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Report

RAPID ASSESSMENT OF MENTAL HEALTH, PSYCHOSOCIAL NEEDS AND SERVICES FOR UNACCOMPANIED CHILDREN IN GREECE

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1. Introduction

1.1 Background-Objective

In September 2017, there were approximately 2,850 unaccompanied children (UAC) in Greece among which 1,096 were accommodated in 50 UAC shelters and 240 in 8 safe zones nationwide[1]. According to data published in July 2017 by the Greek Asylum Service, Ministry of Migration Policy, there was an increase in the number of unaccompanied minors seeking for asylum (UASC) since 2013; specifically, in 2013 there were 200 UASC; during the next years (2014-2015) the number was more than doubled while in 2016 there was a vast increase reaching 2352 UASC. Based on the available data for 2017 it is expected that the respective number of UASC will remain at the same level (1247 UASC for the 1st semester).[2]

Given the conditions forcing UAC to leave their home countries, the hardships they faced prior to their entering Greece as well as their present state it is expected that all these traumatic circumstances represent potential risk factors for them developing, in due course, a series of psychosocial and mental health issues. However, according to anecdotal shelter services providers' reports, services for unaccompanied children are not always sufficient to meet the current mental health and psychosocial support (MHPSS) needs of UAC this being also in pair with existing shortcomings of the overall system of providing mental health services to children and adolescents in the country. Therefore, a further inquiry on the extent of such needs of UAC, on the characteristics of those needs as well as on the availability of appropriate services to meet them was found to be necessary.

According to published data (as of April 2017) there are 54 shelters nationwide hosting approximately 1120 UAC[3] *(*including *long-term* and *transit* structures*).*[4] There are 3 types of shelters: for younger boys and girls (≤14 years old); for girls >14 years old and for boys >14 years old. The population of UAC (per sex and age) is not equally distributed among these 3 groups. Specifically, according to referrals: boys are the vast majority (92.3%) while girls equal to 7.7%; on the other hand, older UAC are 93.5% while younger UAC (boys and girls ≤14) equal only 6.5%. Therefore, estimations of MHPSS needs concern mainly older boys (main target group).

In light of the above, in April 2017 UNICEF commissioned a rapid assessment of MHPSS needs and services for UAC in Greece with the further aim to inform planning for expanded services. Specifically the objectives of the rapid assessment were:

1. To assess the range, scope and scale of mental health issues facing UAC in Greece including those living in shelters and those in other locations including reception and identification centers (RICs), and reception centers
2. To map existing MHPSS and child protection legislation, policy and services in Greece and assess the capacity to meet the increased case load, scope and range of specific MHPSS support needs of UAC, including but not exclusively the most severe cases;
3. To identify good practices and possible gaps in the current Greek legal and policy framework as well as service provision response to the increased case load and particular MHPSS needs of UAC;

[1] More information at: 30.09.2017 Situation Update: UAC in Greece, published by EKKA with support of UNICEF. Available at: http://www.ekka.org.gr/files/EKKA%20dashboard%2030-9-2017.pdf

[2] Source: Greek Asylum Service, Ministry of Migration Policy. Available at: http://asylo.gov.gr/wp-content/uploads/2017/07/Greek_Asylum_Service_Statistical_Data_GR.pdf

[3] More information at: 019.04.2017 Situation Update: UAC in Greece, published by EKKA with support of UNICEF; Call for proposals at https://www.unicef.org/about/employ/?job=503378

[4] According to Ministerial Decision 11.1/6343/GGB 329509.12.2014

4. To propose a set of recommendations on how to best address existing gaps including immediate and medium/long term actions in light of the realities of the Greek context.

As for its scope, the rapid needs assessment focused on the reported MHPSS needs of UASC living in Greece including those living in shelters, reception and identification centres (RICs), reception centres, and safe zones. The mapping of the current response looked across the range of child protection and mental health legislation, policies and services, working closely with the Ministry of Migration Policy, Ministry of Labour and Social Solidarity, Ministry of Health, and EKKA (that were members of the SC of the project)..

A direct measurement of those needs and their satisfaction would have been one possible way of exploring the subject; however, given the objective limitations of the particular field of inquiry, indirect measurement mainly provided by relevant key informants (viz. mainly personnel having "first-line" contact with UAC) was considered to be the most appropriate alternative way of data collection.

