Co-funded by the European Union

UNHCR The UN Refugee Agency

An Roinn Dlí agus Cirt, Gnóthaí Baile agus Imirce
Department of Justice, Home Affairs and Migration

Creating Supportive Spaces:

Addressing the mental health and wellbeing needs of asylum seekers through trauma-informed approaches in accommodation settings

An Evidence Review

The project is co-funded by the European Union via the Technical Support Instrument, and implemented by UNHCR, in cooperation with the European Commission Reform and Investment Taskforce.
The views expressed herein can in no way be taken to reflect the official opinion of the European Union.

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List of abbreviations

ACEs	Adverse Childhood Experiences
EU	European Union
EUAA	European Union Agency for Asylum
IPAS	International Protection Accommodation Service
MDD	Major Depressive Disorder
MHPSS	Mental Health and Psychosocial Support
PTSD	Posttraumatic stress disorder
TIA	Trauma-Informed Approach
TIC	Trauma-Informed Care
TIP	Trauma-Informed Practice
TSI	Technical Support Instrument
UK	United Kingdom
UNHCR	United Nations High Commissioner for Refugees

Acknowledgements

This literature review was developed as part of the Supportive Spaces Project co-funded by the European Union via the Technical Support Instrument (TSI), and implemented by UNHCR, in cooperation with the European Commission Reform and Investment Taskforce. The paper was written by Leah James, Mental Health and Psychosocial Support (MHPSS) Consultant at UNHCR Ireland with Annabel Egan, Senior Programme Associate at UNHCR Ireland.

Sincere thanks are due to the individuals listed below who provided quality assurance, technical advice and critical input to refine the findings and recommendations presented in this paper, significantly strengthening the final document.

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Members of the Supportive Spaces Advisory Group: Augusto Arnone (European Commission, SG REFORM); Stephen Crosby (IPAS); Maria Hennessy (UNHCR Ireland); and Enda O'Neill (UNHCR Ireland).

Executive Summary

This literature review synthesises global and European evidence on the mental health and psychosocial support needs of asylum seekers and the role that trauma-informed approaches (TIAs) can play in improving wellbeing within accommodation settings. It was developed as part of a Technical Support Instrument (TSI) project led by UNHCR in collaboration with the European Commission and is designed to inform the development of a trauma-informed training programme for staff working in Ireland's International Protection Accommodation Service (IPAS) and in private accommodation centres in Ireland.

Purpose

The purpose of this review is threefold: first, to examine the mental health and psychosocial support (MHPSS) needs of asylum seekers, with particular attention to how accommodation conditions and system-level factors impact wellbeing; second, to assess the relevance and effectiveness of trauma-informed approaches within accommodation and related service environments; and third, to provide evidence-based recommendations to inform the development of a multi-level trauma-informed training model for accommodation staff.

Key Findings

Asylum seekers face disproportionately high levels of psychological distress stemming from cumulative adversities experienced before, during, and after displacement. These include conflict, persecution, torture, gender-based violence, forced migration journeys, and the structural stressors of asylum systems such as prolonged uncertainty, temporary accommodation, and limited access to services. Mental health problems, including depression, posttraumatic stress disorder (PTSD), and anxiety, are significantly more prevalent in asylum seekers compared to host populations, with women and children at even higher risk.

Accommodation settings play a critical role in either mitigating or exacerbating psychological distress. Accommodation settings with limited privacy, control, and autonomy, particularly large-scale or congregate models, have been associated with poorer mental health outcomes. Overcrowding, noise, forced relocations, restricted daily routines, and a lack of access to social support contribute to feelings of powerlessness and despair. Conversely, evidence shows that stable, private, and community-integrated accommodation can promote recovery and wellbeing. Protective factors include the ability to cook one's own meals, access quiet or personal space, proximity to support services, and meaningful opportunities for participation and social inclusion.

Staff working in accommodation settings are also impacted by the challenges of the asylum system. While many staff report that their work is meaningful and rewarding, they are often exposed to distressing stories and emotional exhaustion. Frontline workers, in particular, experience a high risk of burnout and vicarious trauma, especially in the absence of adequate supervision or organisational support. Staff with personal histories of trauma, including those who are themselves refugees or migrants, may face compounded risks without adequate safeguards.

The Trauma-Informed Approach (TIA) offers a promising framework for creating more supportive accommodation environments for both asylum seekers and staff. Grounded in principles of safety, trust, choice, collaboration, empowerment, and cultural responsiveness, TIA recognises the widespread impact of trauma and stress and seeks to prevent re-traumatisation across service delivery and policy environments. When integrated well, TIA benefits not only asylum seekers but also staff.

While empirical evidence specific to asylum accommodation settings is limited, research from adjacent sectors (including health, education, housing, and social care) suggests that trauma-informed models can improve engagement, reduce crisis incidents, and strengthen relationships between service providers and users. Barriers to implementation include a lack of conceptual clarity and systemic constraints that conflict with trauma-informed principles, while facilitators include leadership commitment, lived-experience involvement, tiered training models, cross-sectoral collaboration, and integrated staff wellbeing strategies.

Recommendations

This review synthesises findings to assemble recommendations for the development of trauma-informed training for IPAS and private accommodation centre staff. It proposes a tiered training model, structured across three levels: (1) foundational knowledge for all staff; (2) applied skills for frontline workers; and (3) leadership strategies for supervisors and policy makers. It also presents practical and policy recommendations to embed TIA into asylum accommodation systems, including design of trauma-informed housing and culturally responsive services.

The following key recommendations are offered:

1. Embed TIA principles into accommodation policies and operations to reduce harm and foster healing.
2. Mandate tiered trauma-informed training for all staff, adapted to role and context.
3. Systematically support staff wellbeing through organizational approaches such as supervision, mental health service access, and structured peer support.
4. Design accommodation environments with wellbeing in mind, drawing from trauma-informed and culturally responsive principles.
5. Involve asylum seekers in co-designing services, ensuring dignity, autonomy, and community connection.
6. Foster cross-sectoral coordination between international protection, health and mental health, and housing services.
7. Invest in rigorous evaluation and research to build the evidence base and avoid tokenistic implementation.

In sum, this review aims to support IPAS and its partners in advancing a shared, trauma-informed approach to accommodation – one that promotes the wellbeing of both residents and staff, and contributes to the development of safer, more effective and responsive systems of care.

1. Introduction

Understanding the mental health and wellbeing needs of asylum seekers requires attention to the cumulative impact of adversity across the migration trajectory. Substantial evidence shows that asylum seekers are frequently exposed to a continuum of stressors before, during, and after migration.[1] These may include armed conflict, persecution, torture, sexual and gender-based violence, human trafficking, as well as the loss of livelihood and social networks, and pervasive legal and social uncertainty during displacement.[2] These experiences contribute to disproportionately high rates of post-traumatic stress disorder (PTSD), depression, and anxiety in the refugee and asylum seeker population, which can persist long after arrival in a host country.[3]

Despite these vulnerabilities, research also shows that many asylum seekers employ significant personal and cultural resources in the face of adversity.[4] Drawing on previous coping experience and social and cultural strengths, many can survive and even thrive when provided with basic support and a sense of safety, including through appropriate accommodation and attentive staff. But a growing body of evidence indicates that this potential for recovery is often obstructed by the very systems into which asylum seekers are received – systems that can act as new sources of stress and can unintentionally exacerbate existing mental health difficulties and prolong or prevent recovery.[5]

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[1] Miller, K. E., & Rasmussen, A. (2017). The mental health of civilians displaced by armed conflict: An ecological model of refugee distress. *Epidemiology and Psychiatric Sciences*, *26*(2), 129-138. https://doi.org/10.1017/s2045796016000172; Steel, Z., Chey, T., Silove, D., Marnane, C., Bryant, R. A., & Van Ommeren, M. (2009). Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement: A systematic review and meta-analysis. *JAMA*, *302*(5), 537-549. https://doi.org/10.1001/jama.2009.1132

[2] Ibid.

[3] Blackmore, R., Boyle, J.A., Fazel, M., Ranasinha, S., Gray, K.M., Fitzgerald, G., Misso, M., Gibson-Helm, M. (2020a). The prevalence of mental illness in refugees and asylum seekers: A systematic review and meta-analysis. *PLOS Medicine,* 17 (9), e1003337. https://doi.org/10.1371/journal.pmed.1003337; Blackmore, R., Gray, K. M., Boyle, J. A., Fazel, M., Ranasinha, S., Fitzgerald, G., Misso, M., & Gibson-Helm, M. (2020b). Systematic review and meta-analysis: The prevalence of mental illness in child and adolescent refugees and asylum seekers. *Journal of the American Academy of Child & Adolescent Psychiatry, 59*(6), 705–714. https://doi.org/10.1016/j.jaac.2019.11.011; Patanè, M., Ghane, S., Karyotaki, E., Cuijpers, P., Schoonmade, L., Tarsitani, L., & Sijbrandij, M. (2022). Prevalence of mental disorders in refugees and asylum seekers: A systematic review and meta-analysis. *Global Mental Health, 9*, 250–263. https://doi.org/10.1017/gmh.2022.29

[4] Burgund Isakov, A., & Marković, V. (2024). Systematic review of trauma-informed approaches and trauma-informed care for forced migrant families: Concepts and contexts. *Trauma, Violence & Abuse, 25*(5), 3999–4015. https://doi.org/10.1177/15248380241266161; van Eggermont Arwidson, C., Holmgren, J., Gottberg, K., Tinghög, P., & Eriksson, H. (2022). Living a frozen life: A qualitative study on asylum seekers' experiences and care practices at accommodation centers in Sweden. *Conflict and Health*, *16*(1), 47. https://doi.org/10.1186/s13031-022-00480-y

[5] Mental Health Foundation. (2024). *The Mental Health of Asylum Seekers and Refugees in the UK*. Mental Health Foundation.; Mulcaire, J., Smetham, D., Holt, L., Zard, S., Brady, F., & O'Driscoll, C. (2024). Impact of the asylum determination process on mental health in the UK and EU+: A systematic review and thematic synthesis. *BMJ Public Health*, *2*(2). https://doi.org/10.1136/bmjph-2023-000814; Murphy, F., & Vieten, U. M.

Lengthy and uncertain asylum procedures are a well-documented source of psychological distress, with applicants describing feelings of anxiety, powerlessness, and hopelessness due to prolonged waits for decisions, opaque and convoluted procedures, and, at times, re-traumatizing interviews.[6] Accommodation conditions, including the instability of accommodation, within the asylum system are also a critical determinant of wellbeing.[7] While access to shelter is a necessity, research highlights the broader importance of housing environments that offer asylum seekers safety, privacy, autonomy, and opportunities for connection and stability. These factors are essential for restoring dignity, creating community networks, and supporting mental health and wellbeing. Unfortunately, many reception and accommodation systems are characterised by overcrowding, instability, constrained autonomy, and social isolation. Such conditions have been shown to exacerbate rather than diminish distress and undermine rather than improve well-being.[8]

The challenging conditions prevalent across the asylum system also impact staff working within it, including those who work in accommodation settings.[9] While many staff report finding work with asylum seekers to be empowering and satisfying, especially when organisational staff wellbeing supports are in place, exposure to distressing stories, heavy workloads, and limited resources can

(2022). Asylum seekers and refugees in Northern Ireland: The impact of post-migration stressors on mental health. *Irish Journal of Psychological Medicine*, *39*(2), 163-172. https://doi.org/10.1017/ipm.2020.102

[6] Stewart, R. (2006). *The mental health promotion needs of asylum seekers and refugees: A qualitative study in direct provision centres and private accommodation in Galway City.* Galway City Development Board, Health Promotion Services, HSE West. http://hdl.handle.net/10147/44902

[7] Brake, T. M., Dudek, V., Sauzet, O., & Razum, O. (2023). Psychosocial attributes of housing and their relationship with health among refugee and asylum-seeking populations in high-income countries: Systematic review. *Public Health Reviews*, *44*, 1605602. https://doi.org/10.3389/phrs.2023.1605602; Hajak, V. L., Sardana, S., Verdeli, H., & Grimm, S. (2021). A systematic review of factors affecting mental health and well-being of asylum seekers and refugees in Germany. *Frontiers in Psychiatry*, *12*, 643704. https://doi.org/10.3389/fpsyt.2021.643704; McShane, S., Block, K., Baker, E., Li, Y., & Bentley, R. (2025). Beyond shelter: A scoping review of evidence on housing in resettlement countries and refugee mental health and wellbeing. *Social Psychiatry and Psychiatric Epidemiology*, *60*(7), 1541-1562. https://doi.org/10.1007/s00127-025-02851-1; Rast, E., Hintermeier, M., Bozorgmehr, K., & Biddle, L. (2024). Housing and health: A multidimensional, qualitative analysis of the experiences of asylum seekers and refugees living in German reception centres. *SSM-Qualitative Research in Health*, *5*, 100407. https://doi.org/10.1016/j.ssmqr.2024.100407; Spira, J., Katsampa, D., Wright, H., & Komolafe, K. (2025). The relationship between housing and asylum seekers' mental health: A systematic review. *Social Science & Medicine*, *368*, 117814. https://doi.org/10.1016/j.socscimed.2025.117814; van Eggermont Arwidson et al., 2022; Ziersch, A., & Due, C. (2018). A mixed methods systematic review of studies examining the relationship between housing and health for people from refugee and asylum seeking backgrounds. *Social Science & Medicine*, *213*, 199-219. https://doi.org/10.1016/j.socscimed.2018.07.045.

[8] Ibid.

[9] European Asylum Support Office (EASO). (2021a). *Practical guide on the welfare of asylum and reception staff, Part II: Staff welfare toolbox.* (EASO Practical Guides Series). Luxembourg: Publications Office of the European Union. https://euaa.europa.eu/sites/default/files/Practical-guide-staff-welfare-part-II-toolbox.pdf; Fernandes, P., Buus, N., & Rhodes, P. (2024). Vicarious impacts of working with refugees and asylum seekers: An integrative review. *Journal of Immigrant & Refugee Studies*, *22*(3), 482-502. https://doi.org/10.1080/15562948.2022.2049949

result in burnout, vicarious or secondary trauma, and other adverse mental health effects.[10] Given that research suggests that more than two thirds of the general population has experienced traumatic events in their lifetime,[11] it is likely that staff may have exposure to trauma and stress in their personal lives, unrelated to their workplace, which can also impact their ability to support others. This may be especially true in accommodation settings in which some staff are themselves refugees or migrants.

International human rights and refugee law affirm the right of all individuals to seek asylum from persecution, and with that right comes a corresponding duty on the part of states to uphold and implement protection procedures in a manner that is safe, dignified, and humane.[12] A central ethical and legal obligation is the principle to *do no harm*, ensuring that the processes and environments designed to offer refuge do not become additional sources of trauma and persistent distress.

