SUMMARY

BE Ad-Hoc Query 1292 and 1294 - Part I & II: Reception and Care of Vulnerable Applicants for International Protection with Special Reception Needs

Practices in Member States

Background:

The Study and Policy Unit from the Directorate of Policy Support of the Federal Agency for the Reception of Asylum Seekers (Fedasil) conducted a study on vulnerable applicants for international protection with special reception needs. The aim of the study was to **establish a detailed picture of the practices in the field relating to the definition and identification of vulnerabilities and special reception needs, and the extent to which the particular needs of vulnerable persons within the reception network are taken into account** in a general sense. The methodology used for this study therefore made specific use of information collected in the field, namely among the staff in the reception facilities and external organisations which - whether mandated by the Agency or not - are specialised in the housing and/or accompaniment of vulnerable persons.[1]

The study was carried out in two phases which comprise different activities. The literature study, legal analysis, observations and exploratory discussions and the survey among the staff of the social and medical units in the reception facilities form the basis for the **summary report of the first phase** published in December 2016 (available in French and Dutch on https://www.fedasil.be/sites/default/files/content/download/files/syntheserapport_kwetsbare_personen_2016_0.pdf).

The **second phase** comprised in-depth focus groups with staff of the reception facilities, a survey among external organizations that provide care and sometimes accommodation for applicants for international protection and an analysis of European practices in relation to the protection of vulnerable applicants for international protection with special reception needs. The final report of this study was published in December 2018 (available in French and Dutch on https://www.fedasil.be/sites/default/files/content/download/files/fedasil_studie_kwetsbare_personen.pdf).

The Belgian Reception model provides reception in **collective reception centres** as a rule and the reception in **individual reception facilities is reserved for specific groups**: beneficiaries of international protection (during the so-called transition period in which they go from life in a reception facility to independent living), applicants likely to be granted international protection (nationalities with an average recognition rate of 80%) and applicants with certain special needs. The aim is to install a clear link between reception and the procedure for international protection.

It was decided to set up a European survey because there were indications of important differences between countries on identifying and caring for vulnerable applicants for international protection with specific needs[2], despite the fact that all member states must respect the same European Reception Directive[3].

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[1] The Study and Policy Department carried out a study into how the policy on vulnerability is shaped. It was not an evaluation study, but a step towards an evidence-based policy. One aspect of the research was the institutional model, in addition to the practices of social assistants.

[2] On the basis of the AIDA country files, the European Council on Refugees and Exiles (ECRE) published a report in March 2016 on the reception of asylum seekers, which showed that despite the European Reception Directive of 2013 (recast) there are different approaches to vulnerability. This finding was also confirmed in the context of the attention to specific needs during the procedure for international protection.

[3] European Council on Refugees and Exiles (2016), Wrong counts and closing doors: The reception of refugees and asylum seekers in Europe.

The objective of the ad hoc query was twofold. On the one hand, we wanted to obtain an overview of country practices concerning the identification of vulnerable applicants for international protection with specific needs and the adapted care provided to them. On the other hand, we wanted to use the ad hoc query to identify any good practices that might serve as inspiration. This comparison between Member States does not pronounce on the performance and should therefore not be interpreted as formal benchmarking. For this, there is too much diversity between the reception systems.

This Ad-Hoc Query is **not about procedural needs** in relation to the application for international protection, but is about the legislation and identification in the context of reception (AHQ Part I) and the care and accommodation (AHQ Part II) of applicants for international protection with special reception needs.

The Belgian National Contact Point of EMN sent two ad hoc queries to all national contact points of the European Migration Network (EMN) on 26 March and 3 April. It was decided to launch two separate queries because of the large number of questions. **The first query concerns the legislation concerning vulnerable applicants for international protection and the moment at which, by which actors and on the basis of which procedures and tools applicants for international protection are screened for vulnerability and special reception needs**. The **second query concerns the presence of special reception and care facilities for vulnerable applicants, the allocation procedures and the demand for good practices and bottlenecks in the reception and care** of vulnerable applicants with special reception needs.