1.2 Methodology

Mental health and psychosocial support is a term used to describe a wide range of actions that address social, psychological and psychiatric problems that are either pre-existing or emergency-induced. These supportive actions are carried out by various services that need practical assessments leading to recommendations that can be used immediately to improve people's mental health and well-being.[1] To inform planning and/or expanding of already existing services to satisfy the MHPS needs of UAC in Greece, a multi-component rapid assessment was conducted during May-July 2017 by a three member research team (psychiatrist, social scientist and psychologist).

First, a desk review was realized to describe the national context in general, to identify good practices currently applied in other countries concerning services to address MHPS needs of UAC and to map existing UAC-related child protection and MHPS support legislation, policy and services.

At the same time, the range, scope and scale of MHPS needs of UAC living in shelters nationwide was outlined based on estimations provided by the Coordinators (or other key staff) from 34 (63%) out of the 54 shelters, hosting 730 (62%) out of the 1,173 UAC;[2] respondents were asked to report via an e-form[3] worrying signs concerning MHPS issues of UAC and their severity *according to their knowledge and/or based on their personal experience* (Annex 1).

Next, a series of focus group discussions (FGDs) involving staff of shelters hosting UAC and semi-structured interviews (SSIs) involving key-informants on mental health and psychosocial services for UAC were conducted in various places nationwide. The aim was to assess the capacity of shelters and relevant services to meet the range of UAC MHPS needs; to identify weaknesses in legal and policy framework; to identify gaps in service provision; and to identify good practices currently applied in the field in Greece. Specifically:

A total of 10 FGDs were conducted from 6 to 26 of June 2017 (4 in Athens, 2 in Mytilene, 2 in Alexandroupolis and 2 in Thessaloniki). In 7 of the groups 46 staff members of equal number of shelters hosting UAC participated, including coordinators, professionals of various specialties (social workers, psychologists, lawyers, sociologists, etc.), supportive staff (caregivers, pedagogues, guards, cooks etc.) as well as interpreters and

[1] World Health Organization & United Nations High Commissioner for Refugees. Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings. Geneva: WHO, 2012.

[2] EKKA with the support of UNICEF (2017). Unaccompanied Children (UAC) in Greece - Situation Update: 4 May 2017. Available at: http://www.ekka.org.gr/files/aglika4.5.17.pdf

[3] KoBoToolbox "MENTAL HEALTH AND PSYCHO-SOCIAL NEEDS AND SERVICES FOR UAC-MHPSS Rapid Assessment". Available at: https://ee.kobotoolbox.org/x/#YBxK

cultural mediators; in the remaining 3 groups, the Coordinators of 17 shelters participated (see Annexes 2 and 3 for FGD protocol and participants respectively).

Further information on services response to MHPSS needs of UAC was collected through discussions with 14 key-informants of various professional specialties (child psychiatrists, pediatricians, lawyers, education professionals, psychologists and social workers, see Annex 4), including four representatives of National Center for Social Solidarity-Administrative Service for placements of UAC in shelters nationwide as well as representatives of mental health or other services (such as Babel, Sismanogleio Hospital, Child psychiatric Department of Praxis, C&A psychiatrist in ARSIS shelter for UAC, UAC cross-cultural school of Iliaktida[1]).

Based on the combination of the results of the above research components, a set of recommendations was drafted for undertaking immediate and medium/long term action in order to address existing gaps.

Limitations

This assessment constitutes a snapshot of the situation of UAC's MHPS needs and support services response in a rapidly changing environment in terms of population (continuous flow and changes), of shelters (at the beginning of the process there were 54 shelters while at the end were 51) and of shelters' staff (also continuous flow and changes); therefore the assessment results refer mainly to the period of the assessment.

Given the limited timeframe but also the character of the rapid assessment, not all relevant agencies' stakeholders eventually participated in the FGs and the SSIs; despite multiple invitations and communication by various means (in written, via phone, through third parties, see Annex 4) for many of the coordinators of shelters located in Athens it wasn't feasible to participate in a FGD. Similarly, because of overload or other practical reasons, even planned interviews with specific key-informants eventually were not realized. On the other hand, coordinators of shelters from other areas (e.g. Lesvos) as well as key-informants were available and, as a result, the initial target in terms of number of groups and participants was fully achieved.