In this context, the Trauma-Informed Approach (TIA) offers a critical framework for enhancing asylum accommodation services while aligning with the principle of 'do no harm' and supporting the wellbeing of both asylum seekers and the staff who work with them. TIA recognises the widespread impact of trauma and other adversities, emphasises pathways to recovery, and integrates this knowledge into policies and practices to support wellbeing.[13] When done well, such an approach can mitigate the chronic stress, loss, and disempowerment that asylum seekers may face through the protection process. Evidence indicates that trauma-informed training enhances staff awareness of the impact of adversity, supports recognition of related needs, and strengthens referral pathways to safeguarding and mental health support.[14] It fosters the ability to interpret intense behavioral and emotional expressions through a trauma-sensitive lens, a shift in perspective designed to lead to more empathetic and effective interactions and reduce the likelihood of re-traumatization.[15] It can also improve staff well-being by encouraging staff care and

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[10] EASO, 2021a; Roberts, F., Teague, B., Lee, J., & Rushworth, I. (2021). The prevalence of burnout and secondary traumatic stress in professionals and volunteers working with forcibly displaced people: A systematic review and two meta-analyses. *Journal of Traumatic Stress*, *34*(4), 773-785. https://doi.org/10.1002/jts.22659

[11] Benjet, C., Bromet, E., Karam, E. G., Kessler, R. C., McLaughlin, K. A., Ruscio, A. M., ... & Koenen, K. C. (2016). The epidemiology of traumatic event exposure worldwide: Results from the World Mental Health Survey Consortium. *Psychological Medicine*, *46*(2), 327-343. https://doi.org/10.1017/S0033291715001981

[12] United Nations High Commissioner for Refugees. (n.d.). *The 1951 Refugee Convention and 1967 Protocol relating to the Status of Refugees*. https://www.unhcr.org/media/1951-refugee-convention-and-1967-protocol-relating-status-refugees

[13] Substance Abuse and Mental Health Services Administration (SAMHSA). (2014). *SAMHSA's concept of trauma and guidance for a trauma-informed approach.* (HHS Publication No. SMA 14-4884). U.S. Department of Health and Human Services.

[14] Mooney, S., Fargas, M., MacDonald, M., Bunting, L., O'Neill, D., Walsh, C., Hayes, D., & Montgomery, L. (2024). *'We are on a journey': Implementing trauma-informed approaches in Northern Ireland*. Safeguarding Board for Northern Ireland. https://www.safeguardingni.org/latest/we-are-journey-implementing-trauma-informed-approaches-northern-ireland-evidence-report.

[15] Ibid.

recognizing the effects of both primary and vicarious trauma.[16] However, while encouraging, the evidence base is still evolving and not without significant limitations, including a shortage of research focused on asylum-related contexts.

1.1. Purpose of this review

This literature review aims to synthesise current evidence for use by practitioners, policy makers and other stakeholders involved in supporting asylum seekers, particularly within accommodation settings. This review prioritises multi-country systematic reviews and meta-analyses published in the last 10 years, although, when relevant, primary sources are cited as well. It is not a systematic review, but rather a narrative synthesis structured around three key themes:

1. **The mental health and psychosocial support (MHPSS) needs of asylum seekers**, with attention to the impact of asylum processes and accommodation conditions and policies, as well as **support needs of staff** working within these systems;
2. **The effectiveness of trauma-informed approaches**, including their impact on service users, staff, and systems, both broadly and within asylum-specific contexts; and
3. **Practical recommendations for trauma-informed training and implementation**, aimed at fostering more supportive accommodation environments that reduce harm, promote healing, and support integration into host societies.

Ultimately, this review aims to contribute an evidence-based foundation to inform the development of a trauma-informed training for staff of accommodation centres for asylum seekers in Ireland. While this review draws primarily from international and European literature, it is important to acknowledge the small but vibrant body of research specific to the Irish context.[17] Nevertheless, findings from Ireland and Northern Ireland generally align with broader international trends, including those related to the mental health impacts of asylum procedures, the importance of stable and respectful accommodation, and the need for trauma-informed support for both service users and staff. As a result, Ireland-specific studies are not treated separately in all cases, unless they offer unique insights or diverge meaningfully from global patterns.

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[16] Ibid.

[17] E.g., Daly, F., & Riordan, J. (2024). Assessing care deficits in Ireland's international protection and accommodation system: Lessons learned in COVID-19 and beyond. *Journal of Migration and Health*, *10*, 100255. https://doi.org/10.1016/j.jmh.2024.100255; Hoare, R. (2022). Using composite case material to develop trauma-informed psychoeducation for social care workers looking after unaccompanied minors in residential care in Ireland. *Health & Social Care in the Community, 30*, e5863–e5874. https://doi.org/10.1111/hsc.14017; Isaloo, A. S. (2020). Liminality in the Direct Provisional system - Living under Extreme Rules and Conditions. In L. Moran (Ed.), *Remaking social futures through biographic, narrative and lifecourse approaches: Story-making and story-telling in pandemic times (The sociological observer, 3(1))*. Sociological Association of Ireland.; Murphy & Vieten, 2020; Ní Raghallaigh, M. (2014). The causes of mistrust amongst asylum seekers and refugees: Insights from research with unaccompanied asylum-seeking minors living in the Republic of Ireland. *Journal of Refugee Studies*, *27*(1), 82-100. https://doi.org/10.1093/jrs/fet006; Stewart, 2006.

2. Mental health and psychosocial support needs of asylum seekers and staff

A substantial and growing body of global research highlights the elevated risk of mental health problems among forced migrants, including refugees and asylum seekers. These vulnerabilities arise from the complex and cumulative effects of adversity across the entire migration process, as described by the triple-trauma paradigm: trauma experienced in the country of origin, trauma endured during the migration journey, and trauma encountered upon arrival in the host country.[18] Mental health outcomes among asylum seekers are shaped not only by individual factors but also by broader environmental and systemic influences, such as racism, poverty, legal precarity, housing instability, and limited access to care.[19]

Research consistently shows that asylum seekers and refugees are at much higher risk of experiencing mental health problems than the general population and that asylum seekers are at higher risk than resettled refugees.[20] Global studies report wide variability in prevalence rates of mental health conditions among refugees and asylum seekers, ranging from 5-80% for depression and 4% - 88% for PTSD.[21] A recent meta-analysis of 40 studies across 18 countries found prevalence rates of major depressive disorder (MDD) (32%), PTSD (31%), bipolar disorder (5%), and psychosis (1%).[22] This is in comparison to approximately 4.4% worldwide prevalence for MDD and 3.9-5.6% for PTSD, suggesting that depression is seven times more likely and PTSD four to five times more likely in refugees and asylum seekers than in the general population.[23] Among child and adolescent refugees and asylum seekers, a systematic review and meta-analysis found overall prevalence of PTSD (23%), depression (14%), anxiety disorders (16%), and attention-deficit/hyperactivity disorder (8.6%).[24]

Women and girls have a higher risk of depression and anxiety than boys and men, and evidence suggests that they are disproportionately exposed to certain adversities.[25] A metanalysis found that 44% of women refugees and asylum seekers in high income countries reported lifetime exposure to

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[18] Blackmore, et al., 2020a; MHF, 2024; Patanè at al., 2022; van Eggermont Arwidson et al., 2022.
[19] European Asylum Support Office (EASO). (2020). Mental health of applicants for international protection in Europe: *Initial mapping report*. https://euaa.europa.eu/sites/default/files/EASO-Mapping-Report-Mental-Health-EN.pdf
[20] Apers, H., Van Praag, L., Nöstlinger, C., & Agyemang, C. (2023). Interventions to improve the mental health or mental well-being of migrants and ethnic minority groups in Europe: A scoping review. *Cambridge Prisms: Global Mental Health*, *10*, e23. https://doi.org/10.1017/gmh.2023.15; Hajak et al., 2021; Satinsky, E., Fuhr, D. C., Woodward, A., Sondorp, E., & Roberts, B. (2019). Mental health care utilisation and access among refugees and asylum seekers in Europe: A systematic review. *Health Policy*, *123*(9), 851-863. https://doi.org/10.1016/j.healthpol.2019.02.007; ; Toar, M., O'Brien, K. K., & Fahey, T. (2009). Comparison of self-reported health and healthcare utilisation between asylum seekers and refugees: An observational study. *BMC Public Health, 9*, Article 214. https://doi.org/10.1186/1471-2458-9-214
[21] Patane et al., 2022.
[22] Ibid.
[23] Ibid.
[24] Blackmore et al., 2020b.
[25] World Health Organization (2023). *Mental health of refugees and migrants: Risk and protective factors and access to care*. Geneva: World Health Organization. https://www.ncbi.nlm.nih.gov/books/NBK597273/?utm

sexual violence (compared to 27% across both sexes).[26] Intimate partner violence is estimated to affect 29% of people with insecure migration status, primarily women.[27]

Research conducted in Ireland reflects similar trends to those observed internationally, with significant variability in reported rates of mental health disorders among refugees and asylum seekers. Prevalence estimates for PTSD range from 15% in clinical screening at new-arrival health assessments[28] to as high as 46% in a longitudinal study of individuals in the asylum process.[29] Similarly, rates of depression and anxiety vary across studies, with one recent health assessment finding that, among newly arrived asylum seekers, 9.1% met criteria for depression and 3.7% for anxiety.[30] Notably, asylum seekers in Ireland are significantly more likely to report symptoms of PTSD and depression or anxiety than refugees.[31] Clinical practice data suggest that asylum seekers are up to five times more likely to be diagnosed with a mental health disorder compared to Irish citizens.[32]

Despite high risk of psychological distress, research shows that asylum seekers frequently demonstrate strong capacity for adaptation and effective coping. Protective factors include future orientation, spirituality, social connectedness, having education and employment opportunities, and opportunities for advocacy and caring for others.[33] Peer support is commonly identified as a strategy to provide relief from distress - this includes talking to others in the same situation and

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[26] Cayreyre, L., Korchia, T., Loundou, A., Jego, M., Théry, D., Berbis, J., Gentile, G., Auquier, P., & Khouani, J. (2024). Lifetime sexual violence experienced by women asylum seekers and refugees hosted in high-income countries: Literature review and meta-analysis. *Journal of Forensic and Legal Medicine*, *101*, 102622. https://doi.org/10.1016/j.jflm.2023.102622.

[27] Innes, A., Carlisle, S., Manzur, H., Cook, E., Corsi, J., & Lewis, N. V. (2024). Prevalence of physical violence against people in insecure migration status: A systematic review and meta-analysis. *PLoS one*, *19*(3), e0300189. https://doi.org/10.1371/journal.pone.0300189.

[28] Kiely, B., Larkin, J., Mullan, K., Ó Tuathail, M., Coughlan, E., Marshall, D., Fitzgerald, M., & O'Reilly, F. (2024). Prevalence of psychological distress detected by the PROTECT and PHQ-4 questionnaires and subsequent mental health diagnosis: A cross-sectional analysis of the outcomes of new arrival health assessments for refugees and asylum seekers in Ireland. *BMC Public Health, 24*, Article 979. https://doi.org/10.1016/j.jmh.2025.100317.

[29] Ryan, D. A., Benson, C. A., & Dooley, B. A. (2008). Psychological distress and the asylum process: A longitudinal study of forced migrants in Ireland. *Journal of Nervous and Mental Disease, 196*(1), 37–45. https://doi.org/10.1097/NMD.0b013e31815fa51c.

[30] Kiely et al., 2024.

[31] Toar, M., O'Brien, K. K., & Fahey, T. (2009). Comparison of self-reported health and healthcare utilisation between asylum seekers and refugees: An observational study. *BMC Public Health, 9*, Article 214. https://doi.org/10.1186/1471-2458-9-214

[32] McMahon, J. D., Macfarlane, A., Avalos, G. E., Cantillon, P., Murphy, A. W. (2007). A survey of asylum seekers' general practice service utilisation and morbidity patterns. *Irish Medical Journal*, *100*(5), 461–464. https://pubmed.ncbi.nlm.nih.gov/17727121/

[33] Lindert, J., Samkange-Zeeb, F., Jakubauskiene, M., Bain, P. A., & Mollica, R. (2023). Factors contributing to resilience among first generation migrants, refugees and asylum seekers: A systematic review. *International Journal of Public Health*, *68*, 1606406. https://doi.org/10.3389/ijph.2023.1606406

sharing support and advice, which can provide opportunity not only to receive support, but also to help others, contributing to a sense of purpose.[34]

The mental health of asylum seekers is highly influenced by exposure to adversity. This includes exposure to *traumatic events*, defined as events that are experienced by an individual as physically or emotionally harmful or life threatening and that trigger a response that overwhelms the ability to cope.[35] What constitutes trauma is subjective and can manifest differently in each person. Although trauma is often a primary focus of research, other types of experiences can be equally impactful for mental health. *Chronic stress*, the cumulative impact of daily stressors (which may not be traumatic but can still cause distress), such as uncertainty, limited opportunities, financial hardship, and poor living conditions – has significant implications for wellbeing.[36] Loss and grief are central experiences for displaced populations, including loss of loved ones, but also of one's sense of home, community, culture, safety and identify.[37] In displaced populations, grief and mourning rituals may be disrupted, further intensifying the likelihood of acute and prolonged grief reactions.[38]

The impact of adversity on mental health for forced migrants can be understood across three critical stages: in their country of origin (pre-migration), during transit, and upon arrival and stay in the host country (post-migration).[39]

Pre-Migration. Before leaving their home countries, forced migrants may have experienced significant stressors and potentially traumatic events, including war, conflict, violence, torture, imprisonment, persecution, domestic violence, and other human rights violations all of which may have long-lasting impact on mental health.[40] Evidence shows high rates of torture among asylum seekers, which is a strong predictor of adverse mental health, including PTSD.[41]

Importantly, a strong body of global evidence shows that adverse childhood experiences (ACEs) such as abuse and neglect, having parents with mental health problems or who are incarcerated or

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[34] van Eggermont Arwidson et al., 2022.
[35] SAMHSA, 2014; Safeguarding Board for Northern Ireland (SBNI). (2024). *Trauma-Informed Organisational Toolkit*. Safeguarding Board for Northern Ireland. https://www.safeguardingni.org/resources/trauma-informed-toolkit
[36] Mulcaire et al., 2024.
[37] Renner, A., Schmidt, V., & Kersting, A. (2024). Migratory grief: A systematic review. *Frontiers in Psychiatry*, *15*, 1303847. https://doi.org/10.3389/fpsyt.2024.1303847
[38] Jones, L. (2020). Grief and Loss in Displaced and Refugee Families. In: Song, S., Ventevogel, P. (eds) *Child, Adolescent and Family Refugee Mental Health*. Springer, Cham. https://doi.org/10.1007/978-3-030-45278-0_8
[39] Blackmore et al., 2020a; European Asylum Support Office (EASO). (2021b). Consultations with Applicants for International Protection on Mental Health: A participatory approach supported by Member State authorities and civil society. https://euaa.europa.eu/publications/consultation-applicants-international-protection-mental-health
[40] Blackmore et al., 2020a; EASO, 2020; Miller & Rasmussen, 2017; Steele et al., 2009.
[41] Hearns, A., Hyland, P., Benninger-Budel, C., & Vallières, F. (2021). ICD-11 PTSD and CPTSD: Implications for the rehabilitation of survivors of torture seeking international protection. *Torture Journal*, *31*(3), 96–112. https://doi.org/10.7146/torture.v32i3.125780.

separated, and being bullied, predicts psychological, health, and social outcomes across the lifespan in the general population – effects that also apply to refugees and asylum seekers.[42]

Transit. The migration journey itself can be perilous and life-threatening, involving perceived and actual threats such as unsafe sea or land passages, abuse from traffickers, and witnessing violence – potentially traumatic events which can contribute to mental health vulnerability. [43] Many migrants experience a lack of basic needs during transit, and some face prolonged stays in transit countries which may also exacerbate mental health needs.[44]

Post migration. Upon arrival in a host country, forced migrants face a new set of challenges, including loss, confusion, legal limbo, social isolation, culture-shock and poverty, that can have a powerful influence on their mental health, often compounding the effects of previous stress and trauma.[45] In a 2020 mapping of mental health needs among international protection applicants in Europe by the European Union Agency for Asylum (EUAA) (previously known as the European Asylum Support Office (EASO)), lengthy asylum procedures were identified as a leading source of mental health concerns among applicants (following traumatic experiences in the country of origin such as insecurity, conflict and war, and pre-existing health conditions).[46]

2.1 Asylum Determination Process

Extensive evidence demonstrates that lengthy asylum procedures, including delays in processing asylum claims, prolonged uncertainty regarding their outcome, potentially re-traumatising interviews, and persistent fear of deportation, are a source of acute psychological distress.[47] Applicants may experience loss of hope, motivation, and overall life satisfaction, sometimes developing somatic problems such as stomachaches, headaches, and sleep disturbances.[48] Some reports have made the case that asylum systems can be traumagenic, in that they can constitute

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[42] Abate, B. B., Sendekie, A. K., Merchaw, A., Abebe, G. K., Azmeraw, M., Alamaw, A. W., ... & Kassa, M. A. (2025). Adverse childhood experiences are associated with mental health problems later in life: An umbrella review of systematic review and meta-analysis. *Neuropsychobiology*, *84*(1), 48-64. https://doi.org/10.1159/000542392; Madigan, S., Deneault, A. A., Racine, N., Park, J., Thiemann, R., Zhu, J., ... & Neville, R. D. (2023). Adverse childhood experiences: A meta-analysis of prevalence and moderators among half a million adults in 206 studies. *World Psychiatry*, *22*(3), 463-471. https://doi.org/10.1002/wps.21122

[43] MHF, 2024; Blackmore et al., 2020a.

