



MASARYK UNIVERSITY

European Master's Programme in Human  
Rights and Democratisation

A.Y. 2019/2020

Unaccompanied Refugee Minors:  
A Resilient Demographic, Gravely at Risk

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## **Abstract**

Between 2015 and 2017, Germany saw unprecedented levels of Unaccompanied Refugee Minors arrive at its borders. The system was wholly unprepared for this over 5-fold increase in URM migration that took place, it was and still is unable to fulfill its obligations towards this highly vulnerable demographic. This paper aims to analyze the legal framework the URM demographic finds itself in upon arrival into Germany with the aim of highlighting some of the mayor gaps in the system. These gaps are primarily the lack of culturally adequate physical and psychiatric disease screening and follow-up testing; being placed under the care of completely overburdened official guardians; no statutory health coverage for all URMs; along with the dismal state of knowledge about this demographic. After this analysis, the second chapter of this work aims at helping to close the knowledge gap by borrowing from research on the effects of childhood trauma around the world. The findings suggest that URMs are indeed the most vulnerable of refugee groups due to the impact of trauma on the physical and psychiatric health of this population. The link between trauma and mayor physical and psychiatric illnesses, such as cancer, PTSD, depression and many others, is explored along with its effects on behavior, covering citing increases in risky health behaviors, as well as crime and addiction. However, not all hope is lost, the third chapter of this paper, covers the resilience of this group and how establishing better practices for integration can have a great positive impact on this populations' health outcomes. Some best practices as well as suggestions for reform are covered, and these include, a stronger non-official guardianship system, standardized culturally appropriate screening for mental and physical disease, as well as incentivizing socio-psychological support through the use of culturally integrative activities, that promote mental health and support for their multi-cultural identities.

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## Background & Introduction

Migration is as old as humanity, tracing its roots all the way back to our hunter-gatherer ancestors. Although, modern day migration is still in large part the displacement of people seeking a more hospitable environment, today that often means displacement due to war and persecution. In recent years, ongoing conflicts in the Middle East, North Africa, Central Asia and the horn of Africa have resulted in millions being displaced and forced to leave their homes. In 2015, 21.3 million people worldwide were displaced.<sup>1</sup> Many of these displaced people seek to build their new life in Europe and although it is nothing new, the heavily politicized migration of 2.68 million refugees, in 2015-2016 into Europe<sup>2</sup> was deemed a crisis.<sup>3</sup> In 2017, the number of displaced people almost tripled to 65 million being forcibly displaced with 22.5 of them being refugees out of which more than half were children under the age of 18.<sup>4</sup> In the span of 2015-2017 Germany became the biggest host for asylum seekers in Europe, having received 1.4 million applications for asylum, of which around 500,000 were from asylum seeking children and adolescents under the age of 18.<sup>5</sup> Along with this surge in migration an unprecedented high number of Unaccompanied Refugee Minors was also registered. In Germany the number of URM's saw over a 5 fold increase from 2014 (4,400) to 2015 (22,255).<sup>6</sup> At the time the country's legal system found itself totally unprepared to take into care so many URM's. Since then there have been many reforms to the system and many more that are still needed. The first chapter of this analysis provides the legal framework in which these URM's find themselves in Germany. It does this by first going through the applicable international law, to then show how its been embedded into national law and procedures dealing with arrival processing and ultimately care of URM's. The analysis showed there are a number of salient gaps in the system, primarily the lack of data available on the

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<sup>1</sup> United Nations High Commissioner for Refugees. "Figures at a Glance." UNHCR, 18 June 2020, [www.unhcr.org/figures-at-a-glance.html](http://www.unhcr.org/figures-at-a-glance.html).

<sup>2</sup> "Asylum Statistics." Asylum Statistics - Statistics Explained, 16 Mar. 2020, [ec.europa.eu/eurostat/statistics-explained/index.php/Asylum\\_statistics](http://ec.europa.eu/eurostat/statistics-explained/index.php/Asylum_statistics).

<sup>3</sup> Ylä-Anttila, Tuukka, Gwenaëlle Bauvois, and Niko Pyrhönen. "Politicization of migration in the countermedia style: A computational and qualitative analysis of populist discourse." 2019.

<sup>4</sup> United Nations High Commissioner for Refugees. "Figures at a Glance." UNHCR, 2017, [www.unhcr.org/figures-at-a-glance.html](http://www.unhcr.org/figures-at-a-glance.html).

<sup>5</sup> Ibid

<sup>6</sup> "Asylum applicants considered to be unaccompanied minors by citizenship, age and sex Annual data." Statistics for 2008–2015. Eurostat, 21 May 2020; Online: [http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=migr\\_asyunaa&lang=en](http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=migr_asyunaa&lang=en).

condition of URMs and the lack of effective mechanisms to provide adequate protection of all rights upholding the principle of ‘in the child’s best interest’. Partially due to this gap in knowledge, the next chapter aims at demonstrating the incredibly high level of vulnerability this demographic has, in particular in relation to trauma and its consequences. It does this through an analysis of medical studies done with this population throughout the world, in addition to gathering and presenting information on the possible personal, social and economic consequences of untreated trauma in this demographic. Finally, the third chapter provides some best practices arrived by a review of expert literature as well as several studies, covering the risk and resilience of this population. The analysis aims to answer the question can the acquisition of new data through standardization and homogenization of medical screening and practice, along with a reform of the role of guardianship and the creation and fostering of psychosocial support programs significantly mitigate the impact of trauma in the URM population? The analysis concludes finding that unfortunately more data is required to draw any definitive conclusions but that nevertheless it seems like a promising path to protection and realization of the full rights of URMs in Germany.

### **Definitions & Terminology**

**URM:** The term Unaccompanied Refugee Minor, in this work, is used to describe any foreign child or a foreign juvenile under the age of 21 that did not enter the host country accompanied by a person with the right of custody or guardian, regardless of the recognition of their status as refugee, asylum seeker or displaced person.

**ARM:** Accompanied Refugee Minor, refers to a minor under the age of 21 who entered the country accompanied by a parent or legal guardian.

**ASC:** Refers to both URMs and ARMs combined.

**Foreign:** Refers to anyone not holding the nationality of the host country

**Refugee:** the term refugee follows the Article 1 of the 1951 Convention Relating to the Status of Refugees and the 1967 Protocol (Geneva Convention) definition which

states a refugee is, “a person who is outside his/her country of nationality or habitual residence; has a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion; and is unable or unwilling to avail himself of the protection of that country, or to return there, for fear of persecution”<sup>7</sup>

**Psychosocial Needs:** refers to an interrelation between psychological and social factors intervening on the well-being of an individual. A psychosocial approach tends to respond to people’s interconnected social and psychological needs, addressing them in an integrated manner.

**Psychosocial Care:** An internationally agreed approach to victims of disaster, catastrophe or violence to foster resilience and positive outcomes. Psychosocial care aims at easing resumption of normal life by preventing longer-term consequences of potentially traumatic situations.<sup>8</sup>

**Mental Health:** Refers to a portion of psychosocial health and an essential component of health. The WHO constitution states: “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”<sup>9</sup> An important implication of this definition is that mental health is more than just the absence of mental disorders or disabilities.

**Societal costs:** Refers to costs that are related to the inability to find and maintaining a job, not being in education, loss of productivity caused by absenteeism, disability and illness

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<sup>7</sup> United Nations High Commissioner for Refugees. “*About Us.*” UNHCR, 2002; [www.unhcr.org/about-us.html](http://www.unhcr.org/about-us.html).

<sup>8</sup> “*Mental Health and Psychosocial Support.*” International Committee of the Red Cross, 20 July 2020; [www.icrc.org/en/publication/4174-mental-health-and-psychosocial-support](http://www.icrc.org/en/publication/4174-mental-health-and-psychosocial-support).

<sup>9</sup> “*Mental Health: Strengthening Our Response.*” World Health Organization, World Health Organization, 30 Mar. 2018, [www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response](http://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response).

## Chapter 1

### Legal Standing Of URM's In Germany

#### International and European Legal Framework

In Germany, the legal and administrative framework URM's find themselves in is set within a number of international agreements. Primarily, the United Nations Convention on the Rights of the Child (CRC), which is founded on 4 core principles:

1. The best interests of the child shall take primacy in all actions concerning them, “whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies”<sup>10</sup>
2. “States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's race, color, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.”<sup>11</sup>
3. “States Parties shall ensure to the maximum extent possible the survival and development of the child.”<sup>12</sup>
4. “States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.”<sup>13</sup>

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<sup>10</sup> “*Convention on the Rights of the Child.*” OHCHR, 20 Nov. 1989, [www.ohchr.org/en/professionalinterest/pages/crc.aspx](http://www.ohchr.org/en/professionalinterest/pages/crc.aspx). Art. 3 par. 1

<sup>11</sup> *Idem.* Art 2 par. 1 CRC

<sup>12</sup> *Idem.* Art 6 par. 2 CRC

<sup>13</sup> *Idem.* Art. 12 par. 1 CRC

In all formation and application of law to minors, state parties are obligated to guarantee protection and humanitarian assistance in the fulfillment of the rights set forth in the CRC and other international agreements concerning those seeking refugee status or those already considered refugees, such as the Geneva Refugee Convention.<sup>14</sup> The guarantee of this humanitarian assistance in pursuit of rights is also specifically mentioned in the CRC under Art. 22. Although the CRC was signed on 26<sup>th</sup> of January 1990, it only came into force in Germany in 1992 being ratified into national law<sup>15</sup> that year. However the full force of the convention only became applicable in Germany after the reservations were withdrawn in 2010.<sup>16</sup> This marked an important step for minors and in particular for URM as prior to the removal of reservations, the rights of the child outlined by the CRC were not to be applied through the asylum procedure. As an example of many, reservations could mean that a 16-year-old URM could be handled as an adult in the asylum seeking procedure.<sup>17</sup> The primacy given to the 'best interest of the child' is also entrenched in the Charter of Fundamental Rights of the EU.<sup>18</sup> In addition URM are afforded more legal protection as they were deemed "a particular vulnerable group with special rights" by EU directives on Common European Asylum System.<sup>19</sup> In the last 15 years, the EU has adopted additional legislative instruments that directly address the situation of URM. These include the EU asylum instruments of 2011-2013 outlined in directives creating the Common European Asylum System,<sup>20</sup> the EU Anti-Trafficking

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<sup>14</sup> United Nations. "Convention Relating to the Status of Refugees." OHCHR, 28 July 1951, [www.ohchr.org/EN/ProfessionalInterest/Pages/StatusOfRefugees.aspx](http://www.ohchr.org/EN/ProfessionalInterest/Pages/StatusOfRefugees.aspx).

<sup>15</sup> "Übereinkommen Über Die Rechte Des Kindes." BMFSFJ, 2014, [www.bmfsfj.de/bmfsfj/service/publikationen/uebereinkommen-ueber-die-rechte-des-kindes/86530](http://www.bmfsfj.de/bmfsfj/service/publikationen/uebereinkommen-ueber-die-rechte-des-kindes/86530). VN-Kinderrechtskonvention im Wortlaut mit Materialien, Berlin: BMFSFJ

<sup>16</sup> "The Rights of the Child in Germany: The UN Convention on the Rights of the Child and Its Implementation in National Law." Schmahl, Stefanie, 2016. 10.1007/978-3-319-23189-1\_7.

<sup>17</sup> "The Withdrawal of Germany's Unilateral Statement on the UN Convention on the Rights of the Child." Siegfried, Jule, Berenike Schriewer, and Patrick Braasch. *German YB Int'l L.* 53 2010: 973.

<sup>18</sup> "Charter of Fundamental Rights of the European Union." Lex Access to European Union Law, 2012, [eur-lex.europa.eu/legal-content/EN/TXT/?uri=celex%3A12012P%2FTXT](http://eur-lex.europa.eu/legal-content/EN/TXT/?uri=celex%3A12012P%2FTXT).

Art. 24 par. 2

<sup>19</sup> European Commission. "Communication from the Commission to the European Parliament and the Council Towards a Reform of the Common European Asylum System and Enhancing Legal Avenues to Europe." EUR, 2016, [eur-lex.europa.eu/legal-content/en/TXT/?uri=celex%3A52016DC0197](http://eur-lex.europa.eu/legal-content/en/TXT/?uri=celex%3A52016DC0197).

<sup>20</sup> Wagner, Martin, et al. "The implementation of the common European asylum system." Maastricht Centre for Human Rights, 2016, <https://cris.maastrichtuniversity.nl/en/publications/the-implementation-of-the-common-european-asylum-system>

Directive (2011) and the EU Return Directive (2008). Although there has been great progress in advancing the legal protection afforded to URM's the practical application of the law varied widely resulting in inconsistent protection of their rights and in 2013 propelling the European Parliament to call for a "a handbook drawing together these various legal bases, addressed to Member States and to all practitioners, in order to facilitate proper implementation by Member States and to strengthen the protection of unaccompanied minors"<sup>21</sup> which resulted in Council of Europe, Committee of Ministers, Action Plan on Protecting Refugee and Migrant Children in Europe (2017-2019), CM(2017)54-final, Nicosia, 19 May 2017.

This Action Plan outlines foremost that all legal responsibilities are due to these children by all Council of Europe member states, as they are all signatories to, The United Nations Convention on the Rights of the Child (CRC)<sup>22</sup>, the first international instrument to acknowledge the unique needs of refugee and asylum-seeking children. Additionally, it provides states with guidance on implementation directed at a more consistent protection of URM's rights throughout Europe.<sup>23</sup> The directives seek to guide state parties towards the creation of a 'child friendly approach' to the legal handling of minors.

A child friendly approach can be defined as "accessible, age appropriate, speedy, diligent, adapted to and focused on the needs and rights of the child, respecting the rights of the child including the rights to due process, to participate in and to understand the proceedings, to respect for private and family life and to integrity and dignity".<sup>24</sup>

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<sup>21</sup> Committee on Civil Liberties, Justice and Home Affairs. "Report on the Situation of Unaccompanied Minors in the EU." REPORT on the Situation of Unaccompanied Minors in the EU - A7-0251/2013, 2012, [www.europarl.europa.eu/sides/getDoc.do?pubRef=-%2F%2FEP%2F%2FTEXT+REPORT+A7-2013-0251+0+DOC+XML+V0%2F%2FEN](http://www.europarl.europa.eu/sides/getDoc.do?pubRef=-%2F%2FEP%2F%2FTEXT+REPORT+A7-2013-0251+0+DOC+XML+V0%2F%2FEN).

<sup>22</sup> Convention on the Rights of the Child (n 10).

<sup>23</sup> United Nations High Commissioner for Refugees, Uni. "Joint General Comment No. 3 (2017) of the Committee on the Protection of the Rights of All Migrant Workers and Members of Their Families and No. 22 (2017) of the Committee on the Rights of the Child on the General Principles Regarding the Human Rights of Children in the Context of International Migration." Refworld, UN Committee on the Protection of the Rights of All Migrant Workers and Members of Their Families (CMW), 2017, [www.refworld.org/docid/5a2f9fc34.html](http://www.refworld.org/docid/5a2f9fc34.html).

<sup>24</sup> Decker, Scott H., and Nerea Marteache, eds. "International handbook of juvenile justice". Springer, 2017.

The child friendly approach has been reinforced by the Council of Europe's Guidelines on child-friendly justice, with the goal of embedding children's rights into all aspects of the migration process to ensure all children's rights are protected. Said approach has very high standards, including that all those who work with minors need to be adequately trained on how to treat children with care and respect through services and systems that are independently monitored. This places a tremendous burden on state parties and in practice it is found to have great variation in its implementation.<sup>25</sup> The legal standard for the quality of care minors should receive has indeed been set to ideal, as it should, however we are still a long way from a child-friendly justice system that guarantees "the effective implementation of all children's rights at the highest attainable level".<sup>26</sup> <sup>27</sup> So, regardless of the general push in EU policy towards reaching common standards, in particular say in relation to reception structures and processes, 'they still vary largely which results in unequal treatment and at times sub-par care conditions.'<sup>28</sup> A deeper analysis of the legal structure surrounding URM in Germany follows.

### **Arrival, Accommodation and General Assistance:**

Legally, URM in Germany are subject to the stipulations of Book VIII of the Social Code, in which the Child and Youth Welfare Act is codified<sup>29</sup>. This means that URM are cared for, accommodated and assisted in the same manner national minors are under the regular youth welfare system. Integrating URM

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<sup>25</sup> Joly, Danièle. *"Haven or hell?: Asylum Policies and Refugees in Europe"*. Springer, 2016.

<sup>26</sup> Council of Europe, Committee of Ministers. *"Guidelines of the Committee of Ministers of the Council of Europe on child-friendly justice"*. Vol. 5. Council of Europe, 2011.

<sup>27</sup> Rap, Stephanie. *"The Right to Effective Participation of Refugee and Migrant Children: A Critical Children's Rights Perspective."* United Nations University-Institute on Comparative Regional Integration Studies (UNU-CRIS) Working Paper Series 3, 2019: 1-30.

<sup>28</sup> Ine Lietaert, Malte Behrendt, Océane Uzureau, Sarah Adeyinka, Marina Rota, Floor Verhaeghe, Charles Watters & Ilse Derluyn, 2020. *"The development of an analytical framework to compare reception structures for unaccompanied refugee minors in Europe"*. European Journal of Social Work, 23:3, 2019. 384-400, DOI: [10.1080/13691457.2019.1682974](https://doi.org/10.1080/13691457.2019.1682974)

<sup>29</sup> *"Bekanntmachung Der Neufassung Des Achten Buches ..."* Bekanntmachung der Neufassung Des Achten Buches Sozialgesetzbuch, 2012, No. 79, pp. 3545-3579 (INFORM - P60279) [www.ilo.org/dyn/natlex/docs/ELECTRONIC/52677/98452/F1934841947/SGB%208.pdf](http://www.ilo.org/dyn/natlex/docs/ELECTRONIC/52677/98452/F1934841947/SGB%208.pdf).

into the regular youth welfare system has its benefits and risks for the URM demographic. On the one hand affording them every protection a German minor would have, making their protection independent of their residency status, but on the other not accounting for their particularly vulnerable situation.<sup>30</sup>

As of 2015, when first entering Germany, URMs are taken into preliminary care by the youth welfare office on site, within a short period of time an assessment is carried out as to whether they stay on site or are distributed to somewhere else in Germany.<sup>31</sup> Once that is settled a guardian is appointed as part of the clearing procedure that follows. During this process URMs' condition, and needs are assessed and matched with suitable accommodation and other pertinent youth welfare services. It is of importance to note, that although legally possible, it is extremely rare that a URM will be returned, barring any extreme circumstances, all URMs are permitted to stay until coming of age.<sup>32</sup> Legally, this is how this process should be handled and superficially it seems workable. In practice however many gaps emerge in the application of their rights through this system. As noted above the primacy of the Child and Youth Welfare Act, over the Asylum & Residency Acts, is intended to ensure that "when unaccompanied minors enter Germany, all necessary measures (pursuant to the international legal provisions) are to be taken to ensure the protection of the best interests of the child in the framework of the State's guardian role"<sup>33</sup> The primacy of the Youth Welfare Act is most important on arrival, as URMs find their way in Germany, the Residence Act becomes increasingly more important in relation to opportunities for integration, social participation and family reunification.<sup>34</sup> When it comes to reaching adulthood, the resident act becomes decisive for their

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<sup>30</sup> Sierau, Susan, et al. "Alone, but protected? Effects of social support on mental health of unaccompanied refugee minors." *European child & adolescent psychiatry* 28.6, 2019: 769-780.

