PHASE 1

STUDY INTO VULNERABLE PERSONS WITH SPECIFIC RECEPTION NEEDS

Summary of the key findings




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[1] As part of the study, a Steering Group was set up. As a cross-functional group, the Steering Group guides each phase of the study. The Steering Group fulfils various functions in this respect. It encourages the involvement of the various stakeholders and collects their input whenever this is necessary. By supporting and encouraging the study, the Steering Group plays a facilitating role whenever staff from the Study and Policy Unit are doing fieldwork. Additionally, the Steering Group is also responsible for following up the activities and the results of the study by providing feedback for the developed study methodology. Finally, the thematic knowledge of the members of the Steering Group makes it possible to provide innovative avenues of research to enhance the study. Selected on the basis of their professional profile, the members of the Steering Group all have extensive knowledge of the reception network and/or expertise with regards to one or more vulnerabilities. The members of the Steering Group are: Michael Kegels (Direction Operational Services, Fedasil), Geert Knockaert (Direction Operational Services, Fedasil), Isabelle Plumat (Direction Operational Services, Fedasil), Sarah Strauven (Direction Operational Services, Fedasil), Joris Kennis (Direction Operational Services, Fedasil), Karen Lauwers (Red Cross), Renaud Mommaerts (Red Cross), Aude Titeux (Red Cross), Antoinette Dutilleux (Federal Migration Centre), Sophie Van Balberghe (CGRS), Aintzane de Aguirre (External expert) and Séverine Zeegers (UNHCR).

Abbreviations used

CIDT	Cruel, Inhuman or Degrading Treatment
CLB	Student Guidance Centre
CGRS	Commissioner General for Refugees and Stateless Persons
EASO	European Asylum Support Office
EMN	European Migration Network
IGP	Individual Guidance Plan
IO	Belgian Immigration Office
LGBT(I)	Lesbian, Gay, Bisexual, Transgender/Transsexual (Intersexed)
LRI	Local Reception Initiative
MDM	Multi-disciplinary Team Meetings
PTSD	Post-traumatic stress disorder
FGM	Female Genital Mutilation
VwV	Vluchtelingenwerk Vlaanderen (Refugee Work Flanders)
WHO	World Health Organisation
UNHCR	United Nations High Commissioner for Refugees

I. Introduction

Vulnerability within reception is not a new issue. The reception law of 2007, via Articles 11, 22 and 36, already explicitly acknowledges the need for better protection of vulnerable persons who request international protection. For example, Article 11 states that the Agency shall give special attention to the condition of these persons during the allocation of reception places. Article 22 states that during the thirty days following the allocation of a mandatory registration place, the personal situation of the beneficiary of the reception shall be investigated, to ascertain whether the reception is adapted to his or her specific needs. If this does not appear to be the case, the allocated reception place may be changed. Article 36 of the reception law also states that the Agency, in order to meet the specific needs of these persons, can conclude agreements with specialised institutions or associations.

We can observe that this issue has come under much more scrutiny in recent years. At the level of Community law, the provisions of Articles 21 and 22 of Directive 2013/33/EU of the European Parliament and the Council of 26 June 2013 laying down standards for the reception of applicants for international protection, do in fact require that the reception agencies of European Member States take account of the situation and the needs of vulnerable persons who request international protection. In order to achieve this, Member States need to establish mechanisms in the first instance, which make it possible to identify any potential vulnerabilities, and secondly, assess individual needs so as to be able, if necessary, to carry out an adaptation of the reception modalities. We also observe at the national level this renewed focus for the vulnerabilities of persons who request international protection. For example, the current Secretary of State for Asylum and Migration, Mr Theo Francken, requested in his general policy statement of 28 November 2014 to have a "maximum focus for the most vulnerable groups among candidate refugees".

Regarding the reception of persons requesting international protection, various Belgian and European legal instruments consequently anticipate the establishment of mechanisms to identify vulnerabilities, and to take account of specific needs by ensuring dignified reception which is adapted to the identified vulnerabilities. The legal frameworks therefore appear to be rather favourable for vulnerable persons (or persons at risk of vulnerability) within the reception, and the observed standards for their protection are relatively high. A number of initiatives have already been set up within the reception network to make it easier to identify vulnerable residents with specific reception needs. There are also projects - which may or may not be organised in collaboration with external organisations - which are aimed at providing specific support for vulnerable residents. However, 9 years after the implementation of the reception law, an assessment of this issue has still not been made by the Agency. Consequently, it appears to us to be particularly relevant to study the practices with regard to

the identification and the consideration given to the particular needs of vulnerable persons within the reception, given that these persons account for a significant proportion of the residents within the reception network.

The Study into vulnerable persons with specific reception needs has therefore set itself the initial objective of establishing a detailed picture of a) the way in which the reception network applies the protective provisions with regard to the identification of vulnerable persons and b) the extent to which the particular needs or requirements of these residents are taken into account in a general sense. The latter refers to the extent to which account is taken of all the needs of residents without being limited to the material reception and medical needs, throughout their presence in the network. Secondly, we will strive in a qualitative manner to assess the real impact of the identification mechanisms used, and the actions carried out with regard to taking identified needs into account. On the basis of this and if necessary, we intend to formulate recommendations for improving the reception conditions of vulnerable persons with specific reception needs.

The first phase of the study was conducted within the specific asylum and reception context of 2015. According to figures from EASO, more than 1,392,155 applications for international protection were submitted to the EU+ (Member States of the European Union plus Switzerland and Norway) in 2015[2]. As such, from the summer of 2015 onwards, Belgium was confronted with a sharp increase in arrivals of persons requesting international protection. The number of asylum applications in 2015 was twice the amount of the previous year. Around 80% of all newcomers were from Iraq, Syria or Afghanistan. The number of persons for whom Fedasil needed to arrange a reception place therefore increased significantly. The number of reception places doubled in the space of less than six months: at the end of 2015, Belgium had 33,400 reception places, compared with 16,000 structural reception places at the start of July. Some of these were often emergency reception places which were set up for a limited time. To compensate for the shortage of reception places, the federal government decided to entrust part of the reception organisation to private operators. At the same time there was huge pressure on the reception system, and the reception facilities were confronted by a growing workload and work pressure.

This context undoubtedly influenced the results of the initial phase of the study. Due to this situation, some of the activities of the study were postponed, and some of the reception operators were forced to cancel their participation in the study so they could confront the situation. A number of reception facilities could no longer participate in the scheduled observation sessions due to a lack of time or because the activities which were supposed to be observed were temporarily not taking place, and not

[2] https://www.easo.europa.eu/sites/default/files/public/EN_%20Annual%20Report%202015_1.pdf

all of the staff on the ground took part in the survey. However, the material which was collected during the fieldwork in 2015-2016 did provide interesting findings with regard to vulnerabilities and specific needs within the reception network. These findings are summarised in this report, based on the reports of the various component activities from the initial phase of the study. These latter reports are included as annexes[3].

The annexes and the results described in this report only relate to the period in which the data for the first phase of the study were collected, namely the start of 2015 until July 2016. What has since changed with regard to the subject matter of this study[4] has not been incorporated into these documents from the first phase. To the extent possible, these changes and their potential impact on the issues under study will be included in the second phase of the study. Additionally, we would also like to point out that the original aim of the first phase of the study was to highlight the situation across the entire reception network (= Fedasil and the reception partners) and consequently all the reception partners were involved in the data collection in the field (observations, exploratory discussions and the survey). However, not all reception partners were willing to take part in these activities and some of them ultimately withdrew from the study. The results of this initial phase of the study are therefore not applicable to the entire reception network.

Following an overview of the methodology used during the study, the general framework of the study will be set out, and the key findings will be presented. These findings relate to the concept of vulnerability, the reception needs of vulnerable persons, and the identification and care of vulnerable persons with specific reception needs.

[3] For now these annexes are only available in French and Dutch.
[4] Among the various changes, the most important are the introduction of the new registration form at the IO, and the publication of the Proposal for a directive of the European Parliament and the Council laying down standards for the reception of applicants for international protection (recast) (COM(2016) 0465).

II. Methodology

As mentioned in the introduction, the aim of this study is to establish a detailed picture of the practices in the field relating to the identification of vulnerabilities and specific 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 makes specific use of **information collection in the field**, namely from among the staff in the reception facilities of the reception network, external organisations which - whether mandated by the Agency or not - are specialised in the housing and guidance of vulnerable persons, and to the extent possible also from among the residents of the reception network itself.

The study will be carried out in two phases which comprise different activities, and of which four have so far been carried out: **a literature study, a legal analysis, observations and exploratory discussions, and a survey**. These four activities from the first phase form the basis for the present summary report, and are discussed in more detail below.

