



# Consultations with Applicants for International Protection on Mental Health

*A participatory approach supported by Member State authorities and civil society*

December 2021



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*I am aware that the outcome of this consultation will not benefit me anymore. But hopefully it will help other applicants who will follow. In any case, I really had the feeling throughout this talk that somebody was truly listening to me.*

*(Quote from a participant from Ethiopia)*

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Contributions were received from applicants from following third countries: Afghanistan, Congo Brazzaville, Democratic Republic of Congo, Egypt, Eritrea, Gabon, Guinea, Iran, Iraq, Ivory Coast, Libya, Mali, Nigeria, Pakistan, Palestine (Gaza), Senegal, Syria, The Gambia, Turkey and Venezuela. Experts facilitating the consultations came from Belgium, Bulgaria, Germany, Greece, France, the Netherlands and Spain.

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# Contents

List of abbreviations .....	3
Background.....	4
1 Introduction.....	5
1.1 Mental health and well-being: definitions and EASO's approach .....	7
1.2 The socio-ecological model.....	9
1.3 Note on the legal framework .....	11
2 Approach and methodology .....	13
2.1 Terminology .....	13
2.1.1 Target group.....	14
2.1.2 Facilitation of the consultations .....	14
2.1.3 General safeguards during the consultation and consent.....	15
2.1.4 Analysis.....	16
2.2 Feedback on the process and consultations.....	16
2.3 Limitations and other considerations .....	18
3 Presentation and analysis of consultation outcome.....	19
3.1 Country of Origin: Awareness on Mental Health.....	22
3.1.1 Identifying mental health concerns .....	22
3.1.2 Causes of mental health concerns .....	24
3.2 Responses to mental health concerns .....	26
3.2.1 Access to support.....	27
3.2.2 Considerations around gender, age and diversity .....	28
3.2.3 Concluding remarks .....	31
3.3 Country of Asylum: Post-Migration .....	32
3.3.1 Identification and causes of mental health concerns.....	32
3.3.2 Access to support.....	34
3.4 The European reception and asylum systems: challenges and recommendations.....	35
3.4.1 Main challenges identified.....	37
3.4.2 Considerations around gender, age and diversity .....	38
3.5 Main recommendations from the participants .....	40
3.6 In summary.....	43
3.6.1 Considerations around information provision and COVID-19 .....	46
4 Discussion .....	48
5 Conclusion .....	52
6 Annex I: Participants by country and gender .....	55
7 Annex II: EASO survey on critical incident management .....	56
8 Annex III: Reporting templates (adult/youth).....	57
9 Bibliography .....	67

## List of abbreviations

<b>APD</b>	Directive 2013/32/EU of the European Parliament and of the Council of 26 June 2013 on common procedures for granting and withdrawing international protection (recast)
<b>AI</b>	asylum interview – referring in this document to the Personal interview
<b>CEAS</b>	Common European Asylum System
<b>CM</b>	complaint mechanism
<b>COI</b>	country of origin information
<b>CoO</b>	country of origin
<b>COVID-19</b>	SARS-CoV-2 virus
<b>CSOs</b>	civil society organisations
<b>Dublin III regulation</b>	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).
<b>EASO</b>	European Asylum Support Office
<b>EU</b>	European Union
<b>EU+ countries</b>	Member States of the European Union plus Norway and Switzerland
<b>FRA</b>	European Union Agency for Fundamental Rights
<b>MENA</b>	Middle East and North Africa
<b>MoU</b>	Memorandum of Understanding
<b>MS</b>	Member States of the European Union
<b>NCP</b>	national contact person
<b>NGO</b>	non-governmental organisation
<b>RCD</b>	Directive 2013/33/EU of the European Parliament and of the Council of 26 June 2013 laying down standards for the reception of applicants for international protection (recast)
<b>SGBV</b>	sexual and gender-based violence
<b>SOP</b>	standard Operating Procedure
<b>S-R</b>	Survey Reception
<b>S-AI</b>	Survey Asylum interview
<b>QD</b>	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)
<b>WHO</b>	World Health Organization
<b>VEN</b>	EASO Vulnerability Experts Network

## Background

The EASO Vulnerability Experts Network (VEN)<sup>1</sup> identified mental health in asylum as a priority for the period 2020-2021. VEN members observed that first-line officers face challenges when working with applicants with mental health concerns. Such applicants sometimes appear withdrawn, are reluctant to take advantage of the support interventions offered, show aggressive behaviour against themselves (self-harm) or towards other residents or staff in reception centres, or are verbally aggressive towards case officers. As a first step, in 2020, EASO conducted a survey on the needs of first-line officers. In July of the same year, the survey was followed by an initial mapping report<sup>2</sup> titled '*EASO Initial mapping report on mental health concerns of applicants for international protection*'.

The report outlined **ten key recommendations** to be taken into consideration by reception and asylum authorities to create a more conducive environment for applicants and staff alike. The report and recommendations were shared and addressed during a thematic meeting on mental health held in July 2020, with the participation of members of three EASO networks (Asylum, Reception, Vulnerability Experts networks). The outcome of the meeting captured the following priorities for EASO support on the topic of mental health:

- **Priority 1:** Development of a set of standards for psychosocial programming for reception and during the personal interview
- **Priority 2:** Development of information material to create awareness on mental health (for professionals, residents of reception centres in general and concerned applicants)
- **Priority 3:** capacity building for reception and asylum professionals (e.g. on country of origin information (COI) and cultural background of applicants) linked to the exchange of good practices within a multidisciplinary setting (stronger involvement of professionals from the health sector in certain meetings)

In view of designing responses to support the Member States in line with the identified priorities, EASO conducted a consultation with the applicants themselves, aiming to capture their voices with respect to mental health and mental health concerns in asylum and reception. A qualitative consultation exercise was conducted in May and June 2021, involving a total of 81 applicants and refugees. The consultation was held with the support of the authorities and civil society organisations (CSOs) from seven Member States (BE, BG, DE, EL, ES, FR, NL)<sup>3</sup>. The exercise looked into the applicants' own perception of what mental health means, explored the origins and consequences of mental health concerns and inquired on how best to understand and address such concerns. The findings discussed and captured in this summary report are evidence-based and will be used as a basis to design and develop material in line with the above-mentioned priorities.

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<sup>1</sup> EASO conducts its work through various networks. The VEN is composed by Member States (MS) authorities which are referred to as the steering group and civil society organisations (CSOs) part of the advisory group. The European Commission (EC), the Fundamental Rights Agency (FRA) and UNHCR take part in the networking meetings which aim to prioritise support activities while also allowing for the exchange of good practices. Currently the VEN counts 61 members.

<sup>2</sup> See <https://easo.europa.eu/sites/default/files/EASO-Mapping-Report-Mental-Health-EN.pdf>.

<sup>3</sup> Belgium (CSO), Bulgaria (authority and CSO), France (CSO), Germany (authority), Greece (CSO), Spain (CSO), The Netherlands (authority).

# 1 Introduction

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*People are suffering from pressure. When people are emotionally and mentally unwell, they become complicated, they are psychologically tired. This means their mind is knotted, you have knots all over. Imagine a big plate of spaghetti.*  
(Quote from a participant from Syria)

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In its holistic approach, EASO addresses the topic of mental health and well-being as an integral part of health. Good mental health is related to physical, mental and psychological well-being. Attention is paid to the person as a whole, taking into consideration the applicant's cultural and social background. Mental health concerns are viewed through the lens of psychological distress rather than psychiatric disorders *per se*. This is important because the Common European Asylum System (CEAS) makes reference to vulnerable groups and mental disorder<sup>4</sup>. EASO does not neglect the importance of providing effective and timely treatment and care to applicants of international protection who have been diagnosed with a mental disorder, nor the applicants' need thereof. Nevertheless, it should be pointed out that the conditions applicants present are often normal reactions (e.g. feeling worried, anxious, hopeless, sleepless, restless) to abnormal events (e.g. witnessing violence, experiencing the loss of loved ones, exploitation, abuse, torture, detention). While mental disorders are part of the consideration, applicants, as any person, are immersed in complex dynamics. Therefore, attention should also be paid to the interactions between individual factors set by cultural and structural norms and the surrounding environment.

The topic of mental health of applicants within the European asylum and reception systems has been receiving increasing attention. While most applicants for international protection in Europe have shown remarkable resilience, research findings show that around half of the applicants and refugees arriving in Europe experience psychological distress, mainly resulting from traumatic experiences<sup>5</sup>. The cumulation of trauma in applicants for international protection has not yet been effectively addressed, as pointed out by first-line officers working in reception and conducting the personal interviews<sup>6</sup>. Conflict-related violence, coupled with ongoing stressors related to flight and displacement, can affect a person's well-being<sup>7</sup>. However, mental health concerns in applicants for international protection are not only linked to conflict, war and persecution. The applicant's gender and age, as well as their possibly prolonged exposure to traumatic events, can play a role on how such concerns materialise, with poor social support in

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<sup>4</sup> 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*; Article 21 RCD refers also to victims of female genital mutilation.

<sup>5</sup> 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.

<sup>6</sup> See <https://easo.europa.eu/sites/default/files/EASO-Mapping-Report-Mental-Health-EN.pdf>

<sup>7</sup> According to EASO Country of Origin Information Reports, mental illness is widespread in some of the key countries of origin of refugees, 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 those countries are limited while people enduring mental issues are stigmatised. Various sources point out that half of the Afghan population and up to one fifth of Iraqis population face mental health problems, while in Nigeria one out of seven persons has serious mental illnesses and one in four suffers from 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.

the country of asylum also playing an important role<sup>8</sup>. Long waiting times for the decisions on applications for international protection resulting in insecurity of legal status<sup>9</sup>, limited or no access to education and employment opportunities and, at times, placement in detention facilities (including pre-Dublin transfers), to name just a few factors, increase the risk of prolonged concerns or of developing mental disorders and health problems.

The weight of events experienced in the country of origin (CoO), during transit, or in the country of asylum, can have a long-lasting impact<sup>10</sup>. The matter has been discussed in several reports. According to a recent study requested by the FEMM Committee of the European Parliament, which draws on an extensive survey of scientific literature, international organisations' reports, websites, press and discussions with relevant experts, pre-existing traumatic experiences endured by refugee women intersect in the countries of asylum with administrative delays, uncertainties in the asylum process, structural barriers to services and support, leading to poverty and the deterioration of their physical and mental health<sup>11</sup>. Furthermore, the stigma surrounding mental health and related disorders might be an additional barrier preventing applicants from reaching out to available support services. The same can be said about mistrust into what is considered 'western systems', including the health sector.

The fact that often a purely western approach is used to address mental health concerns, as well as other more specific needs identified by applicants, creates an additional barrier for those in need. This issue was raised not only in the survey conducted by EASO in 2020, but also in the above-mentioned study: 'Besides, traumatic experiences at all migration stages exacerbate physical problems and cause many mental health issues, not least psychiatric disorders, such as post-traumatic stress disorder and depression. Psychotherapeutic interventions are usually based on European cultural elements and understanding of therapy and do not incorporate different senses of self'<sup>12</sup>.

In addition, health and well-being (including mental health) are a dynamic process which should be considered in terms of the type and timing of the support interventions proposed. More emphasis should also be placed on both the providers and the receivers of certain interventions. It is important to keep in mind the culture, traditions, norms and values of those arriving in the EU. Furthermore, to better analyse the situation and provide the necessary support, gender, age and transit routes would need stronger

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<sup>8</sup> Summerfield, D, *War and mental health: a brief overview*, British Medical Journal, vol. 321, July 2000.

<sup>9</sup> Most of the potentially traumatic events were reported to have been experienced in the home country (60 %) and during the journey (89 %). However, the trauma of being a refugee was also reported, e.g. deprivation of activity, worries about people who were left behind, loneliness and fears of being sent back. See Lebano, A., Hamed, S., Bradby, H. et al. , *Migrants' and refugees' health status and healthcare in Europe: a scoping literature review*, BMC Public Health 20, 1039 (2020).

<sup>10</sup> See <https://easo.europa.eu/sites/default/files/EASO-Mapping-Report-Mental-Health-EN.pdf>

<sup>11</sup> European Parliament Policy Department for Citizens' Rights and Constitutional Affairs Directorate-General for Internal Policies, *The traumas endured by refugee women and their consequences for integration and participation in the EU host country*, April 2021, p. 6: 'Health issues are part of the vulnerabilities of migrant populations because of diseases endemic in the countries of origin, inadequate health care received, and health complications during the migration journey, together with often insufficient health facilities in transit camps and accommodation centres'.

<sup>12</sup> European Parliament Policy Department for Citizens' Rights and Constitutional Affairs Directorate-General for Internal Policies, *The traumas endured by refugee women and their consequences for integration and participation in the EU host country*, April 2021, p. 7.



considerations by the services providers<sup>13</sup>. To understand how to improve resilience<sup>14</sup>, hearing from the applicants themselves is crucial. This is exactly the goal of this summary report of the consultations conducted with applicants. EASO aims at getting a better understanding of what mental health means and implies for applicants for international protection arriving in EU+ countries. This will, in turn, inform the development of effective, timely and appropriate support initiatives that asylum and reception authorities can put in place, with a tailored approach, to care for the applicants entrusted to them.

## 1.1 Mental health and well-being: definitions and EASO's approach

The **European Commission (EC)** defines mental health as the capability of 'self-realisation, being at ease when forming the relationships with other people, to contribute to the life in the community and being productive at work. A mentally healthy individual is also able to overcome normal tensions, sorrows and life setbacks'<sup>15</sup>. Furthermore, 'Mental health is influenced by many factors, including genetic predisposition, socio-economic background, adverse childhood experiences, chronic medical conditions or abuse of alcohol or drugs. Therefore, mental health and well-being are interlinked issues that are affected by policies and actions in a range of sectors, including education, health, employment, social inclusion and efforts to tackle poverty'<sup>16</sup>.

In referring to mental health, the **World Health Organization (WHO)** recalls that 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. An important implication of this definition is that mental health is more than just the absence of mental disorders or disabilities'<sup>17</sup>.

The **International Covenant on Economic, Social and Cultural Rights**<sup>18</sup>, **Article 12(1)**, indicates that: 'The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.' Article 12 also highlights that the right to health does not mean the right to be healthy but rather that it takes into account the individual's biological and socioeconomic preconditions, and a State's available resources<sup>19</sup>.

The references made to the complexity of health, mental health and well-being by both the European Commission and the WHO are to be acknowledged. In its efforts to address the health and well-being of applicants for international protection, EASO always takes into account mental health, in line with the above-mentioned definitions, while also considering that the mental health of applicants is influenced by many factors.

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<sup>13</sup> Half of the asylum seekers were assessed as having at least a medium risk of psychological trauma. Prevalence rates were higher among females and asylum seekers from Africa. See: *Mental Health and Traumatization of Newly arrived Asylum Seekers Adults in Finland: A population-based study*; MDPI, July 2021.

<sup>14</sup> Resiliency simply put can be understood as 'bouncing back' from an unwanted state of despair to a functioning one.

<sup>15</sup> [https://ec.europa.eu/health/non\\_communicable\\_diseases/mental\\_health\\_en](https://ec.europa.eu/health/non_communicable_diseases/mental_health_en)

<sup>16</sup> [https://ec.europa.eu/health/non\\_communicable\\_diseases/mental\\_health\\_en](https://ec.europa.eu/health/non_communicable_diseases/mental_health_en)

<sup>17</sup> <https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response>

<sup>18</sup> UN General Assembly, *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, United Nations, Treaty Series, vol. 993, p. 3.

<sup>19</sup> [https://www.who.int/hhr/Economic\\_social\\_cultural.pdf](https://www.who.int/hhr/Economic_social_cultural.pdf)

The **Inter-Agency Standing Committees (IASC)** Guidelines on Mental health and Psychosocial Support in Emergency Settings<sup>20</sup> provide a good understanding on how to approach the topic of ‘mental health and psychosocial support’ in the humanitarian setting which is relevant to an extent for the discussion in this report. According to the guidelines, ‘*Mental health and psychosocial support (MHPSS)* is a composite term used to describe any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder’<sup>21</sup>. The guidelines indicate that agencies outside the health sector often tend to speak of supporting psychosocial well-being while professionals working in the health sector tend to speak of mental health. Staff working as health professionals have often used the terms ‘psychosocial rehabilitation and psychosocial treatment’ to describe non-biological interventions for people with mental disorders.

**EASO** differentiates between mental health concerns or problems on one hand and mental health disorders on the other. Both can be triggered by individual circumstances of applicants which can impact their well-being. With the right support and by strengthening the resilience of applicants, such feelings of being unwell can be mitigated and even prevented. In the context of this report, EASO does not necessarily refer to certified mental disorders<sup>22</sup> that can be pre-existing and/or have been diagnosed in the country of asylum by a professional. Well-being can be impacted by different factors, including social<sup>23</sup> (poverty, family separation, etc.) and/or psychological (pre-existing problematic drug use, exposure to traumatic experiences, etc.) circumstances and factors.

When speaking about mental health of applicants, exposure to traumatic events is often implied. The term ‘traumatic event’ is used in this report on several occasions.

*‘The traumatic event can include direct injury, witnessed events or events experienced by others that are learned about. Examples of the first category can include disasters, severe automobile accidents, violent personal assault, being kidnapped, tortured or diagnosed with a life threatening illness and other threats to one’s physical integrity. Witnessed events can include observing the serious injury or unnatural death of another person due to violent assault, accident, war or disaster. Events experienced by others that are learned about are, for example, violent assault, accident or serious injury.’<sup>24</sup>*

The way impacted persons might respond to a traumatic event differs. However, the most common reactions involve a general feeling of anxiety, sleeplessness, withdrawal or acting out, and signs of depressive symptoms.

<sup>20</sup> IASC, [Guidelines on Mental Health and Psychosocial Support in Emergency Settings](#), 2007.

<sup>21</sup> IASC, [Guidelines on Mental Health and Psychosocial Support in Emergency Settings](#), 2007, p. 16.

<sup>22</sup> ‘Mental disorders (or mental illnesses) are conditions that affect your thinking, feeling, mood, and behaviour. They may be occasional or long-lasting (chronic). They can affect your ability to relate to others and function each day.’. See <https://medlineplus.gov/mentaldisorders.html>.

<sup>23</sup> IASC, [Guidelines on Mental Health and Psychosocial Support in Emergency Setting](#), p. 1, ‘... in the early phase of an emergency, social supports are essential to protect and support mental health and psychosocial well-being.’

