PSYCHOSOCIAL CARE FOR UNACCOMPANIED MINORS IN EUROPE: IS THERE AN ECONOMIC CASE?

Discussion paper

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SISST | Terre des Hommes International Federation | DESTINATION UNKNOWN protect children on the move

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This study was conducted by the Italian Society of Traumatic Stress Studies (SISST) in partnership with Terre des Hommes International Federation (TDHIF) and co-produced by SISST and TDHIF in the framework of the Destination Unknown campaign.

The Italian Society of Traumatic Stress Studies promotes, disseminates and implements the study and treatment of psychological trauma and its consequences, in Italy. SISST is part of the European Society of Traumatic Stress Studies, a European organisation which coordinates and strategically leads national societies toward an integrated policy strategy to jointly work toward the prevention and treatment of trauma in different contexts.

TDHIF is a network of ten independent non-governmental organisations (NGOs) located in Canada, Denmark, France, Germany, Italy, Luxembourg, the Netherlands, Spain and Switzerland (Terre des Hommes Foundation in Lausanne and Terre des Hommes - Switzerland). Terre des Hommes organisations provide active support to children, their families and their communities without any form of discrimination, in the framework of the United Nations Convention on the Rights of the Child. Terre des Hommes does this by mobilising political will through advocacy, running 854 development and humanitarian projects in 67 countries (2016), and carrying out research and evaluations all in close partnership with the populations concerned – including children – as well as local and national NGOs.

Destination Unknown is an international campaign to protect children on the move led by Terre des Hommes. The Destination Unknown campaign is rooted in more than a hundred field projects in fifty countries that provide direct help and protection to migrant children, youth and families. The team is made up of around 40 campaign members acting locally and regionally in 48 countries and in 10 regions. Destination Unknown campaign produces field-based and policy expertise in collaboration and networking with peer Civil Society Organisations, networks, related campaigns, academics and research centres.

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Terminology

APPLICATION FOR INTERNATIONAL PROTECTION:

It means an application for international protection as defined in Art. 2(g) of Council Directive 2004/83/EC, i.e. including requests for refugee status or for subsidiary protection status, irrespective of whether the application was lodged on arrival at the border, or from inside the country, and irrespective of whether the person entered the territory legally (e.g. as a tourist) or illegally.

SEPARATED CHILDREN:

Separated children are children separated from both parents, or from their previous legal or customary primary caregiver, but not necessarily from other relatives. These may, therefore, include children accompanied by other adult family members.

UNACCOMPANIED MINORS (UAMs):

Unaccompanied minors (UAMs): also called unaccompanied children are children, as defined in article 1 of the Convention on the Rights of the Child of 20 November 1989 (CRC), who have been separated from both parents and other relatives and are not being cared for by an adult who, by law or custom, is responsible for doing so.
An asylum applicant considered to be unaccompanied minor is a minor (aged less than 18) who arrives on the territory of the Member States unaccompanied by an adult responsible for him or her whether by law or by the practice of the Member State concerned, and for as long as he or she is not effectively taken into the care of such a person. It includes a minor who is left unaccompanied after he or she has entered the territory of the Member States.

PSYCHOSOCIAL NEEDS:

They refer 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. This is always a necessity, but becomes an indispensable condition in all such situations where it is impossible to separate the social, psychological-emotional, ad anthropological consequences of the events.

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 (International Red Cross definition).

MENTAL HEALTH:

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." An important implication of this definition is that mental health is more than just the absence of mental disorders or disabilities.
Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community.
Mental health and well-being are fundamental to our collective and individual ability as humans to think, emote, interact with each other, earn a living and enjoy life. On this basis, the promotion, protection and restoration of mental health can be regarded as a vital concern of individuals, communities and societies throughout the world.

MENTAL HEALTH PROMOTION AND PROTECTION

A series of actions to create living conditions and environments that support mental health and allow people to adopt and maintain healthy lifestyles. These include a range of actions to increase the chances of more people experiencing better mental health. An environment that respects and protects basic civil, political, socio-economic and cultural rights is fundamental to mental health promotion. Without the security and freedom provided by these rights, it is very difficult to maintain a high level of mental health.

ECONOMIC EVALUATION:

A tool to measure and evaluate resource use associated with interventions and/or policy programmes. A full economic evaluation is a comparative analysis of alternative courses of action in terms of both costs (resource use) and consequences (outcomes, effects) (Drummond 2005). This definition distinguishes full economic evaluation from economic analyses which focus solely on costs and resource use, or partial economic evaluations. Full economic evaluation is not a single research method; it is a framework for structuring specific decision problems.

ECONOMIC EVALUATION:

Overall, a cost analysis estimates the total costs of running a programme. Costs are the value of the resources (people, building, equipment and supplies) used to produce a good or a service. Cost analysis is very important for realizing costs from varying perspectives (e.g. incurred by programme, by participant) and it includes not just financial, but also economic costs. Furthermore, cost analysis provides the first step of a full economic evaluation. In this study, the cost analysis focused on cost of service use for unaccompanied minors. Cost analyses were based on the current service provision to determine the price of resources allocated in delivering/providing psychosocial care across the different public/private service providers selected for the research.

DIRECT COSTS:

Costs to the community, related to the diversion of resources to the intervention and treatment directly related to unaccompanied minors. These constitute costs to the social care service.

SOCIETAL OR INDIRECT COSTS:

These costs are related to the inability to find and maintaining a job, not being in education, loss of productivity caused by absenteeism, disability and premature death, costs of the criminal justice system.

PERSONAL COSTS:

Unaccompanied minors may earn less as adults than their lean counterparts because of job discrimination, other health-related problems.

ECONOMETRIC MODELLING:

A pragmatic tool to address research questions when there is an anticipation of gaps in available data. In such circumstances, it is common in economic analysis to use modelling techniques to synthesise and analyse evidence from various different sources in a single overarching model.
Economic modelling is useful when there is:

- **An absence of "hard data"**, where modelling can be used to provide a best estimate to inform policy
- **A need for "temporal extrapolation"** beyond the observed data, such as short-term data observed in a clinical trial that is used to predict costs or outcomes over a longer period
- **A need for "contextual extrapolation"**, where data collected in one setting are applied in another
- **A linking of intermediate and final outcomes**, such as clinical outcome measures and associated health outcomes
- **A comparison of interventions** where a direct comparison has not been made in a clinical trial (relative effectiveness or cost-effectiveness)

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EXECUTIVE SUMMARY

Background

This document aims to provide an overview of the scope of activities of the International Organization for Migration (IOM) in relation to the protection of unaccompanied migrant children and support for this group. It significantly draws on IOM's operational data and programmatic information, collected through internal knowledge management tools; at the same time, this information is supplemented by a mapping of the activities of IOM Field Offices covering the period 2009–2011. This paper also benefits from a review of existing international standards and policy frameworks as well as recent research conducted on the topic of unaccompanied migrant children.

The document is divided into four parts: Chapter 1 provides the introductory framework, together with an overview on the topic of unaccompanied migrant children and a summary of conclusions drawn from the work of IOM in this context. Chapter 2 presents a short overview of the international legal standards that exist in relation to unaccompanied migrant children. Chapter 3 highlights IOM's work for unaccompanied migrant children in the different fields of the Organization's migration-related activities. Chapter 4 explores the broader context of inter-organizational partnerships between IOM and other actors and international cooperation with regard to unaccompanied migrant children. In addition, an annex containing a more detailed legal framework is provided to complement the information provided in chapters 1–4.

Key findings

Based on the model of mental health care developed in the report and the comparison with the current cost in Germany and Italy the key cost-benefit findings are:

FOR ITALY (for 1000 units)	FOR GERMANY (for 1000 units)
Current costs: 17,182,500 Euro	**Current costs:** 30,810,000 Euro
Cost increment: 3,378,250 Euro	**Cost increment:** 5,257,600 Euro
Overall benefits: 7,959,550 Euro	**Overall benefits:** 9,185,450 Euro
Overall savings: 4,581,300 Euro	**Overall savings:** 3,927,850 Euro
Cost-benefit ratio: 1:2.36	**Cost-benefit ratio:** 1:1.75
For every 1 Euro spent more than current situation, 2.36 euro is saved.	For every 1 euro spent more than current situation, 1.75 euro is saved.
The most important areas of savings/benefits: **Long Stay Residential Care:** approximately 6,000,000 Euro **Primary care:** approximately 1,000,000 Euro **Problem Behaviour:** approximately 550,000 Euro	The most important areas of savings/benefits: **Long Stay Residential Care:** approximately 6,000,000 euro **Primary care:** approximately 2,000,000 euro **Psychiatric Medication:** approximately 800,000 euro

1. INTRODUCTION

Children and youth migrating have become a recognized part of today's global and mixed migration flows. In the migration policy arena, unaccompanied minors are considered a new area of concern with manifold policy implications. Thousands of unaccompanied and separated children from third countries are currently present in Europe finding themselves in a variety of different situations:

- **unaccompanied and separated children who are seeking asylum or protection, because of a fear of persecution, armed conflict or disturbance in their own country;**
- **unaccompanied and separated children who are the victims of trafficking for sexual or other exploitation;**
- **unaccompanied and separated children who have travelled to Europe to escape conditions of serious deprivation or human rights violations;**
- **unaccompanied and separated children who come to look for new opportunities or a better life;**
- **unaccompanied and separated children also arrive in Europe seeking family reunification with family members already present.**

Unaccompanied children have common rights under the UN Convention on the Rights of the Child to special protection and assistance. In the recent years, the EU has adopted several legislative instruments directly addressing the situation of these children, including: the completion of the EU asylum instruments (2011-2013), the EU Anti-Trafficking Directive (2011) and the EU Return Directive (2008). In 2013, the European Parliament Resolution on the situation of unaccompanied children called for "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". Moreover, the EU plays a role in fostering an integrated approach of care to respecting and protecting the rights of unaccompanied and separated children, regardless of their status.

Unaccompanied children face a long period of instability and insecurity while they await immigration proceedings (Perez Foster, 2001); a significant proportion of them require social, emotional and psychological support as a result of their life experiences and adaptation to the migration process. However, **there is a vacuum of integrated and implemented protocols to provide adequate psychosocial care to this population** (Bean, Eurelings-Bontekoe, Mooijaart, & Spinhoven, 2006).

High rates of Post-traumatic Stress Disorder (PTSD), other anxiety conditions, depression, aggression, psychosomatic complaints, and suicidal ideation are concerning issues among unaccompanied children (Bhaba & Schmidt, 2008; Chavez & Menjívar, 2010). Addressing psychosocial needs of UAMs is an essential aspect of any model of integrating unaccompanied children in the European context as psychosocial interventions have proven to be effective in preventing longer-term consequences and costs for the society.

The implementation of an adequate system of psychosocial care requires an accurate analysis, facts and figures about the size of the phenomenon, the way public money is invested in the reception of UAMs (the nature and the costs of services provided), the efficiency of such investment and the result or consequences of such public spending. The long term potential impact and costs of today's services provided to foreign unaccompanied minors must also be considered. **This research responded to the need of evaluating whether the psychosocial care for UAMs is worthwhile and it makes an adequate use of "limited" public social-healthcare resources.** Therefore, the research aimed to provide an economic evaluation of psychosocial care delivered to UAMs by assessing the potential net benefit to the society for the costs of psychosocial care. Such a study encompasses the public policy dimension, as it may impact on public opinion about the "cost burden" – today and/or tomorrow - for the receiving

society of missed psychosocial care when children arrive in Europe.

The proposed research is offering an innovative approach based on the following:

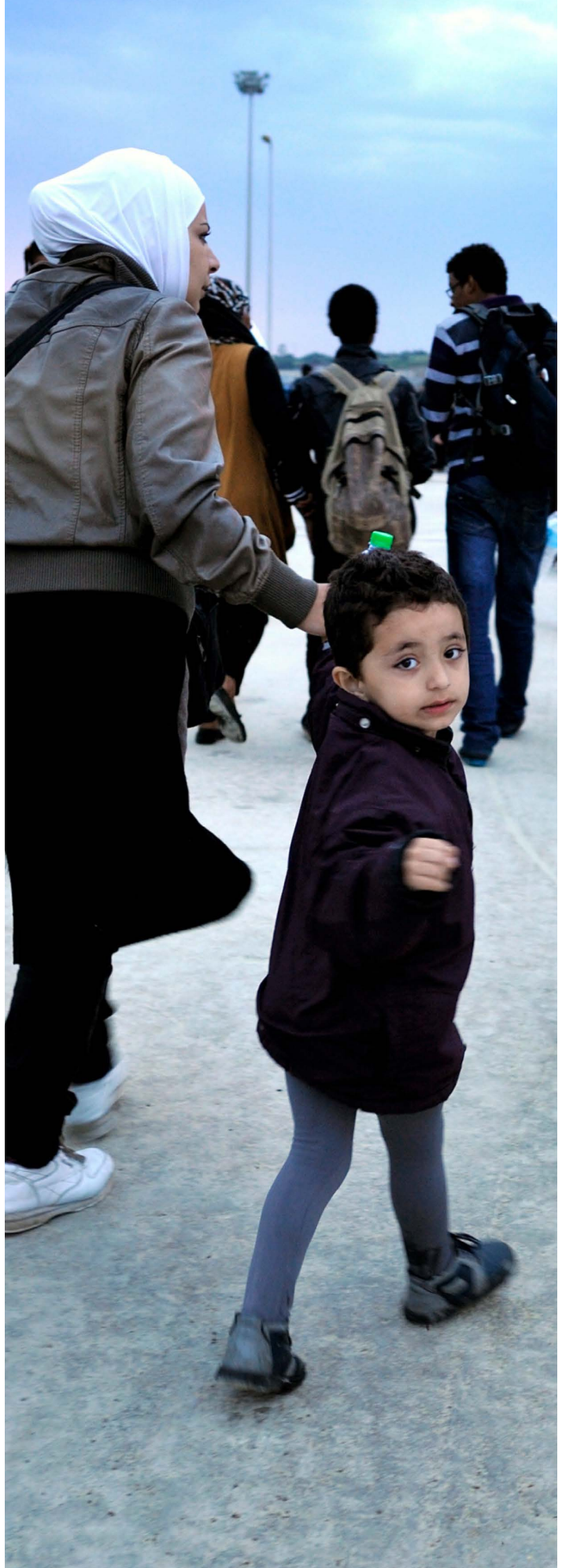
- **It bridges social-health economics with child protection, migration/asylum and human rights creating a multidisciplinary view around the needs and rights of UAMs.**

- **It provides a scientific projection of the long-term societal impact/effects of our current actions (or lack thereof) regarding the protection and psychosocial care services for the increasing number of foreign unaccompanied children arriving to Europe.**

The core research hypothesis was that if foreign UAMs were not provided with an adequate psychosocial care since their arrival in Europe and throughout their migration process, this would cause higher societal costs both in the short-term - negative impact on their migration process (i.e. disappearance, risks of exploitation, marginalization) - and in the longer-term - higher co-occurring use of illicit substances social and health disorders, lower educational attainment, unemployment, homelessness.

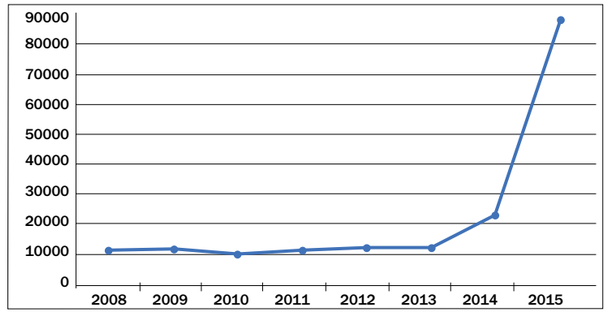
Data were collected in two European countries: Italy and Germany. The choice was based on a comparison between an "arrival/front-line" Country, sited in the Mediterranean area - and one "resettlement" Country. Italy (the front-line country) represents an entry point for many unaccompanied children. An early and adequate psychosocial support provided in this context is crucial for later adjustment of UAMS. Germany was proposed based on available services and being it often the desired destination for many UAMs arriving to Europe.

In order to set the stage for the economic evaluation study, this report first briefly reviews the literature about psychosocial needs of unaccompanied children; then, the systems of care in Germany and Italy are outlined. The review is followed by the aims, scope, and methodology of the study. The fourth chapter presents data analyses followed by the results. The report ends with policy recommendations.



1.1 Setting the context

Graph 1. Asylum applicants considered to be unaccompanied minors in the EU *(excluding Croatia for the period 2008-2011)*



data source: Eurostat 2016

Eurostat data showed that in 2015, 88.300 asylum seekers applying for international protection in the Member States of the European Union (EU) were considered to be unaccompanied minors. While their number always stood between 11 000 and 13 000 in the EU over the period 2008-2013, it almost doubled in 2014 to reach slightly more than 23 000 persons, then nearly quadrupled in 2015.

In 2015, a substantial majority of unaccompanied minors were **males** (**91%**) and over half were **aged 16 to 17** (**57%**, or 50 500 persons), while those **aged 14 to 15 accounted for 29%** (25800 persons) and those **aged less than 14 for 13%** (11800 persons). Around **half** (**51%**) of asylum applicants considered to be unaccompanied minors in the EU in 2015 **were Afghans**.

In 2015, **the highest number of asylum applicants** considered to be unaccompanied minors **was registered in Sweden** (with almost 35300 unaccompanied minors, or **40%** of all those registered in the EU Member States), followed by **Germany** (14400, or **16%**), Hungary (8800, or 10%) and **Austria** (8 300, or **9%**).

The largest shares of unaccompanied minors among all young asylum applicants in 2015 were recorded notably **in Italy** (where **56.6%** of all asylum applicants aged less than 18 were unaccompanied in 2015) and **Sweden** (**50.1%**), followed by the **United Kingdom** (**38.5%**), the **Netherlands** (**36.5%**), **Denmark** (**33.7%**), **Finland** (**33.2%**) **and Bulgaria** (**33.1%**).

Highlight: in total **in the EU, unaccompanied minors accounted for almost a quarter (23.0%) of all asylum applicants** aged less than 18 in 2015.

Most of the asylum applicants considered unaccompanied minors in the EU Member States were Afghans (51% of the total number of unaccompanied minors registered in 2015). Of the 45 300 Afghans considered unaccompanied minors in the EU in 2015, more than half were registered in Sweden (23 400).