Data collected via the e-form (concerning the scale and the spectrum of MHPS needs of UAC) derived from the staff (coordinators or other responsible professionals) of shelters (based on their knowledge and/or observations) and not from assessments of the UAC themselves; therefore, they should be considered as indications for UAC's mental health and psychosocial needs of rather than the real scale and type of needs (given that no documentation was available for the reported cases). In the same way, results of FGDs and SSIs reflect shelters' coordinators, staff and key-informants' awareness and perception of MHPS needs of UAC as well as knowledge of services response to these needs at the time of data collection. Collection of data on MHPS needs of UAC directly from children was not originally planned in the context of this assessment mainly because of practical reasons (such as restricted timeframe and need of interpretation in multiple languages).

In most of the cases FGDs and SSIs took place either in the offices of organizations running the shelters or in the premises of the Institute of Child Health. There were only a few cases where the research team was given the opportunity to visit some of the shelters (as the groups took place in a room close or within the shelter) but even in these cases it wasn't feasible and was considered to be non-ethical for the researchers to see the whole premises since UAC were around and not informed on the visit.

1 As mentioned in "World Health Organization & United Nations High Commissioner for Refugees. Checklist on Obtaining General (non-MHPSS) Information from Sector Leads/Clusters. In: Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Major Humanitarian Settings. Geneva: WHO, 2012", *education is among the key aspects of the context in which a mental health and psychosocial response occurs*; for this reason it was considered that it would be useful to include one at least source of information on UAC educational issues.

2. Literature Review

2.1 Unaccompanied children as a high-risk population and existing research on UAC MHPSS needs

During the past decade, there has been an increase in evidence on the prevalence of mental disorders in refugee children and the underlying risk factors but knowledge remains relatively limited when it comes to resilience building, treatment and the efficacy of services. Studies arise from post-conflict areas or from Western countries with newly arrived (asylum seeking) or resettled (refugee) children and young people. The characteristics of these groups, societal contexts and service systems obviously differ, requiring a wide range of approaches.[1] Most epidemiological studies have focused on post-traumatic stress disorder, but when they have been extended to other conditions such as depression, the impact of both past trauma and current life adversities on child psychopathology has clearly emerged[2]. Unaccompanied children (UAC) have an elevated risk of psychopathology and lower service engagement compared to refugee children living with their parents.

UAC are considered a high risk population for mental health problems and are likely to present with a wide range of physical and psychological issues often originating in trauma, exposure to war, death of family members, persecution, violence, rape, escape from forced recruitment into military or paramilitary organizations, and most of the times have been through long and arduous journeys before reaching their country of destination. Increased levels of depression, anxiety disorders and post-traumatic stress in refugee children are well described in the literature. [3,4,5.]

Many UAC have been separated from their parents or caregivers for a long time. While in their country of origin, UAC may have experienced a wide range of traumatic events including homelessness, inability to cover basic needs such as food and education, violence (as witnesses, victims, and/or perpetrators), physical injuries, infections and diseases, lack of medical care, loss of loved ones, war and torture. During their journey to another country UAC often face some of the same types of traumatic events or hardships that they faced in their country of origin, as well as new experiences such as hazardous boat, train or bus rides, robbery and assaults, coercion or abuse by adults, kidnapping, sexual violence, exposure to the elements without proper supplies and gear, harassment and bribery by local authorities, uncertainty about the future and in some cases detention.[6]

These traumatic experiences combined with other developmental stressors in childhood and adolescence increase the likelihood of mental health problems for UAC[7]. Research in UAC indicates high levels of psychological distress in the form of emotional and behavioural problems and PTSD[8]. There is variability in

[1] Vostanis, P. (2016). New approaches to interventions for refugee children. *World Psychiatry*, *15*(1), 75-77.

[2] Ziaian, T., de Anstiss, H., Antoniou, G., Baghurst, P., & Sawyer, M. (2012). Resilience and its association with depression, emotional and behavioural problems, and mental health service utilisation among refugee adolescents living in South Australia. *International Journal of Population Research*, *2012*.