<sup>24</sup> [https://www.ema.europa.eu/en/documents/scientific-guideline/guideline-development-medicinal-products-treatment-post-traumatic-stress-disorder-ptsd\\_en.pdf](https://www.ema.europa.eu/en/documents/scientific-guideline/guideline-development-medicinal-products-treatment-post-traumatic-stress-disorder-ptsd_en.pdf)

## 1.2 The socio-ecological model

EASO recommends the use of a **socio-ecological model** when trying to address the mental health and well-being of applicants for international protection. This is in line with the European Mental Health Action Plan<sup>25</sup> which discusses mental health and mental disorders across the life course of a person, pointing out the importance of highlighting the potential factors which jeopardise well-being, linked to inequality and social determinants. Therefore, a multidisciplinary approach is as crucial as are partnerships between the different services providers and sectors, necessary to address such concerns.

The socio-ecological model was created as a way to visually illustrate individual, family, organisational, community, and societal factors that influence individuals' mental health and well-being. It reflects what we know from the research about how people's mental health is affected, both positively and negatively, at all levels. Research alone does not capture experiences of mental health and well-being but offers us a foundational framework<sup>26,27</sup>.

*A socio-ecological model takes into consideration the following levels, which are interconnected.*

- **Individual level** and personal factors (e.g. age, sexual orientation, race/ethnicity, economic status etc.).
- **Community level** including relationships (e.g. Relationships with family members, friends, partners etc) and interactions (e.g. with neighbours/hoods or clans - including tribal and/or ethnicity in some instances); structures in place (e.g. institutions such as schools, faith groups, health care services, workplace, housing situation etc)
- **Society level** and structural factors capture the importance of culture, beliefs, norms and values, customs and traditional practices (including those which are harmful). These elements are linked to policy and laws (including customary law) as well as regulation (e.g. at local, national, or regional level) which can improve or maintain a certain status quo.

The socio-ecological model outlined above is widely used to explain mental health and well-being by public health experts as well as those working in the field of gender-based violence prevention. However, in the context of asylum, the use of this model requires additional reflection. It is important to keep in mind that, in their journey, applicants for international protection live in more than one reality.

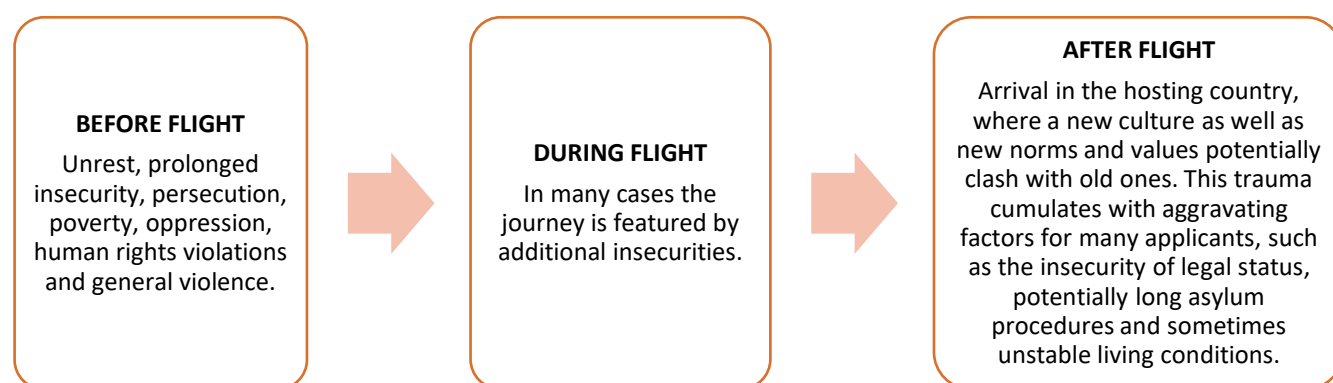
They often pass through **three different stages**: the situation in the country of origin which makes the person of concern leave their home country; the experiences made and the circumstances faced during transit; the arrival in the country of asylum.

<sup>25</sup> WHO, Regional Office for Europe, [The European Mental Health Action Plan 2013-2020](#), 2015, p. 1-2.

<sup>26</sup> <https://mch.umn.edu/resources/mhecomodel/>

<sup>27</sup> <http://wiki.preventconnect.org/socio-ecological-model/>

Figure 1 The three stages of flight



All the three stages (and the corresponding realities), as well as their impact, are to be taken into consideration when speaking about the mental health and well-being of applicants arriving in Europe.

Figure 2 Socio-ecological model taking the stages of flight into consideration

Factors	Intervention Level	Inter-connection	Considerations throughout all stages of flight
<b>Individual</b> and personal factors (e.g. age, sexual orientation, race/ethnicity, economic status).	<b>MICRO LEVEL</b>		<b>BEFORE FLIGHT</b> <b>DURING FLIGHT</b> <b>AFTER FLIGHT</b>
<b>Community</b> -related factors including relationships (e.g. relationships with family members, friends, partners) and interactions (e.g. with neighbours/hoods or clans, including tribal and/or ethnicity in some instances); structures in place (e.g. institutions such as schools, faith groups, healthcare services, workplace, housing situation).	<b>MESO LEVEL</b>		
<b>Society</b> and structural factors capture the importance of culture, beliefs, norms and values, customs and traditional practices (including those which are harmful). These elements are linked to policy and laws (including customary law) as well as regulation (e.g. at local, national, or regional level) which can improve or maintain a certain <i>status quo</i> .	<b>MACRO LEVEL</b>		

Viewing mental health and well-being under this light by using a socio-ecological model is consistent with the definition of mental health provided by the EC<sup>28</sup>, according to which mental health is influenced by many factors.

### 1.3 Note on the legal framework

While this report presents in summary the feedback received from applicants for international protection on the matter of mental health, it seems relevant to recall briefly the key legal obligations incumbent on the MS authorities when it comes to the provision of health care to applicants for international protection.

As part of the more general provisions<sup>29</sup> on access to healthcare, the CEAS grants access to mental health care. **Article 17(2) and (3) RCD** obliges Member States to grant applicants material reception conditions which guarantee their subsistence and protect their physical and mental health. **Article 19 RCD** stipulates that Member States must provide the necessary healthcare, including, as a minimum, emergency care and essential treatment of illnesses and of serious mental problems. Under **Article 19 RCD**, applicants who with 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.

**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 (treatment, legal support etc), which includes not only medical but also psychological care and treatment. The relevant support to be provided also highlighted in **Article 9(1) of the victims’ rights directive (Directive 2012/29/EU)**<sup>30</sup>, which stipulates that Member States must provide victims with information, advice, and support.

Other relevant provisions are found in **Article 24 APD**, dealing with the provision of adequate support to persons in need of special procedural guarantees, and in **Article 30 QD** covering healthcare<sup>31</sup> for beneficiaries of international protection. 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).

The provisions laid down in the cited directives are linked to other important legal documents, such as the **European Convention on Human Rights (ECHR)** and the **Universal Declaration of Human Rights** where the

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<sup>28</sup> ‘**Mental health is influenced by many factors** (emphasis added), including genetic predisposition, socio-economic background, adverse childhood experiences, chronic medical conditions or abuse of alcohol or drugs. Therefore, **mental health and well-being are interlinked issues** (emphasis added) that are affected by policies and actions in a range of sectors, including education, health, employment, social inclusion and efforts to tackle poverty’, available at [https://ec.europa.eu/health/non\\_communicable\\_diseases/mental\\_health\\_en](https://ec.europa.eu/health/non_communicable_diseases/mental_health_en).

<sup>29</sup> **Article 22 RCD** requires Member States to assess whether vulnerable persons have special reception needs. If this is the case, the authorities are expected to react appropriately to the applicants’ needs, even if such 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, the special needs must be considered and adequate support guaranteed.

<sup>30</sup> <https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32012L0029&from=EN>

<sup>31</sup> **Article 30(1) QD**: ‘Member States shall ensure that beneficiaries of international protection have access to healthcare under the same eligibility conditions as nationals of the Member State that has granted such protection.’.

provision services to persons in need are enshrined under **Article 25** (in both texts) as well as the **International Covenant on Economic, Social and Cultural Rights**<sup>32</sup>, whose **Article 12** recognises the right of everyone to ‘the enjoyment of the highest attainable standard of physical and mental health’.

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<sup>32</sup> <https://www.ohchr.org/en/professionalinterest/pages/cescr.aspx>

## 2 Approach and methodology

The consultation was designed by using a semi-structured ‘dialogue or discussion’ format. In practice, a rather informal meeting between professionals and selected applicants was conducted using preformulated guiding questions to steer the discussion on mental health. Two slightly different sets of questions were proposed, depending on the age of the participants. The set of questions for children and youth (between the age of 14 and 18 years of age) was slightly altered to make them easier to follow. The initial draft guiding questions were discussed and agreed in online group meetings with all experts appointed by the national contact points (NCPs) of the VEN and agreed to support the consultations.

### The set of question covered four main parts to be addressed during the consultations

**Part I** comprised a set of open-ended questions on mental health concerns in the country of origin, with the aim to increase our understanding of participants’ perspectives on how mental health is perceived and experienced in their home countries. This section further covered how perceptions and experiences of mental health concerns may differ depending on gender and age. In addition, the block of questions aimed to gather insights on the types of support interventions available at home and how they appear to differ depending on age, gender or social status.

**Part II** comprised a set of open-ended questions on mental health concerns in the country of asylum, with the aim to increase our understanding of participants’ perspectives on how such concerns manifest and which factors cause or exacerbate them, both in the context of reception and during the asylum interview. This section also covered coping mechanisms and how they may vary depending on gender, age and vulnerabilities. In addition, the block of questions had the purpose to capture the experience and awareness of available support services, the response mechanisms in place and their related weaknesses.

**Part III** captured a set of open-ended questions on the impact of COVID-19 on the life of applicants with the aim to increase our understanding on how the pandemic and related restrictive measures might have influenced applicants’ mental health. Questions on general information provision linked to mental health and well-being were here included as well and the best ways to provide such information.

**Part IV** captured questions to evaluate the process, such as the importance of the consultation and the format used, as reflected both by applicants and experts alike.

### 2.1 Terminology

The term **mental health** was meant to be interpreted broadly. As in the previous survey conducted on the matter, the consultation approached the issue of mental health concerns through the lens of psychological distress rather than psychiatric disorder<sup>33</sup>. During the preparatory online meetings, the EASO team and MS experts discussed the importance of terminology as used in a western context (e.g. psychiatric disorders, stress, depression, trauma but even just mental health, etc.), which might be conceptualised differently

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<sup>33</sup> Mental health is an integral part of health. Good mental health is related to physical, mental and psychological well-being. The interpretation of vulnerability in the framework of the 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) Qualification Directive (QD)**<sup>33</sup> as well as in **Article 21 Reception Conditions Directive (RCD)**<sup>33</sup>. 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)**).

depending on where applicants come from. Therefore, thorough consideration of the terms to use during the consultations was highlighted. One should not assume that applicants have the same understanding of mental health as in Europe.

While reference to mental disorders is made in both directives (APD and RCD), the consultations with applicants did not address exclusively persons presenting a mental health disorder certified by a clinician<sup>34</sup>. The topic of mental health was discussed in broader terms, inviting applicants to share what they felt was relevant. The MS experts supporting these consultations, together with interpreters, were encouraged to be flexible in finding alternatives in describing a feeling of being unwell ‘mentally’ or ‘emotionally’. Emotional well-being or emotional problems were referred to as, for example, feeling really bad, worrying very much, being very anxious, restless or not being able to sleep, feeling unable to handle the condition alone. This approach seemed to fit better, as feelings of distress were not “labelled” as a mental disorder from the beginning. Where possible, the terms selected to describe mental health concerns were tested with the final group of participating applicants, with the support of trained interpreters.

### 2.1.1 Target group

Hearing the voices of applicants<sup>35</sup> directly was crucial for EASO. Thoughtful selection criteria were chosen to ensure that the voices of women, men, young and elderly people were equally taken into consideration as well as to ensure the greatest diversity of participants in terms of country of origin, religion and cultural background. It was advised to invite applicants able to communicate in English or in the local language spoken by the facilitators. Nevertheless, where MS managed to involve trained interpreters to support the consultation, the discussions were held in the language of the applicant. All interpreters supporting in the consultation were informed beforehand of the purpose of the discussion and of the importance to use the correct terminology and to translate word by word what the participants said.

It was also ensured that applicants under severe distress or facing any other serious physical or mental condition during the time of the consultations **were not** involved in the consultation. This was to reduce the risk of triggering any kind of discomfort in the applicants. It was also agreed **not to involve any applicants** who would have not had their personal interview yet. This was to reduce the risk of applicants feeling insecure after the consultation, and that the discussion outcome might influence their procedure.

### 2.1.2 Facilitation of the consultations

The consultation was facilitated by representatives of three national authorities and five CSOs in seven Member States (BE, BG, DE, EL, ES, FR, NL)<sup>36</sup>:

1. **Belgium** represented by **Solentra** (CSO)
2. **Bulgaria** represented by **SAR** (national authority) and **Mission Wings foundation** (CSO)
3. **France** represented by **Terre d’asile** (CSO)

<sup>34</sup> 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). **ICD-9** is a list of codes intended for the classification of diseases, developed by the WHO.

<sup>35</sup> While the main focus of this consultation was on applicants for international protection, in one MS the same exercise was conducted in parallel with persons who had already been granted refugee status. Gathering more information from persons who have received a form of protection status in Europe and learning more from them might provide a useful angle to further elaborate the topic at hand, also when linking it with the issue of integration overall.

<sup>36</sup> DE: 13 applicants; FR: 21 applicants; BE: 2 refugees; BG: 22 applicants; NL: 7 applicants; EL: 4 applicants; ES: 12 applicants.



4. **Germany** represented by **BAMF** (national authority)
5. **Greece** represented by the **Melissa network** (CSO)
6. **Spain** representation by **Progestion**<sup>37</sup> (CSO)
7. **The Netherlands** represented by **COA** (national authority)

The supporting organisations were identified with the cooperation of the VEN national focal points (NCPs). A working group composed of all the experts appointed by the NCPs met to discuss the initial draft guiding questions for adults and youth. This discussion allowed to finalise two sets of guiding questions and corresponding reporting templates<sup>38</sup>. In addition to the reporting templates, the experts received a guidance document developed by the EASO vulnerability team, which captured the do's and don'ts to bear in mind during the consultation, ethical considerations and other safeguards to respect. The importance of abiding by COVID-19 health measures set at national level, hence different from country to country, was discussed. Before the start of the consultation, the EASO vulnerability team organised an information session for all selected facilitators and presented them the finalised question templates and consultation guidance. Following the consultation, all experts involved were given the opportunity to read a summary of the key findings and to provide comments.

The consultation was conducted through focus group discussions and individual face-to-face interviews. The type of data collection instrument was provided to the supporting organisation based on their work and was mainly relating to the profile of respondents, while also taking into account the COVID-related restrictions.

Despite the COVID-19 restrictions, a total of **10 focus group discussions** were conducted with a total of **58 applicants** (22 women and 36 men). Four focus groups were held with men, one with young male (aged between 14 and 17), four with women and one was a mixed group with both men and women participating.

In addition, **23 individual interviews** (13 women and 10 men) were conducted.

### 2.1.3 General safeguards during the consultation and consent

Homogenous group composition was advised, taking gender, age, nationality, cultural/religious background, and family composition into consideration to allow for an open discussion.

It was important to ensure that all participants, facilitators, interpreters and applicants understood that the discussion was not a counselling session but an exercise to gather general information on the topic of mental health and emotional distress. Facilitators were advised not to discuss any personal stories in focus group settings, in order to reduce the risk of re-traumatisation and/or stigmatisation after the discussions. It was agreed that after care (psychosocial follow-up) would be available in case the content discussed during the consultation triggered negative emotions in participants. Gender was considered throughout the process. Facilitators, participants and interpreters were arranged in same-sex groups where possible and deemed necessary.

The purpose and process of the consultation was explained beforehand to the participants, before deciding whether to join the consultation. The information provided also covered what is expected from the participants, their role in the process, the length of the discussion and what their feedback would be used for (to support EASO develop guidance on psychosocial programming for EU Member State authorities). It was also clarified that participation was voluntary, meaning that participants could withdraw at any point,

<sup>37</sup> At the time of finalising this report, **Progestion** run a Reception Centre in Peñafiel (Spain). Total capacity: 45 persons; composition: 18 from Mali, 16 from Afghanistan, and the rest from Senegal, Guinea and Haiti. Residents are supported by 25 staff members (psychologist, lawyer, Spanish teacher, educators, and reception staff).

<sup>38</sup> Guiding questions for adults and young applicants are included in two reporting templates (see [Annex III](#)).

and not remunerated. This was done to enable participant to provide informed consent on their participation.

When engaging young participants, their caregiver or guardian was informed of the purpose of the discussion to confirm their consent<sup>39</sup>. Generally, and especially in the case of young participants, it was agreed that the facilitators and participants should preferably already know each other. This was to nurture a trusting atmosphere from the very start of the consultation. For group consultations, the group size was to be considered and formed in compliance with the national COVID-19 restrictions in place.

### 2.1.4 Analysis

The data collected by the facilitators was examined based on a thematic analysis aimed at identifying and emphasising patterns, and thus help to create a joint understanding of what was shared by the participants. The themes were ingrained in the body of the research questions and were approached analytically, as key angles from which the question of mental health of applicants should be investigated and understood. The research team also paid attention to the analysis of explicit and implicit meaning in the collected narratives.

## 2.2 Feedback on the process and consultations

### *Profile of participants*

A **total of 81 persons** (79 applicants and 2 refugees) were reached during the consultations period. Respondents came **from 21 third countries**<sup>40</sup>: Afghanistan (24), Mali (9), Syria (8), Eritrea (7), Guinea (6), Iran (5) and Egypt, Nigeria, Democratic Republic of Congo (DRC), Gabon, Gambia, Venezuela, Iraq, Turkey, Palestine (Gaza), Georgia, Pakistan, Libya, Congo Brazzaville, Ivory Coast, Senegal (1 to 3 participants per country)<sup>41</sup>.

Besides nationality, facilitators considered the gender, age and educational level of participants, the size and type of reception facility and accessibility to smartphones. Below are some key findings on age, gender, educational background and the reception facilities hosting the respondents.

### *Participation by age and gender*

- **35 women participated** - average age 24 years (the youngest female participant being 20 years old).
- **46 men participated** - average age 24 (the youngest male participant being 14 years old).
- The **majority of participants** were between **25 and 40 years old**. The youngest was 14 years old and the eldest 59.