Both queries were answered by 22 national contact points of the EMN: Austria (AU), Belgium (BE), Cyprus (CY), Estonia (EE), Finland (FI), France (FR), Greece (EL), Hungary (HU), Italy (IT)), Croatia (HR), Latvia (LV), Lithuania (LT), Luxembourg (LU), Malta (MT), Netherlands (NL), Norway (NO), Austria (AU), Poland (PL), Slovakia (SK), Czech Republic (CZ), United Kingdom (UK) and Sweden (SE).[4]

Bulgaria, Denmark, Germany, Ireland, Portugal, Romania, Slovenia and Spain did not participate in the survey.

Content:

Instead of a general overview of the respective country practices, the summary is limited to the most important differences and similarities that came to the surface after analysis. We make a distinction between (1) definition, (2) identification, (3) care and (4) good practices and challenges[5].

[4] At the time of the survey, the 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 did not apply to Ireland, Denmark and the United Kingdom. The United Kingdom continues to apply the Reception Directive of 2003. On 24 January 2018 Ireland notified its wish to accept and be bound by Directive 2013/33 / EU. The European Commission Decision (EU) 2018/753 of 22 May 2018 confirms the participation of Ireland in Directive 2013/33/EU. The 2013/33/EU Directive applies to Ireland as from 24 May 2018.

[5] The compilation of all replies from the participating Member States are available on the website of the Belgian National Contact Point of the European Migration Network: https://emnbelgium.be/publication/ad-hoc-query-reception-and-care-vulnerable-applicants-international-protection-special or on the website of EMN Europe: https://ec.europa.eu/home-affairs/what-we-do/networks/european_migration_network/reports/adhocqueries_en.

1. Definition

Most European member states explicitly refer to vulnerable persons and their special needs in their current national legislation. In most countries it concerns **a list of categories of vulnerable persons in the context of the transposition of the European Reception Directive (recast)** or a **restriction or extension** of this non-exhaustive list.

A number of countries (including **BE, CY, EE, FR, IT, LU, MT, NL and SK**) mention the **10 categories as included in Article 21 of the Reception Directive**[6]. The Dutch legislation does not provide a literal summary, but refers to vulnerable persons 'as referred to in Article 21 of the Reception Conditions Directive'.

Other countries have **added certain categories (CZ, EL, HR, LT, LV, PL**). For example, **Greece** mentions persons with a post-traumatic condition, in particular survivors and relatives of victims of shipwrecks. In addition to the categories of the Reception Directive, **Poland** also mentions bed-ridden persons and vulnerable persons because of gender, sexual orientation and gender identity. **Latvia**, in addition to the categories of art. 21 of the European Reception Conditions Directive also mention 'persons who must be specially protected, whose ability to exercise their rights and to comply with the obligations during the asylum procedure is limited' and thus also take into account the procedural needs of a person. **Croatia** mentions persons who are not legally competent and the **Czech Republic** also speaks of a parent or family with an adult child with a medical disability.

A number of countries (**AU, FI, HU, NO, SE and UK**) **do not work with the categories in the Reception Conditions Directive or limit the number of categories**. In **Austria** there is no legal definition at federal level of vulnerable applicants for international protection, but at the regional level, vulnerable groups are defined in the welfare legislation. For example, the care laws of the provinces of Lower Austria and Vorarlberg define the following categories as vulnerable: the elderly, pregnant women, single parents and victims of torture, rape or other forms of serious psychological, physical or sexual violence, while in other provinces vulnerable categories are not listed[7]. No reference is made to persons with serious illnesses or mental disorders in **Slovakia, Hungary and the United Kingdom**. And victims of trafficking in human beings are not mentioned in the last two countries. In **Finland** special needs are taken into account due to age, physical and mental state of applicants for international protection. And in **Sweden** only mention is made of unaccompanied foreign minors.

The reference to vulnerable persons with specific needs is in many countries of recent date. It goes back to the European Directive 2013/33/EU establishing standards for the reception of applicants for international protection (recast), which, in principle, had to be transposed into national law by July 2015. This was the case, for example, in Poland, Estonia and France. In principle, the European Reception Directive of 2003 already asked for attention for vulnerability in the reception of applicants, but this remained largely a dead letter for a long time. There were a few countries, including Belgium, Italy and the United Kingdom, which already registered vulnerable persons in their national legislation as part of the first European Reception Conditions Directive.