For the second phase of the study, two activities are planned, namely interviews and an analysis of European practices. The aim of the **interviews** is to allow three different actors to express their thoughts. We will firstly focus on what staff from the reception facilities (social workers and health workers) have to say. Given that these interviews will only take place after the survey, they will complete and enhance the information already provided by the social workers and health workers, and deepen our understanding of the data. Secondly, we will also let the residents of the reception facilities themselves have their say, and we will try to assess how they value the attention given to their specific needs within the reception. Finally, we would also like to highlight the experiences and practices of external organisations which, whether or not mandated by the Agency, are specialised in the housing and guidance of vulnerable persons. Thanks to their considerable experience in supporting one or more vulnerable profiles, the surveyed professionals can either supplement, refute or confirm the collected testimony of the staff from the reception facilities. However, the study is not limited to Belgian practices. One component of the study will in fact consist of **an analysis of the practices of various European countries**. This analysis will be carried out by submitting a request to the Belgian contact person at the European Migration Network (EMN). Using an "ad-hoc query", the EU Member States and Norway will be surveyed on the way in which they identify, within the context of reception, vulnerable persons who request international protection, as well as how the particular reception needs of vulnerable residents are taken into account. The European *good practices* collected in this way will form an important basis for formulating recommendations for the Belgian context.

These two activities of the second phase will be developed more in detail and implemented after the conclusion of the first phase, namely the presentation of the present summary report to the Steering Group and its subsequent discussion with the group. This summary report therefore describes the findings which have resulted from the various activities of the first phase of the Study into vulnerable persons with specific reception needs, which firstly provide input for the second phase and secondly, reinforced by the results of the second phase, will result in the final report of the study. In this final report, specific recommendations will be made, based on the results of the first and second phases. These recommendations will help to improve the practices of identifying and supporting vulnerable persons with specific reception needs. Ideally, the final report and recommendations will be part of a larger project, for which the Study into vulnerable persons with specific reception needs will merely be the first step. The importance of such a study is clearly not just to propose theoretical recommendations, but also to present the necessary instruments so as to incorporate them in practice.

II.1. Literature study

The literature study forms the starting point of the study. The aim of this activity is to obtain the necessary thematic knowledge which will enhance the quality and legitimacy of our study. The insights provided by the literature study will also make it possible to put the collected empirical data into perspective. A separate literature study is conducted for each "category" of vulnerable persons. The categories which we use here are the 10 categories defined by 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, namely: *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*. Both national and European sources are consulted with regard to vulnerability in the context of asylum and migration. These may be scientific sources, reports from organisations whose work encompasses the issues being studied, and other relevant sources. The most important findings of this literature study are incorporated, per category of vulnerable persons, into a comprehensive literature file[5]. We hereby limit ourselves to three core aspects, namely definition, vulnerabilities and needs. These files will enable us to provide access to relevant information in a comprehensible manner in

[5] The literature study is being conducted throughout the various phases of the main study, and may be supplemented based on the findings from the various phases. This means that the literature study is not yet definitive.

terms of definition, vulnerabilities and needs per category of vulnerable person. The literature files can be made available to staff from the reception facilities during the final phase of the study.

II.2. Legal analysis

Any person who leaves his/her country of origin out of fear that his/her life or personal safety is in danger, can already be seen as a person in a vulnerable situation. Whether a person is legally identified as a vulnerable person will, however, depend on specific personal characteristics or traumatic experiences. The legal analysis clarifies the legislative framework with regards to these persons, as established at the international, European and national level.

II.3. Observations and exploratory discussions

As previously mentioned, the methodology used for this study primarily incorporates information collected in the field. A better insight into vulnerabilities and the extent to which the reception network tries to provide relevant solutions, can only be achieved by being present in the field and collecting the opinions and experiences of those actors who are in direct contact with the target group. The fieldwork includes various components such as observations and exploratory discussions. The observations consist of "observing the reality", "witnessing the social behaviours of individuals or groups in the place of their activities, or their place of domicile, without changing the normal progression […]"[6], in other words, being physically present on the ground. The observations and exploratory discussions enable us, thanks to an initial contact on the ground, to collect information which will enhance the preparations for the subsequent activities.

Given that it was impossible, for practical reasons, to organise observation sessions throughout all facilities of the reception network, the observation locations were selected on a pragmatic basis instead. Account should therefore be taken of the fact that the selected observation locations are not representative for the practices of the entire reception network. The observations also need to be interpreted in the previously described reception context of 2015. Due to this context, a number of standard work processes and reception practices were suspended or only carried out to a limited extent. This meant that a number of reception facilities could no longer participate in the proposed observation sessions due to a lack of time or because the activity which was supposed to be observed was temporarily not taking place. Another consequence was that several reception operators had to

[6] A.-M. ARBORIO AND P. FOURNIER, Le questionnaire, Paris, Armand Colin, "l'enquête et ses méthodes", 3rd edition, 2010.

cancel their participation in the study in order to confront the situation. Although the consequence of this was that the observation section of the study was less extensive than planned, the context of 2015 offers a unique glimpse into the adaptation of reception practices when they are put under extreme pressure. In the end, the observations took place in 6 federal centres (Charleroi, Kapellen, Klein Kasteeltje, Morlanwelz, Rixensart and Sint-Truiden), 1 centre from Caritas International (Louvranges) and 1 centre from a private operator (Mouscron). During this initial phase of the fieldwork, the observations were supplemented by exploratory discussions with relevant actors in the field, with the aim of understanding the way in which the identification and assessment of the specific needs of vulnerable persons is handled. Discussions took place in July 2015 with the Dispatching of Fedasil, the Vulnerability Unit of the IO, Ciré, Caritas and VwV. This study does not focus on vulnerabilities and needs in the asylum process. The information collected from among asylum agencies was only used, in the context of this study, to assess whether measures to identify vulnerabilities in the asylum process have an impact on vulnerability in the reception, and which measures these were. We will not make any further recommendations in this study regarding the asylum process itself.

A report was drawn up for every observation session and every exploratory discussion. These reports form the basis of the analysis whose results are presented in the Annex Observations and Exploratory Discussions. This annex provides an overview of the practices collected during the observations and exploratory discussions. It is an illustration of the various perspectives that are used and a description of the process of the identification of and care for vulnerabilities of persons who request international protection. We would like to emphasise again that the results of the observations and the exploratory discussions should be interpreted within the asylum and reception context of 2015.

II.4. Survey

Besides obtaining a more qualitative insight into the practices in the field, the study also aims to collect more quantitative data. This was done via a survey. The compiled survey was addressed to social workers and health workers (doctors, nurses and psychologists) who are active within the Fedasil reception facilities and Fedasil's reception partners. Thanks to their regular contact with residents, they are a source of useful information for the questions which are posed as part of the study.

The questionnaire consisted of 10 questions, including some which contained open or closed sub-questions. The questionnaire was divided into four main sections: A. Description of the vulnerability; B. Vulnerable persons with specific reception needs; C. Identification of vulnerabilities and D. The care for vulnerabilities. The questionnaire was submitted to all of the population being studied, in other

words all social workers and health workers active in the reception facilities of Fedasil and the partners, without sampling. Participation was strongly encouraged (but not mandatory). The information received was treated anonymously. However, this study is not intended to evaluate the actors in the field, or to make judgements on the opinions expressed. The sole aim of the study is to establish an overview of the situation of the (negative and positive) experiences in the field, relating to the identification and care of residents with specific reception needs. In order to make comparisons, data about the respondents was collected, in terms of "municipality where your reception structure is situated", "province where your reception structure is situated", "reception operator", and "what is the total amount of residents for whom you are currently responsible". Ultimately, a total of 218 respondents took part in the survey, of which the majority were social workers active in an LRI. This equates to an overall participation rate of around 15%. Just as for the observations and exploratory discussions, the reception context of 2015 should be taken into account. As indicated in the introduction, the results of this data collection activity only pertain to one part of the whole reception network.

An extensive report of the survey can be consulted in Annex Survey.

III. General framework

Persons who request international protection are generally vulnerable persons, given that people who leave their home and familiar environment are confronted with a number of difficult challenges. Vulnerability can arise from circumstances in a person's homeland, during the migration, on arrival in the host country, and in the person's experiences with the asylum system. However, the UNHCR states that from among these persons, there are a number who are confronted with additional difficulties and who therefore require additional support, including unaccompanied children or children who have become separated from their parents, persons with medical or psychological needs, families with young children, single parents, victims of human trafficking and survivors of torture, sexual or gender-based violence[7]. These categories correspond to the vulnerable groups included in the Reception Directive of 2013 laying down standards for the reception of applicants for international protection[8] which states that: "Member States shall take into account, in the national law implementing this directive, 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"[9].