### *Educational level*

A total of 66 participants shared information about their educational level out of which:

- 15 respondents indicated abitur, diploma or university education like master's degrees in certain fields (e.g. education, psychology, interior design, veterinarian, economics etc).
- The **biggest share, 40 participants** indicated to have undergone some level of formal education from 4 up to 8 years of schooling as well as gymnasium level.

<sup>39</sup> For that purpose, EASO developed a draft consent form in case MS experts did not have access to the relevant consent forms used at national level.

<sup>40</sup> For an analysis by gender and by country, refer to [Annex I](#).

<sup>41</sup> See [Annex II](#) for a summary of information on the profiles of participants.

- **Only 11 participants** indicated no form of education<sup>42</sup> (formal and/or informal).

### *Reception facilities*

- At the **time of the consultation**, participants were staying either in **arrival centres** or in **other collective reception** centres.
- The capacity in these centres was indicated to be from **45 to max 1 250 residents**.
- The **average length of stay** was indicated to be **from 6 weeks** (for the arrival facilities) up to a stay of **max two years** in other reception facilities.

### *Other*

All 81 participants had **access to a smartphone**<sup>43</sup>. However, not all of them had access to free Wi-Fi.

### *Feedback and learning*

Feedback indicated that the conversations were very relevant and beneficial for both applicants and facilitators. The talks opened space for authentic interaction. Facilitators indicated that the flow and content to cover during the consultations was designed in such a way that allowed them to learn more about the target group they work with daily. Some described the conversations they facilitated as useful ‘eye openers’ and were surprised by the information shared by the applicants. The importance of setting aside time to interact was seen useful by applicants and first-line officers. This helped getting a better understanding of the situation of applicants.

Facilitators agreed that, even though the questions turned out to be quite complex for some applicants, they were all eager to talk and share their knowledge on the topic. A facilitator in one of the focus groups wrote in the feedback that some participants even called friends during the break and asked them to join the consultation.

In the section dedicated to observation, facilitators also shared that quite often emotional distress was first described by the applicants through physical complaints such as constant headaches, sleeping problems as well as drug addiction.

During the consultation process, facilitators also observed that it takes time for applicants to open up and talk about mental health at a personal level. It takes time to build trust and to feel one is in a safe space to share. Having more time to spend with applicants is necessary in order to ensure to implement the right interventions at the right time (e.g. relaxation exercises versus individual counsellor or well-being coaching). This point was stressed in particular by the French facilitators.

Participants reported that, despite the length of the discussion, the chance to talk about their feelings related to their community, rather than to their personal sphere, generated a feeling of relief. A group of women from African countries stated that they loved talking about this topic and appeared to be simply proud to have been considered to take part in this ‘European study’ and to share their knowledge.

Managing expectations was also seen as important. For example, a facilitator in one of the focus groups indicated that some applicants hoped that the consultation was also an opportunity for counselling - even though the purpose of the consultation had been explained beforehand. In order to manage expectations, it

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<sup>42</sup> Some participants from Eritrea indicated education by the military but not in terms of formal school education.

<sup>43</sup> It was also mentioned, in particular by single mothers, that **phones can help to ‘keep children busy’** who normally have not much else to do. It was pointed out however as well, that the use of smart phones and social media alike was at times counterproductive since **misinformation** is being shared via social media. According to participants many young boys **are addicted** it seems to these gadgets.

is crucial to set clear boundaries between the different interventions, in this case a consultation process designed to gather information for evidence-based programming on one hand, and psychosocial support or counselling on the other hand. A minimum of one counselling session was organised (post-consultation and with the applicant's consent) for the applicants for whom such a need or a wish for more in-depth counselling was identified. Overall, feedback from facilitators and applicants alike suggests that consultations (whether guided or not) may help establishing a platform for dialogue that is beneficial in a number of ways.

First, they may facilitate a more meaningful, sensitive and culturally appropriate interaction between facilitators and applicants, based on a better knowledge of the applicant's views and understanding of mental health.

Second, such types of meetings, if held regularly, can help build trust in applicants and thus facilitate a process where they feel listened to and heard. Many applicants are ready to share some of their concerns only weeks, or even months, after they have arrived - once they feel comfortable and cared for by first-line officers.

Finally, taking further this consultation and participatory approach can strengthen the partnership between EASO, the Member States and several of the facilitators who expressed their interest in supporting future similar actions. At the same time, the input received will benefit the further development of guidance for psychosocial programming as well as feed into other ongoing EASO projects<sup>44</sup>.

## 2.3 Limitations and other considerations

The selection criteria of only involving applicants who already had their personal interview aimed to mitigate the risk that applicants could form an additional expectation whereby the consultation could influence the decision on their claim. Nevertheless, the engagement of persons who have already been granted a form of protection status (e.g. refugees<sup>45</sup>) might have led to an even better understanding of the actual needs along the whole path to asylum, with the aim to strengthen resilience. The number of young and elderly applicants for international protection was limited as well.

Further, the consultation was held in the month of Ramadan. This reduced the reach of respondents in some Member States. Due to the fasting and connected tiredness, some applicants who had initially expressed interest, opted out because they felt not capable to participate in the exercise any longer. The ongoing COVID-19 restrictions in most Member States also limited access to applicants. The initially planned focus group discussion format was used by some, while other experts had to hold individual sessions instead.

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<sup>44</sup> Findings will inform the ongoing work of EASO on the topic of critical incident management. They will also be used in the collaboration between EASO and the European Monitoring Centre for Drugs and Drug Addiction on the topic of drug use in reception.

<sup>45</sup> Only two refugees in total participated in this consultation.

### 3 Presentation and analysis of consultation outcome

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*Mental health is an important subject to talk about.  
It's very important to find someone who listens to you.  
(Quote from a female participant from Nigeria)*

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#### In summary

The information received from applicants indicated that, when discussing the reasons for mental health concerns, a distinction seemed to be made by the applicants between **external** and **individual causes** for feeling unwell. The information received has been analysed and is presented first by addressing topics shared by participants looking at the **country of origin** and then from the angle of the **country of asylum, post-migration**.

#### *In the context of the country of origin*

As **external causes** for distress, situational and structural factors were mainly pointed out. Reference was made to: injustice, impunity, poverty, oppression, lack of rights and inequality (particular for women and girls), conflict and war, lack of a social protection system in place and absence of future perspectives in terms of employment and education. Isolation and forced 'silence', mistrust in social and family connections due to prolonged insecure living conditions in the country of origin were also mentioned. Participants understood that a good mental health state and well-being is clearly linked to their social relationships, to employment opportunities and to their economic daily realities.

According to some female respondents from Nigeria<sup>46</sup>, these external causes of distress make community members, and particularly women and girls, extremely vulnerable. It was shared that human trafficking networks take advantage of their precarious social condition. Reference was made by Nigerian participants to the criminal activities of such networks, that haunt them even after they have reached Europe. There is evidence that trafficking in human beings and the use of certain spiritual rituals are interlinked. EASO's 2021 COI report 'Nigeria - Trafficking in Human Beings' contains specific information on this practice<sup>47</sup>, which is also narrated by other non-official sources<sup>48</sup>. While in some instances traditional spiritual rituals are used to bring about health and healing, in the context of human trafficking they aim at the opposite. They are used to instil fear into the victims.

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<sup>46</sup> [http://www.scielo.org.za/scielo.php?script=sci\\_arttext&pid=S2225-71602019000100007](http://www.scielo.org.za/scielo.php?script=sci_arttext&pid=S2225-71602019000100007)

<sup>47</sup> 'Traffickers from Edo used the native justice system which relies on oaths and lucky charms/fetishes (juju) to seal the debt agreement with trafficking victims before departure. Through these oaths traffickers promised victims to arrange their travel to Europe and victims committed themselves to paying back the debt and not making any problems, including revealing the identity of the trafficker(s) to law enforcement authorities.' EASO, 'Nigeria – Trafficking in Human Beings', COI Report, April 2021, p. 34.

<sup>48</sup> 'Using these very old belief systems passed down through generations is a psychological form of control that is much stronger than any violence that can be done to them.', <https://www.theguardian.com/global-development/2017/sep/02/juju-curse-binds-trafficked-nigerian-women-sex-slavery>.

Furthermore, traditional belief systems (such as witchcraft and *juju*<sup>49</sup> [ጋጋ]) - particularly mentioned by participants from certain African countries) as well as the false interpretation and/or abuse of religion (as also indicated by participants from North Africa, the Middle East and Afghanistan) were also seen as a problem. Such misinterpretation can lead to mental health concerns among many community members.

However, pre-existing health conditions (e.g. people living with disabilities) can also be associated with mysticism. Greed and jealousy by other community members are often used as the only explanation models for why someone falls sick or is unwell. Reaching out to herbalists or other traditional healers, as well as to witchcraft and *juju*, is often seen as the only solution.. While in some instances herbalists and other healers are considered useful and deemed to have saved lives, it was shared that some of them are evil and harmful. Those who disagree with participating in such treatments however might jeopardise their safety. Pure reliance on faith, herbalism or traditional healers was therefore criticised by some.

In terms of gender considerations, most cited women and children (both boys and girls) as particularly vulnerable. Participants from Afghanistan (female and male alike) shared that the fear of the Taliban, and what it means to women and girls in their country, is inexplicable. Women and girls are in constant hiding. Girls do not go to school out of fear to be kidnapped. Women feel constantly afraid and helpless. A participant expressed this feeling by saying: *'It is the same for everyone, children, elderly and young people ... being afraid and wanting to flee the country is normal in Afghanistan'*.

Women and girls under the Taliban are perceived as invisible and not worth to be protected according to participants. They have no rights, are treated as objects (forced marriage) and can be used (raped) whenever a man (Taliban) so pleases. But also male family members can become victims. They can be abducted and ransom is requested from their family. Failing to pay may lead to the beheading of the male family member by the Taliban.

However, gender inequality was pointed out not only by respondents from Afghanistan. It was also discussed by most respondents from sub-Saharan Africa and the MENA (Middle East and North Africa) region.

As for the **individual causes** linked to the feeling of being unwell, it was stressed especially by participants from certain African nations that, in many of the communities and countries of origin of the applicants, mental health concerns and sickness are perceived as something 'coming or being imposed from the outside' (e.g. prolonged experiences of violence and conflict or attack by evil spirits for example) rather than the result of something genetically and biologically 'wrong' within the impacted person. The importance of acknowledging the link between the individual (micro), the community (meso) and the structural/societal levels (macro) was pointed out.

This standpoint whereby the causes for being unwell are interpreted as something outside of the individual area of control, also entails a shift of responsibility in terms of healing, protection and support which, as a consequence, is placed automatically onto the family and the community as a whole and not on the

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<sup>49</sup> The term *juju* refers to an object that has been deliberately infused with magical power or to the magical power itself. It can also refer to the belief system involving the use of *juju*. For further info, see <https://www.britannica.com/topic/juju-magic>.

<sup>50</sup>EASO, 'Nigeria – Trafficking in Human Beings', COI Report, April 2021, p. 34: *'The people interviewed as part of our surveys use the word "juju" to refer not only to their beliefs and the rituals they have undergone during their journey, but also to the object that materializes the promise and that is composed of the items used during the oath of allegiance [...] or to the representations of the deities used during the rituals.'*  
[https://coi.easo.europa.eu/administration/easo/PLib/2021\\_04\\_EASO\\_COI\\_Report\\_Nigeria\\_Trafficking\\_in\\_Human\\_Beings.pdf](https://coi.easo.europa.eu/administration/easo/PLib/2021_04_EASO_COI_Report_Nigeria_Trafficking_in_Human_Beings.pdf);

individual only. Therefore, putting the burden of healing and recovery not solely on the impacted individual seems liberating to an extent.

The term ‘silence’ was used by many participants in the consultations when speaking about the root causes of mental health concerns, as well as when dealing with their consequences. Participants (e.g. from Middle Eastern countries and Afghanistan) shared that one is not supposed to talk about problems. Being weak (which includes talking about one’s worries) is considered shameful. The suffering due to the abuse and violation experienced is to be kept secret in order not to trigger further repercussions (including by spirits, as certain Nigerian female participants mentioned).

One participant from Iraq described this by saying, *‘In Iraq, everyone is psychological ill. You very rarely find someone who is actually healthy. The government has caused this, they are criminals.’*

#### *In the context of the country of asylum*

Looking at the **external causes** or sources of distress after arriving to the EU, once again situational and structural factors have been indicated predominately. Nevertheless, participants mentioned different factors, which can be summarised as: a perceived ineffective asylum system with long waiting times, professionals who are not empathetic enough, support services which are not always perceived as useful.

The lack of needs-based and appropriate accommodation as well as insufficient information on the asylum procedure and reception system were mentioned as well, along with the fact that too often applicants lack opportunities to take part in meaningful activities. According to some, this leads to a deterioration of pre-existing conditions and triggers negative coping mechanisms such as drug use or engagement in criminal activities. In this regard, young men were pointed out as a particularly vulnerable group. Instead, women and children were mentioned regarding the need to address accumulated traumatic experiences.

On a more general note, a cumulation of negative experiences is seen as problematic by many. The feeling of being unwell, ascribable to external sources in the country of origin and which pushed many to leave their countries in the first place, is prolonged by the difficulties faced during transit and the situation in the country of asylum. A loss in productivity due to social isolation, lack of educational and employment opportunities and long waiting times for legal status, which increases tension in individuals, deteriorate the mental health state of many. Applicants arrived with high hopes of finally feeling safe and being able to take advantage of new opportunities, which however did not materialise according to them. Some young male adults tend to cope with this situation by abusing and dealing drugs.

The will and ability to forget the negative experiences was mentioned by some participants as important to move on. However, this wish to forget clashes with the requirement, within the asylum procedure and particularly during the personal interview, to recall negative or traumatic experiences for the purpose of providing evidence substantiating one’s application.

Many respondents agreed that having a family and/or children, regular social interaction, routines as well as religious affiliation can serve as protective factors. Participants also mentioned that children typically acculturate faster when they have the chance to go to school.

In terms of reception, and taking the countries of origin into account, it was emphasised especially by participants from African countries that they feel safer and more protected when they are initially accommodated in a community living arrangement rather than in individual housing arrangements. Some pointed out the reception conditions they had experienced in Greece as inhuman and inappropriate for all persons arriving no matter their age or gender.



In terms of **individual causes** arising in the country of asylum, participants made a reference to the fact that some have certain personalities which might be more likely to get the support needed in the country of asylum than others. The applicants who are considered to be more extroverted and pro-active, and who are not shy to ask for help, seem to be able to access the services more easily.

Participants stressed the importance of having a personal exchange with first-line officers, of being seen, heard and acknowledged as the person they are, not only in reception but also during the personal interview. Applicants for international protection want to be seen as anyone else, a person with needs, hopes, wishes and fears.

### 3.1 Country of Origin: Awareness on Mental Health

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*‘Normal behaviour’ is acceptable by the community. But when you start noticing that a person is ‘different’, it is not acceptable anymore. Mental health concerns are often acknowledged too late. They are noticed when people are already ‘crazy’.*

*(Quote from a female participant from Gambia)*

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#### 3.1.1 Identifying mental health concerns

Participants mentioned **three main indicators** of mental health concerns:

1. Behaviour
2. Appearance
3. How a person expresses emotions

Acceptable versus unacceptable **behaviour** within a society was discussed by most participants as an indicator to assess if someone is unwell or is ‘crazy’. The level of aggressiveness in the person of concern plays a critical role in this regard as well. Sudden body movements, as well as roaming the streets at unusual times, are signs that the person is not well. While a high level of aggressiveness was seen as an indicator and is considered unacceptable, withdrawal, isolation and detachment can also be considered unacceptable behaviour in particular in societies where social interaction is important (e.g. this was mentioned particularly by participants from African countries).

Generally, if the behaviour can be handled by the immediate surrounding and a daily routine is possible, the impacted person is/stays integrated. This changes, however, when a person becomes a threat to themselves and/or others because of their actions, or if their behaviour is perceived as inappropriate by their nuclear family or the community as a whole. Behaviour was discussed also because it relates to stigmatisation and to the issue of ‘being different’. Being different constitutes a problem not only for the impacted person, but also for the person’s family. Behaving out of the ordinary or of what is culturally and socially considered appropriate was referred as ‘shameful’.

In terms of **appearance**, neglect of personal hygiene (including torn clothes or hardly getting dressed) has been pointed out by many as a strong indication of how a person feels.

Lastly, the way community members having mental health concerns **communicate their needs and emotions** (e.g. raising one’s voice, screaming, talking to oneself, incoherent speech) are indicators that something is not right.



### Terminology used by participants to describe mental health concerns

Participants were asked to share the words used in their country of origin to describe persons suffering from distress and mental health concerns. According to the facilitators, some participants were slightly uncomfortable with sharing these terms while being eager to participate in the consultation.

Table 1: Terminology shared<sup>51</sup>

Term	Meaning	CoO of the participant	Language/dialect
<i>khole</i>	Being disturbed	Guinea	Guerze
<i>darui</i>	Crazy, being disturbed		Susu
<i>djourou</i>	Someone who is mentally not 'complete' or possessed by the devil		Pular
<i>drogudjo</i>	A person who uses addictive products/drugs		Peulh
<i>fato</i>	Crazy, being disturbed	Mali	Bambara
<i>tourinte</i>	Crazy, being disturbed	Senegal	Soninke
<i>dof</i>	Crazy, being disturbed		Wolof
<i>kangalo</i>	Crazy, being disturbed	The Gambia	Pular
<i>moto ya liboma</i>	Crazy persons	DRC	Lingala
<i>liboma</i>	Mentally unstable		
<i>muzri/musri</i>	Miserable, bad, despicable	Palestine	Arabic
<i>majnun</i>	Crazy	Egypt	
<i>deli</i>	Crazy	Turkey	Turkish
<i>kafayı yemiş</i>	Someone who lost their mind		
<i>ravani</i>	Stronger than crazy, similar to stupid	Iran	Persian
<i>raddadeh (see also below)</i>	Someone who is rejected- also used to express tiredness, stress, and indicate that 'someone has lost their mind		
<i>rad dadeh/da had na terol</i>	Someone who crosses a line	Afghanistan	Pashto
<i>diwara</i>	Weak		
<i>zayef</i>	Weak - mainly used for men, to indicate that they are like a woman		
<i>simesh kame/besor</i>	Someone who is not all 'clear' and normal		
<i>resideh tahesh</i>	A person who is at the end, someone who has reached their limit		
<i>Diwaneh/ lewanay</i>	A person who behaves abnormally		
<i>dalivan aida/lewanay</i>	Someone who is crazy		

While some of the terms above were used to describe the condition of a person who is considered emotionally unwell, it was also indicated that such persons are sometimes insulted or verbally abused. In worst-case scenarios, they can suffer physical attacks.