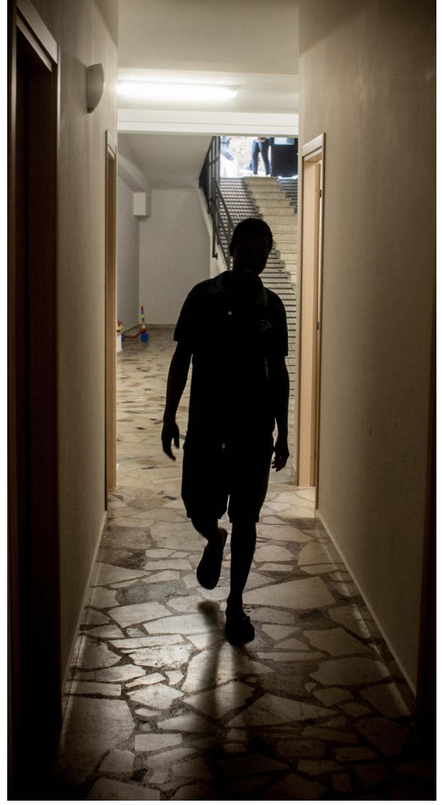
Afghans represented the most numerous citizenship of asylum seekers considered unaccompanied minors in fifteen EU Member States. **Syria** (16% of the total number of unaccompanied minors) **was the second main country** of citizenship of asylum seekers considered unaccompanied minors in the EU Member States in 2015.

Of the 14 300 Syrians seeking protection in the EU Member States and considered unaccompanied minors in 2015, 7 in 10 applied in one of the following three Member States: Germany (4000), Sweden (3800) and Hungary (2200).

The increasing number of unaccompanied children in the EU challenge the health and social care systems of Member States, who are called to strengthen their capacity to support health and psychosocial needs of these children. The situation has challenged even more the provision of services provision to unaccompanied children and the allocation of related resources (Arnold, Chalmers, et al., 2008; Colucci, 2015; Hjern & Bouvier, 2004).

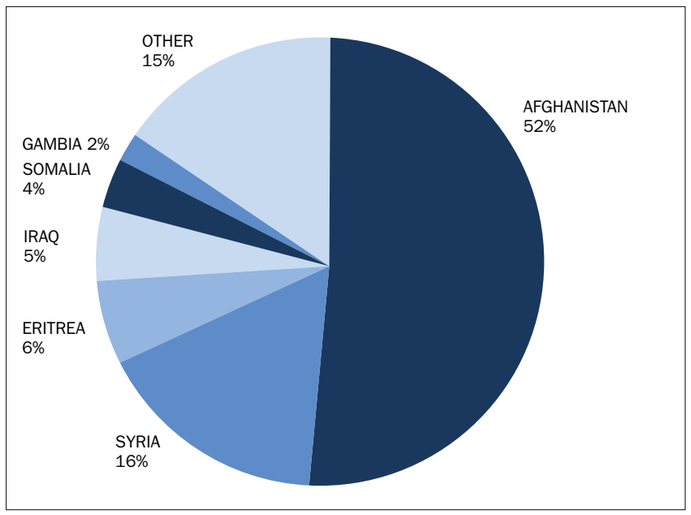
Access to psychosocial care for unaccompanied children is of special concern because of the long lasting consequences of lack or inadequate care on the psychological well-being of this population.

Underutilization of care and services has been associated with serious mental health problems, including trauma, stressors associated with settlement poor academic achievement and integration. It was, therefore, important for the study to examine barriers and facilitators to psychosocial support and mental health service access and delivery for refugee young people specifically; in the absence of such research "policy makers, service planners, and mental health professionals have little option but to draw unreliable inferences in terms of costs and resource allocation.



1.2 Prevalence and needs

Graph 2. Asylum applicants considered to be unaccompanied minors in the EU by country



data source: Eurostat 2016

Unaccompanied children may have multiple risk factors for potential mental health problems, including trauma, forced migration and stressors associated with settlement (Hodes, 2002). Surveys in refugee children and young people have reported varying prevalence of mental health symptoms and problems; with estimates for post traumatic stress disorder (PTSD) ranging from 3- 94%, depression/depressive symptoms from 3 – 47% and anxiety symptoms from 3 – 95%, ((Catani, Jacob, Schauer, Kohila, & Neuner, 2008; Feldman & Vengrober, 2011 Paxton, Smith, Win, Mulholland, & Hood, 2011).

Children are particularly sensitive for the accumulation of stressors that occurs in such contexts, and the detrimental developmental effects are not restricted to specific mental health diagnoses such as PTSD and depression. **A broader and multifaceted set of outcomes needs to be taken into account when studying children affected by mass trauma**. For example, unspecific internalizing as well as externalizing behaviour problems have been associated with exposure to war and conflict (Betancourt, Mcbain, Newnham, & Brennan, 2013; Saile, Ertl, Neuner, & Catani, 2015). In addition, **consequences of childhood traumatic experiences are not limited to the immediate aftermath of trauma but have long-term effects that last into adulthood, e.g. higher incidences of mood and anxiety disorders** (Carr, Martins, Stingel, Lemgruber, & Juruena, 2013) **as well as functional impairments related to the ability to work, perform household duties, or have satisfying intimate relationships** (McLaughlin et al., 2010). Thus, an effective psychotherapeutic intervention for war-traumatized children may not only reduce current psychological problems but also have an important long-term impact on the mental health well-being and functioning in adulthood.

Within the population of refugee children and adolescents, unaccompanied refugee minors (URMs) are considered a particularly vulnerable group when it comes to the development of mental health problems (Vervliet, Lammertyn, Broekaert, & Derluyn, 2014). A number of studies have shown that URMs have experienced a high number of stressful and traumatic events, related to both, war violence as well as physical and sexual maltreatment (Derluyn & Broekaert, 2007; Huemer et al., 2009). Consequently, the prevalence and severity of psychopathology such as PTSD, depression or anxiety has found to be higher in URMs than in adolescent non-refugees or in accompanied refugee children (Derluyn, Broekaert, & Schuyten, 2008; Huemer et al., 2009; Thommessen, Laghi, Cerrone, Baiocco, & Todd, 2013). According to recent studies, from 20 to 50% of URMs in industrialized countries suffer from PTSD symptoms that tend to remain stable over time in untreated individuals. However, **access to mental health care seems to be rather restricted for refugee children in general and, more specifically, for unaccompanied minors.** In this regard, Martina Ruf and colleagues (Ruf, Schauer, & Elbert, 2010) found that whereas 19% of the refugee children and adolescents were diagnosed with PTSD, only 4.8% reported to be in psychotherapeutic treatment. Bean et al. studied a group of 920 unaccompanied refugee minors in the Netherlands and discovered that almost 50% of the sample reported that their need for mental health care was unmet (Bean, Eurelings-Bontekoe, Mooijaart, & Spinhoven, 2006).

Several studies indicate high rates of post-traumatic stress disorder (PTSD), depression or anxiety disorders in young refugees (Papageorgiou, 2000; Servan-Schreiber, Le Lin, & Birmaher, 1998; Fazel, Wheeler, & Danesh, 2005). In addition, late-onset PTSD, a phenomenon which develops after early symptoms of depression and anxiety (Smid et al., 2011), is easily overlooked and pushes prevalence rates even higher. Independently from the time of incidence, there seems to be a high risk of symptoms and diagnoses becoming chronic.

Unaccompanied refugee minors show a significantly higher prevalence of PTSD, anxiety (Derluyn et al., 2008) depressive disorder, borderline personality disorder and psychosis (Wiese & Burhorst, 2007) when compared to minors accompanied by their families. Being unaccompanied on entry to the host country puts a child at risk of psychological disorders. UASC often experienced higher numbers of adverse events than did accompanied children. Children and adolescents who flee persecution and resettle in high-income countries often endure great physical and mental challenges during displacement, and suffer continuing hardships after arrival. Most of these refugees come from geographically distant, low-income settings. The adverse events that necessitated their flight are often only the beginning of a long period of turbulence and uncertainty. Young people might travel for weeks or months in dangerous circumstances to seek asylum in a high-income country, and are sometimes temporarily or permanently separated from family and need to use professional traffickers to reach their destination. Children with disrupted or minimal school education are suddenly immersed in a new education system. Racial discrimination and bullying, exacerbated by policies to accommodate asylum seekers in already impoverished and disadvantaged areas, are widespread.

Immigration policies for dispersal and detention can negatively affect refugees' attempts to settle in their host community. However, rapid resolution of asylum decisions eases access to social, health, education, and employment opportunities and infrastructures. Refugee children in high-income countries do not usually lack basic material necessities, yet certain factors nonetheless place their healthy development at risk. In this Review, we draw attention to the specific risk and protective factors that affect the psychological well-being of refugee children.

A systematic review of individual, family, community, and societal risk and protective factors (Fazel, Reed, Panter-Birck, & Stein) for mental health in children and adolescents who are forcibly displaced to high-income countries showed that exposure to violence has been shown to be a key risk factor, whereas stable settlement and social support in the host country have a positive effect on the child's psychological functioning. Research designs are needed that enable longitudinal investigation of individual, community, and societal contexts, rather than designs restricted to investigation of the associations between adverse exposures and psychological symptoms.

According to the growing volume of literature there is evidence that young refugees in general (Ehntholt and Yule, 2006; Lustig et al., 2004) and UM in particular (Hodes et al., 2008; Thomas, Nafees & Bhugra, 2004; Vervliet, 2014) are confronted with many traumatic experiences in their home countries and during flight. Unaccompanied refugee minors (URMs) are a diverse group with loss and vulnerability as common denominators. URM is defined as any child under the age of 18 who is physically separated from both parents and is an asylum seeker, recognised refugee or other displaced person (Bean et al. 2007). Compared to accompanied refugee children and non-immigrants, URMs have more traumatic stress reactions (Bean et al. 2007; Hodes et al.2008). The prevalence of psychiatric disorders has been found to be higher in URMs compared to refugee minors accompanied by families (Wiese & Burhorst, 2007). A Belgian study reported severe symptoms of anxiety, depression and PTSD in 37-47% of 166 URMs (Derluyn & Broekaert, 2007). A third of 222 male Afghan asylum-seeking URMs aged 13–18 years in the UK reported above threshold for anxiety, emotional and behavioural problems

migrant emergency Sicily, Italy 2014

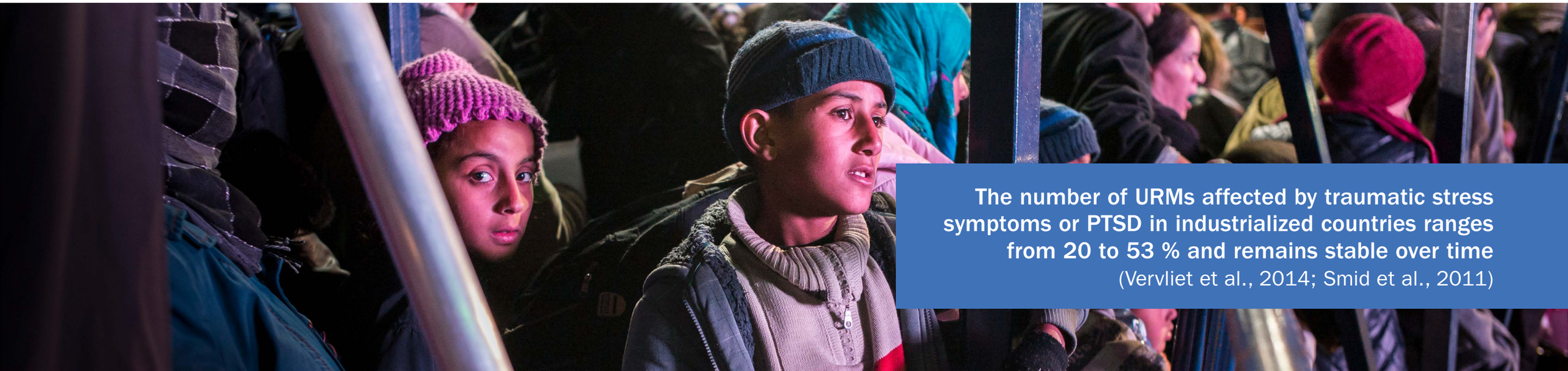
and PTSD, and 23% for depression (Bronstein et al. 2012; Bronstein et al., 2013). In a Norwegian study structured diagnostic interviews with 160 male asylum-seeking URMs aged 14–20 years showed that 41.9% had a psychiatric disorder, PTSD being the most prevalent (30.6%), followed by depression (9.4%), agoraphobia (4.4%) and GAD (3,8%) (Jakobsen et al, 2014). The corresponding prevalences for minors in general are also heterogeneous but lower; anxiety 5-9% (Klein 1994), depression 2–8% (Harrington 1994; Thapar et al. 2012) and PTSD 4% (Katzman et al. 2014).

Research on young refugees' utilisation of mental health services is limited, particularly regarding inpatient psychiatric services and involuntary care. Bhui et al. reported that refugees were not over-represented in inpatient psychiatric care compared to non-refugees. However, a separate analysis on URMs was not included (Bhui et al.2006). **The major finding was that URMs, from an epidemiological perspective, were markedly over-represented in both voluntary and involuntary inpatient psychiatric care.** However, as mentioned above, URMs in different host countries and with different origins have high levels of mental health problems (Huemer et al. 2009; Bronstein et al. 2012; Bronstein et al. 2013; Jakobsen et al. 2014). The psychiatric morbidity, along with the higher rate of self-harm or suicidal behaviour, contributed to the over-representation of URMs in voluntary and involuntary inpatient psychiatric care (Gordon 2002). Another possible explanation is lack of outpatient mental health services adjusted for the URM population. Bean et al. found that almost 50% of URMs reported an unmet mental health need, and that URMs with a need experienced higher levels of emotional distress than non-URMs (Bean et al. 2006). This is in line with our finding that URMs exhibited more self-harm or suicidal behaviour than non-URMs. Psychosocial care should focus on psychotraumatology and on the importance of coordinating support measures involving school, legal guardians and social services.

The over-representation may also be related to the insecure asylum status of URMs. This uncertainty, including difficulties obtaining legal residence documents, is associated with psychological problems (Fazel et al. 2012; Vervliet et al. 2014). At referral, 86% of URMs displayed symptoms relating to stress in the asylum process, including indications or a decision from migration authorities that would involve returning to another EU country often associated with previous adversities. This seems to have created a sense of despair and elicited an acute stress reaction (Hodes et al. 2008; Bronstein et al. 2013). Higher rate of suicide attempts and hospital-treated suicidal behaviour in groups of asylum seekers have been documented (Staehr & Munk-Andersen 2006; Goosen et al.2011). Further, immigrant background has been associated with use of restraint among adolescents in psychiatric treatment (Furre et al. 2014). The URM group was older and contained more boys compared to the non-URM group. This picture probably reflects a similar gender and age difference in the catchment population. This is not surprising considering that younger refugee children and particularly girls may be exposed to more threats than older boys during a strenuous journey from the country of origin to Europe.

The relation between cumulative trauma and psychological symptoms is not always clear from existing evidence because of the difficulty in differentiation of potential confounding factors, including age at the onset of adverse events, age at migration, and age-related policies for education, accommodation, and the decision-making processes for asylum in host countries. These variables intersect with the nature and duration of adverse exposure, affecting age-specific responses. For example, children in their late teens confronted with a short period of exposure to violent conflict are likely to have benefited from a long period of stable psychosocial development, whereas children growing up in situations of long standing conflict are likely to have had greater cumulative adversity. This greater adversity might increase the likelihood of psychological difficulties in these children, or conversely, strengthen their capacities for resilience. The living arrangements of UASC might have a negative effect particularly on children younger than 15 years, as reported in one study of asylum centres. **Children are more likely to suffer adverse mental health consequences when detained in restrictive rather than routine reception facilities. Rapid but careful resolution of asylum claims reduces the duration of uncertainty, insecurity, and associated distress for children. Insecure asylum status is associated with a range of psychological problems.**

For various reasons, URMs are seen as an especially vulnerable group within the refugee population. The dose effect proposed by Mollica and colleagues (Mollica, McInnes, & Poole, 1998) assumes that post-traumatic stress can be predicted from the number of traumatic experiences. In comparison to adolescent non-refugees and accompanied refugees, URMs are reported to have experienced a higher number of traumatic/stressful events (Bean et al., 2007; Derluyn, Mels, & Broekaert, 2009; Michelson & Sclare, 2009; Wiese & Burhorst, 2007). Furthermore, the traumatic experience of separation from a significant person (e.g., parents) is associated with an increased risk of PTSD (Heptinstall E, Sethna & Taylor, 2004). In addition, the family is seen as "a buffer against stress" (Ehntholt and Yule, ibidem) in the context of migration which is, by definition, lacking for unaccompanied children. Therefore, Huemer and colleagues (2009) conclude that **"URMs are a highly vulnerable group who likely suffers from more psychiatric morbidity than comparable populations**". This conclusion is confirmed by comparison studies revealing that URMs manifest greater prevalence or severity of psychopathology than adolescent non-refugees and accompanied refugees (Thommessen et al., 2013).



The number of URMs affected by traumatic stress symptoms or PTSD in industrialized countries ranges from 20 to 53 % and remains stable over time
(Vervliet et al., 2014; Smid et al., 2011)

Smid and colleagues (2011) observed 18 % of late-onset PTSD in their URM sample two years after their arrival in the Netherlands. A German study revealed a prevalence of 19 % for PTSD in accompanied young refugees with only one of the affected children and adolescents receiving mental health treatment (Ruf, Schauer and Elbert, 2010). Bean, Eurelings-Bontekoe, Mooijart, and Spinhoven (2007) reported a rate of 49 % for unmet psychosocial support need in unaccompanied children. Hence, the question arises how URMs can gain access to effective mental health care and which treatment approach is most feasible for this distressed population of young people from divergent cultural backgrounds. In another study, Derluyn et al. (2008) compared 1,249 migrant and 602 native Belgian adolescents between 11 and 18 years. Migrant adolescents experienced significantly more traumatic events than non-migrant adolescents. Gender significantly influenced the prevalence of emotional and behavioural problems, with girls being more vulnerable.

The impact of the immigration process can be largely divided into factors related to the period of arrival and the post-application period. Detention in centres following arrival to the new country can adversely affect the mental health outcome of refugee young persons (Rothe et al., 2002). Reijneveld et al. (2005) examined the effects of different reception policies and processes on unaccompanied adolescent asylum seekers' mental health (see table 1).