With regard to the definition of vulnerability, reference is indeed often made to "categories" of vulnerable people. This categorical approach in defining vulnerability is also used in Belgian legislation. As surmised from the legal analysis (see annexes), Article 36 of the reception law of 2007 provides[10] a few examples, although no fixed definition of the term "vulnerable groups". Consequently, the following groups are considered as vulnerable: minors, unaccompanied minors, single parents accompanied by minors, pregnant women, disabled people, victims of human trafficking, victims of violence or torture, and elderly people. With the transcription of the recast Reception Directive into national law, the following additional groups will be explicitly included in Article 36 of the reception

[7] http://www.unhcr-centraleurope.org/pdf/what-we-do/caring-for-vulnerable-groups/response/response-to-vulnerability-in-asylum-project-report.html

[8] 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, http://eur-lex.europa.eu/legal-content/EN/TXT/HTML/?uri=CELEX:32013L0033&from=en

[9] On 13.07.2016, the European Parliament and the Council published a proposal to recast 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 (http://ec.europa.eu/dgs/home-affairs/what-we-do/policies/european-agenda-migration/proposal-implementation-package/docs/20160713/proposal_on_standards_for_the_reception_of_applicants_for_international_protection_en.pdf). This took place within the context of the reform of the current structure of the *Common European Asylum System*. One of the proposals of the European Commission in this regard is to revise the Reception Directive from 2013 with the aim of further harmonising the reception conditions in the EU. An important revision of the proposal is to no longer use the term "vulnerability", and the abolition of references to the categories of vulnerable persons as described in the Reception Directive of 2013 (Articles 21 & 22). The proposal instead uses the term "persons with special reception needs", "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". The potential impact of this proposal was not included in the first phase of the study. This will be included in the second phase of the study.

[10] http://www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=nl&la=N&cn=2007011252&table_name=wet

law: persons with serious illnesses, persons with mental disorders and victims of female genital mutilation. The identification of vulnerabilities carried out during the registration of asylum applications by the IO is also based on categories (see annexes): (unaccompanied) minors, elderly people (+65 years), pregnant women, persons with medical problems, persons with psychological problems, single women, persons with children, victims of human trafficking, victims of violence (physical, psychological, sexual) and LGBT.

However, it should be borne in mind that such a categorical approach of vulnerability is more illustrative than definitive. This means that persons who apply for international protection, but who do not fall within an established category of vulnerability, may well have specific reception needs. And conversely, someone who falls within a specific category may not necessarily have specific reception needs. Some people will also require specific support within the reception, without needing procedural guarantees, and vice-versa. For example, a wheelchair user may require adapted accommodation, but may not necessarily require specific support in relation to their asylum process[11]. Some categories of persons, such as children, are self-evidently considered as vulnerable persons with specific needs, while for other persons, vulnerability is determined instead by their individual circumstances and contexts. As such, vulnerability is best approached as a complex phenomenon, formulated by a multiplicity of personal (internal) factors and (external) environmental factors. These factors may include: family composition, physical health, psychological health, migration route and networks. These factors are not definite, and can change over time. This means that the list of vulnerable persons referred to in the Reception Directive of 2013 and Article 36 of the reception law, as well as the categories used during the registration of an asylum application, are not exhaustive. In addition to the described categories of vulnerable persons, other persons applying for international protection may also be considered as vulnerable, including illiterate or differently-literate persons, single men, persons with a high or low level of education, or persons whose physical safety is in danger, e.g. due to their sexual orientation and gender identity[12]. Moreover, a person may fall within several categories of vulnerable persons. Finally, some vulnerabilities are more difficult to identify than others. The focus is generally on visible vulnerabilities such as physical limitations, pregnancy, or minority. On the other hand, mental health problems, victims of human trafficking, torture or rape, for example, require a more thorough identification.

Taking into account this complexity of vulnerabilities, the categories of vulnerable asylum seekers from 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, are

[11] http://www.unhcr-centraleurope.org/pdf/what-we-do/caring-for-vulnerable-groups/response/response-to-vulnerability-in-asylum-project-report.html
[12] http://www.evasp.eu/RapportoTransnazionaleOnline.pdf

only taken as a starting point for the purposes of this study. Specifically, this means that we will leave room throughout the various phases of this study for other vulnerabilities to be identified, than the categories of vulnerabilities summarised in these provisions.

IV. Summary of the key findings

The following section presents the key findings of the initial phase of the study. This takes the form of a summary of the findings of the various components of this initial phase. For the first phase of this study, 8 important findings are retained which relate to **the concept of vulnerability**, **the reception needs of vulnerable persons**, **and the identification and care of vulnerable persons with specific reception needs**.[13]

For every activity of the initial phase, a more extensive version of the findings can be consulted in the respective annexes.

IV.1. The concept of vulnerability

1. A broader interpretation of vulnerability, linked to the reality in the field.

With regards to the concept of vulnerability, this initial phase of the study has shown that the way in which staff in the field interpret the term vulnerability depends on their own experience in the field. This means firstly that not every member of staff in the field interprets vulnerability in the same way, and secondly that for the staff in the field, the interpretation of the concept of vulnerability or of which persons are vulnerable, **is broader than the categories of vulnerable persons as defined by the European and Belgian legal frameworks, or as identified during registrations of asylum applications at the IO**.

Although staff in the field also referred to the same categories of vulnerable persons as defined by the legal frameworks and the IO, they went further by also referring to aspects which make a person vulnerable, or **vulnerability factors**. The staff in the field were referring in particular to persons with psychological/psychiatric problems, elderly persons, pregnant women, single mothers with small children, disabled persons, persons with medical/health problems, victims of violence and unaccompanied foreign minors as categories of vulnerable persons. Additionally, they also identified what they saw as other vulnerable persons, by referring to factors which could make persons vulnerable and which, in their opinion, should be taken into account when determining the reception needs of these persons. In other words, an interpretation of vulnerability which is closer to their own reality in the field.

[13] French and Dutch quotes included in the report were freely translated into English.

In the study, we identified the following factors which, according to the staff in the field, could make a person in reception vulnerable: **not being proficient in a contact language, being part of a large family, being part of a "closed community", having cultural and religious practices which differ significantly from those of the host country, being isolated, having limited autonomy, having a low level of education, being illiterate, having a problematic family situation, having a different sexual orientation or gender identity, having an addiction to alcohol or drugs, and being a young adult**.

When a person arrives in a new country with a **different culture and religion** than that of their country of origin, the differences in terms of traditions, values and customs may lead to a "*culture shock*" for this person. Confusion and stress caused by change can make a person particularly vulnerable. Related to this vulnerability factor, some staff in the field believed that **women from "*closed communities*"** are vulnerable. Persons who cannot express themselves in a contact language (Dutch, French or English) were also identified by a number of staff in the field as being vulnerable. These persons could be vulnerable because they cannot communicate with those in their environment, and have more limited independence, which may be an obstacle to their integration. Various staff in the field also observed that **a low level of education and illiteracy** are also vulnerability factors.

> *Persons from countries or regions where life is significantly different to life in Belgium, (persons who often come from rural areas without shops, public transport or electric appliances, and who sometimes speak languages for which there are few interpreters, etc.) are also vulnerable in my opinion (LRI, R42)*

> *Women from closed communities find themselves among a diverse group, including emancipated women. They are then in a dilemma with regards to their husband/community and the new environment. (Collective reception centre, R29)*

> *Someone who does not speak or understand any of the national languages or English is extremely vulnerable, since they cannot communicate with those in their environment. It is also laborious to have something explained, and this requires more time and guidance. Everything must be shown visually and the person must be led step by step by someone who can personally accompany him or her. Their independence is consequently limited. (LRI, R106)*

When these factors are combined with inadequate knowledge of a contact language, the degree of vulnerability can increase significantly. Although **persons with a different sexual orientation or gender identity** fled their country precisely because of being victims of discrimination and violence, they are also confronted with the same discrimination and violence in the host country, according to staff in the field. Their sexual orientation or gender identity may be a vulnerability factor if they are housed in a reception centre which is not adapted to their needs, due to other residents and the sharing of communal areas. This vulnerability factor was also primarily identified by staff from collective reception facilities.

Being a young adult was also identified as a vulnerability factor by various members of staff. Although legally adults, young adults (18 to 25), and in particular those who arrived alone and were minors during their asylum procedure, were considered by staff in the field to be vulnerable, just like unaccompanied foreign minors. Being of adult age is generally associated with independence and responsibility, for which some of these young people are not ready. In this respect, members of staff also referred to **young people who were housed in a LRI** as vulnerable and **their degree of autonomy** as a possible vulnerability factor. The **lack of a social network** is therefore also an important factor in terms of vulnerability, according to staff in the field. For some members of staff, **single men** are therefore also vulnerable, primarily in terms of integration.