[3] Fazel, M., Reed, R. V., Panter-Brick, C., & Stein, A. (2012). Mental health of displaced and refugee children resettled in high-income countries: risk and protective factors. *The Lancet*, *379*(9812), 266-282.,

[4] Lustig, S. L., Kia-Keating, M., Knight, W. G., Geltman, P., Ellis, H., Kinzie, J. D. & Saxe, G. N. (2004). Review of child and adolescent refugee mental health. *Journal of the American Academy of Child & Adolescent Psychiatry*, *43*(1), 24-36.

[5] Bronstein, I., Montgomery, P., & Ott, E. (2013). Emotional and behavioural problems amongst Afghan unaccompanied asylum-seeking children: results from a large-scale cross-sectional study. *European Child & Adolescent Psychiatry*, 1-10.

[6] http://nctsn.org/trauma-types/refugee-trauma/guidance-unaccompanied

[7] Appleyard, K., Egeland, B., Dulmen, M. H., & Alan Sroufe, L. (2005). When more is not better: The role of cumulative risk in child behavior outcomes. *Journal of child psychology and psychiatry*, *46*(3), 235-245.

[8] Bronstein, I., & Montgomery, P. (2011). Psychological distress in refugee children: a systematic review. *Clinical child and family psychology review*, *14*(1), 44-56.

the reported emotional and behavioural problems scores across studies on refugee children; however, these differences can be attributed to contextual differences including differences in countries of origin and reception, as well as the tools measurements used[1] [2].

Unaccompanied children have traveled a long way and worked very hard to meet their goal of arriving to another country but despite the difficulties and hardships they have faced they often demonstrate resilience and resourcefulness that can be leveraged as strengths in the healing process. However, living every day with uncertainty about their future and at the same time lacking resources such as health insurance, transportation, education, and vocational training they can present with various symptoms influenced by both the conditions in their country of origin and the conditions in the country they arrive at. As recorded by the US-based National Child and Traumatic Stress Network (NCTSN), exposure to traumatic events can have a profound and lasting effect on the daily functioning of UAC, demonstrating in different ways such as hypervigilance and suspiciousness, difficulty engaging with caregivers due to emotional detachment and cynicism, stomachaches and headaches, pains in the body that do not appear to have a physical cause, crying a lot, hopelessness, nightmares, trouble paying attention, trouble falling asleep or sleeping too much, fear or anxiety, jumpiness and recurring and unwanted thoughts about the traumatic events they have faced. In addition it is common for UAC to get upset in situations reminding them of the traumatic events they have been through, to avoid thinking or talking about anything that reminds them of these events, to lack the desire to play with others or to participate in activities that they used to enjoy and to have difficulty in managing behavior or emotions[3].

In a 2016 rapid assessment of MHPSS needs of refugees, asylum seekers, and migrants in camps in Northern and Central Greece[4] the most common problems and stressors for children among them were found to be the following: Lack of safe play areas and spaces; Lack of access to needed healthcare (e.g. children missing vaccinations); Children did not like the food; Behavioural difficulties, acting out and being 'out of control"; Nightmares (e.g. from bombings in Syria); Bedwetting; Developmental disorders (such as autism) and developmental delays; Many children had no boundaries with strangers which made them more vulnerable to abuse (combined with parents, who were tired and apathetic); Children acted more like adults (e.g. asking about registration, legal procedures etc.); Mental health problems such as ADHD, autism, PTSD; Discrimination, conflict and bullying among different ethnic groups (e.g. Afghan children did not go to school because others threw rocks at them).

Studies of Syrian refugee children have documented a wide range of psychosocial problems[5,6] including: persistent fears and anxiety; difficulties sleeping; sadness, grief and depression (including withdrawal from friends and family); aggression or temper tantrums (shouting, crying and throwing or breaking things); nervousness, hyperactivity and tension; speech problems or mutism and somatic symptoms. Violent and war-

[1] Miller, K. E., & Rasmussen, A., (2010). War exposure, daily stressors, and mental health in conflict and post-conflict settings: bridging the divide between trauma-focused and psychosocial frameworks. *Social science & medicine*, *70*, 7-16.

[2] Van Ommeren, M., (2003). Validity issues in transcultural epidemiology. *The British journal of psychiatry: the journal of mental science*, *182*, 376-378.

