerns. However, it is also evident that a holistic, coordinated and timely response is still lacking in some EU+ countries. A good number of applicants have suffered trauma either in their country of origin, during transit or in the country of asylum.

Mental health, however, is not (yet) seen as a priority for many authorities even though it is evident from the feedback received that when mental health concerns are neglected, the consequences not only negatively impact the affected applicant but the whole system. The initial symptoms further deteriorate, aggressiveness increases in applicants with a low tolerance to violence and conflict, and that has the potential to affect all residents and staff alike. Integration into the reception facility, community or host community becomes even more challenging. Misuse of medication, substance abuse, suicidal behaviour are consequences, as well as dropping out of asylum procedures. Applicants struggling even more to remember key past events for their scheduled personal interviews are other apparent consequences.

According to a report by the Fundamental Rights Agency (FRA) from 2017, most cases of trauma, torture and/or drug abuse take place in countries of origin. Incidents do also occur, however, both in transit countries and within the EU28.

Professionals working in the field of reception ask for a stronger focus on prevention compared to response. Further, it was stressed that the working environment needs to allow the first-line officers to provide appropriate care to applicants in need. Sticking to a tight timeline in terms of procedure combined with targeted, relevant and clear information on the process are seen as important for all applicants, but especially for applicants with special needs. Legal advice and psychosocial support services are to be free and streamlined. Accelerated procedures are seen as challenging since they do not allow for a proper assessment of vulnerabilities. Applicants with mental health concerns who may potentially hide their problems for cultural or religious reasons and find themselves in accelerated procedures are particularly affected.

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According to respondents, while children, men and women might have different ways of showing mental health concerns and will need a gender and age-appropriate response, it is also clear that in Europe more support programmes for young, single men are needed.

3.1 General Findings

Approximately 43% of respondents working for reception authorities were specialised professionals such as psychologists, psychiatrists or other health officers. Another 38% hold managerial roles such as team leaders, coordinators and programme managers. The other respondents consider themselves first-line reception officers and other support staff. Four of the respondents did not answer this question or it was not applicable. Most respondents are involved on a regular basis with the identification of vulnerable applicants including those with a mental health concern. 86% of respondents stated additional responsibilities (e.g. information provision to applicants on services available, etc.). The actual or official assessment and identification of applicants and their relevant needs is conducted only by 35% of respondents, while referring and managing cases is completed by approximately 48% and 53% respectively.

Interestingly, slightly over 50% shared that service provision in their respective EU+ country is being outsourced to social workers from the public sector or vulnerability focal persons working with international, local non-governmental organisations (NGOs) or contractors for the purpose of identification and assessment or needs including case management. The outsourcing of services is important to note, since this may add a layer of complexity. Not only in terms of division of roles and responsibilities but also in terms of communication.

Therefore, clear and regular communication between the teams involved who jointly care for the same applicants is recommended. This is to ensure a holistic, timely and professional approach without duplicating efforts and putting applicants in a position where they are re-traumatised by repeating their concerns to multiple people on several occasions.
3.2 Identification and response

About 18% (17 responses) stated that the time between the actual or official identification of a vulnerable applicant with mental health concerns and the intervention can range between immediate action and a maximum of three days. It was also mentioned that there are differences in terms of the importance given to a case, which depends on the age of an applicant and severity of the case. For example, one EU+ country stated that while the cases of unaccompanied children are followed up within two weeks, adults had to wait a minimum of a month.

Figure 8. Time needed between the identification of vulnerability and the follow-up (S-R Q 3.3)

The colour yellow indicates the highest number of responses received per question for each questionnaire.
Child applicants

When the vulnerable applicant is a child (below the age of 18) the response changes to a certain extent. 73% of respondents agreed that a change in approach when the applicant is a child is needed, while 16% of respondents mentioned that the age of an applicant does not necessarily trigger a different approach.

Good practices shared by respondents and recommendations to consider:

• **The accompanied child:** When children live with their families, parents need to be actively involved in the process (either in terms of consent) but also in terms of information provision as to the actions being taken. Culture and/or religion might be important to consider when engaging parents so as to ensure information regarding the child is fully understood. If the safety of the child could be jeopardised when disclosing specific needs, a risk assessment has to be conducted prior to the disclosure of information.

• **The unaccompanied or separated child:** If the child is an unaccompanied minor or separated child the legal representative/guardian is to be involved in the process to ensure relevant, child-friendly and age-appropriate follow-up. In some cases, the involvement of the school/teachers might be of benefit to the applicant. Respondents also stated that when children are involved, in addition to the fact that a follow-up takes place faster, professionals tend to check in with the child more frequently than they would with adults.

• Lastly, **adjustments in living arrangements** might be considered in some cases, protection measures are considered where possible, or recommendations in delaying the personal interview (depending on the case) will be made. A general comment made by respondents was that a child (accompanied or not) should not be characterised in medical terms.

Identification of applicants with special needs

In general, it was stated that while referrals often take place immediately upon the identification of an applicant with special needs (children or others), the follow-up action, however, is delayed. This is mainly due to lack of professionals available to attend to the applicant. In some cases, applicants received an immediate written referral to a service but must wait a minimum of two weeks (often longer) to receive the final service required. It was also shared that referrals are sometimes conducted in an ad hoc manner and depending on needs as opposed to being part of a standardised protocol. Informal calls rather than documented pathways for referral were also indicated as an ongoing practice. While this might work faster in some cases, such informal referral mechanisms are person-driven, meaning certain applicants in need might not benefit.

The three leading challenges in identifying applicants with mental health concerns, in order of prevalence:

• **Lack of knowledge and basic training** of staff on how to identify and assess mental health concerns (26 responses out of 62)

• A general **lack of staff** to focus on vulnerable cases like applicants with mental health concerns (23 responses out of 62)

• **Lack of time and space** available to create a confidential and trustful situation for staff to engage with applicants in need (21 responses out of 62)
Respondents also stated that applicants are often seen to be experiencing a culture shock after arrival. In their view, the impact of this has thus far been underestimated. Some applicants are overwhelmed with the situation they find themselves in. It is hard for them to accept offers or realise the importance of health services provided in the country of asylum. One recommendation to tackle this problem was to ensure the introduction of improved orientation sessions for applicants on the country of asylum, including on culture, services available and the asylum system.

3.2.1 Prevalence of mental health symptoms and specific vulnerable groups

A part of the survey focused on symptoms observed by first-line professionals in applicants placed in their respective reception facility. With a long list of 28 symptoms presented in the questionnaire, respondents have indicated many if not most of them as being observed in applicants in reception. Drawing on this, it is highly likely an individual often presents a combination of symptoms.

According to findings, a high number of applicants currently accommodated in reception facilities in EU+ countries exhibit the following signs (see Figure 10):

- General anxiety (48 out of 62 responses)
- Sleeping problems and nightmares (43 out of 62 responses)
- Physical representation of distress (somatisation e.g. constant headache, stomach pain, etc.) (39 responses)
- Substance abuse (including alcohol/cigarettes) (38 out 62 responses)

Some further symptoms indicated by more than 50 % of the respondents included: constant worrying (36 responses), feelings of hopelessness (35 responses), feelings of being sad and unhappy and lack of concentration (34 responses each), no energy to engage in former hobbies and lack of personal hygiene (32 responses each). Aggressive behaviour and language towards staff (31 responses) and aggressive behaviour...
and language towards staff or family also features highly among the symptoms indicated by respondents (with 31 and 19 responses respectively).

It is not the purpose of this initial mapping report to come up with a diagnosis relating to the symptoms observed by survey participants. It is notable though that symptoms highlighted by the respondents are very common (amongst others) in persons who have suffered trauma\(^{31}\). Showing signs of depression is also very common in persons who have been through traumatic events.

Respondents also acknowledged the fact that many applicants overall find it hard to adjust to the new setting and environment (country) they suddenly find themselves in. Some applicants arrived hoping to work but seem overwhelmed with the way employment is organised in Europe. Some are not aware of their own skills, even though they might speak several languages, or they lack the skills and support to present their skills effectively. The combination of difficult experiences in the past and the exposure to a new culture and way things work in this new environment might be more than some applicants can handle.

**Particularities concerning children**

The majority of respondents (57 %) stated that the symptoms listed in Figure 6 also apply to children. 21 % indicated that symptoms differ when working with children. 19 % stated that sometimes children react differently.

**Additional symptoms typically presented by children:**

- poor academic performance in school;
- lack in physical hygiene;
- bedwetting (enuresis);
- general lack of attachment versus being overly clingy to staff and others;
- increased aggressive behaviour towards family but also other children;
- being bullied and isolated by peers;
- general anger management problems;
- physical representation of stress particularly manifesting as stomach problems as well as headaches;
- hyperactivity;
- misbehaving for attention;
- eating disorders.

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\(^{31}\) Traumatic incidents can be: a car crash, natural disaster, displacement, but also conflict and war like situation, loss of loved ones, torture, violence and abuse etc. Acute trauma results normally from a single incident (e.g. car crash); There are however also traumatic events which are ongoing or repeated like in cases of domestic violence, abuse; There are also very complex situations e.g. the exposure to multiple traumatic events happening simultaneously and over a longer period of time - like in a situation of war, flight, and transit situations which applicants for international protection often find themselves in. For additional information, also refer to [Center for Early Childhood Mental Health Consultation, Types of traumatic experiences](https://www.childtrauma.org/types-of-traumas), Adapted from National Child Traumatic Stress Network, 2008 (last accessed June 2020).
**Figure 10**. Main symptoms seen in applicants in reception facilities (S-R Q 2.3)

### Other vulnerable groups and gender considerations

There was a consensus that applicants for international protection are generally often vulnerable due to the circumstances they find themselves in. However, a majority (61%) of respondents agreed that within this group, certain applicants are even more vulnerable than others.

**Factors to consider concerning mental health concerns and pointed out by respondents include:**

**Age and gender:** being a torture victim and sexual and gender-based violence survivors; being an applicant passing through a specific transit country, general experiences during conflict and transit; long stays in detention in the country of origin or asylum and sexual orientation were mentioned.

Sexual and gender-based violence (SGBV) committed against women in the country of origin or transit seems to have a great impact on women's mental wellbeing even after they arrived in the country of asylum according to survey respondents. Women who are single parents are also considered more vulnerable. Belonging to sexual orientation and gender identity minorities was considered a challenge particularly in terms of discrimination even in the country of asylum.

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32 The yellow colour in the bar chart indicates the highest number of responses received per item for each questionnaire.
In addition to the observed long periods between identification and follow-up (according to 43.5 % of the respondents shown in Figure 8) a high number of applicants are not placed or do not have access to reception facilities, which constitutes a problem. One respondent from an EU+ country indicated that it is estimated that this group of asylum seekers (applicants living on the street) present with a high prevalence of PTSD\textsuperscript{33}. Looking at the information shared, transfer back decisions made in accordance with Dublin III Regulation seem to have a negative impact on applicants and their mental wellbeing.

3.2.2 Hiding mental health concerns

68 % indicated that the majority of applicants in their view were trying to hide their concerns (only 10 stated they never had anyone trying to hide their problems and nine were not sure).

The three leading reasons for why applicants for international protection do not share their mental health conditions are due to the following, in order of prevalence:

1. Cultural and family reasons (33 responses out of 62);
2. Lack of insight into their condition (31 responses out of 62), which is often the case when it relates to more serious mental health problems;
3. Fear of stigmatisation by community, family, and host community (26 responses out of 62).