> *Young people who have just turned 18. Officially, they are no longer unaccompanied minors, but it is also very difficult for these people too; just because they have reached the official age of adulthood does not necessarily mean that they are adults. Often, they are still developing their identity, but this identity has also been disrupted by their flight from their country. (LRI, R24)*

> *Every asylum seeker is, in his own way, vulnerable. For example, single men are socially integrated less quickly, and often appear to be "more lonely". They remain within circles of asylum seekers from their own country, region or part of the world more often, because they would otherwise be alone. This is an obstacle to proper integration, but at the same time provides support to the asylum seeker. In the case of families, you can see that school, children, neighbours, etc., lead to faster contact whereby integration is achieved more quickly. This is clearly the major weakness of single persons/strength of families. Inadequate knowledge of Dutch is usually experienced as the most significant vulnerability of both single persons and families. As a result, they miss out on a lot of important information (for example, regarding studies for their children or job orientation), and they fall behind more quickly in society. It hinders them moreover in their day-to-day contact, and creates a vicious circle. (LRI, R18)*

However, the vulnerability of a person is not only determined by person-related characteristics, it may also arise from external factors related to the asylum procedure or the reception. With regards to the way in which the reception is organised, various aspects may influence a person's vulnerability. Among other things, staff in the field highlighted the location of a reception structure, the size of the reception facility and the amenities in the reception facility. Indeed, some reception facilities are situated in isolated, small villages which are far from cities, and therefore far from certain amenities and services such as public transport or assistance services. This can have a negative impact on, for example, the possibilities of residents to build up a social network, which as mentioned previously is a vulnerability factor. Also, large, collective reception facilities with few possibilities for privacy, a lack of individual space and where there is a lot of noise, can also increase the vulnerability of certain residents, for example persons with mental disorders. Members of staff also pointed out that some reception facilities may exacerbate the vulnerability of certain residents, due to facilities not being adapted to their needs. In this respect, reference was often made to persons with more limited mobility, such as elderly persons or persons with a physical disability, but also pregnant women and women who have just given birth. For example, some reception structures lack

adapted sanitary facilities for these residents, or in the case of women who have just given birth, adapted nutrition for the baby.

This first finding shows that who is or is not vulnerable is not a fixed construct which can always be determined in advance. A person may not be identified as vulnerable during the registration of their asylum application because they do not fall within one of the defined groups, but may subsequently be identified as vulnerable during their stay in the reception. A categorical approach of vulnerability therefore runs the risk that non-categorised situations, which also require adapted reception measures, are overlooked. Pigeonholing persons into categories which are too rigid should be avoided. Moreover, categorising persons may also "stigmatise" them. Furthermore, a person is often not vulnerable because they fall within a given category (for example pregnant women), rather, a multiplicity of different factors tends to make a person vulnerable (for example, single pregnant women). It should also be borne in mind that vulnerable persons also have strengths and skills which must be identified and reinforced. Precaution is therefore advised in categorising persons according to given vulnerabilities. The use of categories should be used instead as a means of remaining alert for certain vulnerabilities, assessing certain situations, and providing sufficient attention to appropriate support in the reception.

We don't look at "groups". We look at every person individually and try to help everyone as best we can according to their needs. (LRI, R99)

IV.2. Reception needs of vulnerable persons

As already established, the vulnerability of a person is not only determined by person-related characteristics, but can also arise from external factors. This **multidimensionality** has also been observed with regards to the reception needs of vulnerable persons. In particular, we identified specific needs in terms of guidance or follow-up for persons, and specific needs in terms of the reception facility itself.

2. Reception needs on various levels

In terms of guidance or follow-up a general need was identified during the study for **multi-disciplinary, intensive and individual guidance for vulnerable persons, based on trust**. Such personalised guidance is necessary, given that the needs of vulnerable persons are so varied. Moreover, this approach means that the persons in question open up, and confide their needs. A multi-disciplinary follow-up also entails cooperation with, or if necessary referral to, external specialised services. Who is actually part of the multi-disciplinary team depends on the vulnerability of the person. The multi-disciplinary team needs to be responsible for a regular evaluation of the needs of vulnerable persons.

> *They need to provide people with a tailored reception which provides a solution to their needs, for example for specific medical assistance, psychological guidance, etc. No general framework can be provided in this respect, but it needs to be looked at and adjusted on an individual basis. (LRI, R168)*

Moreover, such guidance requires **the availability of interpreters, time, and sufficient numbers of trained staff**. Interpreters are needed to be able to communicate with the persons in question regarding their needs. Time is required to be able to conduct more personalised discussions with vulnerable persons, and listen to them. And there needs to be sufficient numbers of staff present who also need to have an understanding of vulnerabilities. In short, time and staff are necessary to provide a qualitative reception to vulnerable persons.

In terms of the reception facility, we observed that there is a need for **a safe, calm and structured environment, for privacy and space, and for small reception facilities in close proximity to external assistance services**. This refers to both general assistance services (hospitals, pharmacy) and more specialist assistance (psychiatrists, psychologists). This external assistance must be reachable in terms of distance, but also have a low threshold.

> *Vulnerable persons are persons who, due to their baggage, experiences, trauma and loss, etc., find it difficult to take control of their own lives. [...] It is necessary to provide sufficient areas for them to have privacy, where they can retreat and feel safe and secure. (LRI, R93)*

As can be ascertained from the literature study, it is possible, **depending on the vulnerability** of a person, **to also identify specific** needs. In addition to the general reception needs described above, other specific needs were observed, depending on the vulnerability of the person in question, both in terms of guidance and the reception facility itself.

> *The reception needs of persons with physical limitations are not comparable to the reception needs of someone with a psychological problem, which are not comparable to the reception needs of a single mother who is infected with the HIV virus. In general, the specific reception needs of vulnerable groups are therefore all of the additional measures necessary for ensuring that a vulnerable person can receive a higher, and at least acceptable, quality of life. (LRI, R160)*

Given that **children** are often reluctant to request support themselves for specific needs, arrangements are often made on their behalf, and the support offered primarily focuses on their parents. However, vulnerable minors require direct support, separate from the support provided to their parents. Specifically, in cases where the parents display vulnerabilities themselves. The heterogeneity of **unaccompanied foreign minors** requires an individual approach in terms of guidance needs. For **victims of human trafficking**, a culture and gender sensitive approach is appropriate. Focus points for the guidance of vulnerable **persons with mental disorders** include specific psychological support and psycho-education. **Persons who have been tortured, raped or exposed to other serious forms of psychological, physical or sexual violence,** require, in terms of guidance, access to specific medical and psychological care, among other things, as well as a culture and gender sensitive approach. Victims of female genital mutilation (FGM) in particular require a safe and confidential environment which makes it possible to broach the subject of FGM, namely, showing understanding for the person, the culture and the situation in a safe environment, and investing time and effort in building up a relation of trust with the person involved. **Pregnant women** would require, in the opinion of staff in the field, maternity care in their own language or a language in which they are proficient. **Large families with children** would require, among other things, support in the education of the children. For **single mothers with children**, various staff in the field referred primarily to the need for childcare in the area, so that mothers can follow language classes, for example. **Persons who cannot express themselves in a contact language** are vulnerable because they cannot communicate with people in their environment, and are more limited in their autonomy. These persons consequently require more visual communication.

With regards to needs at the reception structure level, vulnerable **unaccompanied foreign minors** have a specific need for a safe, stable and caring environment, in which it is possible to build social contacts and a supporting network. To ensure this, it is recommended to provide continuity of care and limit the number of transfers. **Victims of human trafficking** require a safe and confidential

environment to prevent human traffickers being able to contact the victim again. The specific needs of **elderly persons** relate, in the opinion of staff in the field, to reception facilities which are adapted to their limited mobility. **Persons with a physical limitation** primarily require, according to the various respondents, an adapted living environment (for example, adapted toilets, no bunk beds), accessible facilities (for example, no long distances to the restaurant of the reception centre) and specific equipment (for example, wheelchairs, crutches or hearing devices). For persons who **have been exposed to a serious form of psychological, physical or sexual violence**, access to healthcare is an important need. For example, FGM has multiple long and short term negative consequences for health. In the event of medical complaints, women and girls do not necessarily make the connection with the circumcision. Complaints are seen as part of 'womanhood', and not as a consequence of the circumcision. That is why it is essential to refer women to specialised doctors who are familiar with FGM.

These observations show that not only vulnerability, but also reception needs, are best approached as a complex construct with various dimensions. The dimensions which were observed during the study relate to guidance and reception. Moreover, more general reception needs can be distinguished from needs which are specific depending on the vulnerability of a person. As touched upon in the general context, it should be borne in mind that not everyone who is vulnerable has specific reception needs and conversely, someone who has not been identified as vulnerable may well have specific needs. This multi-dimensional character of vulnerability and reception needs has implications for the identification and care of vulnerable persons. These two aspects will be discussed below.