Vulnerable applicants for international protection	
Categories of the European Reception Conditions Directive	BE, CY, EE, FR, IT, LU, MT, NL, SK
European Reception Conditions Directive with additional categories	CZ, EL, HR, LT, LV, PL
More limited list of categories	AU, FI, HU, NO, SE, UK

Terminologically, no consistent difference seems to be made between vulnerability and specific needs. Only in three countries (**HU, MT and UK) is it explicitly specified that an individual evaluation should determine whether a vulnerable person actually has special needs**.

[6] It concerns: minors, unaccompanied minors, disabled people, elderly people, pregnant women, single parents with minor children, victims of human trafficking, persons with serious illnesses, persons with mental disorders and persons who have been subjected to torture, rape or other serious forms of psychological, physical or sexual violence, such as victims of female genital mutilation.
[7] ECRE (2016), Wrong counts and closing doors: The reception of refugees and asylum seekers in Europe.

"By this definition vulnerable persons are especially unaccompanied minors, minors, disabled people, elderly people, pregnant women, single parents with minor children and persons who have been subjected to torture, rape or other serious forms of psychological, physical or sexual violence, ***of whose unique situation it can be individually determined that they require special needs****."*(HU)

2. Identification

When identifying vulnerable applicants with specific reception needs, we can make a distinction between: (a) who does the identification, (b) when dies the identification takes place and (c) the way in which the identification takes place.

a) Actors of identification

In some countries, the immigration and reception of applicants for international protection lies with the same authorities. In this context, it is possible that there is **no separate identification of reception needs and procedural needs**, despite the fact that the various European Directives are partially pushing forward other vulnerable categories. For example, the European Directive 2013/32 / EU on common procedures for granting and withdrawing international protection (recast) mentions that some applicants need special procedural safeguards based, inter alia, on their age, gender, **sexual orientation, gender identity**, disability, serious illness, mental illness or as a result of torture, rape or other serious forms of psychological, physical or sexual violence. The European Reception Conditions Directive (recast) states in Article 21 that 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 serious illnesses, persons with mental disorders and persons who have been subjected to torture, rape or other serious forms of psychological, physical or sexual violence, such as victims of female genital mutilation must be taken into account.

In some countries (**AU, BE, CY, EE, EL, FR, HR, HU, IT, LT, NO, PL, SE, UK**), the (first) identification takes place, following an application for international protection, by **the (border) police or by the immigration services**, of which the authorized personnel have followed **training to identify vulnerabilities and special needs (AU, FR, HR, PL, LV, LU, SE)** or have developed **guidelines or standard operating procedures (CZ , EL, FI, HR, IT, NO, PL, SE, UK)**.

Also in the countries where initial identification takes place in the context of the request for international protection, the **identification of vulnerability is continued in the reception facilities (AU, BE, HR, HU, IT, LT, NO, SE, UK)** by the personnel of the reception structure, including social workers, members of the medical and / or psychosocial team, educators, employees of other services and external services.

As mentioned above, in some countries, **external services** such as **international organizations, NGOs, non-profit organizations and private and public service providers (EL, FI, HR, IT, MT, LV, SE, UK)** are also used for identification purposes. In **Croatia**, staff from the competent Center for Social Welfare, the Croatian Red Cross, Jesuit Refugees Service and other NGOs participate in the identification of vulnerable applicants. **Finland, Greece, Latvia, Sweden and the United Kingdom** use **external medical services**. **Greece** also cooperates with UNHCR and EASO. **Italy** also cooperates with international organizations, European Agencies and NGOs. In **Luxembourg**, some reception structures work together with an ethno-psychological team of the Red Cross consisting of 8 professionals (psychologists, nurses, psychiatric nurses) to detect the vulnerabilities of residents as quickly as possible, to ensure adequate care and to guarantee the referral to the health care system, mainly medical specialists.

b) Time of identification

In most countries, initial identification of vulnerability takes place **immediately or shortly after making the application for international protection (AU, BE, CY, EE, EL, FR, HR, HU, IT, LT, NO, PL, SE, UK)**. A number of countries report that the first screening for vulnerability takes place **in the first days after arrival in the reception facility (CZ, FI, MT, NL, SK, LU, LV)**.