[44] EASO, 2020.

[45] Mulcaire et al., 2024; Murphy & Vieten, 2022.

[46] EASO, 2020.

[47] EASO, 2020; Murphy & Vieten 2020; Pollard, T., & Howard, N. (2021). Mental healthcare for asylum-seekers and refugees residing in the United Kingdom: a scoping review of policies, barriers, and enablers. *International Journal of Mental Health Systems*, *15*(1), 60. https://doi.org/10.1186/s13033-021-00473-z; Sneddon, H. (2018). *Mental health and wellbeing of asylum seekers and refugees: Evidence review and scoping.* Public Health Agency (PHA). Northern Ireland. https://www.strongertogetherni.org/wp-content/uploads/2019/04/Mental-health-of-refugees-Long-report-FINAL-24-9-18-Helga-Sneddon.pdf; van Eggermont Arwidson et al., 2022; Whitehouse, K., Lambe, E., Rodriguez, S., Pellecchia, U., Ponthieu, A., Van den Bergh, R., & Besselink, D. (2021). A qualitative exploration of post-migration stressors and psychosocial well-being in two asylum reception centres in Belgium. *International Journal of Migration, Health and Social Care*, *17*(3), 241-258. https://doi.org/10.1108/IJMHSC-08-2020-0082.

[48] EASO, 2020.

new sources of stress and trauma, reinforce past trauma, and ultimately significantly exacerbate mental health difficulties of applicants.[49]

An EU Agency for Fundamental Rights study on good practices and challenges in the integration of young refugees in the EU (based on 190 interviews with experts and 163 interviews with people in need of international protection) identified lengthy procedures, often lasting years, together with uncertainty about outcomes, poor reception conditions, and the need to repeatedly tell one's story at different stages as key factors influencing applicant mental health.[50] Asylum interviews, particularly those involving detailed recounting of traumatic experiences, may be experienced as distressing, uncomfortable, and humiliating, with some participants reporting nightmares afterward.[51] Insufficient or inaccessible information (e.g., a lack of understandable information in one's own language) on the asylum processes and entitlements, and limited support in preparing asylum claims further contribute to confusion and distress.[52]

Uncertainty and lack of future perspective contribute significantly to mental health concerns.[53] In a qualitative study of asylum seekers in collective accommodation in Sweden, van Eggermont Arwidson and colleagues introduced the concept of "frozen life," a state characterised by overwhelming uncertainty and lack of control related to the indefinite waiting time for a decision on their asylum claim.[54] They found that geographic and social isolation in remote accommodation settings, language gaps, and lack of integration skills contributed to a sense of living a heavily confined, "frozen" existence. The loss of meaningful roles, relationships, and personal identity, such as those related to profession, education, or family status, deepened this experience. Among respondents, the experience of "frozen life" was linked closely to constant worrying and overthinking (e.g., regarding the possibility of deportation) with serious consequences for both physical and mental health.

A 2024 systematic review and thematic synthesis by Mulcaire and colleagues corroborated these findings.[55] Synthesizing data from 45 studies involving over a thousand asylum seekers and refugees across the UK and EU, the review identified consistently high levels of psychological distress experienced both during and after the asylum process. The distress was linked to systemic uncertainty and environments described as "hostile" due to restrictive policies and procedures. Key contributors included procedural ambiguity, repeated delays, and policies leading to a loss of autonomy. Participants here also described being "frozen in time", caught in a bureaucratic limbo

[49] MHF, 2024.
[50] European Union Agency for Fundamental Rights (FRA) (2019). *Integration of Young Refugees in the EU: Good Practices and Challenges*. https://fra.europa.eu/en/publication/2019/integration-young-refugees-eu-good-practices-and-challenges
[51] Murphy & Vieten 2020; Mulcaire et al 2024; Schock, K., Rosner, R., & Knaevelsrud, C. (2015). Impact of asylum interviews on the mental health of traumatised asylum seekers. *European Journal of Pyschotraumatology, 6*(1). https://doi.org/10.3402/ejpt.v6.26286
[52] EASO, 2021b.
[53] Sneddon, 2018; EASO, 2020.
[54] van Eggermont Arwidson et al., 2022.
[55] Mulcaire et al., 2024.

that impeded emotional progress. The review called for urgent policy reforms, including shorter, more transparent asylum processes, limits on sudden reallocations and detainment, and a review of specific asylum processes like reception centres and interviews.

Alongside the asylum process itself, many studies show that poverty, financial insecurity, and limited work opportunities intensify stress and social exclusion. Restrictive employment policies, such as prohibitions on work during asylum processing, are linked to feelings of frustration, marginalization, and hopelessness.[56] Growing anti-immigrant sentiment, creating environments of hostility, discrimination, and social exclusion, are further compounding the challenges of displacement and resettlement in many settings.[57]

2.2 Accommodation and Living Conditions

Systematic reviews consistently show that housing is a critical determinant of mental health for asylum seekers.[58] Overcrowded and inadequate accommodation has been consistently linked to elevated rates of psychological distress, including depression, anxiety, and PTSD symptoms.[59] Contributing factors include a lack of privacy, persistent noise, inadequate hygiene, fear of harassment or discrimination, and minimal autonomy over daily living arrangements. A key driver of distress is the lack of choice and agency regarding where and how asylum seekers live. The inability to influence basic aspects of one's environment, including routines, food preparation, or visitation rights, has been associated with chronic stress, overthinking, and a sense of helplessness.[60]

A 2025 systematic review by Spira and colleagues synthesised findings from 21 studies and concluded that poor living situations significantly worsen mental health outcomes.[61] Specifically, collective housing and detention centers were identified as highly detrimental, leading to increased rates of self-harm and psychological distress, while private and community housing offered better alternatives. The authors determined that the negative impact of housing stems from a lack of autonomy, feelings of unsafety, and insufficient support, and called for urgent policy reforms to ensure secure and humane housing for all asylum seekers.

A 2023 systematic review by Brake and colleagues explores how the psychosocial aspects of housing profoundly impact the health of asylum seekers and refugees in high-income countries.[62] This synthesis of 32 studies emphasises that a true "home" extends beyond just physical shelter to foster a sense of control, belonging, and satisfaction, which are crucial for well-being. The research highlights that while material conditions are important, it's the interconnected psychosocial attributes, such as the perceived lack of control over one's living situation and challenges in

[56] MHF, 2024; Miller & Rasmussen, 2017; Mulcaire et al., 2024.
[57] Mental Health Foundation. (2025). *The mental health of asylum seekers and refugees in the UK: 2025 Edition*. Mental Health Foundation.
[58] Brake et al., 2023; McShane et al., 2025; Spira et al., 2025; Ziersch & Due, 2018.
[59] Spira et al., 2025.
[60] McShane et al., 2025.
[61] Spira et al., 2025.
[62] Brake et al., 2023.

developing a sense of safety and belonging, that significantly influence mental and, to some extent, physical health.

Likewise, a 2025 scoping review by McShane and colleagues emphasises that housing for asylum seekers extends "beyond shelter," acting as a crucial social determinant of health.[63] The research identifies four key housing factors—policy, suitability, environment, and time—that significantly impact mental health outcomes, often negatively due to issues like poor quality, unsuitable location, and lack of accessibility. Ultimately, the review concludes that current housing policies often fall short in addressing the unique needs of asylum seekers, highlighting the need for flexible, culturally appropriate, and sustained housing support to foster better mental health and successful integration.

Similar findings were shared in a 2023 *Migrant Voice* report based on experiences of 170 migrants housed in UK hotels.[64] Residents highlighted challenges associated with hotel living, including poor quality accommodation and food, cramped conditions, lack of privacy, insufficient financial support for basic necessities and travel, and hostile treatment by hotel staff. These conditions were described as degrading and disempowering, ultimately contributing to both physical and mental health deterioration. The report argued that such accommodation models reflect not only systemic inefficiencies but also deliberate deterrence strategies.

Ireland context. Studies conducted in Ireland demonstrate similar links between asylum systems, accommodation, and the mental health needs of asylum seekers. Beginning in 2000, Ireland began implementation of an emergency accommodation system known as Direct Provision and Dispersal ("Direct Provision") to house the increasing number of international protection applicants. While a limited number of Direct Provision centres are state-owned and operated, the majority are privately run facilities such as converted hotels. Asylum seekers may remain in Direct Provision for several years while awaiting the outcome of their applications.[65] Research has shown that prolonged stays in Direct Provision are linked to significant challenges and psychological distress,[66] including among children.[67] This period is often characterised by uncertainty, social isolation, and what has been termed "living liminality."[68] Extended time in Direct Provision has been associated with higher levels of self-reported PTSD, depression, and anxiety.[69]

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[63] McShane et al., 2025.
[64] Migrant Voice (2023). No rest. No security. Report into the experiences of asylum seekers in hotels. https://www.migrantvoice.org/img/upload/No_rest,_no_security._Report_into_the_experiences_of_asylum_seekers_in_hotels_-_Migrant_Voice_2023_.pdf
[65] Daly & O'Riordan, 2024.
[66] Daly & O'Riordan, 2024; Isaloo, 2020; Murphy & Vieten, 2020; Stewart 2006; Toar et al., 2009.
[67] Ombudsman for Children's Office. (2020). *Direct Division: Children's views and experiences of living in Direct Provision* [Report]. Ombudsman for Children's Office. https://www.oco.ie/app/themes/oco/images/direct-division/pdf/Ombudsman-for-Children-Direct-Division-Report-2020.pdf
[68] Daly & O'Riordan, 2024; Isaloo, 2020.
[69] Toar et al., 2009.

In 2020, the Advisory Group on the Provision of Support including Accommodation to Persons in the International Protection Process critically assessed the Direct Provision system.[70] The group concluded that the model, "which places applicants for long periods in segregated, congregated accommodation with little privacy or scope for normal family life," was not fit for purpose. They recommended the creation of a permanent support system that includes a streamlined decision-making process and a shift away from institutionalised or collective housing. Specifically, they proposed that applicants be provided with own-door accommodation, secured through local authorities, within three months of submitting their protection application. However, these recommendations have not been implemented, an outcome attributed to the Covid-19 pandemic, a dramatic increase in international protection applicants (especially due to the Ukraine crisis), and a severe national housing crisis.[71] In March 2024, a new Comprehensive Accommodation Strategy was published which includes a commitment to reform the accommodation system for refugees including a move away from relying on the private sector.[72]

Housing factors contributing to distress.

Synthesizing findings across studies, the following housing factors are shown to impact mental health:

Type of housing and housing conditions. There is a wide range in the type and condition of housing available in asylum settings in Europe, ranging from detention facilities to collective housing (including both large-scale 'instutionalised' settings, as well as smaller group dwellings) to private apartments or community homestays. Collective and shared housing such as in reception centres or converted hostels and hotels is more likely to be used as 'temporary' or 'initial' accommodation upon arrival or during asylum claims, and as 'emergency' housing to temporarily accommodate a sudden increase in numbers of asylum seekers.[73] However, in some settings, collective housing can be used for extended periods, sometimes for multiple years.[74] Collective housing, especially when used for extended periods, is generally associated with increased distress, while private and homestay housing are seen as better alternatives and movement to

[70] Government of Ireland. (2020). *Report of the Advisory Group on the Provision of Support including Accommodation to Persons in the International Protection Process.* Published 21 October 2020 (last updated 13 December 2021) by the Department of Justice, Home Affairs and Migration.
[71] Amnesty International Ireland. (2024). *Ireland's Direct Provision system: 25 years later, still a "temporary" solution*. Retrieved from https://aims.amnesty.nl/2025/06/03/irelands-direct-provision-system-25-years-later-still-a-temporary-solution/; Department of Children, Equality, Disability, Integration and Youth. (2022). *White Paper on ending Direct Provision: Progress report* [Government report]. Government of Ireland.
[72] Department of Children, Disability and Equality. (2024, March 27). *Government agrees new comprehensive accommodation strategy for International Protection applicants*. Gov.ie. https://www.gov.ie/en/department-of-children-disability-and-equality/press-releases/government-agrees-new-comprehensive-accommodation-strategy-for-international-protection-applicants/; Department of Children, Equality, Disability, Integration and Youth. (2024). *Comprehensive Accommodation Strategy for International Protection Applicants*. Government of Ireland. https://assets.gov.ie/static/documents/comprehensive-accommodation-strategy-for-international-protection-applicants.pdf
[73] Brown et al., 2024.
[74] McShane et al., 2025; Rast et al., 2024.

these settings is associated with improved mental health.[75] Immigration detention is most detrimental to mental health, inflicting long-term psychological harm including increased rates of depression, PTSD and self-harm.[76]

Research generally links collective settings to poorer conditions.[77] In some collective settings, overcrowding and lack of privacy disrupt sleep, cause interpersonal difficulties, and lead to stress.[78] Inadequate hygiene, dampness, and cold in accommodation are also sources of stress.[79] Some collective settings are 'catered' rather than 'self-catered' and the inability to cook one's own food is linked to increased distress.[80]

However, in some contexts, collective accommodation is linked to positive outcomes. The EUAA consultation report found that participants from African countries reported feeling safer and more protected when they are initially accommodated in a communal living arrangement rather than in individual housing arrangements,[81] suggesting that there may be contextual differences in reactions to collective housing. Although research has often highlighted links between life at collective accommodation centers and aggression among certain groups,[82] there is also evidence that collective living can elicit networks of peer support and meaningful care practices.[83]

Such findings introduce the possibility that not all forms of collective housing are equally problematic, but rather that frequently correlated conditions, such as overcrowding, lack of privacy, and lack of control create adverse effects, while other aspects of communal living can in fact be protective. Despite this, some researchers argue that even when good practices are in place, the very structure of collective accommodation impedes stability and community integration and can be problematic in the long term. Researchers call for consideration of other forms of accommodation, including community homestays which offer further opportunity for integration.[84]

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[75] Spira et al., 2025

[76] EASO, 2020; EASO, 2021b; Hedrick, K., Armstrong, G., Coffey, G., & Borschmann, R. (2019). Self-harm in the Australian asylum seeker population: A national records-based study. *SSM - Population Health, 8*. https://doi.org/10.1016/j.ssmph.2019.100452; Von Werthern, M., Robjant, K., Chui, Z., Schon, R., Ottisova, L., Mason, C., & Katona, C. (2018). The impact of immigration detention on mental health: A systematic review. *BMC Psychiatry*, *18*(1), 382. https://doi.org/10.1186/s12888-018-1945-y

[77] Hajak et al., 2021.