IV.3. Identification of vulnerable persons with specific reception needs

On the basis of the survey, it can be surmised that the vulnerable persons most often encountered by the members of staff who took part in the questionnaire are single parents with minor children and accompanied children. This corresponds to the profile of vulnerable persons which the Vulnerability Unit of the IO indicated having encountered at the time of the exploratory discussion in June 2015. Other important profiles most often encountered by the staff in the field who took part in the questionnaire are pregnant women, persons with mental disorders and persons who had been victims of serious forms of psychological, physical or sexual violence. To a lesser degree, a significant portion of respondents indicated that they had never worked with disabled persons, victims of human trafficking, elderly persons and persons with serious illnesses. This more or less corresponds to the information collected by the IO, who indicated at the time of the exploratory discussion that they had identified few persons with medical complaints and elderly persons.

It should also be borne in mind that this profile of vulnerable persons in the reception network is only a snapshot, namely of the period in which the questionnaire was administered. However, it is important to bear this profile in mind for the findings which follow.

3. A process supported by various services, staff and instruments

The IO and the Dispatching of Fedasil are important initial actors in the identification of vulnerabilities among persons who apply for international protection. The identification of vulnerable persons with specific reception needs already starts during the registration of this application by the IO. A registration form is completed with basic information regarding the asylum seeker; including identity, family in Belgium and information regarding health problems or complaints. According to the IO, regarding the question about health problems, people often indicate themselves whether they have psychological problems or they have medical certificates. An interpreter is also present during the registration, if necessary. The Vulnerability Unit of the IO is responsible for the interviews of persons who were identified as vulnerable on the basis of the registration form. Staff at the unit are trained in specific interview techniques, such as conducting interviews with minors and vulnerable persons (EASO training modules). If an interviewer who is not part of the Vulnerability Unit observes during an interview that the person in question is in fact vulnerable (for example, in an impaired mental state), he or she will contact the Vulnerability Unit, or an internal memo will be drawn up in which the vulnerability is indicated. This internal memo is subsequently handed over to the CGRS, along with the person's file. This internal memo will also be appended to the person's electronic file. For matters which concern Fedasil, Fedasil will also be informed by the IO. At the time of the exploratory discussion with the IO, no "vulnerability checklist"

was used, only the information available on the registration form[14]. This information is added to the administrative file of the person in question (in other words, it is also handed over to the CGRS). Fedasil will also receive a copy. The aim is that if the IO can already identify specific vulnerabilities during registration, the Dispatching of Fedasil will take them into account when allocating a reception place. The Dispatching itself will also carry out an identification of the primary medical vulnerabilities. Medical staff from Dispatching will organise an individual meeting if a medical problem is identified in a person. This identification can take place using the registration form of the IO, an objective observation by staff from Dispatching, a declaration from the person him or herself, or notification by an external organisation which will inform Dispatching that a person will register who has specific reception needs. The medical staff will assess whether an adapted reception place is necessary. If this is the case, a medical checklist will be filled out.

If specific vulnerabilities and reception needs were not detected by the IO and Dispatching, **the staff in the reception facilities are the next important actors in the identification process**. Almost all the staff in the field who took part in the survey did in fact consider that they play an important role in identifying vulnerable persons and their reception needs. The identification of vulnerable persons with specific reception needs constitutes an important step in providing appropriate care.

In the collective facilities, the identification of vulnerable persons and their specific reception needs is a process which is supported by various members of staff and instruments. The most important actors in this identification process are the social workers and the medical service. However, during the observations in the field, it was apparent that other persons play an important (informal) role in alerting vulnerabilities, including on-call staff, teachers and co-residents. In principle, staff at the (federal) reception centres have three instruments at their disposal which should help to identify vulnerabilities: the Individual Guidance Plans (IGP), the reports of the Multi-Disciplinary Team Meetings (MDM), the assessment reports and the daily briefings. For many centres, the IGP should be the perfect instrument to assess the functioning of a resident and identify any potential need. The IGP is intended to be a working tool throughout the various reception phases and structures, and to make it possible to monitor the overall progression of the resident during his or her entire process. Through effective follow-up and implementation of the IGP, the very persons who would otherwise not request help, are detected. In this way, it is possible to work proactively and provide continuous care. The MDM is the moment for exchange, where the focus is on the welfare and individual follow-up of every resident. With regard to the MDM, every centre organises one in a different way. The implementation of the MDM differs in terms of the staff present, the number of times that an MDM is organised and the

[14] Since August 2016, the IO has uses a new registration form which specifically enquires about vulnerabilities ((un)accompanied minors, older than 65, pregnant, medical problems, psychological problems, single women, persons with children, victims of human trafficking, victims of violence (physical, psychological, sexual), LGBT), so that these can already be detected at an early stage.

way in which the files of the residents are discussed. Besides IGPs and MDMs, we observed that the collective centres also organise other occasions which facilitate the identification of vulnerabilities. The assessment report is an extensive assessment of the resident during the arrival phase (from day 1 to day 30). The briefing refers to the daily, often practical, follow-up of the residents in the centre. A daily briefing can ensure, for example, that vulnerabilities and needs can be followed up immediately, and not postponed until an MDM.

The procedural character of identification was also emphasised during the exploratory discussions with staff from VwV and Ciré/Caritas who organise the individual reception of asylum seekers. Staff indicated that the identification of vulnerable persons requires the presence of various instruments**.** The most important processes and instruments in this regard are: the medical information in the transfer request, the intake, the occasional and periodic discussions with the resident, the on-site assessments (using home visits), the multi-disciplinary meetings and the peer reviews. Social workers have a pivotal role in identifying and detecting vulnerabilities. Carrying out a periodic assessment constitutes an important challenge as it risks becoming a mere formality. **That is why it is essential that social workers are aware of their usefulness and importance during this process.**

4. Various general and specific factors hampering identification

At the time of the exploratory discussion, the focus of both the IO and Dispatching **was above all on identifying vulnerabilities in terms of medical cases**. An individual meeting with a health worker took place on request (of the person in question, or the IO, an NGO, etc.), and a medical checklist was only completed for these persons. The Dispatching of Fedasil often based its own assessment on the IO's registration forms. However, these forms often turned out to be incomplete. On the one hand, this may have something to do with the way in which the information was registered with the IO, or on the other hand, with the information the person provided to the IO[15]. Another difficulty is the fact that some vulnerabilities, including more psychological vulnerabilities, only manifest themselves at a later stage, namely once a person has already been housed in a given reception facility.

Based on the results of the survey, we observed noticeable differences in the ability of staff in reception facilities to identify vulnerable persons and their specific reception needs. Although it appeared from the observations described previously that the staff are aware of vulnerabilities or various factors of vulnerabilities, and of the general and specific reception needs of vulnerable persons, and that they have various instruments at their disposal, it is apparently not straightforward to identify these needs, or at least not for all vulnerable persons. In general, the staff from the

[15] See previous footnote, that since August 2016, the IO uses a new form in which the various categories of vulnerabilities are surveyed. The impact of this change could consequently not yet be examined in this study.

reception facilities who took part in the survey indicated that they are primarily able to identify the specific needs of pregnant women, single parents with children, and accompanied children. On the other hand, they consider themselves less able to identify the specific needs of victims of serious forms of psychological, sexual or physical violence, victims of human trafficking and persons with mental disorders. However, with the exception of victims of human trafficking, this concerns vulnerable persons which a large number of respondents often or at least occasionally works with, according to the survey. Staff from the reception facilities appear to be confronted with various factors which hamper the identification of vulnerable persons with specific reception needs.

The most important factors cited by members of staff are: lack of time, the language and communication barrier and related lack of qualified interpreters (meaning that it is difficult for persons to express their needs and for supervisors to assess them), the need to broach subjects which could be sensitive, the difficulties of building up a bond of trust (among other things, due to a short stay in the reception facilities, language problems and lack of time), a lack of information handover during transfers, a lack of knowledge or experience of vulnerabilities, and a related lack of training with regard to vulnerabilities.

A lack of time was attributed, among other reasons, to overcrowding and a high workload in some structures, and lack of staff.

> *The persons who care for them must have the means and especially the time to devote to them. Unfortunately, there is a lack of time in the congested structures. (Federal reception centre, R26)*
>
> *[…] As a social worker, I have 85 residents for whom I am responsible. I have no time to keep an eye on a particular person for the whole day, and give them continual guidance. It is therefore primarily to do with the fact that we do not have enough staff. (Federal reception centre, R195)*

Staff in the field also consider **not being able to communicate with the residents** as an obstacle to identifying vulnerable persons with specific reception needs. The language barrier means that it is difficult to discuss certain matters. Employing professional interpreters would provide a solution in this respect. However, members of staff indicated that there is a **lack of interpreters, and in particular, interpreters who have any notion of the vulnerabilities of the target group**. Firstly, there is a shortage of such interpreters, and secondly, interpreters are not always immediately available (either by telephone or physically) if the situation requires it.