Most countries also indicate that the identification of vulnerabilities and special needs is a **continuous process through the procedure for international protection and reception (AU, BE, EE, FI, HR, HU, IT, LT, LU, NL, NO, PL, SK, UK)**.

c) Identification procedures

Vulnerability is identified in the member states via **(screening) interviews using questionnaires or checklists** (AU, BE, CY, EE, EL, FI, FR, HR, HU, IT, LT, LU, LV, MT, NL, NO, PL, SE, UK), **observation** (AU, BE, CZ, FI, LV, UK), **individual evaluations** (BE, CZ, FI, HR, LU, LV, MT, SK, SE), **multidisciplinary consultation** or exchange of information between different bodies (BE, EE, EL, FR, IT, LT, NL, SK) and **medical examinations**.

Except for Cyprus, France, Hungary, Malta, the Netherlands and the United Kingdom, the countries that participated in the query state that a **medical examination or health status assessment** is carried out by doctors, nurses and / or external medical services at the time of the registration and / or after arrival at the reception facility. In a number of countries the medical team is **assisted by a psychologist (AU, LT)**. For example, there is a qualified psychologist present in the Registration Centre for Foreigners in Lithuania who is responsible for assessing the psycho-emotional state of the applicants, the psychological diagnosis and the identification of vulnerable persons who have been traumatized / tortured.

Some countries mention the use of the **PROTECT instrument (BE, HR, HU)**. The target group of PROTECT are persons who have undergone traumatic experiences, i.e. persons who are subjected to torture, rape or other forms of serious psychological, physical or sexual violence. The questionnaire focuses on signals and symptoms of the most common psychological problems, such as Post Traumatic Stress Disorder (PTSD), anxiety and depression with the intention to detect vulnerable applicants for international protection with traumatic experiences. **Croatia** adapted the questionnaire with the aim to do early identification of vulnerabilities in a more standardized way. In providing social assistance, so-called individual clients plans are used in **Finland** to identify the needs of the applicant and to plan the adapted services accordingly. These plans can be adjusted if necessary. In **Malta**, the 'Vulnerable Adults Assessment Procedure' is used in which the concerns regarding the welfare of the applicant and the reinforcing and protective factors are assessed.

Several countries **(AU, CZ, EE, FR, HR, LU, LV, PL)** mention that the persons responsible for the identification of vulnerabilities have received **training**, have sufficient **experience** and / or have the **necessary internal guidelines and procedures**.

3. Care

For a good understanding of the organisation of the care for vulnerable applicants for international protection with specific needs, an overall picture of the organisation of reception systems in the various European Member States and Norway should be outlined. However, this was not possible within the framework of these ad hoc queries. That is why we will only look at the specific provisions for vulnerable persons mentioned by the countries surveyed.

The **reception conditions for unaccompanied minors are not included** in this summary, but can be found in the compilation of the answers of the Member States.

Victims of trafficking in human beings are taken care of by specialized institutions that are not part of the reception system for applicants for international protection in all countries that mention this category.

A number of countries state that they have reception structures that are **accessible** to applicants with **physical disabilities or reduced mobility** such as adapted rooms and sanitary facilities for wheelchair users (**BE, CZ, HU, LU, LV, NL, NO, PL**).

A number of countries indicate that they do **not have special reception centres** for vulnerable applicants for international protection. Vulnerable applicants are accommodated in **generic centres where efforts are made to provide appropriate care and support**, possibly with the help of external services or organizations **(EE, HU, IT)**. Only in cases for which generic reception cannot provide for adequate care, a **transfer to an adapted place** outside the reception system for applicants for international protection is considered (**CZ, EL, LT, LV, NL**).

> *"The only reason we are using specialized care for our clients is when we are not able to handle it so the next step is to find the special facility and sign a contract with it."* (CZ)

However, some countries do provide **separate reception centres for vulnerable applicants with special reception needs** that are part of the reception system for applicants for international protection (**AU, BE, FI, HR, LU, MT, NO, PL, SE**).

It concerns reception facilities for:

- Vulnerable applicants in general: in **Croatia** and **Slovakia**
- Applicants with chronic diseases / physical conditions: in **Austria** and **Norway**
- Applicants with mental illness / psychological problems: in **Belgium**, **Finland** (also for addiction problems), **Norway** and **Austria**
- Single women (with children): in **Belgium, Luxembourg, Malta, Austria** (with only female caregivers) and **Poland**.