Table 1. Risk and protective factors for mental health problems in refugee children

RISK FACTORS	PROTECTIVE FACTORS
PRE-MIGRATION	**PRE-MIGRATION**
Exposure to violence and trauma	Socio-economic status
Bereavement	Faith
Gender	Traditional upbringing
High education	**POST-MIGRATION**
Unmet basic needs	Younger age
Displacement	Socio-economic status
Prosecution	Foster care
POST-MIGRATION	High education
Younger age	Peer relationships
Restrictive detention	Social support
Bullying	Connectedness to school and community
Marginalisation	Rapid solution of the asylum status
Relocation	Belief systems
Uncertainty	Coping strategies

The experiences of detention, care at the centre, asylum application and immigration interview can be distressing for asylum seeking young persons that compound the adverse psychological affects of experiences prior to and during migration, thus placing them in situations that can be perceived as being worse than the adversities before migration.

The uncertain status of the asylum application has been associated with poor psychological functioning. Quicker resolution of asylum claims, on the other hand, reduces the period of uncertainty and insecurity associated with the process of asylum application and the related distress (Bodegard, 2005). For unaccompanied refugee minors, proving that they are less than 18 years old can be a matter of significant stress. The challenges of ascertaining an accurate age can delay the case for over a year, thus increasing their sense of insecurity (Jones, 2010). This can hinder their ability to settle and integrate, hence causing unnecessary anxiety about deportation or forced return home (Thomas et al., 2004). In a recent UNICEF report (Brownlees & Finch, 2010), children and young people talked about their concerns and volunteered information about their well-being. While some talked about the past and their concerns for their family, their main anxieties appeared to be linked to present circumstances, overwhelming concerns about their asylum applications, and their loneliness and isolation.

There is robust research evidence including some larger and multiple small scale studies, which indicates the adverse impact of restrictive reception policy.

Among refugee young people, those who are unaccompanied are at higher risk because of the interplay between traumatic experiences and separation from significant emotional relationships. Parents often buffer the effects of difficult experiences in a child's life, and family and community support are important requisites for the successful coping of children traumatized by war or violence (Bat- Zion & Levi-Shiff, 1993; Jensen & Shaw, 1993; Macksoud et al., 1996). Refugee children who have experienced the loss of their family and community have shown more emotional distress and poorer adjustment than children who experienced the refugee process with their families (Masser, 1992; Melville & Lykes, 1992).

The mental health and emotional well-being of unaccompanied refugee and asylum-seeking children and young people have received an increasing attention in recent years (Chase et al., 2008). Most of the literature and research to date, has, however, been informed by clinical constructs of mental health, with relatively little attention being paid to the broader aspects of psychosocial well-being. Although it is difficult to determine the extent of children's vulnerability, some young population groups often stand out in their exposure to multiple risk factors due to their unusual life experiences. These experiences have not only a direct impact on their mental health and well-being, but also indirect effects through secondary social and cultural difficulties, and multiple changes in their life circumstances such as being placed in public care or becoming homeless. Certain factors are of prominent risk for refugee children, and these are related to both their previous experiences and their adjustment to a new society (Huemer & Vostanis, 2010).

Unaccompanied minors settled in different countries appear to be at particularly high risk for distress-related symptoms and are less likely than other refugees to receive psychological care. Unaccompanied asylum seeking children and adolescents are a highly diverse group. Their different ethnic backgrounds, possible influences on upbringing, temperament and other intrinsic characteristics, along with the multiple motives and circumstances of leaving their country of origin affect the parameters of psychopathology. Despite this diversity, **they are collectively vulnerable due to the legislative situation, their stressful past, and the sensitive developmental period of their lives during which these events are occurring. Exposure to violence has been particularly shown to be a key risk factor, whereas stable settlement and social support in the host country have a positive effect on the child's psychological functioning**. Carer and family factors and living arrangements have also received much attention in recent research. Overall, the ability to integrate into the host society while maintaining a sense of one's cultural identity is protective, but its effect has not been quantified (Fazel et al., 2012).

1.3 Psychosocial care guidelines and models

Psychosocial care guidelines and models

1.3.1 Current models of care

The main tasks of the staff in reception facilities are supervising, counselling and providing social support to UAMs: they are responsible for identifying and addressing their needs. Thus, in most (Member) States, the staff operating in the reception facilities provide psychological support (Belgium, Croatia, Cyprus, Estonia, Finland, France, Luxembourg, Poland, Slovak Republic, United Kingdom, Norway), assist UAMs in the administrative procedures (Austria, Belgium, Croatia, Finland, France, Luxembourg, Poland, Slovenia, United Kingdom, Norway), provide education, language or training courses to UAMs (Austria, Cyprus, France, Lithuania, Luxembourg, Slovak Republic, United Kingdom, Norway) and are responsible for the organisation of leisure or recreational activities (Austria, Belgium, Cyprus, Finland, Luxembourg, Poland, Slovak Republic, Norway). In some (Member) States, they monitor the UAMs' education plans (Belgium, Finland, Lithuania, Luxembourg, Norway) or oversee the benefit entitlements to the health care system for UAMs (Croatia, Norway).
A good practice is found in Belgium, Finland and Norway, where each UAM is assigned an individual contact person in the reception centre to help and advise them more personally. In order to perform those tasks, some (Member) States require the staff in the reception facilities to be appropriately qualified to work with UAMs, by holding a degree in a relevant field (i.e. being graduated social workers, educators). This is the case in Belgium, Croatia, Czech Republic, Cyprus, France, Italy, Slovak Republic, Sweden, the Netherlands, United Kingdom, Norway, and for certain positions in Finland. Other (Member) States do not require any specific qualification but provide ongoing training to their staff (Hungary, Latvia, Lithuania, Slovenia). In Belgium, Cyprus, Finland, France, Ireland and the Netherlands, the staff receives training in addition to their qualification to deal with UAMs or with asylum seekers in general (e.g. Slovak Republic). In Austria, the basic welfare support legislation does not foresee any minimum qualification or experience requirements for supervisors of UAMs, and in Cyprus, the residential care officers are not provided with any specific training in accommodating the needs of UAMs.

The staff responsible for the care of UAMs is composed of a wide range of professionals. Where reported by (Member) States, these include: social workers (e.g. Austria, Belgium, Croatia, Czech Republic, Cyprus, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Lithuania, Luxembourg, Malta, Slovenia, Slovak Republic, United Kingdom, Norway), psychologists (e.g. Austria, Croatia, Czech Republic, Greece, Hungary, Italy, Latvia, Luxembourg, Slovak Republic). Teachers (e.g. Czech Republic, Greece, Hungary, Italy, United Kingdom), educators (e.g. Belgium, Croatia, Czech Republic, Estonia, Italy, Luxembourg).

The Reception Conditions Directive (Art. 13) and its Recast (Art. 17) stipulate that "Member States should ensure the availability of material reception conditions to applicants for international protection sufficient to provide dignified living conditions". Material reception conditions include housing, food and clothing, and a daily expense allowance, which aim to ensure applicants' subsistence and basic needs during their stay at reception facilities. These may be provided in kind, or in the form of financial allowances or vouchers or in a combination of these provisions. States' non material reception conditions (e.g. access to legal advice, healthcare, education, employment, etc.) provided to both asylum-seeking and non-asylum seeking UAMs.

For asylum-seeking UAMs and those granted international protection, the EU lays down certain common reception standards and content of the protection granted. All (Member) States provide
the following common rights, e.g. access to employment (Art. 26), access to education (Art. 27), access to procedures for recognition of qualifications (Art. 28), social welfare (Art. 29), healthcare (Art. 30), access to accommodation (Art. 32) etc.

The recast Qualification Directive also ensures that UAMs who have been granted international protection continue to be represented by a legal guardian and are placed in appropriate facilities. Finally, it also sets the conditions for the withdrawal and cessation of international protection and the rights attached to such status. This plan includes sports and hobby activities, private tuition and support for school attendance.
The Action Plan on Unaccompanied Minors 2010 for durable solutions for unaccompanied minors based on an individual assessment of the best interests of the child. The durable solutions referred to in the Action Plan include: return and reintegration of the UAM in the country of origin; granting of international protection status or another legal status allowing the minor to successfully integrate in the Member State of residence; and resettlement. In the majority of Member States, a durable solution for a UAM is not defined in legislation. Legislation in Italy, established a National System for the reception of unaccompanied minors with the aim of ensuring durable solutions in the child's best interests. In other (Member) States (Ireland, Lithuania) no such provisions exist in legislation for the definition of durable solutions for UAMs. The majority of (Member) States including Norway have however highlighted specific efforts made to identify durable solutions for unaccompanied minors, including return and reintegration (Belgium, Cyprus, Estonia, Germany, Ireland, Latvia, Luxembourg, Malta, Netherlands, Poland, Slovenia, Spain, Sweden, the United Kingdom, Norway).

Competent authorities deciding on the durable solution for the child include a range of organisations, for example, the Immigration Office (Belgium), Youth Welfare Office (Germany); Ministry of Justice (France); Child and Family Agency (TUSLA in Ireland); the Police (Slovenia); the Directorate of Diversity and Inclusion (IMDi) in Norway (when the chosen durable solution is integration); and the Home Office, as well as local authorities in the United Kingdom. In practice, the deciding authorities take account of the views of the minor, the minor's guardian and other agencies involved, and in some situations, may involve the minor directly through an interview (Belgium). In several (Member) States (Belgium, Cyprus, Germany, France, Ireland, Latvia, Slovenia, Slovak Republic, Spain, United Kingdom, Norway), a best interests determination procedure Organisations or individuals representing the UAM, or the UAM directly, may be involved in the procedure in about a third of (Member) States, including: the legal guardian of the UAM (Belgium, France, Germany, Slovenia, Slovak Republic, Spain); the UAMs themselves (Belgium and Spain, under specific circumstances); and social workers (Ireland). Whilst it may be in the best interests of the UAM to find a durable solution as quickly as possible, in reality the time frame for the determination procedure varies across (Member) States, and in most cases, is not limited.

Among this population, **there is a significant number of unaccompanied children and adolescents who go missing or abscond from reception and care facilities**. The data about this phenomenon are limited, as well as the socio-demographic profile of children who are likely to go missing or abscond. In 2013, the EC commissioned study on missing children: the outcomes identified 'unaccompanied migrant children' as a specific category of missing children in the EU providing data on the numbers of missing UAMs in 12 EU Member States (Belgium, Cyprus, Czech Republic, Denmark, Estonia, Finland, Italy, Luxembourg, Slovak Republic, Slovenia, Spain and Sweden), ranging from 1,754 in Italy to 1 in Cyprus (2012). The study also highlighted differentiated responses to missing unaccompanied children as opposed to responses to missing national children. Indeed, an assessment of the magnitude and nature of the problem of children going missing or absconding is hampered by the fact that only half of the (Member) States hold statistics on UAMs who went missing or absconded; where statistics are available, these are often not comparable or not systematically collected. The magnitude of the problem also relates to the size of the inflow and numbers of UAMs in a (Member) State. Ireland and Italy report a significant decrease in the number of UAMs going missing.

A report published in 2012 in Italy, suggests that immediate reception and integration of the children by municipalities and reception centres (in so-called 'bridge facilities') had played a major role in reducing disappearances. This suggests that institutions play an important role in preventing disappearances.

One of the most commonly reported possible reasons for disappearances is UAMs wishing to transit to another (Member) State (Austria, Bulgaria, Belgium, Cyprus, Czech Republic, Greece, Finland, France, Italy, Latvia, Lithuania, Luxembourg, the Netherlands, Poland, Portugal, Slovenia, Sweden) or to another part of the same state (e.g. Spain) where UAMs may have family/ friends/ diaspora (Austria, Belgium, France, the Netherlands, Poland, Portugal, Slovenia, Spain), or it is more likely that they can access the labour market due to better economic conditions in the country (Bulgaria, Slovenia, Spain), or where they have pre-arranged a job opportunity (Czech Republic). Other possible reasons for why UAMs may disappear reported by (Member) States include: fear of a negative decision on application for international protection and/ or fear of removal, being a victim of trafficking (though they may not recognise themselves as victims), avoidance of age assessment.

Children who disappear during the first days (or even first 24 hours) are often reluctant to be registered and/or taken to reception facilities, for example: they may be using the reception centre as a temporary shelter while they are having problems within their community; or may have another final destination. Children who disappear further on during the 2nd and 3rd phases of reception are those who may find it difficult to adapt to new context. Furthermore, there are minors who disappear under a removal order just before they turn 18; or those who have received negative decisions in one of the procedures that could have provided them with a residence permit; or they just decide to seek their future elsewhere.

TRAUMA-FOCUSED COGNITIVE BEHAVIORAL THERAPY

In terms of **psychotherapeutic treatments**, despite the urgent need for effective treatments for trauma-affected UMRs, there is a considerable research gap with respect to evidence-based psychotherapy approaches for this high-risk group of children and adolescents. To our knowledge, to date there are no randomized treatment trials explicitly investigating PTSD treatments for URMs. There is, however, a first case series addressing the feasibility of trauma-focused cognitive behavioural therapy (TF-CBT) for unaccompanied minors with post-traumatic stress symptoms (Unterhitzenberger et al., 2015). This study could show that TF-CBT is applicable and feasible for URMs and is associated with an important decrease in symptoms of PTSD. In general, TF-CBT is considered as being one of the most successful treatment approaches for trauma-related disorders in children and adolescents (J. A. Cohen, Mannarino, Kliethermes, & Murray, 2012; J. a Cohen, 2005). In their systematic review on treatments for (accompanied) refugee children, Tyrer and Fazel (2014) concludes that the studies that used cognitive-behavioural therapy (CBT), i.e. which focused on exposure to traumatic experiences through verbal processing, were most successful in symptom amelioration (Tyrer & Fazel, 2014). Next to TF-CBT, Narrative Exposure Therapy (NET) was reported to be another effective treatment approach supported by empirical evidence. In this regard, the authors concluded that "NET […] is an example of how complex interventions can be delivered in resource-poor settings " (Tyrer & Fazel, 2014, p. 9).

NARRATIVE EXPOSURE THERAPY

Narrative Exposure Therapy (NET) is a brief trauma-focused treatment approach developed specifically to meet the needs of traumatized survivors of multiple, repeated traumatic event
(Schauer, Neuner, & Elbert, 2012). The efficacy of NET with adults affected by war and torture has been proven in several randomized controlled trials (Robjant & Fazel, 2010). KIDNET, a child-friendly version of NET has been advanced to specifically treat children and adolescents suffering from psychological disturbances, in particular PTSD, related to traumatic war and flight experiences (Neuner et al., 2008; Ruf, Schauer, Neuner, et al., 2010). In contrast to other trauma-focused exposure treatments, during KIDNET the child does not identify a single traumatic event as a target in therapy. Instead, KIDNET constructs a narrative that covers the child's entire life, while giving a detailed account of past traumatic experiences. Thus, KIDNET seems to be particularly suited for children who are exposed to repeated traumatic experiences of various types. This is typically the case for children living or coming from war-torn areas including URMs.

NARRATIVE EXPOSURE THERAPY - KIDNET

KIDNET consists of six to 10 sessions depending on the given context. During each session, the child, assisted by the therapist, constructs a detailed chronological account of his or her own biography. Particular attention is given on any stressful and traumatic events. The autobiography is recorded by the therapist in written form and, during the following session, chronologically reordered, completed, and carried forward with. The aim of this procedure is to transform the generally fragmented reports of the traumatic experiences into a coherent narrative. During the confrontation with the adverse life events, therapists ask for current and past emotional, physiological, cognitive, and behavioural reactions, and they probe for respective observations. The child is encouraged to relive these emotions while narrating. The exposure to the traumatic experience is not terminated, until the related fear reaction presented and reported by the child does not show a significant diminution. In the last session, the participant receives a written report of his or her biography. The report may also consist of a series of non-verbal symbols and pictures for younger children.

Another important characteristic of KIDNET is that the approach is not only short and pragmatic but also easily to disseminate and thus administrable by local professionals without lengthy training or academic education in psychological or medical fields. This is of particular importance in the context of mass disasters that often strike low-income countries with limited psychosocial resources. The evidence for KIDNET, so far, consists of a few randomized trials with children (Catani et al., 2009; Ruf, Schauer, Neuner, et al., 2010) and adolescents (Ertl, Pfeiffer, Schauer, Elbert, & Neuner, 2011; Schaal, Elbert, & Neuner, 2009), single case reports, as well as a pilot case series (Onyut et al., 2005).

GROUP PSYCHOTHERAPY

There is some evidence that established forms of group psychotherapy can be successfully adapted for severely affected children and adolescents living in war regions (Neuner, Catani, & Ertl, 2015). Given the dramatic numbers of refugee minors with mental health problems, group-based psychotherapy would offer a more pragmatic and cost-effective solution than individual therapy approaches. Bolton and colleagues (2007) investigated a group variant of interpersonal therapy (IPT) for depression in northern Ugandan youths. IPT targets four interpersonal areas: grief, interpersonal disputes, role transitions and interpersonal deficits. The effects of group IPT were limited to the reduction of depression symptoms among girls (Bolton, Bass, Betancourt, & al, 2007), whereas boys did not show a significant improvement after therapy. Furthermore, Mc Mullen and co-worker (McMullen, O'Callaghan, Shannon, Black, & Eakin, 2013), 2013) evaluated a mixed individual and group-based variant of Trauma-Focused Cognitive-Behavioural Therapy (TF-CBT) for former male child soldiers and war-affected boys in Congo. It was implemented by expert clinicians and included, next to various unspecific methods for stress management and relaxation, specific trauma-focused procedures such as creating a trauma narrative and cognitive processing. The authors could show a significant reduction of PTSD symptoms and co-morbid distress. The same group (O'Callaghan, McMullen, Shannon, Rafferty, & Black, 2013) replicated this study with sexually exploited and war-affected girls in Congo with local social workers as therapists and found promising effects.

1.4 The system of care in Germany and Italy

GERMANY

Many children and youths who lodge an application for asylum in Germany are fleeing for many reasons: becoming separated from their parents during their flight or while being smuggled into Europe; lack of opportunities for school education or training; impending harmful practices (e.g. genital mutilation of girls and young women in African countries); forced marriage; of girls and young women and of sexual abuse or forced prostitution; child labour (Afghanistan, Angola, Kenya), persecution as a result of refusal to enter national service or fear of conscription (Russian Federation), collective punishment for the crimes of a family member (Ethiopia) or enforced recruitment as child soldiers (African countries such as Angola, Sierra Leone, Somalia, Guinea and in Afghanistan, Syria).