[3] NCTSN: Guidance for working with Unaccompanied Migrant Children (http://nctsn.org/trauma-types/refugee-trauma/guidance-unaccompanied)

[4] https://mhpss.net/?get=283/IMC-2016-MHPSS-Assessment-North-and-Central-Greece.pdf

[5] Mercy Corps, (2014). Advancing Adolescence: getting Syrian Refugee and Host-Community Adolescents back on Track. https://data.unhcr.org/syrianrefugees/download.php?id=5366.

[6] Cartwright, K., El-Khani, A., Subryan, A., & Calam, R., (2015). Establishing the feasibility of assessing the mental health of children displaced by the Syrian conflict. *Global Mental Health*, *2*.

related play, regression and behavioural problems are also found among children[1][2]. In a recent study (2017)[3] concerning sexual exploitation and abuse of migrant children in Greece, the existing gaps and challenges in intervention efforts and how they contribute to victimization of children were explored (given also the fact that in Greece despite the increased number of new coming UAC there are extremely few formally recognized cases of minors-victims sexual exploitation and human trafficking). One out of the six major risk factors highlighted for migrant children's victimization concerned the "weak and insufficiently resourced" Greek child protection system. Furthermore, the analysis of the significant gaps in government and non-governmental responses to the situation emphasized an urgent need for substantially improved child protection policy and practice, including recruiting and training qualified staff and improving coordination and case management.

Apart from limited research on the prevalence of UAC mental health problems and relevant stressors there has been even less research on factors which promote mental health or at least moderate stressors in this population, despite the acknowledgement of their direct relevance to planning interventions. Although not always theoretically driven, such studies have identified several individual (coping strategies, spirituality, and internal locus of control), family (financial circumstances, family acceptance and support) and community factors (social support networks, school retention)[4]. Though important, these findings are not fully capitalized on mainly due to the lack of a coherent model connecting them in order to inform the development of interventions and services.

Given the above, the European Society for Child and Adolescent Psychiatry (ESCAP) qua leading scientific organization on the field, has recently issued a respective public statement[5] to sensitize societal agents in taking appropriate action for recognizing and addressing UAC's mental health problems and providing them with quality MHPSS. These recommendations primarily focus on general social inclusion measures which account substantially for primary and secondary prevention of mental health issues but also include mental health promotion measures, provision of comprehensive, adequate and accessible MHPSS trained for addressing specific challenges of that particular population as well as identifying reliance factors and also establishing data collection monitoring mechanisms for the subject matter[6].

2.2 Evidence on good practices in MHPSS for UAC in other countries

In terms of children's multiple needs, services often aspire to a socio-ecological model, but this is not usually supported by research evidence; most studies are currently based on self-reported data and programs and interventions are rarely implemented at individual, family (where existent) and community levels. At the same time, interventions usually draw on a variety of psychological frameworks, which are largely trauma-focused, whether implemented individually or within groups, but without incorporating the community level. Overall,

[1] IMC and UNICEF (2014). Mental Health/ Psychosocial and Child Protection for Syrian Adolescent Refugees in Jordan. IMC & UNICEF: Amman, Jordan

[2] James, L., Sovcik, A., Garoff, F., & Abbasi, R. (2014). The mental health of Syrian refugee children and adolescents. Forced Migration Review, (47), 42.

[3] Digidiki V & Bhabha J (2017). Emergency Within an Emergency: The Growing Epidemic of Sexual Exploitation and Abuse of Migrant Children in Greece. FXB CENTER FOR HEALTH & HUMAN RIGHTS | HARVARD UNIVERSITY. Available at: https://cdn2.sph.harvard.edu/wp-content/uploads/sites/5/2017/04/Emergency-Within-an-Emergency-FXB.pdf

[4] Tol, W. A., Song, S., & Jordans, M. J. D. (2013). Resilience in children and adolescents living in areas of armed conflict: a systematic review of findings in low-and middle-income countries. *J Child Psychol Psychiatry*, *54*, 445-60.