In **Norway** and **Greece**, **women who are victims of trafficking or domestic violence** are transferred to women's refuge centres to ensure their safety. The other countries indicate that single women (with children) are received in separate parts of the generic reception centres or at least separated from the rooms for single men.

The **notion of vulnerability is also associated with the security of the applicant** for other categories of vulnerable groups. For example, the **Swedish** reception system has two safety accommodations where persons who risk being the victim of intimidation and bullying in the regular reception can be taken care of. It concerns LGBTI persons and persons who are at risk of being harassed based on their age, gender, religion, mental or physical disability. **The Netherlands** provides for the possibility of accommodating applicants belonging to minorities (LGBTI, Christians, etc.) in separate and safe accommodations within the generic shelter to guarantee their safety:

> *"The Central Agency for the Reception of Asylum Seekers (COA) has the possibility to shelter vulnerable asylum seekers (e.g. LGBTs, Christians, minorities etc.) in separate and safe accommodation if their safety cannot be guaranteed. At some locations vulnerable individuals are already sheltered together and sometimes even in a separate part of the reception facility. In some cases, vulnerable persons will be assigned an individual room or near the entrance of the reception facility (and therefore close to the security staff). Every case is assessed individually to come to a suitable solution. During this assessment, it should be taken into consideration that specific reception for a vulnerable individual should not lead to social isolation or to rewarding intolerance behaviour of other asylum seekers. Lastly, there is also a possibility to relocate a vulnerable person to another reception centre or, as a last resort solution, to relocate an individual in a crisis location outside a reception centre."* (NL)

Cyprus is in the process of starting a reception centre for vulnerable applicants. In anticipation of this centre, vulnerable applicants are currently being referred to referring to social welfare centres.[8]

4. Good practices

Adapted reception structures for people with special needs

Several countries mention having **adapted reception structures** for vulnerable applicants with special needs as a good practice (**AU, BE, HR, FI, SE**).

Most (Member) States also mention having **separate rooms, dormitories or wings** for single men, single women, families and unaccompanied minors in their reception centres as good practice.

Cooperation with other actors

Various (Member) States also mention the **importance of cooperation with other actors**. This concerns both the cooperation with external care providers, NGOs, charity organizations and international organizations (including IOM, UNHCR, Caritas International, Red Cross, Jesuit Refugees Service). It concerns both reception partners or organizations that organize customized care and accompaniment (**BE, CZ, EL, IT, LT, LV, NL, NO**) and actors that offer their services in the existing reception structures (**BE, HR, IT, LT, LU, LV, NO, PL, SK**)

> *"A good practices related to the care and reception of vulnerable applicants for international protection with special needs is a collaboration between Croatian Law Centre, Croatian Red Cross and UNHCR on the project entitled "**Protection of Victims of Torture among Vulnerable Groups of Migrants**", funded by The United Nations Voluntary Fund for Victims of Torture (UNVFVT), which is directed principally towards providing direct assistance to identified victims of torture among vulnerable groups of migrants. Main goal of this project is early identification of victims, regulation of their status, and their referral to national institutions for appropriate assistance. The project includes providing psychological support (individual and group consultation), social assistance and legal aid and it is continuously carried out since 2010."* (Croatia)

In **Greece**, several government departments have concluded a **cooperation protocol** to establish a common framework of procedures for identification, referral, reception and guidance and activities for female applicants who are (potential) victims of violence and their children[9].

Poland stresses the importance of **developing a procedure** to achieve a harmonised and adapted reception and care of vulnerable applicants:

> *"A procedure for dealing with foreigners who require special treatment in the area of social assistance. The aim of the procedure is to indicate the procedure for the granting and implementation of social assistance to foreigners who require special treatment in the field of social assistance. In addition, another goal of this procedure is to standardize the treatment of the abovementioned group of foreigners and to maintain the quality of social assistance provided at the highest level, adapted to the special needs of foreigners. The procedure describes how to proceed with care, including elderly people, indicating the need to provide such help for foreigners, for example, transportation to the centre, accommodation in a room with a bathroom, care for a proper diet and medical equipment if necessary. The procedure also includes guidelines for dealing with unaccompanied minors, including the need to safeguard their interests, in particular the possibility of family reunification, child well-being and social development, safety and security considerations, in particular when there is a risk that a minor is a victim of trafficking, according to his age and maturity. Another group of*

[8] Information dates from March and April 2019.