A few participants explained the words used in their language but did not provide any specific term. A participant from Libya indicated that his community describes someone who is mentally unwell as someone

<sup>51</sup> The suggested terms were verified twice with interpreters. However, there might still be discrepancies between the terms and their translation, depending on the regions of origin and dialect spoken.

who is dying slowly. An Eritrean respondent said that ‘light on’ means someone feels good while ‘light off’ means someone is mentally unwell.

### 3.1.2 Causes of mental health concerns

**External causes** are seen as main triggers for mental health concerns by all participants. As indicated in the summary section, such external causes were linked to war, conflict, violence and long-lasting exposure to traumatic experiences (major reason indicated by participant from countries like Iraq, Afghanistan, Syria and Palestine). Inequality, a state of impunity and poverty were also indicated by African participants as a trigger for mental health concerns, along with difficult economic and insecure political situation.

Mental health and well-being were discussed by participants by emphasising the link between the individual (micro), the community (meso) and the structural and societal levels (macro). Generally, participants agreed that the causes of mental health concerns do not necessarily relate to individual factors (e.g. gender, age or even pre-existing health conditions). In their experience, society, structural elements and relationships (e.g. values, beliefs, norms, impunity, inequality) put pressure on individuals, which can result in severe tension and, in the worst-case scenario, can lead to serious mental and health problems (infertility linked to consequences of child marriage due to sexual, psychological and physical violence for example, drug addiction and depression, just to name a few).

#### *Statements on causes for mental health concerns clustered per region*

##### **1) Middle East and North Africa (MENA Region) and Pakistan**

A participant from **Turkey** stressed the fact that silencing society by suppressing freedom of speech creates mistrust and fear in communities. In the long run, this can lead to sickness and psychological problems.

The fact that hundreds of people were killed and died in battles and the silence surrounding such incidents were shared as difficult by participants from **Iraq**. One of them said, ‘*Nobody talks about it, no one says anything, no one does anything about it.*’ Many respondents shared that the use of drugs (including alcohol) is a common negative way of coping with such situations among young men in particular.

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*At this moment, our society is left only with screaming loudly!*  
(Quote from a female participant from Iraq)

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A participant from **Afghanistan** stated that war, the resulting loss of family members and the reduced sense of community led to exposure to a violent life. This situation, coupled with a ‘violent education’, leads to a point where even women and children sometimes agree to commit suicide attacks.

Two other participants, one Afghan who was born and raised in Iran and another Afghan born and raised in Pakistan, indicated that they were marginalised and discriminated their whole life due to the fact that their families had migrated. Not being able to access educational or work opportunities in the same way as other community members had impacted their well-being and sense of belonging. Racism was described as a problem by both.

Intolerance between ethnic or religious groups was mentioned in the case of **Egypt**. Reference was made to the worsening co-existence between Muslim and Christian Egyptian communities and the harassment against one another. Religion, traditions, the political climate and its consequences seemed to play a crucial role as to why many community members do not feel ‘healthy’ living in Egypt.

**2) Sub-Saharan Africa and Horn of Africa:** *Eritrea, Ethiopia, Congo Brazzaville, Mali, Ivory Coast, Senegal, Guinea, the Gambia, Nigeria, DRC, Gabon*

The root causes of suffering are understood as major negative events to which a person was exposed to (e.g. climate of general violence, domestic violence (including forced marriage), prolonged suppression and exploitation, use of spiritual power (reference was made to witchcraft, *juju* and evil healers).

Traditional beliefs around witchcraft, combined with lack of professional support services, lack of opportunities to make a living and the fact that, according to participants, Africa is a continent without rules, were indicated as factors that make it very challenging to feel safe, well, healthy and cared for. For many, mistrust within the community is a major concern. The perception is that one can only trust very close family members, and sometimes not even them.

A **Nigerian** female participant indicated that, where she comes from, there is a ‘law of silence’: since one cannot trust anyone, it is better not to talk. This law of silence was presented when talking about traditional ceremonies or *juju*. Rituals are used to theoretically help community members but, in fact, they can make people worse. In some cases, such practices appear to be used to regulate power relationships within communities, to exert control over community members and to ensure submission by inflicting fear of disobedience (for the purposes of trafficking, for example). The ‘oath of silence’ associated with these practices serves as a key vehicle of control: if someone talks about the rituals, the person or their offspring will be cursed or get ill, or a family member will die<sup>52</sup>.

A participant from **Ethiopia** indicated that while there are very trustworthy and good mediums or priests (traditional healers), there are also evil ones. The latter are often responsible for causing mental health problems: they prescribe substances to their patients as part of their voodoo rituals, and this may manipulate them psychologically. According to the participants, it is very hard to differentiate the good from the evil healers.

Participants from **West** and **East Africa** indicated that mental health concerns are often connected to witchcraft, the spirits obsessing a person, or attacks by the devil triggered by either family or community members because they are jealous of the achievements made or because the affected person has acted against certain traditional rules. It was however also mentioned that the daily stress linked to mere survival is not to be underestimated. This was pointed out particularly by Nigerian and other West African participants. The fact that many feel left alone with their problems and have no one to confide in makes them feel particularly unhappy.

In the case of **The Gambia**, for example, participants shared that globalisation and westernisation are believed to play a role in the younger generation falling sick. The belief is that the spirits of ancestors make young people go crazy to avenge for the fact that younger generations are no longer interested in them. The spirits attack according to the participants the ‘strong and young ones’ in society and target hardly weak community members (e.g. the elderly and/or small children). Young adults are at risk of attacks who are also the ones on whom the rest of society relies.

<sup>52</sup> On the topic of *juju* linked to trafficking of human beings, see <https://www.bbc.com/news/uk-wales-29599158>.

### 3) South America: Venezuela

A Venezuelan participant mentioned that persons with mental health concerns are not easy to be identified. Often such persons are jobless or overwhelmed by the responsibilities to make a living for themselves and their family members. Many have lost their livelihoods and are forced to live on the street. Generally, it was shared that life expectancy seems to have dropped. Emotional suffering and the lack of food, work and medical services are known challenges for many Venezuelans. Such social conditions touch upon one's core existence. They shape the perception of self, influence self-esteem and, consequently, affect mental health.

## 3.2 Responses to mental health concerns

Both **positive** and **negative coping mechanisms** to deal with stressors impacting mental health and wellbeing were shared by the applicants consulted.

### *Positive coping mechanisms*

- **The importance of communication**

Having the opportunity to talk about individual concerns was mentioned as a positive coping mechanism, in particular for children. When they are given an opportunity to talk about the 'bad things' they have seen and experienced, they feel better faster.

- **The importance of a healthy lifestyle**

Eating healthy food, drinking enough water and reducing fats and sweets was seen as important for all, but particularly children. Adults should engage in regular sport activities and exercise, combined with a healthy diet and sufficient sleep.

- **The importance of being engaged in activities - keeping busy**

Engagement in a daily routine, work commitments and social interaction were indicated as effective coping mechanisms. Family gatherings and parties had proven to be useful distractions from worries and problems in the past. However, ongoing conflicts, insecurity and the growth of mistrust between different community groups caused by the regimes back home prevented gatherings which used to be attended 'with an open mind and heart'.

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*The devil should be slaughtered,  
and this is possible by keeping  
yourself busy.*

*(Quote from participants from Eritrea)*

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- **The importance of belief**

For some participants, religion and sharing their concerns and thoughts with God through prayers help to cope and strengthen resilience. A participant from Ethiopia indicated that going to church and using holy water helps to calm discomfort and address mental health concerns. Some of the Muslim participants from West African countries indicated that reaching out to their imams for advice and support is often useful.

### *Negative coping mechanisms*

- **The risk of engaging in self harm, including addictive behaviour**

Some participants shared that community members start using drugs as a coping mechanism (reference was made to alcohol and other drugs). This often leads to a deterioration of pre-existing conditions and can trigger more serious health and mental health problems. Young men are at risk.

It was also noted by a male participant from Turkey that young people are getting more and more addicted to social media. In his opinion, this can be seen as a problem since social media are used to detach from the reality around them.

- **Divergence from traditions and belief**

According to one participant from Syria, Syrian youth escape their destroyed home country by trying to reach neighbouring countries, particularly Lebanon but also Europe. It is common, in Syria, for young people to start drinking, behave promiscuously and act out. A Syrian participant stated that this behaviour is partially to punish their families for the injustice the older generation has placed on them. The same participant said that, in his village, there was nothing else to get distracted with. The only thing one could do at this point was to sit under a tree to rest a bit. Reference to religion and prayer was made by saying, *'Many young people have lost their way. May Allah show them the way and take care of them.'*

- **Detachment**

It was mentioned that some parents seek detachment or distraction to avoid worrying about their current situation. Sometimes, this can lead to parents not taking the problems of their children seriously enough and not give them the necessary attention they however need. This can create problems in the children at a later stage.

### 3.2.1 Access to support

In terms of service provision and response to the persons suffering from mental health concerns, participants discussed different options.

#### *Access to services and response*

Most respondents agreed that, in their home countries, support is not available for everyone. The services offered by professionals were discussed along the lines of inequalities within society. Differences between rural and urban settings and between the rich and the poor were discussed. Access to good medical care, including psychologists and psychiatrists, is mainly for educated and well-off people living in the city. The poorer and less educated population living in rural areas have no or little access to professional support.

Political affiliation was pointed out as an important factor to access services generally. In countries like Iran and Syria, it was stated that in the past impacted individuals were usually encouraged to see a psychologist or psychiatrist where possible. However, due to the current situation in Syria, with no or limited access to specialists and to a functioning health system, reaching out to family and friends is the only way forward. Nevertheless, a participant from Syria said that even when the situation was still calm, access to professionals such as psychiatrists or psychologist was limited. They were practicing only in specific villages and towns. Overall, medication is seen as useful by respondents originating from the MENA region.

Sometimes, the concerned persons are also advised to see a 'native'<sup>53</sup> doctor. This was mainly shared by respondents from African countries, where the practice is common especially in rural communities.

#### *Confidentiality*

Confidentiality is a major concern when it comes to mental health. Some consider it difficult to keep such conditions private. This could result in people not reaching out for the necessary help due to fear of

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<sup>53</sup> Reference is made to traditional healers.

stigmatisation. For instance, if someone had to share that they see a doctor in the specific village 'XY', everyone would know that this person has a problem and sees a psychiatrist.

### *Linked challenges*

The medical and psychosocial support available to people who suffer from a mental health concern and are considered sick is, in many settings, limited. The stretched financial means of many families sometimes force the impacted persons to live on the street. In case of aggressive behaviour, such impacted persons may end locked up in homes or tied with ropes, in order to control and prevent them from escaping into the community. Such practice was reported by participants from different countries, from both the MENA region and other African countries. In terms of support received from 'native doctors', doubts were raised about the actual help they can give. Some participants stated that the support they offer is in their opinion 'a big lie'.

### *Informal support*

In less serious situations, speaking to a good friend, socialising and engaging in group activities are considered useful coping mechanisms available in the countries of origin. This was particularly mentioned by participants from Middle Eastern countries.

Family members were seen as controversial. While many indicated that close family members for example are a main source of strength and support, a lesser number of participants felt that sometimes family can cause discomfort, or that it is sometimes culturally inappropriate to share shortcomings, emotional pain, or problems with close family members. Opening up about problems was either seen as a sign of weakness or considered, in some cases, as shameful.

## 3.2.2 Considerations around gender, age and diversity

### *Linked to gender*

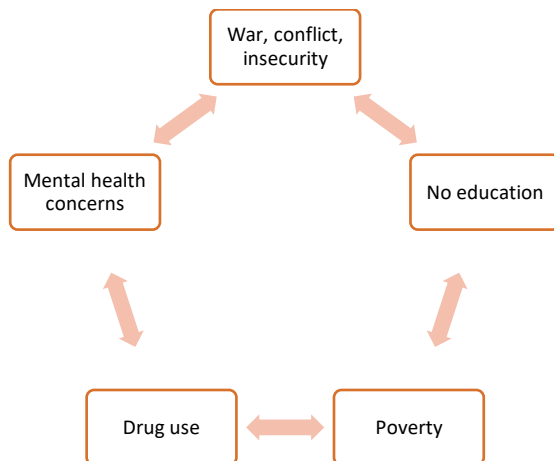
According to the participants, men tend to be more aggressive in the way they interact with others when they feel unwell (e.g. they get into physical fights while women rather engage in verbal quarrels (e.g. through insults). Verbal aggression by women is often directed at younger family members, namely children. It was also mentioned that women who are violated and abused by male family members, often pass the anger and violence onto their children. They release their frustration, anger and pain by abusing<sup>54</sup> their children. Nonetheless, female Afghan participants stated that mothers and daughters often are best friends. Their bond is strong, also because they are each other's only point of reference for support

Young and adult men are seen as vulnerable too due to the fact that they strongly feel the responsibility to be the protectors and providers for their families. In countries with little or no opportunities, this is a hard task. Failure to fulfil their role and responsibility is a trigger for violent behaviour, drug use, engagement in criminal activities or simply a general feeling of stress and being unwell. Women and children often pay the price of this situation, as was mentioned in particular by female Afghan participants. Domestic violence takes a toll on the physical and mental health of all those involved.

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<sup>54</sup> Reference was made to verbal as well as physical abuse.

Figure 3 The cycle of feeling unwell described by an Iraqi female participation



The high prevalence of gender-based violence within families and in society was raised as a concern by many. It was explained that violence against women is widely accepted, authorities do not intervene, not even when a woman is killed by her husband. This lack of accountability as well as large-scale impunity were explained, in the case of Afghanistan, as a consequence of the nation's four decades of war, conflict, insecurity and gender inequality. Community members do not know anymore what it means to be safe, secure and healthy. Women mainly stay inside and hardly go out due to fear to be attacked by the Taliban.

Reference to inequality, impunity and lack of access to justice were also pointed by participants originating from other countries. Eritrean participants indicated that men and women are not equal and that a man who does not hit his wife is not considered a man. Female participants from the DRC stated that, even though there is a Ministry for Women and Children to ensure access to justice for women and children, this ministry is actually of no help and the whole system is perceived as corrupted.

Gambian participants added that mental health concerns seem especially relevant among women between the age of 20 to 30 seem, as a result of forced marriages. Participants mentioned that many women who refuse and try to escape marriage, are raped and forced to marry their perpetrator. The

story of a woman who became pregnant after being raped was shared: the woman got 'crazy' after delivering the baby who was a product of sexual violence. It was mentioned that the event was treated with silence. Female participants from The Gambia stated that nobody talks about sexual violence because it is considered shameful and can cause ostracism from the family and the society.

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*In our country, justice is made for men.*  
*(Quote from a female participant from the DRC)*

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No protective shelters are available in Iran for women and children who seek refuge, despite the high prevalence of domestic violence and abuse in the country. This lack of support can lead to a deterioration of symptoms in the victims, because female community members (including children) feel hopeless and without a way out of this situation.

Participants (including men) have shared that women are perceived as vulnerable because, in many societies, they are pressured to:

- Endure harmful traditional practices, such as forced marriage (e.g. including child marriage) or, upon request of the in-law family, they are forced to undergo female genital mutilation and cutting.



- Bear children often at a very young age.
- Live under the protection of a man; in many societies women cannot live on their own or otherwise are badly seen by community.
- Hide their religion to be able to get a job or to find a husband (e.g. in the case of Christian Egyptians).
- Accept polygamy, which is widespread in some countries.
- Accept that they cannot inherit, which causes as a consequence inequality not only for the women but also for their children.

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*Men do what they want. It is even acceptable for them to beat women. Not only the fact that women have to accept being beaten, we women cannot choose what we want to wear and have to follow the rules the men have decided for us.*  
(Quote from a female applicant from Iran)

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All these ‘expectations’ on women create unhealthy pressure, which can lead to high levels of stress and consequently trigger mental health concerns or even more severe conditions.

On a more general note, it was mentioned that men too experience inequality in the family setting. A Syrian participant indicated that in their culture the oldest son is considered the most important child, and the youngest son will stay in the family home and live there with his wife. While the oldest and youngest sons get everything and are taken care of normally, the rest of the children do not really matter.

#### *Linked to Age*

Overall, children were considered by many as particularly vulnerable and most exposed to suffering. This is because childhood is the time of physical and emotional development. Children exposed to ongoing violence are impacted in their development, tend to cry easily and may refuse to learn.

Participants from Afghanistan indicated that it is difficult to tell if boys and girls show different signs when they feel unwell emotionally. This is because boys and girls do not interact, not even when they are very young. In particular, girls up to the age of 12 are not visible. Similarly, participants from Eritrea indicated that children till the age of 12 years do not count. Nevertheless, children can reach out and talk openly in many settings to the elderly or the adults in the family and receive advice and support through such channels where needed.

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*Parents simply suffer because they see their children suffer and are not in a position to change their situation.*  
(Quote from a male participant from Gaza)

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*We only observe children physically, but we do not assume they can have mental problems. Perhaps they sleep or eat less than normally, but that will always have a physical cause.*  
(Quote from participants from Eritrea)

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Parents and caregivers were also seen as a vulnerable group. The consequences of conflict, war, flight and poverty impact them, while they try to stay strong for their children. They often feel guilty for failing to provide the basic necessities (e.g. food, shelter, physical safety). This leads to an increased level of frustration, stress and hopelessness. Nevertheless, participants from Syria and Iraq (including a Kurdish participant from Iraq) also stated that as long as the children are with their parents, no matter where, they will be happy and well.

Some participants pointed out the generational conflict as a challenge (e.g. in the case of Afghanistan). Prolonged war has led to many single-headed households. Single parents often entrust their children to the



grandparents while they try to make an income. Grandparents are often not in a position to support children and young people appropriately. This leads to neglect and, often, young men end up engaging in criminal activities to make an extra income.

### *Linked to diversity*

The consulted participants practice different religions. Nevertheless, belief was indicated by many as an important aid in times of distress. However, some also indicated that religion or belief are abused in certain contexts for the purpose of control (reference was made to justifying the kidnapping of young girls for the purpose of child marriage). In this case, it becomes harmful.

An Afghan participant said that a person showing unacceptable behaviour (behaving against social norms) are often physically beaten by others. This is also true for children. One scenario was described where a mother was beating her daughter, who seemed mentally disabled. She was beaten because she had left the home without permission and, therefore, did not behave according to the rules (which do not allow for Afghan girls to move freely outside the family home). The participant indicated: *‘When I went there to stop the beating, the woman told me that she is fed up with taking care of the girl’*. The incident shared can be seen potentially as an indication of the pressure carried by people responsible to care for those in need, including the support they may need in handling not only stress of daily care duties but also difficult emotions. Another incident shared by an Afghan participant regarded a situation where a seemingly mentally disabled man was looking for food. Community members accused him of trying to steal. The person was taken to the outskirts of town and beaten to an extent that he needed hospitalisation.