According to some respondents, applicants hope that their mental health concerns are a quick fix, meaning a visit to a doctor who prescribes some medication is considered enough. Some applicants do know that they need help, but since they do not see the country in which they find themselves as their intended final destination, they would rather not officially enter into the health system. In their view, their plans to move on could be jeopardised. Lastly, relating to cultural and family-related reasons. Religion is very important to

\textsuperscript{33} According to this respondent, 15 % of asylum seekers living outside organised reception facilities (mainly on the street) in this specific EU+ State are thought to be suffering from PTSD. The number of applicants represented by this percentage was not shared in the survey, however.
some applicants and some might feel their religion dictates to deal with their concerns and problems on their own.

*Figure 12. Reasons for hiding of mental health concerns by applicants (S-R Q 2.8)*

Hiding mental health concerns

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lacking information on what is available to them</td>
<td>10</td>
</tr>
<tr>
<td>Lack in trust in the health system in your MS</td>
<td>6</td>
</tr>
<tr>
<td>Applicants not acknowledging the fact that they are in your MS</td>
<td>31</td>
</tr>
<tr>
<td>Fear of potential medical treatment/hospitalization</td>
<td>19</td>
</tr>
<tr>
<td>Fear of associated costs to see specialists</td>
<td>4</td>
</tr>
<tr>
<td>Fear for their safety/family members safety</td>
<td>16</td>
</tr>
<tr>
<td>Fear of stigmatization by community members</td>
<td>16</td>
</tr>
<tr>
<td>Cultural / Family reasons</td>
<td>33</td>
</tr>
</tbody>
</table>

Fear of potential **medical treatment** and in particular **hospitalisation** was also rated highly by survey participants as a reason for applicants in need not to share their concerns. This could potentially be linked to the fact that some applicants are not aware of what is available to them or that they have never experienced a well-functioning and caring health system.

3.2.3 Perceived sources of mental health concerns

While traumatic experiences in the country of origin are indicated by respondents as the main source for distress and mental health concerns, other sources were linked to more recent events (during transit or in the country of asylum).

The **three leading sources** for mental health concerns of applicants for international protection according to survey participants are, in order of prevalence:

- **Negative experiences** in the country of origin (e.g. due to a specific event(s) and experiences that happened during war/conflict/insecurity) (52 responses out of 62);
- **Current uncertainty and lack of future perspective** (35 responses out of 62);
- **Events** taking place in detention in the country of origin/transit (e.g. torture) (30 responses out of 62).

Sources that ranked just after the above include: family violence in the country of origin (28 responses out of 62), pre-existing mental health conditions, and lengthy asylum procedures (27 responses out of 62 respectively).
Figure 13. Potential source of the mental health concerns exhibited by applicants (S-R; Q 2.9)

Comments made by respondents:

- The lengthy asylum procedures (up to 4 years) are seen as a challenge. During this time, applicants lose hope, willpower, optimism and general life satisfaction. They develop depression and all ideas about the future are conditioned by uncertainty of the future. Ongoing concern and anxiety first start to show their impact physically (ongoing headaches, all sorts of stomach pain, sleeping disorders, etc.) and then manifest mentally soon after.
- Some applicants are present in an EU+ country for years and when their applications are denied they file a subsequent application.
- Cumulative traumas (country of origin, transit, country of asylum) and a deterioration of health conditions in the country of asylum is a problem.
- Freedom-restrictive measures linked to the procedures under the Dublin III Regulation (sign-in at police station, detention) have a severe (negative) impact on the mental health of applicants.
- More and more applicants, including unaccompanied minors, report experiences of torture during their journey, especially when transiting through Libya. Torture in detention in countries of origin is also widespread and SGBV is increasingly reported as well.
- Some applicants with mental health problems were sent by family members for different reasons (protection/burden relief). Even though some of them want to return voluntarily, the family would not accept them.

34 The yellow colour in the bar chart indicates the highest number of responses received per item for each questionnaire.
From the responses received, traumatic events experienced in the country of origin or transit will need to be addressed in terms of response by providing medical and/or psychosocial support. Through this, uncertainty and a lack of future perspectives in the country of asylum, among others, could potentially be prevented.

Recommendations to be further elaborated and discussed could concern:

- Development of clear, targeted, tailored and age-appropriate information material, which is provided in a timely manner to all applicants regardless of whether they are present in a reception facility/accelerated procedures/detention or awaiting return;
- Encouragement of strategic discussions by EU+ country authorities on how best to avoid lengthy asylum procedures and ensure timely implementation of the APD provisions;
- Encouragement of timely, improved and effective and efficient coordination and communication in terms of the requirements under the Dublin III Regulation and with pre-transfer detention used only as a last resort.

3.2.4 Mental health and legal status

About a third of the respondents agreed that having a legal status decreases feelings of general anxiety, depression, and hopelessness of the individual. Refugees or people with subsidiary protection present much more confidently and allow themselves to think of a future. Feelings of uncertainty, which seems to paralyse many, are lifted. According to respondents, while obtaining a legal status as soon as possible is in the best interest of applicants that qualify, and granting of protection may ease anxiety in some people, it might also trigger distress, which is not to be underestimated. Respondents mentioned that some now carrying the label of being a refugee are struggling with this fact. It is confirmed now that they indeed cannot return to their home country due to risk of persecution. The emergence of feelings associated with the deep loss of one’s country, loss of loved ones, loss of what was before, and more, are being slowly realised and are difficult to deal with for some.

3.3. Support to applicants with mental health concerns

Respondents shared that comprehensive support services are not available in most cases but instead support mainly refers to emergency support.

3.3.1. Available support services

While certain services are available in all EU+ countries, other services are only accessible for applicants in a few countries. Respondents also shared that in some EU+ countries, provision of support is linked to the individual working with the applicant. The personal engagement of the applicant can make a follow-up possible. Streamlined processes are lacking.

Services available in most MS:
- **Ongoing management**, referrals and free medical/psychosocial follow up is available (particularly for victims of torture, child abuse, SGBV) (40 responses out of 62);
Hospitalisation can be provided (where needed) (40 responses out of 62);
• Adjusted and appropriate accommodation (34 responses out of 62);
• Social and educational support activities, employment opportunities (34 responses out of 62);
• A mechanism is available (identification, assessment, response) of special needs including mental health concerns (31 responses out of 62) and monitoring of medication intake (31 responses out of 62).

While hospitalisation emerged as a support service available in many EU+ countries when the need arises, it is simultaneously also seen by applicants as a source of fear (refer to figure 10). According to responses received, some applicants either have no experiences of a western health system or do not trust the system altogether. Cultural and religious reasons could play a role and therefore are important to consider.

Figure 14. Availability of services in the EU+ country (S-R Q 4.1)

<table>
<thead>
<tr>
<th>Service</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalisation</td>
<td>40</td>
</tr>
<tr>
<td>Adjusted and appropriate accommodation</td>
<td>34</td>
</tr>
<tr>
<td>Social and educational support activities, employment opportunities</td>
<td>34</td>
</tr>
<tr>
<td>A mechanism is available (identification, assessment, response) of special needs including mental health concerns</td>
<td>31</td>
</tr>
</tbody>
</table>

Only 13% of respondents stated their EU+ country had links to community healers/traditional healers or certain groups of refugee communities for support. This might be important to note since community mental health options and the importance of rebuilding social connections including participation in community activities, for example traditional/religious community rituals, were indicated by respondents as crucial for applicants to cope with general problems including those which are mental health related.

Services needed for applicants to better cope with their situation:

1. **Basic service provision**: including basic healthcare, security/protection, food, appropriate shelter, timely registration, information provision, etc. (39 responses out of 62);
2. **Specialised support**: including counselling provided by professionals, medical interventions, financial allowances, social support services, etc. (33 responses out of 62).

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35 The yellow colour in the bar chart indicates the highest number of responses received per item for each questionnaire.
3. **Opportunities to rebuild social connections**: including family reunification, opportunities to talk to family members back home or in transit; space ‘to make meaning/sense’ of what has happened (e.g. abuse, persecution); support from community; participation in traditional/religious community rituals (e.g. assisted mourning - a symbolic burial for a lost family member); opportunities to integrate into host community), etc. (30 responses out of 62).

Survey participants indicated that to stabilise applicants and facilitate coping, rebuilding social connections are crucial.

**Figure 15**. *Important services to cope with mental health concerns (S-R Q 4.2)*

<table>
<thead>
<tr>
<th>Most important service</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognition and justice</td>
<td>13</td>
</tr>
<tr>
<td>Routine</td>
<td>17</td>
</tr>
<tr>
<td>Specialised support</td>
<td>33</td>
</tr>
<tr>
<td>Opportunities to rebuild social connections</td>
<td>30</td>
</tr>
<tr>
<td>Age appropriate services</td>
<td>22</td>
</tr>
<tr>
<td>Basic Support Services (food, shelter, protection)</td>
<td>39</td>
</tr>
</tbody>
</table>

**Recommendations by first line officers to facilitate healthy coping with mental health concerns of applicants:**

- **First a focus on** the applicants’ overall safety;
- **Crucial** to secure basic trust by allocating time and respectful engagement with the applicant;
- **Engage the person** in need where possible in meaningful activities;
- **Social connections** and support are the basis for a healthy mental state;
- **Family** and maintaining a routine are important, especially for minors;
- **No ‘one size fits all’ approach** – important to have an individualised approach;
- The asylum process tends to be too long;
- Family separation is counterproductive – **timely family reunification** where possible or regular means to communicate;
- To stabilise predictability of everyday events – creation of future perspectives.

To be able to provide effective support, an understanding of how the symptoms are framed is also needed. This means an understanding not only of how reception officers, specialised staff or case officers conceptualise mental health but also the applicant themselves. Cultural and religious considerations are

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36 This is also highlighted in the Inter-Agency-Standing-Committee (IASC), *Guidelines on Mental Health and Psychosocial Support in Emergency Settings*, 2007. According to the IASC, many survivors, particularly in non-Western societies, experience suffering in spiritual, religious, family or community terms. Survivors might feel significant stress due to their inability to perform culturally appropriate burial rituals, in situations where the bodies of the deceased are not available for burial or where there is a lack of financial resources or private spaces needed to conduct such rituals. Similarly, people might experience intense stress if they are unable to engage in normal religious, spiritual or cultural practices. This might need stronger consideration, in particular when looking at applicants for international protection who often for a very long time are not able to connect with community members or family due to detention.

37 The yellow colour in the bar chart indicates the highest number of responses received per item for each questionnaire.
crucial when working with applicants arriving in Europe from different countries and with various educational and economic backgrounds. The importance of religion and how mental health is understood and managed with respect to religion is not to be underestimated. Experiencing one’s mental health concern as fate and something God has placed on you can be one example. Hassan et al (2015), for example, noted that some refugees with an Islamic background experiencing mental health issues may describe themselves as possessed, attacked or slapped by a jinn as a way to rationalise their experiences of mental health disturbances. A similar way of rationalising mental health concerns can be seen in many other countries such as West African states such as Nigeria, Togo or Ghana, where a belief in juju (spiritual belief system involving objects etc) and witchcraft is prevalent. It is important to note that distress is experienced, described and recognised differently in specific cultural settings and this will potentially need to be more prominently considered by staff working in the field of asylum in Europe as well. This is important to note not only when it comes to providing the appropriate culture- and gender-sensitive support to such applicants but also in terms of relevance for applications, where a mental health concern could potentially be a reason for persecution in the country of origin.