[78] McShane et al., 2025; Spira et al., 2025.

[79] McShane et al., 2025 ; Rast et al., 2024; Spira et al., 2025.

[80] McShane et al., 2025.

[81] EASO, 2021a.

[82] E.g., Al, A. A. (2020). The asylum procedure in Germany: Desperation and uncertainty as risk factors for violence among young adult asylum seekers in collective accommodations. *Journal of Interpersonal Violence*. *37*(7-8), NP4108-NP4132. https://doi.org/10.1177/0886260520957976

[83] van Eggermont Arwidson et al., 2022.

[84] Hynie, M. (2018). The social determinants of refugee mental health in the post-migration context: A critical review. *Canadian Journal of Psychiatry, 63*(5), 297–303. https://doi.org/10.1177/0706743717746666; Ní Raghallaigh, M., Smith, K., & Scholtz, J. (2021). Problematizing parenting: The regulation of parenting practices within reception centres for Syrian refugees in Ireland. *Journal of Refugee Studies*, *34*(3), 3362-3380. https://doi.org/10.1093/jrs/fez110

Length of stay in 'temporary' housing. Research consistently shows that prolonged stays in reception centers and other forms of collective accommodation are associated with long-term consequences for quality of life and exacerbated mental health problems.[85] The longer individuals remain in temporary housing unsuitable for long term use, the more likely they are to experience social isolation, hopelessness, and psychological distress.

Autonomy and control. The ability or inability to make choices about one's daily life is a central mechanism by which housing impacts mental health.[86] Asylum seekers report frustration over inability to choose where they live, improve conditions, or make basic daily choices like food and routine.[87] Restrictions imposed by centres, such as those that limit ability to cook culturally appropriate food, come and go, or have visitors, can deepen distress and lead to feelings of powerlessness.[88] This is especially significant for asylum seekers who have experienced past trauma or other forms of adversity in which they had little control over their outcomes; for these, individuals, regaining control can be a key step in healing, and the inability to do so can compound distress.[89]

Instability due to transfers. Forced residential assignment and frequent transfers between accommodation settings disrupt social networks, reduce the ability to build connections, access services, and pursue work or education, ultimately preventing a sense of belonging and comfort.[90] These unpredictable shifts, often occurring with little notice, contribute to a feeling of 'prolonged temporariness' or being unable to plan for the future, which can be a major sources of stress.[91]

Engagement in meaningful activities. Lack of access to education, employment, or volunteering, whether due to legal restrictions, language barriers, or location, contributes to boredom, frustration, and loss of self-worth.[92] Lack of access to educational and work opportunities may also make it difficult to maintain a future oriented perspective and rather can amplify a tendency to reflect or ruminate on distressing past events. This may be particularly pronounced in settings in which asylum seekers are unable or not permitted to work for a certain period (or at all). The EUAA consultation report noted that some asylum seekers, especially young men, turned to risky or illegal behaviours in the absence of purposeful activities.[93]

Perceived safety. Housing environments characterised by violence and aggression or otherwise perceived as unsafe or threatening can trigger feelings of alienation, fear, and hypervigilance,

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[85] McShane et al., 2025.
[86] Spira et al., 2025; Rast et al., 2024.
[87] Spira et al., 2025; Rast et al., 2024.
[88] EASO, 2020; Spira et al., 2025; Stewart, 2006.
[89] Owen, C., & Crane, J. (2022). Trauma-informed design of supported housing: A scoping review through the lens of neuroscience. *International Journal of Environmental Research and Public Health, 19*(21), 14279. https://doi.org/10.3390/ijerph192114279
[90] FRA, 2019; MHF, 2024; Rast et al., 2024.
[91] McShane et al., 2025; van Eggermont Arwidson et al., 2022.
[92] Mulcaire et all., 2024; Whitehouse et al., 2021.
[93] EASO, 2021b.

especially among asylum seekers with trauma histories.[94] For children, lack of perceived safety is shown to cause restless sleep, nightmares, and behavioral problems.[95] Residents in collective accommodation settings reported fear of harassment and discrimination, especially by women, and reports have linked collective accommodation with increased risk of domestic violence which is in turn associated with heightened distress.[96]

Geographic location, social support, and isolation. The location of accommodation in regard to social networks, health care services, employment, safe recreational and outdoor space and public transport has significant effects on wellbeing.[97] Reception centres that segregate asylum seekers from local communities (whether intentionally or inadvertently) can intensify feelings of "otherness" and discrimination, reducing social connections. Lack of social support from peers, the local community, and professionals can result in loneliness and marginalization, further destabilizing mental health.[98]

Racism, discrimination, and public hostility. A significant body of research highlights the adverse mental health and broader health effects of racism and discrimination experienced by minority groups, including asylum seekers and refugees, finding strong associations between experiences of racism and discrimination and trauma symptomology.[99] The safety and location of asylum accommodation are closely tied to the attitudes of the surrounding community. In recent years, countries such as Ireland and the UK have witnessed a rise in anti-immigration protests, including targeted demonstrations against asylum seeker accommodation centres. These protests are sometimes hostile or violent and are often fueled by misinformation amplified through social media.[100] A 2025 report from the Mental Health Foundation in the UK linked such events to heightened fear, distress, and insecurity among asylum seekers and refugees.[101]

Likewise, instances of interpersonal and systemic racism and discrimination encountered in communities, health systems, and in centres themselves can be highly distressing to residents and, like protests, can trigger past experiences of trauma. Research highlights persistent discriminatory and racist policy and practices against refugees and asylum seekers in European

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[94] Spira et al., 2025.
[95] Ibid.
[96] Gewalt, S. C., Berger, S., Ziegler, S., Szecsenyi, J., & Bozorgmehr, K. (2018). Psychosocial health of asylum seeking women living in state-provided accommodation in Germany during pregnancy and early motherhood: A case study exploring the role of social determinants of health. *PloS one*, *13*(12), e0208007. https://doi.org/10.1371/journal.pone.0208007; Milman & Frederiksen, 2023.
[97] McShane et al., 2025.
[98] EASO, 2020; Spira et al, 2025.
[99] Carter, R. T., Kirkinis, K., & Johnson, V. E. (2020). Relationships between trauma symptoms and race-based traumatic stress. *Traumatology, 26*(1), 11–18. https://doi.org/10.1037/trm0000217; Kirkinis, K., Pieterse, A. L., Martin, C., Agiliga, A., & Brownell, A. (2021). Racism, racial discrimination, and trauma: A systematic review of the social science literature. *Ethnicity & Health*, *26*(3), 392-412. https://doi.org/10.1080/13557858.2018.1514453
[100] MHF, 2025.
[101] Ibid.

healthcare systems at individual and institutional and structural levels.[102] Although systematic research is limited, some reports have likewise described racist comments and harassment from accommodation staff.[103] Asylum seekers may avoid reporting racist crimes or experiences due to concerns about their immigration status, mistrust of authorities, or previous negative experiences with law enforcement.[104]

Suitability to meet cultural, health, family, and other needs. Housing must align with the social, cultural, familial, and personal health needs of residents. Housing that does not respect gender norms or religious practices can increase stress and conflict within living arrangements. Likewise, housing arrangements should meet health needs, for example proximity to relevant healthcare providers (including mental healthcare providers), and provide accommodations for persons with disabilities.[105] Researchers have questioned whether collective accommodation centres are appropriate for families in light of research showing that parents in these settings are disempowered and that staff, who are frequently underqualified, take on a regulatory role in regard to parenting, resulting in negative outcomes for parents and children.[106]

Transition to community after receiving status. The literature highlights that the transition from asylum seeker to refugee status can be highly stressful due limited access to work and education and to the need to move, often rapidly, to private housing with limited supports in place to secure such housing.[107] New refugees may struggle to understand the system to secure adequate housing and in many settings, a lack of affordable or quality social housing exacerbates these challenges, as does discrimination by landlords. For example, in Ireland, newly entitled refugees may struggle to navigate the complex housing system, which is compounded by a critical shortage of affordable social housing and insufficient Housing Assistance Payment (HAP) support.[108] Discrimination by landlords and letting agents has been documented, with some refugees facing repeated

[102] Pattillo, M., Stieglitz, S., Angoumis, K., & Gottlieb, N. (2023). Racism against racialized migrants in healthcare in Europe: A scoping review. *International Journal for Equity in Health*, *22*(1), 201. https://doi.org/10.1186/s12939-023-02014-1; Stevens, A. J., Boukari, Y., English, S., Kadir, A., Kumar, B. N., & Devakumar, D. (2024). Discriminatory, racist and xenophobic policies and practice against child refugees, asylum seekers and undocumented migrants in European health systems. *The Lancet Regional Health–Europe*, *41*. https://doi.org/10.1016/j.lanepe.2023.100834

[103] MHF 2024; Migrant Voice, 2023.

[104] MHF, 2025.

[105] Rast et al., 2024.

[106] Ní Raghallaigh et al., 2021.

[107] Brown, P., Gill, S., & Halsall, J. P. (2024). Housing 'histories' of refugees. In *Refugees and Housing: Policy, Practice and Lived Experience* (pp. 69–93). Palgrave Macmillan. https://doi.org/10.1007/978-3-031-74754-0; Foreman, M. & Ní Raghallaigh, M. (2020). Transitioning out of the asylum system in Ireland: Challenges and opportunities. *Social Work and Social Sciences Review, 21*(1), 34–51. https://doi.org/10.1921/swssr.v21i1.1365; FRA, 2019.

[108] Murphy, K. & Stapleton, A. (2024). *Access to autonomous housing for beneficiaries of International Protection in Ireland*. ESRI Research Series 184, Dublin: ESRI/EMN. https://doi.org/10.26504/rs184

rejections.[109] An ESRI report highlighted that as of January 2024, nearly 6,000 people with protection status remained in Direct Provision in Ireland, and cited challenges such as language barriers, lack of knowledge about the system, mental health problems among asylum seekers, and discrimination in the housing market. This report also underscored the role of isolated reception centres which impact resident employment, mental health, access to services and social connections, as well as insufficient resources for transition services and monitoring of housing outcomes.[110]

In summary, a broad body of international research demonstrates that the nature, quality, and stability of accommodation deeply affect asylum seekers' mental health, showing that housing is not merely a logistical concern but a central social determinant of health.

2.3 Barriers to addressing mental health needs

Despite significant mental health needs among asylum seekers, mental health remains underprioritised in many European countries, with services often predominantly focused on emergency care rather than encompassing a holistic preventative and promotive approach.[111] While many EU+ countries report having "somewhat functioning" systems in place for assessment, referral, specialized care, and case management for applicants with mental health concerns, these systems are frequently fragmented, under resourced, and lacking in coordination and timeliness.[112] In Ireland, similar challenges persist; despite recognition of high psychological vulnerability among asylum seekers, access to timely, culturally appropriate mental health services is severely limited.[113]

Moreover, evidence suggests that even when mental health and psychosocial support services exist, asylum seekers may underutilise them. This can be due to a wide range of factors, many linked to culture and gender, such as financial and transportation constraints, lack of education and awareness regarding available services, family responsibilities, limited participation in public life, mistrust of providers, stigma, and language issues, even when interpreters are available.[114] Mistrust towards "Western systems," including the health sector, can further impede seeking support. Western approaches to mental health treatment and diagnosis can have limitations when applied across cultures due to variations in how distress is understood and expressed.[115]

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[109] European Council on Refugees and Exiles. (2024). *Housing — Republic of Ireland* [Asylum Information Database]**.** https://asylumineurope.org/reports/country/republic-ireland/content-international-protection/housing/

[110] Murphy & Stapleton, 2024.

[111] EASO, 2020.

[112] Ibid.

[113] O'Connell, M., Duffy, R., & Crumlish, N. (2016). Refugees, the asylum system and mental healthcare in Ireland. *BJPsych International*, *13*(2), 35-37. https://doi.org/10.1192/s2056474000001082

[114] Jolof, L., Rocca, P., Carlsson, T. (2024). Trauma-Informed care for women who are forced migrants: A qualitative study among service providers. *Scandinavian Journal of Mental Health, 0(0).* *https://doi.org/10.1177/14034948241237591*; MHF, 2024; Satinsky et al., 2019. Stewart, 2006.

[115] MHF, 2024.

For asylum seekers in some forms of collective accommodation, access to care can be further complicated by an absence of standardised procedures for information sharing and facilitating access to mental healthcare and an overreliance on outreach organisations to do so.[116] Additionally, 'digital exclusion' may occur due to poor internet access and a lack of private space for remote consultations, which are increasingly common.[117] Lack of childcare is a significant barrier, especially among women.[118]

2.4 Staff wellbeing needs

The presence of skilled and empathetic staff is essential to effectively support asylum seekers navigating complex and often distressing systems. However, working in the asylum system, particularly in accommodation and other frontline support roles, can have profound impacts on the wellbeing of staff themselves.[119] These roles are associated with elevated risks of depression, anxiety, or burnout in comparison with staff in other settings.[120] Staff frequently report noticeable changes in how they feel, behave, and act, both at work and in their private lives.[121] These challenges have grave implications for staff and their families and can also impede the ability of staff to provide meaningful, sustained support to asylum seekers. Key factors impacting staff wellbeing include the following:

- **Personal trauma history and exposure to distressing narratives**. Staff, like asylum seekers, may have their own history of trauma and stress, and those who are themselves refugees or migrants are at additional risk.[122] Further, in the course of their work, frontline staff are consistently exposed to distressing accounts of war, torture, and other traumatic events shared by asylum seekers;[123] in EUAA consultations, officers working with asylum seekers have noted daily exposure to traumatic content as a main stressor.[124] This exposure can lead to secondary or vicarious trauma responses, where workers experience symptoms parallel to those of the trauma survivors they assist, including hypervigilance, intrusive

[116] Brookes, R., Longley, N., Eisen, S., & Roberts, B. (2023). Service Provider Views on Mental Healthcare Access for UK Asylum Seekers Residing in Home Office Contingency Accommodation: A Qualitative Research Study. *BJPsych Open*, *9*(S1), S3. https://doi.org/10.1192/bjo.2023.88
[117] Brookes et al., 2023.
[118] Jolof et al., 2024.
[119] Fernandes et al., 2024.
[120] EASO, 2021a.
[121] Ibid.
[122] Roberts et al., 2021.
[123] European Union Agency for Asylum. (2024a). *Mental Health and Well-being of Applicants for International Protection: Part II – Practical guide for implementing mental health and psychosocial support (for first-line officers)*. https://euaa.europa.eu/sites/default/files/publications/2024-11/Practical-guide-mental-health-well-being-applicants-part-ii-first-line-officers.pdf
[124] EASO, 2021a.

thoughts, or altered worldview.[125] These effects may then be compounded by the staff member's own history of trauma, resulting in increased distress.