[5] ESCAP to politicians: urgent call to take action for the mental health of young refugees, https://www.escap.eu/care/position-statement-announcement/position-statement

[6] Hebebrand J., Anagnostopoulos D., Eliez S., Linse H., Pejovic-Milovancevic M., Klasen H., (2016). A first assessment of the needs of young refugees arriving in Europe: what mental health professionals need to know. European Child & Adolescent Psychiatry, January 2016, Volume 25, Issue 1, pp 1–6.

the clinical and socio-ecological fields are gradually converging and therefore there is a need to conceptualize intervention programmes and service development for UAC and refugee children in general in an integrated context. Limitations of public services in most countries, such as Greece, should also be taken under consideration especially given the huge mismatch between refugee numbers and resources, with this gap usually filled in part by non-governmental organizations (NGOs) of varying philosophies, missions, structures and funding streams[1].

According to a 2017 Systematic Review[2] on the effectiveness of protection interventions on unaccompanied and separated children in humanitarian crises there is a lack of quality studies evaluating the effectiveness of MHPSS interventions in UAC populations. The review highlights that evidence on MHPSS interventions is extremely limited and thus:

> *"…Further research is required that evaluates outcomes of contextually appropriate MHPSS interventions, with sensitivity to those issues that may be specific to UAC. In order to build up evidence of good practice, research is critically needed to:*
>
> – *Review relevant evidence on the impact of separation on mental health and psychosocial well-being from non-humanitarian contexts and consider how this may apply in humanitarian contexts*
>
> – *Evaluate the impact of separation in humanitarian crises on children's mental health and psychosocial distress in the short, medium and long term – identify examples of contextually-appropriate MHPSS interventions with UAC and evaluate their impact on children's mental health and psychosocial well-being*
>
> – *Additionally, it is recommended that a clear approach for the evaluation of MHPSS outcomes for UAC is developed to promote culturally validity in evaluation."*

The researchers also raise questions about what constitutes 'evidence', given the wealth of information about UAC that could not be considered eligible for the review due to inevitable intrinsic limitations. The broader literature on UAC should be synthesized to identify themes and promising interventions with UAC that would then be rigorously evaluated to further develop the evidence base on this topic.

Nevertheless, though not evaluated in a systematic and quantitative manner, there is currently some experience on dealing with the increased psychosocial needs of UAC, their mental health issues which are often interrelated with their social conditions and the provision of appropriate services to them including access to MHPSS. Some of these interventions, initiatives or practices appear to be quite effective in either addressing various existing MHPSS needs of UAC or in tackling potential risk factors triggering the manifestation or worsening of mental health problems in UAC populations.

[1] Vostanis, P., (2016). New approaches to interventions for refugee children. *World Psychiatry*, *15*(1), 75-77.

[2] Williamson, K., Landis, D., Shannon, H., Gupta, P., & Gillespie, L. A., (2017). The Impact of Protection Interventions on Unaccompanied and Separated Children in Humanitarian Crises.

Examples of specific UAC care good practices/programs from other countries

NIDOS Institute (The Netherlands) [1]

a. Responsibility of care The responsibility for the day-to-day care of UAC lies in part with youth care organizations or with foster parents. NIDOS accommodates the UAC younger than 15 years old in foster homes while UAC aged 15-18 are accommodated in a special Centre for the first period of up to three months. During this period the minors are observed by juvenile protectors and mentors, after which time they decide together whether continuing accommodation is the most suitable option for the UAC in question. Neither the age nor the fact that there is or isn't a residence permit are the main criteria in this; what matters is the UAC's development and maturity. The Children Living Groups are designated for children aged up to and including 15 years old. In the residential units there is 24-hour supervision. The Small Living Units are designated for young people aged 15 to 18, usually of varying nationalities. In a small residential unit, four young people stay under supervision. For every four young people a counselor is present 28.5 hours a week. NIDOS has its own pool of foster families and there are currently 1,200 children staying in these families.