[9] http://www.isotita.gr/wp-content/uploads/2017/12/Protocol-on-Cooperation-for-Refugee-Women.pdf

foreigners to whom the help procedure is applied are bedridden persons, who in case when the state of health requires it, are placed in a special facility such as a nursing care facilities, health care center, hospice." (Poland)

A number of countries mention cooperation with external actors for the reception of severely ill applicants (**CZ**) and the adapted care for applicants with mental health problems and addiction problems (**FI**) as good practice.

Exchanging information

Some countries (**BE, SK**) mention the importance of **regularly exchanging information between the employees and care providers involved** (social workers, asylum authorities, medical staff, NGO staff and external service providers), internally and externally to the reception structure. And the recording of this information and the follow-up in a **social file or supervision plan**.

Training and support of field staff

The **training and support of field workers** are also considered a good practice (**EL, NL**). For example, employees in **Greece** are informed and given guidelines for the identification and referral of vulnerable female applicants, (potential) victims of gender-based violence, in collaboration with non-governmental organizations.

Information to asylum seekers

Developing information tools and informing applicants for international protection are mentioned as good practice by **the Netherlands and Croatia**.

Informatie aan asielzoekers

5. Challenges

Four countries (**AU, EE, FR, NL, UK**) did not answer the question concerning the challenges in the care and reception of vulnerable applicants for international protection.

Hungary indicates that it is a transit country and that, despite the fact that they are trying to provide appropriate care, most refugees only want to travel on to Western Europe. For example, they saw severely ill persons leave despite the appropriate medical care that was offered to them.

At the time of the AHQ, **Cyprus** was in the process of opening a special reception centre for vulnerable applicants. At that time, there was only one general reception facility in Cyprus with a capacity of 400 beds. Applicants who after screening belong to the category of persons with special reception needs are not referred to this generic reception centre because they do not have the necessary infrastructure, but are referred to social welfare services.

The other countries (**BE, CZ, EL, FI, HR, IT, LV, LT, LU, MT, NL, PL, SE, SK, NO**) cited the following obstacles and bottlenecks in the care and reception of vulnerable applicants:

Shortage of adapted places and care

Several countries report a **shortage of places that are suitable for accommodating and caring for vulnerable applicants for international protection** (**BE, CY, CZ, EL, FI, IT, MT, SK, SE**). **Belgium**, **Slovakia** and **Sweden** point to the shortage of adapted places for people with physical disabilities and **Slovakia** indicates that the reception facilities must be made more accessible. In Slovakia, there is also no place in the reception facilities for persons with complex mental problems or a psychiatric diagnosis. Here too, the reception structures should be better equipped to provide the necessary therapies such as art and music therapy. In **Greece** and **Italy** there is a shortage of adapted reception places for unaccompanied minors. **Italy** also points out that there is a need for a balanced territorial distribution of unaccompanied minors, as these are now mainly concentrated in the disembarkation areas.

Just like the shortage of adapted places within the reception network, **external service organisations** also suffer from a **capacity shortage**, leading to a waiting times before the applicant gains access to the care. The **Czech Republic** indicates that it is extremely difficult to find externally organised care for certain vulnerable profiles due to the lack of capacity. The same applies in **Belgium**, **Finland** and **Luxembourg** where one is confronted with a limited capacity of certain medical and psychological services and consequently waiting lists.

Lack of time

A number of countries also point to the **lack of time to conduct a thorough identification or follow-up of vulnerable persons** (**BE, IT, LV, MT**). And **Italy** reports the need to ensure that the different procedures, including identification, health check, age determination and international protection, are completed within the legal timeframe.

Communication problems: language barriers and cultural differences

Three countries refer to **language barriers** in communication with applicants for international protection (**BE, HR, LV**). **Belgium** and **Croatia** specifically mention that there is a **shortage of qualified interpreters** to facilitate the identification and care of vulnerable applicants.
Belgium, **Croatia**, **Latvia** and **Lithuania** indicate that it is difficult to raise certain sensitive issues. This mainly concerns psychological problems and sexual and gender-based violence. **Croatia** reports that there is a shortage of training to train employees in this. **Belgium** and **Latvia** indicate that even though staff have received training, it remains very difficult to raise issues that are taboo-related.