<sup>31</sup> Federal Office for Migration and Refugees. "Migration, Integration, Asylum. Political Developments in Germany 2015". Annual Policy Report by the German National Contact Point for the European Migration Network, 2016.

<sup>32</sup> Tangermann, Julian, and Paula Hoffmeyer-Zlotnik. "Unaccompanied Minors in Germany: Challenges and Measures after the Clarification of Residence Status; Focussed Study by the German National Contact Point for the European Migration Network (EMN)." 2018: 106.

<sup>33</sup> Bundesarbeitsgemeinschaft Landesjugendämter: "Handlungsempfehlungen zum Umgang mit unbegleiteten Minderjährigen. Verteilungsverfahren, Maßnahmen der Jugendhilfe und Clearingverfahren". 2. aktualisierte Fassung, 2017. Online: [http://www.bagljae.de/downloads/128\\_handlungsempfehlungen-zum-umgang-mit-unbge.pdf](http://www.bagljae.de/downloads/128_handlungsempfehlungen-zum-umgang-mit-unbge.pdf) (15.06.2020).

<sup>34</sup> Tangermann (n 32)

future.

## **Legal Status under the Residence Act**

When URMs enter Germany they also enter a sort of legal loophole in that as third-country nationals they are required to hold a residence title (which most don't hold), to stay in Germany, as minors however, they are issued a suspension of removal by the responsible migration authority.<sup>35</sup> <sup>36</sup> However the suspension of removal is not a residence permit, it simply stipulates the temporary suspension from removal.<sup>37</sup> Although providing for temporarily relief of immediate deportation the high level of uncertainty in this situation can become extremely stressful for the already overloaded URM population.<sup>38</sup> Moreover, as on average it takes 8.3 months to go through an asylum process,<sup>39</sup> many URMs will turn 18 in the meantime, without knowing the result of their legal process, which understandably adds even more uncertainty and stress.<sup>40</sup>

## **Possibilities of Residence through asylum process:**

URMs are entitled to apply for asylum to the Federal Office for Migration and Refugees; this application can result in 'protected status' under Art. 16a of the Basic Law<sup>41</sup>, 'refugee status' or in becoming a 'beneficiary of subsidiary protection' under section 3 and 4, respectively, of the Asylum Act. It is also

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<sup>35</sup> Künnecke, Arndt. "The German Federal Law on Integration." *Acta Universitatis Carolinae Iuridica* 64.2, 2018: 85-98.

<sup>36</sup> Federal Office for Migration and Refugees (n 31).

<sup>37</sup> "Act on the Residence, Economic Activity and Integration of Foreigners in the Federal Territory." Act on the Residence, Economic Activity and Integration of Foreigners in the Federal Territory 1) *Residence Act*, 2020, [www.gesetze-im-internet.de/englisch\\_aufenthg/englisch\\_aufenthg.html](http://www.gesetze-im-internet.de/englisch_aufenthg/englisch_aufenthg.html). Section 60a subs. 2

<sup>38</sup> Bean, Tammy, et al. "Comparing psychological distress, traumatic stress reactions, and experiences of unaccompanied refugee minors with experiences of adolescents accompanied by parents." *The Journal of nervous and mental disease* 195.4, 2007: 288-297.

<sup>39</sup> Deutscher Bundestag. "Antwort der Bundesregierung auf die Große Anfrage der Abgeordneten Luise Amtsberg, Beate Walter-Rosenheimer, Dr. Franziska Brantner, weiterer Abgeordneter und der Fraktion BÜNDNIS 90/DIE GRÜNEN - Drucksache 18/2999 - Situation unbegleiteter minderjähriger Flüchtlinge in Deutschland." 2015, Drucksache 18/5564, Berlin: Deutscher Bundestag.

<sup>40</sup> Espenhost, N. & Noske, B. "Asylum und Aufenthaltsrecht. In S. Brinks, E. Dittmann & H. Müller (Eds.), *Handbuch unbegleitete minderjährige Flüchtlinge*" 2017 (pp. 49-59). Frankfurt/Main: IGfH-Eigenverlag.

<sup>41</sup> "Basic Law for the Federal Republic of Germany." Deutscher Bundestag, 23 May 1949, last amended on 28 March 2019. Article 16<sup>a</sup>: [www.btg-bestellservice.de/pdf/80201000.pdf](http://www.btg-bestellservice.de/pdf/80201000.pdf).

possible to be granted a 'removal ban' under section 60 of the Residence Act.<sup>42</sup> Although there is no separate procedure for URM, their cases are to be handled by "specially-commissioned case-officers,"<sup>43</sup> who are to ensure the procedure is child friendly and respects the 'best interest of the child'.<sup>44</sup>

A favorable asylum decision will result in a form of permission for residence. If the application results in being granted protection status, they will receive a residence permit under the Residence Act.<sup>45</sup> If the URM is granted asylum or refugee status a 3 year permit is granted and in the case of subsidiary protection for 1 year.<sup>46</sup> Lastly, if a removal ban is determined, they are also issued a residence permit lasting a minimum of 1 year.<sup>47</sup>

It is important to note that URM are not obligated to apply for asylum upon arrival and that it may be to their advantage to build their case and use the Residency Act to apply for residency instead. This is primarily due to the possibility of their case being found 'manifestly unfounded' which could lead to "the acquisition of a residence permit by other means being barred in the long term."<sup>48</sup> This means that the person responsible for the minor, in this case the guardian, must decide what path to take, considering the best interest of the child<sup>49</sup>, however if not handled carefully this could deteriorate the chances of this minor staying in Germany. If however, based on the facts, it is likely that the

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<sup>42</sup> Zeller, Maren, and Philipp Sandermann. "Unaccompanied Minors in Germany. A success story with setbacks?." *Social Work & Society* 15.2, 2017.

<sup>43</sup> BAMF - Federal Office for Migration and Refugees. "Unaccompanied Minors." BAMF, 10 Dec. 2019,

[www.bamf.de/EN/Themen/AsylFluechtlingsschutz/UnbegleiteteMinderjaehrige/unbegleiteteMinderjaehrige-node.html](http://www.bamf.de/EN/Themen/AsylFluechtlingsschutz/UnbegleiteteMinderjaehrige/unbegleiteteMinderjaehrige-node.html).

<sup>44</sup> BAMF - Federal Office for Migration and Refugees. "The stages of the German asylum procedure. An overview of the individual procedural steps and the legal basis, Nuremberg: Federal Office for Migration and Refugees." 2017.

<sup>45</sup> Act on the Residence (n 37) Section 25 subs. 1 and 2.

<sup>46</sup> Idem: Section 26 subs, 1 second and third sentences.

<sup>47</sup> Idem: Section 26 subs. 1 fourth sentence.

<sup>48</sup> Noske, Barbara: "Herausforderungen und Chancen. Vormundschaften für unbegleitete minderjährige Flüchtlinge in Deutschland, München: Bundesfachverband unbegleitete minderjährige Flüchtlinge e. V.", 2010 Online: [http://www.b-umf.de/images/vormundschaftsstudie\\_2010.pdf](http://www.b-umf.de/images/vormundschaftsstudie_2010.pdf)

<sup>49</sup> Zeller (n 42)

child will need international protection<sup>50</sup>, then the Guardian is required to apply for it.<sup>51</sup>

### **Alternatives under the law on residence**

Other than requesting asylum, there are other alternatives to securing residence through the law on residence. URM's not applying for asylum will normally apply directly for a residence document at the appropriate immigration office, they will then receive a deportation ban until they are 18 or until their case is decided.<sup>52</sup> There are 3 main ways for URM's to acquire a residence permit:

1. If the young person starts a vocational training before the age of 21, their deportation suspension will be suspended until the completion of the training.<sup>53</sup>

2. If the young person can prove that he or she is "well-integrated,"<sup>54</sup> which holds the following conditions. From 2011 it applies to:

- All people who have entered Germany before the age of 17.
- Those who have been resident in Germany for four years without interruption,
- attended school for four years,
- and graduated from school or successfully completed vocational training.
- Those whose application was completed before the age of 21.

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<sup>50</sup> "Asylum Act." Bundesministeriums Des Innern, 11 Mar. 2016, Section 1 subs. 1 no. 2: [www.gesetze-im-internet.de/englisch\\_asylvfg/](http://www.gesetze-im-internet.de/englisch_asylvfg/).

<sup>51</sup> "Social Code - Book IV - General Rules for Social Security." Sozialgesetzbuch (SGB) - Viertes Buch (IV) - Gemeinsame Vorschriften Für Die Sozialversicherung, Bundesgesetzblatt, 2006. Section 42 subs. 2 sentence 5 of the Social Code (Book Eight): [www.ilo.org/dyn/natlex/natlex4.detail?p\\_lang=en](http://www.ilo.org/dyn/natlex/natlex4.detail?p_lang=en).

<sup>52</sup> Zeller (n 42)

<sup>53</sup> "Gesetz Über Den Aufenthalt, Die Erwerbstätigkeit Und Die Integration Von Ausländern Im Bundesgebiet (Aufenthaltsgesetz - AufenthG) § 60a Vorübergehende Aussetzung Der Abschiebung (Duldung)." § 60a AufenthG - Einzelnorm, [www.gesetze-im-internet.de/aufenthg\\_2004/\\_60a.html](http://www.gesetze-im-internet.de/aufenthg_2004/_60a.html).

<sup>54</sup> BAMF (N 44)

3. The last option and also the least common is, 'if the young person is adopted, or married to a German partner, or expecting a child, his or her status might change according to the status held by the other persons involved'.<sup>55</sup>

### **Legal Amendments since 2014**

Since 2014 there have been several legal reforms that impact the situation of URMs in Germany, in particular with regards to permanence, accommodation and integration. It is through these reforms that the different possibilities to remain in the country, listed above, became possible. The Federal Professional Association for URMs,<sup>56</sup> has provided a chronological list of the reforms and their impacts, following are the key Acts and their corresponding reforms:

**The Act Redefining the Right to Remain and the Termination of Residence**<sup>57</sup>, that came into force on the 1<sup>st</sup> of August 2015, Expanded into "Section 25a of the Residence Act, grants all minors who entered Germany before turning 17 and whose removal has been suspended or who have permission to remain pending the asylum decision a right to remain after four years' lawful residence in Germany"<sup>58</sup> and it also introduced the right to remain until the completion of studies or training, stipulating that so long as the program was applied to before the age of 21, the URM will be allowed to remain in Germany until completion of vocational training or studies,<sup>59</sup> which if successfully completed can also lead to the acquisition of residence, as previously discussed.

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<sup>55</sup> Gravelmann, R. (2016). *Unbegleitete minderjährige Flüchtlinge in der Kinder- und Jugendhilfe. Orientierung für die praktische Arbeit.* München, Basel: Reinhardt.

<sup>56</sup> BumF - Bundesfachverband unbegleitete minderjährige Flüchtlinge e. V. "*Unbegleitete minderjährige Flüchtlinge: Zahl der Asylanträge erheblich gesunken. Pressemitteilung vom 25.07.2020.*", 2017. Online: [http://www.b-umf.de/images/2017\\_10\\_25\\_PM\\_Zahlen.pdf](http://www.b-umf.de/images/2017_10_25_PM_Zahlen.pdf) (16.01.2018).

<sup>57</sup> BumF (n 56)

<sup>58</sup> Residence Act (n 37) in the version promulgated on 25 February 2008 (Federal Law Gazette I p. 162); most recently amended by Article 4b of the Act of 17 February 2020 (Federal Law Gazette I p. 166).

<sup>59</sup> BumF (n 56)

The **Asylum Procedures Acceleration Act**<sup>60</sup> came into force on 24 October 2015, whose mayor impact on for URM is the increase in the age of capacity to pursue asylum proceedings from 16 to 18 years of age, which ensures the protection of a guardian to support and advise through the asylum procedure. Additionally, of importance for URM is the ban from work for unsuccessful candidates from safe countries of origin.<sup>61</sup> Again highlighting another consideration a guardian must have before applying for asylum on a minor's behalf.

The **Act on the Improvement of Care Arrangements for Foreign Children and Juveniles** is the first of these acts to treat URM separately from the larger general refugee group. The act came into force on 1 November 2015, and was "explicitly adopted because of the large numbers of unaccompanied minors arriving in the country and the concomitant overburdening of individual municipalities."<sup>62</sup> The Act changes the arrival process to include 'preliminary taking into care'<sup>63</sup> discussed above as well as an age assessment procedure<sup>64</sup>, further discussed below and a mechanism for distribution of URM through the Federal Republic<sup>65</sup>, that within its possibilities, attempts to keep the best interest of the child as a top priority, but was however put in place precisely because of the overwhelmed States in the Republic of Germany.<sup>66</sup>

**The Act Amending the Federal Training Assistance Act**, which came into force on 1 January 2016, can have a particularly strong impact on the integration of URM into German society.

The Act states URM in 'possession of a residence title or of suspension of removal are entitled to 'federal training assistance, (BAföG)<sup>67</sup> not only after four

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<sup>60</sup>BumF (n 56)

<sup>61</sup> Residence Act (n 37) Section 29a in conjunction with Annex II of the Asylum Act (n 41)

<sup>62</sup> Tangermann (n 32)

<sup>63</sup> Social Code (n 51) Section 42a of Book VIII.

<sup>64</sup> Idem: Section 42f of Book VIII.

<sup>65</sup> Idem: Section 42b of Book VIII.

<sup>66</sup> Tangermann (n 32)

<sup>67</sup> "The German Federal Training Assistance Act (BAföG) Provides Educational Opportunities." BMBF, 7 May 2020, [www.bmbf.de/en/the-german-federal-training-assistance-act-bafog-provides-educational-opportunities-2010.html](http://www.bmbf.de/en/the-german-federal-training-assistance-act-bafog-provides-educational-opportunities-2010.html).

years, but also after only 15 months.’<sup>68</sup> This could have a major impact on possibilities for integration and permanence of URMs in particular considering it widens their options for training and protects them from deportation by facilitating enrolment in training through federal support. If enrolled in education or training, they cannot be deported.<sup>69</sup> Unfortunately however, URMs whose permission to stay is due to a pending asylum decision, do not qualify.<sup>70</sup>

Another legal reform dealing with age assessment, came into force in 2015 as the age assessment procedure by public authorities was codified,<sup>71</sup> and it explicitly requires an age assessment to be carried out in the course of ‘preliminary taking into care’ of unaccompanied minors. Although it has been codified the practice differs widely between German regions.<sup>72</sup> After much noise in the media over URMs lying about their age<sup>73</sup> along with the murder carried out by someone registered as a URM, led local politicians to call for mandatory medical age examinations.<sup>74</sup> However, these examinations remain ‘highly uncertain in addition to being cumbersome and expensive,’<sup>75</sup> and therefore “It should not be left to the discretion of individual authorities to have doubts and take action. Instead, there should be clear rules stipulating that in cases where no official and genuine document can be presented other measures must be taken to assess a person’s age, e.g. through a medical examination, if necessary. However the assessment should remain in the care of the youth welfare office”<sup>76</sup>

There are two legal reforms currently underway that will have a significant impact on the URM demographic, the first is draft Act Supporting Children and

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<sup>68</sup>BumF (n 56)

<sup>69</sup> Residence Act (n 37) Section 60a subs. 2 fourth sentence.

<sup>70</sup>BumF (n 56)

<sup>71</sup> Social Code (n 51) Section 42f of Book VIII.

<sup>72</sup> Deutscher Bundestag (n 39) 34 et seq.

<sup>73</sup> Leubecher, Marcel. "Viele Jungs sind wohl fünf bis acht Jahre älter", 2017 Die Welt.

<sup>74</sup> Leubecher, Marcel. "*Medizinische Altersfeststellung gesetzlich vorschreiben*". Die Welt, 08.12.2017. Online: <https://www.welt.de/politik/deutschland/article171425092/Medizinische-Altersfeststellung-gesetzlich-vorschreiben.html>

<sup>75</sup> Ueberbach, Stephan. "*Ärztepräsident kritisiert obligatorische Alterstests. Deutschlandfunk*", 02.01.2018. Online: [http://www.deutschlandfunk.de/minderjaehrige-fluechtlinge-aerztepraesident-kritisiert.1773.de.html?dram:article\\_id=407274](http://www.deutschlandfunk.de/minderjaehrige-fluechtlinge-aerztepraesident-kritisiert.1773.de.html?dram:article_id=407274)

<sup>76</sup> BMI - Bundesministerium des Inneren. "*Belastbare Feststellung des Alters zwingend notwendig.*" Meldung vom 03.01.2018. Online: <https://www.bmi.bund.de/SharedDocs/kurzmeldungen/DE/2018/01/statement-altersfeststellung.html>.

Juveniles: Children and Juvenile Support Act<sup>77</sup> and the second is the reform on Guardianship law which is currently over 110 years old.<sup>78</sup> The purported implications of these reforms and additional recommendations will be covered in best practices section.

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<sup>77</sup> "Entwurf Eines Gesetzes Zur Stärkung Von Kindern Und Jugendlichen." BMFSFJ, 2017, [www.bmfsfj.de/bmfsfj/service/gesetze/entwurf-eines-gesetzes-zur-staerkung-von-kindern-und-jugendlichen/119554](http://www.bmfsfj.de/bmfsfj/service/gesetze/entwurf-eines-gesetzes-zur-staerkung-von-kindern-und-jugendlichen/119554).

<sup>78</sup> "Oberloskamp, H: Gutachtl. Stellungnah.: Oberloskamp, Helga, Borg-Laufs, Michael, Mutke, Barbara": 9783472065920: Books, [www.gutachtliche-Stellungnahmen-sozialen-Arbeit-Familiengerichtsverfahren/dp/3472065923](http://www.gutachtliche-Stellungnahmen-sozialen-Arbeit-Familiengerichtsverfahren/dp/3472065923).