53% (33 out of 62) stated that they have identified protective factors during their years of professional work with applicants for international protection. These factors according to respondents help applicants to better cope with their situation as asylum seekers in a foreign country. (16 respondents were not sure and 12 stated they have not seen any indication of protective factors).

**Protective factors identified:**

- Applicants have been registered in a **timely manner**, are informed about the process and understand it;
- **Fair** access to the asylum procedure;
- Knowledge that they are **not alone** (access to staff when need arises);
- Ability to communicate with family and friends;
- Future prospects (e.g. involved in regular work, education as soon as possible, etc.);
- Ability to speak the local language of the country of asylum;
- Personality type;
- Routine – basic daily tasks - particularly in the case of children.

3.3.2 Access to support services

**Six respondents out of 62 in total** indicated that certain applicants are excluded from support services (psychosocial and legal services) in their respective EU+ countries if they belong to one of the groups indicated below:

- cases being processed in accordance with Dublin III Regulation;
- applicants whose cases have been rejected;
- applicants who do not reside in reception facilities;

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38 See also: International Medical Corps, Assessment Report, Understanding Mental Health and Psychosocial needs and Service Utilisation of Syrian Refugees and Jordanian Nationals, 2017, p. 13.

39 Persons with severe mental disabilities in the country are potential targets of accusation of witchcraft and in turn could be exposed to acts which are of such severe nature that they would amount to persecution - EASO, Country Guidance Nigeria, February 2019, p. 56-57.

40 No indication was made by respondents if rejected refers to first instance and/or finally rejected cases only.
• applicants with addiction problems.

However, in most EU+ countries, all applicants with special needs do receive basic services. Some respondents indicated that in their EU+ country, NGOs provide support services (e.g. tailored psychosocial support) and not the authorities as they outsource the support services.

48% of the respondents working in the field of reception indicated that they had at least once had an experience with an applicant trying to abuse the system by pretending to suffer from a mental health problem as to benefit from certain safeguards. 40% have never come across someone not telling the truth about their mental health condition.

**In order of priority, respondents mentioned that applicants do sporadically use mental health concerns as an excuse to:**

1. change a specific reception facility (attempt to improve living conditions);
2. receive more benefits;
3. influence an application for international protection in their favour (one mention).

### 3.3.3 Referrals and collaboration

The majority of respondents agreed that referrals to specialised services are important when working with a vulnerable population like applicants with mental health concerns. In many EU+ countries, the referral partner is placed within the reception facility (see 33 responses linked to the 32 responses below). Seven participants (from six EU+ countries) stated that their respective facility does not have an official referral mechanism or memorandum of understanding (MoU) with a public mental health entity. It was shared that the existence of such MoUs depend also on the location of the reception facility; there seems to be a difference in terms of urban versus rural.

*Figure 16. Referrals and collaboration (S-R Q 4.4)*

<table>
<thead>
<tr>
<th>Available mechanisms</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>No established referral mechanism or MOU with MH provider</td>
<td>7</td>
</tr>
<tr>
<td>Sporadically - when the need arises</td>
<td>16</td>
</tr>
<tr>
<td>We do not have the funds or time to engage in exchange with such partners</td>
<td>1</td>
</tr>
<tr>
<td>We only refer in extreme and severe cases (e.g. when the applicant is a danger to him/herself or others)</td>
<td>6</td>
</tr>
<tr>
<td>We regularly collaborate with a mental health support service/psychosocial support unit (or similar)</td>
<td>32</td>
</tr>
<tr>
<td>We have professionals/NGOs within the reception centre/camp who support applicants/refugees in need</td>
<td>33</td>
</tr>
</tbody>
</table>
3.3.4 When mental health needs of applicants are not addressed

Evidence suggests that not all applicants with special needs benefit from services they would indeed require. Respondents shared negative consequences observed when these needs are not met.

Negative consequences when service provision is neglected include:

- increase in substance abuse is more likely;
- self-medication with illicit (or other) drugs increases;
- depressive symptoms prevalent;
- general aggressiveness increases in applicants with a low tolerance to violence and conflict;
- a worsening of the mental state of applicants combined with aggressive outbursts, misuse of medications, and suicidal behaviour;
- in case of pre-existing conditions, initial symptoms deteriorate further, and pathology can become worse and more chronic as a consequence;
- integration into the reception facility community and/or host community is challenging;
- self-harm, arson and increase in suicidal tendencies become more evident;
- blaming others for problems, which results in conflicts within the community of applicants and staff;
- damaging property (within the facility but also outside);
- drop out of the asylum procedures (applicant no longer sees sense);
- since symptoms deteriorate, this can affect memory and applicants may be less likely to remember past events for their personal interview.

3.4. Monitoring, documentation and sharing of information

32 % of respondents stated that their EU+ country had a form of monitoring mechanism in place as to identify and address gaps in services delivered to persons with special needs, compared to 40 % that stated there was no mechanism in place (25 % were not sure and 2 participants did not respond to this question). About a third of survey participants answered yes. These percentages are similar to responses provided by survey participants focusing on the personal interview (see Chapter 4. Mental health of applicants in the personal interview). In terms of recording and documentation of information on the mental health condition of applicants, half of the respondents (50 %) stated that the mental health concerns are recorded in the applicant’s file. 29 % stated that documentation sometimes takes place and the rest of the respondents stated that they do not record but pass on information verbally. It was stated that information is confidential and only shared between medical professionals.

Below is a quotation from a respondent when asked if mental health concerns are recorded in the applicant’s file for further processing by other relevant staff (e.g. for case officers during the personal interview).

‘We wish we could write "yes always" because of the importance, but due to confidentiality and the fact that the work is not fully recognised, there is no formal provision (or training) for regular staff in reception centres to record such important information.’
Another concern raised by survey participants was that ‘history and knowledge’, meaning an applicant’s individual file, do not in all cases travel with the applicant, in the event that an applicant changes reception facilities.

Comments made by respondents on data protection and documentation:

- According to the law and internal procedures, we have the files separated and classified, and always ask for the consent of the applicant before sharing any of the information;
- Certain information is shared colleague to colleague (verbally) but not officially;
- All files are data protected;
- Information with other entities are shared in basics only with an indication that further information can be queried where needed;

19% stated that with the consent of the applicant information on their mental health is being shared with other authorities. For example, information is shared with the asylum office with the aim to potentially provide evidence for the applicant’s claim or to guarantee a sensitive approach during the personal interview.

Information on the applicant is shared in some EU+ countries with the centre for social work (or similar) when:

- minors are involved and a potential case of family violence has been identified;
- in cases of severe mental health problems such as applicants suffering from psychotic disorders and who potentially have no insight into their condition, which puts the applicant at risk of harm;
- an applicant who presents with self-harm tendencies or tendency of harming others;
- in cases of victims of human trafficking.

3.4.1 Statistics

Data collection on mental health concerns of applicants for international protection seems not to take place in a coordinated manner in many EU+ countries. The majority (61%) of respondents stated that data of applicants with mental health concerns is not collected, while 16% confirmed collecting such information. It was also mentioned that while data is being collected, this is being done by specific entities like the health sector and therefore not necessarily available to everyone within a reception facility. Survey respondents were encouraged to share current data on mental health affecting applicants from their respective reception facilities. Only limited data was shared.

EU+ country I - February 2020:

Total occupancy 70 applicants, 20 applicants identified with serious mental health concerns:

- Paranoid schizophrenia: 1
- Anxiety disorder/Psychosis: 1
- General anxiety/tension: 2
- Depression: 9
- Obsessive Compulsive Disorder: 2
- Narcissistic personality disorder: 1
- Substance abuse (drugs/alcohol): 4
Another EU+ country indicated to have registered in their specific reception facility a total of 21 applicants with serious vulnerabilities in 2019. Nine applicants with mental health issues, and an additional twelve applicants were identified as victims of torture/bad treatment/rape.

In 2020, during the first two months, three applicants with serious vulnerabilities were identified:

- Attempted suicide: 1
- Substance abuse: 1
- Other mental health concern: 1

Main concerns observed were suicide attempts and applicants presenting with depressive symptoms. Only concerns were shared no actual data.

When asked if other organisations or departments collect relevant information on the mental health conditions of applicants for international protection, 73 % of respondents either answered ‘not sure’ or ‘no’.

27 % were positive that data on mental health concerns in applicants is collected, particularly by NGOs charged with collecting such data. Further, the Ministry of Health was mentioned by some EU+ countries as the main entity holding this information. Others stated that each reception facility collects information as well. A centralised database holding information on vulnerable applicants including those with mental health concerns seems not to be the case in most of the respondent EU+ countries.

Below are some website links containing health information, including information for applicants on services available in certain EU+ countries:

- Pharos, (the Netherlands)
- GZA (Asylum Seeker Healthcare), (the Netherlands)
- Institute of Public Health Serbia, (Serbia)
- Oficina de Asilo y Refugio, Asile en cifras, 2018 (Spain)

An additional survey on data collection and its purpose, data collection mechanisms and those collecting data, with a focus on vulnerable applicants - including those with mental health concerns - may be useful. This is in light of the limited responses received on data collection.

3.5. Effectiveness of the European reception system to support applicants with mental health concerns

Almost 42 % were positive that the current reception system in Europe was sufficiently equipped to support applicants with mental health concerns. 29 % were not sure, while 27 % of the respondents felt their reception system was not comprehensive enough.
Main challenges identified relating to mental health:

I. Movement of applicants: Frequent moves by applicants (changes of reception facilities) makes a continuation of support challenging

II. Lack of resources: There is a need to develop special needs-friendly budgets (e.g., tendency noted that when budget is cut, it often targets staff and activities which would benefit vulnerable applicants); Specialists (e.g., psychiatrists, psychologists, etc.) are often project-based and not considered mandatory and therefore their services are not mainstreamed; A psychiatrist who can prescribe medication is beneficial; Reception centres tend to be understaffed and overcrowded; Lack of interpretation services.

III. Lack of awareness: Some professionals are not culturally sensitive enough to understand the conceptualisation of mental health of applicants coming from a different religious or cultural background; Awareness that applicants may only display ‘normal reactions to abnormal circumstances’; Information for staff and applicants on self-help / psycho-education.

IV. Lack of a streamlined/standardised approach: Variations even within an EU+ country as to which services are available in different locations, and the response itself (urban vs rural); Focus centres on response rather than prevention.

V. Other points raised: The mental health system is lacking even for own citizens; Staff is professional enough to work with applicants, the root causes need to be addressed, which are mainly lengthy asylum procedure in EU+ countries; Accelerated procedures do not necessarily allow for proper identification/assessment and follow up of applicants.

While a better understanding and knowledge of the applicants’ cultural and religious backgrounds by staff working in reception facilities is seen as important, 63 % overall trust in the expertise of their team members.