Relationship of trust

Several countries also point to the **need for a relationship of trust** between the applicant and the field employee to discuss certain topics and to identify vulnerabilities (**BE, HR, LV, LT**). For example, **Croatia** states that it is very difficult for vulnerable applicants to build up a relationship of trust, especially with regard to subjects that are difficult to discuss, such as psychological problems and sexual violence.

Lack of experience with the problem on behalf of the field staff

Some countries (**BE, LT, LV**) indicate that the field staff receive **insufficient or no training with regard to certain problems**. **Belgium** and **Latvia** note here that even if field employees were trained on certain topics they will not raise the issue if they know that they cannot provide an adequate follow-up for the problem.
Lithuania reports that the identification and care of victims of torture poses the greatest challenge, among other things due to the lack of experience among case handlers, social workers and psychologists to correctly assess the specific traumatic experiences associated with torture.

Cooperation with external organisations

In several countries there are **bottlenecks in the cooperation with external organisations** for the care and / or reception of vulnerable applicants for international protection. This concerns the quality of the services offered, the capacity (see above), the uneven geographical distribution of the external service organisations, the experience with the target group, the coordination, the exchange of information and the financial aspect of the cooperation.

Belgium indicates that it is difficult or even impossible for reception centres to monitor the **quality of care** provided by external services.

The **uneven geographical spread** of the external organisations, where there is a concentration in the (large) cities and the more remote areas are deprived, is experienced as a problem in **Belgium**.

Three countries (**BE, CZ, LT**) mention the **lack of experience with the target group** on behalf of the external organizations as a bottleneck. For example, external organisations may be reluctant to receive or treat applicants for international protection for fear of lacking intercultural competences,

means of communication or specific experience to provide good care or they refuse applicants for international protection because they are not part of the target group of the organisation.

However, it is not only the external organizations that refuse the request for help, **vulnerable applicants also have a lack of experience with (external) services and refuse or are reluctant to accept the care offer** (**BE, LV, SK**). This mainly concerns care provided in the context of psychological problems, sexual violence (including female genital mutilation) and domestic violence. **Slovakia** states that the attitude of the applicants to psychological treatment often poses a challenge in view of the fact that, for example with PTSD, it is not culturally accepted.

Another problem in the cooperation with external organisations or between several actors within the asylum and reception system is the **coordination and exchange of information** (**BE, HR, NO, PL**). For example, **Norway** argues that information management and information sharing are continuing challenges that impact all aspects of the care and reception of applicants with vulnerabilities. In general, information on health and other vulnerabilities is sensitive information and the management and sharing of such information should be thoroughly regulated. This leads in some cases to delays that may lead to adequate care not being provided on time. And the number of different agencies and institutions involved in the identification of vulnerabilities makes the exchange of information even more complicated. Furthermore, the transfers of applicants between different reception facilities can also cause information to lag behind, resulting in bottlenecks for the reception facilities, the care providers and the care for the applicant.

Belgium and **Croatia** also mention the difficulties that exist in **the sharing of information between the various actors involved**. Belgium also explicitly refers to the medical professional secrecy and the (shared) professional secrecy that even makes the exchange of information between the (social and medical) services within the same reception structure, between asylum authorities or with external organisations difficult.

Both **Belgium** and **Poland** report the **financial aspect associated with the reception and care** of vulnerable applicants. For example, Belgium refers to possible bottlenecks in connection with the reimbursement of assistance provided by external services.