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*All bombs leaves scars, red scars and wounds. These scars after a while become black. When the scars are black, people themselves become all red – meaning they are the wound now. Red = wounded. Black = aggressiveness and sickness. In Iraq everyone is psychological ill. You rarely find someone that is healthy.*  
*(Quote from a female participant from Iraq)*

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Discrimination and exploitation were also mentioned by some participants when speaking about persons who visibly present with a form of physical or mental disability. In some countries such persons are targeted and taken advantage of purposely, because they find it hard to comprehend what happens to them or have no choice. They are picked and forced to do jobs that nobody else would be willing to do; or they work without being paid, receiving in exchange just a place to sleep and some food to survive.

Generally, participants mentioned that, due to a fear of repercussion, some community members tend to not show that they are in need of support and share their concerns with anyone, but rather withdraw and isolate. Presenting mental health concerns is seen as shameful and a sign of weakness (being like a woman). It is considered an inability to cope with problems. Participants from the Middle East and from countries like Iraq, Iran and Afghanistan shared that, broadly speaking, strange or abnormal behaviour is more accepted of men than women. A participant from Afghanistan explained, *‘What a man can get away with, a woman could never’*.

### 3.2.3 Concluding remarks

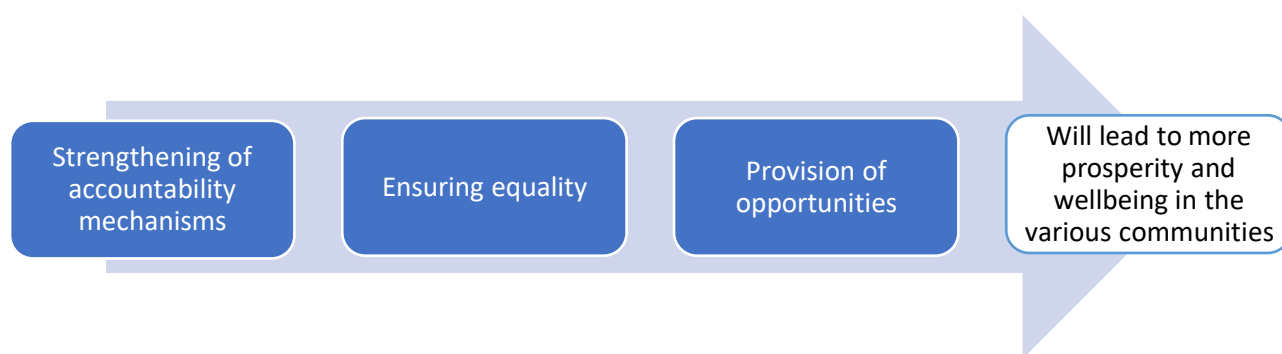
The state of impunity and lack of security and protection of basic rights existing in many of the countries of origin of applicants nurture a sense of loneliness and a feeling of distress in the daily struggle to survive. The discrepancy between the rich and the poor and the fact that certain opportunities are only open for the elite are considered a problem.

External factors like lack of protection, as well as lack of accessible, affordable and effective (formal or informal) support for initial concerns can lead to more serious problems. If not addressed, these problems risk to deteriorate the condition of the impacted persons. Ultimately, this can result in the person being rejected by the family and the community as a whole.

Patriarchal structures, inequality, corrupt and oppressive regimes, as well as war are seen as the main causes for a widely felt condition of being ‘unwell’. Simply put, in order to positively cope with daily stressful situations, the members of any society need to be able to voice their concerns, to openly speak about the problems at hand, and to be provided with opportunities for education, employment and healthy forms of leisure. Promoting equality between different ethnic and religious groups, while also ensuring gender equality, is considered a prerequisite to ensure strong and healthy societies which can prosper in their socio-economic development and guarantee the safety and protection of all community members.

Figure 4 below attempts to summarise the input shared by the respondents to the consultation in terms of what needs to be in place to ensure overall well-being in their country of origin.

*Figure 4 Underlying issues to be addressed to ensure overall well-being in the countries of origin*



### 3.3 Country of Asylum: Post-Migration

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*We think about the asylum procedure too much. Our future is at stake. Hope is infinite, but maybe we are waiting for nothing.*  
*(Quote from a participant from Guinea)*

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#### 3.3.1 Identification and causes of mental health concerns

The cumulation of trauma in a place that was supposed to fulfil big hopes for a better life was described by many as the main cause of their despair. A feeling of powerlessness related to lack of knowledge of the language, difficulties to orient at the new place of residence, food that is very different from what one is used to in the home country, having nothing to do, the sense of having no control over the course of the asylum procedure and the related decision to name a few. These go along with the unknown and fear of unmet expectations which one has or expectations families have back home towards their family member now in Europe in terms of support to be provided from abroad.

A general sense of exhaustion and tiredness within the community of applicants ensues. Some victims of trafficking also realise that the traffickers who promised them a better life with work opportunities have in fact deceived them.

Verbal confrontations between residents, crying children as well as physical fights in reception centres were described as the rule rather than the exception. This atmosphere is exacerbated by the fact that many have experienced horrible things before reaching Europe. Nervousness and a feeling of not being seen and heard by decisionmakers further deteriorates the already tense feeling many applicants have.

While the indicators of mental concerns described by participants are similar to those identified for their countries of origin, namely changes in behaviour, appearance and the way a person expresses emotions, they present in a slightly different way than back home.

### *Signs observed*

All the causes described by applicants seem to trigger feelings of uncertainty, fear, anxiety, anxiousness, frustration, hopelessness, and guilt towards those left behind. Residents showing signs of distress, feeling unwell or upset, were described as feeling lost, distant, restless, depressed and, often, just simply sad and withdrawn. Many stay in their rooms, change their day and night routine, eat and drink less, isolate themselves and avoid any interaction. In some instances, they are aggressive. While some sleep constantly, others have sleeping problems. Young men seem particularly prone to start using drugs such as cannabis and alcohol to overcome their worries about the future.

### *Causes shared*

Main causes relate to trying to cope with the past and what happened during transit, while at the same time handling a situation of great insecurity in terms of legal status, the unknown in a new country and the hope to receive the legal papers to be able to reunite with the rest of the family (reference was made to nuclear family - wife and children). Many indicated that they miss their loved ones. Participants stated that residents with the signs described as above are everywhere.

As to drug use, a participant from Palestine indicated that he believes that a good portion of young male residents take drugs in the reception centre he stays to forget past negative memories and to cope with the insecurity faced in the country of asylum.

### *Below a non-exhaustive list of reasons which are said to trigger mental health concerns*

- Long waiting times for decisions to be made by authorities.
- Forced to be 'inactive' due to regulations on employment and education in some MS or lack of willingness to provide access to such opportunities by the respective authorities.
- Not having a routine.
- Lack of privacy due to high-density living situation in most reception facilities and/or not having a choice on with whom to live (problems related to co-habitation).
- Change in diet (type of food) upon arrival can create digestion problems.
- Receiving a negative decision on one's application or a decision of transfer under Dublin III Regulation, coupled with a feeling of disbelief and hopelessness that '*one went through all this for nothing*'.
- Realisation that promises or hopes made are not materialising.
- Cultural shock and lack of language skills.
- A feeling of loneliness due to separation from family (loss of family members, waiting for family re-unification); not knowing how to re-unite (family members are missing) and the inability to be in touch with family members left behind.
- Lack of social interaction.
- Realisation that 'home' is lost (roots/feeling of belonging).

While participants listed several challenges that they and other residents face, the majority of them also stated that even though the situation in Europe is experienced as harsh and tough, the psychological pressure in Europe is different from the one in their home country. Some described the stress level as ‘less’ severe. A person from the DRC indicated that ‘opening one’s heart’ feels easier in Europe.

### 3.3.2 Access to support

Respondents indicated that, compared to their country of origin, they feel overall cared for. More professional support is available to them and in most cases, free of charge. People feel they are treated better in Europe and there seems to be more understanding for one another overall. Nevertheless, the challenges in terms of access to relevant support and the actual response were also discussed. Participants shared the importance of offering both **formal** and **informal** support services when it comes to the topic of mental health and well-being.

#### *Access to formal support*

It was shared that it would be good to have social workers or psychologists present from the moment of arrival in Europe and when entering reception. Being listened to or simply being asked how one feels and not being judged alone gives a feeling of relief.

In terms of ongoing support provision, participants provided mixed answers in terms of awareness of available professional psychological support in reception. While some indicated to be aware of opportunities and to know whom to contact (e.g. social workers or psychologists), others indicated to have no knowledge of any offers available to them.

Sometimes support is not accessed because doctors or professionals do not have interpreters available, which makes the visits impractical for applicants in need. One participant from Ethiopia shared that, when she asked for help, the support she received by professionals in a clinic was limited due to the language barrier. She was treated for symptoms only, which were breathing problems and a general feeling of anxiety. She was not given the chance to talk about what she thought were the causes for her breathing problems, i.e. the negative experiences made in detention during transit. She stated that she was later offered to speak to a psychologist. According to the participant, at that point she felt it was too late and was not ready anymore to bring her thoughts back to the suffering she endured during transit and detention in particular.

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*It is not good enough to just tell us that we are stressed. We want to be listened to and we want to get means to manage stress, techniques which help us get the worrisome and negative thoughts out of our heads.*  
(Quote from participants from Ethiopia)

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Another participant shared those residents complaining about pain are often given pain killers immediately, without seeing a specialist to find out more about the actual cause of the pain experienced.<sup>55</sup> Simply being asked about their own reasoning and opinion on what causes the suffering, was indicated as important though.

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<sup>55</sup> This statement links to the fact that causes for feeling unwell are considered to be external factors and might need more considerations when working with this target group as to provide effective support.

The ability to access services in the host countries was often linked to the personality of an individual and how much extroverted one is. The applicants who are outspoken and pro-active have better chances to get what they want and need than the applicants who are not used to ask questions, who are however many.

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*All of us are waiting for a decision and there is not much to do for us. When I heard about the opportunity to take part in this consultation, I gladly accepted just to be busy and to occupy my mind as not to worry.*  
(Quote by a male participant from Turkey)

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Participants stated that, before being willing or able to reach out to professionals, one must have their basic needs covered (e.g. food, appropriate and safe shelter). However, this is not the case for applicants in some Member States.

The importance of self-reliance and autonomy was pointed out, as it facilitates a stronger feeling of being in control of a respective situation. Participants from Ethiopia indicated that, in addition to general support offers, self-help tools like stress management techniques might be welcome by many.

#### *Informal support*

Being provided with space to exchange and interact with people from their own community was ranked high in terms of usefulness to strengthen resilience and ensure overall well-being, as is the presence of family members. Joint activities they can plan to an extent, meetings or outings were seen as helpful since they encourage to get out of the ‘thinking in circles’ mode and reduce the risk of getting caught up in constant worrying. Respondents overwhelmingly shared thoughts about the importance of (and the need for more) socialisation, social interaction and group activities.

All participants agreed that being active and involved helps to avoid agonising about the outcome of the personal interview. As an example, participants mentioned language classes, gardening, joint cooking events or trips as activities which are considered effective and would allow applicants to get to know better not only one another but also the country they currently reside.

A healthy lifestyle, regular and appropriate food intake, sports, listening to music and watching series/TV shows from back home were seen as further beneficial to mitigate the risk of developing mental health concerns.

Practicing religion and being able to attend certain religious festivities, ceremonies and rituals were considered helpful.

### 3.4 The European reception and asylum systems: challenges and recommendations

Generally, applicants are grateful to have reached Europe and appreciate the fact that they are provided with accommodation and the opportunity for a personal interview to receive legal status in Europe. Much has improved compared to where they came from and what many had to endure during transit. However, participants did indicate that in their opinion there is room for improvement overall.

The dense living conditions and the often-lacking consideration of the composition and type of placement in terms of nationalities or gender would need stronger focus by the authorities involved<sup>56</sup>, to address the safety and security needs that individual applicants might have<sup>57</sup> and offer applicants a sense of safety. The moment applicants leave reception or are transferred to different accommodation (joint housing versus individual accommodation) is to be more strongly considered since this is when often a deterioration of mental health (e.g. depression), suicidal ideation and increase in domestic violence is observed.

The fact that many applicants are left for months waiting for their claims to be assessed further increases a feeling of general despair, uselessness and hopelessness which, in some instances, can lead to negative coping mechanisms<sup>58</sup>. The presence of social workers or psychologists who can support incoming applicants by just 'being there' from the moment of arrival was seen as crucial.

Pre-existing mental health concerns and the consequences of traumatic experiences from back home or during transit are sometimes overlooked or not addressed in a timely and culturally appropriate fashion. The root causes of the symptoms are often neglected and there is a persisting tendency to react to and treat symptoms only. The importance of staff<sup>59</sup> showing empathy and having the intercultural competency to engage with applicants was highlighted. The availability of interpreters was seen as important.<sup>60</sup>

Some expressed the opinion that the asylum system in Europe is designed to discourage people to apply for asylum. The asylum procedure is perceived as too long in most Member States. It creates feelings of hopelessness and frustration in many applicants. It was mentioned that applicants overall feel not completely safe (this was linked to applicants being forced to move or feeling that they have to move<sup>61</sup>). The lengthy process of family re-unification was also pointed out as an area of main concern.

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<sup>56</sup> The importance of considering the culture and social background of applicants was highlighted by many: e.g. Eritreans seem to better cope in reception facilities (joint community living arrangements) when they first arrive than when they are tried to be integrated into municipalities, where they often feel overwhelmed otherwise. Certain nationalities prefer to discuss during in-person and group gatherings rather than in individual sessions.

<sup>57</sup> In terms of safety and security, certain facilitators from France expressed concerns around potential victims of trafficking and referenced problems with Nigerian women who arrived and seemed feeling insecure linked to trafficking networks and potential repercussions.

<sup>58</sup> Some examples discussed were: increase in drug use and engagement in criminal activities by mainly young male applicants. Potentially secondary movement were also indicated.

<sup>59</sup> Reference was particularly made to the way the security personnel responds to applicants.

<sup>60</sup> The importance of language for communication in asylum, the need to gather timely information about the languages applicants speak and are comfortable with as part of standard needs assessments in order to provide adequate language support, the need for adequate support and training for language support staff is stressed by Translators without borders: Translators without Borders, Research Report: Putting Language on the Map in the European Refugee Response, September 2017. Available at: <https://translatorswithoutborders.org/wp-content/uploads/2017/04/Putting-language-on-the-map.pdf>.

<sup>61</sup> While there is no sufficient information in the reporting templates to explain the main root causes for movement, reference was made during the discussions to movements organised by the authorities, such as Dublin transfers, return or change of reception facilities; own-choice moving was also mentioned, e.g. due to a feeling of insecurity triggered by own family or community members who made some applicants explore options to move to other MS.

### 3.4.1 Main challenges identified

#### *Attitude and behaviour of staff*

In terms of **reception**, concerns were raised around the selection of staff in some of the reception centres. While social workers and other first-line officers overall were perceived as supportive, others (reference was made in particular to security personnel assigned to reception facilities) were described as rude, disrespectful, and even at times insulting. It was mentioned that their focus is purely on enforcing the rules and regulations set out by the authorities rather than generally guiding applicants.

Linked to the **personal interview** situation, it was mentioned that decisionmakers in some cases give the impression to applicants that ‘they don’t trust’ what was shared with them by the applicants. As a result, the applicants leave with the feeling that ‘they are not believed’, which makes them feel not understood and even angry. In addition, the first impression plays a huge role. It was also highlighted how a kind welcoming is beneficial to the interview, as the first impression plays an important role in shaping the applicant’s feeling of the whole interview.

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*I am thankful to have a roof over my head, that I am warm and have some food to eat. If I compare that to the conditions I experienced in Greece, I am extremely thankful.*

*(Quote from a male participant from Afghanistan)*

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Applicants felt that a caring and emphatic attitude, also referred to as ‘humanity’, from reception staff and case officers is sometimes insufficient. Some said, that ‘officials need to remember that applicants did not start their journey to Europe for fun’. They continued by pointing out that ‘some organisations seem to pretend to support applicants but at the end they harm them with their action’<sup>62</sup>.

#### *Reception facilities and cohabitation*

Many of the applicants indicated to have reduced interaction with other residents due to the dense living conditions. Many residents from different cultures and countries live closely together, which creates tension and makes meaningful interaction challenging. Many of the participants indicated that the atmosphere in the facilities is often perforated by a sense of constant aggression.

Lastly, while those participating in the consultations stayed in reception, few reflected on joint living arrangements versus individual accommodation.

The concerns shared and raised by applicants living alone, particularly those originating from African countries, are captured below:

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*There are four of us in the flat and nothing brings us together. The living room is empty, no sofa, the space is empty. This does not encourage dialogue and helping one another.*

*(Quote from participants from Guinea)*

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- Africans are social by nature. Living alone is often experienced as challenging and can impact well-being.
- Finding directions in a new place, e.g. by using public transport, was perceived as frightening since there is nobody to ask for advice.

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<sup>62</sup> Not more was documented on this issue during the consultation but a follow-up exercise was initiated.



- A feeling of general insecurity in some of the neighbourhoods was mentioned. It can be a source of tension and was particularly mentioned as a problem by female applicants.

#### *Food and hygiene in reception*

Some shared that the food provided is often not compatible to their own staple diet. According to some applicants, some of the meals have a 'strange smell' due to unknown herbs. Also, at least at the beginning of the stay, some residents suffer from digestion problems. Some feel sick and therefore decide not to eat what is provided. This creates tension with the persons providing the food. Further, applicants perceive it as a waste of money.

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*I never used to be sick. Since I am here, I am sick very often. The lack of hygiene here is a problem for me. (Quote from a male participant from Turkey)*

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In one group session, reference was made to lack of hygiene (e.g. bed bugs and infestation of other insects like cockroaches) which was seen as a hazard. According to the participants, not much was done about it by the responsible officers. Residents from another facility also indicated that while new bedsheets and other non-food items were available, they were not given to the residents in need who

continued to use old and stained items instead. Further, some of the reception facilities just lack simple dustbins for the disposal of waste. One example shared was that, due to the lack of dustbins, baby diapers are left in the toilets and this leads to unpleasant odour.

#### *Lack of activities*

The lack of leisure and joint activities in some facilities leads to applicants being idle for months. It triggers low tolerance to frustration as well as lethargy, which implies a risk for minor mental concerns to deteriorate.