3.6. Good practices shared

Respondents shared following good practices for consideration:

- Established protocols on how to handle and engage with applicants with mental health concerns.
- Initial health screening includes mental health and is conducted by specialists.
- Information provision to applicants on health is provided as soon as an applicant arrives at a centre. The day after registration, a professional nurse gives the first general health information, and the first health consultation is given to applicants on a voluntary basis where requested.
- Providing incoming applicants with information including what types of available services in terms of psychosocial support, including a psychological assessment, etc.
- Specific NGO support to identify and follow up on applicants with mental health concerns.
- An integrated mental health support programme for vulnerable groups, including applicants for international protection.
• Government-led reception facilities have a **psychologist** on the team and **finance the mental health programmes of NGOs.**
• **Availability of specific resources**, accommodation and specialised care for people with mental health problems.
• Sufficient, well **trained professionals** as part of the team to support timely identification and follow up of vulnerable applicants. If a permanent placement is not possible, a specialist that visits on a specific day and time and this information is made known to staff and applicants alike.
• The **combination of relevant services** is provided: health, psychosocial and legal advice. This holistic approach also includes family members if the need arises.
• **Immediate follow up on applicants with substance abuse problems**, including hospitalisation, helps with stabilisation.
• Unaccompanied minors have a **guardian assigned** in a **timely manner.**
• **Time and availability** of staff helps applicants to stabilise emotionally and as a consequence better settle in and integrate.
• Information on and support with **Assisted Voluntary Return and Reintegration (AVRR)** reduces misconception and other fears.
• Support with and information on **family reunification**, where possible.
4. Mental health of applicants in the personal interview

‘Delays in the asylum procedure further deteriorate the mental health condition of the applicant.’

Summary

Persons arriving in Europe and asking for international protection often have a difficult past. Many of these applicants interviewed by respondents have experienced violence, abuse and persecution. Often these acts or threats of such acts have not stopped after they have fled their home country but have instead continued in countries of transit. Libya, in particular, has been pointed out by many participants in this survey as a country of concern that has placed many applicants in unimaginable situations. According to respondents, detention, torture, exploitation and other forms of cruelty have been reported by the majority of applicants passing through Libya.

It is not only experiences pre-arrival in Europe that are relevant when discussing mental health of applicants in the personal interview. Respondents shared that applicants that reapply after a negative decision and/or have been in the asylum system for several years (4-5 years) in particular appear to be more prone to presenting with mental health concerns. This is also due to the fact that procedures in many EU+ countries are still taking too long.

While the feedback received indicates that symptoms present in adult applicants are similar irrespective of their gender, it was also clear that children have their own particularities. Nevertheless, the respondents stressed the resilience of children. Overall, respondents agreed that one problem not yet sufficiently addressed is the importance of providing tailored, clear, and simple information to applicants on the asylum procedure and what is important for their personal interview. Too many applicants reach the interview stage of the procedure without being sufficiently prepared. This is simply because they were not aware what is important. This is even more so the case when they were mentally unstable. Lastly, most of the traumatic experiences are extremely personal. Sharing these experiences with case officers at the first meeting can be challenging. Therefore, preparation of applicants for the interview is important.
4.1 General findings

When asked if mental health concerns of applicants influence the flow of the personal interview only two out of 29 case officers stated that they were not sure. The majority (93%) agreed that mental health had an impact on the way an interview is conducted and potentially also the outcome. The main areas of impact on the personal interview indicated by respondents included: **time and flow, demand on skills, quality, credibility and understanding including interpretation**.

Challenges identified by case officers for their daily work:

- **Time and flow**: interviews take longer, more breaks are needed, unwanted interruption and potential re-scheduling of an interview were indicated as major concerns.

- **Demand on skills**: case officers stated that when working with applicants who are impacted by mental health concerns, they require an even more sensitive and empathic approach. The interviews are often very emotional and the way questions are posed is important so as not to re-traumatise the applicant. It was shared that in some cases forgetting the past was a form of coping. Case officers shared concerns around availability of protective mechanisms but also knowledge on how far case officers can or should go for the sake of the interview without further harming applicants who were/are severely traumatised.

- **Quality of the interview and credibility**: case officers agreed that the quality of the interview is impacted, since often such applicants cannot give a consistent narrative as to what happened. This was raised as a concern by some as it relates to credibility. It is difficult to tell when a story is false, or an applicant is just unable to share. In some cases, this uncertainty can negatively impact claims according to respondents.

- **In terms of interpretation**: working with interpreters can be challenging by itself, and it is even harder to work through interpreters with applicants with mental health concerns in some cases.

4.2 Prevalence of mental health symptoms and specific vulnerable groups

Almost three quarters (72%) of case officers suggested that a lack of concentration and the inability to appropriately answer questions were the main indicators that applicants might present with mental health concerns. These were often combined with an inconsistent narrative, unclear statements, increase in anxious behavior or lack of willingness to engage. Overall, case officers agreed that a common sign of applicants potentially having an underlying mental health problem is that they often appear as even more nervous and hesitant to engage in the interview than other applicants.
Gender consideration

The points raised here were more general and not necessarily linked directly to mental health concerns. Nonetheless, it is important to share that female case officers stated that they sometimes find themselves in an interview situation with male applicants who do not pay them the necessary respect because they are women. It was also shared that the move towards individual interviews conducted with female applicants who are normally used to being accompanied by their male partner (often seen to be their guardian) can be counterproductive in some cases. While the fact of providing women with a safe space to share their own story in their own words is generally seen as positive, a concern was raised that some women who have never learnt to speak for themselves can feel disempowered and overwhelmed talking during the interview suddenly on their own for the first time. Preparation of the women was seen as important.

Specificities concerning children

79% of the respondents agreed that the symptoms children present are different than those of adults. There was a perception, however, that children potentially deal better with stress in the country of asylum than adults overall.

\[41\] The yellow colour in the bar chart indicates the highest number of responses received per item for each questionnaire.
Case officers shared the following observations where referring to children:

- extremely restless and nervous during the interview;
- their general development seems affected;
- lack of concentrations accompanied by the fact that some of them are not able to put their fears into words during the interview;
- often feelings of shame and a wish to die, combined with a fear of being considered weak when sharing emotions;
- feelings of guilt for not having lived up to the expectations of their families in the countries of origin;
- children engage much more often in self-harming activities, triggered by traumatic experiences during transit or due to separation from their families;
- aggressive behaviour, which is often a consequence of frustrations and a feeling of powerlessness often related to lengthy procedures;
- emotionally trying to distance themselves during the interview - playing cool so as to distance themselves from their emotions.

4.2.1 Mental health concerns and credibility

Survey participants stated that even if applicants have experienced trauma during conflict or have a pre-existing condition, the fact that the support after arriving in Europe is not automatically granted further deteriorates their mental wellbeing. Basic initial service provision in the EU in terms of accommodation, medical, psychological support follow-up and counselling is too often delayed.

Further complicating the situation and reasons for inconsistency in some of the applicants' statements is the fact that many applicants do not seem to really understand what is indeed needed for their claim. Some also feel guilty and ashamed of sharing what has happened to them or their family members to a stranger during the interview. Lastly, some applicants fail to remember and respectively share what they went through as a mechanism of the unconscious to protect themselves from re-traumatisation.

The three leading sources for mental health concerns of applicants identified by case officers were linked to:
1. Traumatic experiences in the country of origin (insecurity, conflict and war) (24 responses out of 29);
2. Pre-existing health conditions (18 responses out of 29);
3. Lengthy asylum procedures in the country of asylum (16 responses out of 29).

The three main reasons for applicants to make inconsistent, shifting or not sufficiently detailed statements during their interview:
1. Applicants sometimes do not really understand what is and is not important for their claim (17 responses out of 29);
2. Applicants sometimes do not want to share certain information because they feel guilty or ashamed of what has happened to them (14 responses out of 29);
3. Applicants who have had negative (‘sad/bad’) experiences seem to avoid recalling (forget) some of the information as not to be emotionally affected again (way of coping) (13 responses out of 29).
Twelve respondents suggested that an additional reason for inconsistency in some cases could be that applicants might try to abuse the asylum system. 90% of respondents stated, however, that while it might happen, in their view it occurs rarely.

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42 The yellow colour in the bar chart indicates the highest number of responses received per item for each questionnaire.

43 The yellow colour in the bar chart indicates the highest number of responses received per item for each questionnaire.
Using mental health concerns to benefit

Applicants sometimes feel a need to use mental health as an excuse to be granted certain safeguards.

As main reasons for applicants for international protection to pretend to have a mental health concern were:

- to be grouped into the category of applicants with special needs, which entitles applicants to additional rights and benefits;
- to receive more compassion from the interviewer and hope that their case is less likely to be denied;
- mental health concerns are there, but they are exaggerated to get subsidiary protection;
- when inconsistent answers are pointed out, the applicant says it is because of their mental health problem or because they are illiterate;
- some applicants threaten suicide if they are transferred under Dublin III Regulation;
- applicants claim to have mental health problems so as to avoid being transferred to Turkey.

Examples shared:

- Sometimes family members abuse the system by making their already vulnerable family members even more vulnerable to potentially benefit. An example shared was the one of two brothers asking for asylum in an EU+ country and the younger brother has been diagnosed with a mental health issue and was prescribed with medication. The older brother, however, who was supposed to make sure that the younger brother takes his medication, neglects this duty or even intentionally prevents the younger brother from taking the medication so that he would appear more vulnerable.
- Though a rare occurrence, there have been cases where parents appeal to their children to pretend to have severe mental health problems (e.g. suicidal thoughts) that have not been supported by statements from social workers or medical experts statements on the respective child.
- The number of medico-legal reports submitted by applicants have increased significantly. These reports are submitted to substantiate cognitive/mental difficulties (which could have consequences for the personal interview) or psychological and/or physical consequences of persecution or serious harm (torture) in the country of origin. Often, however, such claims or medico-legal reports go against other findings in the course of status determination proceedings. This can happen both in terms of the ability of the applicant to fully or sufficiently participate in such proceedings, as well as the applicant’s credibility in relation to their need for international protection vis-à-vis the country of origin information.

Reasons for failing to provide necessary documentation

Respondents indicated the below three challenges as the reasons applicants fail to provide the necessary documentation to support their claims during the interview:

1. Applicants are not aware that it is their responsibility to substantiate the application (risk of persecution, etc. but also with regards to other documentation including medical reports) (14 responses out of 29);
2. Applicants have no insight into their condition and therefore do not see a specialist despite recommendation (10 responses out of 29);
3. Applicants referred to specialists are not medically/psychologically assessed in a timely manner, in order that the information gathered can be used for the purpose of their interview (10 responses out of 29).
Applicants losing their documents during flight or not having enough time to collect all relevant information during flight both received eight responses (27.5%).

Figure 20\textsuperscript{44}. Reason for failing to provide information (Q 2.9)

Survey participants stated that even if applicants know that it is the applicants’ obligation to provide medical records to support their claims, they are also required to identify a specialist willing to provide them with a medical/psychological assessment report. Normally this assessment report is not free of charge but completed for a fee and to be covered by the applicant.

In addition, in some instances, medical statements are viewed as problematic by the asylum authority in professional terms as they put forward a stand (recommendation) regarding the need of international protection of the applicant rather than a psychological/psychiatric/medical assessment only.

14 % of respondents (4 out of the 29) who participated in the survey stated that they are not sure or do not know if applicants can bring a person of trust/psychologist to the interview.