A majority of unaccompanied minors are, therefore, not capable of asserting reasons for flight that would correspond to the criteria for "political persecution" under asylum law. And "political persecution" is a precondition both for the recognition as a person entitled to asylum in accordance with the German legislation1. In the case of unaccompanied minors who do not lodge any application for asylum, the local Foreigners' Authorities are responsible for examining whether the preconditions for a prohibition on deportation in accordance with § 60, Paragraphs 2 to 5 or 7 of the Residence Act have been met (see Chapter 4.1.5). There are no figures recorded across the Federal Republic in respect of this group. The overall percentage rate of UNAMs who lodge an application for asylum therefore remains unclear, as does the percentage rate of those who instead apply to a Foreigners' Authority for protection from deportation, or who "disappear". Likewise, it is not possible to make any statements concerning the principal countries of origin of those UNAMs who do not lodge any application for asylum.

Entry procedures and initial reception

The processes and procedures that are applied upon the entry into Germany of unaccompanied minors, do not always follow any one precisely prescribed model that remains consistent throughout Germany. Apart from the asylum procedure and some aspects of border control, the reception of UNAMs is a responsibility of the 16 German Länder, which, on their part, delegate certain duties to districts (Landkreise), cities and local communities. Depending on the Federal State in which an unaccompanied minor is apprehended, procedures can therefore differ substantially in relation, for example, to taking UNAMs into care and finding accommodation for them (cf. Cremer 2007: 23). There can also be further differences, depending on whether a minor is detected at one of Germany's external

borders or at an airport, or is apprehended by the police within Germany, or initially remains undetected and later, on a "voluntary" basis, applies to an authority or a facility for young persons.

In order to enter the Federal Republic of Germany, it is a fundamental requirement for under age nationals of third countries – just like their adult counterparts – to be in possession of a passport and, in many cases, a visa. The latter must be applied for at a German diplomatic mission in the subject's country of origin. Unaccompanied minors, however, often do not have any opportunity to apply for a visa. In many countries of origin there is, by reason of crises or acts of war, no functioning administrative framework capable of issuing a valid passport, and the embassies of possible countries for flight are not always accessible or within reach. There is also the additional problem that minors, by reason of their age and their particular situation, do not generally fulfil the preconditions for the issuing of a visa. As a result, their entry into the Federal Republic will generally take place on a legally irregular basis, either by air (most frequently via the airport in Frankfurt am Main) or by land or sea.

If a minor who is travelling alone is not able to produce the requisite visa at the time of his or her attempt to enter Germany, then the border authorities (the German Federal Police) are entitled to refuse entry. In these cases, as a matter of principle, there will be no notification of the locally responsible Youth Welfare Office. Likewise, the "third country regulation" contained in the Asylum Procedure Act, which is aimed at preventing entry into Germany from so-called safe third countries, will be applied to UNAMs. If it can be verified that legally irregular migrants or asylum-seekers are attempting to enter Germany via a neighbouring country, then they can be refused entry or forcibly returned to that country, irrespective of their age.

In cases in which unaccompanied minors are discovered by the Federal Police after they have already entered Germany without permission – and therefore can no longer be refused entry at the border – then the Federal Police will, within the framework of their competency, examine the possibility of terminating their residence – that is to say, of "return after illegal entry". Insofar as a return after illegal entry can be accomplished promptly, the local Youth Welfare Office will as a rule not be informed. Insofar as detention is necessary for the purpose of ensuring the forced return after illegal entry, the Federal Police will apply to the Court with local jurisdiction for this. In such applications the police will draw attention to the fact that the person concerned is under age, and in such cases the court will inform the locally responsible Youth Welfare Office. In the event that a forced return after illegal entry does not appear to be adequate or necessary, the minor is transferred to the relevant Foreigners' Authority (Ausländerbe- hörde) or the responsible Youth Welfare Office (Jugendamt). In the event of the minor being transferred to the Foreigners' Authority, this authority must inform the Youth Welfare Office. There are also some cases in which minors are handed over directly by the local or Federal Police to residential, care or "clearing house" institutions. In such cases the institution must inform the Youth Welfare Office and the Foreigners' Authority.

In order to be able to decide how to proceed in each individual instance, it is necessary to know, or to be able to ascertain, the age of the person attempting to enter Germany on a legally irregular basis. In practice, however, this often turns out to be problematic. Persons who have entered illegally frequently carry no identity papers with them, and very often, according to the Federal Police, make statements concerning their actual age that are transparently untrue. Theoretically, in connection with a subject's entry, it is possible to determine a notional age, thus enabling the person in question to be taken into detention in order to secure his or her forced return. According to § 49 of the Residence Act, the obligation to provide information then rests upon the foreign national. This person has the opportunity to cause further information to be obtained concerning the determination of his or her age – for example, in the form of a radiological examination. The practical implementation of this possibility is not, however, without controversy at the legal level, since there are no legal bases for the notional assumption of a date of birth.
Furthermore, judges sometimes refuse applications to take unaccompanied minors into detention, and medical examinations can turn out to be imprecise.
In order to increase the awareness and capabilities of its staff in terms of dealing with unaccompanied minors, the Federal Police carries out centrally-organised seminars and non-centrally organised vocational classes on potential challenges arising from the entry of UNAMs into Germany.

There are no complete statistical records of the number of unaccompanied minors who have, in recent years, been permitted or refused entry into the Federal Republic (cf. Müller 2000: 8-11). In particular, information is lacking concerning 16 and 17-year-olds. The Federal Police only records its findings concerning unaccompanied minors who do not yet have the capacity to act in procedures pertaining to the right of residence – that is, who are under the age of 16.

A few costs arising in relation to the entry and residence of these minors are impossible to ascertain, because a multitude of Federal and, above all, regional authorities are involved in the reception and residence of such minors. In addition, depending on their respective residence status and accommodation, UNAMs also receive various benefits in accordance with the German Asylum Seekers Benefits Act (Asylbewerberleistungsgesetz, AsylbLG), the German Code of Social Law (Sozialgesetzbuch, SGB) or on the basis of both laws.

Taking into care, determination of age and clearing procedure

Unaccompanied minors who are not immediately refused entry or returned after having entered Germany illegally, and who have within Germany no persons entitled to have care and custody of them and no legal guardians, are, following their arrival and/or their initial apprehension inside Germany, handed over to the respective Youth Welfare Office (Jugendamt) with responsibility in that locality. If UNAMs themselves come forward to the BAMF, to a Foreigners' Authority or to some other public institution, then this body should notify the Youth Welfare Office. The Youth Welfare Office is, according to § 42 of book VIII of the German Code of Social Law (Sozialgesetzbuch VIII, SGB VIII), responsible for taking the children or youths concerned "into care". This regulation is a short-term protective measure and includes the authority to place a child or a young person provisionally in accommodation with a suitable individual, in a suitable institution or in some other form of adequate accommodation. Equally, "the appointment of a legal guardian or carer shall be arranged without delay". For these purposes, a Family Court or Guardianship Court must be applied to for a decision concerning custody of the child.

Directly following the taking into care of the subject, a clarification or **"clearing procedure"** is carried out.

This is a matter of getting to the bottom of what circumstances have led to the child being taken into care and to what extent youth welfare needs to be granted – i.e. which potential measures would be in the interest of the respective unaccompanied minor and/or which measures would endanger the best interests of the child (cf. Arbeit erwohlfahrt 2008: 5).

In the context of the "clearing process", the structure of which can vary in accordance with the Federal State and locality and which lasts a varying amount of time, it is possible to undertake an assessment of age in the case of a young person whose age is unclear. In addition, further personal data, information concerning family members in Germany, in Europe and in the subject's home country and the reason for the migration of the child and/or the young person are asked for and determined. The legal guardian appointed by the court will decide, following an initial discussion with the young person, whether an application for asylum should be lodged with the BAMF. In some places in the Federal Republic, the clearing procedure is carried out directly by the Youth Welfare Office, while in others it takes place in special "clearing houses", in which – at least provisionally – UNAMs are also able to find accommodation. These will often be fixed communal homes with ten to 15 places and qualified specialist staff to look after the children and youths. The clearing houses are intended to ensure suitable care and accommodation for young persons, including their placement on language courses and in schools.

The Youth Welfare Office is both entitled and obliged to take a child or a young person into its care if a foreign child or a foreign young person shall come to Germany unaccompanied and there shall be neither persons entitled to care for the said child or young person nor legal guardians resident within the country. The duration of the "clearing procedure" can range from a few days to three months.
The appointment of a legal guardian by a Guardianship Court / Family court does not necessarily occur within a certain time frame. In some Länder, guardianship for unaccompanied minors is usually arranged within few days. In other Federal States, where the appointment of a guardian can take longer, preliminary guardianship measures may be taken until a permanent solution is reached. According to the law, legal guardianship for minors can be assigned to one person, several persons, Youth Welfare Offices or civil society associations.

The legal capacity of 16 and 17-year-olds to act, as determined in the Residence Act (Aufenthaltsgesetz) and the Asylum Procedure Act, is interpreted in such a way that UNAMs within this age bracket who lodge an application for asylum can be placed in accommodation for (adult) asylum-seekers and distributed inside Germany, provided the Youth Welfare Office does not ascertain that there is any particular need for youth welfare and does not order accommodation in a youth welfare institution.

There have been plenty of criticisms of the procedure for establishing the age of UNAMs made by organisations giving assistance to refugees and experts (cf. Cremer 2007: 25). In cases in which unaccompanied minors do not state their age or are not able to prove it, or if the authorities have doubts about the asserted minority of a young person, then employees of the local Youth Welfare Offices, of the clearing houses or even of the local Foreigners' Authorities will perform an estimation of the age of the subject by means of a visual inspection. In respect of this, the children and/or youths have the right to refute the authorities' estimation of their age by means of suitable documents or medical certificates. There are, however, very few centralised records as regards whether, and to what extent, any measures going beyond the visual inspection (such as X-ray examinations of the carpus or visual inspection of the teeth) are, in individual instances, set in motion. Such measures are in principle possible in accordance with § 49, Paragraph 6 of the Residence Act. However, they are considered by human rights organisations to be humiliating or an intrusion upon the physical integrity of the children or youths (cf. Cremer 2007: 25).

If an application for asylum is lodged, either by the legal guardian or by the minor himself or herself, generally following the end of the clearing procedure, the BAMF is responsible for establishing the legal capacity to act (and thus also the age) of the minor in question in respect of the asylum. In this case, a responsible official from the BAMF who has been trained to deal with unaccompanied minors will perform an estimation of the subject's age. A second person must be called in for this. The BAMF will not itself cause any medical certificates to be drawn up, but any documentation that is already available from the Länder authorities should be included in the estimation process. Allowance is made for the particular protection enjoyed by minors to the extent that in the event of any doubt there will be a presumption in favour of the person concerned that this person has not yet reached the age of 16. As a result, it should be assumed that the subject was born on the last possible date (31.12.) of the presumed year of birth. If the responsible official comes to believe that the young person has not yet reached the age of 16, the application for asylum by the person concerned will be considered to be "provisionally invalid", and the institution for reception will be notified of the need for a legal guardian to be appointed. The application for asylum will not become valid until approved by the legal guardian.

Once the clearing procedure has been concluded, unaccompanied minors are found accommodation with a suitable person, in an institution for children or young persons or some other form of supervised accommodation. In some Federal States, there is regularly the additional possibility of accommodation within institutions for reception designated for adult asylum-seekers. Some of these reception centres have special areas or neighbouring buildings intended to provide suitable accommodation and provisions for young persons. In the case of child refugees under the age of 14, accommodation with foster families is also possible. These can include both relatives and other families who are given permission by the legal guardian to take the child in. The range of different forms of accommodation for UNAMs is broad, as is the range of forms of social and educational care available.

ITALY

In the past five years, they may be in Italy:

a) unaccompanied adolescents who are either asylum seekers or who may benefit from measures of temporary protection for humanitarian reasons (which may be specific to the country of origin);
b) UAMs who come to Italy to join their parents, who might not fulfil the requirements to start reunification procedures (the so-called "partially UAM");
c) UAMs exploited by criminal organizations (with ties to prostitution, begging, child labour or drug pushing) who are often abducted or who come with the consent of their families of origin;
d) UAMs, who reach Italy illegally, though trafficking channels run by organized crime or who arrive, just like adults, with a specific economic migratory project; they often have to help their families pay for the debt incurred for their leaving. (Campani, 2013).

Despite the attention of the Government, the actual number of UAMs within the territory of the State is difficult to define since most of them do not fulfil residence regulations and move a lot within Italian territory. The CMS, by virtue of Article 5 of the Decree of the President of the Council of Ministers No 535/1999, requires public officials, civil servants and public organizations providing health and care services to immediately inform the CMS if they are aware of the entry/presence of a UAM within the territory of the State. Yet, the data that have been regularly collected and published, however significant, are by no means complete. In fact, not all competent Authorities within the territory of the State systematically report the presence of UAMs. Suffice it to think that many of them are the victims of trafficking, and are therefore "hidden"; some are facing criminal proceedings, and some are "accompanied" by adults, who are not able, in fact, to take care of them. By the same token, not all UAMs who enter Italy come into contact with the institutions, nor are they necessarily intercepted by Law Enforcement Authorities. CMS data do not include UAMs who applied for asylum. They are, in fact, surveyed by the National Asylum Commission and by SPRAR.

According to the ANCI Report, the Regions that have the highest presence of UAMs are Lombardy and Lazio, followed by Piedmont, Emilia Romagna and Friuli Venezia Giulia. The traditional trend is that the phenomenon is mainly concentrated in the central-northern regions, even if the minors may have arrived by sea. Besides wars, it is poverty, associated with low social and educational statuses and poor employment opportunities, which drives minors to migrate. They hope to find a better situation in Italy, towards Europe. Analyses suggest that UAMs do not have structured migratory projects with pre-defined expectations. When minors see migration as a way to flee conflicts and persecution, their arrival in Italy is often accidental and determined by external factors. Or their arrival may be the result of progressive adjustments to the opportunities that arise during their journey from time to time. Only at a later stage, do they usually apply for international protection.

The practices of entry into Italy, as in other European countries, are governed by a series of laws and regulations, but above all provisions it is the general principle of the "best interests of the child". According to this principle Italian or foreign minors are protected by the Italian State and assisted in every need and necessity, especially children who are in the country without adult that accompany them.

Entry and assessment procedures

Like for adults entering or staying in or in transit in the Schengen Area, to enter Italy foreign minors need to have a passport or other travel document recognized as valid by all Schengen States. However, all UAMs are entitled –simply by virtue of their being under-age (and thus non-removable) - to obtain a "residence permit for minors", even if they do not have official documents, on the basis of their declarations.

At the same time of the residence permit application, under Article 343 of the Civil Code requires that a "Public Guardianship" case must be opened within 30 days for all UAMs. A minor who has a residence permit for minors can convert it into a "residence permit for foster care" if, following the decision "not to repatriate the minor" by the Ministerial Directorate, he/she is placed in foster care directly by a decision of the Juvenile Court, or upon the initiative of the Social Services, made enforceable by the Guardianship Court. A residence permit for foster care allows a UAM to work in all the cases in which the Italian law permits minors to work. It can be converted into a residence permit for study or work reasons when he/she turns 18.

If a UAM has a residence permit for foster care (due to a decision not to repatriate the minor and a foster care decision taken by the Juvenile Court or the Social Services and made enforceable by the Guardianship Court), he/she can immediately access the labour market – in compliance with the regulation on child labour - and the permit is converted into a residence permit for study or work reasons when he/she turns 18. A minor who is fostered by a third-country national regularly staying in Italy and who lives with him/her, is registered in the foster parent's residence permit as long as he/she is under 14; and is given a residence permit for family reasons when turning 14. A UAM who might suffer persecution in his/her country, for reasons of race, religion, nationality, political beliefs or belonging to a social group, is entitled to apply for asylum through his/her guardian.

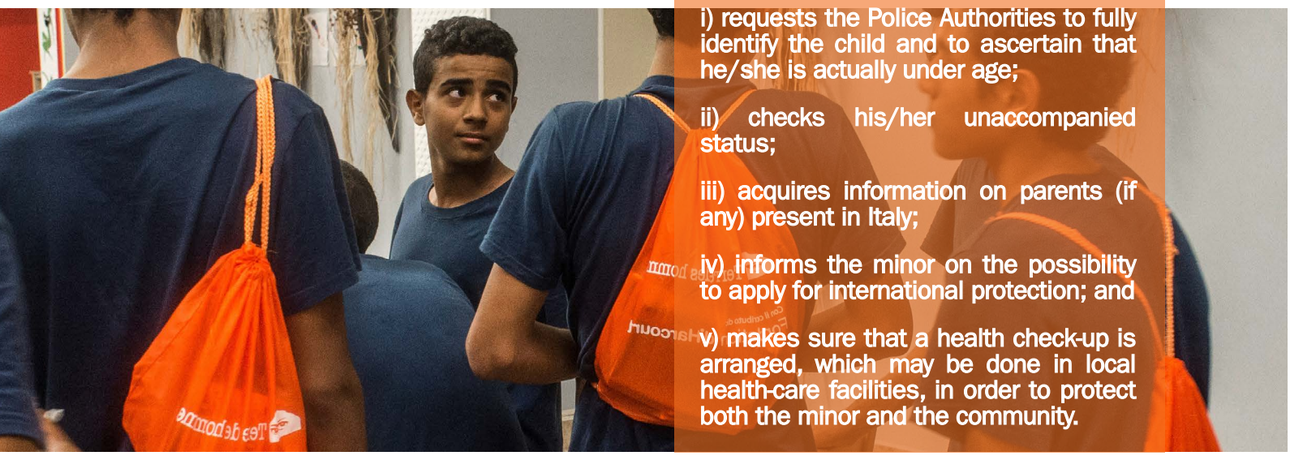
The asylum application is examined by the Local Commission for the Recognition of Refugee Status. If the minor is granted a refugee status, he/she receives a residence permit for asylum reasons. If the asylum application is rejected, the Commission can still invite the Questore (Provincial Chief of Police) to issue a residence permit for humanitarian reasons, if the repatriation of the minor may be dangerous or inappropriate. Anyhow, the minor is entitled – through his/her guardian - to lodge an appeal against the Commission's decision before an ordinary Court.