#### *Documentation and the personal interview*

According to some participants, sometimes applicants are requested by officials' documentation that they may not be in the position to produce (or to obtain). This puts high pressure on some.

#### *Denial of protection*

Participants shared that a negative outcome of an application for international protection may have a serious impact on the mental health state of applicants. Applicants shared that, in particular for young people who have left everything behind to save their lives, just to realise that their application for international protection has not been successful, is hard to accept. Many of those young applicants are hopeless, disappointed and their condition deteriorates. Sometimes they become aggressive, violent, engage in criminal activities or start using drugs.

### 3.4.2 Considerations around gender, age and diversity

#### *Linked to gender*

Gender seems to play a role on the impact of migratory movement towards asylum countries. Women overall seem more exposed and more vulnerable to suffering from mental health concerns compared to other applicants. A male participant from Afghanistan indicated that it is important to provide support to women because they are even more impacted by the 'bad things' that happen to them. Reference was made to disturbing events women are exposed to on transit routes.



It was also shared that women coming from rather restricted social environments (e.g. in the case of Afghanistan or Iran) and who have arrived on their own or with their children as single mothers often feel overwhelmed upon arrival. Some are simply not used to speak or to request support because they have never learnt to act independently.

Women were also perceived as more vulnerable when it comes to exploitation and abuse by other residents in the reception facilities. Single women who often left their countries due to sexual and physical violence, are at risk to be once again taken advantage of. It was shared that they fall easily into a trap when ‘some men speak softly to them’ and they believe whatever is said to them.

Female participants from Nigeria indicated that they do not feel safe, not even in Europe. Reference was made to the ‘madams and their boys’ who made them go to Europe. They are now waiting for their pay back<sup>63</sup>. Participants from Nigeria were afraid of being

tracked down and felt a need for hiding. One

Nigerian participant shared that a security personnel was informed about her anxiety and agreed that she could have an additional lock on her door. Being provided with this opportunity made her feel more at ease. Another female participant from Afghanistan

mentioned that to feel safer within the reception

facility, they dismantle door handles to avoid unwanted visitors, since their rooms doors cannot be locked from inside.

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*Women grew up in an environment where the laws are against them, so everywhere they go they are still stressed and anxious.*

*(Quote from participants from Iran)*

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A female participant shared that the fact that mothers always have to take care of their children, without a break and in an already difficult situation, leads to high tension in many female applicants. The lack of privacy and the constant noise is something many struggle with too.

While family was generally experienced as a protective factor, some made reference to an increase in domestic problems, including family violence linked to frustration about slow procedures, lack of financial means and exposure to a new cultural environment which often is experienced as threatening one’s own values and beliefs. Women were pointed out as particularly vulnerable.

To speak with someone external about one’s problems was seen as beneficial in some cases; particularly when family members have not arrived together and certain experiences do not want to be disclosed or discussed with close family members yet, but with a ‘neutral’ person first<sup>64</sup>.

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*Women are the building stones of society.*

*When a woman falls, so falls the child.*

*(Quote from participants from Iraq)*

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Also, young single male applicants were pointed out as potentially vulnerable. Many young men are addicted to drugs, as pointed out by some. It was suggested that these people would benefit from being separated from one another and provided with medical care. The lack of timely and meaningful interventions, also focusing on

rehabilitation, was criticised. It was stated that many residents do not want to have anything to do with applicants faced with an addiction problem. This isolates them even further.

*Linked to age*

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<sup>63</sup> While the term ‘trafficking’ was not used, the way the situation was described by this group of female participants referred clearly to trafficking in human beings for the purpose of potential sexual exploitation and abuse.

<sup>64</sup> This was shared by a young female participant from Afghanistan.

Stronger support for children and their parents was advocated for. Even if parents try not to show how worried they are, children feel it. They are more anxious and suffer for their parents too. Furthermore, children are still developing their personality. Therefore, it is crucial to act because they are more at risk to diverge into unhealthy behaviour.

It was pointed out that some children attending public schools are bullied, particularly when they do not speak the local language. Going to school generally was however seen as a protective factor since it reduces the risk for isolation and provides a routine for the child and for their caregivers, where applicable. Sufficient space for children to play (outside on a playground and inside) helps children to cope with the situation in reception, which for many lasts much longer than expected.

### 3.5 Main recommendations from the participants

Participants in the consultations were asked<sup>65</sup> to share ideas on how to prevent and mitigate risks for mental health concerns to deteriorate. They were also asked how to improve the well-being of applicants in reception and during the personal interview and strengthen their resiliency. **Six main recommendations** emerged when analysing the narratives, which are **relevant for determining** and **reception authorities**. While some considerations were more discussed under reception and/or the personal interview, the importance of empathy by the professionals, providing applicants with a transparent perspective or 'outlook' and provision of tailored, clear and relevant information was pointed out for all the staff working with applicants for international protection.

#### General considerations

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*We are eight people in the flat. And we do not speak the same language and do not yet speak the local language well enough. We do not have the same background, or the same stories. Sometimes spending time with people we do not know well, does not do us good.*

*(Quote from a male participant from Afghanistan)*

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- Professionals working with applicants need to **have the time, skills, tools and resources** to take more into consideration the background, culture and gender of the applicant in their daily duties.
- Participants highlighted the importance of **addressing children with respect**, calling children by their names, understanding their origin and background, learning their interests. This will make them feel recognised as individuals.
- The need for a more **thorough selection process of interpreters** was put forward. Reference was made to interpreters who should always behave 'appropriately'.
- **Stress management techniques** such as breathing exercises was seen as a useful tool for applicants who are extremely anxious and nervous.
- **Medical support** (mild medication) should be provided to those in need, so they can calm down and succeed in their interview (presenting all information in a coherent manner).
- **Prioritising** cases of young applicants who are about to turn 18 was seen as vital, since additional challenges might arise if the applications are not processed in time.
- **Receiving meaningful and relevant information** was frequently pointed out as important. Areas indicated as vital for the applicants are: information on how to contest a decision, what Dublin transfers entail, but also how return is organised by the authorities.

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<sup>65</sup> Refer to Annex II and questions 12 – 14 in particular

### Applicants shared following points linked to reception

**Co-habitation** was pointed out as an important point by respondents. They suggested that the way different nationalities are grouped might require more attention by the reception authorities. It was shared that it happens quite often that the balance between different nationalities is not kept, which leads to those in minority feeling left out from conversations due to language barriers. This leads consequently in certain instances to misunderstandings (e.g. they feel joked about or talked badly about) that could potentially be avoided if the language skills and country of origin considerations were taken into account more seriously.

Further, applicants states that a feeling of well-being and safety is achieved when they are given the chance to **personalise their living spaces**.

**Access to the Internet** and a **TV** was also seen as important to feel more comfortable and connected to the outside world and to family and friends back home.

It was also shared that in many cases applicants prefer to cook for themselves. If this is not possible, adjusting the food provided to the staple diet of the residents of certain reception facilities was suggested. A jointly agreed food plan between those responsible for organising food provision and the applicants was seen as a good practice as well.

The **induction of new arrivals** into reception was seen as essential. Different cultures have very different habits. One participant used the example of applicants who are used to use standing toilets. Once in Europe, they have initially mistaken showers for toilets, which led to tension and confusion within the resident community. Clear and simple directions by reception staff to newcomers on how to use facilities in general was therefore recommended. It was also pointed out that involving residents in this type of induction session is beneficial.

Lastly, environmentally friendly **waste management and education** of residents on how to keep public areas clean, were seen as crucial. The involvement and active participation of residents to provide such education and information to newcomers was recommended.

### Applicants shared following points linked to the personal interview

Participants suggested that during the personal interview **applicants be given more time** to explain their claim. Acknowledging that everyone has their own pace is important and minimises the applicants' feeling of pressure that is otherwise felt during the interview.

Some participants and particularly those from African countries noted that decision makers hardly smile and are perceived as 'too serious'. Therefore, appearing friendlier, **smiling more**, eases the situation, according to them.

Being able to **choose the gender of the case officers and interpreter** was particularly suggested as important by women who have experienced gender-based violence.

**Clarifying expectations** was seen as vital. Clearer information on what is needed from the applicants for their personal interview would reduce the extreme feeling of stress in almost all applicants.

**Awareness** of a rough timeline and flow of the personal interview, according to the participants, might mitigate the

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*The asylum procedure (personal interview) is the biggest problem for us. We all are afraid that our application is rejected and we are forced to go back. Where and how we live is secondary. The second worry for many of us is the Dublin procedure since some of us were registered previously in another country but we do not want to go back there.*  
*(Quote from a male participant from Afghanistan)*

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risk of being misinformed by others. Such information can reduce the risk of criminal networks luring applicants into trying to move to another location.

Availability of **legal advice pre-interview** and interlinked **psychological support** to prepare for the interview (preparation of a narrative) was suggested, since this will help ease the mind of applicants so they 'do not to lose it' during the interview.

Having a **person of trust** to be able to attend the interview or remain at the premises may be reassuring and comforting.

**Avoiding the cancellation of personal interviews** where possible was also mentioned.

**In-person information** on the procedure would make it easier to clarify items on the spot according to respondents, in particular for those with literacy problem who depend on others when receiving written information (e.g. in form of leaflets, guides). Such information provision should comprise **how to contest a decision**.

It was proposed to allow applicants to **practice the interview situation** (e.g. in form of mock interviews) to feel more comfortable during the actual interview.

Ensuring **undivided attention** during the personal interview was pointed out as very important by many respondents. The fact that case officers often have to simultaneously type what is being shared impacts the flow of the interview negatively, in their view. The interview does not feel natural because of the many interruptions, which is irritating and makes the applicants forget what they wanted to share. A suggestion given was to record the interview instead, so the decision maker can focus on the applicant.

Some respondents also suggested that having **the personal interviews taking place closer to reception facilities** or other familiar and regularly attended spaces could potentially reduce the feelings of discomfort in some applicants (e.g. those being very anxious, applicants living with disabilities, children), as they would be in a familiar surrounding which gives them a stronger feeling of safety and reassurance.

According to respondents, **two personal interview** slots should be available to all applicants. Talking about the past brings along negative memories. Many applicants tried to forget certain facts and need time to open up and be ready to share. Splitting the personal interview into two interviews could facilitate such a process. 'A "pre-interview" can help to empty one's heart'. Being familiar with the case worker will make applicants feel more comfortable and secure. When a rapport is established, sharing difficult information might be easier for some. During the pre-interview, the case officers would be provided with an opportunity to discuss experience not purely from an administrative point of view. A second interview can help in correcting or potentially adjusting information where needed.

**Appealing interview office space**, which appears less formal, can help applicants and particularly children to feel more relaxed, was seen as crucial.

**Empathy** and case officers being more 'human' were seen as important. Participants shared that this could be simply achieved by making a joke, providing a glass of water when one enters, offering something small to eat (e.g. crackers) or similar gestures.

### 3.6 In summary

The discussions held with 81 applicants and beneficiaries of international protection during the consultations with Member State experts led to six potential recommendations to achieve stronger resiliency in applicants and can be summarised as follows.

**1. Protection** is secured (to nurture a sense of safety and security and self-reliance)

**2. Involvement of skilled and empathetic workforce** is ensured

**3. A personalised approach** is ensured (while ensuring the provision of basic services for all)

**4. Awareness** is created (through transparent and tailored Information provision)

**5. Creation and access to social networks** is promoted (family, community)

**6. Coordination and accountability** is secured

Examples provided falling under each of the six recommendations provided and which are relevant for reception and the personal interview are captured below in table 2.

Table 2: Six recommendation at a glance

RECEPTION	PERSONAL INTERVIEW
<b>1. Protection</b> is secured (to nurture a sense of safety and security and self-reliance)	
<ul style="list-style-type: none"> <li>Appropriate initial accommodation by taking gender, age, cultural background linked to country of origin (region), past experiences and family composition into account</li> <li>Personalising living spaces provides a sense of safety and belonging, just as being given partial control of security (e.g. allowing to place a padlock)</li> <li>Ability to choose roommates where possible</li> <li>Ownership of one's life in reception (e.g. daily routines, possibility to cook, personalise living space)</li> </ul>	<ul style="list-style-type: none"> <li>Timely processing of claims particularly when lodged by persons with special needs and children approaching adulthood (minors approaching their 18<sup>th</sup> birthday)</li> </ul>
<b>2. Involvement of skilled and empathetic workforce</b> is ensured	
<ul style="list-style-type: none"> <li>Respect and acknowledgement towards applicants by all staff and officials (including security personnel guarding the facilities)</li> <li>Access to social workers, psychologists from the moment of arrival</li> </ul>	<ul style="list-style-type: none"> <li>Respectful, patient, friendly, non-judgemental attitude by case officers and interpreters alike</li> <li>Intercultural communication skills by all involved in the interview including the interpreters</li> </ul>
<b>3. A personalised approach</b> is ensured (while ensuring standards for basic service provision for all)	

<ul style="list-style-type: none"> <li>• Access to culturally-appropriate formal and informal<sup>66</sup> prevention and response support services to all applicants at all times of the asylum trajectory, while taking gender, age and diversity into account</li> <li>• Access to recreational activities for all applicants but particularly children</li> <li>• Safe and child friendly spaces to play</li> </ul>	<ul style="list-style-type: none"> <li>• Minimum of two interview slots scheduled<sup>67</sup> and allowing for mock interviews to prepare<sup>68</sup></li> <li>• Breaks to be considered</li> <li>• Preparing the interview setting in a more informal way<sup>69</sup></li> <li>• Option to have a support person available during the interview (e.g. legal counsellor, social workers/psychologist)</li> </ul>
<b>4. Awareness is created (through transparent and tailored Information provision)</b>	
<ul style="list-style-type: none"> <li>• Targeted and simple welcoming information<sup>70</sup> and induction to the reception facilities and to the services available, taking age, gender, diversity into account</li> <li>• Active participation in sharing such information and lessons learnt by fellow residents</li> </ul>	<ul style="list-style-type: none"> <li>• Expectations towards the applicant and roles and responsibilities of case officers, interpreters and accompanying supporting persons, if applicable, should be clear <b>before</b> the actual interview takes place</li> <li>• Information on the interview provided in person, where possible<sup>71</sup></li> </ul>
<b>5. Creation and access to social networks is promoted (family, community)</b>	
<ul style="list-style-type: none"> <li>• Opportunities to (re-)connect, unite and interact with family, within groups and with other social networks<sup>72</sup></li> <li>• Opportunities for applicants to design, organise, implement self-help initiatives<sup>73</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Possibility of a person of trust to accompany an applicant to the interview or to remain on the premises n</li> </ul>

<sup>66</sup> Formal support provision (targeted and tailored support) was strongly linked to where an applicant finds themselves in the asylum trajectory (disembarkation, during reception, negative decision, during Dublin transfer or return) and depending on the specific needs identified. Short term psychosocial first aid upon arrival for everyone, longer term ongoing support for those applicants in need who face difficulties in coping with their new reality, psychosocial support provided in collaboration with community members (paraprofessionals who have received some basic training) were put forward as good practice. But also the importance of offers which combine support by legal and psychosocial counsellors (e.g. linked to return or transfer - Dublin) was stressed and, according to the applicants, has not yet been addressed sufficiently. The moment when applicants receive a negative decision was pointed out as crucial and accompanying support would be needed. It was mentioned that when there is a staff shortage, in a situation of a global pandemic or in detention, check-in calls via phone are also perceived as a useful alternative to communicate.

<sup>67</sup> The first encounter is to create some basic rapport and enable applicants to feel more comfortable when the actual interview takes place. This first part of the interview could be used also to agree if bringing a person of trust (legal/psychosocial support) can be considered useful and needed; the second appointment focuses on finalising, updating, clarifying the information shared.

<sup>68</sup> The provision of stress management techniques was deemed useful for applicants.

<sup>69</sup> In particular with children and applicants with special needs, including persons living with disabilities.

<sup>70</sup> Such information should include cultural expectations and how people interact with one another (dos and don'ts) to mitigate the risk of culture shock and to support acculturation. Having information on **how things work** in a new country provides a basic feeling of safety and security as well. Such information can also point towards potential challenges applicants might face (e.g. discrimination, stigmatisation, racism) as well as opportunities (e.g. integration-related). Information on dos and don'ts in reception facilities taking cultural background into consideration can help to reduce risk of tension between residents and resulting situations of discomfort.

<sup>71</sup> Particularly when it comes to applicants with special needs e.g. literate population, children, elderly, persons living with disabilities.

<sup>72</sup> See also the reference made by Fedasil in the June 2021 report, which indicates the importance of considering family composition and its impact on the well-being of applicants.

<sup>73</sup> For example provision of stress management techniques, nurturing of community activities and interaction (including activities where applicants take the lead, organise or have certain responsibilities within the facilities) were considered beneficial. See also the reference made by Fedasil in the June 2021 report, which indicates the importance of involvement and participation of applicants. This area can be linked to many topics including remarks made around the provision food, with the suggestion to give applicants the opportunities to cook their own meals rather than being provided with food. The process of cooking and eating together is seen by many applicants as healing in itself since it brings people together eating their own staple diet.

<ul style="list-style-type: none"> <li>• Availability of volunteering or training activities or training opportunities</li> <li>• Training of paraprofessionals (persons from the applicant community to provide additional support)</li> </ul>	
<b>6. Coordination and accountability is secured</b>	
<ul style="list-style-type: none"> <li>• Access to a functioning complaint mechanism (CM)<sup>74</sup> with an attached effective and efficient response for accountability<sup>75</sup> purposes</li> <li>• Being involved in designing daily routines in reception</li> <li>• Availability of a coordinated and multi-disciplinary response since vulnerabilities are often multi-layered<sup>76</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Managing expectations by providing information on the interview, explaining what information is requested from the applicant and the role of the case officer</li> <li>• Provision of information on how and with whom to contest decisions<sup>77</sup> and transparent communication (including on Dublin transfers, return)</li> <li>• Accountability mechanisms (CM and response)<sup>78</sup></li> </ul>

Figure 5 attempts to summarise the input shared by the respondents to the consultation in terms of what needs to be in place to ensure overall well-being in their country of asylum and to strengthen resiliency.

<sup>74</sup> While a complaint mechanism as such was not requested by participants, some anecdotes shared might indicate that there is a need to further strengthen such mechanisms, including a more effective response to complaints (see reference made under [3.3.2 Access to support](#) as well as [3.4.1 Main challenges identified](#) and the sections Attitude of staff or Food and Hygiene)

<sup>75</sup> Safeguarding protocols are to be in place and made known to all applicants, including children, disabled people etc. All staff will need to be reminded of their obligations under the code of conduct and other relevant policies (e.g. child protection, sexual exploitation and abuse, anti-sexual harassment).