4.2.2 Mental health condition and protection

Approximately 21 % of respondents indicated that in some cases, a form of protection to applicants might be granted due to their mental health concerns. Respondents also stated, however, that in these selected cases this happens mainly when connected to other circumstances in the case. This refers mainly to subsidiary protection status (see Article 15(c) QD). Some applicants with very severe mental health issues may get a residence permit on compassionate grounds when the mental health condition would be seen as making the applicant extremely vulnerable in case of return. (This might also apply in some cases to victims

\textsuperscript{44} The yellow colour in the bar chart indicates the highest number of responses received per item for each questionnaire.
of human trafficking). Identification of self-harm tendencies were also indicated by 21% as a reason for granting some form of protection.

Examples shared by respondents:

- In a recent decision regarding an applicant from Syria, the authorities granted subsidiary protection to an applicant with reference to the risk faced if returned to Syria due to his mental health. The reasoning behind was that he would attract the attention of the authorities in his country of origin due to his mental health concerns which eventually would make the authorities look more into his person (he had a brother who was a military draft evader and therefore in risk of persecution).
- One respondent referred to the ‘sliding scale’ concept from the CJEU ruling in case C-465/07, the Elgafaji case, and indicated that serious mental health concerns, as a personal circumstance, would increase the likelihood of a serious and individual threat to a civilian’s life or person. This is by reason of indiscriminate violence in situations of international or internal armed conflict, or where mental health concerns might put the applicant at risk at the hands of the authorities in the country of origin (particular social group) a form of protection is granted.

According to the EASO country of origin information reports, mental illness in countries such as Afghanistan, Iraq or Nigeria is widespread due to years of exposure to war, conflict, violence and trauma. At the same time, mental health infrastructures and specialists in these countries are limited while people suffering from mental health concerns are stigmatised. Various sources suggest that half of Afghanistan’s population and up to one fifth of Iraq’s population face mental health problems. In Nigeria, one out of seven persons will have serious mental illnesses and one in four will have some form of mental disorder. Presenting the profiles of applicants with regard to qualification for refugee status encountered in the caseload of EU+ countries, and aiming to assist other authorities in the examination of applications, EASO country guidance identifies, among others, people with disabilities and severe medical issues, including mental health concerns. The individual assessment of whether applicants of this profile face a reasonable degree of likelihood of persecution is to be conducted while taking into account risk-impacting circumstances. In addition, the persecution of persons of this profile could be for reasons of membership of a particular social group, defined by an innate characteristic and distinct identity linked to their stigmatisation by the surrounding society.

Specific vulnerable groups

Certain groups of applicants are, according to 45% of professionals, more prone and vulnerable to mental health concerns than others (e.g. applicants placed in detention, in accelerated procedures, applications processed according to the Dublin III Regulation, applicants of a certain age, nationality, gender, family

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status or composition, sexual orientation). 38% respondents were not sure and 14% (4 responses) answered ‘no’.

In terms of groups perceived as particular vulnerable to mental health concerns the below list was provided:

- **Applicants that have taken certain routes to reach Europe** have gone through more traumatic experiences than applicants passing through alternative routes (Libya is mentioned as one very difficult transit country also in terms of trafficking).
- **Applicants that have been tortured** in country of origin and/or during transit.
- **Applicants that have lived in an EU+ country** without a permit for a long period, or applicants that have re-applied several times already.
- **Applicants in accelerated procedures**, who are unsure about their access to reception conditions in the longer term, their access to the reception system ending or who are likely only getting a temporary stay permit after a negative first instance decision.
- **LGBTI-applicants who are also often being discriminated in the country of asylum** due to their sexual orientation.
- **Women (mainly single women)**.
- **Applicants who find themselves in detention** (particularly when they have already experienced detention in their country of origin by authorities). In detention, the applicants are faced with the uncertainty of an upcoming deportation and having to live under difficult conditions in prison-like conditions. In some cases, the applicants are separated from family members, which also poses a serious threat to their mental health condition.
- **Children** including unaccompanied children.
- **Applicants with prolonged stays on the Greek islands** (hotspots).
- **Applicants whose applications are processed according to the Dublin III Regulation**.

4.2.3 The principle of the benefit of the doubt

The responses about the application of the criteria of Article 4(5) QD (benefit of the doubt) when the applicant has mental health concern(s) are shown below.

**Figure 21. Benefit of the doubt (S-AI Q 2.10)**
Three participants did not answer this question.

**Additional comments:**

- Established practice reveals extra caution in cases of torture or other serious forms of psychological, physical or sexual violence, on condition that the account of the events is generally credible and coherent, and (reasonably) substantiated by material evidence (psycho-medical reports) put forward by the applicant, the legal representative, or any other competent instance.
- Some respondents indicated that impact of mental health concerns on memory in applicants and performance during interview has not yet been given enough attention.
- The application of Article 4(5) QD depends on the individual case officer, determining authority or the judge in court handling the case.

### 4.3 Access to support services

Service provision to applicants in need seems to differ across EU+ countries. This is also the case in relation to an applicant’s profile. **Only 10 %** stated that **access to services is standardised** and the same for all applicants with mental health concerns.

**Groups with easier access to services included:**

- people with a higher educational/professional background;
- applicants, including children, who are represented by a legal representative or guardian;
- applicants who make it known they have a problem;
- applicants in detention with serious, obvious conditions.

The above indicates that in most EU+ countries, applicants that are either outspoken or educated enough to address the right officials, or legally represented applicants (in particular in the cases of children), have a higher chance of accessing services than applicants who can not make themselves heard for whatever reasons. Mental health concerns that are combined potentially with other disabilities might put applicants in even more challenging and risky positions.

**To complement the above, respondents shared that according to their experiences, the needs of the following profiles of applicants are even more at risk of being overlooked:**

- men in general, and young men in particular, do not dare to ask for assistance or are not seen likely to need assistance and are therefore potentially overlooked;
- applicants in detention are often overlooked (lack of legal advise and psychological attention);
- applicants in accelerated procedures/border procedures (since there is no provision of legal advise in many cases);
- women and elderly persons are often reluctant or even embarrassed to express their needs.
Support needs in terms of age and gender

Figure 22. Support needs and age considerations (S-AI Q 3.7)

According to the findings of this survey, there seems to be a consensus that men (particularly young adult males) need stronger consideration and tailored support services to tackle their needs, in terms of mental health but potentially also other support needs are to be considered.

In addition to age, gender, and gender identity, respondents mentioned the following groups should receive more attention:
- applicants that have travelled through Libya;
- survivors of gender-based violence;
- victims of human trafficking;
- applicants in detention;
- applicants with pre-existing medical conditions;
- applicants that have stayed in an EU+ country for several years and have not yet received a decision or interview date or potentially have received a negative decision at first instance.

Referrals

Seven respondents stated that their EU+ country currently has an efficient and functioning referral system in place when it comes to mental health of applicants. In terms of legal support and representation for applicants with mental health concerns, 41% stated that this is being taken care of sufficiently. However, it is was again noted that the burden of proof, as with all relevant elements of the case, rests with the applicant who will have to take the necessary steps to substantiate their claim. In some EU+ countries this includes also paying for medical certificates that might be requested.
4.4 Standard operating procedures involving applicants with mental health concerns

One country stated that their standard operating procedures (SOPs) are not public, while almost 21% stated that a combination of efforts is implemented. 17% of respondents have no standardised approach in place when dealing with applicants with mental health concerns or they are not sure about the approach to be used. Others, 14%, indicated that the response depends on a case-by-case basis.

One respondent shared the following steps in terms of consideration of mental health concerns during the personal interview:

(i) mental health issues that appear severe;
(ii) psychological/medical treatment and follow-up already has been initiated;
(iii) the requested additional medical information is considered crucial to the outcome of status determination proceedings, the applicant receives a tailored questionnaire which is to be provided to a medical professional to be filled in. After that, further processing is decided.

Almost a third of respondents indicated that the interview is suspended for applicants presenting with mental health concerns until a medical certificate/statement is available. The same number of respondents stated that the interview is conducted, information is gathered by the case officers, the mental health concern is documented, and the supervisor takes a decision on the next steps in the specific case.

4.5 Monitoring, documentation and statistics

The majority of respondents indicated that either they were not sure or that there was no monitoring/gaps in service assessments in place. Only 17% stated that their department collects information on the mental health state of applicants. Simultaneously, it was shared that the data was part of the applicant’s file, or potentially reports submitted by medical professionals from other departments, but were not necessarily collected in a standardised manner as part of the asylum authorities’ process for data collection.

Documentation

Only two out of 29 respondents stated that they do not receive sufficient and timely information on applicants prior to the interview. However, respondents did share that in cases where applicants suffer from mental health concerns, often these applicants have not yet had a consultation with a professional, were not aware that this information could support their claim, or their results were not yet ready (medical/psychological assessment) to submit during the personal interview.

4.6 Good practices

While certain challenges remain, participants did share some good practices from their respective EU+ countries regarding applicants with mental health concerns.
Respondents shared following good practices for consideration:

- Access to and participation of psychologists/social workers in case of need in the personal interview;
- Allowing applicants to submit their case in writing to reduce the level of stress;
- Flexibility in adjustment or rescheduling of interviews when deemed necessary;
- Referring applicants for professional support where it was not yet conducted;
- Participation of all case officers in the EASO training module on interviewing vulnerable persons;
- Free of charge provision of legal counsellor to support such applicants in their claim;
- Being respectful and understanding to the need(s) of the applicant.
5. Discussion and conclusion

‘The behaviour of applicants we work with affects us.’

Respondents participating in the survey did not only share challenges but also provided several recommendations on how to ensure more effectiveness in preventing mental health concerns of applicants and how to respond to their needs. According to participants, a good number of applicants present with mental health concerns due to exposure to traumatic events in their country of origin. These concerns are exacerbated by prolonged asylum procedures, lack of staff to respond appropriately, lack of access to applicants in need in accelerated procedures, overcrowded reception facilities, placement in detention and lack of access to relevant information. Respondents agreed that a stronger focus should be placed on prevention of mental health concerns in applicants instead of response only. This can, however, only be successful when sufficient investments are made in national asylum systems, in terms of human resources, direct service provision, development of streamlined procedures and providing appropriate space for reception.

5.1 Recommendations

In terms of resources, it was suggested to address the needs of vulnerable applicants in a timely manner and support with meaningful interventions while keeping prevention of mental health concerns at the core. Recently some AMIF/EU funded projects have started to help, for example with early recognition of mental health issues at the reception centres. Additional funding for similar projects was considered useful by respondents.

On an organisational level, strong commitment and investment by authorities into reception and staff in general was suggested. A need for more flexibility in terms of scheduling work was stressed, which should be linked to the identified needs of the applicants. The importance of access to applicants in detention by specialists (e.g. psychologist, psychiatrists etc.) was highlighted. Further, clear protocols, SOPs, clear job descriptions to avoid overlaps by staff working in this field needs attention. Investment in staff wellbeing was highlighted and lastly, the availability of interpreters to support professionals in their work needs stronger consideration.