- **High workload, limited control, and systemic limitations.** A persistently high workload and often unpredictable working environment, due to fluctuating numbers of arrivals and a lack of resources to manage daily tasks, significantly contribute to occupational strain and health risks for staff.[126] Staff in high-intensity, emotionally charged environments, like homeless shelters (which can be analogous in some ways to collective accommodation settings), report higher rates of compassion fatigue and burnout.[127] Poor communication and tense interactions between staff and asylum seekers can contribute to mutual frustration and distrust.[128]
- **Moral distress and 'hostile environments'.** Staff may work in environments that they have little power to change and therefore feel inundated and ineffectual when pressured by asylum seekers to address diverse needs with limited resources.[129] Governmental narratives and policies designed to deter asylum claims, such as rapid expulsions or limited service entitlements, can create moral dilemmas and psychological strain for staff tasked with implementing them.[130] Further, staff may struggle due to discriminatory community attitudes toward migrants, which may also be directed toward them.[131] Anti-migrant activists visiting asylum accommodation and harassing staff and residents can be a significant stressor.[132]
- **Emotional labor and "othering"**: To cope with the emotional burden of their work, staff may engage in emotional regulation or distancing strategies.[133] In some cases, this can lead to 'othering', where residents are framed as fundamentally different or problematic.[134] This process reinforces problematic power hierarchies[135] and asylum seekers have reported mistreatment, discriminatory behavior, or retaliation for complaints by staff, especially in poorly supported or high-stress settings.[136]
- **Lack of supervision and support**: Many staff lack access to adequate supervision, debriefing, or formal mental health support, and opportunities for peer support or reflective practice are often informal or inconsistent.[137] While staff roles demand emotional resilience,

[125] Fernandes et al., 2024; Kirwan, D. & McLaughlin, K. (2024). Trauma-informed care in a homeless women's shelter: A mixed method evaluation. *International Journal of Homelessness*, *4*(2), 171-199. https://doi.org/10.5206/ijoh.2023.3.16652
[126] EASO, 2021a.
[127] Kirwan & McLaughlin, 2024.
[128] Whitehouse et al., 2021.
[129] Fernandes et al., 2024; Whitehouse et al., 2021.
[130] Fernandes et al., 2024; Migrant Voice, 2023.
[131] Pollard & Howard, 2021.
[132] MHF, 2024.
[133] Milman & Frederiksen, 2023.
[134] Ibid.
[135] Whitehouse et al., 2021.
[136] Migrant Voice, 2023.
[137] Mooney et al., 2024.

they are not always supported with the organizational supports and structures needed to sustain this.

- **Inadequate training and other workplace factors:** Staff may also lack adequate training or experience or access to ongoing supervision, placing unfair expectations on them for complex roles.[138] Managers have also rated high levels of bureaucracy, lack of structure at work, and job insecurity as major reasons for stress.[139]

2.5 Supporting staff resilience

Despite consensus that working in the asylum system, particularly in accommodation settings, presents unique and significant challenges, the literature also highlights evidence for staff resilience in this demanding environment, often supported by specific interventions and organisational cultures. The concepts of 'vicarious posttraumatic growth' and 'vicarious resilience' suggest that assisting trauma survivors can be empowering for professionals, providing potential for fostering meaning, purpose, and sustained well-being, even amidst exhausting work environments.[140]

A growing body of literature emphasises the need for adequately resourced and accessible organisational staff wellbeing policies and support packages to facilitate resilience and to prevent secondary and vicarious trauma and burnout.[141] For example, emerging work provides guidance on becoming a "vicarious trauma-informed organization" which recognises the potential negative effects of work with populations exposed to severe adversity and proactively addresses this impact through policies, procedures, and practices.[142] A systematic review found that an organisational culture that recognises the risks of such work and promoted open discussion of these risks is associated with reduced vicarious trauma reactions among staff in qualitative studies.[143] While literature highlights self-care as an important aspect of staff wellbeing, researchers argue that placing the entire responsibility on individual staff to maintain their well-being in the face of secondary trauma is inadequate and that organizational supports are critical.[144]

Organisational supports associated with positive outcomes for staff include trauma-informed training[145] (discussed in detail in the following sections), as well as ongoing capacity building to strengthen job-related knowledge and skills. Facilitating access to mental health and psychosocial support, high-quality supervision, peer support, and training on self-care and boundary setting are

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[138] Ní Raghallaigh et al., 2021.
[139] EASO, 2021a.
[140] Fernandes et al., 2024.
[141] EASO, 2021a.
[142] Office for Victims of Crime. (n.d.). *Vicarious Trauma Toolkit: Vicarious trauma—Organizational readiness guide and compendium of resources*. U.S. Department of Justice, Office of Justice Programs. https://ovc.ojp.gov/program/vtt/vt-org-and-compendium
[143] Sutton, L., Rowe, S., Hammerton, G., & Billings, J. (2022). The contribution of organisational factors to vicarious trauma in mental health professionals: A systematic review and narrative synthesis. *European Journal of Psychotraumatology*, *13*(1). https://doi.org/10.1080/20008198.2021.2022278
[144] Mooney et al., 2024.
[145] MHF, 2024.

all associated with improved staff wellbeing.[146] Providing clear and relevant information packages for applicants on asylum procedures and support services can ease interactions with staff and improve trust.[147] Finally, researchers call for recruitment of diverse and qualified staff, including employment of relevant professionals such as social workers and community workers in accommodation centres, including those with refugee backgrounds.[148]

In summary, the demanding nature of working with asylum seekers, characterised by exposure to people in distress, has inevitable impacts on staff mental health. While these challenges are to be expected even in a well-functioning system, they are often exacerbated by systemic problems such as insufficient human resources, high workloads, inefficient asylum procedures, and poor reception conditions – which affect both staff and residents alike. Addressing these issues requires comprehensive organisational support, including trauma-informed training, psychosocial interventions, as well as policy changes aimed at fostering a more humane and efficient asylum system.[149] Researchers emphasise that this holistic approach is crucial for supporting both asylum seekers and the professionals dedicated to assisting them.[150]

3. The trauma informed approach: Definition, relevance for asylum seekers, and effectiveness

Building on the overview of mental health needs and contributing factors among asylum seekers and staff provided thus far, the current section provides a concise review of the literature on trauma-informed approaches to addressing these needs, as well as limitations in the existing evidence-base.

Terminology and conceptual clarification

Despite increasing use in policy and practice, there is an acknowledged lack of definitional consensus and conceptual clarity regarding the terms Trauma-Informed Approaches (TIA), Trauma-Informed Care (TIC), and Trauma-Informed Practice (TIP). These terms are often used widely and interchangeably, complicating both implementation and evaluation efforts.[151] In brief, based on how these terms are used in the literature, TIA often describes a comprehensive approach, including service delivery as well as an organisational and systemic framework, TIC tends to focus on service delivery and interpersonal interactions, and TIP can refer more specifically to the individual skills and actions of practitioners. However, it is important to reiterate that there is significant overlap and interchangeable use among these terms in practice and literature.[152] In this paper, the term 'TIA' is used broadly to encompass all aspects of implementation of a trauma-

[146] EASO, 2021a; Sutton et al., 2022.
[147] EASO, 2020.
[148] Ni'Raghallaigh et al., 2021.
[149] EASO, 2021b.
[150] van Eggermont Arwidson et al., 2022.
[151] Mooney et al., 2024
[152] Ibid.

informed perspective, however other terms are also applied interchangeably in line with what is used by cited sources.

It is critical to distinguish these terms from 'trauma-focused' or 'trauma-specific' services or interventions. Trauma-focused/specific services are clinical treatments or therapies (e.g., Cognitive Behavioral Therapy (CBT), Narrative Exposure Therapy (NET), and Eye Movement Desensitization and Reprocessing (EMDR)) delivered by mental health professionals to address trauma-related symptoms such as PTSD.[153] In contrast, TIA, TIC, and TIP are organisational and relational approaches designed to prevent harm and support healing environments for all participants, regardless of whether they have trauma-related conditions.[154]

3.2 Defining a trauma-informed approach for asylum seekers

A trauma-informed approach (TIA) is a foundational framework for service design and delivery that recognises the widespread impact of trauma and other adversity and respond in a way that minimises re-traumatization and supports recovery.[155] Rather than asking, *"What's wrong with you?"*, a trauma-informed perspective asks, *"What has happened to you?"* This shift reframes individuals' responses as understandable adaptations to past adversity rather than signs of pathology.[156] Without a trauma-informed lens, asylum processes, particularly those involving repeatedly sharing one's history (e.g., through personal interviews), uncertainty, and perceived hostility, risk causing additional harm. [157] TIA is therefore seen as necessary for policies and practices to "do no further harm."[158]

At its core, TIA involves integrating knowledge of trauma and adversity into all policies, procedures, and practices. It is underpinned by the following key principles: **Safety** (physical and psychological); **Trustworthiness and transparency; Peer support; Collaboration and mutuality; Empowerment, voice, and choice**; and **Recognition of cultural, historical, and gender-specific factors**,[159] each described further below:

- TIA emphasises the creation of **safe, predictable, and supportive environments**, which are crucial for fostering trust and psychological wellbeing. In asylum contexts, this includes ensuring a sense of both physical and emotional safety in accommodation settings and in relationships with staff.[160] This may entail ensuring security in accommodation centres,

[153] Ibid.
[154] Ibid.
[155] SBNI, 2024.
[156] NHS Education for Scotland. (2017). *Transforming Psychological Trauma: A Knowledge and Skills Framework for the Scottish Workforce*. NHS Education for Scotland.
[157] Mulcaire et al., 2024; Omiyefa, S. (2025). Global mental health policy innovations: Investigating trauma-informed care, housing-first models, and refugee interventions. *International Research Journal of Modernization in Engineering Technology and Science, 7*(3).
[158] Daly & Riordan, 2024; McAnallen, A., & McGinnis, E. (2021). Trauma-informed practice and the criminal justice system: A systematic narrative review. *Irish Probation Journal*, *18*, 109–128.
[159] SAMHSA, 2014.
[160] Public Health Wales (PHW) NHS Trust. (2025, March 6). *Creating trauma-informed physical environments: A TrACE guide* [PDF]. ACE Hub Wales / Public Health Wales NHS Trust.; Mulcaire et al., 2024.

eliminating triggers that are reminders of prior traumatic events, and promoting consistency and predictability.[161]

- Establishing **trust and transparency** is a key process, especially for trauma survivors who have experienced betrayal by individuals, authorities, or systems in the past, making it feel dangerous to establish trust in new relationships.[162] Trust-building between staff and asylum seekers requires time, consistency, and relational sensitivity—elements often hard to come by in current systems.[163] Trust building also benefits from accurate and honest information sharing that establishes realistic expectations, for example regarding accommodation conditions, asylum process timelines, and other factors.
- **Peer support,** a fundamental element of trauma-informed care, highlights the value of shared experience and involves facilitating peer-led programs where asylum seekers and/or staff can support each other.[164] Connecting with others who have faced similar challenges can help people to feel understood and less alone, and can also provide opportunities for meaning-making through applying learning from one's own struggles to support others.
- The principle of **collaboration and mutuality** emphasizes the importance of shared decision-making, equal partnerships, and a sense of commonality between service providers and those they serve.[165]
- **Empowerment** is a cornerstone of trauma-informed care. As asylum seekers frequently experience disempowerment, voicelessness, and a loss of agency in past adversities and within asylum systems, TIA responds by prioritizing autonomy, offering meaningful choices, and validating individuals' perspectives. It includes practices that help individuals regain control over their lives, build coping strategies, and access supportive connections.
- Effective TIA must also be **culturally responsive**. Experiences and expressions of trauma vary widely across cultural groups, and Western mental health frameworks and identification approaches may not always align with asylum seekers' own understandings of distress.[166] Research shows that culturally adapted interventions significantly improve outcomes across diverse populations.[167] This includes the use of culturally appropriate assessment tools and the inclusion of interpreters as cultural mediators to enhance both

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[161] SBNI, 2024.
[162] NHS Education for Scotland. (2024). *Transforming Psychological Trauma: National Trauma Training Programme online resources* [PDF]. National Trauma Transformation Programme.
[163] MHF, 2024 ; Rast et al., 2024.
[164] European Union Agency for Asylum (EUAA) (2024b). *Guidance on mental health and well-being of applicants for international protection: Part III – Toolbox to support those working in the first line*. EUAA. https://euaa.europa.eu/publications/mental-health-well-being-applicants-part-iii-toolbox
[165] SBNI, 2024.
[166] Magwood, O., Kassam, A., Mavedatnia, D., Mendonca, O., Saad, A., Hasan, H., Madana, M., Ranger, D., Tan, Y., & Pottie, K. (2022). Mental health screening approaches for resettling refugees and asylum seekers: A scoping review. *International Journal of Environmental Research and Public Health*, *19*, 3549. https://doi.org/10.3390/ijerph19063549
[167] Apers et al., 2023; Bokore, N., McGrath, S. L., McGuire, P., Karod, A., Rahimpour, M., & Asokumar, A. (2023). Developing a Trauma-Informed Culturally-Based Intervention (TICBI) Approach for Refugee Resettlement Practices. *International Journal of Social Work, 10*(1). https://doi.org/10.5296/ijsw.v10i1.20561

communication and trust.[168] Training for staff should integrate cultural competence as a core element.[169]

Researchers and advocates highlight that achieving these outcomes requires both staff training and broader systemic change, including review and revision of the policies that shape how services are delivered. Staff must be trained to understand how trauma affects memory, communication, and behavior, and to respond with empathy and flexibility.[170] This shift moves services away from rigid, bureaucratic interactions and toward more compassionate, person-centered care. However, even well-trained staff cannot be effective if policies and procedures remain misaligned with trauma-informed principles. Policies that generate uncertainty, limit autonomy, or foster punitive conditions can cause and reinforce trauma and undermine recovery. **Thus, systems-level policy reform is not an optional add-on—it is an essential pillar of trauma-informed implementation**.[171]

Ongoing efforts to support system-level reform include for example, those undertaken by the UK Home Office's Asylum Mental health and Wellbeing team which is actively working to support adoption of an overall culture of trauma-informed care by rolling out internal training developed in partnership with lived experience groups and commissioning related research which resulted in policy recommendations.[172] The Safeguarding Board of Northern Ireland (SBNI) has done extensive work focused on development of trauma-informed systems in Northern Ireland, including the development of a trauma-informed toolkit[173] and a recent review with Ulster University exploring the experiences of five community, justice, and health organisations implementing an organisational TIA.[174] At the EU level, the European Union Agency for Asylum has developed a multi-part guide aimed at embedding mental health and well-being-informed practices into asylum systems. This guidance emphasises the need for cross-sectoral coordination, skilled staffing, designated