<sup>76</sup> Specific drug rehabilitation and linked support interventions in and outside reception facilities and tailored support and referrals to appropriate authorities for victims of human trafficking were suggested.

<sup>77</sup> A human, well prepared and dignified way of organising their return (refer to the return directive (Directive 2008/115/EC), Article 12 on Procedural Safeguards; Article 13 on Remedies; Article 14 on Safeguards pending return), including voluntary return mechanisms in place. Additional **information on reintegration opportunities in the country of return** for both forced and voluntary return candidates is important. Also for those for which a Dublin transfer is organised, information on the process and the reasons behind is crucial. Being informed about **mechanisms and options to appeal** was also pointed out as relevant for many.

<sup>78</sup> While a complaint mechanism as such was not requested by participants, some anecdotes shared might indicate that there is a need to further strengthen such mechanisms, including more effective response to complaints (see reference made under [3.4.1 Main challenges identified](#) and the sections Attitude of staff).



Figure 5 Post-migration reflection on mental health and well-being



### 3.6.1 Considerations around information provision and COVID-19

While COVID-19 was and is still impacting people globally at different levels, some questions were asked to the applicants taking part in the consultation with the aim to learn what worked in terms of information and service provision and what challenges they faced during this pandemic.

Many stated that initially information about COVID-19 was not that clear. Information on the virus was often shared through leaflets or posters translated into the local language of residents, but many residents cannot read and therefore did not receive important information.

In terms of well-being, many indicated that the pandemic hit everyone in the same way. Delays in the provision of services or the lack thereof, and interruptions in the processing of applications created problems. The disruption and prohibition of personal encounters was difficult for many. Some were simply scared to die or to be very sick. COVID-19 added to the already existing stress level. While the importance of wearing masks and washing hands was shared and it was also recommended to use hand sanitiser regularly, disinfection material was however not always provided, and some had to buy their own products, which was not always easy.

Regarding the channels used to share information, in-person meetings and group sessions were generally highlighted as preferred channels of communication by respondents from African countries. Such session should be complemented with leaflets, posters and text messages. Text messages communicating the changes in rules adopted by governments in terms of restriction are considered a useful way to inform a good number of people in a timely manner. Young people indicated that the videos are an information channel they can relate to.

During the pandemic or in case of staff shortage which make it more difficult to organise in-person meetings, checking in with applicants through phone calls is seen as a good alternative. In some Member States such an approach was taken and helped residents to realise that they have not been forgotten. Most respondents

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*We all had to be in quarantine. We were not allowed to leave our room, only in extremely urgent circumstances. Nevertheless, there was only one joint public shower and toilets were shared by approximately 50 women and men. I don't think this is a way to stop a pandemic?*  
(Quote from a participant from Afghanistan)

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indicated that having smartphones is crucial to reduce the feeling of loneliness and to stay connected with family members in other European countries and/or back home.

Respondents overall indicated that information on health education in general but in particular also on drug use would be helpful. Some also indicated that other general information, i.e. ‘information normal people would like to receive’ (e.g. where you can do sports) should be provided. The focus should not exclusively be on asylum and reception.

Lastly, some respondents indicated a need to provide opportunities to verify certain information. In some reception facilities there seems to be a tendency whereby residents share, on purpose, mixed messages and incorrect information. This creates discomfort and even fear. Nevertheless, it was also shared that receiving information from people one knows and trusts, i.e. own community members, is important.

On a positive note, some applicants indicated that the pandemic reinforced social ties. As they were forced to stay inside and spend time with their families and other residents, they became closer.

#### In summary

Information provision was pointed out as a horizontal activity<sup>79</sup>. Linked to COVID-19, respondents indicated the importance of a clear and standardised communication strategy to support information being shared in an effective and efficient way with the relevant target groups. It was indicated however that this is also true for information on other relevant health topics (e.g. mental health, drug use). While personal interaction was preferred to share and receive information, the use of different channels (leaflets, posters, animation, text messages, information on the website etc) to reach applicants was seen as central compared to using one sole channel only.

Introducing hotline services (scheduling check-in phone calls/video calls in particular when physical contact is challenging, e.g. in times of pandemic, due to long distances or due to lack in staff) is seen as a useful alternative to enable applicants and refugees to be heard and seen by the relevant authorities and services providers.

Receiving wide-ranging updates (e.g. on COVID-19 restrictions or other more general health education information) via text messages and WhatsApp was indicated as useful. Besides this kind of information, applicants would also appreciate information on general topics such as recreational activities, opportunities to do sport, etc.

Access to a smartphone was seen by many as extremely important in order to be able to stay connected in particular with family members left behind. This decreases loneliness and provides a feeling of connectedness. Nevertheless, social media are also seen by many as challenging due to issues connected with mixed or false messaging, including ‘fake news’ as well as the risk of addiction to phones and social media especially for the young.

On the topic of information provision, respondents indicated that involving the community of residents<sup>80</sup> strengthens participation and also creates a sense of familiarity and trust in many applicants. Verifying and cross-checking the information provided by community members was however pointed out as central to avoid spread of misinformation on important matters linked to reception and the asylum procedure.

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<sup>79</sup> See reference made under 4.3.3. item 1: Protection and item 4: Awareness & Information above

<sup>80</sup> In many MS this is already the case. See, for example EASO, [Briefing Paper ‘Access to Information in the Context of Asylum: Exploring Existing Resources, Good Practices and Ways Forward’](#).

## 4 Discussion

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*Emotional well-being is the most important part. If one feels well, at the end it does not matter where they live or stay. All will be just so much easier.*

*(Quote from a male participant from Turkey)*

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Five of the six recommendations which emerged after analysing the feedback received during the consultations with applicants are similar to some of the recommendations outlined in EASO's initial mapping report<sup>81</sup>. The report, from 2020, contains ten key recommendations to be taken into considerations by reception and asylum authorities to create a more conducive environment for applicants and staff alike<sup>82</sup>.

Further, the six recommendations put forward by applicants also link to the 11 principles formulated in the Inter Agency Standing Committees (IASC) guidance note on mental health and psychosocial support (MHPSS) for refugees, asylum seekers and migrants on the move to Europe as well as to the European Mental Health Action Plan of the WHO<sup>83</sup>, comprising seven objectives of which four can be linked to speaking points raised by the applicants. Furthermore, within the 17 global development goals (SDG) of the sustainable development agenda, [SDG 3 on Good Health and Well-Being](#) refers to mental health on three occasions<sup>84</sup> and entails a commitment to tackle the issue.

Below is a comparative table between the findings of this report, the recommendations made by the first-line officers of EU+ countries who took part in an EASO survey in 2020, and regional and global and considerations on the topic of mental health as it relates to applicants for international protection in Europe.

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<sup>81</sup> See EASO's initial mapping report: [Mental health of applicants for international protection in Europe](#). Furthermore, some of the findings also link to recent activities conducted by EASO (to date still being analysed) on the topic of critical incident management. Refer to [Annex III](#) for some first insight.

<sup>82</sup> A total of 91 submissions from 25 countries (22 Member States plus Norway, Serbia and Switzerland).

<sup>83</sup> The WHO's European MH Action Plan has seven objectives: four core objectives and three cross-cutting which, altogether, cover the full scope of this Action Plan. For each of the objectives, actions are proposed for the Member States and the WHO to achieve measurable outcomes in terms of policy and/or implementation. Actions should be prioritised according to the needs and resources at national, regional and local level.

<sup>84</sup> SDG Target **3.4**: ... By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being SDG Target **3.5**: Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol. SDG Target **3.8**: Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

Table 3: Corresponding statements

APPLICANTS <sup>85</sup>		FIRST LINE OFFICERS <sup>86</sup>		WHO Objectives <sup>87</sup>		IASC MHPSS Key principles <sup>88</sup>	
<b>Recommendation 1:</b> Protection is guaranteed (to nurture a sense of safety and security and self-reliance)	➡	<b>Recommendation 5:</b> Investment in reception facilities and space to provide tailored support	➡	<b>Objective b):</b> People with mental health problems are citizens whose human rights are fully valued, protected and promoted	➡	<b>Principle 7:</b> Identify and protect persons with specific needs	
<b>Recommendation 2:</b> Provision of skilled and empathetic workforce is ensured	➡	<b>Recommendation 1:</b> Investment by EU+ countries' authorities in human resources, including specialists, as well as project funding to support vulnerable groups	➡	<b>Objective d):</b> People are entitled to respectful, safe and effective treatment	➡	<b>Principles 1 and 2:</b> 1. Treat all people with dignity and respect and support self-reliance. 2. Respond to people in distress in a humane and supportive way	
<b>Recommendation 3:</b> A personalised approach is ensured (while ensuring standards for basic service provision for all)	➡	<b>Recommendation 4:</b> Access to and early identification and assessment of vulnerable applicants	➡	<b>Objectives a), c), e):</b> a) Everyone has an equal opportunity to realise mental well-being throughout their lifespan, particularly those who are most vulnerable or at risk; c) Mental health services are accessible and affordable, e) Health systems provide good physical	➡	<b>Principles 5, 7 and 9:</b> 5. Prioritise protection and psychosocial support for children, in particular children who are separated, unaccompanied and with special needs. 7. Provide treatment for people with severe mental disorders. 9. Make interventions culturally relevant and ensure adequate interpretation	

<sup>85</sup> Source: EASO consultation with applicants for IP, 2021.

<sup>86</sup> Source: EASO Initial mapping on MH concerns in applicants for IP, 2020.

<sup>87</sup> Source: WHO, [The European Mental Health Action Plan 2013-2020](#), 2015.

<sup>88</sup> Source: [Mental Health and Psychosocial Support for Refugees, Asylum Seekers and Migrants on the Move in Europe. A Multi-Agency Guidance Note](#), 2015.

				and mental health care for all; available in the community according to need		
<b>Recommendation 4:</b> Awareness is created (through transparent and tailored information provision)	➡	<b>Recommendation 2:</b> A strong, clear and relevant information package for applicants	➡	<b>Objective g):</b> Mental health governance and delivery are driven by good information and knowledge.	➡	<b>Principles 3 and 4:</b> 3. Provide information about services, supports and legal rights and obligations. 4. Provide relevant psychoeducation and use appropriate language
<b>Recommendation 5:</b> Creation and access to social networks is promoted (family, community)	➡	Pointed out as crucial but not formulated as a recommendation as such: <i>The importance for applicants to stay connected to family, friends and social networks</i>	➡			<b>Principle 6:</b> Strengthen family support
<b>Recommendation 6:</b> Coordination and accountability is secured	➡	<b>Recommendation 8:</b> Authorities to respect reasonable timelines for issuing decisions without jeopardising quality of the work	➡	<b>Objective f):</b> Mental health systems work in well-coordinated partnerships with other sectors	➡	<b>Principle 10:</b> Do not start psychotherapeutic treatments that need follow up when follow up is unlikely to be possible
						<b>Principle 11:</b> Monitoring and managing well-being of staff and volunteers <sup>89</sup>

<sup>89</sup> EASO published in September 2021 a three-folded **Practical guide on the welfare of asylum and reception staff** which can be accessed via the EASO website: [Part I standards and policy](#); [Part II: Staff Welfare toolbox](#); [Part III: Monitoring and evaluation](#). EASO has also produced a **video animation on the importance of early identification of stress in staff** which can be accessed at <https://www.youtube.com/watch?v=dE4QHKZiRk0>.

Overall, the considerations provided by respondents in the present consultation on mental health are quite straightforward and broadly acknowledged, as illustrated. The applicants' request for a more human and judgement-free approach, presents however a challenge when confronted with the inherent limits of the asylum and reception system in terms of timely and relevant support services available in some Member States, which are not always culturally-sensitive and applicant-centred. The issue is strongly felt not only by applicants but also by first-line officers who, in most cases, conduct their work with strong commitment.

There is a great demand for empathy on the part of case officers. The essence of their job is to examine the information shared, to assess and to make a decision. Nevertheless, applicants want to be seen, heard and responded to without judgement. Stronger consideration should be attached to finding ways to explain applicants the roles and responsibilities of the professionals involved in the asylum process and the limitations they face.

Lastly, idioms of distress describe specific expressions of mental health concerns, including mental disorders, and are often recognised in their complexity only by individuals sharing the same culture. Therefore, ensuring that the professionals working for asylum authorities have a good understanding of the cultural, social, economic and religious background of applicants for international protection is crucial to professionally conduct work. Investment in asylum to allow for sufficient human resources, including the involvement of cultural mediators and trained interpreters, is important.

## 5 Conclusion

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*‘From Eritrea to Ethiopia we were chased by a dog, from Ethiopia to Sudan we were chased by a wolf. We have experienced all the horrible things but have not had the time to go through a grieving process. If we would talk or show tears and cry, it would have been too dangerous.*

*(Quote from a female participant from Eritrea)*

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People are forced to flee and abandon their home as a result of persecution, violations of human rights, abuses, violence, conflicts and discrimination by the state or other actors. Settling in another country is often not their choice. Applicants try to find ways to cope with the new situation through available legal means to access and obtain protection in receiving countries. ‘We did not leave our home countries for fun’, said some applicants during the consultation. Since 2015, many EU+ countries have worked hard to ensure that their asylum and reception systems are strengthened, closely aligned with the CEAS and better prepared in case of another influx of persons in need of protection. Nevertheless, some bottlenecks have emerged in recent years in the processing of applications for international protection as well as in the management of reception. Some important topics have not received sufficient attention yet. Mental health and well-being and how to prevent deterioration of mental health concerns from the very beginning throughout the asylum trajectory seems to be one area which can be strengthened and would benefit from a more tailored and holistic approach.

The aim of this report is to share insights into how applicants for international protection conceptualise mental health, the linked needs identified by this target group and the recommendations provided to allow for additional evidence-based efforts on the topic, to be implemented by EASO. The applicants consulted for this summary made it clear that many might feel unwell, emotionally destabilised or even sick due to past and/or present experiences. Reference was made to insecurity, prolonged conflict, poverty, lack in accessing their (human) rights, and abuses, to name just a few, experienced in their country of origin. Severe violence, exploitation, loss of loved ones and other hardship experienced during transit further deteriorated the way many applicants felt physically and mentally upon their arrival in Europe. According to some applicants, medication might be a short-term solution for some to address some pressing symptoms (e.g. severe pain, headache, panic attacks), but a medical approach alone to the pain experienced does not tackle the actual root causes of their problems, which are mainly felt as being caused by external factors. There is a strong wish for first-line officers’ support to acknowledge this fact.

What applicants have implied in this consultation is confirmed by academic literature: ‘The danger of the medicalisation of everyday life is that it deflects attention from what millions of people worldwide might cite as the basis of their distress – for example poverty and lack of rights’<sup>90</sup>; ‘... structural poverty and injustice, violent conflict, crippling national debt repayments, environmental degradation and grossly inadequate or absent provision of health, education and social services mean that hundreds of millions of people are mired in mere survivalist mode...’<sup>91</sup>.

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<sup>90</sup> Summerfield, D., *How scientifically valid is the knowledge base of global mental health?*, BMJ (Clinical Research ed.), vol. 336. pp. 992-994, 2008.

<sup>91</sup> Summerfield, D., [Afterword: Against “global mental health”](#), Transcultural Psychiatry, 2012; vol. 49(3-4), pp. 519-530.



As shared by applicants, many of them have experienced the worst: back home, during their journey and upon their arrival on European shore. These experiences of danger and vulnerability provoke, in many, a feeling of general anxiety.

Some of the traumatic experiences and consequent reactions and behaviour might be, depending on the circumstances, more socially acceptable than others. Therefore, closer consideration is needed especially when working with survivors of rape, applicants belonging to a minority group (e.g. the LGBTIQ community), persons living with a disability, persons living with a chronic disease such as HIV/AIDS, drug addicts etc. For example, research suggests that a high percentage of female mental health patients reports, if asked, a childhood history of sexual abuse<sup>92</sup>. This is also the case for some applicants participating in this study. Prejudices towards certain groups of survivors of trauma and violence might however not only exist within family settings or within a certain community, but also among service providers working for authorities. First-line officers when working with this population will need to be aware of the respective norms, values and belief system. This is also true for other support staff (medical staff, security personnel, interpreters, etc.).

Furthermore, the biomedical approach which focuses for example on mental disorders as an impairment of brain function may not always be the most appropriate in this context. One could argue that potentially various other approaches, for example systemic thinking or the psychoanalytic and psychotherapeutic understanding of why certain problems manifest, are potentially closer linked to explaining why a person is feeling well or not.

In terms of support to newcomers, the focus should be on prevention and how to mitigate the risk of developing long-lasting mental health problems, which can be partially achieved by providing immediate short-term support to all applicants upon arrival in the EU. Timely and thorough medical screening by professionals who are used to work with migrant population, accompanied by opportunities for psychosocial counselling sessions upon arrival or upon request, would support early identification of mental health concern. At a later stage a distinction is to be made between medical, protection, social and community interventions to support newcomers, applicants and beneficiaries of international protection who are already in EU+ countries.

The distress experienced, which often is cumulative in nature, can be addressed successfully by applicants to a certain extent. According to the respondents, simply being seen as the complex human beings they are, persons who have been for longer or shorter periods exposed to severe distress, could suffice. Responding to applicants in a humane and supportive way, listening to them and not acting judgmentally, being engaged and timely providing truthful perspectives on what is yet to come, in a format which is understood, is likely to foster a sense of safety and security which consequently leads to a stabilisation of their mental state and mitigates the risk of deterioration of the initial conditions. This is particularly important for applicants arriving with dependants, since children will sense the insecurity, anxiety and distress that their parents and caregivers experience.

Facilitators supporting this consultation clearly indicated that more investment in mental health and psychosocial support services for applicants throughout the asylum trajectory will be needed. According to them, the longer applicants live in a situation of limbo (no decision, no employment, no family reunification, no opportunities, no decent living conditions, no integration), the more detrimental it is to their (mental) health. This will lead to long term challenges that beneficiaries of international protection and MS authorities will have to deal with.

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<sup>92</sup> Briere, J. & Scott, C., *Principles of Trauma Therapy: A Guide to Symptoms, Evaluation, and Treatment*, Sage Publications, 2014, p. 9.