## Medical Care

As previously discussed, access to healthcare extends to all minors in Germany, regardless of their residence status.<sup>79</sup> The youth welfare office must ensure healthcare during ‘preliminary taking into care’<sup>80</sup>, and during the regular taking into care that follows on from this.<sup>81</sup> Healthcare is also to be provided if URMs are accommodated in residential youth welfare institutions in the phase after taking into care.<sup>82</sup> So basically the Youth Welfare office is responsible for healthcare of minors at all stages of the asylum process. During the first two phases, the youth office must “ensure the minor’s best interests as a whole. In cases of severe physical injury and a life-threatening state of health, immediate medical care takes priority over all other interventions.”<sup>83</sup> Although in theory this should provide access to healthcare, while an asylum decision is pending many treatments for chronic or psychological illnesses will be withheld, awaiting a response. “The practical consequence of this is that unaccompanied minors attributed to this group find it difficult to gain access to medical benefits beyond healing or alleviating acute illnesses and pain (including visual aids, braces, treatment of growth disorders).<sup>84</sup> This is clearly problematic and has been widely criticized by experts<sup>85 86 87</sup> and politicians<sup>88</sup> as it prevents minors from getting access to basic care.

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<sup>79</sup> Espenhorst; Noske (n 40) 68.

<sup>80</sup> Social Code (n 51) Section 40 of Book VIII.

<sup>81</sup> Idem: Section 42 subs. 2 third sentence.

<sup>82</sup> Idem: Sections 33 to 35 or Section 35a subs. 2 no. 3 or 4 & Section 40 first sentence.

<sup>83</sup> Trenczek, Thomas; Düring, Diana; Neumann-Witt, Andreas. “Inobhutnahme. Krisenintervention und Schutzgewährung durch die Jugendhilfe”, 2017 §8a, §§ 42, 42aff. SGB VIII. 3. Auflage. München et al.: Richard Boorberg Verlag.

<sup>84</sup> Tangermann (n 32)

<sup>85</sup> Schmeling, Andreas, et al. “Forensic age estimation: methods, certainty, and the law.” Deutsches Ärzteblatt International 113.4, 2016: 44.

<sup>86</sup> Thevisen, Patrick, et al. “Ethics in age estimation of unaccompanied minors.” Journal of Forensic Odonto-Stomatology 30.1, 2012: 85-102.

<sup>87</sup> Espenhorst; Noske (n 40) 68.

<sup>88</sup> Deutscher Bundestag (n 39).

## Medical Screenings & Referrals

Mostly due to the overburdening of certain German regions, ‘preliminary taking into care’ was established. This was done so as to introduce a brief medical examination, which determines whether the health of the minor in anyway precludes them from undergoing the federal distribution procedure.<sup>89</sup> One of the largest problems attaining statistics on the URMs’ health, is that the brief medical examinations, are not regulated by law and hence each region has its own version, this lack of standardization makes attaining comparable data very challenging. Additionally it also entails that URMs will get differing care depending on the region they are processed,<sup>90</sup> which raises other ethical issues. For these and other reasons pediatric experts are calling for a standardization of this initial medical examination and have made a proposal as to how.<sup>91</sup> However, so far the government has not heeded their proposal and URMs continue getting unstandardized, at time sub-par care and examinations, while researchers continue to long for more data and better communication systems.<sup>92</sup>

After the initial screening, a more in-depth medical examination is to take place. Although it is at this point that URMs potential need for therapeutic, psychological, or medical treatment is assessed. Many illnesses, in particular psychiatric ones are not being identified. ‘The National Association of Catholic Educational Assistance Facilities and services found that from the 500 cases in need of therapy, only 25% were identified during the clearing procedure of

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<sup>89</sup> Social Code (n 51) Section 42a subs. 4 no. 4 of Book VIII.

<sup>90</sup> Voss, Klaas et al. “*Erstuntersuchungen bei unbegleiteten minderjährigen Ausländern: eine bundesweite Bestandsaufnahme.*” 2019: Online: <https://www.thieme-connect.com/products/ejournals/abstract/10.1055/a-0719-5296>

<sup>91</sup> DGPI/GTP/BVKJ - Deutsche Gesellschaft für Pädiatrische Infektiologie (DGPI e.V.) / Gesellschaft für Tropenpädiatrie und Internationale Kindergesundheit (GTP e.V.) / Berufsverband der Kinder und Jugendärzte (BVKJ e.V.) “*Empfehlungen zur infektiologischen Versorgung von Flüchtlingen im Kindes- und Jugendalter in Deutschland.*” 2015: Online: [https://www.bvkj.de/fileadmin/pdf/Fluechtlinge\\_DGPI-GTP-BVKJ-Stellungnahme\\_V1\\_28Okt2015.pdf](https://www.bvkj.de/fileadmin/pdf/Fluechtlinge_DGPI-GTP-BVKJ-Stellungnahme_V1_28Okt2015.pdf)

<sup>92</sup> Ibid.

regular taking into care.<sup>93</sup> Some pediatric experts have stated that this may be in part due to the difficulty in assessing URMs mental state upon arrival and that more time is needed for evaluation.<sup>94</sup> Hence, these very same pediatric association experts are calling for a separate pediatric medical examination for URMs to be carried out in a comprehensive & culturally sensitive manner.<sup>95</sup> It is widely accepted that the state of research on URMs' health in general and even more so in Germany is underdeveloped.<sup>96</sup> A review of the research available exposes the lack of reliable data, and what is published refers to specific health-studies, in specific regions or municipalities, and has therefore no general applicability.<sup>97</sup> Echoing this point, the German government itself stated in its parliamentary discussion of 2017, on the topic of unaccompanied minors, that so far there exists no representative study for the spread and prevalence of disease among the URM population.

### **Healthcare in Practice:**

In addition to not knowing what the health condition of URMs in Germany is, there are also no demonstrative studies illustrating the health care provisions for this demographic. From what is known, bureaucratic and practical issues seem

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<sup>93</sup> Deutscher Bundestag: *“Unterrichtung durch die Bundesregierung. Bericht über die Situation unbegleiteter ausländischer Minderjähriger in Deutschland.”* Drucksache 18/11540, Berlin, 2017: Deutscher Bundestag.

<sup>94</sup> DAKJ - Deutsche Akademie für Kinder- und Jugendmedizin e. V. *“Maßnahmen zur medizinischen Erstversorgung von Flüchtlingen und Asylbewerbern im Kindes- und Jugendalter in Deutschland. Stellungnahme der Kommission für Globale Kindergesundheit der Deutschen Akademie für Kinder- und Jugendmedizin (DAKJ)”* (Version vom 10.02.2016). Online: [https://dakj.de/wp-content/uploads/2016/09/150216\\_Langversion\\_Stellungnahme\\_Komm\\_glob\\_Kindergesundheit\\_DAKJ.pdf](https://dakj.de/wp-content/uploads/2016/09/150216_Langversion_Stellungnahme_Komm_glob_Kindergesundheit_DAKJ.pdf) (02.08.2020).

<sup>95</sup> Ibid.

<sup>96</sup> Frank, Laura; Yesil-Jürgens, Rahsan; Razum, Oliver; Bozorgmehr, Kayvan; Schenk, Liane; Gilsdorf, Andreas; Rommel, Alexander; Lampert, Thomas. *“Gesundheit und gesundheitliche Versorgung von Asylsuchenden und Flüchtlingen in Deutschland”*, in: *Journal of Health Monitoring* 2017 2(1). Online: <http://edoc.rki.de/oa/articles/reTk1hLXDlb6I/PDF/29FxSCKCayeJY.pdf>

<sup>97</sup> Janda, Aleš; Gehring, Stephan; Kitz, Christa; Kobbe, Robin; Pfeil, Johannes; Rau, Cornelius; van Eys, Susanna; Hufnagel, Markus. *“Providing healthcare for refugee minors: Experiences in Germany.”* *Journal of Pediatrics*. [https://www.academia.edu/36753129/\\_DE\\_Unbegleitete\\_Minderj%C3%A4hrige\\_in\\_Deutschland\\_Herausforderungen\\_und\\_Ma%C3%9Fnahmen\\_nach\\_der\\_Kl%C3%A4rung\\_des\\_aufenthaltsrechtlichen\\_Status](https://www.academia.edu/36753129/_DE_Unbegleitete_Minderj%C3%A4hrige_in_Deutschland_Herausforderungen_und_Ma%C3%9Fnahmen_nach_der_Kl%C3%A4rung_des_aufenthaltsrechtlichen_Status)

to be the major barriers in access to healthcare provision. Bureaucratically, the main issue is that not all URMs are covered by state health insurance<sup>98</sup>, which bars them from access to funding for interpreters and acceptable healthcare standards.<sup>99</sup> Practically, the main issues are the 'lack of psychologists specialized in children and youth, as well as the lack of adequately trained interpreters'<sup>100</sup>, the absence of which, is particularly of note in more rural areas of the country. Due to the small supply and large demand for psychologist and interpreters, the waiting times to actually see a therapist can be unacceptably long.<sup>101</sup> Summing up URMs mental and physical condition, as well as, how many are treated and what kind of access to healthcare this population has is still unknown. The 'Psychological Perspective' chapter of this work attempts to expose and manage this and other gaps in knowledge of the URM demographic.

### **Legal Representation of URMs**

As URMs per definition are unaccompanied, one of the first responsibilities of the German government is to assign them a legal representative,<sup>102</sup> which must be done within three days of arrival.<sup>103</sup> In order to achieve this efficiently emergency power of representation is given to the Youth Welfare Office (YWO).<sup>104</sup> The Youth Welfare Office is then responsible for all aspects of care, including health and accommodation, but must still consider the best interest of the child as a priority and take into account the presumed will of any individual with legal custody or legal guardian.<sup>105</sup> It is at this point in time that the YWO, may request the family court to appoint a guardian, it is however not obligated to

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<sup>98</sup> Ibid.

<sup>99</sup> Deutscher Bundestag (n 93) 46.

<sup>100</sup> Janda (n 97)

<sup>101</sup> Deutscher Bundestag (n 93) 64 et seqq.

<sup>102</sup> BAMF - Federal Office for Migration and Refugees (n 44)

<sup>103</sup> Social Code (n 51) Section 42 subs. 3 fourth sentence of Book VIII.

<sup>104</sup> Tangermann (n 32)

<sup>105</sup> Social Code (n 51) Section 42a subs. 3 of Book VII.

do so<sup>106</sup>. In particular as a vast majority of URMs end up with the YWO as their legal guardian.<sup>107</sup> Legal representation by the YWO is practically problematic as it is the legal guardian that needs to appeal to authorities for review in the case that a public authority acts unlawfully, or when they may take an action that is not in line with the best interest of the child, yet it is the YWO itself which is making these decisions and so it would theoretically have to stand against itself. The YWO is however required by the Act on the Improvement of Care Arrangements for Foreign Children and Juveniles<sup>108</sup> to take appropriate staffing and organizational arrangements, so as to prevent this conflict of interest. It is for this and other reasons (discussed below) that the appointing of a Guardian other than the YWO is preferable. However as we shall see, it is currently extremely challenging to find adequate legal guardianship for URMs.

### **Guardianship:**

Ultimately it is in the hands of the family court to appoint Legal Guardians to URMs<sup>109</sup>. Guardianship lasts until the URM becomes of age according to their own countries' law, so if the URM originates from Taiwan, where the age of majority is 20, then the Guardian maintains said role until that age.<sup>110</sup> "The appointment of a guardian is conditional on the person in question being a minor and parental custody being in abeyance"<sup>111</sup> Although, individuals and associations who meet the family court's criteria may be appointed as guardians,<sup>112</sup> as discussed above, in practice most URMs are assigned the YWO as their official guardian, even with the family court having to take into consideration "whether a suitable voluntary guardian, in particular a relative or, for instance, a member of a guardianship association specialized in

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<sup>106</sup> Espenhorst, Niels/Schwarz, Ulrike. "Alterseinschätzung, in: Brinks, Sabrina/Dittmann, Eva/Müller, Heinz (ed.): *Handbuch unbegleitete minderjährige Flüchtlinge. Reihe Grundsatzfragen (53)*, Frankfurt: Internationale Gesellschaft für erzieherische Hilfen Sektion Bundesrepublik Deutschland", 2017 p. 113-122.

<sup>107</sup> Trenczek (n 83) 281.

<sup>108</sup> Bundesgesetzblatt Teil (n 51)

<sup>109</sup> BAMF (n 43)

<sup>110</sup> Tangermann (n 32)

<sup>111</sup> German Civil Code BGB. "German Civil Code BGB". Section 1773 subs. 1, 2013. Online: [www.gesetze-im-internet.de/englisch\\_bgb/](http://www.gesetze-im-internet.de/englisch_bgb/).

<sup>112</sup> Idem, section 1779 subs. 2 first sentence & Section 1791a.

unaccompanied minor foreigners, or other guardianship association, is available.”<sup>113</sup> This common practice also led to the setting of an upper limit of 50 URM per official Guardian.<sup>114</sup>

The Federal working group of Land youth welfare offices defines the profile of tasks of guardians of unaccompanied minors as:<sup>115</sup>

- Personal contact person
- Legal representative
- Person with the right of custody
- Developer of life prospects
- Contributor towards the assistance planning procedure, and
- First point of contact in proceedings pertaining to asylum and residence law

All of which must be done in the best interest of the child.<sup>116</sup> This role means that the guardian is responsible for all decisions affecting the development of the minor and that they are able to take decisions on their behalf without being subject to instruction<sup>117</sup>, other than the mandatory supervision via a yearly report guardians must send to the Family Court.<sup>118</sup> In order to maintain guardianship, guardians must maintain personal contact with URM on the basis of in person visits in the minor’s customary environment,<sup>119</sup> these visits should take place no less than monthly, but are however not limited in this regard.<sup>120</sup>

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<sup>113</sup> Deutscher Bundestag (n 93) 66.

<sup>114</sup> BMFSFJ - Bundesministerium für Familie, Senioren, Frauen und Jugend. “*Vormundschaften. Hintergrundmel- dung*”, 2016. Online: <https://www.bmfsfj.de/bmfsfj/themen/engagement-und-gesellschaft/fluechtlingspolitik-und-integration/menschen-staerken-menschen/vormundschaften/96624>

<sup>115</sup> BAG - Bundesarbeitsgemeinschaft Landesjugendämter. “*Handlungsempfehlungen zum Umgang mit unbeglei- teten Minderjährigen. Verteilungsverfahren, Maßnahmen der Jugendhilfe und Clearingverfahren. 2. aktualisierte Fassung.*” 2017. Online:

[http://www.bagljae.de/downloads/128\\_handlungsempfehlungen-zum-umgang-mit-unbge.pdf](http://www.bagljae.de/downloads/128_handlungsempfehlungen-zum-umgang-mit-unbge.pdf)

<sup>116</sup> Ibid.

<sup>117</sup> Tangermann (n 32)

<sup>118</sup> Espenhorst (n 106)

<sup>119</sup> German Civil Code (n 111) Section 1793 subs. 1a.

<sup>120</sup> Espenhorst (n 106) 161

The volunteer sole guardianship system needs to be fortified, as currently the common practice is to assign the YWO as the official guardian,<sup>121</sup> although the government itself acknowledges the superiority of volunteer guardianship. This can be seen in the German government stating “Voluntary sole guardians can become more engaged with the young people and give them more personal assistance. In some cases, voluntary sole guardians can offer unaccompanied minor foreigners contacts and assistance for which official guardians do not have the time. A voluntary sole guardian is also much better able to remain a trusted, reliable contact for the young adult, even after the guardianship has come to an end.” This can be particularly crucial when the URM needs counseling or even more basically, psycho-social support,<sup>122</sup> as someone with 50 cases in their mind can not possibly attend to them all with the adequate care. Additionally there seems to be tremendous variation in the time required to have a guardian appointed, ranging from the process taking 2 weeks to 4 months.<sup>123</sup> As YTO care cannot start until a guardian is appointed, and there is no one directly responsible for them in the meantime, this can be tremendously detrimental to the URMs mental and physical health.<sup>124</sup> Another problem with the appointment of guardians is that not only are there not enough volunteer guardians, there are great discrepancies as to their qualifications or as put by the government it’ self “not only are there too few guardians available, they are also not all adequately qualified”<sup>125</sup> Lastly a study by Barbara Noske, found that not only is the range of qualifications quite broad between guardians, but also there is no standardized practice as to the role that guardianship entails, mostly due to the wide range of practices done throughout the differing German municipalities.<sup>126</sup> In part for due to this wide variation there are no empirical studies so far on the connection between how guardianship is exercised and the resulting URMs development

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<sup>121</sup> Deutscher Bundestag (n 93) 68

<sup>122</sup> Noske, Barbara. “Herausforderungen und Chancen. Vormundschaften für unbegleitete minderjährige Flüchtlinge in Deutschland, München: Bundesfachverband unbegleitete minderjährige Flüchtlinge e. V.” 2010. Online: [http://www.b-umf.de/images/vormundschaftsstudie\\_2010.pdf](http://www.b-umf.de/images/vormundschaftsstudie_2010.pdf)

<sup>123</sup> Deutscher Bundestag (n 93) 67

<sup>124</sup> Von Nordheim, Franziska; Karpenstein, Johanna; Klaus, Tobias. “Die Situation unbegleiteter Minderjähriger Flüchtlinge in Deutschland. Auswertung der Online-Umfrage”. 2017, Berlin: Bundesfachverband unbegleitete minderjährige Flüchtlinge e.V.

<sup>125</sup> Deutscher Bundestag (n 93) 69

<sup>126</sup> Noske (n 122)

and integration.<sup>127</sup> However according to Tobias Lettl, the role of guardian “appears to be of especial significance, particularly for unaccompanied minors, since integration-related issues such as those in school, play a major role in this context”<sup>128</sup> As is the case for much of the information on URMs (or the lack there of), studies on the roles and effects of Guardianship are still lacking, however there has been some legal reform suggested as well as some potential policy changes that could aid URMs through integration and transition to adulthood. These recommendations will be explored in the ‘Best Practices’ chapter, for now it is of note that Guardianship may indeed be key for the future well being of URMs in Germany.

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<sup>127</sup> Tangemann (n 32)

<sup>128</sup> Lettl, Tobias. “*Die Vertretung unbegleiteter Minderjähriger nach §§ 1773ff. BGB*”, in: Juristische Arbeitsblätter, Heft 7/2016, 481-487.

## Chapter 2

### A Psychological Perspective:

So far, we have covered the legal, however as discussed in the following section, this view is in contrast with the psychological one, which primarily concerns itself with the welfare of the individual and not with who is responsible for URMs and what are the minimum legal standards that the responsible party must hold. Arguably, it is precisely the maintenance of a solely legal perspective that haunts the care system and bars children from attaining the help they need. One study from Belgium holds that “considering unaccompanied refugee children and adolescents as ‘refugees’, entitled to gain temporary protection and residence documents until they attain the age of majority leads to minimal standards of care and reception and an important neglect of their psychological needs.”<sup>129</sup> For this very reason and due to the blatant gap in knowledge of the mental-health of URMs, this paper will build a psychological perspective that demands that those responsible for URM care have an adequate reception and care system for these children in order to meet their unique situation and needs.