[168] González Campanella, A. (2023). Availability and acceptability of interpreting services for refugees as a question of trauma-informed care. *Interpreting and Society: An Interdisciplinary Journal*, 3(1), 75–94. https://doi.org/10.1177/27523810231159174; Magwood et al., 2022.
[169] Teixeira-Santos, L., Bobrowicz-Campos, E. & Abreu, W. (2024). How can we help? A training needs assessment for non-health professionals and volunteers working with asylum seekers and refugees. *J Public Health (Berl.)*. https://doi.org/10.1007/s10389-024-02216-z; Vindevogel, S., Boumahdi, Y., Alabbas, F., & Magerman, J. (2025). Transcultural mental health and psychosocial support in asylum reception centres: A Delphi review of guidelines for the frontline workforce. *International Journal of Migration, Health and Social Care*. https://doi-org.colorado.idm.oclc.org/10.1108/IJMHSC-12-2024-0126.
[170] Mulcaire et al., 2024; Teixeira-Santos et al., 2022.
[171] Mulcaire et al 2024.
[172] UK Home Office. (2024, October 16). *Asylum mental health: Workstreams, tools and case studies* [PDF]. GOV.UK. https://www.gov.uk/government/publications/asylum-mental-health-workstreams-tools-and-case-studies
[173] SBNI, 2024
[174] Safeguarding Board for Northern Ireland, Trauma Informed Practice Committee. (2025). *Developing trauma informed systems in Northern Ireland: Executive summary*. Safeguarding Board for Northern Ireland. https://www.safeguardingni.org/resources/developing-trauma-informed-systems-northern-ireland-executive-summary

funding, and national mandates to ensure meaningful and sustainable adoption of trauma-informed strategies at the systems level.[175]

3.2.1 Adaptations of TIA for asylum seekers: Cross-cultural trauma-informed care and trauma-informed housing design

TIA has been adapted in various ways to meet the needs of asylum seekers and other unique groups. Two approaches especially relevant for asylum seekers are culturally-based or cross-cultural trauma-informed approaches,[176] and trauma-informed housing design.[177]

Cross-cultural trauma-informed care is an emerging approach developed to address the mental health needs of refugee and migrant populations within resettlement contexts by explicitly integrating cultural considerations into all levels of service delivery.[178] It is grounded in two core pillars: the trauma-informed pillar, which acknowledges that trauma can affect entire communities and requires systemic responses; and the culture-informed pillar, which recognises the influence of cultural beliefs on trauma experiences and help-seeking behaviors.[179] Together, these pillars inform stratified, culturally-responsive interventions designed to foster healing partnerships between providers and refugee communities, while addressing the risk of misdiagnoses, mistrust, and disengagement from care.[180]

Implementation of cross-cultural trauma-informed care takes various forms, including interactive training curricula, culturally-based intervention models, family- and community-based approaches, and trauma-informed environmental design. Training programs typically combine knowledge (e.g., refugee trauma, cultural idioms of distress) with practical skills (e.g., mindfulness, psychoeducation), and emphasise shifting from deficit-based to trauma-informed perspectives.[181] A recent Delphi review developed guidelines for transcultural mental health and psychosocial support in asylum reception centres, highlighting themes such as building trust and rapport, cultural diversity and mental health, building strengths and resources, ethically-informed and culturally sensitive communication, and human rights and social justice.[182] Specific culturally-based interventions like the Trauma-Informed Culturally-Based Intervention (TICBI) model are

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[175] European Union Agency for Asylum. (2024c). *Practical guide on mental health and well-being of applicants for international protection: Part I – for senior management* [PDF]. Publications Office of the European Union. https://euaa.europa.eu/sites/default/files/publications/2024-11/Practical-guide-mental-health-well-being-applicants-part-i-senior-management.pdf

[176] Bokore, et al., 2023.

[177] Owen & Crane, 2022.

[178] Bokore et al., 2023; Im, H., & Swan, L. E. (2020). Capacity building for refugee mental health in resettlement: Implementation and evaluation of cross-cultural trauma-informed care training. *Journal of Immigrant and Minority Health, 22*(5), 923–934. https://doi.org/10.1007/s10903-020-00992-w.; Im, H., & Swan, L. E. (2022). "We learn and teach each other": Interactive training for cross-cultural trauma-informed care in the refugee community. *Community Mental Health Journal*, *58*(5), 917-929. https://doi.org/10.1007/s10597-021-00899-2

[179] Im & Swan, 2020, 2022.

[180] Omiyefa, 2025; Burgund Isakov & Marković, 2024.

[181] Im & Swan, 2020, 2022.

[182] Vindevogel et al., 2025.

developed through community-based participatory research and incorporate spiritual and cultural values to enhance relevance and engagement.[183]

Evidence supporting cross-cultural trauma informed care highlights improvements in provider knowledge, empathy, and trauma responsiveness, particularly in refugee care contexts.[184] Studies show enhanced engagement, reduced barriers to care, and better treatment outcomes when services are culturally adapted.[185] Integrating cultural and religious elements into care is credited by participants as a source of strength and resilience.[186] Nonetheless, challenges remain, including definitional ambiguity, limited system-level outcome measures, methodological heterogeneity, and the complexity of culturally tailoring interventions across diverse populations.[187]

Trauma-informed housing design. As described earlier, housing is a critical social determinant of health, and its conditions play a pivotal role in shaping the mental health and well-being of asylum seekers.[188] Trauma-informed design is a burgeoning field that specifically targets the built environment to support well-being and alleviate the physical, psychological, and emotional impacts of trauma.[189] Even small changes in the physical environment can have a significant impact on how people interact with and experience a space.[190]

Trauma-informed housing design emphasises safety, autonomy, dignity, and well-being. Ensuring both physical and psychological safety is foundational; environments should minimise exposure to environmental stressors and avoid features that might trigger traumatic memories.[191] For instance, poor living conditions, such as an inability to lock doors, can heighten feelings of vulnerability and distress.[192] Equally important is the promotion of autonomy and control.[193] As described earlier, asylum seekers often face profound disempowerment in their daily lives, including limited control over personal routines, finances, or food choices. Housing design can counteract this by

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[183] Bokore et al., 2023.
[184] Im & Swan, 2020, 2022; Palnati, M., Martinez, A. E., Audil, A., Tovar, E., Macfarlane, P., Gerber, M., & Wagner, K. (2024). Simulation-based trauma-informed care education instills empathy and improves clinician practices towards refugee and migrant populations. *MedEdPORTAL*, *20*, 11475. https://doi.org/10.15766/mep_2374-8265.11475.
[185] Michael, L., Marchelewska, E., Omidi, N. & Stewart, I. in collaboration with project participants and facilitators. (2024). Wellbeing and Integration program for women. Evaluation Report. Cairde.; NHS Scotland, 2024.
[186] Bokore et al., 2023.
[187] Champine, R. B., Lang, J. M., Nelson, A. M., Hanson, R. F., & Tebes, J. K. (2019). Systems measures of a trauma-informed approach: A systematic review. *American Journal of Community Psychology, 64*(3–4), 418–437. https://doi.org/10.1002/ajcp.12388; Fernandez et al., 2023; Thirkle, S. A., Kennedy, A., & Sice, P. (2021). Instruments for exploring trauma-informed care. *Journal of Health and Human Services Administration*, *44*(1), 30-44. https://doi.org/10.37808/jhhsa.44.1.2.
[188] Brake, et al, 2023.
[189] Owen & Crane, 2022.
[190] PHW NHS Trust, 2025.
[191] Ibid.
[192] Rast et al, 2024.
[193] Owen & Crane, 2022.

incorporating features that enable choice and self-reliance, such as private cooking facilities or flexible use of space.

Privacy and dignity are also central to trauma-informed design. Overcrowded accommodations and shared living arrangements, especially in detention-like settings, are consistently associated with increased psychological distress, interpersonal conflict, and a diminished sense of security.[194] Designing spaces that afford personal privacy can help foster a sense of stability and reduce tension.[195] Additionally, environments that promote health and well-being through cleanliness, natural light, access to green space, and areas designated for self-care are linked to improved mental health outcomes.[196]

Avoiding institutional features is another important consideration. Facilities such as former military barracks or centralised reception centers can resemble detention environments and evoke past trauma, undermining feelings of safety and autonomy. Finally, the involvement of individuals with lived experience in the design and planning process is essential. Incorporating their perspectives ensures that the resulting spaces are person-centered and better aligned with the real needs and preferences of those they aim to support.[197]

3.3 Effectiveness of trauma-informed approaches: General outcomes

3.3.1 Methodological challenges and limitations

Before detailing results, it is important to note that the literature consistently highlights significant methodological limitations in the existing research evaluating the effectiveness of trauma-informed approaches.[198] As mentioned earlier, the lack of standardisation and clarity regarding the terms TIA, TIC, and TIP complicates research and evaluation efforts.[199] Many studies do not explicitly define or operationalise the approach being implemented and the resulting heterogeneity makes it difficult to compare findings across studies and establish a consistent evidence base.[200] Researchers also note that even in studies that stated they were applying the SAMHSA definition of TIA, definitions varied, with some only referring to one or two of the principles and others not using any of the principles.[201]

Many studies lack rigorous designs such as randomised controlled trials or other methodologies incorporating comparison groups or longitudinal designs, and rather depend on retrospective designs, often with a small sample sizes.[202] A systematic review noted that the low quality and high

[194] McShane et al., 2025.
[195] Owen & Crane 2022.
[196] Owen & Crane 2022; PHW NHS Trust, 2025.
[197] PHW NHS Trust, 2025.
[198] Mahon, 2022; McAnallen & McGinnis, 2021; Mooney et al., 2024.
[199] McAnallen & McGinnis, 2021; Mooney et al., 2024.
[200] Mooney et al., 2024.
[201] Berring, L. L., Holm, T., Hansen, J. P., Delcomyn, C. L., Søndergaard, R., & Hvidhjelm, J. (2024). Implementing trauma-informed care—Settings, definitions, interventions, measures, and implementation across settings: A scoping review. *Healthcare, 12*(9), 908. https://doi.org/10.3390/healthcare12090908.
[202] Mooney et al., 2024; Irish Probation Journal, 2021.

heterogeneity of studies on organisational TIC interventions make it difficult to draw conclusions with certainty.[203]

There are also concerns regarding the validity and reliability of outcome measures and instruments.[204] The availability and validation of instruments specifically designed to measure TIA or TIC are still developing, and if and how trauma-informed approaches can be effectively measured continues to be debated.[205] It is unclear how best to measure the extent to which an organisation or system is truly trauma-informed and distinct from traditional practices.[206] As a result, the use of ad hoc surveys and self-report measures with potential bias is common.[207] More work is needed to assess and report on the psychometric properties of existing measures so that researchers can make educated decisions about their use.[208]

Finally, there is a scarcity of rigorous evaluations in certain sectors, such as education, and evaluations in emerging areas, like trauma-informed suicide prevention, are in their early stages with inconclusive results.[209] Likewise, research on implementing TIC at systemic level is still at an early stage, with a scarcity of empirical evidence on *how* it is implemented in systems (e.g., healthcare, asylum/immigration, child welfare systems).[210]

In summary, despite promising trends (detailed below), the strength of the empirical evidence is limited by ongoing methodological challenges and the lack of consistent terminology and measurement.[211] The literature calls for more rigorous research, including experimental designs and validated measures, to build a more solid evidence base.[212]

3.3.2 Reported outcomes

Despite these methodological challenges, the literature identifies a range of potential positive outcomes attributed to implementing TIA. There is growing evidence suggesting that trauma-informed systems and practice can lead to positive outcomes at the levels of **individual service users**, at the levels of **staff** trained in TIA, and at **organisational/systemic** level.[213]

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[203] Fernandez et al., 2023.
[204] McAnallen & McGinnis, 2021; Mooney et al., 2024.
[205] Champine et al, 2019; Thirkle et al., 2021.
[206] Champine et al., 2019.
[207] Mooney et al., 2024.
[208] Champine et al., 2019.
[209] Mooney et al., 2024.
[210] Mahon, 2022.
[211] Fernandez et al., 2023; Goodman, L. A., Sullivan, C. M., Serrata, J., Perilla, J., Wilson, J. M., Fauci, J. E., & DiGiovanni, C. D. (2016). Development and validation of the Trauma-Informed Practice Scales. *Journal of Community Psychology*, *44*(6), 747–764. https://doi.org/10.1002/jcop.21799; Mahon, 2022; McAnallen & McGinnis, 2021; Mooney et al., 2024.
[212] Champine et al., 2019; Fernandez et al., 2023; Goodman et al., 2016; McAnallen & McGinnis, 2021; Mooney et al., 2024.
[213] Mooney et al., 2024.

In a detailed 2024 report for the Safeguarding Board of Northern Ireland (SBNI), Mooney and colleagues summarise outcomes of TIA across sectors, drawing from both international literature through a rapid evidence assessment and empirical fieldwork conducted in Northern Ireland:

- At the **service user and family level**, reported outcomes include increased satisfaction with services, where individuals feel more valued, heard, and understood. Clinically, TIA have been associated with improved psychological and behavioral outcomes such as reduced trauma symptoms (e.g., PTSD), improved quality of life, higher self-esteem, enhanced family functioning, and better educational attainment. There is also moderate evidence suggesting positive effects on child wellbeing, including reductions in behavioral problems and PTSD symptoms. Parents and caregivers benefit from improved confidence, decreased caregiving-related stress, and strengthened family safety and functioning. Service users also report feeling safer and more engaged, both in terms of attendance and active participation, reflecting greater agency and voice within services.[214]
- In terms of **staff outcomes**, at post-training, staff frequently report enhanced knowledge, attitudes, and beliefs regarding trauma and its impacts. There is evidence of increased confidence, readiness, and improved self-reported practices, alongside greater satisfaction with training programs. Staff also note better understanding of service users' needs, improved relational skills, and a stronger capacity to respond to trauma in intentional and supportive ways. Additionally, the adoption of trauma-informed principles is linked to enhanced staff morale, job satisfaction, self-awareness, and self-care, as well as reduced levels of vicarious trauma and workplace stress. Improved team relationships and reductions in staff absenteeism and burnout are also reported, suggesting trauma-informed care can foster healthier and more sustainable working environments.[215]
- At the **organisational and systemic level**, trauma-informed approaches have been associated with a range of operational improvements. These include cost savings, increased quality of care, and improved participant engagement with services, such as higher attendance and better compliance with treatment. In youth justice settings, TIA has contributed to reductions in violent behavior and decreased reliance on coercive interventions like restraints and seclusion. In child welfare systems, outcomes include greater placement stability and reduced distress from frequent moves. Healthcare systems have reported enhanced quality of care, higher rates of follow-up on outpatient referrals, and less time spent in restraints during mental health crises. Educational institutions adopting trauma-informed practices have seen decreased suspension rates and fewer behavioral incidents.[216]

[214] Ibid.
[215] Ibid.
[216] Ibid.