In terms of expertise and a skilled workforce, training courses on an ethical work approach (as it relates to code of conduct and accountability) were suggested as well as training in both psychiatric and non-psychiatric emergencies. Stress and anger management related training modules were seen useful for first-line workers and a general information package on migration and asylum for specific specialists such as medical doctors, psychiatrists and psychologists, who support in providing medical certification for applicants was seen as crucial. Support sessions on how to keep the balance between information needed for the purpose of the personal interview and not further traumatising the applicant were discussion points.
raised mainly by case officers. More information for caseworkers on how and why psychological trauma can affect memory was seen as important. Lastly, standardised psychological and psychiatric reports prepared by professionals would facilitate officers conducting personal interviews in particular when making a decision on an applicant’s application.

In terms of service provision, an improved triage mechanism upon arrival was suggested. Inclusion of a mental health screening as part of the initial health screening of applicants was recommended. A streamlined approach (at least within the EU+ countries) on assessing, diagnosing persons with special needs, reporting and documentation of findings for asylum purposes is seen as advantageous. Respondents from both asylum and reception authorities agreed that more time is needed to engage with applicants and to allow for the necessary, individualised, and relevant follow-up. While some applicants with mental health problems might benefit from specific reception conditions (or potentially hospitalisation), for others a change in location and separation from family might be counterproductive. Therefore, a comprehensive but also individualised approach is crucial. Pre-screening of applicants before the personal interview might be of benefit for applicants and caseworkers alike. Such a holistic approach would allow for early identification of existing as well as potentially emerging mental health concerns and support prevention of the same.

A set of protective factors for applicants with mental health concerns were identified by respondents. These could be taken into consideration by authorities when designing prevention and response mechanisms and meaningful interventions. Protective factors included: timely registration and proper information provision about the process and procedure, access to staff where necessary, daily routines, staying connected to family, friends and social networks. The importance of being connected, being able to speak to loved ones so as not to feel isolated is empowering in itself. Therefore, the impact of measures implemented in some EU+ countries where phones are confiscated, leaving applicants with limited opportunities to engage with families and their community, need to be considered. Cultural considerations and sharing of personal conceptualisation of mental health of applicants are to be considered by professionals engaged with applicants in need.

Improved coordination, networking and collaboration between the reception and asylum authorities as well as with the health sector and social services is seen as very much needed. An example shared was a joint lessons learnt workshop with the health sector and social services to discuss a joint way forward.

Public awareness and communication on mental health of applicants was suggested as an area to strengthen and explore. While in some EU+ countries communication seems enough between the various authorities and government partners, the communication on services available to applicants in other EU+ countries needs improvement. Many applicants do not have the necessary knowledge as to what is available to them, by whom and why it is relevant (e.g. why medical certificates could be important for their asylum claim, etc.). Tailored information provision and guidance tackling such issues should be looked into.

The CEAS suggests a timeline to follow for certain procedures. Lengthy procedures increase risks of applicants presenting with mental health concerns. Therefore it is in the interest of EU+ countries to respect timelines in the APD and monitor and evaluate services provided.

Lastly, the development of minimum standards where vulnerable applicants such as applicants with mental health concerns are involved would further enable first-line workers to be more effective and efficient.

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48 See Article 31(3) APD: ‘Member States shall ensure that the examination procedure is concluded within six months of the lodging of the application’.
Having a shared understanding of the basic needs to be covered by local facilities, for instance, would facilitate the work of first-line officers in reception. A continuation of actively sharing good practices between EU+ countries was considered helpful as well.

Regular monitoring of the work involving vulnerable applicants (including visible and not obvious vulnerabilities) and the setting of quality benchmarks to ensure work is conducted in a streamlined and standardised manner throughout the asylum procedure and reception has been identified as an area for improvement. Having a joint and standardised monitoring system, including a data collection system in place developed by authorities and specialists, could facilitate staff and management to easier orient themselves. This orientation would help in terms of duties and responsibilities to be carried out by each employer and employee and increases efficiency and effectiveness of the asylum system overall.

In summary, to enable professionals in systematically addressing mental health concerns of applicants and to avoid deterioration of their condition, the following considerations were shared:

- **Investment** by EU+ State authorities in: human resources including specialists as well as project funding to support vulnerable groups (like for example young, single, adult men)
- A strong, clear and relevant information package for applicants on: country of asylum information, asylum procedure, support services (including on how to access legal and psychosocial/psychiatric support)
- Training for officers on recognising mental health concerns in applicants both in reception and in the personal interview as well as training on asylum and cultural background of applicants for health professionals
- Access, early identification and assessment of vulnerable applicants (including those placed in detention and in accelerated procedures)
- Investment in reception facilities and space to provide tailored support (including free legal and psychosocial support to all applicants in need while taking gender, age, cultural background, and disabilities into consideration as well as potential substance abuse problems)
In addition, respondents mentioned a need for:

- **Closer and improved networking and collaboration** between asylum and reception authorities and the public health sector including mental health service providers.

- **Development of a standardised medical certificate/reporting format** to be used throughout the EU+ countries, particularly relevant for case workers for further processing (decision-making).

- **Authorities to respect reasonable timelines** for issuing decisions without jeopardising quality of the work and to take mental health considerations more into account when considering the use of accelerated procedures.

- **Authorities to take mental health concerns more into account when designing reception systems** and particularly when considering the use of detention/restriction of movement.

- **Development of a comprehensive data collection system** without jeopardising the privacy/confidentiality of vulnerable applicants.

**5.2 Way forward**

‘A well-placed investment helps everyone involved, while ignorance and avoidance does not.’

Looking at the overall findings and the mandate of EASO, the agency could as a first step support EU+ country authorities by jointly developing a basic guidance on psychosocial programming for staff working in reception facilities and during the asylum procedure. In addition, attention could be given to the development of relevant information material for applicants in general. This would be particularly relevant for those with mental health concerns and their families and could be used by asylum and reception authorities. The information package is to be developed according to the needs of the final target group (applicants). Such information material facilitates the required information provision by authorities to applicants with special needs. Further, a joint kick off meeting between selected professionals from EU+ countries from reception, asylum, the health sector and social services to trigger discussion on the topic could be coordinated.

In addition, developing simple and practical tools for case officers on basic questions to ask during the personal interview for applicants with potential mental health concerns could be another area in which EASO can support. Such guiding questions are to be posed in an ethical and sensitive manner to applicants.
who have potentially experienced traumatic events. It would also be important for case officers to learn more on how trauma can affect memory and influences the interview process therefore as a consequence. Lastly, general capacity building on the CEAS and asylum in Europe for a group of selected medical professionals and psychologists in form of train-the-trainer sessions may be a further suggestion. The three networks of reception, asylum processes and the VEN will advise which areas to prioritise.
6. References


International Medical Corps, Assessment Report, Understanding Mental Health and Psychosocial needs and Service Utilisation of Syrian Refugees and Jordanian Nationals, 2017.


7. Annexes

Annex I: Survey questionnaire reception (S-R)

1. General Information

1.1. EU Member State:
- Austria - France - Malta
- Belgium - Germany - Netherlands
- Bulgaria - Greece - Poland
- Croatia - Hungary - Portugal
- Cyprus - Ireland - Romania
- Czechia - Italy - Slovak Republic
- Denmark - Latvia - Slovenia
- Estonia - Lithuania - Spain
- Finland - Luxembourg - Sweden
- Other (please indicate)

1.2. Employer:
- Asylum Authority
- Reception Authority
- Local NGO
- International NGO
- United Nation
- Other

1.3. I hold the following position...

1.4. Have you received training on how to deal with applicants who might present with a mental health concern? Yes/No/Not sure
If you answered with Yes – please indicate what kind of training and provider.

2. Conceptualising Mental Health in Reception

2.1. In your line of work, are you faced with asylum applicants who have in your view some form of mental health concerns? Yes/No/Sometimes/Not sure

2.2. How many applicants/refugees, who present with a mental health concern, are you faced with in average per month?
   - Less than 3 a month
   - Between 4-10
   - More than 10
2.3. If you answered with Yes or Sometimes to question 2.1. - which of the signs and symptoms listed below did you observe in applicants at your reception facility which might indicate a mental health concern? (Please pick only the most common ones).

- Forgetfulness/lack of concentration
- Aggressive behaviour directed towards other residents or staff
- Incapable to hold a meaningful conversation
- Aggressive behaviour directed towards oneself (self-harm tendencies)
- Self-talks and/or communication which does not make sense
- Increased use of substances like alcohol, cigarettes but also illegal drugs
- Sharing of very personal information and asking very personal questions
- Increased use of pain killers to numb feelings of potential pain
- Appearing as not to understand questions being asked and to respond accordingly
- Incapability to take care of dependants (e.g. neglecting the duty of care of children/other family members)
- A general feeling of anxiety
- No energy/will in engaging in any activities (e.g. past hobbies)
- In a constant state of worrying
- Leaving the reception centre/camp for days without indication where he/she went
- Feelings of guilt and shame on things which happened
- Significant changes in eating or sleeping habits
- General feeling of mistrust
- Isolation from family and friends
- Feelings of hopelessness
- Avoiding any information sessions or other session offered in the reception centre/camp
- General feeling of being sad and unhappy
- Applicants sharing believes in being possessed by evil spirits or use of witchcraft against them, ‘seeing or hearing things’ which are not there (e.g. hearing voices)
- Mood swings (one moment crying/followed by happiness)
- Lack in personal hygiene even though opportunities to wash clothes/shower are provided
- Talks about wanting to die (suicide)
- Physical presentation of distress (e.g. increased headache, back pain, gastrointestinal problems)
- Aggressive behaviour directed towards family members (e.g. verbal/physical abuse)
- Sleeping problems/bad dreams
- Other (please specify)

2.3.1 Do the symptoms picked differ when the applicants are children?

Yes/No/Sometimes

In case you answered with Yes or Sometimes kindly indicate the differences:

2.4. Are there applicants who are particularly vulnerable in terms of mental health concerns (e.g. applicants in regular vs accelerated procedures, Dublin cases, age, nationality, gender, family status or composition, sexual orientation or experiences they endured e.g. torture, SGBV etc)?

Yes/No/Not sure

If you answered with Yes – please briefly explain:
2.5. Are there applicants with mental health concerns who are excluded from ongoing and comprehensive support (e.g. depending on the location/type of facility placed, regular vs accelerated procedures, Dublin cases, age, nationality, gender, family status or composition, sexual orientation)?
Yes/No/Sometimes/Not sure
If you answered with Yes or Sometimes – please explain:

2.6. Are you aware of applicants who falsely pretended to have a mental health concern to benefit from adjusted reception conditions (e.g. move from detention to open centre; transfer from one open centre to another; single accommodation) or other procedural guarantees (e.g. placed in regular procedures)?
Yes/No/Other (please specify)

2.7. Are you aware of applicants/refugees who do not want to be identified as having a mental health concern?
Yes/No/Not sure

2.8. If you answered with Yes – select the main reason(s) listed below:
- Cultural / Family reasons
- Fear of stigmatisation by community members
- Fear of a potential negative impact on their asylum claim (for example believing that this could lead to an increase in the length of procedure ahead)
- Fear for their safety/family members safety
- Fear of associated costs to see specialists
- Applicants not acknowledging the fact that they are in need of support
- Fear of potential medical treatment/hospitalization
- Lack of trust in the personnel they interact with
- Lack in trust in the health system in your MS
- Lacking information on what is available to them
- Other (please explain)

2.9. Mental Health problems noted in applicants at your reception facility, are normally (Please pick the most important ones):
- Pre-existing health/mental health concerns which were already a problem in the country of origin during peaceful times
- Linked to the loss of community and lack of a social support system (including family) in the country of asylum (Europe)
- Linked to negative experiences in the country of origin (e.g. due to specific event(s) and experiences which happened during war/conflict/insecurity etc)
- Linked to the reception conditions in the country of asylum which might not be appropriate
- Linked to events taking place in detention in the country of origin/transit (e.g. torture)
- Linked to violence experienced in the country of asylum (Europe) e.g. SGBV
- Linked to family violence experienced in the country of origin
• Linked to a ‘transfer back’ to country of asylum as per the Dublin Regulation
• Linked to negative events/experiences during flight (transit)
• Linked to detention/pre-transfer detention
• Linked to negative events/experiences in the country of asylum (Europe)
• Linked to low prospects of being granted protection
• Linked to a lack in provision of timely support services (e.g. accommodation/medical/psychosocial/legal and counselling etc) in the country of asylum (Europe)
• Linked to uncertainty and lack of future perspective
• Linked to lengthy asylum procedures and a lack of legal status in the country of asylum (Europe)
• Other (please specify)

Please explain very briefly why you picked the item above (e.g. examples without identifying applicants).