b. Responsibility for guardianship The guardianship of unaccompanied minor asylum seekers is based on one of the basic laws of the Netherlands, the Dutch Civil Code, stating that all minors residing in the Netherlands must be provided with legal guardianship. All minors, Dutch or foreign, must have a legal guardian. Usually this is a parent, and in the absence of a parent, the government must ensure that a guardian is appointed. Consequently, this also applies to UAC. This takes place by means of legal proceedings resulting in appointing a guardian by the court. Guardianship is therefore always a result of a judicial decision. Usually the judge appoints NIDOS Institute as guardian. The Dutch authorities have recognized NIDOS as a guardianship and family guardianship (supervision) institution. The guardianship is assigned to the foundation. The guardianship is actually carried out by professionals, so-called juvenile protectors, employed by NIDOS. Every recognized institution functions under the Youth Care Act. This means that certain quality requirements must be met by the organization, such as the procedure (the tasks that have to be carried out and how this should be done), the recruitment of professionals for the counseling of minors, the right of complaint and the accounting for methodical work by means of file creation. The task of NIDOS is tested against the Civil Code and the Youth Care Act and a governmental body supervises its execution and funds.

c. Suicide prevention Unaccompanied children regularly demonstrate suicidal behavior. The thoughts may be compulsive and hard to suppress or stop. Worrying continuously, especially during the night when everything seems worse, may result in exhaustion and that may be another reason to think about suicide. In 2011, NIDOS started recording incidents that showed a large number of them involved suicidal and self-harming behaviour. Youth care workers and mentors often appeared to have reached their limit, frustrated and unsure of how best to address this. Subsequently, training courses were organized with a number of youth care workers becoming suicide prevention trainers supporting their colleagues. Following this, staff dedicated to psycho-social issues was appointed in every region.

d. Promotion of expertise and screening tools Since 2012, behavioural scientists have been offering training courses for all youth care workers, such as job training for new youth care workers focused on specific aspects of working with unaccompanied children; training for child abuse-dedicated staff focused on the identification of signs and risks of child abuse; and courses in development psychopathology focused on the recognition of, and guidance on, psycho-social issues for dedicated staff working in this field.

[1] http://www.asylumcorner.eu/guardianship-for-unaccompanied-minors-in-the-netherlands-the-role-of-nidos/

Moreover, given that research has shown that it is difficult for youth care workers to properly assess the seriousness of psycho-social issues of unaccompanied children, in 2014, NIDOS started using the SDQ (Strengths and Difficulties Questionnaire) in their systematic screening.

Early identification of Mental Health problems (United Kingdom)

Early identification of Mental Health problems can be challenging. Regardless of language barriers, traumatized children might not volunteer the disclosure of distressing experiences such as torture, sexual exploitation, trafficking and witnessing the death of others. UAC might also struggle sharing private information with constantly changing interpreters where there is no opportunity to build a trustworthy relationship. They might present with subtle signs and symptoms which have initially been missed in a number of cases.

Given that GP staff, Mental Health and Social Care Professionals working with UAC as well as interpreters should have cultural awareness training to empower them to recognise the signs and symptoms of psychological illness in UASC, Mersey Care NHS Trust provided Guidance for frontline staff working with asylum seekers. It also commissions a Child and Adolescent Mental Health Service (CAMHS) which is available to Children in Care and their caregivers and delivers specialist assessment, consultation, diagnosis formulation and treatment in a range of settings, including community and locality settings. There is also provision of inpatient services for young people which provides assessment, intervention and in-patient treatments. Initial assessments are carried out by the CAMHS Assessment and Response Team and then UAC are referred to the appropriate service.

Housing for unaccompanied adolescents (United Kingdom)

UAC aged 16 and 17 are often placed in independent or semi-independent accommodation[1]. This may include residential care supported by key workers, emergency use of bed and breakfast accommodation and supported hostels. Kent County Council harbors one of the largest numbers of UAC. Over 50% of those children have been placed in independent living arrangements followed by nearly one third of UAC in non-long-term foster care. Foster care has been usually used as a placement for children under the age of 16 and girls[2]. The Home Office's UASC Funding Instructions commit to an age-based daily amount of money granted to local authorities looking after UASC. The highest sum is reimbursed for children aged younger than 16 years. The form of accommodation appears to have a considerable impact on UAC's safety, security and wellbeing and, hence, on their future personal development. The form of accommodation provided for UAC should therefore be focused on their health and wellbeing needs rather than age. The young person's views are also taken into account. A full assessment of the child's need helps to ensure that the child or young person is cared for in the most appropriate placement option.[3]

[1] Good practice when working with refugee and asylum-seeking children, Community Care, Ala Sirriyeh; April 2011 [Online]. Available from: http://www.communitycare.co.uk/2011/04/15/research-good-practice-when-working-with-refugeeand-asylum-seeking-children/

[2] Good practice when working with refugee and asylum-seeking children, Community Care, Ala Sirriyeh; April 2011 [Online]. Available from: http://www.communitycare.co.uk/2011/04/15/research-good-practice-when-working-with-refugeeand-asylum-seeking-children/

[3] Dansokho, M., & Council, H. B. (2016). Unaccompanied Asylum Seeking Children–Health and Wellbeing Needs Assessment.