The language and communication difficulties can be a source of misinterpretation and misunderstanding, and can hamper **the building up of a bond of trust**. Building up this bond of trust between the social workers and residents is further hampered by the fact that residents have a short stay in a reception facility. In fact, the identification of vulnerable persons with specific reception needs is a continual process, which is based on trust and impossible to realise in a short space of time. In particular, if it concerns immediately discernible vulnerabilities such as mental health problems. Although they are organised on a regular basis, the conversations with social workers often only make it possible to detect indications of vulnerabilities, and not paint a full picture of the situation. Vulnerabilities are often a complex combination of various factors.

> *We see the persons regularly but briefly, and we don't live with them so we are not always aware of the scope of the problem (in the case of mental problems, for example). Furthermore, we do not always receive the information from the previous centre in the event of a transfer. (LRI, R76)*

With regard to **making it possible to discuss certain subjects which could be sensitive**, reference was primarily made to human trafficking, violence, sexuality, pregnancy and mental problems. For example, discussing human trafficking would be difficult both for the person in question and for the social workers in reception centres. Staff in the field pointed out that they have limited experience with this subject to be able to broach it with residents. Victims of human trafficking would also find it difficult to talk about their situation. To this end, a good relation of trust is necessary with the social worker, which requires a lot of time. Persons who are exposed to psychological, physical or sexual violence would also find it difficult, due to fear or shame, to talk about what they have experienced. Additionally, the subject could be taboo in certain cultures. Pregnancy and sexuality also remain difficult subjects to broach. For example, according to respondents, some pregnant residents are not familiar with pregnancy follow-up by a gynaecologist, because pregnancy and childbirth is handled differently in their country of origin. In some countries of origin, sexuality is also a taboo subject, meaning that women do not want to talk about this issue. This is also the case for mental disorders, where a kind of taboo prevails in some cultures. Due to a lack of knowledge about certain cultural habits, staff from the reception centres do not always know how to react to such cultural sensitivities. Furthermore, these subjects are also too difficult to discuss via interpreters.

It is often not known whether a person has been a victim of human trafficking. Residents talk very little about their past. (LRI, R78)

Often difficult to identify, shame and fear often go hand in hand meaning that very little is said on the matter. Social workers are usually not really trained in supporting these people. How can you make it possible to discuss these subjects and refer people, or even provide help yourself? (Federal reception centre, R61)

(Extra) difficult for boys to talk about sexual violence. In many cultures, this remains a taboo, which makes it difficult to help them. (Federal reception centre, R194)

Talking about it. Being accepted, saying what happened despite their culture and the shame which the person can feel. Fear of not being taken seriously, fear of divorce, fear of being rejected by family, even if they are not in Belgium. (LRI, R129)

Language/communication is the most difficult issue in finding out why the person in question has difficulties. Often, the matter is so serious that it is difficult to put into words. (LRI, R40)

Accepting and discussing the psychological problem, language problem: discussing problems in another language is difficult for all parties concerned; recognising the underlying factors, finding a therapist who is proficient in the foreign language, correctly assessing the risks (for example with suicidal tendencies). (LRI, R105)

The information handover during transfers constitutes an important factor for members of staff from individual reception initiatives in particular, as it can hinder the identification of vulnerable persons with specific reception needs. Various members of staff who are active in an LRI complain that the information from the social and medical file (for example ongoing psychological guidance, medical data, information regarding difficult issues which have been discussed, etc.) is not always correctly handed over when a resident is transferred from a collective centre to an LRI. The result is that the individual reception facilities need to undertake an identification of vulnerabilities again, losing a lot of valuable time in the process.

Children are not individually guided and consequently seen less as individuals, meaning that problems are detected less quickly. The responsibility of the parents is assumed - something I experience positively. However, parents do not always want to go along with the proposed guidance. (VwV, R166)

In addition to these more general difficulties which hamper the identification of vulnerable persons and their reception needs, specific difficulties can also be encountered, depending on the vulnerability of the person. **Specifically for accompanied minors**, for example, staff from reception centres experience the difficulty that children cannot express their own needs, and that they often act as intermediaries for their parents. This often means that the needs of children are overlooked. **Specifically for the identification of the needs of unaccompanied foreign minors**, members of staff experience difficulties in the cooperation with guardians, and in uncovering the facts as to why these minors fled. Some staff in the field find that the cooperation with guardians does not always run smoothly, meaning that the follow-up of the needs of unaccompanied foreign minors is difficult. **Specifically for disabled**

persons, staff experience difficulties in the identification of their needs due to the complicated diagnosis or recognition of the disability itself. **Specifically for elderly persons**, staff from the reception centres experience difficulties in the identification of needs due to a difficult medical follow-up which is more intensive than for other residents, the age difference between the supervisors and the elderly persons, and the limited attention for these persons. Staff from the reception centres indicate that, due to the age difference, it is sometimes difficult to put themselves in the living environment of elderly persons.

> *Elderly people in the centre are often invisible, meaning that we are often unaware if there are problems. (Federal reception centre, R51)*

Finally, it was observed that **the identification of reception needs in particular constitutes a challenge if there is a situation of multiple vulnerabilities**, for example a single woman with a child and with a serious medical problem.

5. Impact of the reception context on identification

In addition to the general and specific factors described above, which may hinder the identification of vulnerable persons and their needs within the reception facilities, we also observed that the reception context can have an impact on this identification. This was primarily observed at the level of the previously mentioned instruments intended to support identification in the reception facilities. The increased influx in 2015 put pressure on the use of some of these instruments, which resulted in an array of different practices across the collective reception centres. With regards to the IGP for example, we observed that while one centre still planned a monthly update of the IGP, this was no longer the case at another centre due to a lack of time. This was also observed for the assessment reports. During the observations, there was little or no mention of the assessment reports. If there was mention of them, the reception centres indicated that it was no longer completed due to a lack of time. In some centres, the MDM was limited to a discussion of only the medical cases, due to a lack of time. In other centres, the MDMs were replaced with daily briefings due to a lack of time, or by more informal information exchanges during the day regarding residents.

The observations relating to the identification of vulnerable persons and their specific reception needs demonstrate that identification should be considered instead as a continual process in which the various services and staff play a role. This process already starts with the registration of persons with the IO. However, the process is hampered by numerous and various barriers. At the level of the IO and Dispatching, due to the focus on medical vulnerabilities, there is a risk that attention will be drawn away from other less visible vulnerabilities, meaning that there is an important identifying role for the reception facilities

in this respect. At the level of reception structures, the barriers relate to factors inherent to individual persons (difficulties in talking about certain subjects) or the staff from reception centres (for example a lack of knowledge and experience) and also to factors at the level of the reception facilities and the reception context. With regards to the factors at the level of reception facilities, the organisation of the reception network and the internal operation of reception facilities can have unintended negative consequences for identification. Although, for example, keeping the stay in the reception network as short as possible is often seen as a positive element, this limits the time that staff have to carry out an adequate identification of vulnerable persons with specific reception needs. It is the combination of these factors which has negative consequences for identification. Moreover, some of the factors can themselves be seen as factors of vulnerability, such as the language barrier and other cultural habits, which hamper the identification of other vulnerabilities and which staff of reception centres consider should be taken into account during the identification of vulnerable persons and their specific reception needs. A multi-dimensional approach of vulnerabilities and reception needs therefore also requires a multi-dimensional approach to identification.

IV.4. Care for vulnerable persons with specific reception needs

Once vulnerabilities and needs have been identified, appropriate support needs to be provided within the reception network. The care for vulnerable persons with specific reception needs can be organised within the reception facilities themselves, or by using external services.

Most of the staff from reception facilities who took part in the survey believe that not only do they have a role to play in identifying reception needs, but also in supporting vulnerable persons with specific reception needs.

> *The benefit of an LRI is that a family is able to properly function as a family, while their process is pending. The specific benefit with our LRIs is that we as social workers are immediately contactable in the event of problems. Our offices are also situated in the shared accommodation. This means that we can build up a certain bond of trust with asylum seekers, which benefits our operation and daily management. They begin to feel that they can function as a family here, and that they can get help if necessary. Our interpretation of 'bed, bath and bread' therefore goes much further and is especially focused on the human aspect. The central question is 'How would I want to be received if I ended up in their situation?' This interpretation requires additional dedication, but in our opinion it is the most workable way to prepare people to be a part of our society. For vulnerable persons such as asylum seekers (whether families or unaccompanied foreign minors), we are obliged to build up a bond of trust before any specific reception needs can be addressed. During any contact with asylum seekers, we always take account of their history (psychosocial problems). If you can show that people are able to trust you, they will open themselves up more, and their specific reception needs can be explored jointly, as well as the best possible alternatives to provide a solution. (LRI, R14)*

6. Good practices in the care of vulnerable persons

As mentioned previously, there are already a number of initiatives within the reception network - which may or may not be organised in collaboration with external organisations - which are aimed at providing specific support for vulnerable residents. During the fieldwork, a number of "good practices" were collected.