Health and mental health services focusing on well-being will therefore need to consider formal and informal mechanisms while having the asylum trajectory in mind. While psychological first aid interventions are valuable considerations when applicants first arrive and find themselves in acute distress, e.g. during disembarkation, other services such as ongoing individual counselling sessions or community self-help and psycho-social group support might be more useful at a slightly later stage. Community-based intervention and self-help initiatives need to be part of the design of useful psychosocial programming in any case. This can only be done by acknowledging where applicants for international protection originate from and what their actual belief system relating to health is. In particular, applicants arriving from some African countries still feel strongly about traditional treatment of certain conditions, including spiritual healing. Healthcare delivery in sub-Saharan Africa is pluralistic, consisting of both traditional and bio-medicine. According to the WHO, 80 % of the African population uses some form of traditional medicine for primary healthcare. In fact, people often move back and forth between self-care, clinics, and healers<sup>93</sup>. Therefore, acknowledging that certain traditional practices<sup>94</sup> and rituals may have a supporting effect on applicants' health, including mental health, and offering space for such practices within an integrated mental health response will be essential.

Such interventions need to be embedded in a clear and simple communication strategy, so that applicants are aware of what to expect, when, by whom and know why accessing such offers might be beneficial to them. The feedback received from applicants in the present consultation, coupled with lessons learnt from other research, could serve as basis to develop guidance to address the well-being of applicants for international protection in a comprehensive and sustainable way. Promoting access to health services, including mental healthcare, for people with a migration background, including refugees, is also highlighted as eminent in the new EU Action Plan on Integration and Inclusion (2021-2027)<sup>95</sup>.

To conclude, a proactive collaboration between reception and asylum authorities and other relevant authorities like for example the health sector and social services within a MS, while embracing European standards in asylum and reception and complementing global initiatives<sup>96</sup>, will be crucial.

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<sup>93</sup> <http://www.uniteforsight.org/traditional-eye-practices/module1>

<sup>94</sup> Reference is made to only non-harmful traditional practices.

<sup>95</sup> <https://ec.europa.eu/migrant-integration/news/the-ec-presents-its-eu-action-plan-on-integration-and-inclusion-2021-2027>

<sup>96</sup> For example, the [Global compact on refugees](#), and the [Global compact on safe, orderly and regular migration](#) which are linked to efforts made under the Sustainable development agenda 2030.

## 6 Annex I: Participants by country and gender

### Participating countries

#### Respondents by country of origin, country of asylum and gender<sup>97</sup>

Country of origin	Country of asylum														Total		
	DE		FR		BE		BG		NL		EL		ES				
	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F+M
1.Afghanistan	3	3		5				13							3	21	24
2.Congo Brazzaville			1												1		1
3.DRC			3												3		3
4. Egypt			1												1		1
5. Eritrea									4	3					4	3	7
6. Gabon			1												1		1
7. Gambia	1														1		1
8. Gaza		1														1	1
9. Georgia													1			1	1
10. Guinea (Conakry)			2	2									2		2	4	6
11. Iran							1				4				4	1	5
12. Iraq	1				1		1								3		3
13. Ivory Coast			1												1		1
14. Libya				1												1	1
15. Mali			1										8		1	8	9
16. Nigeria			1												1		1
17. Pakistan				1 <sup>98</sup>				2								3	3
18. Senegal			1										1		1	1	2
19. Syria	1	1				1	5								6	2	8
20. Turkey		1														1	1
21.Venezuela	1															1	1

<sup>97</sup> Non replies in this category: 1 female in France.

<sup>98</sup> One man in France was born in Afghanistan but grew up in Pakistan.

## 7 Annex II: EASO survey on critical incident management

The considerations shared by the applicants also link to a **recent study** conducted by **EASO on critical incident management**, where first-line officers shared that mental health concerns of applicants can trigger critical incidents. The following points were raised for consideration with a view to mitigate the risks of such incidents.

- A general mitigation of risks regarding critical incidents can be achieved through good practices such as regular psychosocial counselling sessions for applicants and by providing them with opportunities to engage in daily routines and activities so they can feel ‘useful’ and make better use of time spent in reception centres.
- Information sessions on problematic drug use were also indicated as important for the concerned persons as well as the family and community at large.
- Having the possibility to talk to and spend time with people who are not residents might be enough for some applicants and help them not to feel ‘forgotten’ by the system.
- Clear information provision and truthful communication with the applicants is crucial not only before a critical incident takes place but also as to prevent any in the first place.
- The importance of support services being provided in the applicants’ mother tongue, where possible, was highlighted. This applies to support after an incident but is also relevant in general terms.
- Regarding the personal interview, it was emphasised that it is crucial that applicants are made aware beforehand of the overall procedure and of what it entails, in order to manage expectations. It was also suggested that having more than one meeting with case officers before the interview might help applicants in the actual interview situation. This was also highlighted again during the consultations by applicants.
- A respondent made a suggestion regarding the usefulness in reception facilities of so-called ‘floor walkers’ who can be approached by applicants when needed and provide initial support. At the same time, floor walkers would be in a position to monitor the situation of applicants. Such floor walkers can help to identify mental health concerns and/or other protection related issues at an early stage, so as to mitigate the risk of problems arising later.
- Regular meetings between various facility actors (reception/asylum/police authorities/UNHCR/ NGOs, etc.) and community representatives are seen as important by respondents. Such meetings, in particular when resident representatives are involved, can facilitate the creation of a trustful and transparent communication channel and help to identify problems before they arise. Such community support interventions as well as stronger involvement of applicants were also raised as an important point in the consultation on mental health.

## 8 Annex III: Reporting templates (adult/youth)

### General information on adult participant(s)

Total number of participant(s)	
Country(ies)/of origin (including statelessness)	
Age (average age in case of a group)	
Gender of participant(s): F/M/X	
Participant(s) is (are) in this Member State since: (average number of months/years in case of a group setting)	
Years of formal education of participant(s) (average in case of a group setting) Participant(s) is(are) literate (can read and write) in at least one language: YES/NO	
Participant(s) has(have) access to a smartphone:	
<b>Location of the intervention</b> (In case of a collective reception centre, provide some basic info on total number of residents; type of facility; average length of stay in the facility) (In case of personal interview outside a reception centre, describe briefly context in which this consultation takes place)	

A) Conceptualising Mental Health in country of origin			
Nr	Proposed question	Feedback received from participant(s)	Observations by facilitators (e.g. engagement of applicants & interest, which Q easy to answer/which not, group dynamic etc)
1	<p>In the country you come from, how can people tell that a community member is not well for example that their mind is not so strong? That s/he has a problem?</p> <p><i>Follow up question:</i></p> <ul style="list-style-type: none"> <li>Do the signs/conditions you just described look different for girls and boys and youth compared to adults? Briefly explain</li> <li>What is still acceptable behaviour and what behaviour is not acceptable within your community?</li> </ul>		

2	These condition(s)/signs you described do they have local name(s)? How do you call such problems or people suffering from such problems? Please share them in your mother tongue and explain word by word what they mean.		
3	<p>What do people think causes emotional problems/or situations where people emotionally do not feel well?</p> <p><i>Follow up question:</i></p> <ul style="list-style-type: none"> <li>Are these causes you just shared common views in your country? Do you think there are differences in what causes emotional problems in children and adults? If so - briefly explain.</li> </ul>		
4	<p>What do people normally do back home when they do not feel well and are sad/upset? What helps them? Is this different for children compared to adults?</p>		
5	<p>How do people with such problems as you described normally get help in your country?</p> <p><i>Follow up question:</i></p> <ul style="list-style-type: none"> <li>Who is normally the first contact person to provide support/help?</li> <li>Does everyone get the same support or are there people who cannot be helped?</li> </ul>		
B) Post-Migration			
Nr	Proposed question	Feedback received from participant(s)	Observations by facilitators (e.g. engagement of applicants & interest, which Q easy to answer/which not, group dynamic etc)
6	<p>What signs do you see most frequently in fellow residents which suggest that they are under severe distress, emotionally upset and not well?</p> <p><i>Follow up question:</i></p> <p>How often do you see applicants with such problems?</p>		
7	<p>Are the signs you see here in in Europe in the community of residents (like women, men, children, youth and the elderly) the same or different from what you see back home? If different - in what way?</p>		

8	<p>What do you think are the main causes of such problems you described for adult applicants, boy and girl children and youth here (Europe)?</p> <p><i>Follow up question:</i></p> <p>Who in your view are most likely to have or develop such problems or show emotional distress here – and why?</p>		
9	How are applicants with such problems are treated by others? What have you observed?		
10	What do applicants where you live and have such problems normally do to better handle their situation?		
11	<p>What support is available to applicants who face such problems?</p> <p><i>Follow up question:</i></p> <ul style="list-style-type: none"> <li>• And which one's do you consider most helpful and why?</li> <li>• How do you know about these services? Is this support free of charge?</li> </ul>		
12	<p>What do you think is missing to support applicants with such problems best like being upset, feel unwell and sad?</p> <p><i>Follow up question:</i></p> <ul style="list-style-type: none"> <li>• Are there specific needs men, women, children, youth have in terms of activities, services to make them feel better</li> </ul>		
13	<p>Looking at your <b>present accommodation (reception)</b> – what in your view makes applicants feel bad and creates stress?</p> <p><i>Follow up question:</i></p> <p>What is in place where you stay which you think makes applicants feel better about themselves? In particular also children/youth?</p>		
14	<p>What in your opinion would make applicants and particularly also youth more at ease - <u>before</u> and <u>during</u> the <b>personal interview for the asylum application</b>?</p> <p><i>Follow up question:</i></p>		



	<ul style="list-style-type: none"> <li>Is there anything case officers can/should do to put the mind of applicants at rest and make them feel more comfortable?</li> </ul>		
C) WELL-BEING and COVID-19			
Nr	Proposed question	Feedback received from participant(s)	Observations by facilitators (e.g. engagement of applicants & interest, which Q easy to answer/which not, group dynamic etc)
15	<p>In what ways has COVID-19 impacted the life of residents including children/youth in the reception facilities? What was/is most difficult for residents?</p> <p><i>Follow up question:</i></p> <ul style="list-style-type: none"> <li>Can you share what you have observed in applicants?</li> <li>What has helped applicants/youth to stay strong/well during the pandemic?</li> <li>Have you received any information on how to best handle/deal with such a difficult situation like the pandemic?</li> </ul>		
16	<p>Generally speaking, what information on health and well-being would be helpful/useful for applicants (women, men, youth) in your view?</p> <p><i>Follow up question:</i></p> <ul style="list-style-type: none"> <li>What is the best way to reach applicants with information including youth and children?</li> <li>What channels are most effective?</li> <li>Who should provide what information?</li> </ul>		
17	<p>In what ways has COVID-19 impacted the life of residents including youth in the reception facilities? What was / is most difficult for residents?</p> <p><i>Follow up question:</i></p> <ul style="list-style-type: none"> <li>Can you share what you have observed in applicants?</li> <li>What has helped applicants/youth to stay strong/well during the pandemic?</li> <li>Have you received any information on how to best handle/deal with such a difficult situation like the pandemic?</li> </ul>		

18	Is there anything else you would like to share on this topic which we have missed in your view?		
19	If I can kindly ask you before we say goodbye - How important you think this talk/this topic is for applicants/youth – what would you say:  <i>Very important – Important - A little bit important – Not so important</i>		
D) ADDITIONS BY THE FACILITATING AUTHORITY OR CIVIL SOCIETY ORGANISATION			
A. General input/comments on the topic by the facilitators including: brief general social and demographic assessment of the community being served; identification of main Mental Health (MH) needs and psycho social problems faced in your view by the population ( <b><u>incl. linkages to potential consequences like substance and drug abuse problematic, critical incidents, domestic violence related concerns, suicide attempts etc</u></b> ); brief evaluation of MH services / programmes offered within the respective organisation/authority and determination of priorities on the topic of MH from your point of view (for applicants/for first line officers). B. What worked well in terms of questions and what not and why; (which Q's needed to be reformulated or avoided, general impression of flow of engagement by respondents etc); What should EASO consider in case of a similar exercise to improve the intervention/make it easier for facilitators etc C. Potential interest in being involved on the topic of MH also in the near future? (e.g. presenting findings, follow up survey, participation in case of a working group on MH, other?) – if so how?			
E) DETAILS			
Member State:			
Organisation/ Authority facilitating the intervention:			
Facilitator/s name/s:			
Interpreter/s names:			
Date:			

Many thanks for your contribution!

### General Information on youth participant(s)

Total # of participant(s)	
Country(ies)/of origin (including statelessness)	

Age (average age in case of group)	
Gender of participant(s): F/M/X	
Participant(s) is (are) in this Member State since: (average # of months/years in case of a group setting)	
Participant(s) years of formal education (average in case of a group setting)	
Participant(s) is literate (can read and write) in at least one language: YES / NO	
Participant(s) have access to a smart phone:	
<b>Location of the intervention:</b> (In case of a collective reception centre, provide some basic info on total # of residents; type of facility; average length of stay in the facility; (In case of personal interview outside a reception centre - describe briefly context in which this consultation takes place)	

A) Conceptualising Mental Health in country of origin			
Nr	Proposed question	Feedback received from participant(s)	Observations by facilitators (e.g. engagement of applicants & interest, which Q easy to answer/which not, group dynamic etc)
1	<p>In the country you come from, how can people tell that a community member is not well for example that their mind is not so strong? That s/he has a problem?</p> <p><i>Follow up question:</i></p> <ul style="list-style-type: none"> <li>Do the signs/conditions you just described look different for girls and boys and youth compared to adults? Briefly explain</li> <li>What is still acceptable behaviour and what behaviour is not acceptable within your community</li> </ul>		
2	How do you call such problems or people suffering from such problems? Please share them in your mother tongue and explain word by word what they mean.		
3	<p>What do people back home think causes emotional problems/or situations where people emotionally not feel well?</p> <p><i>Follow up question:</i></p>		

	<ul style="list-style-type: none"> <li>Are these causes you just shared common views in your country? Do you think there are differences in what causes emotional problems in children and adults? If so - briefly explain.</li> </ul>		
4	What do youth or children normally do back home when they do not feel well and are sad/upset? What helps them?		
5	<p>How do people with such problems as you described normally get help in your country?</p> <p><i>Follow up question:</i></p> <ul style="list-style-type: none"> <li>Who is normally the first contact person to provide support/help?</li> <li>Does everyone get the same support or are there people who cannot be helped?</li> </ul>		
B) Post-Migration			
Nr	Proposed question	Feedback received by participant(s)	Observations by facilitators (e.g. engagement of applicants & interest, which Q easy to answer/which not, group dynamic etc)
6	<p>What signs do you see most frequently in fellow residents which suggest that they are under serious distress, emotionally upset and not well?</p> <p><i>Follow up question:</i></p> <ul style="list-style-type: none"> <li>How often do you see applicants with such problems?</li> </ul>		
7	Are the signs you see here in the community of residents (like women, men, children, youth and the elderly) the same or different from what you see back home? If different - in what way?		
8	<p>What do you think are the main causes of such problems you described for adult applicants, boy and girl children and youth here (Europe)?</p> <p><i>Follow up question:</i></p> <ul style="list-style-type: none"> <li>Who in your view are most likely to have or develop such problems or show emotional distress here – and why?</li> </ul>		

9	How are residents with such problems treated by others? What have you observed?		
10	What do applicants where you live and have such problems normally do to better handle their situation?		
11	<p>Are there specific programs for children and youth in place to help them deal with difficult situations?</p> <p><i>Follow up question:</i></p> <ul style="list-style-type: none"> <li>And which one's do you consider most helpful and why?</li> <li>How do you know about these services? Is this support free of charge?</li> </ul>		
12	<p>What do you think is missing to best support applicants with such problems e.g. like being upset, feel unwell and sad?</p> <p><i>Follow up question:</i></p> <ul style="list-style-type: none"> <li>Are there specific needs men, women, children, youth have in terms of activities, services to make them feel better</li> </ul>		
13	<p>Looking at your <b>present accommodation (reception)</b> – what in your view makes applicants feel bad and creates stress in the residents surrounding you?</p> <p><i>Follow up question:</i></p> <p>What is in place where you stay which you think makes applicants feel better about themselves? In particularly also children/youth?</p>		
14	<p>What in your opinion would make applicants and particularly youth more at ease - <u>before</u> and <u>during</u> the <b>personal interview for the asylum application</b>? Any suggestions?</p> <p><i>Follow up question:</i></p> <ul style="list-style-type: none"> <li>Is there anything case officers can/should do to put the mind of applicants at rest and make them feel more comfortable?</li> </ul>		
C) WELL-BEING and COVID-19			
Nr	Proposed question	Feedback received by participant(s)	Observations by facilitators (e.g. engagement of applicants & interest,

			which Q easy to answer/which not, group dynamic etc)
15	<p>In what ways has COVID-19 impacted the life of residents including youth in the reception facilities? What was / is most difficult for residents?</p> <p><i>Follow up question:</i></p> <ul style="list-style-type: none"> <li>• Can you share what you have observed in applicants?</li> <li>• What has helped applicants/youth to stay strong/well during the pandemic?</li> <li>• Have you received any information on how to best handle/deal with such a difficult situation like the pandemic?</li> </ul>		
16	<p>Generally speaking, what information including around health would be helpful/useful for residence and in particular youth?</p> <p><i>Follow up question:</i></p> <ul style="list-style-type: none"> <li>• What is the best way to reach youth with information including children?</li> <li>• What channels are most effective?</li> <li>• Who should provide what information?</li> </ul>		
17	<p>Is there anything else you would like to share on this topic which we have missed in your view?</p>		
18	<p>If I can kindly ask you before we say goodbye - How important you think this talk/this topic is for applicants/youth – what would you say:</p> <p><i>Very important – Important - A little bit important – Not so important</i></p>		
D) ADDITIONS BY THE FACILITATING AUTHORITY OR CSO			
<p>A. General input/comments on the topic by the facilitators including: brief general social and demographic assessment of the community being served; identification of main Mental Health (MH) needs and psycho social problems faced in your view by the population (<u>incl. linkages to potential consequences like substance and drug abuse problematic, critical incidents, domestic violence related concerns, suicide attempts, children getting missing, exploitation etc</u>); brief evaluation of MH services / programmes offered within the respective organisation/authority and determination of priorities on the topic of MH from you point of view (for applicants/for first line officers).</p> <p>B. What worked well in terms of questions posed to children/youth and what not and why; (which Q's needed to be reformulated or avoided, general impression of flow of engagement by respondents etc); What should EASO consider in case of a similar exercise to improve the intervention/make it easier for facilitators etc</p>			

C. Potential interest in being involved on the topic of MH also in the near future? (e.g. presenting findings, follow up survey, participation in case of a working group on MH, other?) – if so how?	
E) DETAILS	
Member State:	
Organisation/ Authority facilitating the intervention:	
Facilitator/s name/s:	
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Many thanks for your contribution



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