3.4 Effectiveness of trauma-informed approaches: Asylum seeker/refugee outcomes

While there is strong consensus on the importance and potential benefits of implementing TIAs in asylum settings to prevent harm and improve the experience of asylum seekers, there is very limited direct evidence specifically evaluating the measured outcomes of TIA implementation within asylum contexts or in accommodation centers on the mental health of the asylum seekers housed there (e.g., measuring a reduction in PTSD or depression rates across a center population after TIA implementation).[217] Rather, the literature often focuses on the negative impact of the absence of trauma-informed approaches[218] and on the principles that should guide practice.[219] Studies on TIA for forced migrant families have also tended to focus more on the experiences of trauma than on the approaches to address it.[220] In some cases, there are existing evaluations of interventions like mental health screening programs which highlight considerations like cultural and psychological safety to prevent re-traumatization, but are not evaluations of full organisational TIA implementation.[221] In recognition of this gap, researchers have called for assessment of the efficacy of interventions specifically for enhancing mental health and well-being during the asylum process, including trauma-informed training, culturally tailored services, and peer support programs.[222]

In regard to **service user outcomes**, some conclusions can be drawn from studies in analogous populations. A mixed-methods evaluation of a TIC training in a female-only homeless shelter in Ireland (which can be considered an analogous setting given vulnerabilities and congregate living) showed a statistically significant reduction in incident severity and a 50% reduction in calls to emergency medical services post-TIC training.[223] While not asylum-specific, this demonstrates measurable organisational improvements in terms of improved safety and reduced crisis interventions in a collective accommodation setting for a vulnerable population.

Several studies have assessed TIA training outcomes for **staff that support asylum seekers,** finding positive effects on knowledge, attitudes, and practice. Cross-Cultural Trauma-Informed Care (CC-TIC) training for refugee mental health significantly improved providers' knowledge of trauma impacts, cultural expressions of trauma, and culturally-responsive trauma-informed care.[224] Simulation-based TIC education positively influenced clinicians' knowledge and attitudes regarding TIC for displaced peoples, leading them to express greater willingness to incorporate TIC into clinical practice and self-report percentage increases in behaviors that promote equitable care.[225] In a homeless women's shelter, TIC training resulted in increased staff trauma understanding,

[217] Omiyefa, 2025; Daly & Riordan, 2024; Mulcaire et al., 2024.
[218] Omiyefa, 2025.
[219] Daly & Riordan, 2024; Mulcaire et al., 2024.
[220] Bokoro et al., 2023.
[221] Magrood et al., 2022.
[222] Hajak et al., 2021.
[223] Kirwan & McLaughlin, 2024.
[224] Im & Swan, 2020.
[225] Palnati et al., 2024.

confidence, and competence, fostering healing relationships and enhanced self-care for staff.[226] A TIC training provided to oral healthcare professionals in Australia with the aim of enhancing their ability to provide culturally safe and responsive care to refugee and asylum seekers was found to increase staff confidence and knowledge regarding TIC, suggesting its potential to improve healthcare interactions and outcomes for a vulnerable patient group.[227]

As part of an impact and process evaluation of TIP training conducted for UK Home Office Staff,[228] researchers found that understanding of TIP increased immediately after the training and remained higher than baseline six months later. Many participants found it difficult to recall specific elements of the TIP sessions, though interactive components were better recalled. The vast majority (89%) of staff reported that they planned to make changes immediately following the training and a third shared that they had in fact made changes related to TIP when surveyed six months later. Interviewing techniques and communication with asylum seekers were most commonly reported changes.

3.5 Barriers and facilitators

Barriers. While TIA is widely recognised as crucial for supporting asylum seekers, researchers observe that its implementation and effectiveness are subject to several limitations and barriers. A significant limitation is the **lack of a coherent conceptualization** or definitional consensus across the literature.[229] This conceptual confusion can lead to wide variation in how TIAs are interpreted, adopted, and implemented across different settings and organisations.[230] The approach is sometimes described as a "fuzzy and complex concept" with a lack of focus on practical and tangible outcomes.[231] However, some level of model 'flexibility' may be intentional and can be seen a strength that allows TIA to be highly adaptable according to contextual needs (despite challenges that this may bring for evaluation). Moreover, some of this criticism may be linked to the reality that TIA is "not a one-off activity" or a "standalone intervention."[232] Instead, it requires a systemic organisational transformation, involving culture change and ongoing work at all levels of the hierarchy, rather than merely training or screening, and this inherent complexity makes comprehensive implementation challenging.[233]

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[226] Kirwan & McLaughlin, 2024.
[227] Kelton, S., Marcus, K., Liston, G., Masoe, A., & Sohn, W. (2022). Refugee and Asylum Seeker Trauma Informed Care Training for Oral Healthcare Professionals in NSW, Australia. *Frontiers in Oral Health*, *3*, 907758. https://doi.org/10.3389/froh.2022.907758
[228] UK Home Office. (2025). Trauma-Informed Practice training evaluation: Awareness and Leadership TIP training module evaluation. Revealing Reality. UK Home Office. (PPT Slides, unpublished); UK Home Office, 2024.
[229] Champine et al., 2019.
[230] Mooney et al., 2024.
[231] Thirkle et al., 2021.
[232]Mooney et al., 2024; SBNI, 2024.
[233] Mooney et al., 2024.

Some implementers have observed that the **term "trauma-informed" can itself be a barrier**, as the focus on trauma can be understood as overly clinical by some actors.[234] In fact, in practice TIA often entails focus on adversities broadly, including but also moving beyond trauma to other forms of adversity, and is focused on wellbeing of all stakeholders (asylum seekers and staff), not specifically on treatment of people with mental health conditions. In some settings, these concepts may benefit from a reframing to increase clarify and gain buy-in,[235] for example as a "wellbeing-focused" or "MHPSS-focused" approach.

A recurring challenge involves **staff reluctance** and lack of preparedness. Many frontline workers report feeling ill-equipped to engage on the topic of trauma or respond to disclosures, citing fears of offending or retraumatizing service users or "opening a can of worms" without the capacity to provide adequate support.[236] Staff may also fear causing themselves distress, particularly when they struggle with own stressors, trauma histories, and mental health reactions.[237] Resistance can also be compounded by perceptions that TIA is either "not core business" or is already embedded in current practice, coupled with overwhelming workloads and time constraints.[238] These challenges are intensified by recruitment and retention and staff wellbeing difficulties across the asylum and social service workforce.

Staff reluctance may also be related to another key barrier, the **lack of clear guidance, protocols, and insufficient training**.[239] Many staff lack a consistent understanding of what trauma-informed practice entails, what constitutes effective training, and how to respond appropriately to trauma disclosures. Inadequate, inconsistent, or one-off training without necessary follow-up hinders implementation fidelity and may result in poor or harmful practice.[240]

Resource limitations present another major barrier. Service providers across sectors frequently report insufficient organisational infrastructure, limited funding, high caseloads, and inadequate staffing, all linked to a lack of dedicated staff time for introducing new practices or reforming systems, especially in community and voluntary services reliant on short-term funding.[241] These factors in turn associated with burnout and poor staff retention. These financial and operational constraints are further exacerbated by broader political and economic pressures that deprioritise mental health and psychosocial support for displaced populations. There is a risk that TIA

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[234] Ibid.
[235] Ibid.
[236] Mahon, D. (2022). Implementing Trauma Informed Care in Human Services: An Ecological Scoping Review. *Behavioral Science*, 12, 431. https://doi.org/10.3390/bs12110431; Mooney et al., 2024; Murphy, R., Murphy, M., Ali, A., Sheaf, G., Ó Súird, M., Ward, M. E., McGarry, S., Ní Cheallaigh, C., Shields, D., Geary, U., Ryan, M., Rivest-Beauregard, M., & Vallières, F. (2025). *Barriers and facilitators affecting the implementation of trauma-informed care within healthcare settings: A systematic scoping review* [Unpublished manuscript]. Trinity College Dublin.
[237] Fernandes 2025; Im & Swan 2020; Mooney et al., 2024.
[238] Mooney et al., 2024.
[239] Ibid.
[240] Im & Swan 2020; Mahon 2022; Pollard & Howard, 2021.
[241] Bokoro et al., 2023; Murphy et al., 2025.

implementation can become "tokenistic" or a "tick box" exercise if not adequately resourced and supported, leading to inconsistencies between ambitions and allocated resources.[242]

Compounding these issues is the **incompatibility between existing systems and trauma-informed principles**. Many institutional structures and policies, particularly in health, justice, and migration sectors, are legacy systems that are rigid, bureaucratic, and fundamentally at odds with the values of trauma-informed care.[243] For instance, the traditional health system's tendency to pathologise symptoms and the justice system's punitive nature can clash with TIA principles.[244] As detailed earlier, the asylum determination process has been described as "traumagenic," sometimes involving repeated, disbelieving interviews and poor accommodation conditions that can trigger past trauma.[245] Policies such as the UK's "hostile environment" approach which was developed in the early 2010's to deter people arriving "irregularly" from entering the UK can further erode trust, restrict access to services, and create a climate of fear around data sharing, deterring help-seeking and increasing distress.[246]

Cultural responsiveness and communication challenges also impede effective implementation. Many trauma-informed models are rooted in Western conceptualizations of trauma, often failing to account for refugees' diverse cultural frameworks and expressions of distress. Without culturally adapted approaches, asylum seekers may feel misunderstood, anxious, or disengaged.[247] Language barriers further complicate access to care, especially when professional interpreters are unavailable or inadequately trained. Miscommunication during sensitive interactions can lead to dissatisfaction or even retraumatization, particularly when informal or unqualified interpreters are used.

A lack of robust monitoring and evaluation also constrains the development of effective TIA programmes.[248] The literature highlights a paucity of rigorous, large-scale studies measuring the long-term impacts of trauma-informed initiatives in asylum contexts. Methodological weaknesses, including small sample sizes, over-reliance on self-report data, and heterogeneous populations, make it difficult to draw clear conclusions about efficacy.

Facilitators. Despite these barriers, several facilitators can enhance the implementation of TIAs for asylum seekers. Foremost among these is **strong leadership commitment and organisational buy-in**, which drives system-level change and resource allocation.[249] Cultivating a supportive organisational culture, grounded in open communication and staff wellbeing supports is critical to

[242] Mooney et al., 2024.
[243] Ibid.
[244] McAnallen & McGinnis, 2021; Mooney et al., 2024.
[245] MHF, 2024.
[246] MHF, 2024 ; Mulcaire et al., 2024; Pollard & Howard, 2021.
[247] Im & Swan, 2020.
[248] Mooney et al., 2024.
[249] Mooney et al., 2024; Murphy et al., 2025.

ensure staff engagement.[250] The provision of adequate staffing and funding, along with ongoing workforce training, reflective supervision, and peer support forums, are also key enablers.

Service user engagement is another important facilitator. Involving asylum seekers in the design and feedback processes of services can improve relevance and trust.[251] Developing a shared understanding and language around mental health and wellbeing among staff, clients, and organisations supports more consistent practice.[252] **Cross-sectoral collaboration and partnerships**, particularly with social services, legal aid, education, and healthcare, enable coordinated, holistic care.

In their scoping review of TIC in healthcare systems, Murphy and colleagues emphasise the importance of **reflective processes** at all levels of implementation.[253] This may include **regular data collection and evaluation** to monitor uptake and outcomes and encourage accountability. Further, contributing to a growing evidence base, although still limited, helps legitimise TIA implementation and can increase staff confidence.[254]

In sum, while the promise of trauma-informed approaches for asylum seekers is well-recognised, implementation remains challenged by individual, organisational, systemic, and cultural barriers. Moving from aspiration to practice requires not only appropriate funding and training, but a fundamental shift in institutional culture, policy coherence, and service design.

4. Recommendations for trauma-informed training for staff of accommodation centres

Drawing on the evidence outlined thus far, this section outlines recommended components for a TIA training for staff engaged in supporting asylum seekers, particularly in accommodation settings. Researchers emphasise that becoming trauma-informed should be viewed as an ongoing journey of organisational transformation, not a one-off event.[255] Still, training for all staff, from managers to frontline staff, is considered the foundation for effective TIA implementation. Training can take a step-wise approach, with certain topics appropriate for all staff, others for frontline staff, and still others specific to managers and supervisors. Potential training modules are described below.

4.1 Recommended training outline

Module I. Introduction to TIA (knowledge-based training for all staff)

[250] Mooney et al., 2024.
[251] MHF, 2024.
[252] Mooney et al., 2024.
[253] Murphy et al., 2025.
[254] Mooney et al., 2024.
[255] Mooney et al., 2024; Trauma Informed Oregon. (2016). *Roadmap to trauma-informed care*. https://traumainformedoregon.org/implementation/implementation-and-accountability-overview/roadmap-to-trauma-informed-care/; SBNI, 2024.

This initial training module should be mandatory for all staff, including frontline officers and support staff (e.g., reception officers, security, cooks, housekeeping, etc.), managers and supervisors, and owners of accommodation centres, to foster a common language, impart foundational knowledge, and demonstrate organisational commitment.[256]

1. **Understanding adversity and its impact on wellbeing**:

- **Defining adversity, trauma, stress, loss and grief**: Introduce adversity as a broad range of distressing experiences that can significantly impact individuals across the life span, including adverse childhood experiences (ACEs) and traumatic and stressful events during pre-migration, transit, and post-migration stages.[257]
- **Identities and risk and protective factors**: Introduce awareness of risk for particular groups of asylum seekers, such as survivors of torture, sexual violence, human trafficking, domestic violence, as well as minority and marginalised groups. This should include attention to gender-related adversities such as domestic violence, sexual violence during migration journeys, and other forms of gender-based violence and oppression.[258] It should also include focus on cultural diversity and mental health, including how cultural factors may influence manifestation of mental health reactions and help-seeking.[259]
- **Post-migration stressors**: Explain how asylum processes, accommodation conditions and instability, and related factors such as lack of access to educational and work opportunities can compound stress and trauma or cause further distress.[260] This should include focus on effects of racism and discrimination, including anti-immigrant sentiment and protests, as well as acts of racism by service providers.
- **Impact on various domains**: Explain how trauma and other forms of adversity can affect mental health, physical health, capacity for learning, emotional regulation, relationships, and social functioning, highlighting that individuals respond differently; some manage well and may not require targeted intervention while others experiencing more distress would benefit from specialised care.[261] Regardless, a trauma-informed approach is important for *all* individuals.
- **Barriers to service engagement**: Discuss how trauma and other factors can create barriers for individuals in accessing and engaging effectively with services.

2. **Staff wellbeing**

- **Identification of workplace stressors and protective factors** in accommodation center settings and impact on staff wellbeing.

[256] Mooney et al., 2024.
[257] UK Home Office, 2024.
[258] Jolof et al., 2024.
[259] Vindevogel et al., 2025.
[260] Ibid.
[261] NHS Education for Scotland, 2017.

- **Understanding burnout, secondary/vicarious trauma, and work satisfaction**: Recognizing, preventing, mitigating, and responding to burnout and secondary traumatic stress, and enhancing work satisfaction among staff.

3. **Introducing a Trauma-Informed Approach**

- **Definition and differentiation**: Clearly define trauma-informed approach (universal approach) and differentiate from trauma-focused services (specialised treatment), with the training focusing on the former and providing guidance on referral for the latter.[262]
- **"What happened to you?" vs. "What's wrong with you?"**: Emphasise this fundamental paradigm shift in understanding behavior.[263]
- **Core Principles of a Trauma-Informed Approach (The 4 Rs & 6 Principles)**:

The "Four Rs"[264]:

- **Realise** the widespread impact of trauma and other forms of adversity and potential pathways to recovery.
- **Recognise** the signs and symptoms of trauma in individuals and groups.
- **Respond** by fully integrating knowledge about trauma into practices and policies.
- Actively **Resist re-traumatization**.