Generally, the Questore does grant a "residence permit for humanitarian reasons", allowing the UAM to stay in the country legally since his/her turning 18. In the case of adolescents who have no valid documents and declare that they are under age but their age is doubtful; or who are caught committing a crime for which it must be assessed if they are under fourteen; or who declare they are of age but their age is doubtful (e.g. some under-age victims of the exploitation of prostitution claim they are of age), the process provides for age assessment and never removal or refusal of entry.

According to the Italian law, age assessment procedures must be undertaken fully respecting the minor's rights, health and dignity; they must be carried out in the least invasive way possible, and never forcibly. Age assessment procedures must be undertaken by independent and properly trained professionals.

National rules and procedures at the borders

A UAM arriving at a land/sea border of the Italian State must be preliminarily identified by Police Authorities, also following a report by a public official. According to the law, Police Authorities must undertake an initial age assessment and should report the presence of the minor to the Ministerial Directorate, the Public Prosecutor's Office at the Juvenile Court, and the Guardianship Court. Police Authorities check the availability of reception facilities within that district. If there is no availability, they immediately inform the Public Prosecutor's Office at the Juvenile Court, and request the Ministerial Directorate to indicate which facilities they may contact for prompt reception. These reception facilities, called "bridge facilities", are located all over Italy, and take care of the initial phase of reception only. The minors are later transferred to reception facilities that will host them until they come of age. Bridge facilities provide and an immediate and safe placement of the minors; and at the same time they make it possible to carry out the necessary background checks to define the following integration process in the best interest of the child. Once the Police Authorities have been instructed on which bridge facility to use, they transfer the minor and report his/her name to the local Social Services of the Municipality in which the bridge facility is located, to the Public Prosecutor's Office at the Juvenile Court and to the Guardianship Court.
As soon as possible, the Mayor, or a representative of the Mayor, takes the following action at the bridge facility:



i) requests the Police Authorities to fully identify the child and to ascertain that he/she is actually under age;

ii) checks his/her unaccompanied status;

iii) acquires information on parents (if any) present in Italy;

iv) informs the minor on the possibility to apply for international protection; and

v) makes sure that a health check-up is arranged, which may be done in local health-care facilities, in order to protect both the minor and the community.

Then, the Mayor, or one of his/her representative, reports the minor to the Ministerial Directorate. The Ministerial Directorate indicates the Municipalities in which there are reception facilities that have availabilities and best respond to the protection needs of the minor. The bridge facility will take care of the transfer, agreeing on the specifics (when and how) with the Municipality of destination. As soon as the minor arrives within the territory of the Municipality of destination, he/she is taken care of by the local Social Services. They initiate the procedures provided for by the law (request to the Guardianship Court to open a public guardianship case, application for a residence permit for minors, etc.) and update the Ministerial Directorate, the Public Prosecutor's Office at the Juvenile Court and the Guardianship Court. If an official from a local authority identifies a UAM, he/she has to notify:

- The Public Prosecutor's Office at the Juvenile Court, which takes the relevant measures if the minor is in the state of abandonment and, usually, is below fourteen years of age;

- The Guardianship Court, which opens a legal guardianship case;

- The Ministerial Directorate, which uses the information for survey purposes, starts a family tracing investigation, and monitors the situation of the child, or to the SPRAR if the minor has already lodged an asylum application

- The diplomatic mission/consular post of the minor's country of origin, to provide information on the protection measures that have been adopted (except for asylum-seeking UAMs, since this information may entail risks of persecution).

The notifications must be made as soon as possible, irrespective of whether or not the minor has been previously identified, has received a residence permit, and his/her identity has been cleared up (if he/she has given false personal particulars to different authorities). Notification must be made in a way to protect confidentiality. The same reporting obligations to the Public Prosecutor's Office at the Juvenile Court and to the Ministerial Directorate lie upon the Police and other public officials, civil servants and providers of essential public services who trace a UAM. If a minor shows up spontaneously at an Initial Reception Centre, the Centre must immediately notify the Social Services of the relevant local authority and the Questura (Provincial Police Headquarters) within 48 hours. It appointed within 30 days from receiving the child. In practice, the Centre contacts the Social Services of the local authority.

Current regulation strengthens the responsibilities given to the institutions towards minors. Article 1 establishes that on arrival the minor is given all necessary information on his/her rights and the existing legal options. After the involvement of the Guardianship Court, the minor is immediately entrusted to the SPRAR, which allocates a certain number of places to asylum-seeking UAMs every year. The asylum application is examined by the Commission for the Recognition of Refugee Status, which hears the minor and his/her guardian during the proceeding. If the Commission grants refugee status to the minor, he/she will receive a residence permit for asylum reasons. Or else, the minor may be granted "subsidiary protection" or "humanitarian protection". This type of protection is regulated by the Immigration Law and is granted when, according to the Local Commission, there are serious humanitarian reasons justifying the presence of the asylum-seeking UAM in Italy.

The procedure for assessing the age

Italian regulation lacks organic unity when it comes to UAMs' age assessment. Principles and procedural protections are regulated by sources of different nature, mostly secondary sources, and have a limited scope. Some principles refer, in fact, only to criminal offences or to international protection, and, as such, are not directly applicable to all age assessment procedures for presumed UAMs. Other principles are referred to only in secondary sources, such as Ministerial Circulars and Guidelines.

If there is uncertainty or doubt about the age, the presumed minor may undergo an anthropometric or other assessments provided for by law. The law states that the assessment is undertaken with the consent of the minor or his/her legal representative, after the minor

has been informed on the possibility that his/her age is assessed through a medical examination, specifying the kind of medical examination and its possible consequences, and on the fact that his/her refusal to be medically examined does not constitute an impediment to the acceptance and examination of his/her asylum application. However, in practice, in doubtful cases, the verification is made automatically. The assessment is undertaken with methods that are non-invasive and safe and that respects the health, dignity, physical integrity, age and gender of the minor. Unfortunately, the fragmentation of the Italian regulatory framework tends to result in a lack of homogeneity in national and local practices, and in a partial application of principles and safeguards when it comes to age assessment. The most widespread practice is to undertake the age assessment through one medical examination only.

Guardianship

According to current Italian regulation a minor is not considered able to exercise his/her rights, ("unable to act"), and this applies to anyone under 18 years of age. If we consider that besides the age factor, the concerned person is an unaccompanied foreigner, the law provides for the appointment of a guardian, who will guarantee the protection of the minor and the exercise of his/her rights, pursuant to Article 343 of the Civil Code.

The Mayor then usually delegates the local Social Services, even though there are no specific provisions in this regard. In some cities, given the high number of guardianship cases, public guardianship offices have been set up, usually within the Social Services Directorate. The law states that every year the guardian has to submit a report to the court on the conditions and has to take care of him/her on a regular basis. The guardian must – personally or through others (for instance the staff of the Reception Centres) – apply for a residence permit at the Questura, register the minor with the National Health-Care Service and give consent to the medical treatments that may be needed, and enrol the minor at school, recreational activities and working activities, as the case may be. The guardian is also required to legally represent the minor when needed or if the minor is involved in a criminal case, and assist him/her if he/she intends to contest the rejection of the international protection application. Also, the guardian has to accompany the asylum-seeking UAMs to the interview with the Commission for the Recognition of Refugee Status. Finally, the guardian has to manage the minor's assets reliably and conscientiously. The guardian's proxy is however temporary: all these duties have to be performed only until the minor comes of age. In the unfortunate case that a guardian turns out to be unsuited to his role, he/she may be suspended and removed from his office by the Guardianship Court. A guardian may accept more than one assignment and be responsible for a number of minors at the same time.

Unfortunately, it may take a long time for the guardianship case to be opened, which is perhaps even more serious; another major issue has to do with the appointment of guardians. It has already been said that the mayor is usually appointed; the mayor, in turn, delegates a social assistant, a psychologist or a professional educator from the Social Services. However, it has been questioned whether it makes sense to have guardianship exercised as a bureaucratic task by a civil servant, or as an additional burden on top of educational tasks in the reception facility (moreover, the law forbids to appoint people who are in charge of reception facilities).

Reception and care arrangements

UAMs are subject to the rules laid down by the Italian law on the care and protection of children. In particular, the following rules apply: when a child is found in a state of abandonment, the local authority (usually, the municipality) places the minor in a safe place; a guardianship case is opened for a child whose parents cannot objectively exercise their parental authority; and the child, temporarily deprived of a suitable family environment, is assigned to a foster family or a community or community centre, pursuant to article 403 of the Civil Code.
As soon as a minor arrives at their centres, they are taken care of by local social services. These latter initiate every statutory procedure (request the Guardianship Court to open a public guardianship case, apply for the residence permit granted to minors, etc.), update the Ministerial Directorate, as well as the local Public Prosecutor's Office at the Juvenile Court and Guardianship Court.
When a local body official identifies a UAM, it must report the minor to the Public Prosecutor's Office at the Juvenile Court, the Guardianship Court, the Ministerial Directorate, and the diplomatic-consular office of the minor's country of origin.

The responsibility for care and management of UAMs is up to the local social services. The local authority must initiate the procedures provided for by the Italian law, such as the opening of public protection, foster care, the start of an integration process and the application for a residence permit (the so-called "taking charge of the child"). The Ministerial Directorate and SPRAR (for asylum seeking unaccompanied minors) provide funds to the local authorities so as to cover nearly every expense, even if the local authorities are increasingly supplementing the funds of the ministerial bodies through their own budget. Within community/reception centres, UAMs go through an integration project defined by the Social Services of the Municipality, on education, health and leisure facilities; in addition, their juridical-legal position is defined.

As a matter of fact, Italy is characterized by an extreme variation of reception models for UAMs. At the same time, we can identify a common intervention process, where reception is the main protection and security measure, followed by integration policies, with a special focus on training and employment, until minors turn 18 years of age. In Italy, the social policies adopted by local authorities are mainly concentrated on two types of intervention, integration and housing. These policies unfold and develop differently according to the local context, local resources, the role played by the Mayor in defining and managing this phenomenon, and the level of involvement and interaction among local social stakeholders.

1.5 The use of services

Numerous practical barriers reduce or limit children's access to psychosocial the services; in particular, children's access to education, healthcare and housing are very critical. Access to compulsory education is often granted to unaccompanied minors. This is often due to laws which speak about 'all children' being required to attend certain levels schooling, and undocumented children are not excluded. Undocumented children are usually formally excluded from carrying out internships and training, even when part of compulsory education, as it is seen to be linked to work although it is an essential part of a child's education. Further, access to non-compulsory education, such as early childhood education and care, 16- 18 education (where not compulsory), further training and university, is very problematic for undocumented children and young people to access in most EU countries.

Health care services on the other hand present an even more worrying situation. Except in a few countries, unaccompanied minors have the same entitlements to access health care services as adults, with no additional protection. This means that their entitlements in law are very varied across Europe, and range from emergency care only in a large number of EU countries, to equal access as national children in a few. In between these two extremes, several countries provide UAMs access to 'urgent' or 'essential' treatment. This can be interpreted to include most health care services for children or very few, depending on the national, regional or local context, either in law or in practice. Undocumented migrants rarely have access to continuous, specialist (e.g. dentistry, optometry) and mental health care.
There are many practical barriers to various social services: the inability to provide documents required for registration or other administrative purposes, such as identity documents and proof of address; discretionary power on local level and discrimination; lack of awareness of unaccompanied children's rights and the relevant regulations on the part of service providers; complex rules that change often; risk of detection through accessing services.

There seems to be a general agreement that refugee adolescents with mental health problems do not access care adequately (Griffith & Chan-Kam, 2002). A study by Bean et al. (2006) addressed mental health needs and service access among these young persons. Data were collected from unaccompanied young persons and other professionals, including carers and teachers. Their well-being, mental health need and service utilization were compared with a non-refugee group. The findings suggested that unaccompanied refugee young persons who reported a need to access mental health services also experienced a higher degree of distress than local young persons. Professionals, however, overall failed to detect distress and service needs in the majority of refugee young persons. Their referral to specialist mental health service appeared to be initiated by the professionals' perceived needs, and not by what these young persons themselves felt. About half of the refugee young persons eventually reported their mental health needs as unmet. In the absence of parents or other family members, the available carers or guardians should be conscious of these young persons' potentially unmet need to access mental health care, despite their frequently limited information on the past or even recent history.

Sanchez-Cao et al. (2012) investigated the mental health needs and service access pattern among 71 unaccompanied young persons in London. Although two thirds (66.2%) of the sample had high levels of post traumatic stress symptoms, only 17% had any kind of contact with specialist mental health services. Symptoms of depression, rather than post traumatic stress disorder, and duration of stay in the host nation predicted contact with mental health services. This is consistent with the earlier findings of under-utilization of services. Language barriers, lack of knowledge about services, high frequency of relocation, and varied cultural understanding of psychopathology, treatment and attitude towards help- seeking are seen as the underlying factors influencing service access in unaccompanied refugee minors. Bean et al. (2006), as well as Sanchez-Cao et al. (2012), suggested that the young persons who remained in the host country for longer and had an adequate opportunity to acculturate and be accustomed with local health beliefs and practices, showed a better chance of acknowledging needs and asking for help, thereby accessing and utilizing specialist mental health services better.

De Anstiss and Ziaian (2010) held 13 focus groups in Australia with 85 refugee adolescents aged 13-17 years from Afghanistan, Bosnia, Iran, Iraq, Liberia, Serbia, and Sudan. The findings indicated that most were very reluctant to venture beyond their close friendship networks for help with their psychosocial problems due to a range of individual, cultural, and service-related barriers. Michelson and Sclare (2009) found significant differences in referral pathways and service access between unaccompanied and accompanied refugee minors. Unaccompanied asylum seeking children and young persons were more likely to be referred by social care rather than health agencies. They also attended fewer sessions, and missed a greater proportion of scheduled appointments. Despite their elevated risk of PTSD, they were less likely than accompanied children to have received trauma-focused interventions, cognitive therapy, anxiety management and parent or carer training, and also received fewer types of practical assistance with their basic social needs.

Furthermore, refugee young people have been found to be reluctant to ask for help from professionals, and their help-seeking mostly remains confined to their close friends circle (De Anstiss & Ziaian, 2010). They may be even more reluctant to seek help from traditionally western services. Past research has found that a significant proportion of refugee children and young people are reluctant or ambivalent towards psycho-dynamic or other talking therapies. There are a range of views on why existing mental health services are usually unsuccessful in reaching and helping these children. Many suggest that until the children's practical needs have been met, particularly their asylum claim, they would not be ready for this type of service (Brownlees & Finch, 2010). Although unaccompanied minors describe both positive and negative interactions with their general practice and specialist health services, there is a need to find ways to explain the benefits of therapeutic input, in a way which is easy to understand and does not intimidate them (Chase et al., 2008). Along with health services, welfare supports should be incorporated, which may be more acceptable to the young people and their communities.

There still appears to be a general lack of appropriate psychosocial services that social care and general practitioners can refer these young people to. Additionally, there is a gap in appropriate transitional services for refugee young people once they become 18 years old (Chase et al., 2008)**. Transition can be problematic for all young people, but more so in this group because of restrictions imposed by regulations on their further stay in the host country, and also a lack of adult services specific for this population.**

In the 2010, UNICEF questioned the appropriateness of existing services and approaches. Many refugee young people looked after by social services are placed in predominantly white middle class areas, and there is an identified lack of appropriately skilled mental health professionals who are experienced in working with unaccompanied refugees. As a result of this, mental health problems may not be recognized (Brownlees & Finch, 2010). Moreover, there is substantial variation in the quality of care and health agencies in contact with this group, and often a lack of knowledge and experience of their specific cultural needs. This is partly explained by the lack of appropriate training for primary care and other social care professionals to assist them in correctly identifying mental health problems experienced by unaccompanied refugee minors (Chase et al., 2008).

Consequently, changes in our current models of psychosocial and mental health care are recommended to improve access for unaccompanied minors. These included the use of interpreters, addressing the debate around ethnic matching between therapists and patients, promoting sensitivity to otherness, mediation, and the importance of choosing the right time to intervene. Huemer et al. (2009) suggested that interventions for these young persons need to take into account the interfaces of institutional systems, which they are living in. Moreover, it has been suggested that support for unaccompanied refugee minors needs to be multi-faceted, aiming to provide them with as normal a life as possible (Burnett & Peel, 2001). Inter-agency partnerships may, therefore, be helpful in the development of comprehensive care (Thomas et al., 2004). Asgary and Segar (2011) commented that barriers to the care of unaccompanied refugee minors are inter-related and should be addressed by individual professionals, service providers, policymakers, and regulators by collaboration between governmental, non- governmental, health, and legal agencies. Along with providing appropriate health care, treatment facilities should provide targeted social care and facilitate community support. They also argued the importance of effective documentation of any adversities in the asylum process..

1.6 The economic case of psychosocial care for unaccompanied minors

Examining the economic case for psychosocial care of unaccompanied children is more complicated than the words might suggest. One most important reason for that complexity is because an 'economic case' does not simply mean that one intervention or approach costs less than another (although that would certainly be a relevant consideration); rather, **making an economic case requires trading off any difference in cost between two courses of action against the difference in effectiveness.**

Another source of complexity in this particular field is the challenge of identifying and measuring effectiveness.

One challenge comes from the fact that there are both short- and long-term consequences of many mental and other psychosocial problems, and so – potentially – the effects of care could similarly be both short- and long-term. Second, there are different dimensions of effectiveness, with perhaps different meanings for different individuals: schooling, integration, symptom alleviation, functioning in everyday life, including the ability to get a job or to be in a relationship. These different effectiveness (or outcome) dimensions can have implications for how and what resource allocation decisions are taken.

2.DEFINITION AND SCOPE OF THE STUDY

Little evidence exists regarding the cost effectiveness of psychosocial care for unaccompanied minors. Despite this, there is clear evidence that psychosocial interventions, such as schooling, support, leisure activities, counselling and psychotherapy can result in significant savings in the long term for the society.

The study hypothesises that high prevalence of mental health issues, abandonment and lack of integration in the society are avoidable through psychosocial interventions across the whole post-migration process of this population. The study aims to further the work on the cost effectiveness of psychosocial interventions for unaccompanied children providing, as such, useful information for policy makers concerned with the strategies of supporting those children and young people in the most efficient manner possible.