### What we know of the mental-health of URMs:

A population at risk: High levels of psychological distress within the URM demographic result in a elevated risk of developing mental health disorders.

The URM population has characteristically been forced to leave their home nation, escaping human rights violations and/or armed conflict.<sup>130</sup> It has been found that due to this very background URMs show higher frequencies of psychiatric disorders and depressive symptoms, in relation even to ARMs.<sup>131</sup> From the difference in the quality of mental health between these two groups

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<sup>129</sup> Derluyn, Ilse, and Eric Broekaert. “Unaccompanied refugee children and adolescents: The glaring contrast between a legal and a psychological perspective.” *International journal of law and psychiatry* 31.4, 2008; 319-330.

<sup>130</sup> Halvorsen, Kate. “Separated children seeking asylum: The most vulnerable of all.” *Forced Migration Review* 12.7, 2002: 34-36.

<sup>131</sup> Wiese EB, Burhorst I. “The mental health of asylum-seeking and refugee children and adolescents attending a clinic in the Netherlands.” *Transcult Psychiatry* 2007;44:596–613.

and from a few studies done on the matter, we can deduce that family support of these minors, before<sup>132</sup>, during and after the journey can be an important shielding factor.<sup>133</sup> As this protective factor is mostly lacking or inexistent for most of the URM population<sup>134</sup>, the URM demographic is commonly labeled as the most vulnerable of refugee groups.<sup>135</sup>

‘As URMs are a highly vulnerable refugee subgroup in terms of mental health issues’<sup>136</sup>; It is unsurprising that ‘URMs have such a high risk of developing post-traumatic stress disorder (PTSD), anxiety, depression, and externalizing behaviors.’<sup>137</sup> The URM demographic is particularly at risk of developing mental disorders as most suffered through the loss of or separation from their parents at a time critical for emotional and physical development mainly, during the massive transition that is fleeing from home. Undergoing this transition alone is a distinguishing factor from accompanied refugee minors (ARM) and refugees in general. <sup>138</sup>

While undergoing this transition unaccompanied may be the most salient distinguishing factor, URMs battle with several additional psychological burdens. ‘These include direct or indirect exposure to violence in the home country’<sup>139</sup> ‘

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<sup>132</sup> Macksoud, M. & Aber, J. L. “*The war experiences and psychosocial development of children in Lebanon.*” *Child Development*, 1996; 67, 70-88.

<sup>133</sup> Derluyn, I. & Broekaert, E. “*Different perspectives on emotional and behavioural problems in unaccompanied refugee children and adolescents.*” *Ethnicity & Health*, 2007; 12, 141-162.

<sup>134</sup> Mels, C., Derluyn, I., Broekaert, E. & Rosseel, Y. “*The psychological impact of forced displacement and related risk factors on Eastern Congolese adolescents affected by war.*” *Journal of Child Psychology and Psychiatry* 51, 2010; 1096–1104.

<sup>135</sup> Halvorsen (n 130)

<sup>136</sup> Mohwinkel L-M, Nowak AC, Kasper A, et al. “*Gender differences in the mental health of unaccompanied refugee minors in Europe: a systematic review.*” *BMJ Open* 2018; 8:e022389. doi:10.1136/bmjopen-2018-022389

<sup>137</sup> Bean, Tammy; Derluyn, Ilse PhD; Eurelings-Bontekoe, Elisabeth; Broekaert, Eric; Spinhoven, Philip. “*Comparing Psychological Distress, Traumatic Stress Reactions, and Experiences of Unaccompanied Refugee Minors With Experiences of Adolescents Accompanied by Parents.*” *The Journal of Nervous and Mental Disease*: April 2007 - Volume 195 - Issue 4 - p 288-297 doi: 10.1097/01.nmd.0000243751.49499.93

<sup>138</sup> Huemer, J., Karnik, N.S., Voelkl-Kernstock, S. et al. “*Mental health issues in unaccompanied refugee minors.*” *Child Adolesc Psychiatry Ment Health* 2009; 3, 13. Online: <https://doi.org/10.1186/1753-2000-3-13>

<sup>139</sup> Lustig SL, Kia-Keating M, Knight WG, et al. “*Review of child and adolescent refugee mental health.*” *J Am Acad Child Adolesc Psychiatry* 2004; 43:24–36.

high incidences of physical and sexual violence during the journey'<sup>140</sup> as well as 'acculturation-specific stress'.<sup>141</sup> Although these stress factors are also prevalent in the ARM and refugee demographics, URMs must face these challenges as children and mostly without parental support,<sup>142</sup> placing them in a particularly vulnerable situation. These 'cumulative traumatic pre-migration experiences, and post-migration stressors'<sup>143</sup> result in higher incidences 'of post-traumatic stress and depression than in refugee children accompanied by at least one parent.'<sup>144</sup>

### **Status: Mental health condition of unaccompanied refugee minors (URMs) in Germany.**

Although there are many studies lacking in order to ascertain the mental health condition of asylum seeking children & adolescents in Europe' (ASC), let alone of URMs in Germany, there is a growing body of research indicating that this demographic is at high risk of developing mental disorders.<sup>145</sup><sup>146</sup> <sup>147</sup> <sup>148</sup> <sup>149</sup> The most frequently encountered 'mental-health problems in ASC include posttraumatic stress disorder (PTSD), internalizing symptoms such as depression and anxiety, and externalizing behavior' <sup>150</sup> Within the ASC

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<sup>140</sup> Derluyn I, Mels C, Broekaert E. "Mental health problems in separated refugee adolescents." *J Adolesc Health* 2009; 44:291–7.

<sup>141</sup> Keles S, Friborg O, Idsøe T, et al. "Depression among unaccompanied minor refugees: the relative contribution of general and acculturation-specific daily hassles." *Ethn Health* 2016; 21:300–17.

<sup>142</sup> Bronstein I, Montgomery P. "Psychological distress in refugee children: a systematic review." *Clin Child Fam Psychol Rev* 2011; 14:44–56.

<sup>143</sup> Ibid

<sup>144</sup> Pinto Wiese EB, Burhorst I. "The mental health of asylum-seeking and refugee children and adolescents attending a clinic in the Netherlands." *Transcult Psychiatry*. 2007; 44(4):596–613

<sup>145</sup> Bronstein I, Montgomery (n 142)

<sup>146</sup> Derluyn I, Broekaert E, Schuyten G. "Emotional and behavioural problems in migrant adolescents in Belgium." *Eur Child Adolesc Psychiatry*. 2008; 17(1):54–62.

<sup>147</sup> Reavell J, Fazil Q. "The epidemiology of PTSD and depression in refugee minors who have resettled in developed countries." *J Ment Health*. 2017; 26(1):74–83.

<sup>148</sup> Hodes M, Jagdev D, Chandra N, Cunniff A. "Risk and resilience for psychological distress amongst unaccompanied asylum seeking adolescents." *J Child Psychol Psychiatry*. 2008; 49(7):723–32.

<sup>149</sup> Pinto Wiese EB, Burhorst I. (n 144)

<sup>150</sup> Müller, L.R.F., Büter, K.P., Rosner, R. et al. "Mental health and associated stress factors in accompanied and unaccompanied refugee minors resettled in Germany: a cross-sectional

demographic, belonging to the URM group “was found to be highly predictive for higher levels of psychological distress.”<sup>151</sup> This overall higher psychological distress is precisely what develops into an endless number of burdens that extend through the URM life, plaguing this demographic with countless physical and mental illnesses. These burdens include but are not limited to: sleeping problems, concentration disorders, nightmares,<sup>152</sup> depression, withdrawal, anxiety,<sup>153</sup> post-traumatic stress symptoms,<sup>154</sup> somatic symptoms, severe grief reactions and sadness<sup>155</sup>, aggression, diminished interest<sup>156</sup>, hyper-arousal, low self-esteem, severe guilt feelings, fatalistic view of the future,<sup>157</sup> substance abuse, violent behavior,<sup>158</sup> suicidal acts, psychosis and delinquent behavior.<sup>159</sup>

It is puzzling, that although Germany is the biggest host country for ASC<sup>160</sup> there are still not enough studies using psychometric measures as to reliably depict the mental health condition of this population<sup>161</sup>. ‘From the few studies available, the picture of mental health for the URM demographic is particularly dismal.’<sup>162</sup> This was found to be particularly so when contrasted to the mental health of the minors in Europe, and to a lesser, yet still significant, extent, when compared to the ARM demographic. A review of some of the key literature follows, illustrating the stark contrast between the conditions of mental health of these populations.

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*study.*” Child Adolescent Psychiatry Mental Health, 201; 13, 8. Online:  
<https://doi.org/10.1186/s13034-019-0268-1>

<sup>151</sup> Ibid

<sup>152</sup> Davies, Mike, and Elspeth Webb. “Promoting the psychological well-being of refugee children.” Clinical Child Psychology and Psychiatry, 2000; 5.4, 541-554.

<sup>153</sup> Burnett, Angela, and Michael Peel. “Asylum seekers and refugees in Britain: Health needs of asylum seekers and refugees.” BMJ: British Medical Journal, 2001; 322.7285, 544.

<sup>154</sup> Ajdukovic, Marina. “Displaced adolescents in Croatia: Sources of stress and posttraumatic stress reaction.” Adolescence, 1998; 33.129, 209.

<sup>155</sup> Dyregrov, Atle, Rolf Gjestad, and Magne Raundalen. “Children exposed to warfare: A longitudinal study.” Journal of traumatic stress, 2002; 15.1, 59-68.

<sup>156</sup> Ferenci, Beatrix. “Separated refugee children in Austria.” Int’l J. Refugee L, 2000;12, 525.

<sup>157</sup> Steel, Zachary, et al. “Pathways from war trauma to posttraumatic stress symptoms among Tamil asylum seekers, refugees, and immigrants.” Journal of traumatic stress, 1999; 12.3, 421-435.

<sup>158</sup> Almqvist, Kjerstin, and Anders G. Broberg. “Mental health and social adjustment in young refugee children y 3½ years after their arrival in Sweden.” Journal of the American Academy of Child & Adolescent Psychiatry 1999; 38.6, 723-730.

<sup>159</sup> Hubbard, Jon, et al. “Comorbidity of psychiatric diagnoses with posttraumatic stress disorder in survivors of childhood trauma.” Journal of the American Academy of Child & Adolescent Psychiatry, 1995; 34.9, 1167-1173.

<sup>160</sup> Müller (n 150)

<sup>161</sup> Müller (n 150)

<sup>162</sup> Huemer J, Karnik NS, Voelkl-Kernstock S, et al. “Mental health issues in unaccompanied refugee minors.” Child Adolesc Psychiatry Ment Health. 2009;3(1):13. Published 2009 Apr 2.  
doi:10.1186/1753-2000-3-13

However, before going into key studies highlighting the prevalence of mental disorders in the URM and ARM populations, some international studies are briefly discussed to establish benchmarks for anxiety disorder, depression and PTSD, in the non-migrant minors (NMM) demographic.

The first is a study by RG Klein et al, done to establish guidelines for diagnostic and treatment of depression in Canada. This study found that although it is 'challenging to estimate an accurate rate of prevalence for anxiety disorder, mostly due to symptom comorbidity, and other challenges assessing symptomatology, the evidence gathered suggests that anxiety disorder has a prevalence of about 5-9% in the NMM population.'<sup>163</sup> While there is a broad range for the possible prevalence of anxiety disorders in the non-migrant minor population, the range of prevalence for depression is even broader, 'ranging from 2-8%, with studies also citing the challenges involved in diagnosing depression and the broad range of its symptomatology as the largest obstacles in obtaining accurate data.'<sup>164</sup> <sup>165</sup> <sup>166</sup> Finally, the benchmark for the prevalence of PTSD in the NMM demographic has been found to average around 4%.<sup>167</sup> <sup>168</sup> Keeping in mind the average rates of 7% for anxiety disorder, 5% for depression and 4% for PTSD, following are some studies around Europe estimating the prevalence of these and other mental disorders in the ARM and URM demographics.

Exposing the differences between the two demographics, a study in the Netherlands comparing the ARM and URM populations found that there was a

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<sup>163</sup> Klein, R.G. "Anxiety disorders." *Journal of Child Psychology and Psychiatry*, 2009; 50: 153-162. doi:[10.1111/j.1469-7610.2008.02061.x](https://doi.org/10.1111/j.1469-7610.2008.02061.x)

<sup>164</sup> Thapar A, Collishaw S, Pine DS, Thapar AK. "Depression in adolescence." *Lancet*. 2012;379(9820):1056-1067. doi:[10.1016/S0140-6736\(11\)60871-4](https://doi.org/10.1016/S0140-6736(11)60871-4)

<sup>165</sup> Pelkonen M, Marttunen M. "Child and adolescent suicide: epidemiology, risk factors, and approaches to prevention." *Paediatr Drugs*. 2003;5(4):243-265. doi:[10.2165/00128072-200305040-00004](https://doi.org/10.2165/00128072-200305040-00004)

<sup>166</sup> Nordentoft M. "Prevention of suicide and attempted suicide in Denmark." *Epidemiological studies of suicide and intervention studies in selected risk groups. Dan Med Bull*. 2007;54(4):306-369.

<sup>167</sup> Katzman, Martin A et al. "Canadian clinical practice guidelines for the management of anxiety, posttraumatic stress and obsessive-compulsive disorders." *BMC psychiatry* vol. 14 Suppl 1,Suppl 1 2014; S1. doi:[10.1186/1471-244X-14-S1-S1](https://doi.org/10.1186/1471-244X-14-S1-S1)

<sup>168</sup> Pfeiffer PN, Ganoczy D, Ilgen M, Zivin K, Valenstein M. "Comorbid anxiety as a suicide risk factor among depressed veterans." *Depress Anxiety*. 2009; 26:752-757.

substantial difference in the number of traumatic events experienced by each population. Mainly, URMs were self-reportedly found to have experienced higher rates of “physical violence, exposure to life-threatening events, or having survived torture, maltreatment or prison”<sup>169</sup> Consistent with the findings of the study in the Netherlands, a study in Belgium suggests that between 37-47% of URMs exhibited the symptomatology for PTSD, anxiety and depression, a significantly higher rate than that seen in the ARM population.<sup>170</sup>

Although its findings suggest overall lower rates, ‘a study in the UK found that 33% of the 222 male Afghan asylum seeking URMs aged 13-18 years exhibited above threshold for anxiety, emotional and behavioral problems and PTSD, with 23% of the 222, scoring above threshold for depression.’<sup>171</sup>

Yet another study, done in Norway based on structured interviews with 160 male asylum seeking URMs aged between 14 and 20 years, found that 41.9% of them had a psychiatric disorder, with PTSD being most prevalent at 30.7%, followed by major depression disorder with a prevalence of 9.4%.<sup>172</sup>

In line with the previous findings, a study in Italy found 81% of URMs exhibited internalization and externalization problems, compared to 18.5% of their Italian counterparts. Additionally, 72.2% of URMs were determined to have externalizing problems, compared to 27.8% of the Italian adolescents. Finally, Italian adolescents were far more likely to be free of any diagnostic with 74.1% being classified problem free, compared to only 25.9% of URMs.<sup>173</sup>

Lastly, one of the few studies covering these demographics in Germany, done by Müller et al, found that “64.7% of URM and 36.7% of ARM scored above the clinical cut-off for PTSD, 42.6% of URM and 30% of ARM for depression, and

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<sup>169</sup> Wiese (n 144)

<sup>170</sup> Derluyn, I. & Broekaert, E. “*Different perspectives on emotional and behavioural problems in unaccompanied refugee children and adolescents.*” *Ethnicity & Health*, 2007; 12, 141-162.

<sup>171</sup> Ramel, Björn, et al. “*Overrepresentation of unaccompanied refugee minors in inpatient psychiatric care.*” SpringerPlus, 2015; 4.1, 131

<sup>172</sup> Jakobsen, Marianne et al. “*Prevalence of psychiatric disorders among unaccompanied asylum-seeking adolescents in Norway.*” *Clinical practice and epidemiology in mental health: CP & EMH* vol. 10 53-8. 13 Jun. 2014, doi:10.2174/1745017901410010053

<sup>173</sup> Thommessen, S., et al. “*Internalizing and externalizing symptoms among unaccompanied refugee and Italian adolescents.*” *Children and Youth Services Review* 35.1; 2013: 7-10.

38.2% of URM and 23.3% of ARM for anxiety.”<sup>174</sup> Another study in Germany coincided with Müller’s study, finding accordingly higher rates for PTSD, in the URM population.<sup>175</sup> Furthermore, this other study also analyzed the difference between children who had been exposed to trauma, with and without a migrant background. Their main discovery from this comparison was that children with a migration background tend to relive their trauma with more frequency than those without said background, primarily, “Re-experiencing symptoms seem to be central in the refugee minor PTSD profile and thus merit special consideration in the diagnostic and treatment evaluation process.”<sup>176</sup>

Although the rates of mental illness for NMM, URMs and ARMs display a significant amount of variation, it can nevertheless be seen from these statistics that the URM population faces a significantly higher risk of developing mental disorders than their ARM peers or NMM counterparts. However, it is also the sub-group for which we have the least information and hence requires more focused studies, as to adequately measure the size of the problem and propose solutions that may be translated into policy that aids in healing of this highly vulnerable group.

### **Sub Groups: Female/ Older Age**

Although the mental health of the general URM population is clearly at risk ‘there are many subcategories, whose mental health has been found to be even more impacted by trauma and lack of support than the general URM demographic. Even though a study in ‘Belgium claims there is not much of a difference in the prevalence of emotional and behavioral symptoms between migrant and non-migrant children. The study still clearly highlights the importance of heeding

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<sup>174</sup> Müller (n 150)

<sup>175</sup> Pfeiffer, Elisa, et al. *"The symptom representation of posttraumatic stress disorder in a sample of unaccompanied and accompanied refugee minors in Germany: a network analysis."* European journal of psychotraumatology, 2019; 10.1,1675990.

<sup>176</sup> Ibid

special attention to sub-groups, listing URMs and female migrant minors in general, as groups that are particularly at risk.<sup>177</sup> Somewhat echoing these findings, in the UK, Hodes, et al. found that 73.1% of unaccompanied females and 61.5% of unaccompanied males, compared to 35.3% of accompanied girls and 14.3% of accompanied boys to be at high risk of developing post-traumatic-stress-disorder.<sup>178</sup> Another somewhat less expected subgroup in the URM population that was found to face a higher risk, was being of older age<sup>179</sup>. Hence two of the principal subgroups most affected are those of older age and as discussed above, those belonging to the female gender.<sup>180</sup> These studies suggest that belonging to one of those two sub-groups has constantly been a predictive if not influential factor that results in poorer mental health outcomes within this demographic.<sup>181</sup>

It is therefore surprising to see the relatively small number of publications focused on the mental health of the URM demographic, and even fewer focused on these sub groups, in particular, “no standardized examination of the mental health of URMs that resettled in Europe in the wake of the European migrant crisis (2015-2017) has been conducted so far.”<sup>182</sup>With unprecedented numbers of URMs having arrived in Germany during the crisis<sup>183</sup>, there is a dire need for further studies that can aid in illustrating the particular issues faced by this population and potential avenues to address them.