The "Six Principles"[265]: Staff should understand how to embed these into daily interactions,

- **Safety**: Ensuring physical and psychological safety for all, including creating stress-reducing physical spaces.
- **Trustworthiness and Transparency**: Building rapport, clear and consistent communication, being transparent about processes and limitations.
- **Peer Support**: Recognizing the value of shared experiences and connections for recovery.
- **Collaboration and Mutuality**: Working in partnership, empowering individuals to make choices, shared decision-making.
- **Empowerment, Voice, and Choice**: Supporting agency and autonomy and valuing and validating individual strengths.
- **Cultural, Historical, and Gender Issues**: Tailoring responses to cultural backgrounds, understanding cultural expressions of distress, and promoting anti-discriminatory practices.[266]

4. **How TIA can support staff wellbeing**

[262] Ibid.
[263] EUAA, 2024b.
[264] SAMHSA, 2014.
[265] Omiyefa, 2025; SAMHSA, 2014; SBNI, 2024.
[266] Im & Swan, 2020; Vindevogel et al., 2025.

- The role of the above **principles** and **organisational, team, and individual (self-care)** level supports in enhancing staff wellbeing.

Module II. Developing Trauma-Skilled Practice (For Frontline Staff and Supervisors)

This level builds on foundational knowledge, focusing on practical application in daily interactions that staff may have with residents and with each other.[267]

1. **Communication and Relational Skills**:
   - **Empathy and non-judgment**: Training in active and reflective listening, responding without criticism or blame.[268]
   - **Sensitive language**: Using non-stigmatizing and culturally appropriate language.[269]
   - **Building trust**: Strategies for establishing safe, collaborative working relationships with appropriate professional boundaries.[270]
   - **Responding to disclosures**: Guidance on how to make space for and respond to spontaneous or prompted disclosure (e.g., of abuse or trauma) in a trauma-informed way, understanding that some individuals may not want intervention.[271] This includes clear protocols for recording and sharing information when risk is ongoing.
   - **Psychoeducation**: Learning to provide psychoeducation to service users to help them understand their reactions (e.g., fight/flight/freeze responses) and normalise "symptoms" as adaptations.[272]
   - **De-escalation and crisis intervention**: Techniques for managing stress, anger, and de-escalating agitated individuals to ensure safety.[273]
   - **Culturally sensitive communication**: Techniques adapt communication approaches to accommodation cultural and linguistic differences.[274]
   - **Specific skills for engaging with children:** Adapting techniques discussed above for use with children and adolescents across developmental stages.

2. **Environmental and Systemic Considerations**:
   - **Impact of accommodation settings**: Understanding the detrimental effects of certain housing models and conditions on mental health and promoting better alternatives.[275]
   - **Creating supportive environments**: Practical steps for adapting the environment to be stress-reducing and welcoming, including involving service users in the design of physical spaces.[276] This includes accessible information provision, such as 'welcome packages' with

[267] NHS Education for Scotland, 2017; 2024.
[268] EUAA, 2024b; NHS Education for Scotland, 2017.
[269] Hoare, 2022; UK Home Office, 2024; Vindevogel et al., 2025.
[270] NHS Education for Scotland, 2017.
[271] Ibid.
[272] Hoare, 2022; NHS Education for Scotland, 2017.
[273] EASO, 2020.
[274] Vindevogel et al., 2025.
[275] Milman & Frederiksen, 2023.
[276] PHW NHS Trust, 2025.

information about accommodation centre practices as well as the broader international protection system and other services and resources, designed to be easily accessible to asylum seekers, including those with limited English language abilities.

- **Policy awareness**: Understanding how organisational policies (e.g., asylum procedures, accommodation transfer policies, grievance mechanisms, confidentiality, etc.) can interfere with wellbeing and how to apply trauma-informed principles to minimise harm.[277]

3. **Referral Pathways and Collaboration**:

- **Identifying mental health reactions and need for referral to specialised care.** Skills to identify indicators of psychological distress in both adults and children, including signs of PTSD, anxiety, depression and other mental health problems that significantly impede functioning and necessitate referral to mental health specialists.[278] This includes recognizing risk of suicidality and self-harm and associated emergency procedures and safety planning. Staff should feel prepared to recognise such reactions among residents, as well as in themself and in colleagues.
- **Resource mapping**: Knowledge of available internal and external care, support, and specialised intervention services (mental health, legal aid, social services, education, employment) in the locality.[279]
- **Referral process, coordination, information sharing**: Understanding how to collaboratively signpost and refer individuals and/or motivate help-seeking, while providing accurate information about what to expect.[280] Coordination and information sharing with other agencies, respecting confidentiality and consent protocols.[281]
- **Interpreters**: The importance of culturally appropriate professional interpreters and trauma-informed interpreting training and practices to ensure accurate and sensitive communication.[282]

4. Staff wellbeing strategies for frontline staff:

- In-depth training on secondary and vicarious trauma, and vicarious resilience reactions stemming from engagement with residents with trauma histories. Role of mental health and psychosocial support, supervision and peer-led support, practical self-care skills.

Module III. Leadership and Systemic Change Training (For managers and supervisors)

This level focuses on leadership, systemic change, and organisational support for staff well-being.

1. **Organisational Leadership and Culture**:

[277] SBNI, 2024.
[278] EUAA, 2024c.
[279] EUAA 2024c; NHS Education for Scotland, 2017; UK Home Office, 2024.
[280] NHS Education for Scotland, 2017.
[281] Ibid.
[282] González Campanella, 2023.

- **Leadership buy-in and responsibilities**: Training for senior leadership on how TIA enhances policy, practice, and outcomes (including economic outcomes and other organizational objectives), guidance for integrating TIA principles into mission, vision, and strategic plans, and the role of senior leaders in championing and overseeing this approach.[283]
- **Creating a trauma-informed organisational culture**: Understanding how to foster an organisational culture that acknowledges the impact of adversity on staff and residents and prioritises safety, transparency, collaboration, and staff well-being. This includes addressing staff fears and resistance to change, framing TIA as an enabler rather than an added burden.[284] It may also include developing a workplan and an internal workgroup to move TIA efforts forward.[285]
- **Policy integration**: Training on reviewing and amending organisational policies and procedures (e.g., service delivery procedures as well as hiring practices, complaint/grievance processes, disciplinary actions, record-keeping) to align with trauma-informed principles, as well as monitoring and accountability mechanisms.
- **Resourcing**: Understanding the need for and advocating for adequate financial and human resources (e.g., dedicated staff, funding for training, safe environments).[286]

2. **Workforce Development and Support**:

- **Secondary/vicarious trauma and burnout prevention**: Training for managers on recognizing, preventing, and responding to secondary traumatic stress, vicarious trauma, and burnout in self and staff, while promoting vicarious resilience and job satisfaction.[287]
- **Supervision and reflective practice**: Implementing and promoting regular, trauma-informed professional supervision and peer support/learning-exchange sessions for all staff to manage work-related distress and support practice development.[288] This may include focus on modes of support for specific roles associated with increased risk of adverse mental health impacts, such as those engaged in screening or staff in centres for residents with specific needs, including mental health needs.
- **Staff well-being initiatives**: Advocating for and implementing organisational well-being programmes beyond individual self-care, such as flexible working arrangements, stress management training, and further training for managers on creating a supportive work environment. This also includes ensuring access to mental health services for staff and addressing potential barriers to their uptake (including staff concerns about confidentiality and the impact of help-seeking on their employment).[289] This section may also include

[283] Mooney et al., 2024.
[284] Ibid.
[285] TI Oregon, 2016.
[286] Mooney et al., 2024.
[287] EASO, 2021a; NHS Education for Scotland, 2017.
[288] NHS Education for Scotland, 2017; SBNI, 2024.
[289] Mooney et al., 2024.

guidance on a participatory approach to development of a staff wellbeing policy informed by staff input.

- **Train-the-Trainer models**: Developing internal capacity to deliver trauma-informed training more widely within the organisation.

3. **Monitoring and Evaluation**:

- **Implementation tracking**: Developing and using tools to assess the extent to which trauma-informed practices are being adopted at individual, programme, and organisational levels.
- **Feedback and reflective mechanisms**: Establishing channels for regular feedback from both staff and service users (e.g., satisfaction surveys, focus groups) to identify strengths, opportunities for improvement, and monitor perceived safety and engagement.[290]
- **Continuous Improvement**: Fostering an ethos of continuous learning and adaptation based on evaluation findings, recognizing that TIA implementation is an ongoing process.

4.2 Training delivery methods & good practices.

In addition to the content recommendations above, the literature provides key recommendations for training delivery modalities and other good practices.

First, there is clear consensus that effective trauma-informed training for staff should be delivered through a **diverse range of formats** to maximise accessibility, engagement, and contextual relevance. A blended approach, combining in-person sessions, online modules, videos, interactive workshops, discussion groups, role-plays, and case studies, can increase accessibility, accommodate different learning styles and logistical constraints while promoting deeper and more contextually relevant understanding.[291] **Active staff engagement** is critical. Training should provide space for participants to reflect on their own experiences, raise challenges, and identify systemic barriers that may hinder trauma-informed practice.[292] Utilizing a variety of formats as discussed above can increase participation across staff.

Tailoring content to the specific roles and responsibilities of accommodation staff ensures that the material is practical, relevant, and applicable to real-world contexts.[293] It is particularly important to consider the unique and often complex needs of asylum seekers, including across demographic groups and accommodation settings, when designing this training. To do so, the involvement of people with **lived experience** of trauma *and* the asylum system is essential – including both staff and residents. Their perspectives not only ground the training in reality but also challenge assumptions and foster empathy among training participants. Co-produced content can

[290] Murphey et al., 2025.
[291] Im & Swan 2020.
[292] Mooney et al., 2024.
[293] Ibid.

help ensure that the training remains meaningful and responsive to those it ultimately aims to serve.[294]

Training should be **mandatory and embedded** within organisational practice. It must be integrated into induction processes for new staff and supported through ongoing professional development, including periodic refresher sessions to reinforce learning and adapt to emerging needs.[295] **Refresher training and ongoing forums for learning exchange**, such as regular discussion groups, can encourage continued engagement and provide opportunities to overcome barriers.[296] Staff are likely to benefit from opportunities to trouble-shoot together and exchange peer support. Regular and ongoing training and engagement opportunities are particularly essential in organisations with high turnover rates to ensure that new staff are fully supported (and because TIA may be helpful in improving staff satisfaction and reducing staff turnover).[297]

Staff discomfort around engagement on trauma-related topics is a common barrier that must be directly addressed. Staff may feel unprepared or fearful of re-traumatizing clients or themselves. Training should acknowledge these concerns and provide practical guidance, clarifying that TIA is not a clinical or diagnostic tool, but rather a framework for everyday relational engagement.[298] Staff should be prepared to respond to residents' spontaneous disclosures of traumatic or stressful experiences and/or to intense emotions or behaviors in a way that is appropriate and does not cause harm. Moreover, trainers should be prepared to appropriate respond to trainee distress reactions provoked by the training content, and to make appropriate referrals.

Finally, it is critical to include **monitoring and evaluation and research components** into trauma-informed training interventions to assess their effectiveness and to foster leadership and policymaker buy-in and accountability.[299] Evaluation may include measures of participant feedback (e.g., satisfaction surveys), change in knowledge (e.g., pre-post tests) skill development (e.g., observed role play), and indicators of staff wellbeing. Ideally, research should also examine the training's influence on workplace practices and its effects on the wellbeing of asylum seekers. These assessments should be conducted both immediately after the training and at follow-up intervals (e.g., six months later) to capture sustained impact. Importantly, evaluation processes should include structured reflection and feedback loops in which data are used to inform ongoing improvements to training content, delivery methods, and organisational support structures.

5. Conclusions and recommendations

This review demonstrates that asylum seekers face disproportionately high levels of psychological distress due to cumulative exposure to trauma, chronic stress, and systemic adversity across the

[294] NHS Education for Scotland, 2017; SBNI, 2024.
[295] Kirwan & McLaughlin, 2024.
[296] TI Oregon, 2016.
[297] Mooney et al., 2024.
[298] Mooney et al., 2024; NHS Education for Scotland, 2024.
[299] Champine et al., 2019; Mooney et al., 2024

migration trajectory. Critically, the systems designed to protect them, including asylum procedures and accommodation environments, can perpetuate harm through unpredictability, disempowerment, and structural problems.[300] At the same time, asylum seekers are often able to cope, adapt, and function well, particularly when supported by safe, dignified environments, staff who understand the impact of adversity on behavior and wellbeing, and policies that informed by this awareness. For these reasons, TIA is increasingly recognised as essential for improving the quality of care and reducing harm in asylum accommodation settings.

While the literature identifies a growing body of positive outcomes associated with TIA, including improved service user engagement, reduced staff burnout, and enhanced organisational responsiveness, it also underscores persistent limitations in the evidence base, as well as barriers to implementation. These include conceptual ambiguity, inadequate funding, limited staff time and resources, and policy contradictions. TIA cannot be achieved through training alone. It must be embedded within policy frameworks, operational procedures, and physical environments, and must be meaningfully supported by leadership, adequate resources, and mechanisms for continuous improvement.

5.1 Summary recommendations for practitioners and policymakers:

1. **Embed TIA into policy and practice**. Review and revise asylum and accommodation policies to minimise harm, reduce uncertainty, and promote stability, safety, and dignity. Ensure that trauma-informed principles including safety, trust, empowerment, peer support, collaboration, and cultural responsiveness, are reflected in all operational guidance.
2. **Make trauma-Informed training standard and tiered**. Mandate trauma-informed training for all accommodation centre staff, tailored by role (frontline, supervisory, leadership). Ensure that content covers the impact of trauma and adversity, cultural competence, communication skills, de-escalation techniques, and staff wellbeing.
3. **Systematically support staff wellbeing.** Provide ongoing supervision, peer support, reflective practice opportunities, and access to mental health services and resources. Address organizational and systemic causes of burnout through adequate staffing, manageable caseloads, and participatory decision-making.
4. **Design and implement accommodation with wellbeing and cultural competency in mind, drawing from asylum seeker input.** Promote trauma-informed environments that facilitate privacy, autonomy, and community integration. Integrate cultural beliefs and practices into service delivery, and ensure assessments and interventions are adapted to diverse explanatory models of distress. Employ trained interpreters and cultural mediators to enhance communication and trust.

[300] Mulcaire et al., 2024; Spira et al., 2025; Stewart, 2006.

5. **Involve asylum seekers and other stakeholders in co-designing services, ensuring dignity, autonomy, and community connection**. Involve asylum seekers, centre staff, and other stakeholders with relevant lived experience in the design, evaluation, and adaptation of accommodation spaces and services through participatory approaches and feedback mechanisms.
6. **Foster cross-sectoral coordination and collaboration.** Coordinate between asylum, housing, health and mental health, social care, and other sectors to deliver holistic support.
7. **Strengthen the evidence base through rigorous evaluation and research.** Invest in robust evaluation and monitoring tools to assess the implementation and impact of TIAs, especially within asylum-specific contexts, but also in adjacent sectors. This includes studies that assess outcomes for both asylum seekers and staff, explore system-level impacts, and identify what works in different cultural, legal, and organisational settings. Strengthening the evidence base is essential to guide future implementation, secure long-term investment, and avoid superficial or inconsistent application of trauma-informed principles.

By embedding trauma-informed principles at the policy, organisational, and practitioner levels, accommodation systems can better protect mental health and wellbeing, foster recovery, and uphold the dignity of those seeking asylum. Creating truly supportive environments will require not only individual skills and compassion but institutional commitment to structural change.