Finally, the survey also shows that the attention and care for vulnerability are **difficult to sustain in case of a high inflow** of applicants for international protection:

> "*However, with the increase in the numbers of asylum seekers, vulnerable asylum seekers who need single room may face difficulties as there are no available places so people can rarely be accommodate in single room, in such cases, we are trying to find other solutions*." (Croatia)

6. Conclusion

An **adapted reception for vulnerable applicants for international protection is crucial**, not only because it allows applicants to go through their application for international protection optimally, but also to prevent applicants from being subjected to further trauma, which can happen if an applicant is subjected to sub-standard reception and care. [10]

Although improvements have been made to the standards for reception that have to be provided according the Reception Conditions Directive (recast), **Member States still have considerable discretion in their implementation**. Member States are obliged under the Reception Conditions Directive (recast) to provide a decent standard of living for those seeking international protection, but few indications are given as to what this means. The Directive now provides for an increased assistance for persons with special reception needs, but Member States have considerable freedom

[10] ECRE (2015), *Reception and Detention Conditions of applicants for international protection in light of the Charter of Fundamental Rights of the EU*, 90 p.

in determining how and which additional help is provided. The Directive also does not require an administrative procedure to determine whether an applicant has special reception needs.

The survey shows that the **identification of persons with special reception needs is done on an ad hoc basis**. Only a **limited number of countries indicate that they have a procedure laid down in legislation that provides for the identification of vulnerable applicants with special reception needs**. In other countries there are provisions for certain groups of vulnerable persons, but there are no identifying mechanisms included in the legislation to assess who has special reception needs. Still other countries have no provisions in the legislation, but have developed guidelines to assess whether an applicant has special (medical) needs that affect reception and care.

The query further shows that the identification process is characterized by the involvement of a **large variety of actors**, such as social workers (connected to the reception centre), the (border) police, the immigration services, the asylum authorities, NGOs or the applicants for international protection themselves.

In most countries, **initial identification of vulnerability** takes place immediately or **shortly after making / registering / lodging the application for international protection**. This mainly concerns an identification of the most visible vulnerabilities such as single parents, pregnant women and the elderly. Some countries indicate that the initial identification and/or the continuation of the identification takes place in the reception structure and that more than half of the countries surveyed state that identification is a **continuous process** that must be continued throughout the international protection procedure.

In most countries, **medical examinations** are a very important tool in the identification of vulnerabilities and special needs. Consequently, the identification by the medical staff plays a crucial role in the identification of vulnerabilities and we can speak of a **medicalisation of the notion of vulnerability**.

There is **no homogeneous understanding** between Member States about **what constitutes a special reception facility**. A number of (Member) States list facilities that are accessible to persons with a physical disability or that are located in the vicinity of external services. In other countries, special reception facilities are only these facilities that are fully adapted to the needs of the target group with tailor-made support offered by trained staff.

There seems to be a **consensus on the importance of well-trained actors involved in identifying and caring for vulnerable applicants**. For example, all staff working with applicants for international protection (police, asylum officials, social workers, detention officers, interpreters, doctors, psychologists and lawyers) should be trained to recognise symptoms of vulnerability. Certainly with regard to vulnerabilities that are less easy to detect, such as victims of torture / traumatised asylum seekers, training is necessary to recognise the symptoms and signs of torture and trauma and to have knowledge about the special needs of these victims.

Another point of attention is that a number of countries **(partially) outsource the identification and care of vulnerable applicants to NGOs**. It often involves psychological counselling for victims of torture or traumatic experiences. This is seen as a plus, because of the specific expertise of the organisations involved. But in practice these NGOs often have a shortage in their financing, which means that the identification and / or care is not always guaranteed and that there is no means to ensure that everyone who needs help receives it. Consequently, it is necessary for (Member) States to ensure the sustainable and adequate financing of these services.

Finally, there are **striking similarities** between the countries **with regard to the obstacles / obstacles for a good identification and follow-up of vulnerable applicants with specific needs**. It concerns a shortage of reception places that are adapted to the needs of vulnerable applicants for international protection, a capacity shortage among external service providers, a lack of time to do a thorough identification or follow-up of vulnerable persons, language barriers and cultural differences that contribute to the fact that it is difficult to raise certain sensitive issues even if the employees are trained and the difficulty to build up the necessary confidentiality. A problem that recurs is the lack of experience with certain problems encountered by the target group among field employees and the lack of training. In addition, problems arise in the (Member) States with regard to cooperation with external organisations, such as quality, capacity, uneven geographical

distribution, experience with the target group, coordination, exchange of information and the financial aspect of the cooperation. But also the reluctance of the applicants towards the care on offer and bottlenecks in coordination and the exchange of information between different actors remain major challenges.