### **Lack Of Reliable Data/ Adequately Tailored Studies/ Theoretical Bases**

Although trauma and mental health problems, in refugee children and youth, are well documented the estimation of prevalence of post-traumatic stress disorder

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<sup>177</sup> Derluyn, I., Broekaert, E. & Schuyten, G. (n 146)

<sup>178</sup> Hodes (n 148)

<sup>179</sup> Bean, Tammy; Derluyn, Ilse; Eurelings-Bontekoe, Elisabeth; Broekaert, Eric; Spinhoven, Philip (n 129)

<sup>180</sup> Hodes (n 148)

<sup>181</sup> Mohwinkel L-M, Nowak AC, Kasper A. (n 136)

<sup>182</sup> Müller (n 150)

<sup>183</sup> Plener, P.L., Groschwitz, R.C., Brähler, E. *et al.* “Unaccompanied refugee minors in Germany: attitudes of the general population towards a vulnerable group.” *Eur Child Adolesc Psychiatry*, 2017; 26, 733–742. Online: <https://doi.org/10.1007/s00787-017-0943-9>

(PTSD) and depression varies.<sup>184 185</sup> Suggesting we need overall more adequate and accurate studies. 'A 2004 study of the rate of PTSD of refugee children in London, found the prevalence of PTSD to be around 63%'<sup>186</sup>, however more recent research, from 2014/15, places the estimate somewhere between 40-60%<sup>187 188</sup>, with some research, albeit from Australia, placing the prevalence estimate as low as 5%.<sup>189</sup> From these studies, and those cited above, one main conclusion can be drawn; more research in this particular field is required in particular considering the scarcity of studies and the variations within said studies, which are partly explained by a lack of adequate theoretical bases.

### Lack of Theoretical Bases

In addition, adequate studies focusing on the URM demographic need to be developed as a lack of reliable data, assessing the mental health of refugees, is particularly accentuated due to "the lack of theoretical bases to instruments and inattention to using and reporting sound measurement principles."<sup>190</sup> The theoretical and practical instruments currently in place for testing need to be reconceived in a frame that fits this very diverse population, with quite particular set of needs; we cannot simply use trauma tests developed by and for westerners under very different circumstances.

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<sup>184</sup> A.K. Gadeberg, E. Montgomery, H.W. Frederiksen, M. Norredam. "Assessing trauma and mental health in refugee children and youth: a systematic review of validated screening and measurement tools." *European Journal of Public Health*, 2017; Volume 27, Issue 3, Pages 439–446. Online: <https://doi.org/10.1093/eurpub/ckx034>

<sup>185</sup> Reavell J, Fazil Q. (n 147)

<sup>186</sup> Heptinstall E, Sethna V, Taylor E. "PTSD and depression in refugee children: associations with pre-migration trauma and post-migration stress." *Eur Child Adolesc Psychiatry*. 2004;13(6):373-380. doi:10.1007/s00787-004-0422-y

<sup>187</sup> Jensen, T.K., Skårdalsmo, E.M.B. & Fjermestad, K.W. "Development of mental health problems - a follow-up study of unaccompanied refugee minors." *Child Adolesc Psychiatry Ment Health*, 2014; **8**, 29. Online: <https://doi.org/10.1186/1753-2000-8-29>

<sup>188</sup> Vervliet, Marianne & Meyer DeMott, Melinda & Jakobsen, Marianne & Broekaert, Eric & Heir, Trond & Derluyn, Ilse. "The Mental Health of Unaccompanied Refugee Minors on Arrival in the Host Country." *Scandinavian Journal of Psychology*, 2014; 55. 33-37. 10.1111/sjop.12094.

<sup>189</sup> Mace, A. O., Mulheron, S., Jones, C., & Cherian, S. "Educational, developmental and psychological outcomes of resettled refugee children in Western Australia: A review of school of special educational needs: Medical and mental health input." *Journal of Paediatrics and Child Health*, 2014; 50(12), 985-992. <https://doi.org/10.1111/jpc.12674>

<sup>190</sup> Hollifield M, Warner TD, Lian N, et al. "Measuring Trauma and Health Status in Refugees: A Critical Review." *JAMA*. 2002;288(5):611–621. doi:10.1001/jama.288.5.611

Nevertheless, from the data that is available, a high prevalence of mental health problems, due to a number of factors relating to forced migration, is discernible.<sup>191 192 193</sup> As has been established by the studies cited above, there is a higher incidence (in relation to their peers) of psychological problems, particularly signs of depression and PTSD, in the URM demographic.

### **Need More Help But Have Less Contact**

A further detrimental risk was shown in a study, done in the UK, which found that from the URMs in the sample “Forty-seven (66.2%) were at high risk for post-traumatic stress disorder and nine (12.7%) at high risk for depressive disorder. (However,) only 12 (17%) had MHS contact. Predictors of MHS contact were depressive symptoms and duration of time in the UK.<sup>194</sup> So as an additional risk factor, this study suggests that not only are URMs far more vulnerable, they are also far less likely to get help, in particular for non-depressive symptomatology, with only 17% of those needing assistance actually seeking it.<sup>195</sup> In support of this stipulation, a systematic review of health care utilization in Europe, found that despite their higher risk of PTSD, URMs were less likely than their ARM peers, to receive trauma-focused interventions, and also significantly less likely to have been treated using cognitive therapy, anxiety management and/or parent/carer training, as well as receiving fewer types of practical assistance with basic social needs.<sup>196</sup> These findings further highlight how tremendously vulnerable the URM demographic is and make a further plea for

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<sup>191</sup> Hjern A, Angel B, Jeppson O. “Political violence, family stress and mental health of refugee children in exile.” *Scand J Soc Med*. 1998;26(1):18-25. doi:10.1177/14034948980260010701

<sup>192</sup> Nielsen, S.S., Norredam, M., Christiansen, K.L. et al. “Mental health among children seeking asylum in Denmark – the effect of length of stay and number of relocations: a cross-sectional study.” *BMC Public Health*, 2008’ **8**, 293. Online: <https://doi.org/10.1186/1471-2458-8-293>

<sup>193</sup> Montgomery E. “Trauma, exile and mental health in young refugees.” *Acta Psychiatr Scand Suppl* 2011; 124:146.

<sup>194</sup> Sanchez-Cao E, Kramer T, Hodes M. “Psychological distress and mental health service contact of unaccompanied asylum-seeking children.” *Child Care Health Dev*. 2013; 39(5):651-659.

doi:10.1111/j.1365-2214.2012.01406.x  
<https://pubmed.ncbi.nlm.nih.gov/22676633/>

<sup>195</sup> Ibid

<sup>196</sup> Michelson, Daniel, and Irene Sclare. “Psychological Needs, Service Utilization and Provision of Care in a Specialist Mental Health Clinic for Young Refugees: A Comparative Study.” *Clinical Child Psychology and Psychiatry*, vol. 14, no. 2, Apr. 2009, pp. 273–296, doi:10.1177/1359104508100889.

further adequate research, protective policy, economic support for basic needs and socio-psychological support.

### **Secondary Traumatization**

Moreover, refugee minors are further exposed to risk of secondary traumatization through their parents or caregivers, who themselves have often been traumatized or in the case of the URM demographic, may share no bond of affection with the person or institution responsible for their care.<sup>197</sup> The impact of trauma can be severe, and it may take many forms, however when it develops into PTSD it results in greater instances of 'general poor health symptoms, medical conditions and lower health related quality of life, often related to greater frequency and severity of pain.'<sup>198</sup> Overall, we can logically deduce that a 'higher level of exposure to trauma results in a higher risk of developing mental health disorders, including PTSD'<sup>199</sup>, a diagnosis, which studies have revealed to be "somewhat persistent over time and to reduce the quality of life if left untreated."<sup>200</sup> This meaning that without adequate support, a large portion of URMs may be sentenced to a life long battle with PTSD and other mental illnesses.

### **Studies are establishing a clear link between exposure to potentially traumatic events and depression.**

Reiterating with a focus on depression, studies focused on refugee minors who migrate to a developed country, have shown a 'relatively high proportion of them

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<sup>197</sup> De Graeve, K. "Classed Landscapes of Care and Belonging: Guardianships of Unaccompanied Minors." *Journal of Refugee Studies*, 2015. doi: 10.1093/jrs/fev011

<sup>198</sup> Pacella ML, Hruska B, Delahanty DL. "The physical health consequences of PTSD and PTSD symptoms: a meta-analytic review." *J Anxiety Disord*. 2013; 27(1):33-46. doi:10.1016/j.janxdis.

<sup>199</sup> A.K. Gadeberg, E. Montgomery, H.W. Frederiksen, M. Norredam. "Assessing trauma and mental health in refugee children and youth: a systematic review of validated screening and measurement tools." *European Journal of Public Health*, 2017; Volume 27, Issue 3, Pages 439–446.

<sup>200</sup> Priebe S, Matanov A, Janković Gavrilović J, et al. "Consequences of untreated posttraumatic stress disorder following war in former Yugoslavia: morbidity, subjective quality of life, and care costs." *Croat Med J*. 2009; 50(5):465-475. doi:10.3325/cmj.2009.50.465

experience PTSD or depression.<sup>201 202</sup> As with rates of PTSD, depression rates have not been found to be consistent between refugee minors<sup>203</sup> or even between studies that focus on this population.<sup>204</sup> In part due to different methodologies, ranging from clinical interviews to questionnaires and sampling methods, the incidence and reporting of depression differs between studies.<sup>205</sup> The measures of mental illness are also impacted by this populations' varied pre-migration trauma, unique journeys and post migration experiences, which all may have an impact on how they view and self report their mental health.<sup>206</sup> Furthermore, the results are also impacted due to the difficulties identifying symptomatology, in particular with children who are afflicted with re-experiencing or regressive symptoms of PTSD, which include depression.<sup>207</sup> It is these symptoms, which are often the harshest, and most difficult to recognize. This is partly due to them being experienced subjectively, making it challenging to identify by adults and/or caregivers.<sup>208</sup> These issues only partially highlight the complexity of the problem, accentuating the need for adequate testing to be developed and standardly implemented.

Moreover, issues with attaining accurate measurements on the prevalence of depression and other mental illnesses, in the URM demographic, are complicated further by varying expressions of symptomatology, which pose a challenge for diagnoses. The diverse cultural backgrounds pertaining to the URM populations often result in their symptomatology and how it is described, to be expressed differently than their western counterparts. Some 'struggle with the whole concept of 'mental-health' and alternatively may express their symptoms by

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<sup>201</sup> I Mace, A. O., Mulheron, S., Jones, C., & Cherian, S. (n 189)

<sup>202</sup> Reavell J, Fazil Q. (n 147 )

<sup>203</sup> Beiser M, Hou F. "Mental Health Effects of Premigration Trauma and Postmigration Discrimination on Refugee Youth in Canada." *J Nerv Ment Dis.* 2016; 204(6):464-470. doi:10.1097/NMD.0000000000000516

<sup>204</sup> Hameed, S., Sadiq, A., & Din, A. U. (2018). "The Increased Vulnerability of Refugee Population to Mental Health Disorders." *Kansas journal of medicine*, 11(1), 1-12.

<sup>205</sup> Reavell J, Fazil Q. (n 147)

<sup>206</sup> Heptinstall, Ellen & Sethna, Vaheshta & Taylor, Eric. "PTSD and depression in refugee children: Associations with pre-migration trauma and post-migration stress." *European child & adolescent psychiatry*, 2005; 13. 373-80. 10.1007/s00787-004-0422-y.

<sup>207</sup> Reavell J, Fazil Q. (n 147)

<sup>208</sup> Rothe, E. Lewis, J. Castillo-Matos, H. "Posttraumatic Stress Disorder Among Cuban Children and Adolescents After Release From a Refugee Camp." *Psychiatric Services*, 2002; 53(8), pp. 970-976.

describing physical difficulties or somatizations.<sup>209</sup> Hence, not only are there, tremendous variations in the techniques used, this populations' personal experiences and relation to traumatizing events, as well as difficulty identifying regressive symptoms, but in addition to all those issues, the variation in their perceptions of what constitutes health and how they describe their own symptomatology can differ drastically between individuals in this demographic.

Although attaining accurate measures is still some time away, and will require adequate standardized testing to be developed, along with far more in-depth studies of URM demographics to be performed; the rates of depression cited in the studies reviewed are very unsettling. Studies, such as the one with Khmer refugee adolescents resettled in the United States of America (USA), showing that up to 66% presented symptoms of depression.<sup>210</sup> And others, which although suggesting the incidence may indeed not be as high as 66%, it is still to be considered alarming, indicating rates between 25-50%.<sup>211</sup> <sup>212</sup> Whether taking the higher or lower estimate of rates of depression, the mere range in estimation calls for further studies and the overall high estimations of prevalence, for specific focus and policy development.

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<sup>209</sup> Majumder, P. O'Reilly, M. Karim, K. *"This doctor, I not trust him, I'm not safe': The perceptions of mental health and services by unaccompanied refugee adolescents"*. International journal of Social Psychiatry, 2015; 61(2), pp. 129-136.

<sup>210</sup> Berthold, S. *"War Traumas and Community Violence: Psychological, Behavioral, and Academic Outcomes Among Khmer Refugee Adolescents."* 2000; 10.1300/J285v08n01\_02.

<sup>211</sup> Heptinstall, Ellen & Sethna, Vaheshta & Taylor, Eric. *"PTSD and depression in refugee children: Associations with pre-migration trauma and post-migration stress."* European child & adolescent psychiatry, 2005; 13. 373-80. 10.1007/s00787-004-0422-y.

<sup>212</sup> Montgomery, E. *"Trauma and resilience in young refugees: A 9-year follow up study."* Development and Psychopathology, 2010; 22, pp. 477-489.

## Comorbidity: Depression & PTSD

While there is value for policy making in looking purely at the rates of depression in the URM population, studies with war-affected populations have found that depression is one of many mental illnesses associated with PTSD.<sup>213</sup> <sup>214</sup> Two specific examples from studies with war-afflicted populations help to highlight the deep correlation between PTSD and depression. The first, is a study with Bosnian refugee children in Slovenia<sup>215</sup> and the second, is with Somali adolescents in the USA <sup>216</sup>. Not only do these studies help establish the correlation between PTSD and depression, they also point to family cohesion, academic support and social integration as key bases for developing studies and policy that can mitigate the various effects of trauma on this population.

As the focus of this paper is on URMs arriving in Germany, it is of note to mention that although not in a higher prevalence than reported throughout Europe, ASC in Germany are severely distressed and burdened by the experiences of various types of potentially traumatic events. <sup>217</sup> As the biggest host of URMs in Europe during the “migration crisis” influx, the high prevalence and consequences of mental illness in the country is of serious concern and calls for research focused on the mental-health of the URM population in Germany.

Overall, the evidence so far exhibited, points at the need for immediate action to be taken in assessing and treating trauma and in particular PTSD & depression, in this highly vulnerable URM demographic. It is of the utmost importance that this work is carried out and the cycle of trauma stopped, as it has long-term

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<sup>213</sup> Berthold, S. (n 210)

<sup>214</sup> Betancourt, T.S., Newnham, E.A., Layne, C.M., Kim, S., Steinberg, A.M., Ellis, H. and Birman, D. “Trauma History and Psychopathology in War-Affected Refugee Children Referred for Trauma-Related Mental Health Services in the United States.” JOURNAL OF TRAUMATIC STRESS, 2012; 25: 682-690. doi:10.1002/jts.21749

<sup>215</sup> Slodnjak, V., Kos, A., Yule, W. “Depression and Parasuicide in Refugee and Slovenian Adolescents”, Crisis, 2002; 23(3), pp. 127- 132.

<sup>216</sup> Kia-Keating M, Ellis BH. “Belonging and connection to school in resettlement: young refugees, school belonging, and psychosocial adjustment.” Clinical Child Psychology Psychiatry. 2007;12(1):29-43. doi:10.1177/1359104507071052

<sup>217</sup> Müller (n 150)

consequences, persisting through adulthood and even beyond, to the generations that follow.

### **Long-Term Consequences of Trauma**

As has been discussed, there is much adequate research lacking on the mental health of URMs and even more so on the potential long-term effects of adverse childhood experiences and trauma on this population. For this reason, this next section borrows mainly from mental-health research, mostly based in the USA, using the Adverse Childhood Experience Questionnaire (ACE-Q)<sup>218</sup> and from neurobiological research, in order to discuss and analyze, what is known of the effects of childhood trauma on adult health and beyond, to the neurochemistry of children born to parents that were traumatized as children.