Limited access to health and social care for vulnerable immigrant children in Europe is increasingly worrisome as immigration policies harden and more unaccompanied minors do not access to adequate psychosocial care. This study analyses the gap between the current psychosocial care and ‘’an empirically-based model of care” based on the existing scientific literature, international guidelines and the opinions of key informants. It is argued that the lack of available data on the magnitude of the problem and on its individual and public health consequences stems from the conflicting situation faced by health institutions required to simultaneously protect the best interest of each child and allocate limited resources. The findings of the study can be useful for prioritizing decisions regarding psychosocial care in this underserved population.

2.1 Aims of the study

This economic evaluation study was intended to serve two purposes:

a) To provide stakeholders and policy-makers, NGOs, universities with tools for planning and budgeting their psychosocial interventions, as well as for investigating how changes in the structure of operations of the current system can be expected to change the cost and other characteristics of the social care;

b) To provide other countries with a tool with which to explore how the ‘’ideal model” might be replicated in their own country, and how modifications in the structure or operations of the system might be expected to affect the system’s cost.

The study had the objective to define costs and benefits of an empirically-based model of care and to compare costs and benefits of such a model with the current model of care in the two target countries selected for the study, Italy and Germany. For each country, the current model of care was described identifying gaps, strengths and weaknesses against the needs of unaccompanied minors. Due to the heterogeneity of the data collected and of the real procedures followed between the two countries and in the different regions of the same country, the comparison was conducted by confronting the theoretical model with each site. Then, the main differences were underlined and an estimation of the variation in terms of costs/benefits was calculated.

To implement this approach the study first maps the current model of care and existing services across different areas of the two target countries to cost the necessary services to implement the model. Then, it describes the ‘’empirically-based model of care” and it identifies all of its outputs or activities. Next, the myriad inputs that are required to produce each of those activities are identified, quantified and costed. Given the objectives of this study, the actual, historical cost of implementing the programme was regarded as less important than capturing the ‘most likely’ cost scenario. The methodology therefore seeks to determine the ‘most likely’ cost scenario, which provides an opportunity to better understand the cost drivers—factors that influence the level of costs (e.g. the number of trainees per training, or the frequency of supervision). The programme’s highly standardized approach allows the construction of a number of costing algorithms as a means of operationalizing the ingredients approach (Tan-Torres et al. 2003). To apply activity-based costing (ABC), the study grouped specific activities into cost centres for analysis. The sum of the cost centres is comprehensive, thereby including all of the resources used to produce each and every activity of the programme, and together, the entire programme.

3. METHODOLOGY

3.1 Overall approach

The methodology followed three main stages: information gathering, cost analysis, economic model:

INFORMATION GATHERING

a) information gathering (service mapping) to identify the main current system of care and related unit costs:

- **Information obtained from existing organisations and institutions;**
- **Information obtained from relevant agencies and professionals;**

We liaised directly with both governing bodies and organisations such as local authorities to gain data to provide the rationale and justification for projected values assigned to identified costs and benefits associated with the proposed psychosocial services.

- **Consultation with the project advisory group**

The project advisory group members assisted with suggestions of methodological approaches and with facilitating the contact with relevant organisations.

b) **A literature review was also conducted to explore the operating systems and configuration of existing services in Italy and Germany** and to identify the key areas impacting on expenditure related to unaccompanied foreign minors such as the asylum process, age determination, detention, missing children investigations and trafficking. Existing cost analyses were used in particular areas (such as judicial review and police investigations), while existing services were used to extrapolate data and formulate key assumptions regarding the set-up, operation and impact of a psychosocial service. To determine the key components of the ‘’empirically-based model” of care, a psychosocial literature review on effectiveness of interventions for unaccompanied minors was also conducted. The relevant international guidelines were also taken into consideration along with the opinions of key informants.

COST ANALYSIS

The key assumptions for the analysis were

- **the identification of an estimated number of service users**
- **ratio of professionals to service users**
- **appraisal period**
- **types of services**

Data collected by the above methods was analysed in terms of its relevance, suitability and reliability. Where possible, supporting evidence was obtained for cross-referencing so that there would be increased confidence in the data before subsequent modelling of costs and benefits.

The data was then used to identify estimated values for costs and benefits. For example, where unaccompanied or separated migrant children come into contact with authorities, we considered how a legal guardian could engage with and have an effect on relevant processes, such as the asylum process and court proceedings. Potential costs and savings were explored in this context. Weighting was applied in areas where impact was not immediately clear, or may be more or less significant than expected (for example, in the number of children likely to need substantial support from a psychoterapist).

COST ANALYSIS

The model compared the existing model of care with the ''empirically-based model of care".

Data collection involved information gathering about:

1. The norms, directives and laws in unaccompanied migrant minors support and hosting (and the possible modification over time from 2013 to now)
2. The guardians profile and path to recruit and assign them
3. The clearing house typical profile
4. The psychological screening/assessment/therapy
5. The psychosocial support
6. The psychosocial activities provided by services
7. The outcome used

Data were be collected from:

1. Government websites
2. Direct contact with the national officials responsible for migration
3. National health system websites
4. Direct contact with national health system officials
5. Direct contact with NGO on the field
6. Direct contact with psychosocial services
7. Direct contact with clearing house and/or community managers.

3.2 Mapping of services

Researchers identified services and stakeholders in the provision of psychosocial care for unaccompanied minors. Purposive sampling was used, and based on experience in either children and adolescent mental health or refugee health, service providers were invited to participate in the study in either focus groups or key informant interviews.

Key informants. Focus group discussions (FGD) were conducted by a moderator. Interviews were semi-structured and a mixture of questioning strategies was employed around two main issues (Box 1) until saturation was achieved (i.e. interviews/focus groups did not elicit substantially new themes).

Providers were asked to express their views and experiences about barriers and facilitators for psychosocial care of unaccompanied minors in:

1. Referrals and initial access to services
2. Maintaining engagement with psychosocial activities and support/mental health services
3. Service gaps
4. Psychosocial approach and model of care

Stakeholders included politicians, psychiatrists, psychologists and counsellors in specialist and non-specialist mental health services; paediatricians, general practitioners, nurses, teachers social and youth workers, and settlement workers. An understanding and consideration of the impact of culture was identified as the cornerstone of effectively engaging unaccompanied minors who did access services. Participants observed that to be able to engage the young person, the worker and the service organisation must show respect and understanding of the culture. Absence of such respect and understanding was felt to negatively affect engagement with mental health and other services. Providers suggested that culturally competent and sensitive services do not use "a one size fits all approach" and instead match the young person and professional by ethnic background and/or gender. Where matching was not possible, providers felt mental health professionals should be aware of the impact of their own gender, ethnicity, religion, mode of dress and age on their relationship with the young person.

A range of factors was seen as enhancing or impeding service accessibility, including the location and appearance of services, the criteria for acceptance, and appointment systems. Participants suggested greater use of outreach services, and engaging young people from refugee background in community settings where mental health professionals could be seen in a less formal way.

Providers felt that referral to mainstream mental health services was often only successful in young people with a clear diagnosis, and thus was generally restricted to those major psychiatric disorders. Fear and distrust of services were felt to be significant barriers to effective engagement with mental health services. Unaccompanied minors may have had negative experiences of authority during their migration pathway, resulting in lack of trust in institutions and professionals, including hospitals and people in uniform.

Psychosocial issues in unaccompanied children are rarely limited to the domain of mental health alone. Providers reported young people often have other concerns, such as family separation, housing stability, isolation and economic security, which they might feel are higher priority (than mental health) for the young people themselves. Unaccompanied minors are commonly “complex cases” who are often referred from one specialized service to another, or seen by multiple services and workers at the same time. This may cause fragmented care and service provision. Care coordination (across health, mental health, and other welfare agencies) was felt to be a potential solution to facilitate engagement.

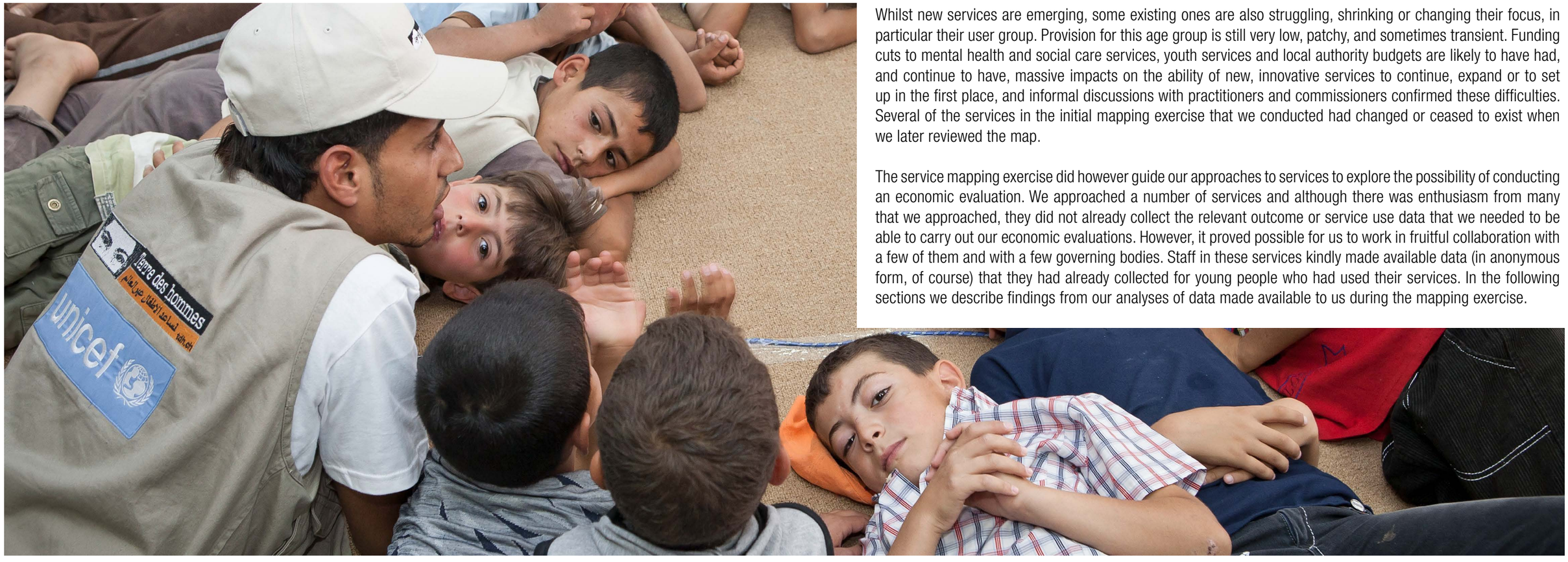
Despite an enabling policy environment, there are substantial challenges in program and service implementation, in part due to limited evidence on “what works” to engage and maintain engagement of unaccompanied minors with psychosocial services in Germany and Italy. Furthermore, unaccompanied minors may be reluctant to seek help for mental health problems. (Behnia, 2003; Ellis, et al., 2010; Guerin, Guerin, Diiriye, & Yates, 2004; Palmer, 2006; Palmer & Ward, 2007; Tribe, 2002; Ward & Palmer, 2005). Behnia (2003) indicated that refugee clients may consider the care of a sick family member a family responsibility as long as their behaviour can be managed at home and that families will seek external help only when the problem can no longer be kept hidden, or becomes unmanageable. External help will commonly include traditional, religious and cultural healing practices (CMY, 2011). Ellis (2010) observed partnerships between mental health service providers, communities, and religious organisations can open pathways to mental health care, and collocation of physical and mental health services (with improved service relationships) has also been found to be important (Savin, Seymour, Littleford, Bettridge, & Giese, 2005). Many children have had traumatic experiences that may shatter “core assumptions about human existence” and destroy “trust in the world or oneself as a safe place”(Victorian Foundation for Survivors of Torture, 1988, p.50). They may have a generalised fear of ‘doctors’ or other people in authority (Victorian Foundation for Survivors of Torture, 2000). Mistrust and social isolation may have been survival strategies during times of organized violence (Nadeau & Measham, 2006), and hostility or discrimination in the country of resettlement may also influence client interaction with services.

Service mapping. The mapping exercise of psychosocial services aimed to provide a picture of existing resources for unaccompanied minors and to identify services for potential economic evaluations. For each service identified we collected information regarding the type of service,provider, targeted age group, contact person, and any data or evaluations of the services currently available.

These services varied in objectives and structure, and in the treatment and interventions they offered. The mapping exercise highlighted many examples of good unaccompanied minor service models, with some innovative approaches to care and support of this population, but rarely services included all steps of care along a continuum from prevention to secondary and tertiary care with a broad-based and flexible approach to both mental health issues and the factors that may lead to, or exacerbate it such as issues with school, integration, housing, finance, substance misuse and employment, with a focus on promotion, prevention and treatment.

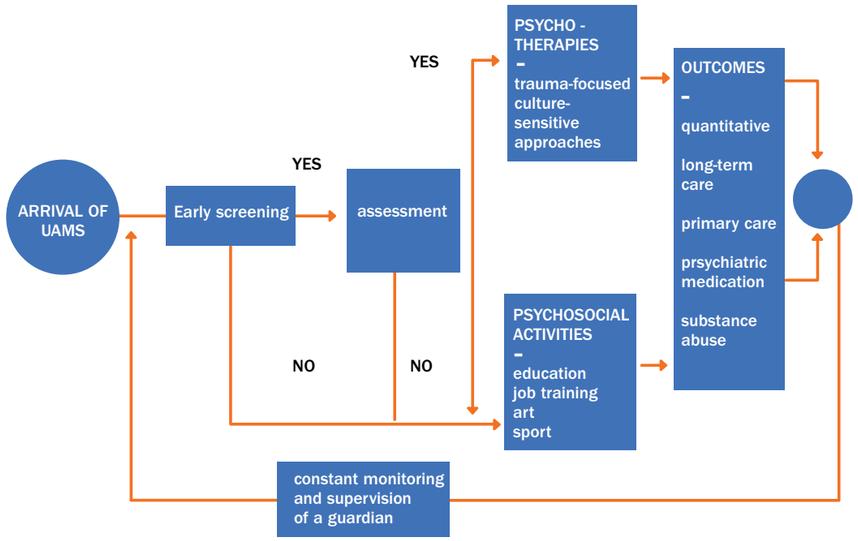
Whilst new services are emerging, some existing ones are also struggling, shrinking or changing their focus, in particular their user group. Provision for this age group is still very low, patchy, and sometimes transient. Funding cuts to mental health and social care services, youth services and local authority budgets are likely to have had, and continue to have, massive impacts on the ability of new, innovative services to continue, expand or to set up in the first place, and informal discussions with practitioners and commissioners confirmed these difficulties. Several of the services in the initial mapping exercise that we conducted had changed or ceased to exist when we later reviewed the map.

The service mapping exercise did however guide our approaches to services to explore the possibility of conducting an economic evaluation. We approached a number of services and although there was enthusiasm from many that we approached, they did not already collect the relevant outcome or service use data that we needed to be able to carry out our economic evaluations. However, it proved possible for us to work in fruitful collaboration with a few of them and with a few governing bodies. Staff in these services kindly made available data (in anonymous form, of course) that they had already collected for young people who had used their services. In the following sections we describe findings from our analyses of data made available to us during the mapping exercise.



3.3 The economic model of Psychosocial care

Researchers selected the model based on data availability and literature. As stated earlier, psychosocial care to UAMs requires a complex organisation and coordination of different service tiers, that are asked to respond to very complex needs across different professional figures and institutions. Interagency referrals are crucial to the well-being of such a vulnerable population. Currently, the system of care does present an effective attempt to respond to the needs of UAMs leading to high societal costs. However, there is a significant fragmentation that hinders the possibility of creating a continuum of care with a coordination amongst actors that would function as a very important prevention tool.
The empirically-based model addresses the fragmentation of services and it functions as an alternative course of action to be compared with the current system of care in the economic evaluation. This approach enabled the researchers to project costs/ benefits for the society if a more articulated psychosocial care would have been offered to unaccompanied minors.
In the graph below the empirically-based model (EBM) is presented.



The flow-chart highlights a process based on a early intervention/prevention strategy to support unaccompanied minors who enter Europe. At their arrival, each minor should be assigned very early to a guardian; the guardian should be responsible for no more than 20 minors. In so doing, the guardian should be in a position of better coordinating the care for those children (legal rights, asylum or permission request, psychosocial care, health care,..).

All unaccompanied minors entering a European country should be screened immediately to assess their psychosocial needs, strengths and risks. This is crucial for the longer term planning of care and to prevent the onset of eventual more serious psychiatric conditions. Depending on the early screening and consequent psychosocial assessment, children would be given the possibility of receiving the most appropriate support and treatment. Furthermore, this would avoid the provision of generic psychological treatment, which has been proven to be ineffective.
Individuals who are more at risk would have the opportunity to undertake psychotherapy, possibly trauma-focused. The therapeutic process would be monitored and evaluated in the short, medium and long term. All unaccompanied minors will be supported with psychosocial activities, that would be evaluated in the short, medium and long terms.

The guardians continuously monitor the minors entrusted to them, during each phase of their hosting (in the clearing houses, in the community or families, in the first step of living alone etc.) until 18 years old and even in the first phase of the adult life. Furthermore, the guardian is entitled to request at any time a risk assessment and a consequent psychotherapy if needed. For this reason the guardian should be trained on legal and psychological issues concerning unaccompanied minors.

4.RESULTS

4.1 Cost analysis

In this section of the report, we examine the identified monetary costs of establishing, implementing and maintaining the EBTM. The costs have been carefully assessed, so as to provide assurance that the proposed model will provide a quality service in terms of provision of care for migrant children, and value for money for the Italian government. The costs have been identified and assessed on a fix number of 1000 UAMs registered for a period of 1 year. Before we compute the cost of the current systems of Italy and Germany, while in the Economic model paragraph the cost (and its increment) due to the application of the EBTM has been shown.

4.2 Mapping of Italian current procedure

In Italy, the Connect project reported that in 2013, 24% of registered Unaccompanied Migrant Children UAMs went missing from reception centres and that many more go missing before registration. The Ministry of Internal Affairs reported that in 2014, 3,707 (26%) unaccompanied migrant children of the 14,243 who were registered after arriving via boat went missing from reception centres. The Ministry of Welfare reported that in 2015, 62% of all unaccompanied migrant children who had arrived between January and May went missing.

We assumed that at least 50% of UAMs before or after the registration go missing every year.