2.10. Do you think that the reception system in your MS as it is, is comprehensive enough to support asylum applicants and refugees with mental health concerns and therefore reduces the frequency, severity of symptoms in applicants?

Yes/No/Not sure

2.10.1. If you answered with Yes – what makes your system comprehensive in your view (lessons learnt).

2.10.2. If you answered No or I am not sure – Please explain what is most needed to improve the situation for such applicants in your view (keeping gender and age of applicants in mind - elderly vs minors, etc.).

2.10.3. Please also explain what is needed for you as a professional working in reception to be enabled to conduct your work as effectively as possible with such applicants:

3. Identification of applicants with mental health problems

3.1. In your current role are you required to (please tick what is relevant):

Identify applicants who are vulnerable (including those potentially suffering from mental health concerns)
Conduct vulnerability assessments with applicants including their mental health condition
Refer applicants for screening upon detection of a potential mental health problem
Manage cases of applicants with special needs including those presenting with a mental health concern
Provide information, counsel/advise support applicants with mental health concerns
None of the above
Other (please specify):

3.2. In case you are not the one identifying/referring/managing vulnerable cases like applicants with mental health concerns – who is responsible in your setting to do so?

• Social worker (public sector)/Reception officer/Vulnerability focal person (or similar)
3.3. Once an applicant/refugee is identified as in need of additional support (mental health) by those in charge of identification, referrals and/or case management - how long does it normally take for a follow up to take place?

- 0-3 days;
- Up to 2 weeks;
- 2 weeks to a month;
- It can take longer than a month;
- We do not have any support system in place (meaning social worker, psychologist, psychiatrist) to refer to;
- Not sure
- It depends on the severity of the case
- Other (please specify)

3.4. In case the applicant with a mental health concern is a child (below 18) - are there any particular considerations you take?

Yes/No/Sometimes
Please explain in one bullet point.

3.5. What in your view are currently the main challenges in your MS in identifying asylum applicants with mental health concerns? (Please pick the 3 main challenges)

- Lack of knowledge and basic training of staff on how to identify and assess mental health concerns
- Lack of understanding in staff of how different cultures and religions might approach mental health
- A general lack of staff to focus on vulnerable cases like applicants with mental health concerns
- A lack of guardians/legal representatives to support in case the person with the mental health concern is a minor
- Not being aware of the needs since there is a lack of information material and therefore knowledge by applicants who to contact to share their special needs including mental health concerns in the reception centre/camp
- Lack of interpretation services available to further clarify what the actual concern of an applicant is
- Lack of time and space available to create a confidential and trustful situation for staff to engage with applicants in need
- A general lack of support services in place in the MS to refer applicants to (so therefore even if identified nothing can really be done in terms of support)
• Difficulties for asylum seekers to access relevant services (e.g. lack of legal status, financial reasons)
• Lack of trust/credibility on the information shared by applicants regarding their condition due to misunderstanding or prejudices on the side of staff
• Other (please specify)

3.6. Do you see a difference between mental health concerns presented by asylum applicants compared to persons who have been granted some sort of legal status (subsidiary protection, temporary protection, refugee status) but are still residing in your reception facility for certain reasons?

Yes/No/Not sure
If you answered with Yes – please indicate kind of difference(s).

4. Response to needs identified

4.1. Which of the below listed services are available in your work setting to applicants identified with a mental health concern:
• Culturally, age, gender and language appropriate information programs about symptoms and “warning signs” of mental health concerns for all residents
• Social and educational support activities, employment opportunities
• Clear, age and gender appropriate information on services available and how to access these independently
• Adjusted and appropriate accommodation
• A mechanism is available (identification, assessment, response) of special needs including mental health concerns as part
• General preventative anger management/stress management sessions for residents are provided
• Ongoing management, referrals and free medical/psychosocial follow up is available (particular for applicants victims of torture, child abuse, SGBV survivors)
• Applicants have access to regular and meaningful social, cultural, educational, sport activities and employment opportunities to prevent mental health concerns
• Substance abuse/rehabilitation programs are available to applicants/refugees
• Scheduled screening tests by primary health care providers to help identify conditions like PTSD, depression etc in applicants in a timely fashion take place
• Hospitalisation can be provided (where needed) Regular screening of children, especially unaccompanied minors (for PTSD and suicidal thoughts)
• Linkages to community healers/traditional healers of certain groups of migrant communities to support treatment where deemed appropriate are in place
• Specific protection arrangements are in place for victims of human trafficking, SGBV, torture or other forms of psychological and physical violence in particular for children
• Referrals partners have language and cultural interpretation capacity
• We do not have the capacity to provide any support services to applicants who might have mental health concerns
• Monitoring of medication intake prescribed to applicants by a staff member in absence of family members to ensure continuity
• Other (please clarify)

4.2. Which of the below is most important for applicants/refugees to better recover from mental health concerns linked to experiences in country of origin and/or transit? (Please only pick the most important ones):
• Basic service provision: (including basic health care, security/protection, food, appropriate shelter, timely registration, information provision etc)
• Age appropriate support: (ensuring child tailored psychosocial support services, age appropriate information, child appropriate accommodation, importance of family/next of kin, education)
• Opportunities to rebuild social connections: (which includes family reunification, opportunities to talk to family members back home or in transit; space ‘to make meaning/sense’ of what has happened (e.g. abuse, persecution), supported by community; participation in traditional/religious community rituals (e.g. assisted mourning - a symbolic burial for lost family member); opportunities to integrate into host community etc)
• Specialised support: (including counselling provided by professionals, medical interventions, financial allowances, social support services etc)
• Routine: (including regular daily activities like sport, hobbies, education/school, employment)
• Recognition and justice: (including acknowledgement by the family of the wrong doing (violence) committed against the applicant; and public (international) acknowledgement of the wrong doing (violence, persecution) committed of perpetrator(s) (state actors/militias etc)
• Other (please specify): Please briefly explain your choice.

4.3. Are there any protective factors you have identified in your line of work which improve or strengthen the mental health (resilience) of applicants - speaking in general terms?
Yes/No/Not sure
If you answered with Yes – please very briefly share:

4.4. How often does your team liaise with mental health support services (Please pick only what is relevant)?
• We do not have an established referral mechanism and memorandum of understanding for collaboration with a mental health entity
• Sporadically - when the need arises
• We do not have the funds or time to engage in exchange with such partners even though support services are in place
• We only refer in extreme and sever cases (e.g. when the applicant is a danger to him/herself or others in the centre/camp)
• We regularly collaborate with a mental health support service/psycho social support unit (or similar) and refer applicants in need
• We have professionals/NGOs within the reception centre/camp who support applicants/refugees in need
• Other (please explain)

4.5. What are, according to your experience, the consequences, when mental health needs of asylum applicants are unmet (also in terms of age/gender)? Please indicate briefly:

4.6. Overall, do you believe the team you currently work with has sufficient expertise to respond to the needs of asylum applicants with potential mental health concerns?
Yes/No/Not sure
If you answered with No, Sometimes or Not sure – explain with one bullet point what is most needed in
If you answered with No, Sometimes or Not sure – explain with one bullet point what is most needed in your view to be able to work as efficient and professional as possible:

5. Prevention and Monitoring
5.1. Are mental health concerns recorded in the applicants file for further processing by other relevant staff (e.g. for case workers during interviews)?
Always/Sometimes/We do not make any notes on such issues
Other (please specify):
In case you answered with Always or Sometimes – kindly explain how you ensure confidentiality of information shared by the applicant:

5.2. Do you currently have a review system in place to address gaps in services delivered for people with special needs (including applicants with mental health concerns)?
Yes/No/Not sure
Other (please specify):

5.3. In your reception facility do you collect statistics on mental health concerns in applicants?
Yes/No/Not sure
If you answered with Yes - Please share recent statistics (while not indicating any personal information)

5.4. Are there other organisations/government bodies who collect data on mental health of specifically asylum applicants in your country?
Yes/No/Not sure
If you answered with Yes – by whom and if possible share a link.

5.5. Which prevention activities are available in the reception facilities (e.g. support groups, empowerment sessions, information sessions/campaigns, outreach etc) on the topic? Please specify if applicable:
6. Good Practices
6.1. Can you share one example of a good practice - where you feel your MS has displayed appropriate response to applicants faced with mental health concerns in reception:

7. Other
7.1. As a conclusion would you agree that mental health concerns in applicants influence your work in the reception facility in certain ways?

Yes/No/Not sure
If you answered with Yes, please explain briefly in your own words how:

7.2. Do you think this survey is useful?

Yes/No/Not sure

7.3. In case you have shared any examples or good practices – do you agree that these can be shared with the networks indicating your: good practice; MS and authority/organisation you work for?