### **Long-Lasting Trans-Generational Cycles of Trauma**

The call for action has been made all the more dire by recent discoveries in the field of neuroscience, which suggest that the impact of trauma in childhood, remains through adulthood and is even passed onto the next generation.<sup>219</sup> It is believed that this cycle of trauma starts when particular brain systems associated with stress responsiveness & social interaction are affected by potentially traumatic experiences, particularly in childhood. These impacts have been found to produce neurotoxicity that has profound and prevailing effects on brain structure<sup>220</sup> and function<sup>221</sup>, which often result in adult psychiatric syndromes, including bipolar<sup>222</sup> and obsessive compulsive disorders.<sup>223</sup>

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<sup>218</sup> Emily M. Zarse, Mallory R. Neff, Rachel Yoder, Leslie Hulvershorn, Joanna E. Chambers & R. Andrew Chambers | Udo Schumacher. “*The adverse childhood experiences questionnaire: Two decades of research on childhood trauma as a primary cause of adult mental illness, addiction, and medical diseases.*” *Cogent Medicine*, 2019; 6:1, DOI: 10.1080/2331205X.2019.1581447

<sup>219</sup> Chung EK, Mathew L, Rothkopf AC, Elo IT, Coyne JC, Culhane JF. “*Parenting attitudes and infant spanking: the influence of childhood experiences.*” *Pediatrics*. 2009;124(2):e278-e286. doi:10.1542/peds.2008-3247

<sup>220</sup> Teicher, M. H., Anderson, C. M., & Polcari, A. “*Childhood maltreatment is associated with reduced volume in the hippocampal subfields CA3, dentate gyrus, and subiculum.*” *Proceedings of the National Academy of Sciences of the United States of America*, 2012; 109(9), E563–572. doi:10.1073/pnas.1115396109

When the impact of trauma is not alleviated by socio-psychological support<sup>224</sup> or other factors of resilience<sup>225</sup>, the impaired functioning of these brain-systems<sup>226</sup> can result in harmful parenting. The parental attachment bond, nurturing and protective behaviors may be damaged or broken<sup>227</sup>, resulting in cycles of trauma and neuropsychiatric illness.<sup>228</sup> The cycle continues as children of families with high levels of exposure to trauma are then traumatized themselves. Due to this childhood exposure to trauma, this population is found to have much higher rates of risky behavior<sup>229</sup>, addiction,<sup>230</sup> <sup>231</sup> <sup>232</sup> mental<sup>233</sup> <sup>234</sup> <sup>235</sup> and physical<sup>236</sup> <sup>237</sup>

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<sup>221</sup> Heim, C., Shugart, M., Craighead, W. E., & Nemeroff, C. B. “*Neurobiological and psychiatric consequences of child abuse and neglect.*” *Developmental Psychobiology*, 2010; 52(7), 671–690. doi:10.1002/dev.20494

<sup>222</sup> Benedetti, F., Bollettini, I., Radaelli, D., Poletti, S., Locatelli, C., Falini, A., ... Colombo, C. “*Adverse childhood experiences influence white matter microstructure in patients with bipolar disorder.*” *Psychological Medicine*, 2014; 44(14), 3069–3082. doi:10.1017/S0033291714000506

<sup>223</sup> Benedetti, F., Poletti, S., Radaelli, D., Pozzi, E., Giacosa, C., Ruffini, C., ... Smeraldi, E. “*Caudate gray matter volume in obsessive-compulsive disorder is influenced by adverse childhood experiences and ongoing drug treatment.*” *Journal of Clinical Psychopharmacology*, 2012; 32(4), 544–547. doi:10.1097/JCP.0b013e31825cce05

<sup>224</sup> Roh, S., Burnette, C. E., Lee, K. H., Lee, Y. S., Easton, S. D., & Lawler, M. J. “*Risk and protective factors for depressive symptoms among American Indian older adults: Adverse childhood experiences and social support.*” *Aging & mental health*, 2015; 19(4), 371–380. doi:10.1080/13607863.2014.938603

<sup>225</sup> Logan-Greene, P., Green, S., Nurius, P. S., & Longhi, D. “*Distinct contributions of adverse childhood experiences and resilience resources: A cohort analysis of adult physical and mental health.*” *Social Work in Health Care*, 2014; 53(8), 776–797. doi:10.1080/00981389.2014.944251

<sup>226</sup> Stamoulis, C., Vanderwert, R. E., Zeanah, C. H., Fox, N. A., & Nelson, C. A. “*Neuronal networks in the developing brain are adversely modulated by early psychosocial neglect.*” *Journal of Neurophysiology*, 2017; 118 (4), 2275–2288. doi:10.1152/jn.00014.2017

<sup>227</sup> Chung, E. K., Nurmohamed, L., Mathew, L., Elo, I. T., Coyne, J. C., & Culhane, J. F. “*Risky health behaviors among mothers-to-be: The impact of adverse childhood experiences.*” *Academic Pediatrics*, 2010; 10(4), 245–251. doi:10.1016/j.acap.2010.04.003

<sup>228</sup> Yehuda, R. “*Childhood trauma and risk for PTSD: Relationship to intergenerational effects of trauma, parental PTSD, and cortisol excretion.*” *Development and Psychopathology*, 2001; 13, 733–753.

<sup>229</sup> Imuneef, M., Qayad, M., Aleissa, M., & Albuhairan, F. “*Adverse childhood experiences, chronic diseases, and risky health behaviors in Saudi Arabian adults: A pilot study.*” *Child Abuse & Neglect*, 2014; 38(11), 1787–1793. doi:10.1016/j.chiabu.2014.06.003

<sup>230</sup> Anda, R. F., Brown, D. W., Felitti, V. J., Dube, S. R., & Giles, W. H. “*Adverse childhood experiences and prescription drug use in a cohort study of adult HMO patients.*” *BMC Public Health*, 2008; 8, 198. doi:10.1186/1471-2458-8-198

<sup>231</sup> Rothman, E. F., Edwards, E. M., Heeren, T., & Hingson, R. W. “*Adverse childhood experiences predict earlier age of drinking onset: Results from a representative US sample of current or former drinkers.*” *Pediatrics*, 2008; 122(2), e298–304. doi:10.1542/peds.2007-3412

<sup>232</sup> Anda, R. F., Brown, D. W., Felitti, V. J., Dube, S. R., & Giles, W. H. (n 230)

<sup>233</sup> Cavanaugh, C. E., Petras, H., & Martins, S. S. “*Gender-specific profiles of adverse childhood experiences, past year mental and substance use disorders, and their associations among a national sample of adults in the United States.*” *Social Psychiatry and Psychiatric Epidemiology*, 2015; 50(8), 1257–1266. doi:10.1007/s00127-015-1024-3

238 239 240 disease. These impairments may then later disrupt the development of the very skills needed, during parenthood, to protect children from exposure to these same illnesses, and so the cycle is perpetuated.<sup>241</sup> (Chart showing cyclical effects of trauma) ANNEX 1

Only recently has neurobiology begun to unravel the full impact of adverse childhood experiences and trauma on adult health.<sup>242 243 244 245</sup> Not only are the consequences of trauma passed on to the next generation but also the entire quality of the URMs' 'adult life is severely impacted by the highly increased rates of addiction, psychiatric illness and physical health issues.'<sup>246</sup> A history of trauma, reflected by high ACE scores can result in an adulthood riddled with "complex clinical profiles with several co-occurring mental and somatic disorders such as posttraumatic stress disorder, depression, borderline

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<sup>234</sup> Anda, R. F., Brown, D. W., Felitti, V. J., Bremner, J. D., Dube, S. R., & Giles, W. H. "Adverse childhood experiences and prescribed psychotropic medications in adults." *American Journal of Preventive Medicine*, 2007; 32(5), 389–394. doi:10.1016/j.amepre.2007.01.005

<sup>235</sup> Gould, D. A., Stevens, N. G., Ward, N. G., Carlin, A. S., Sowell, H. E., & Gustafson, B. "Self-reported childhood abuse in an adult population in a primary care setting. Prevalence, correlates, and associated suicide attempts." *Archives of Family Medicine*, 1994; 3(3), 252–256.

<sup>236</sup> Felitti, V. J. "The relationship of adverse childhood experiences to adult health: Turning gold into lead." *Zeitschrift für Psychosomatische Medizin und Psychotherapie*, 2002; 48(4), 359–369.

<sup>237</sup> Anda, R. F., Brown, D. W., Felitti, V. J., Dube, S. R., & Giles, W. H. (n 230)

<sup>238</sup> Anda, R., Tietjen, G., Schulman, E., Felitti, V., & Croft, J. "Adverse childhood experiences and frequent headaches in adults." *Headache*, 2010; 50(9), 1473–1481. doi:10.1111/j.1526-4610.2010.01756.x

<sup>239</sup> Anda, R. F., Brown, D. W., Felitti, V. J., Dube, S. R., & Giles, W. H. (n 230)

<sup>240</sup> Van Niel, C., Pachter, L. M., Wade, R., Jr., Felitti, V. J., & Stein, M. T. "Adverse events in children: Predictors of adult physical and mental conditions." *Journal of Developmental and Behavioral Pediatrics: JDBP*, 2014; 35(8), 549–551. doi:10.1097/DBP.0000000000000102

<sup>241</sup> ANNEX 1 - Figure 2. Bugle-shaped ACES comorbidity pathway. Diagrammatic conceptualization of a neuroscience-informed causal pathway through developmental stages that explains how and why the ACE-Q literature broadly associates adverse childhood experiences with a wide range of adult mental illnesses, addictions, and medical comorbidities.

<sup>242</sup> Anda, R. F., Felitti, V. J., Bremner, J. D., Walker, J. D., Whitfield, C., Perry, B. D., ... Giles, W. H. "The enduring effects of abuse and related adverse experiences in childhood. A convergence of evidence from neurobiology and epidemiology." *European Archives of Psychiatry and Clinical Neuroscience*, 2006; 256 (3), 174–186. doi:10.1007/s00406-005-0624-4

<sup>243</sup> Chambers, R. A., & Wallingford, S. C. "On mourning and recovery: Integrating stages of grief and change toward a neuroscience-based model of attachment adaptation in addiction treatment." *Psychodynamic Psychiatry*, 2017; 45(4), 451–473. doi:10.1521/pdps.2017.45.4.451

<sup>244</sup> Felitti, V. J. (2009). Adverse childhood experiences and adult health. *Academic Pediatrics*, 9(3), 131–132. doi:10.1016/j.acap.2009.03.001

<sup>245</sup> Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., ... Marks, J. S. "Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. *The Adverse Childhood Experiences (ACE) Study*." *American Journal of Preventive Medicine*, 1998; 14 (4), 245–258.

<sup>246</sup> Emily M. Zarse, Mallory R. Neff, Rachel Yoder, Leslie Hulvershorn, Joanna E. Chambers & R. Andrew Chambers | Udo Schumacher (n 218)

personality disorder, obesity and diabetes.”<sup>247</sup> Following there is a further exploration of the links between trauma and addiction, physical & mental illness.

## Addiction

As Gabor Mate, MD has stated, “Rather than choice, chance or genetic predetermination, it is childhood adversity that creates the susceptibility for addiction.”<sup>248</sup> Using this theory as a starting point, following there is an exploration of the effects of childhood trauma on addiction and its accompanying consequences.

The last century of research on humans and animals strongly indicates that experiencing trauma in childhood, either through primary attachment deprivation, abuse, mistreatment or sustained levels of psychosocial stress, can have negative and dire consequences on adult health and behavior.<sup>249</sup> <sup>250</sup> <sup>251</sup> <sup>252</sup> <sup>253</sup> <sup>254</sup> As previously discussed URM’s have a high risk of experiencing or having experienced exactly these stressors, often leading to trauma. Hence, following is some of the research highlighting the potential consequences, on health and behavior, which these experiences can precipitate, in particular when left untreated.

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<sup>247</sup> Herzog, Julia I, and Christian Schmahl. “Adverse Childhood Experiences and the Consequences on Neurobiological, Psychosocial, and Somatic Conditions Across the Lifespan.” *Frontiers in psychiatry* vol. 9 420. 4 Sep. 2018, doi:10.3389/fpsy.2018.00420

<sup>248</sup> Maté, Gabor. “Addiction: Childhood trauma, stress and the biology of addiction.” *Journal of Restorative Medicine* 1.1, 2012; 56-63.

<sup>249</sup> Harlow, H. F. “The effects of early experiences upon the personal-social, heterosexual, and maternal behavior of rhesus monkeys.” *Transactions of the American Neurological Association*, 1962; 87, 9–10.

<sup>250</sup> Bowlby, J. “Violence in the family as a disorder of the attachment and caregiving systems.” *American Journal of Psychoanalysis*, 1984; 44(1), 9–27, 29–31.

<sup>251</sup> Bowlby, R. “Growing up with attachment theory—a personal view.” *Psychodynamic Psychiatry*, 2017; 45(4), 431–439. doi:10.1521/pdps.2017.45.4.431

<sup>252</sup> Bruska, D., & Tessin, D. H. “Adverse childhood experiences and psychosocial well-being of women who were in foster care as children.” *The Permanente Journal*, 2013; 17(3), e131–141. doi:10.7812/TPP/12-121

<sup>253</sup> Sheridan, M. A., & McLaughlin, K. A. “Dimensions of early experience and neural development: Deprivation and threat.” *Trends in Cognitive Sciences*, 2014;18(11), 580–585. doi:10.1016/j.tics.2014.09.001

<sup>254</sup> Swopes, R. M., Simonet, D. V., Jaffe, A. E., Tett, R. P., & Davis, J. L. “Adverse childhood experiences, posttraumatic stress disorder symptoms, and emotional intelligence in partner aggression.” *Violence and Victims*, 2013; 28(3), 513–530.

In the USA, 'adolescents are responsible for more than 50% of the nation's crimes and their use and abuse of drugs is both a part of the crime and conducive to it.'<sup>255</sup>

In their study, Van Dalen et al, found there were 'three distinctive features of Juvenile offenders: exposure to violence, neurological vulnerabilities & drug abuse.'<sup>256</sup> The link between these is apparent; trauma leads to neurological vulnerabilities<sup>257</sup>, resulting in cognitive and emotional impairment<sup>258</sup>, which is then often self-medicated through drug abuse<sup>259</sup>. This is precisely the point van Dalen et al, make in their study analyzing the neurological impact of exposure to violence and suggesting it is the root cause of faulty emotional regulation and 'hence drug abuse, often sustained by an endless string of crime'.<sup>260</sup>

It is, therefore, no coincidence that a pilot study examining the prevalence of childhood trauma in long-term substance abusers found that 77% of them had been exposed to severe childhood trauma and 58% had lifetime PTSD.<sup>261</sup> The same study then goes on to establish the existence of a strong positive correlation between lifetime substance abuse and exposure to childhood trauma.<sup>262</sup> Lastly, the study maintains that this strong positive correlation remained significant even after controlling for family history of alcohol problems, combat exposure, and lifetime PTSD, including combat related PTSD.<sup>263</sup> This research exposes the tremendous risk URM's face of becoming substance dependent. In

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<sup>255</sup> Dalen, Annaclare. "Juvenile Violence and Addiction: Tangled Roots in Childhood Trauma." *Journal of Social Work Practice in the Addictions*, 2001.

<sup>256</sup> Ibid

<sup>257</sup> Stamoulis, C., Vanderwert, R. E., Zeanah, C. H., Fox, N. A., & Nelson, C. A. "Neuronal networks in the developing brain are adversely modulated by early psychosocial neglect." *Journal of Neurophysiology*, 2017; 118(4), 2275–2288. doi:10.1152/jn.00014.2017

<sup>258</sup> Teicher, M. H., Samson, J. A., Anderson, C. M., & Ohashi, K. "The effects of childhood maltreatment on brain structure, function and connectivity." *Nature Reviews. Neuroscience*, 2016; 17(10), 652–666. doi:10.1038/nrn.2016.111

<sup>259</sup> Ding, Y., Lin, H., Zhou, L., Yan, H., & He, N. "Adverse childhood experiences and interaction with methamphetamine use frequency in the risk of methamphetamine-associated psychosis." *Drug and Alcohol Dependence*, 2014; 142, 295–300. doi:10.1016/j.drugalcdep.2014.06.042

<sup>260</sup> Chaiken, Jan M., and Marcia R. Chaiken. "Drugs and predatory crime." *Crime and Justice* 13, 1990; 203-239.

<sup>261</sup> Triffleman, E. G., Marmar, C. R., Delucchi, K. L., & Ronfeldt, H. "Childhood trauma and posttraumatic stress disorder in substance abuse inpatients." *Journal of Nervous and Mental Disease*, 1995; 183(3), 172–176. <https://doi.org/10.1097/00005053-199503000-00008>

<sup>262</sup> Ibid

<sup>263</sup> Ibid

particular as the relationship between childhood trauma (experienced by most URMs) and lifetime substance abuse remained strongly correlated even after adjusting for all the previously mentioned controls, meaning the collection of potentially traumatic experiences that URMs may have had can directly lead to a lifetime of substance abuse.

### **Poor Physical Health:**

Being sentenced to a lifetime of substance abuse is indeed a horrific prospect, in line with the patterns discussed above, research on 931 Saudi Arabian subjects found that being exposed to 4 or more ACEs increased risky health behaviors, (including but not limited to substance abuse), by 8-21times.<sup>264</sup> This finding provides further evidence of the correlation between trauma and substance abuse. Additionally, the very same study found that not only did being exposed to 4 or more ACE exacerbated the risk of substance abuse, it also resulted in the subjected being 2-11 times more likely to have chronic disease.<sup>265</sup>

Indeed, the strong correlation between adverse childhood experience and chronic, at times even fatal, disease has been broadly studied and shown to be significant for a number of chronic diseases that have a severe impact on quality of life<sup>266</sup>. Following are a few key studies that help to illustrate this pattern.

A study in the USA using data from the 2010 Behavioral Risk Factor Surveillance System (BRFSS) survey, which covered all of the USA and associated states. From this data it was established that 10% of the subjects that had been exposed to ACEs had a diagnosis of cancer<sup>267</sup>, a rate that is more than double than the 4.2% rate found in the general population.<sup>268</sup> Considering the high prevalence of ACE

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<sup>264</sup> Almuneef, Maha, et al. "Adverse childhood experiences, chronic diseases, and risky health behaviors in Saudi Arabian adults: a pilot study." *Child abuse & neglect* 38.11, 2014; 1787-1793.

<sup>265</sup> Ibid

<sup>266</sup> Van Niel, C., Pachter, L. M., Wade, R., Jr., Felitti, V. J., & Stein, M. T. (n 232)

<sup>267</sup> Brown, M. J., Thacker, L. R., & Cohen, S. A. "Association between adverse childhood experiences and diagnosis of cancer." *PLoS One*, 2013; 8(6), e65524. doi:10.1371/journal.pone.0065524

<sup>268</sup> American Cancer Society. "Cancer Prevalence: How Many People Have Cancer".

Available: <http://www.cancer.org/Cancer/CancerBasics/cancer-prevalence>. Accessed 2020 Jun 14.

among URMs, it is indeed a frightening prognosis that around 10% of them may end up diagnosed with cancer.

The more than double 10% rate for cancer diagnosis gets even higher when estimated specifically for lung cancer. A study of over 17,000 subjects, discovered a 3-fold increase in risk of being diagnosed with lung cancer for anyone who had a score higher than 5 in the ACE questionnaire.<sup>269</sup>

As each point on the ACE questionnaire is given due to exposure to a potentially traumatic event, the implications for the URM population are blatant, with so many having been identified as being exposed to many said events. In addition the study also linked the ACE scores with higher possibilities of developing premature death from lung cancer, even after accounting for the risks posed by smoking, “suggesting other possible mechanisms by which ACEs may contribute to the occurrence of lung cancer”<sup>270</sup> and pre-mature death. This meaning that trauma may be contributing in other, yet unexplored, ways to the increased risk of contracting fatal lung cancer.

Cancer however, is not the only physical risk engendered by trauma, another study coming from the USA, found there is a graded relationship between ACE scores and the occurrence of Chronic Obstructive Pulmonary Disease (COPD). Specifically the study found that “Compared to people with an ACE Score of 0, those with an ACE Score of > or =5 had 2.6 times the risk of prevalent COPD, 2.0 times the risk of incident hospitalizations, and 1.6 times the rates of prescriptions. These associations were only modestly reduced by adjustment for smoking. The mean age at hospitalization decreased as the ACE Score increased”<sup>271</sup> These findings suggest that a good portion of the URM demographic may be facing up to a 2.6-fold increased risk of COPD contraction

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<sup>269</sup> Brown, D. W., Anda, R. F., Felitti, V. J., Edwards, V. J., Malarcher, A. M., Croft, J. B., & Giles, W. H. “Adverse childhood experiences are associated with the risk of lung cancer: A prospective cohort study.” *BMC Public Health*, 2010; 10, 20. doi:10.1186/1471-2458-10-20

<sup>270</sup> Ibid

<sup>271</sup> Anda, R. F., Brown, D. W., Dube, S. R., Bremner, J. D., Felitti, V. J., & Giles, W. H. “Adverse childhood experiences and chronic obstructive pulmonary disease in adults.” *American Journal of Preventive Medicine*, 2008; 34(5), 396–403. doi:10.1016/j.amepre.2008.02.002

and the dangers associated with it. In order to identify how this information may be relevant, pertinent epidemiological studies need to be performed within URM demographics.