Half of this percentage (most of them that disappears before registering can be done to specific migration projects (the UAMs want to reach other countries, have relatives or friends to meet, but the other half that go missing from the reception centres have different motivations.

From our mapping in Sicily (Siracusa, Catania and Palermo), in Emilia Romagna (Bologna), Marche (Macerata) and Lombardia (Milano) we can assume that:

The largest number of missing UAMs disappears from the first reception centres.
In the table below you can see the data collected in Bologna.

	FLOW OF UAMs			No OF DEVELOPED PROJECTS			MISSING UAMs		
Type of centre	2013	2014	2015	2013	2014	2015	2013	2014	2015
First Reception	160	197	236	50	105	113	103 (64%)	80 (41%)	73 (31%)
Community	44	54	60	26	26	34	2 (5%)	5 (9%)	1 (2%)
Apartment	24	35	35	12	22	21	0	0	0

The data show that in the first reception centres the percentage of missing was really high in 2013 (64%) and it has decreased in 2014 and 2015. This decrement can be explained with the increasing number of projects developed that passed from 50 in 2013 to 113 in 2015.

From the data collected in Siracusa with local AccoglieRete, a non-profit organization we can observe that until June 2013 on 534 UAMs registered in Siracusa just 134 did not go missing (25%). It even true that on 534 UCM just 4 of them have been associated to a legal guardian after 6 months. From July 2013, AccoglieRete began operating in order to create a system of protection for UAMs arriving by sea on the coast of Sicily. AccoglieRete promotes the role of legal guardians for UAMs and have created a list of 150 legal guardians and more than 35 foster families that support UAMs on a voluntary basis. With the list of legal guardians available the time of assumption of legal guardians has been reduced to 69 days until the end of 2014 and 96 days until 2015.
From the data collected we can suppose that:

The 25% of UAMs go missing after registration because the reception service does not cover their needs in terms of:

- **Projects proposed/psychosocial support**
- **Legal guardian**

We do not have details about the permanence time in the reception centres before they leave them. We can suppose 3 months of staying before leaving (this hypothesis is based considering the time without a legal guardian. The faster situation registered in Siracusa is 96 days so we can consider 3 months the average time of leaving.

The reception contribution from the Ministry of Internal Affairs amounts 45 euros per day for each UAMs. This value is the minimum value that can be integrated by local authorities. Each region would then have a different quota for each UAMs, from a minimum of 45 euros in the south of Italy to 70-75 euro in Emilia Romagna, Marche and Lombardia.

The distribution of UAMs in the Italian regions is shown in the table below (from the report of Ministry of Internal Affairs) :

Table 1. The percentage of UAMs disaggregated by Regions

DATA TO 31/12/2015		
Region	*No of UAMs*	*%*
Sicilia	4,109	34.5
Calabria	1,126	9.4
Puglia	1,102	9.2
Lazio	934	7.8
Lombardia	931	7.8
Emilia-Romagna	783	6.6
Campania	521	4.4
Toscana	510	4.3
Friuli Venezia Giulia	463	3.9
Piemonte	345	2.9
Veneto	322	2.7
Sardegna	220	1.8
Liguria	174	1.5
Marche	96	0.8
Basilicata	92	0.8
Provincia Autonoma di Bolzano	69	0.6
Abruzzo	42	0.3
Provincia Autonoma di Trento	35	0.3
Molise	22	0.2
Umbria	20	0.2
Valle d'Aosta	5	0.0
total	11,921	100

From the distribution shown in the table in the previous page we can see that the regions like Sicily host the 67% of UAMs while the other 33% is hosted by the richest regions. From this distribution we can assume an average contribution of 55 euros per capita per day. It is important to notice how for the Italian children entrusted to the social service the minimum contribution per capita per day is 70 euros.

Costs for psychosocial support (inside the government contribution)

From the data collected in the different longer-term facilities we can segment the official contribution according to the following cost centres:

Table 2. The longer-term facilities cost disaggregated by function

COSTS	%
Staff	51.23
Consultancies	1.20
Food	10.16
Accommodation	3.43
Drugs	0.23
Psychosocial activities	5.53
Transport	0.58
Utilities	10.67
Taxes and general expenses	16.57
Amortization	0.40
total	100

From this segmentation we can consider cost for psychosocial support two voices, staff (a percentage of 66% of it considering the number of social workers inside the communities) and psychosocial activities, with a percentage of 39% of the total cost. This means that on the 55 euros of contribution around 22 of them can be considered as direct (activities) and indirect (personnel) cost for psychosocial support.

Other costs

To this value we should add the legal cost (the legal guardian cost, the courts cost, the policemen cost etc.), the health and mental health cost.

In Italy, the legal guardian is based on voluntary availability for honour (for free). In fact the legal guardianship for unaccompanied minors is paid just if the minor has enough economic availability. From the Palermo Court we received the information that a correct value of the legal guardianship is a contribution of 500 euros per month per UAMs assisted. From the Guardianship CBA - CHTB End Report_2014_FINAL_FOR CIRCULATION we can consider that the guardianship cost is surely paid (in terms of effectiveness) by the legal savings, so we can not consider them as cost to account for mental health care.

The health and mental health cost are around 30 euros per medical examination. Starting from the data collected in Palermo at AUSL 6 Servizio di accoglienza per cittadini extracomunitari, we can suppose that each month on average each UAMs does not be examined more than 2 times, that means 60 euros per month per capita, or 2 euros per day. Again we can round the cost to 3 to take in account general medical cost.

So the total cost per capita per day will be:

- **The total cost per capita per day is Cday= 55+3=58 Euro**

To calculate the total days of contribution per year we will consider that 500 UAMs are hosted 365 days while other 250 (the ones that disappear after the registration) remain in the centres for 90 days.
So the total days of hosting will be:

- **The total days of hosting is Dtot = 750*365+250*90=296250**

Therefore, the total cost for hosting 1000 UAMs per one year would be:

C1000 = Dtot * Cday =296250*58 = 17182500

4.3 Mapping of German current model of care

The German Red Cross in the region of Saxony-Anhalt reported in November 2015 that they witness daily disappearances of unaccompanied migrant children, often very young. The federal police (BKA) is giving out data on missing unaccompanied minors: 4.800 children in Jan.2016, in July 2016 it was 9.000 minor refugees. The real figure must be higher, since not all cases are registered. We can assume that in Germany we have the same rate of disappearing of Italy. Of course, being Germany a country of second hosting (of people coming from European border countries as Italy, Greece and Spain) we assume just the 25% of leaving after registration.

The hosting organization is structured in a similar manner respect the Italian one. From the interview and the data collected in Bielefield that is the biggest centre of hosting in Germany exist 3 different hosting levels. First reception organization where more than 30 UAMs where hosted usually for short time, small communities with less than 30 people (usually between 10 and 20 UAMs and apartment for UAMs or adult (in the first period after the 18 years old) where the UAMs can live alone. In fact in Germany, the UAMs that are recognized minors will follow even at least 12 month after the 18 years old.

From the German national report on unaccompanied minors (Unaccompanied Minors in Germany Reception, return and integration arrangements, 2009) and from the collection of primary data, for each UAMs, depending from the regions the federal contribution varies from 88 euros per day per capita to 161 euros per capita. We can suppose an average value of around 100 euros per day. In this contribution are included more or less the same services that are offered in Italy (and that are described in the table of service segmentation reported in the in the chapter above.

Costs for psychosocial support (inside the government contribution)

Starting from the interviews with clearing house managers, the costs of psychosocial support should consider

two cost centres: staff (a percentage of 66% considering the number of social workers inside the communities) and psychosocial activities, with a percentage of 39% of the total cost. This means that on the 100 euros of contribution around 40 of them can be considered as direct (activities) and indirect (personnel) cost for psychosocial support.

Other costs

To this value we should add the legal cost (the legal guardian cost, the courts cost, the policemen cost etc. again we can skip them from the cost benefit analysis), the health and mental health cost.

From the Guardianship CBA - CHTB End Report_2014_FINAL_FOR CIRCULATION we can consider that the guardianship cost is surely paid (in terms of effectiveness) by the legal savings, so we can not consider them as cost to account for mental health care.

The health and mental health costs are around 50 euros per medical examination. From the interviews in Bielefield with social service personnel, we can suppose that each month on average each UAMs does not be examined more than 2 times (as it happens in Italy), that means 100 euros per month per capita, or 3.3 euros per day. Again we can round the cost to 4 to take in account general medical costs. So total cost per capita per day and total days of hosting can be calculated as:

- The total cost per capita per day is Cday=100+4 =104 euros
- The total days of hosting is Dtot = 750*365+250*90=296250

Remember that in Germany we have just the missing UAMs after registration.

Therefore, the total cost for hosting 1000 UAMs per one year would be:

C1000 = Dtot * Cday =296250*104 = 30810000 euros

4.4 Comparative cost analysis

The results of the cost comparison between the current model of care in Italy and in Germany and the EBM are presented below.

ITALY

The Legal Guardian: in our EBM model the legal guardian has an important role. The guardian encompasses the legal role and he/she plays a care-giving role with the assigned unaccompanied minor. The guardian assists and supports the minor in all the activities and he/she is responsible for their psycho-physical well-being. For this reason, the model supposes an early allocation of the guardian (within the first month) resulting into a lower number of UAM disappearances after their registration.

For this reason, the number of missing children was reduced of 50% in the EBM (i.e. from 250 to 125).

This reduction produces an increment of Dtot and of C1000

Dtot =875*365+125*90=330625

C1000 = Dtot *58=330625*58 =19176250

So the increment Δ_2 due to early legal guardian was:

$$\Delta_2=125*(365-90)*58=1993750$$

Mental health

Mental health costs were segmented as follows:

- Screening cost for all the UAMs registered
- Diagnosis cost for a percentage of the UAMs registered
- Psychotherapy cost for the same percentage of diagnosis one (in a first step we can assume that all the subject that enter in the diagnosis step will be treated with one type of psychotherapy defined during the diagnosis)

Screening

The screening was considered to be done in one session. One session was considered as a standard medication examination with a unit cost of 30 euros. So the screening cost will be:

30*1000=30000

According to recent studies (Ruf, Schauer, & Elbert, 2010; Bean, Eurelings-Bontekoe, Mooijaart, & Spinhoven, 2006), from 20 to 50% of URMs in industrialized countries suffer from PTSD or other symptoms that tend to remain stable over time in untreated individuals. The study hypothesised that from the screening a percentage of 10%, 20%, 30% until 50% of the 750 UAMs were in need of an assessment and psychotherapy.

Assessment

The assessment costs were set to 465 euros (following the fee system of Italian Psychological Association). The costs for the assessment were, therefore, calculated according to the different percentages (reported in the table 3 below)

Table 3. Assessment costs disaggregated for the different percentages of UAMs treated in Italy

%	COSTS
10	1000*10%*465 = 46500
20	1000*20%*465 = 93000
30	1000*30%*465 = 139500
40	1000*40%*465 = 186000
50	1000*50%*465 = 232500

Treatment

A typical psychotherapy treatment covers 45 sessions. The unit cost of a single session was of 90 euros (average value from the Italian Psychological Association). The average costs of treatment was equal to 4050 (45 sessions x 90). The cost of 4050 euros was applied to the different percentages of treated UAMs with the figures below:

Table 4. Treatment costs for the different percentages of UAMs in Italy.

%	COSTS
10	1000*10%*4050 = 405000
20	1000*20%*4050 = 810000
30	1000*30%*4050 = 1215000
40	1000*40%*4050 = 1620000
50	1000*50%*4050 = 2025000

The total costs for mental health care proposed in the EBM are shown in the table below

Table 5. Mental health care cost for different percentage of UAMs treated in Italy.

%	SCREENING	ASSESSMENT	PSYCHOTHERAPY	TOTAL COST
10	30000	46500	405000	481500
20	30000	93000	810000	933000
30	30000	139500	1215000	1384500
40	30000	186000	1620000	1836000
50	30000	232500	2025000	2287500

The EBM increases the value of C1000 as reported in the table below

Table 6. EBTM cost for different percentage of UAMs treated in Italy. In bracket the percentage of increasing respect the current cost is reported.

C1000 baseline	Δ_2	%	MENTAL HEALTH CARE COST	TOTAL COST
17182500	1993750 (11.6%)	10	481500 (2.8%)	19657750 (14.4%)
		20	933000 (5.4%)	20109250 (17.0%)
		30	1384500 (8.1%)	20560750 (19.7%)
		40	1836000 (10.7%)	21012250 (22.3%)
		50	2287500 (13.3%)	21463750 (24.9%)

The increasing main percentage of increasing is due to the hypothesis that with EBTM the number of missing UAMs after registration decreases (from 250 to 125 UAMs). The weight of this increasing is 11.6% respect the current cost, but no one can discuss the opportunity to reduce the number of missing UAMs. The proper Mental Health Care Costs weights from 3% to 13%, depending by the percentage of UAMs under psychotherapy treatment. Even in case of a high number of treatment (50% of the total number of UAMs registered) the EBTM total cost increasing percentage remains around 25%, i.e. more or less covers the distance that currently exist between the government contribution for UAMs and Italian unaccompanied minors.

GERMANY

Legal guardian

We can assume the same reduction of missing UAMs that we have considered in Italy, passing from 250 to 125 missing UAMs.
This reduction produces an increment of Dtot and of C1000

$Dtot = 875*365+125*90=330625$

$C1000 = Dtot * Cday=330625*104 =34385000$

So the increment Δ_1 due to early legal guardian will be: $\Delta_1=125*(365-90)*104=3575000$

Mental health: We repeat the same procedure applied for Italy.

Screening

The cost of one session can be supposed 50 euros, as a standard medical examination

$50*1000=50000$

We can suppose, following the same literature studies of Italy, that from the screening a percentage of 10%, 20%, 30% until 50% of the 1000 UAMs needs to pass to diagnosis and therapy phases.

Diagnosis

Based on the German Youth Service Act the diagnosis cost can be fix at 692 euros. In the table below the cost based on the different percentage of UAMs treated are reported.

Table 7. Diagnosis cost for different percentage of UAMs treated in Germany

%	COSTS
10	69200
20	138400
30	207600
40	276800
50	346000

Psychotherapy

A standard psychotherapy is based on 45 sessions. Based on the German Youth Service Act) per each session the cost is 105.55 euros.

45x105.55=4750

Table 8. Treatment cost for different percentage of UAMs in Germany.

%	COSTS
10	475000
20	950000
30	1425000
40	1900000
50	2375000

The total costs for mental health care with the EBTM applied in Germany are shown in the table below

Table 9. Mental health care cost for different percentage of UAMs treated in Germany.

%	SCREENING	DIAGNOSIS	PSYCHOTHERAPY	TOTAL COST
10	50000	69200	475000	594200
20	50000	138400	950000	1138400
30	50000	207600	1425000	1682600
40	50000	276800	1900000	2226800
50	50000	346000	2375000	2771000

So, the EBTM increase the value of C1000 as reported in the table below

Table 10. EBTM cost for different percentage of UAMs treated in Germany. In bracket the percentage of increasing respect the current cost is reported.

C1000 baseline	Δ_1	%	MENTAL HEALTH CARE COST	TOTAL COST
30810000	3575000 (11.6%)	10	594200 (1.9%)	34979200 (13.5%)
		20	1138400 (3.7%)	35523400 (15.3%)
		30	1682600 (5.5%)	36067600 (17.1%)
		40	2226800 (7.2%)	36611800 (18.8%)
		50	2771000 (9.0%)	37156000 (20.6%)

4.5 Monetised benefits for the Italian and German systems

This section of the report will summarise the key monetised benefits of the application of EBTM including:

1. Long Stay Residential Care
2. Primary care
3. Psychiatric medication
4. Social inclusion and drugs program
5. Alcohol problems

It should be noted that the wider qualitative and social benefits of having an appropriate mental health support, such as the mental or physical well-being of the users, have not been included in this appraisal. In this sense our research is focused on direct outcome base on quantitative and monetizable benefits quite all related to reduction of health cost (see Economic Justification of the Jigsaw Model of Early Intervention & Prevention R.R. Clayton, R. J. Illback 2013). To be sure not to overestimated the benefit we chose; when it is possible to be conservative and lightly underestimate them (choosing the low tail of cost distribution or reducing the number of UAMs involved).

Long Stay Residential Care

For long stay residential care we can take the statistics developed in Jigsow study (R.R. Clayton, R. J. Illback 2013). This data are valid for Irish people and we are conservative if we suppose that UAMs remain in the same proportion of Irish people not well treated for mental health problems.

Moreover to be conservative we suppose that on the percentage of UAMs that in EBTM follows a diagnosis and psychotherapeutic path, just 50% of them without the new model will be admitted for a long stay residential care in their future life. On this group will have:

85% stay for 60 days,

14% stay for 180 days,

1% stay for 365 days

The daily cost for hospitalization can be fix at 500 euros per day (in Italy the cost of one day strongly depends from the regions and can vary between 400 and 1100 euros, we chose 500 euros as a conservative but representative price). We fix the same cost for Germany hospitalization.

Considering the case of 10% of UAMs (100) in Italy that follow a psychotherapy, this means that:

50 of them should be admitted to a long stay residential care,

42.5 for 60 days,

7 for 180 days

0.5 for 365 days

For a cost avoided of 1996250.

So the cost avoided with the model proposed will be shown in the tables below for the different percentage and different countries.

Table 11 Cost Avoided for long stay residential care in Italy

	%	No OF DAYS			COST AVOIDED
Initial population		60	180	365	
1000	10	42.5	7	0.5	1996250
% long stay	20	85.0	14.0	1.0	3992500
50%	30	127.5	21.0	1.5	5988750
daily cost of hospital staying	40	170.0	28.0	2.0	7985000
500	50	212.5	35.0	2.5	9981250

Table 12 Cost Avoided for long stay residential care in Germany

	%	No OF DAYS			COST AVOIDED
Initial population		60	180	365	
1000	10	42.5	7	0.5	1996250
% long stay	20	85.0	14.0	1.0	3992500
50%	30	127.5	21.0	1.5	5988750
daily cost of hospital staying	40	170.0	28.0	2.0	7985000
500	50	127.5	21.0	1.5	9981250

Primary Care

IN ITALY

About primary care we can suppose that over the entire population treated by psychotherapy there are a reduction of the number of examination per year (1 examination at 30 euros less per year) and a reduction of drugs for 21 euros per year. To calculate the reduction of drugs we start from the average drugs expenses per capita per year in Italy that is 210 euros (AIFA report http://www.agenziafarmaco.gov.it/it/content/luso-dei-farmaci-italia-aifa-pubblica-il-rapporto-osmed-primi-9-mesi-2015-0) and we suppose to reduce them of 10%. Over the rest of population not missing (625) that have been followed by a correct guardianship we can estimate to have a conservative reduction of the same variables of 5 euros per year.