Yes/No

7.4. Do you have any other comment(s) or recommendation(s) relevant to the topic?

Thank you!
Annex 2: Survey questionnaire asylum interview (S-AI)

1. General Information

1.1. EU Member State:
- Austria - France - Malta
- Belgium - Germany - Netherlands
- Bulgaria - Greece - Poland
- Croatia - Hungary - Portugal
- Cyprus - Ireland - Romania
- Czechia - Italy - Slovak Republic
- Denmark - Latvia - Slovenia
- Estonia - Lithuania - Spain
- Finland - Luxembourg - Sweden
- Other (please indicate):

1.2. Employer
- Asylum Authority
- Reception Authority
- Local NGO
- International NGO
- United Nation
- Other

1.3. I hold the following position:

1.4. Have you received training on how to deal with applicants who might have a mental health concern(s)?
- Yes/No/Not sure

If you have answered with yes - please indicate what kind of training and the provider:

2. Mental health concerns in applicants and the potential impact on the asylum interview

2.1. In your line of work, are you faced with asylum applicants who have in your view mental health concerns?
- Yes/No/Sometimes/Not sure

2.2. How many applicants, who present potentially with a mental health concern during an interview, are you faced with as an average per month?
- Less than 3 per month
- Between 4-10 applicants per month
- More than 10 applicants a month
- None

2.3. If you answered with Yes to the above question – Which symptoms did you observe in applicants during interviews which could indicate a mental health concern? (Pick the 5 most common one’s):
- Unclear/inconsistent statements regarding the events occurring in the home country and during flight
- Aggressive behaviour including aggressive language used against case workers and others
• Lack of concentration/inability to answer questions posed accordingly
• Withdrawn and shy appearance
• Even though willing, clear lack of understanding of questions posed (not due to lack of language skills/translation)
• Talk about wanting to die (suicide)
• Applicant appeared to be ‘absent’/‘daydreaming’ and therefore could not follow questions
• Sudden random moves (e.g. getting up without being asked)
• Talking about not relevant personal issues and asking the caseworker personal questions
• Trouble walking independently (lack of balance) into or outside of the interview room
• Constant reference to feelings of guilt or shame Shaking limbs or clumsiness
• References made to being possessed by evil spirits or witchcraft used against them
• Lack in personal hygiene (taking reception conditions into consideration)
• Indication of self-harm tendencies (e.g. cuts on arms etc)
• Indication (breath) of use of alcohol
• Extremely restless, nervous and anxious behaviour Indication of intake of strong medicine (apathy)
• Notable mood swings (applicants starts to cry /laugh without apparent reason)
• Indication of scares and wounds on certain body parts (e.g. stemming from physical abuse/torture etc)
• Distant behaviour and lack of willingness to engage in the interview
• Self-Talk or talking to someone actually not being there
• Other (kindly explain):

2.3.1. Are the symptoms ticked above the same for children applicants of international protection?
Yes/No/Sometimes

In case you answered with No or Sometimes kindly indicate the differences in symptoms:

2.4. In your experience, do mental health concerns in applicants influence the flow of an interview?
Yes/No/Sometimes/Not sure

2.5. If you answered with Yes or Sometimes - please explain in brief, in what ways.

2.6. Concerns with regards to the mental health of applicants which are observed during an interview, are normally (pick up to 3 items, indicating priority):
• Pre-existing health/mental health concerns (were already a problem in the country of origin during peaceful times)
• Linked to negative experiences in the country of origin (e.g due to specific event(s) and experiences which happened during war/conflict/insecurity etc)
• Linked to family violence in the country of origin
• Linked to events taking place in detention in the country of origin/transit (e.g. torture)
• Linked to negative events/experiences during flight (transit)
• Linked to negative events/experiences in the country of asylum (Europe) e.g. discrimination
• Linked to violence experienced in the country of asylum (Europe) (e.g. Gender Based Violence)
• Linked to a lack in provision of timely support services (e.g. accommodation/medical/psycho social/legal information and counselling etc) in the country of asylum (Europe)
• Linked to lengthy asylum procedures in the country of asylum (EU Member States)
• Linked to the way asylum interviews are conducted and structured in the MS
• Linked to the loss of community and lack of a social support system (including family) in the country of asylum (Europe)
• Linked to the reception conditions in the country of asylum which might not be always appropriate
• Linked to detention in the country of asylum
• Other (please specify):

2.7. Do you believe that applicants may use mental health concerns as an excuse in their claim or during the interview to benefit during procedures (e.g. suspending the interview etc)?

Yes/No/Sometimes/Not sure

If you answered with Yes or Sometimes – kindly explain in what ways or give an example from your work (without sharing any details on the actual applicant):

2.8. Why in your view do some applicants make inconsistent, shifting or not sufficiently detailed statements during their interview (pick the 3 most common ones from your experience):

• Applicants sometimes do not really understand what is and what is not important for their claim
• Applicants are not aware that timing is critical (provision of all necessary documentation as early as possible)
• In the case of child applicants (unaccompanied children) they might not be supported sufficient enough to prepare for their interview (age appropriate info, legal, psycho social support pre-interview)
• Applicants often feel afraid, nervous and uncomfortable in the situation of the interview
• It seems applicants sometimes simply can’t remember certain details
• Applicants sometimes do not want to share certain information because they feel guilty or ashamed of what has happened to them
• Applicants who have had negative ('sad/bad') experiences seem to avoid recalling (forget) some of the information as not to be emotionally effected again (way of coping)
• Applicants are afraid of negative repercussions (by family/community members) if they share certain information
• Applicants want to abuse the system and therefore may share incorrect information purposely to benefit from certain procedures
• The structure of the interview is fixed, there are not enough open ended questions and therefore do not encourage the narration of the events by applicants
• The applicant is not given the opportunity to provide explanations on any possible inconsistencies, contradictions or missing elements throughout the interview
• The way interviews are conducted in the MS are not conducive for applicants to build enough trust to share information in a way which suits their background (referring to age/culture/gender/sexuality)
• This might be the outcome of misinterpretation of content by the case worker (e.g. personal background /prejudices by the case worker towards a certain nationality etc)
• Lack of guardians/legal representatives available to accompany children throughout and ensure all needed documentation is in place
• Other (please specify)

2.9. Why do applicants with mental health concerns sometimes fail to provide relevant documentation to
prove their condition? (pick the 3 most common ones in your line of work):

- Applicants are not aware that it is his/her responsibility to substantiate the application (risk of persecution etc but also with regards to other documentation incl medical reports)
- Even if referred to mental health specialists, they often lack knowledge on culturally appropriate methods for psychosocial counselling and assessments
- Applicants simply often do not have the time pre flight to collect all relevant documents (e.g. due to insecurity) including medical reports and arrive without any of these documents
- Even if referred to specialists, professional interpreters are not available
- Applicants often come from countries where authorities do not produce trust worthy or any public records in fact
- Applicants referred to specialists are not medically /psychologically assessed in a timely fashion to use information gathered for the purpose of their interview
- Applicants loose documents during their journey Applicants sometimes refuse to see a specialist for different reasons (cultural, fear from authorities or family members if they would do so etc)
- Applicants purposely destroy documents/information and make up their own story
- Applicants have no insight into their condition and therefore do not see a specialist even though recommended
- Applicants hide documents for different reasons (e.g. documents could be linked by authorities with family in their country of origin and negatively impact them)
- Applicants are not aware and informed on the importance certain documentation would carry in their claim
- When in the MS, applicants often are not referred to mental health specialists even though identified as in need, to obtain a report and therefore have nothing to prove their condition
- Reluctance of mental health workers to issue reports which may be used in the context of an asylum procedure
- Other (please specify):

2.10. How is the criteria of Article 4(5) QD (benefit of the doubt) applied when the applicant has mental health concern(s)? (Please pick the most relevant one):

- No different standards are applied
- More weight is given to objective elements (e.g. they hold some kind of medical document)
- The applicant has made a genuine effort to substantiate her/his story (e.g. plausible statements, general credibility of the condition)
- If there is compelling and complementing information by family and friends on their condition even in absence of any medical documents, then the principle can be considered
- Not sure
- Other (please specify)

2.11. Does your MS allow for applicants to be accompanied by a psychologist/psycho-social counsellor/person of trust to support them emotionally during the interview?

Yes/No/Sometimes/Not sure
3. Demographics of the applicants

3.1. Have you had applicants who received a positive decision because their mental health concern potentially would have put them at risk of harm by others in case returned to the country of origin?
   Yes/No/Not sure
   If you answered with Yes – what form of international protection have they been granted:

3.2. Have you had applicants, which received a positive decision because of their mental health concern and the risk of potential self-harm in case returned to their country of origin?
   Yes/No/Not sure

3.3. Have you had applicants which were in your view having serious mental health concerns who have however received a negative decision in their asylum claim due to the lack of timely provision of medical documentation?
   Yes/No/Not sure

3.4. Are specific groups of applicants particularly vulnerable in terms of mental health (e.g. applicants placed in detention, in regular vs accelerated procedures, Dublin cases, age, nationality, gender, family status or composition, sexual orientation)?
   Yes/No/Not sure
   If you answered with Yes– kindly explain which groups:

3.5. Are specific groups of applicants in your MS more likely to get appropriate assistance (access to mental health services and experts) than others to strengthen and support their statements and advice on how evidence is to be used?
   Yes/No/Sometimes/Not sure
   If you answered with Yes or Sometimes – please explain.

3.6. Are specific groups of applicants less likely to benefit from psychosocial support and legal advice needed to prepare for their interviews (e.g. procedural guarantees to be ensured during regular or border or accelerated procedures)?
   Yes/No/Not sure
   In case you answered with Yes or Sometimes – indicate which groups and why:

3.7. In your experience, which age group is mainly presenting with mental health concerns during interviews?
   • Children of younger age (0-14)
   • Adolescents
   • Young Adults (18-35)
   • Middle-aged Adults (36-60)
   • Elderly
3.8. Which gender is more prone to present with mental health concerns in your MS during interviews:
   - Female
   - Male
   - Persons with diverse gender identity

   - Are there any other important characteristics to be shared of applicants who present with potential mental health concerns in your line of work (e.g. applicants who have had history of torture, SGBV, detention, trafficking victim, child abuse etc):

4. Collaboration

4.1. Are case workers in your MS receiving sufficient and timely information on applicants with mental health concerns from colleagues (e.g. social workers, registration, reception officers) before the interview to be able to adjust the procedures accordingly?

   Yes/No/Sometimes/Not sure

   If you answered with No or Sometimes – Please explain what you would need to be better placed to conduct your work effectively.

4.2. What are the standard operating procedures in your MS if an applicant is not fit to participate in the interview?

   • We conduct the interview to gather some information and note however the fact that the applicant has probably a mental health concern and needs to see a specialist; the supervisor decides in a next step how to further proceed
   • We have a referral mechanism in place where the procedure (interview) is suspended until a medical certificate/statement is available to support the applicants claim; such applicants are informed by our caseworkers on where to go and what is needed from them
   • We just simply do not continue with the interview, ask the applicant to schedule a new appointment when he/she feels better
   • We normally do not have such cases
   • Not sure
   • Other (please specify)

4.3. Does the asylum authority in your MS have a functioning and active referral system in place with professional mental health services and legal advisors to support such cases?

   Yes/No/Sometimes/Not sure

   If you answered with YES or Sometimes – please briefly explain which cases are referred and why):

4.4. Are applicants who potentially have a mental health concern sufficiently supported through legal and/or psycho-social support services as to present their case in the best way possible?

   Yes/No/Sometimes/Not sure

   If you answered with No or Sometimes – Please explain what is missing for applicants in your view:
5. Monitoring
5.1. Does your MS have a review system in place to address gaps in services delivered and procedural guarantees ensured for people with special procedural and/or reception needs including applicants who present with a mental health concern?
   Yes/No/Not sure

5.2. Does your department/organisation collect mental health information on applicants you receive for interviews?
   Yes/No/Not sure

If you answered with Yes - please share recent data (without identifying any applicants).

5.3. Are there other organisations/government bodies who collect data on mental health of asylum applicants in your country?
   Yes/No/Not sure

If you answered with Yes – by whom and kindly share a link to recent data if possible.

6. Good practices
6.1. Can you share one example of a good practice where you feel your MS has displayed appropriate response to applicants faced with mental health concerns in an asylum interview situation?

7. Other
7.1. As a conclusion, would you agree that mental health concerns in applicants influence their interview in certain ways?
   Yes/No/Not sure

If answered with Yes, please explain in your own words how:

7.2. Do you think this survey is useful?
   Yes/No/Not sure

7.3. In case you have shared any examples/good practices – do you agree that these can be shared with others indicating your MS and authority/organisation:
   Yes/No

Do you have any other comment(s) or recommendation(s) relevant to the topic?

Thank you!