Although cancer and COPD are known to be highly fatal and therefore some of the most dangerous diseases, others such as liver disease have also been positively correlated to high ACE scores. Principally, yet another study from the USA, tested each of the 10 ACEs separately and found that for each additional point on the ACE-Q, the risk of liver disease increased an average of 1.4 times. Cumulatively, it found that having been exposed 6 or more ACEs increased the risk by 2.6 times.<sup>272</sup> Interestingly, the study also found a high correlation between ACE scores and health risk behavior, which could account for up to 50% of the association between ACEs and liver disease.<sup>273</sup> Increased risk behaviors being correlated with trauma have already been discussed. However, the implications of this study for URMs are that up to 50% of the risk of contracting liver disease can be mitigated by assessing and treating health risk behaviors in the demographic and that it may be mitigated even further by the identification and treatment of trauma.

Even though they are not necessarily fatal, migraine and obesity have also been correlated with higher ACE scores. Particularly one study found that in “young women, adverse childhood events are associated with migraine, particularly chronic and transformed migraine.”<sup>274</sup> Another study, focused on rates of obesity found that ‘2/3 of its participants reported one or more exposure to a potentially traumatic event and with further analysis concluded that trauma in childhood is associated with obesity and that treating it in childhood could moderately

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<sup>272</sup> Dong, M., Dube, S. R., Felitti, V. J., Giles, W. H., & Anda, R. F. “Adverse childhood experiences and self-reported liver disease: New insights into the causal pathway.” *Archives of Internal Medicine*, 2003; 163(16), 1949–1956. doi:10.1001/archinte.163.16.1949

<sup>273</sup> Ibid

<sup>274</sup> Tietjen, G. E., Khubchandani, J., Herial, N. A., & Shah, K. “Adverse childhood experiences are associated with migraine and vascular biomarkers.” *Headache*, 2012; 52(6), 920–929. doi:10.1111/j.1526-4610.2012.02165.x

alleviate adult obesity.’<sup>275</sup> More importantly however, treating obesity in part by looking into someone’s history and treating the trauma, may better inform us on how these mechanisms work and how they can best be mitigated. In the case of URMs, the preventive action is of priority, however longitudinal studies with URMs are lacking and hence it is as of yet difficult to ascertain the causal pathways or how they may be redirected to prevent the maintenance of adult obesity.

As these and the previous studies have made clear so far, the potential risk for contracting disease and either dying from it or perpetually living with a significantly reduced quality of life is indeed much higher for people who have experienced trauma, and the URM demographic has had much higher exposure to potentially traumatic events. This exposure to trauma has been documented to result in pre-mature death as exposed in a study by Brown et al, which found that people with an ACE score higher than 5 died nearly 20 years earlier on average than those with a score of 0.<sup>276</sup> For URMs who are generally highly exposed to potentially traumatic events, these findings are indeed frightening, as it may entail an average loss of over a quarter of their lifetime.

### **Psychiatric Illness:**

We have seen that the potential physical consequences of trauma are can indeed be fatal, however this next section will focus on trauma’s potential for engendering psychiatric illness. Staring with a study that found a link between childhood traumas, in particular neglect, and bipolar I & II disorders.<sup>277</sup>

As being a URM is often accompanied by lack of care and support, the implications of these findings for this demographic are of particular consequence. However, as is

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<sup>275</sup> Williamson, D. F., Thompson, T. J., Anda, R. F., Dietz, W. H., & Felitti, V. “*Body weight and obesity in adults and self-reported abuse in childhood.*” International Journal of Obesity and Related Metabolic Disorders: Journal of the International Association for the Study of Obesity, 2002; 26(8), 1075–1082. doi:10.1038/sj.ijo.0802038

<sup>276</sup> Brown, D. W., Anda, R. F., Tiemeier, H., Felitti, V. J., Edwards, V. J., Croft, J. B., & Giles, W. H. “*Adverse childhood experiences and the risk of premature mortality.*” American Journal of Preventive Medicine, 2009; 37(5), 389–396. doi:10.1016/j.amepre.2009.06.021

the case for most of this epidemiological research, there is an ominous need for more studies focused on this demographic to determine the extent of the risk and the potential avenues for addressing it.<sup>278</sup>

Another study, with a more general focus, reported that adolescents who reported psychotic symptoms were far more likely to have suffered through trauma, either through physical/sexual abuse, exposure to domestic violence or having been bully/victim. The findings suggest that childhood trauma may increase the risk of psychotic experiences.<sup>279</sup> As URMs suffer much higher rates of physical and sexual abuse, as well as frequently having been witnesses to violence. A set of psychotic symptoms should be created and distributed to all responsible for URM care and wellbeing. Knowing this connection between trauma and psychotic symptoms may help them bring them to light in the URM demographic and in so doing aid in their treatment.

It is of particular import to keep an eye on psychotic symptomatology in the URM demographic, in particular as other studies have found that trauma, induced by emotional neglect (predominant in the URM demographic), can lead to higher incidences of hallucination and delusion, meaning that childhood trauma may alter the presentation of schizophrenia in first admission.<sup>280</sup> Additionally, another study found a link between trauma and auditory hallucinations.<sup>281</sup> If this information is not widely available to the care professionals in charge of URMs, their schizophrenia, or psychosis could go undiagnosed, or misdiagnosed, posing a further risk for this already vulnerable population.

Among the risks for psychiatric disorders, having a history of trauma has also recently been correlated with Borderline Personality Disorder (BPD). In their study Meza et al, found that 86% of BPD patients had a history of both neglect

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<sup>278</sup> Watson, Stuart, et al. "Childhood trauma in bipolar disorder." *Australian & New Zealand Journal of Psychiatry* 48.6, 2014; 564-570

<sup>279</sup> Kelleher, Ian, et al. "Associations between childhood trauma, bullying and psychotic symptoms among a school-based adolescent sample." *The British Journal of Psychiatry* 193.5, 2008; 378-382.

<sup>280</sup> Üçok, A., and S. Bikmaz. "The effects of childhood trauma in patients with first episode schizophrenia." *Acta Psychiatrica Scandinavica* 116.5, 2007; 371-377.

<sup>281</sup> Hammersley, Paul, et al. "Childhood trauma and hallucinations in bipolar affective disorder: preliminary investigation." *The British Journal of Psychiatry* 182.6, 2003; 543-547.

and abuse.<sup>282</sup> In particular, patients had often experienced emotional neglect, including parental disinterest, under involvement, and physical neglect by caretakers. From what we have discussed about URMs it is clear this group faces a serious risk of contracting BPD, in particular, as 80% of those diagnosed with BPD were separated from their caretakers,<sup>283</sup> a default factor in the URM demographic.

As previously discussed, depression is also a psychiatric illness correlated with trauma. Chapman et al, in their 2003 study, found that exposure to a single traumatic event increased the chance of lifetime depressive disorder by 1.4 times, being exposed to 2, raised the risk 1.8 fold and lastly being exposed to 5 or more, resulted in a 2.4-fold risk.<sup>284</sup> Considering the long lists of traumas URMs are often exposed to, an up to 240% increased chance of having a lifetime depressive disorder is indeed a heavy burden. A further, and even more worrisome link is that between trauma and suicide, which often finds its roots in depression.<sup>285</sup> Scotland suffers from higher rates of self-harm and suicide rates than other regions in the UK, which cannot be accounted for by psychosocial issues, such as drug and alcohol abuse.<sup>286</sup> This unexplained occurrence, led to a study linking trauma and suicide, which found that those with 4 or more exposures to trauma, were 3 times more likely to have a repeat suicide attempt.<sup>287</sup> Furthermore, a link between suicide and all the psychiatric illnesses that have been discussed so far has been found. There are several studies linking, Psychosis,<sup>288</sup> bipolar disorder,<sup>289</sup> unipolar depression,<sup>290</sup> Schizophrenia,<sup>291</sup>

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<sup>282</sup> Merza, Katalin, Papp, Gábor, & Kuritárné Szabó, Ildikó. "The role of childhood traumatization in the development of borderline personality disorder in Hungary." *The European Journal of Psychiatry*, 2015; 29(2), 105-118. <https://dx.doi.org/10.4321/S0213-6163201500020000>

<sup>283</sup> Ibid

<sup>284</sup> Chapman, D. P., Whitfield, C. L., Felitti, V. J., Dube, S. R., Edwards, V. J., & Anda, R. F. "Adverse childhood experiences and the risk of depressive disorders in adulthood." *Journal of Affective Disorders*, 2004; 82(2), 217–225. doi:10.1016/j.jad.2003.12.013

<sup>285</sup> Barbosa, Luana Porto, et al. "Childhood trauma and suicide risk in a sample of young individuals aged 14–35 years in southern Brazil." *Child Abuse & Neglect* 38.7 2014; 1191-1196.

<sup>286</sup> Corcoran, P., Gallagher, J., Keeley, H. S., Arensman, E., & Perry, I. J. "Adverse childhood experiences and lifetime suicide ideation: A cross-sectional study in a non-psychiatric hospital setting." *Irish Medical Journal*, 2006; 99(2), 42–45.

<sup>287</sup> Ibid

<sup>288</sup> Black, Donald W., George Winokur, and Amelia Nasrallah. "Effect of psychosis on suicide risk in 1,593 patients with unipolar and bipolar affective disorders." *The American journal of psychiatry*, 1988.

auditory hallucinations,<sup>293</sup> Borderline Personality Disorder,<sup>294</sup> and PTSD,<sup>295</sup> to suicide, further increasing the risk the URM population has of ending its own life.

The purpose of outlining all the studies aforementioned is to aid in attaining a more complete picture of the mental health of URMs, by highlighting many of the potential consequences of trauma, which is of particular relevance to this highly traumatized demographic.<sup>296</sup> The implications of these adverse childhood experiences for society are hard to estimate. Nevertheless, some studies suggest that untreated trauma “may generate a public health burden that could rival or exceed all other root causes.”<sup>297</sup> Taxpayers will ultimately carry such a burden, so it is therefore in everyone’s best interest, to invest in mental-health by placing it at the center of preventive health interventions. The aim of this paper is precisely, this, to incentivize government’s to alleviate the trauma carried by URMs, through adequate research with this demographic and policy that can be translated into best practices of care for URMs. Furthermore, this paper argues that it is a socio-economic benefit to invest in this population’s mental health. So, following is a brief analysis of the socio-economic benefit that investing in the mental health of URMs can represent for a nation.

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<sup>289</sup> Isometsä, Erkki T., et al. “*Suicide in bipolar disorder in Finland.*” The American journal of psychiatry, 1994.

<sup>290</sup> Balázs, Judit, et al. “*The close link between suicide attempts and mixed (bipolar) depression: implications for suicide prevention.*” Journal of affective disorders 91.2-3, 2006; 133-138.

<sup>291</sup> Sarchiapone, Marco, et al. “*Childhood trauma and suicide attempts in patients with unipolar depression.*” Depression and anxiety 24.4, 2007; 268-272.

<sup>292</sup> Roy, Alec. “*Reported childhood trauma and suicide attempts in schizophrenic patients.*” Suicide and Life-Threatening Behavior 35.6, 2005; 690-693

<sup>293</sup> Gallagher, Anthony G., et al. “*Chronic auditory hallucinations and suicide risk factors in schizophrenia.*” The Irish Journal of Psychology 16.4, 1995; 346-355.

<sup>294</sup> Brodsky, Beth S., et al. “*Characteristics of borderline personality disorder associated with suicidal behavior.*” American Journal of Psychiatry 154.12, 1997; 1715-1719.

<sup>295</sup> Seedat, Soraya, Murray B. Stein, and David R. Forde. “*Association between physical partner violence, posttraumatic stress, childhood trauma, and suicide attempts in a community sample of women.*” Violence and victims 20.1, 2005; 87-98.

<sup>296</sup> Bean, Tammy, et al. “*Comparing psychological distress, traumatic stress reactions, and experiences of unaccompanied refugee minors with experiences of adolescents accompanied by parents.*” The Journal of nervous and mental disease 195.4, 2007; 288-297.

<sup>297</sup> Emily M. Zarse, Mallory R. Neff, Rachel Yoder, Leslie Hulvershorn, Joanna E. Chambers & R. Andrew Chambers | Udo Schumacher. (n 218)

## Chapter 3

### Best Practices & Recommendations for Reform

The analysis of URMs circumstance and vulnerability began with a look at the legal framework this population finds itself in. The aim was to illustrate the condition the German legal system was in when it was met with the unprecedented challenge of having to care and accommodate around ‘22,255 URMs in 2015; a sum almost 5 times higher than URMs that arrived in 2014, approximately 4,400.’<sup>298</sup> The legal and welfare systems were highly strained, and through covering how it was reformed in part to face this new challenge a number of gaps emerged, showing that current policy is unable to fulfill the rights of URMs, in particular with the principle of acting in their best interest. After exposing some of the issues the legal system has had in supporting the URM population, the analysis went further in an attempt to show how even from the small number of studies dedicated to this population, a pattern of psychiatric illnesses emerges, all of which can have dire consequences for the individual and for society as a whole. This chapter combines the legal and psychological perspective to offer possible approaches that can overcome the current obstacles preventing URMs needs from being met and their rights from being upheld. It goes on to suggest that URMs’ mental health needs to be placed at the center of reception and care policy.<sup>299</sup>

Currently the legal framework that URMs find themselves in upon arrival into Germany has many gaps that don’t adequately mitigate the effects of trauma on this heavily burdened population. The most glaring difficulty for policy creation is the lack of available data previously discussed. It is due to this lack of data that the psychological perspective chapter tries to address these gaps in knowledge to highlight the potential risks and consequences of mismanaging children with high rates of trauma. Although there is much research still missing, the URM demographic has been shown to be extremely vulnerable to the mental health problems they carry with them<sup>300</sup>, which if left unmitigated can last a lifetime and beyond onto the next

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<sup>298</sup> “Asylum applicants considered to be unaccompanied minors by citizenship, age and sex Annual data. Statistics for 2008–2015” (n 6)

<sup>299</sup> Derluyn, Ilse, and Eric Broekaert. (n 139)

<sup>300</sup> El-Awad, Usama. “Promoting mental health in unaccompanied refugee minors: Recommendations for primary support programs.” *Brain Sciences* 7.11, 2017; 146.

generation.<sup>301</sup> These findings suggest placing mental health at the center of policy can help to mitigate some of its physical, mental and social costs.<sup>302</sup>

When placing psychological well being at the center of URM policy a need for effective integration mechanisms become apparent. This is inline with several studies suggesting that effective integration can mitigate many of the consequences of trauma<sup>303 304 305</sup>. In addition to effective integration policy and programs, more help needs to be focused on the most vulnerable. Although the URM population is often described as the most vulnerable of the refugee groups,<sup>306</sup> as previously discussed, there are sub-groups, such as belonging to the female gender<sup>307</sup>, being of older age<sup>308</sup>, or having been exposed to higher number of potentially traumatic events<sup>309</sup>, which face even higher risks. Identifying these additionally burdened groups and providing designing specialized care programs for them can be a powerful addition to combating the effects of trauma in the URM population.<sup>310</sup> Another major issue arose through the analysis of the literature; the problem of identifying URMs in need of specialized psychological support. As was previously mentioned URMs in need are not being identified, with one study showing that only 25% of URMs needing treatment, had been identified in the ‘regular taking into care’ process<sup>311</sup>, the legal point designated for identification of psychological needs. In addition, not only are the vast majority in need not identified, but even those who are, face many difficulties in accessing the care they need. ‘These challenges include, lack of financial support for care, as not all URMs are covered by state-health insurance, lack of available

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<sup>301</sup> Yehuda, R. “*Childhood trauma and risk for PTSD: Relationship to intergenerational effects of trauma, parental PTSD, and cortisol excretion.*” *Development and Psychopathology*, 2001; 13, 733–753.

<sup>302</sup> Ardino, Vittoria, and Giacomo Di Benedetto. “*The economic case of psychosocial care of Unaccompanied Foreign Minors (UAMs) in Italy: A brief policy report.*” *MALTRATTAMENTO E ABUSO ALL’INFANZIA*, 2017.

<sup>303</sup> Kulu-Glasgow, Işık, Monika Smit, and Ibrahim Sirkeci, eds. “*Unaccompanied Children: From Migration to Integration.*” Transnational Press London, 2019.

<sup>304</sup> Katsounari, Ioanna. “*Integrating psychodynamic treatment and trauma focused intervention in the case of an unaccompanied minor with PTSD.*” *Clinical Case Studies* 13.4, 2014; 352-367.

<sup>305</sup> El-Awad, Usama (n 301)

<sup>306</sup> Halvorsen, Kate (n 140)

<sup>307</sup> Hodes (n 148)

<sup>308</sup> Bean, Tammy; Derluyn, Ilse; Eurelings-Bontekoe, Elisabeth; Broekaert, Eric; Spinhoven, Philip (n 129)

<sup>309</sup> Van Niel, C., Pachter, L. M., Wade, R., Jr., Felitti, V. J., & Stein, M. T. (n 232)

<sup>310</sup> El-Awad, Usama (n 301)

<sup>311</sup> Wekerle, Christine. “*Child Abuse & Neglect.*” *Journal*, McMaster University, Hamilton, Ontario, Canada, 2019, [www.journals.elsevier.com/child-abuse-and-neglect](http://www.journals.elsevier.com/child-abuse-and-neglect).

youth therapists, and of adequately trained translators.’<sup>312</sup> In response to these issues following is a potential path to addressing them. It centers on fortifying the role of guardians, standardizing medical screenings and follow-up check-ups with adequate testing, promoting full state sponsored health insurance minimally until the URM’s case for residency or asylum is decided and beyond if decided in favor of them staying in the country. Lastly, promoting integration through socio-psychological activities and support programs to address the vast majority of this population’s need for psychological support.

### **The Role of Guardians Re-Visited**

The role of guardians is central to the well being of minors as they are responsible for “the young person, which includes making decisions such as whether an asylum application is lodged, if a therapeutic treatment can be requested, how schooling can be continued and completed, and where the young person is to live after the clearance process.”<sup>313</sup> One of the key distinguishing features of the URM population is indeed the fact they are deemed unaccompanied. This in turn means that they lack the basic support of a primary care giver, and hence it would follow that fortifying the role of the guardian so as to aid in closing the gap on that need, is the logical direction. Albeit, there are no reliable studies showing the effects of guardianship on integration, which is mostly due to the lack of standardization in the practice and the lack of research on the matter,<sup>314</sup> both points which need to be addressed, by further research and standardization of the roles and responsibilities of guardianship.