For example, post-natal planning and physiotherapy is provided for **pregnant women** in some reception facilities. For **single women**, various psycho-education training courses are provided, which deal with coping, and there is also the Mindspring project (psycho-education) for women. **Single parents with minor children** are accompanied during the enrolment of their children in schools. In some reception facilities, parenting support is offered to single parents with children, more focus on continuous care to enable a possible referral to a psychologist, or the Integrated Youth Assistance is assigned to provide support. For **minors**, the focus lies on information exchange and cooperation with schools. For **unaccompanied foreign minors**, a mentor is assigned from within the reception network (buddy projects), assertiveness training is provided for young people, collaboration takes place with youth assistance services for young unaccompanied foreign minors, and there is more focus

on cooperation with the guardian. For **persons with a disability**, it is examined whether support provided by another resident in the reception centre would be possible. If a **person with a serious illness** has family, it will be arranged that at least one family member can stay with the sick person. In some reception facilities, an on-call assistant psychologist is provided for **persons with psychological or psychiatric problems** (2 hours/week) to meet the person and carry out an initial screening. On the basis of this, an assessment of the problem can be made, and the person can be referred if necessary. And in some reception facilities, there is collaboration with organisations who work with **illiterate persons** or persons who have difficulty in understanding documents.

The survey also enquired into the organisations, services and professionals with whom the reception facilities regularly work, in order to care for vulnerable persons. We observe that for the various categories of vulnerable persons, reception facilities already work with a variety of external services, organisations and professionals. These are **actors in various disciplines**: **mental healthcare** (mental healthcare centres, psychologists, (child) psychiatrists, psychotherapists, relaxation therapists), **medical care** (GPs, pharmacy, dentists, paediatricians, physiotherapists, osteopaths), **leisure time** (sports associations, cultural associations, youth services, youth organisations, music academies, youth clubs, neighbourhood initiatives), **education** (schools, after-school reception, literacy groups), **integration** (Integration Agency), **housing** (social housing company), **parenting** (discussion groups for parents, childcare, foster care, parenting line), **justice** (lawyers), **police** (community officers), **general welfare** (centres for general welfare work, youth advice centres), **sexuality** (sexologists, gynaecologists, NGOs for victims of FGM, discussion groups for women, LGBT organisations, abortion clinics), **specialist care** (care homes, rehabilitation centres, guidance for victims of human trafficking, guidance for drug addicts, guidance for unassisted living). This is only a handful of the many good practices which already exist within the reception network. There are undoubtedly many more good practices with regards to the care of vulnerable persons, which were not collected during the initial phase of the study.

7. Bottlenecks in the care of vulnerable persons

Despite the work which has already been done within the reception network in supporting vulnerable persons, staff in the field revealed that (in the context of the period when the survey was completed), **not all aspects were in place to be able to meet the reception needs of all vulnerable persons in an effective manner**, both within the own reception facilities and in the cooperation with external services.

Staff in the field indicate that within the context of their own reception facility, they are able to offer the necessary support to pregnant women and single parents with children. However, a large number of staff consider themselves to be unable to support persons with mental disorders, persons who have been victims of physical, psychological or sexual violence, victims of human trafficking, disabled persons and seriously ill persons. They point to the same factors which hamper the identification of vulnerabilities in a general sense, namely **a lack of time, the language and communication barrier and related lack of qualified interpreters, the need to broach subjects with people which could be sensitive, the difficulties of building up a bond of trust with people, a lack of information handover during transfers, a lack of knowledge or experience of vulnerabilities, and a related lack of training with regards to vulnerabilities**.

> *There are also many people with psychological problems. In some cases, this is so advanced that our resources are too limited to be able to cope. This relates primarily to the guidance/psychosocial assistance which needs to be provided. As a social worker, I have 85 residents for whom I am responsible. I have no time to keep an eye on a particular person for the whole day, and give them continual guidance. It is therefore primarily to do with the fact that we do not have enough staff. (Federal reception centre, R195)*

According to the staff from predominantly individual reception facilities, **transfers** (of residents from collective structures to an LRI) can also constitute a bottleneck, not just in terms of identification, but also in the care of vulnerable persons. In particular, the continuity of the care is not always ensured during transfers, due to an inadequate handover of information between the reception structures. Moreover, internal information exchange is not sufficient. Besides the handover of information between the collective and individual reception facilities, there is also a need for a handover of information with external actors and services. In practice, this is often not the case. Another important factor, often referred to by most of the members of staff in the survey, and which often particularly hampers care for vulnerable persons with specific reception needs, is precisely the **knowledge about, access to and provision of external services, and in particular for persons with psychological needs**. This bottleneck will be discussed further in the findings below.

8. Knowledge about, access to and provision of external services

It was ascertained from the survey that the specialised external services play an important complementary role, if adequate care cannot be provided from within the reception facility itself for vulnerable persons with specific reception needs. According to staff in the field, not every reception facility is specialised in caring for the specific needs of all vulnerable persons.

Providing systematic reception for all difficult cases is not a tenable solution for any given centre. We are adapted to needs, but at the same time not super-specialised. (LRI, R190)

As previously established, surveyed staff from reception centres believe that vulnerable persons require a multi-disciplinary follow-up, both internally and in cooperation with external actors. The reception facilities within the reception network already work towards this goal with a range of (specialist) external services (see finding 6.).

Despite these cooperative relationships, the study has shown that staff from reception facilities still experience a number of bottlenecks in this regard. For example, reception facilities often conflict with the existing waiting lists of external services, meaning that the necessary care still cannot be provided when the need arises. Staff also refer to external services which are difficult to reach. This is the case in particular for reception facilities which are located in more remote areas, far from cities. Additionally, some persons are not mobile enough to travel far distances, and there is a lack of suitable transport. In some regions, the provision of external assistance services is non-existent or inadequate. With regards to inadequate provision, reference is primarily made to a lack of assistance for extremely vulnerable profiles (for example, youths with addictions), and a lack of provision within mental healthcare. Surveyed staff from the reception centres revealed that they were unable to offer the necessary care to persons with mental health problems, both within their own structure and via external services.

Long waiting lists for mental healthcare. Moreover, this assistance is always provided in Dutch (in our region). (LRI, R15)

In my opinion, adapted reception is not provided for persons with a psychiatric problem. The existing psychiatric hospitals are often inappropriate due to the language barrier, and they are often unwilling to accept foreign-language speakers. Outpatient psychological care is also very difficult to arrange. (LRI, R98)

Psychological help is a necessity for many people, but not always available in smaller municipalities. There are doctors, but they do not like to work with interpreters because the subject matter is very specific. (LRI, R151)

Too few psychologists to refer people to. The medical service needs to make priorities here. Many people do not receive the care they need, due to inadequate resources. Psychiatric help is almost impossible. (Federal reception centre, R195)

The care for some youths with a psychiatric profile is very difficult and besides, nobody is willing to do it. We are often alone in the event of a crisis, and transfers are not possible because no-one wants to take them over. (LRI, R190)

We can only provide a psychiatrist if we urge the person to be admitted. Of course, this must be avoided as much as possible. Arranging for a psychiatrist on a voluntary basis is impossible. The people do not have the means to pay for this themselves, and this kind of care is not free for the people who live here. People with acute psychiatric problems (of which the centre is aware) therefore do not receive what they are entitled to. This is completely unacceptable. A psychologist can only be assigned to talk to them twice per month (and even this provision is limited). Many people require much more care than this. This is also the kind of care which the centre cannot provide. We do not have the time to spend half a day taking care of someone who is psychotic or who has suicidal tendencies, or suchlike. In terms of mental healthcare, people do have rights, but they do not receive what they are entitled to. (Federal reception centre, R195)

There are no services in our municipality which can help people with such disorders. They need to be referred to another city, which requires travel by train or bus. This is not evident for this population. (LRI, R199)

Moreover, the provision of some external services is not adapted to the target group of reception structures. Staff from reception centres often encounter difficulty with the language barrier or the services' lack of experience with asylum seekers. Furthermore, not all residents are familiar with external assistance services, which may not exist in their country of origin (for example, gynaecologists), or some residents may be reluctant to be referred to certain assistance services because the subject is taboo in their own culture (for example, mental healthcare). Finally, members of staff point out their own insufficient knowledge of the existing external services' provision to which they could refer vulnerable persons with specific needs.