With an average value of life of 70 years (less than any standard for European countries) it means that the cost avoided will be the ones shown in the table below.

Table 13 Cost avoided for primary care in Italy

INITIAL POPULATION	%	COST AVOIDED
1000 (875 of them that stay the entire year)	10	466700
1 examination less per year	20	705900
30+3 euros	30	945100
Reduction of expenditure in drugs per year	40	1184300
21+2 euros	50	1423500
Life expectation		
70		

IN GERMANY

As we assume in Italy, we can suppose that over the entire population treated by psychotherapy there are a reduction of the number of examination per year (1 examination at 50 euros less per year) and a reduction of drugs for the same amount. For the rest of population we can suppose a total reduction of 10 euros. With an average value of life of 70 years (less than any standard for European countries) it means that the cost avoided will be the ones shown in the table below.

Table 14 Cost avoided for primary care in Germany

INITIAL POPULATION	%	COST AVOIDED
1000	10	923000
1 examination less per year	20	1391000
50+5 euros	30	1859000
Reduction of expenditure in drugs per year	40	2327000
50+5 euros	50	2795000
Life expectation		
70		

Psychiatric Medication

We can do similar assumption of the primary care, considering that for all the treated UAMs in Italy the reduction in psychiatric medication will be 30 euros per year, while in Germany remains 50 euros. The tables below show the cost avoided for the different percentage treated in the 2 countries.

Table 15 Cost avoided for psychiatric medication in Italy

INITIAL POPULATION	%	COST AVOIDED
1000	10	156000
Reduction of expenditure in drugs per year	20	312000
30 euros	30	468000
Life expectation	40	
70	50	

Table 16 Cost avoided for psychiatric medication in Germany

INITIAL POPULATION	%	COST AVOIDED
1000	10	260000
Reduction of expenditure in drugs per year	20	520000
50 euros	30	780000
Life expectation	40	1040000
70	50	1300000

Problem Behaviour

Find an estimates of the costs to government associated with a range of problem behaviours as problem alcohol use, problem drugs abuse, self-harming, accidents and injuries, antisocial behaviour and crime, poor school adjustment, and a range of other risky behaviours is not easy in an analysis projected all over the entire life. Stating from the analysis of 2009 in US on cost per capita per year related to the alcohol problems (http://www.alcoholcostcalculator.org/business/about/?page=1) that fix the cost in 155$, considering all the other problems behaviours we can estimate the cost of problem behaviour per capita per year in 300 euro and the cost avoided in the treated percentage of UAMs of 10% and in not treated of 1%. Again this numbers are really conservative.

Table 17 Cost avoided for problem behaviour in Italy

INITIAL POPULATION	%	COST AVOIDED
1000	10	276900
Reduction of expenditure per problem behaviour per year	20	417300
30+3 euro	30	557700
Life expectation	40	698100
70	50	838500

Table 18 Cost avoided for problem behaviour in Germany

INITIAL POPULATION	%	COST AVOIDED
1000	10	276900
Reduction of expenditure per problem behaviour per year	20	417300
30+3 euro	30	557700
Life expectation	40	698100
70	50	838500

Total monetised benefits

The total costs avoided by the application of EBTM are reported in the tables below

Table 19 Total Cost Avoided in Italy

%	LONG STAY	PRIMARY CARE	PSYCHIATRIC MEDICATION	PROBLEM BEHAVIOUR	TOTAL
10	1996250	466700	156000	276900	2158888
20	3992500	705900	312000	417300	4057775
30	5988750	945100	468000	557700	5956663
40	7985000	1184300	624000	698100	7855550
50	9981250	1423500	780000	838500	9754438

Table 20 Total Cost Avoided in Germany

%	LONG STAY	PRIMARY CARE	PSYCHIATRIC MEDICATION	PROBLEM BEHAVIOUR	TOTAL
10	1996250	923000	260000	276900	3456150
20	3992500	1391000	520000	417300	6320800
30	5988750	1859000	780000	557700	9185450
40	7985000	2327000	1040000	698100	12050100
50	9981250	2795000	1300000	838500	14914750

4.6 Building the economic case: modelling the effectiveness of psychosocial care

To take into account the real cost of the application of the therapeutic model on the UAMs we need to sum the direct and indirect cost added by the application of the model and subtract the cost avoided by the same application. In the tables below the Italian and German cost-effectiveness analysis has been reported.

Table 19 Cost-effectiveness analysis in Italy

C1000 baseline	Δ1	%	MENTAL HEALTH CARE COST	COST AVOIDED	TOTAL COST
17182500	1993750	10	481500	-2895850	16761900 (-2.4%)
		20	933000	-5427700	14681550 (-14.6%)
		30	1384500	-7959550	12601200 (-26.7%)
		40	1836000	-10491400	10520850 (-38.8%)
		50	2287500	-13023250	8440500 (-50.9%)

We can notice how the cost effectiveness produces a small reduction of the real cost (-2.4%) when the UAMs treated are the 10% of the total population, consistently decreases at 20% (-14.6%), while for an higher percentage of UAMs treated the real cost of hosting UAMs is reduced until a value of 50% when the percentage of UAMs treated reaches the 50%.

Table 20 Cost-effectiveness analysis in Germany

C1000 baseline	Δ_1	%	MENTAL HEALTH CARE COST	COST AVOIDED	TOTAL COST
30810000	3575000	10	594200	-3456150	31523050 (2.3%)
		20	1138400	-6320800	29202600 (-5.2%)
		30	1682600	-9185450	26882150 (-12.7%)
		40	2226800	-12050100	24561700 (-20.3%)
		50	2771000	-14914750	22241250 (-27.8%)

As for Italian analysis even in Germany the cost-effective analysis has a positive trade off, passing from a real increasing in the cost with 10% of UAMs treated (+2.3%) to a reduction of -5.2% at 20% of UAMs treated, until a reduction of 28% when the percentage of UAMs treated reaches the 50%.

We underline that there are many indirect and qualitative cost reduction due to the well being and integration of UAMs in European countries. As far as we aware, this is the first study of the economic impact of youth mental health services. Our study was hampered by an almost complete absence of: relevant previous research to provide a platform from which to build a research design, specialist youth mental health services across the UK with which we could work collaboratively, and good data on outcomes or cost-related indicators. Despite these difficulties, we have gathered new evidence to feed into national and local discussions about this most challenging of mental health areas. Our findings show the wide-ranging and sizeable economic consequences of not identifying or appropriately addressing the mental health needs of adolescents and young adults. We have also shown that two specialist local services appear to have had important impacts on the mental health and broader life quality of the people they support.

From our empirical evidence we believe that the a specific model appears to be successful and that there is a clear role for age-appropriate services to address both the current and longer-term consequences of UAMs issues. The treatment gap is bigger for this population, yet this is precisely the age when many fundamental decisions are taken – in relation to education, employment, personal relationships and so on – each of them with ramifications over the life-course. To neglect the psychosocial needs of unaccompanied minors is not just morally unacceptable but economically enormously wasteful.

4.7 Distribution of migrants in Europe?

Comparing the results of cost-effectiveness in Italy and in Germany (shown in table below)

Table 21 Comparison cost-effectiveness analysis

%	C1000 baseline		COST DIFFERENCE		TOTAL COST	
	Italy	Germany	Italy	Germany	Italy	Germany
10	17182500	30810000	-410304	729552	16761900 (-2.4%)	31523050 (2.3%)
20			-2136931	-1523540	14681550 (-14.6%)	29202600 (-5.2%)
30			-3359807	-3427103	12601200 (-26.7%)	26882150 (-12.7%)
40			-4078930	-4981138	10520850 (-38.8%)	24561700 (-20.3%)
50			-4294302	-6185645	8440500 (-50.9%)	22241250 (-27.8%)

We can notice that:

1. The current cost in the 2 countries strongly differ even if the services offered are comparable. Germany costs quite 2 times more. The main difference depends from the government contribution (55 in Italy and 100 in Germany). From all the other economic parameters the 2 countries do not have this big difference, and from the data mapping in Italy we have seen how the real contribution per capita per day can strongly vary between regions (from 45 to 75).

2. The absolute cost increase/reduction due to EBTM in the 2 countries present to clear zones. For percentage of treatment under the 30% the real savings in Italy are higher than in German, while increasing the number of treatments German saves more.

3. The percentage savings of the application of EBTM presents a clear benefit in Italy respect the German case. In fact with 50% of UAMs treated he percentage saving is quite double in Italy than in Germany (51% vs 28%).

4. Both countries present a collective trend of real-cost when the EBTM is applied.

5. Based on a perspective analysis of benefits (so accounting for benefit in medium and long term) for both countries the cost should be paid during the first years of hosting, while the real reduction is spread over the next 50 years.

From all the observations above we can outline that:

· In term of cost-effectiveness, applying the EBTM, no clear advantage exists to be hosted in Italy or in Germany.

· Considering the current government contribution we can understand the reason why about 25% of UAMs disappear before being registered in Italy and try to reach other European countries. 55 euros per capita per day represent a very low value, less than the one received by Italian unaccompanied minors managed by social services.

· The analysis and the EBMT application in the other European countries can be interesting to understand the current situation and the distance from the EBTM, as if the cots-effectiveness trend presents the same behaviour.

· Being the number of UAMs dramatically increased in the last 3 years (and seems to be confirmed even for 2016) it seems reasonable to distribute the UAMs over the entire European continent or following their request and needs in those countries that they try to reach.

· The increasing of initial cost due to the application of the EBTM, even without the benefit analysis remains in both countries under the 25% even in case of application of treatment in the 50% of UAMs. This amount can be surely paid and sustained by European countries. (currently in Italy the migration hosting cost 2 euros per year per each Italian citizen).

Recommendations

Since we started our work there have been some helpful developments in the area of psychosocial care for unaccompanied minors, which drew on a wide range of evidence to highlight failings in the current system, and set out many challenges for improvement. Another very helpful development was the report from the Children and Young People's Mental Health and Well-being Task force (Department of Health and NHS England 2015). Both reports offer astute, insightful observations on the state of mental health services for this age group, and make important recommendations for improvement over the coming years. We will not cover the same span of recommendations here. Rather, we offer recommendations stemming primarily from what was the focus of our study: the economic issues.

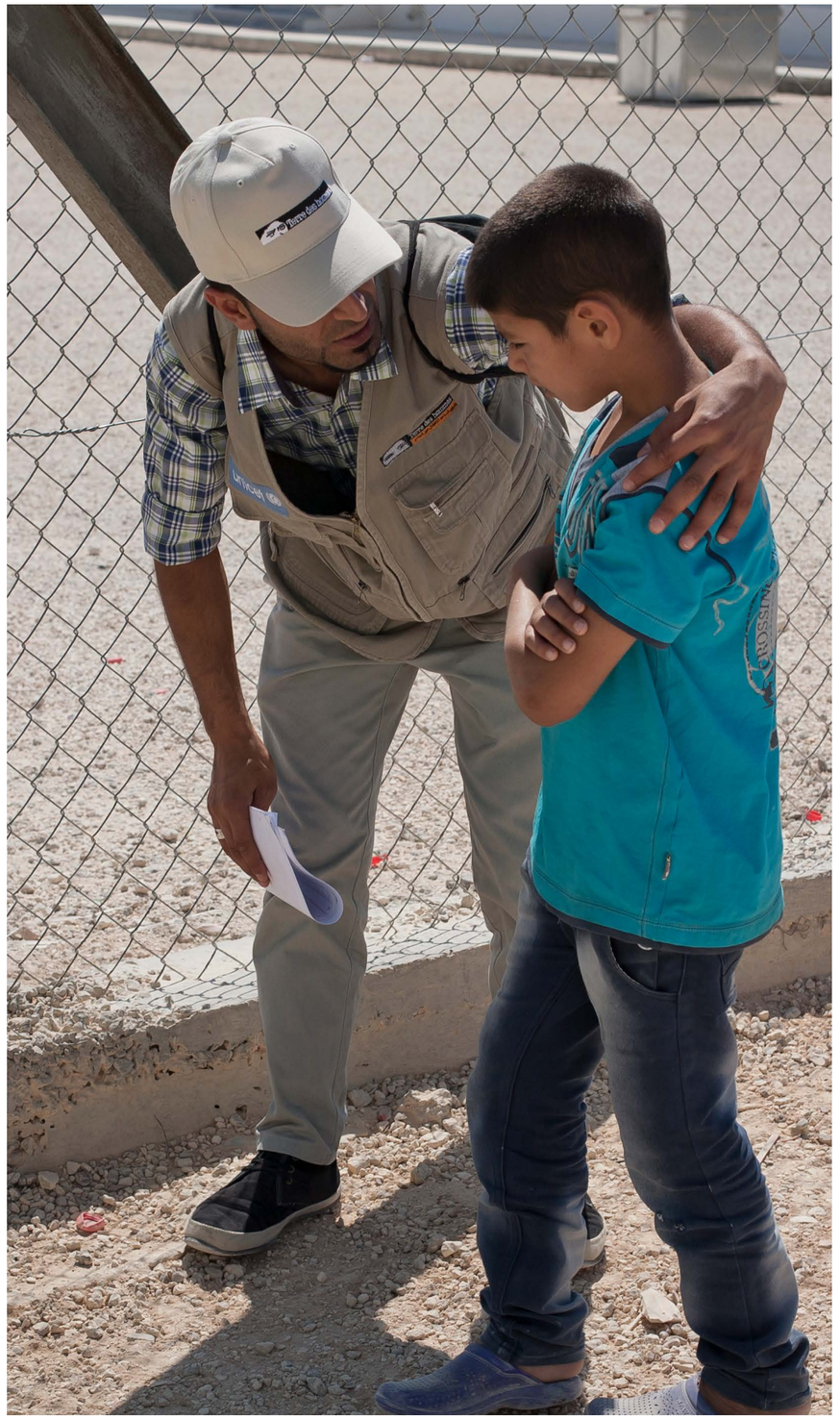
A. Investing early to prevent or reduce the risk of longer term consequences issues emerging in this population is an obvious and sensible approach. There are actions that can be taken that are likely to pay considerable dividends in terms of better lives for the individuals concerned and better use of societal resources. These actions include much earlier and better recognition of their psychosocial needs and mental health issues and the consequences that can follow for UCMs the economic consequences of failing to do so can be immense).

B. Responding to mental health issues that emerge in this population, for example through trauma interventions, also has considerable potential to be not only effective but also highly cost-effective (Bonin et al 2011; Beecham 2014). Disappointingly, however, the body of robust cost-effectiveness evidence in the area is much smaller than commissioners would undoubtedly wish to find to guide their spending decisions.

C. For those mental health issues that are not prevented, the need for earlier recognition and better diagnosis should be obvious, because the consequences of failing to do so can be enormous distress for the young people concerned, as well as for the others. As others have reported previously, the treatment gap for unaccompanied minors is massive. It is therefore an indictment on our mental health system that this dreadful situation has been allowed to continue, or indeed perhaps to have worsened, given what we know about national trends in spending.

D. One challenge is to remove the barriers to access and to treatment-seeking by unaccompanied minors. There is an urgent need for more and better evidence on what works in the youth mental health area.

E. Combating stigma must be part of the response to this state of affairs. There is evidence successful anti-stigma campaigns can generate economic pay-offs that easily exceed the initial investments (McCrone et al 2010; Evans-Lacko et al 2013).



F. Another clear source of difficulty is the transition between youth services and adult services, with many authors referring to this period as a 'cliff edge'. There is little extant evidence to be contributed to discussion of this issue from an economics perspective. We welcome the fact that NICE is in the process of preparing guidance on transitions in many areas of health, including mental health.

G. The consequences of failing to recognise or respond appropriately to mental health issues in childhood and adolescence will often last a lifetime. We have pointed to some of the short-term economic consequences that flow from these failings, and other studies have demonstrated longer-term impacts on, for example, poor educational outcomes, antisocial behaviour and crime, above-average use of health services, difficulties finding employment outcomes and reliance on benefits (Scott et al 2001, Knapp et al 2011, D'Amico et al 2014).

H. What is clear from is that 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. There is an urgent need to bring together different agencies – especially education, youth justice, health, social care, welfare benefits – to discuss and agree priorities and the actions that should follow. This need for co-ordination or integration has been incanted so many times that there is a danger that it is no longer heard. The economic challenges are manifold, especially when public bodies are tightly performance-managed, since there may be few financial incentives to take action when the biggest pay-offs will be to other people's budgets.

I. Most of these actions would be easier to implement, and certainly much easier to monitor and evaluate, if there were data on levels and patterns of spending and provision, and on individual and societal outcomes. We searched hard for data to bring to bear on the economics questions addressed in our study, but with little success. Data on unaccompanied minors with or at risk of mental health issues are spectacularly sparse.

J. Although the co-ordination of risk-reduction strategies, responses to need and delivery of support are most important, co-ordinated data collections and their careful interrogation would certainly help. It is not obvious to us that there is much opportunity to read across from data in one system to data in another. The health, education, social care, housing, employment and other systems operate in uninformed parallel data universes.

K. The particular challenge in the unaccompanied minor psychosocial care area is that there is so little economics evidence to inform those investments.

Conclusions

The terms of reference for this cost-benefit appraisal were to assess whether any financial benefits were achievable from the creation of a system of integrated care for unaccompanied, separated migrant children in Italy and Germany. This assessment found that, overall, this model will have a positive cost-benefit outcome.

This model would bring equity of services to all children and will, as a consequence, improve child care support systems and the European implementation of the UN Convention on the Rights of the Child. Current children's services support structures are geared towards indigenous children in need of protection, safeguarding and family support. Children arriving in Europe from abroad at this age have no understanding of the support systems, their rights as children or what their futures hold. The existing system attempts to see to those needs with NGOs acting as the safety net; however, with the mounting strain on these services, the model will assist all agencies to meet the needs of these children and reduce expenditure in both the medium and long term.

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The photos in this study have been selected to ensure they meet the criteria set out in the Child Safeguarding policy of Terre des Hommes

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