Nevertheless, as a contact point and legal representative, it is imperative the guardian is able to provide adequate protection and guidance to the URM under their care. There are three basic groups of people who can become a guardian. “Firstly a private person or an association on the basis of voluntary work, secondly a person whose profession allows him or her to be a legal guardian and who gets an honorarium and, thirdly, public guardianship by staff from the child and youth welfare office.”<sup>315</sup> In practice, however, the YWO becomes their guardian in 80% of the cases.<sup>316</sup>

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<sup>312</sup> Tangermann (n 32)

<sup>313</sup> Zeller (n 42)

<sup>314</sup> Tangermann (n 32)

<sup>315</sup> Zeller (n 42)

<sup>316</sup> Ibid

These YWO guardians were recently granted a limit of up to 50 minors in their care at any given time.<sup>317</sup> There is in practice no realistic way that one person can adequately care for the administrative, legal, physical & mental health needs of 50 (mostly traumatized) minors. This is the primary reason why voluntary guardians were found to be far more apt for this role.<sup>318</sup> In addition to YWO employees having up to 50 URMs under their care, another issue can arise in terms of representation. ‘As previously discussed the legal representation of a URM by a YWO employee could mean that an employee of the YWO needs to represent a URM against the YWO, which is an apparent conflict of interest.’<sup>319</sup> German law requiring enough organizational separation between the institution and the guardianship employees mitigates this conflict; nevertheless, this requires reform<sup>320</sup>, if the URMs rights are to be adequately protected from this potential conflict of interest. This all suggests that volunteer and professional guardians (not official YWO ones) need to be promoted. This could be done through the excellent partnership the German government has with mayor free welfare institutions and other NGO’s, who were the major source of workers and volunteers, that helped cover the need gaps created by this unprecedented influx of URMs into the country.<sup>321</sup> Although this migration influx incited the government to open its care facilities to the private sector, allowing for more offers and better quality of services, it has not gone far enough.<sup>322</sup> It is through further financial and technical support of these organizations in their hiring of staff and recruitment of volunteers, as well as providing resources these organizations can call upon for support, that an important step to realizing URMs rights in Germany can be taken. This is so long as these institutions maintain their long held independence.<sup>323</sup>

The issues for official guardians however, are not limited to being overburdened, and to the risks involved with conflict of interest in representation, they are also tasked

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<sup>317</sup> Tangermann (n 32)

<sup>318</sup> Ibid

<sup>319</sup> Ibid

<sup>320</sup> Oberloskamp H. “Plans of the German Government to Reform the Law of Guardianship for Minors: A presentation of the present and the future law in Germany.” *LeXonomica*, 2017; 9(1), 51-64. Retrieved from <https://journals.um.si/index.php/lexonomica/article/view/51>

<sup>321</sup> Aflaki, Inga Narbutaitė, and Matthias Freise. “Challenging the Welfare System and Forcing Policy Innovation? Unaccompanied Asylum-seeking Children in Sweden and Germany.” *Journal of Refugee Studies*, 2019.

<sup>322</sup> Merchel, Joachim. “Wohlfahrtsverbände, Dritter Sektor und Zivilgesellschaft.” *Handbuch Soziale Dienste*. VS Verlag für Sozialwissenschaften, 2011; 245-264.

<sup>323</sup> Zimmer, Annette. “Changing the Welfare Mix—Does It Make a Difference? The Case of Germany.” *Small Transformations. The Politics of Welfare Reform—East and West*. Münster/Hamburg/London: LIT, 2003; 72-96.

with a very challenging job, as their responsibilities entail they need to be legal experts on the law of residence and asylum as well as competent counselors and care givers.<sup>324</sup> No single parent would ever be held to such standards, and in practice it has been found that neither official nor volunteer guardians have “a sound knowledge of asylum and residence law.”<sup>325</sup> Even though under national guardianship law covering the role and responsibilities of guardians<sup>326</sup> and Under EU law, Article 25 paragraph 1 a of the Procedures Directive requires that “unaccompanied minors must be represented by a qualified representative who is to perform his or her duties pursuant to the principle of the child’s best interests and possess the necessary expertise to that end.”<sup>327</sup> A potential line of support for guardians could be supplementary curatorship<sup>328</sup>, which would allow for representation of URMs in a single area, which the curator is an expert in. However, the German Federal Court of Justice, in 2013, ruled against the use of curators in the representation of URMs stating that legal expertise on matters of asylum and residence is a legal requirement of guardianship.<sup>329</sup> Nevertheless, Family Courts have continued appointing curators to URM cases citing the applicability of the procedures directive.<sup>330</sup> Therefor this may still be a viable line of support that can be requested from the Family Court, for guardians who feel the legal representation needs of the URM under their care are beyond their expertise. Overall, the law regulating guardianship needs to be reformed as it is now 120 years old and has been affected by so many other laws since then, that it is currently quite difficult to follow.<sup>331 332</sup> There is indeed a planned reform under way, which has among its priorities to simplify and codify the role and responsibilities of guardians as well as aiming to place the responsibility for personal care at the center of the reformed law.<sup>333</sup> If this law is indeed reformed, it could be of great use to guardians in clarifying their roles and responsibilities helping them identify the areas in which they may require expert

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<sup>324</sup> Oberloskamp H. (n 321)

<sup>325</sup> Tangermann (n 32)

<sup>326</sup> Oberloskamp H. (n 321)

<sup>327</sup> The European Parliament and The Council of The European Union. ” *Directive 2013/32/EU of the European Parliament and of the Council of 26 June 2013.* ” Official Journal of the European Union , 2013; Online: [www.easo.europa.eu/sites/default/files/public/Dve-2013-32-Asylum-Procedures.pdf](http://www.easo.europa.eu/sites/default/files/public/Dve-2013-32-Asylum-Procedures.pdf).

<sup>328</sup> German Civil Code BGB. (n 110) Section 1909

<sup>329</sup> Müller (n 150)

<sup>330</sup> Espenhorst, Niels (n 106) 163.

<sup>331</sup> Ibid

<sup>332</sup> Zeller (n 42)

<sup>333</sup> Espenhorst, Niels (n 106)

support, such as curators and allowing them to focus on caring for the URM's under their protection. This additional support to the free welfare associations is of particular importance as "social workers have lamented that ever more municipalities have delegated service provision to volunteers who lack proper training"<sup>334</sup>. If guardians can legally focus on the care of their wards, acquire the much needed training and orientation, they will be better able to direct them towards appropriate culturally integrative activities, and education, which have been shown to be a major mitigating factor for the risks involved with a history of trauma.<sup>335 336 337</sup>

### **Medical Screening:**

Through out this paper, the call for additional research has been regularly voiced. One of the mayor hurdles in acquiring data is that the medical screenings, during preliminary taking into care and regular taking into care, have not been standardized.<sup>338</sup> Even though several pediatric associations have been calling for this to be addressed.<sup>339</sup> If these screenings are to be standardized it is important that they are made culturally appropriate for the URM demographic. This suggestion is echoed by Davidson et al. who in their 'Review of refugee mental health assessment: Best practices and recommendations, concluded that 'efforts should also be directed towards development of culturally comparable, valid and reliable measures of refugee children's mental health and of refugee children's and adults' psycho-educational, neuropsychological and applied memory capabilities'<sup>340</sup> There have been significant efforts to elaborate such instruments, the ACE-IQ<sup>341</sup> has been widely used with a variety of nationalities and although rudimentary it represents an excellent reference and starting point. If measures are successfully designed and then standardized, the

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<sup>334</sup> Sauer, Madeleine, and Judith Vey. "Herausforderungen in der ehrenamtlichen Flüchtlingsarbeit: Zum Verhältnis von Geflüchteten und Unterstützungsgruppen." *Forschungsjournal soziale Bewegungen* 30.3, 2017; 67-77.

<sup>335</sup> Plener, Paul L. "Unaccompanied refugee minors in Germany: attitudes of the general population towards a vulnerable group." *European child & adolescent psychiatry* 26.6, 2017; 733-742.

<sup>336</sup> Rousseau, Cécile, et al. "Resilience in unaccompanied minors from the north of Somalia." *Psychoanalytic Review* 85.4, 1998; 615-637.

<sup>337</sup> El-Awad, Usama (n 301)

<sup>338</sup> Tangermann (n 32)

<sup>339</sup> Janda, Aleš (n 97)

<sup>340</sup> Davidson, Graham R., Kate E. Murray, and Robert D. Schweitzer. "Review of refugee mental health assessment: Best practices and recommendations." *Journal of Pacific Rim Psychology* 4.1, 2010; 72-85.

<sup>341</sup> World Health Organization. "Adverse childhood experiences international questionnaire (ACE-IQ)." Geneva: WHO, 2015.

gap in available reliable data can be significantly narrowed, more URMs in need identified and a more homogenized degree of care available.

In addition to designing adequate tests and standardizing them there is also a need for longitudinal studies with URMs. As some studies have found psychiatric conditions to persist through time when untreated and hence it can serve as a measure of success.<sup>342</sup> It is also important to follow-up with this demographic as according to the German Academy for Pediatrics, “unaccompanied minor refugees also need to be able to develop a feeling for the new safe situation in which they find themselves before their mental state can be evaluated and any therapy initiated.”<sup>343</sup> As such the Academy calls for follow-up comprehensive and culturally sensitive pediatric screenings to take place. These would also be important to detect recurring PTSD symptoms, as it was previously discussed, these can be particularly difficult to diagnose in that they may only be detectable some time after arrival into the host country.<sup>344</sup> These practices of standardization, culturally appropriate testing and follow-up screenings could greatly reduce the impact of trauma on the URM population by facilitating early detection and contributing to the wealth of knowledge that will be instrumental in designing adequate policy.

### **Psycho-Social & Therapeutic Interventions: A Socio-Economic Benefit.**

When considering psychotherapy as an instrument to relieve trauma, it must be considered in the context of the URM demographic. The costs for therapeutic interventions are generally very high, as psychotherapy requires many years of training to exercise and often many sessions before it can provide results. For URMs, however, there are additional costs involved in the use of therapeutic interventions, primarily that of funding adequate translation. As this form of intervention is very

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<sup>342</sup> Vervliet, Marianne. "Longitudinal follow-up of the mental health of unaccompanied refugee minors." *European child & adolescent psychiatry* 23.5, 2014; 337-346.

<sup>343</sup> DAKJ - Deutsche Akademie für Kinder- und Jugendmedizin e. V. "Maßnahmen zur medizinischen Erstversorgung von Flüchtlingen und Asylbewerbern im Kindes- und Jugendalter in Deutschland." Stellungnahme der Kommission für Globale Kindergesundheit1 der Deutschen Akademie für Kinder- und Jugendmedizin (DAKJ), 2016 (Version vom 10.02.2016). Online: [https://dakj.de/wp-content/uploads/2016/09/150216\\_Langversion\\_Stellungnahme\\_Komm\\_glob\\_Kindergesundheit\\_DAKJ.pdf](https://dakj.de/wp-content/uploads/2016/09/150216_Langversion_Stellungnahme_Komm_glob_Kindergesundheit_DAKJ.pdf) (03.08.2020)

<sup>344</sup> Cohen, Judith A., and Michael S. Scheeringa. "Post-traumatic stress disorder diagnosis in children: challenges and promises." *Dialogues in clinical neuroscience* 11.1, 2009; 91.

costly and limited (with waits of over 3 months to see a Psychologist), “it should be reserved for severe cases.”<sup>345</sup> Instead the focus should be on psychosocial support, gained through primary support programs designed to improve intercultural competence, emotion regulation and goal setting, which have been recommended as the best means to support the URM population in handling their trauma.<sup>346 347</sup> Demonstrating their extraordinary resilience, and the effects of psychosocial support, a study from Denmark, found that social support during the first year after arrival was a crucial determinant for positive mental health outcomes.<sup>348</sup> In particular, the study found that a key element for reducing psychological distress and mental illness is that of establishing a “home”, highlighting the importance of minimizing the number of relocations. In addition to the Danish study, there are several others echoing the similar findings, all which suggest, social support is a key element for dealing with trauma.<sup>349 350</sup> It is of note, however, that cultural adaptation through social support programs need to aim at promoting the development of a multi-cultural person, as balancing the culture internally in the process of self-identification, is critical for healthy mental development.<sup>351</sup>

In line with using cost effective strategies, a thorough study by Terre de Homs in partnership with the Italian Society of Traumatic Stress Studies, found that “There is clear evidence that psychosocial interventions, such as schooling, support, leisure activities, counseling and psychotherapy can result in significant savings in the long term for the society.”<sup>352</sup> The study was able to make such a statement despite the fact there is robust-cost effective data missing, as is the case for most of the research on URM, there is not enough reliable data. Nevertheless, the study found that ‘investing

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<sup>345</sup> El-Awad, Usama (n 301)

<sup>346</sup> Ibid

<sup>347</sup> O’Driscoll VJ, Serneels G, Imeraj L. “*A file study of refugee children referred to specialized mental health care: from an individual diagnostic to an ecological perspective.*” *Eur Child Adolesc Psychiatry*, 2017; Online: <https://doi.org/10.1007/s00787-017-0981-3>

<sup>348</sup> Nielsen, Signe S., et al. “*Mental health among children seeking asylum in Denmark—the effect of length of stay and number of relocations: a cross-sectional study.*” *BMC Public health* 8.1, 2008; 293.

<sup>349</sup> Hynie, Michaela. “*The Social Determinants of Refugee Mental Health in the Post-Migration Context: A Critical Review.*” *Canadian journal of psychiatry. Revue canadienne de psychiatrie* vol. 63,5, 2018; 297-303. doi:10.1177/0706743717746666

<sup>350</sup> Ungar, M. “*Resilience after maltreatment: The importance of social services as facilitators of positive adaptation.*” *Child Abuse & Neglect*, 2013; 37(2–3), 110–115. doi:10.1016/j.chiabu.2012.08.004

<sup>351</sup> Schwartz SJ, Unger JB, Zamboanga BL, Szapocznik J. “*Rethinking the concept of acculturation: implications for theory and research.*” *Am Psychol*, 2010; 65:237–251

<sup>352</sup> Ardino, Vittoria, and Giacomo Di Benedetto (n 303)

early to mitigate the risks of trauma can effectively reduce the long-term social and economic impact. Additionally, it suggested this be enacted through earlier and better detection of their psychosocial needs, warning that the economic consequences of failing to do so can be immense.<sup>353</sup> A finding which is in agreement with the previously mentioned suggestion for adequate standardized screenings and follow-up check-ups. Moreover, there are studies suggesting that even though therapy is indeed an expensive resource it also is cost effective in the long run.<sup>354 355</sup>

As has been previously discussed, failing to adequately respond to trauma in childhood can have consequences for generations. If this is considered in light of some of the consequences of trauma: high rates of educational failure, higher need of health services,<sup>356</sup> challenges finding and maintaining employment,<sup>357</sup> anti-social behavior<sup>358</sup>, crime and addiction; the socio economic cost becomes apparent. As the “lifetime consequences of untreated mental health issues in childhood and adolescence will usually spill into many different public budgets and other areas of the economy.”<sup>359</sup> As budget planning is considered, it should be kept in mind that there are cost effective strategies for dealing with the trauma that plagues the URM demographic, so not only is it the German governments legal obligation to do so, but it is also a socio-economic benefit for all those involved.

## **Conclusion:**

The aim of this research was to demonstrate that Germany is under a legal obligation to look after the all the rights of URMs in the country, and to do so in the ‘best interest of the child. In order to protect URMs rights, there is a national legal

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<sup>353</sup> Ibid

<sup>354</sup> Beecham, J. “*Annual Research Review: Child and adolescent mental health interventions: a review of progress in economic studies across different disorders.*” *Journal of Child Psychology and Psychiatry*, 2014; 55(6):714-732, doi: 10.1111/jcpp.12216

<sup>355</sup> Bonin, E. M., Stevens, M., Beecham, J., Byford, S., & Parsonage, M. “*Costs and longer-term savings of parenting programmes for the prevention of persistent conduct disorder: a modelling study.*” *BioMed Central Public Health*, 2011; 11(1):803, doi: 10.1186/1471-2458-11-803

<sup>356</sup> D’Amico, F., Knapp, M., Beecham, J., Sandberg, S., Taylor, E., & Sayal, K. “*Use of services and associated costs for young adults with childhood hyperactivity/conduct problems: 20-year follow-up.*” *The British Journal of Psychiatry*, 2014; 204(6):441- 447, doi: 10.1192/bjp.bp.113.131367

<sup>357</sup> Knapp, M., McDaid, D., & Parsonage, M. (Eds.). “*Mental health promotion and mental illness prevention: The economic case.*” London, UK: Department of Health, 2011.

<sup>358</sup> Scott, S., Knapp, M., Henderson, J., & Maughan, B. “*Financial cost of social exclusion: Follow up study of antisocial children into adulthood.*” *British Medical Journal*, 2001; 323:7306, doi: 10.1136/bmj.323.7306.191

<sup>359</sup> Ardino, Vittoria, and Giacomo Di Benedetto (n 303)

framework, which is meant to guide the government and the agencies involved as to how best to ensure the protection of said rights. However through analysis of this legal structure, many gaps were found, in particular the lack of research to make informed decisions. Due to this lack of research and the small amount of time the government has had to implement new policy, which can adequately protect URM's from arrival to adulthood, there are still many gaps in the system that need to be addressed. The most blatant issues to address are: culturally adequate screening, follow-up checks, promotion of non-official guardianships, and full statutory health coverage from the moment of arrival. If this is done while simultaneously placing mental health at the center of integration policy, it could better protect this very vulnerable demographic from some of the major physical and mental risks associated with trauma, which are primarily, PTSD, depression, bi-polarity, schizophrenia, borderline personality disorder, dissociative disorder, anti-social behavior, addiction, crime, cancer, chronic obstructive pulmonary disease, liver disease and many others which are yet to be studied or not covered in this work. In order to protect URM's from these risks, the German government must close the gaps in its system. It can do so by fomenting non-legal guardianships, who can in turn provide better access to health care and to integration activities that provide psycho-social support, as it is precisely this that has been found to make a tremendous impact on health outcomes. If adequate screening is implemented, along with follow-up checks, all of which need to be standardized and published, this would aid in closing the knowledge gap and providing information for better informed policy. Additionally, URM's need to be more efficiently guided to the help they need by people with enough resources to provide adequate care. If these things are done, Germany will certainly be closer to fully fulfilling URM's rights, in turn helping them to become better integrated, functioning and contributing members of the complex mesh that forms some of today's cosmopolitan societies.

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