These findings show that a large number of initiatives are organised within the reception network, and in cooperation with external services and actors, with regards to care for vulnerable persons with specific reception needs. However, there are still a number of factors which hinder the effective support of vulnerable persons. We encounter many of these bottlenecks at the level of identification. Specifically for the care of vulnerable persons, knowledge about, access to and provision of external services, and in particular for persons with psychological needs, would all appear to constitute a significant bottleneck. The

previously mentioned multi-dimensional character of vulnerability and reception needs requires an integrated approach, both within the reception facilities and externally, in cooperation with external services and actors from various disciplines.

V. Conclusion

Vulnerability in the context of asylum and migration in general, and within the context of the reception in particular, is **not a new issue**. The general consensus is that persons who request international protection are generally vulnerable persons, given that people who leave their home and familiar environment are confronted with a number of difficult challenges. Moreover, among these persons, there are persons who are confronted with additional difficulties and who therefore have *specific (procedural and/or reception) needs*.

We observe that vulnerability and specific needs in the context of asylum have received much more attention in recent years, at the national, European and international level. This is reflected at the European level, among other things, in the minimum standards for the reception of asylum seekers by EU Member States, with special attention for certain groups of vulnerable persons. Various tools have also been developed to identify vulnerabilities and specific needs in the context of asylum and migration, including the *UNHCR Vulnerability screening Tool*[16] and the *EASO tool for identification of persons with special needs*[17]. At the national level, the current Secretary of State for Asylum and Migration, Mr Theo Francken, requested in his general policy statement of 28 November 2014 to have a "maximum focus for the most vulnerable groups among candidate refugees". In the policy statement of 2015, this focus was reiterated, with special focus on unaccompanied foreign minors, LGB asylum seekers, women and single mothers.

Based on the assumption that persons requesting international protection are vulnerable persons, and that among these persons, there are a number who are confronted with additional difficulties and consequently have specific needs, **we can presume that vulnerable persons with specific reception needs make up a significant portion of the residents within the reception network of Fedasil**. However, quantifying the number of vulnerable persons with specific reception needs within the reception network was not straightforward in the context of the initial phase of this study. As was apparent from the findings, the concept of vulnerability is not defined by everyone in the same way. The study has in fact shown that the way in which reception staff interpret the term vulnerability depends on their own experience in the field. Furthermore, a person is often not vulnerable because they fall within a given category, rather, a multiplicity of different factors tends to make a person

[16] This UNHCR tool (2016) for screening and tackling situations of vulnerability is intended to support staff on the ground in the context of asylum and migration processes, in assessing vulnerability factors in the event of detention decisions, referral to certain reception facilities and other support options. See: http://www.unhcr.org/protection/detention/57fe30b14/unhcr-idc-vulnerability-screening-tool-identifying-addressing-vulnerability.html

[17] The aim of this online tool of the European Asylum Support Office is to facilitate, in good time, the identification of persons with special procedural and/or reception needs who apply for asylum in the EU Member States. It can be used at any moment during the asylum process and at any moment during the reception process. See: https://ipsn.easo.europa.eu/easo-tool-identification-persons-special-needs

vulnerable. In addition to the typical categories of vulnerable persons, we identified various factors in the study which could make a person in reception vulnerable, such as not being proficient in a contact language, being part of a large family, being part of a "closed community", having cultural and religious practices which differ significantly from those of the host country, being isolated, having limited autonomy, having a low level of education, being illiterate, having a problematic family situation, having a different sexual orientation or gender identity, having an addiction to alcohol or drugs, and being a young adult. Who is or is not vulnerable is therefore not a fixed construct which can always be determined in advance. Not only vulnerability, but also reception needs, are best approached as a complex construct with various dimensions. It should be borne in mind that not everyone who is vulnerable has specific reception needs and conversely, someone who has not been identified as vulnerable may well have specific needs.

A quantification of the number of vulnerable persons with specific needs in the reception network is further hampered by identification. However, the study has shown that certain factors are an obstacle to this identification. The identification difficulties already manifest themselves during the registration of asylum applications with the IO and the allocation of a reception place by Dispatching where, due to the focus on medical vulnerabilities, there is a risk that attention will be drawn away from other less visible vulnerabilities, meaning that there is an important identifying role for the reception facilities in this respect. Moreover, reception staff point to a number of factors which hamper the identification of vulnerable persons with specific reception needs. These barriers relate to both factors inherent to individual persons or reception staff, and factors at the level of the reception facilities and the reception context: lack of time (due to overcrowding and high workload in some structures and a lack of staff), the language and communication barrier and related lack of qualified interpreters (meaning that it is difficult for people to express their needs and for supervisors to assess them), the need to broach subjects which could be sensitive (such as human trafficking, violence, sexuality, pregnancy and mental problems), the difficulties of building up a bond of trust (among other things, due to a short stay in the reception structures, language problems and lack of time), a lack of information handover during transfers to individual reception facilities (whereby the identification of vulnerabilities needs to be organised again, losing a lot of valuable time in the process), a lack of knowledge or experience of vulnerabilities, and a related lack of training with regards to vulnerabilities. It is the combination of these factors which has negative consequences for the identification of vulnerable persons with specific reception needs. A multi-dimensional approach of vulnerabilities and reception needs therefore also requires a multi-dimensional approach to identification.

Although in this initial phase of the study, we do not have an exact view of the number of vulnerable persons with special needs within the reception network, the observations, exploratory discussions and the survey have demonstrated the **importance of conducting a study into vulnerabilities within the reception network**. This initial phase of the study has enabled us to form a picture of the way in which the reception network applies the protective provisions with regards to the identification of vulnerable persons, and the extent to which the particular needs of these residents are taken into account in a general sense. We observed that, **in the field, there are still a number of general requirements regarding the identification and care of vulnerable persons with special reception needs**:

- *The concept of vulnerability is too narrowly interpreted within the reception. Instead, "**vulnerability factors**" should be taken into account.*
- *Given the complexity of vulnerabilities and specific needs, a more intensive, individual and multi-disciplinary approach is required. **A multi-disciplinary follow-up** also entails cooperation with, or if necessary referral to, external specialised services.*
- *Moreover, **the cooperative relationships with external partners/services** need to be developed further, in particular in order to provide the necessary care to vulnerable persons with specific needs.*
- *Reception staff themselves indicate that they are insufficiently trained, or not trained at all, to cope with specific vulnerabilities and needs. There is therefore **a need for more specific training** for reception staff. This goes hand in hand with an observed need for more awareness among both reception staff and the external actors they cooperate with in the context of the care for vulnerable persons with specific needs.*
- *Another finding is that **the identification tools** used in the reception centres (such as MDMs and IGPs) are not applied in a coordinated manner. Moreover, the use of these tools is strongly influenced by the reception context.*
- *The need for more **adapted means of communication** was also observed (for example, for communicating with deaf and blind persons).*
- *In terms of communication, **the lack of (specialised) interpreters** also constitutes an important bottleneck within the reception.*
- *Another observed bottleneck for the identification and care of vulnerable persons with specific needs is **the transfers and information exchange** between the reception structures. In some cases, this is not organised in an optimal manner.*
- *Having **more time and a more suitable staff framework**, as well as **clarifying the role and responsibilities** of the various actors involved in identifying and caring for vulnerable persons, also constitute some of the important needs which were observed in the field.*
- *The study also shows that **the ways in which the reception is organised** can have an impact on the vulnerability of persons, such as the location of the reception facilities (e.g. in remote, small villages), the size of the reception structures (e.g. few possibilities for privacy, a lack of individual areas), and the facilities in the reception structure (e.g. lack of adapted sanitary facilities). There is therefore a need for more adapted reception structures.*

This study was not intended to merely highlight the bottlenecks or needs relating to the identification and care of vulnerable persons with special needs within the reception network. This initial phase of the study has also demonstrated that a lot has already been done to optimise the identification and care of vulnerable persons with specific needs within the reception network. But **despite the work which has already been done within the reception network in identifying and supporting vulnerable persons with specific needs, not all aspects are in place to be able to meet the reception needs of all vulnerable persons in an effective manner, both within their own reception facility and in the cooperation with external services.** On the basis of these initial findings within the study, specific recommendations will consequently be proposed. These recommendations will be supplemented on the basis of the findings of the second phase of the study. In this second phase, we will strive in a more qualitative manner to assess the real impact of the identification mechanisms used, and the actions carried out with regards to taking identified needs into account, from the experiences of the residents themselves, among others.

VI. Annexes

Legal analysis

Observations and exploratory discussions

Survey