Using "Mindfulness" in group contexts (Belgium)

In their daily support, it is important to keep depressed and dejected children active in a regular structure. At Minor Ndako reception and guidance center for children in Brussels, Belgium, there are good experiences of using 'mindfulness' in a group context. They also have positive experiences of group discussions with a psychologist working together with a cultural mediator. Psychoeducation approaches are also used, providing children with insight into their functioning helping them to understand their difficulties, such as worrying, depressed feelings, or angry outbursts. For example, psychoeducation on symptom recognition and management, such as for nightmares, can be put in place relatively early through schools or community settings, preferably by adults (such as shelter professionals in the case of UAC), who may require additional input in their own right. For children who require a more active intervention, groups of relatively brief duration can be implemented by non-specialist facilitators under clinical supervision, aiming at trauma reprocessing, and these should suffice for a substantial proportion of children[1].

Pharos School-Based Education Program for Refugee Children (The Netherlands)[2]

Goals: *1) To give attention to the difficulties refugee children face and to strengthen peer support systems for refugee children by offering opportunities to share their experiences with other children*

2) To foster teacher support for refugee children

3) To strengthen coping ability and resilience among refugee children

The Pharos program for secondary school students was originally developed and implemented in the Netherlands, and subsequently implemented in the United Kingdom. It has three components:

1. "The refugee lesson" is a series of eight lessons focusing on the experiences refugee children have in common. The lessons are conducted by a teacher, together with a mental health care professional), for a group of 8 to 12 children. Examples of topics include living in the new country; where do I come from?; who am I?; important things and days; friendship and being in love; and prospects for the future. The aim is for students to share their experiences and develop skills that will enable them to cope more effectively with stressful experiences and not to explicitly bring up traumatic experiences for discussion. Emphasis is placed on the supportive factors in the social environment.
2. The "Refugee youth at school" component is a training manual, accompanied by videotapes, for teachers and others involved with this group. The themes are backgrounds of refugee youth, coping with loss, dealing with children who have been traumatized and preventive activities in the classroom.
3. "Welcome to school" is a series of 21 lessons emphasizing non-verbal techniques such as drawing and drama. The lessons aim to improve the well-being of youth seeking refuge or asylum and to prevent them from developing psychosocial problems by building bridges between the past, the present and the future. Classmates become companions and learn how to support each other.

[1] Vostanis, P. (2016). New approaches to interventions for refugee children. *World Psychiatry*, *15*(1), 75-77.)

[2] Watters, C. & Ingleby, D. (2002). Refugee children at school: Good practices in mental health and social care. Education and Health, 20 (2), 43–46.

Changing Cultures Program for Refugee Youth (Australia)[1]

Goal: *To enhance mental health and wellbeing of refugee young people aged 15-18 years old through education and training.*

This Australian program focused on a needs assessment of refugee youth in order to influence program development and delivery, organizational development and capacity building, and community development and evaluation. Data was gathered on needs pertaining to this refugee group, and consultations provided to teachers and service providers to inform program evaluation and modification. Programs that were modified in accordance with the Changing Cultures Program were school curriculum, peer support groups in schools, tertiary programs that provided vocational and language counselling, and programs provided by community agencies.

A major outcome of the project was that it allowed many services to focus on strengthening and building networks, by:

- undertaking the professional development of teaching staff to improve their knowledge of what services to offer young people
- improving the links between students and services so that services could be accessed more comfortably and independently
- facilitating the co-delivery of programs

[1] Bond, L., Giddens, A., Cosentino, A., Cook, M., Hoban, P., Haynes, A. et al. (2007). Changing cultures: Enhancing mental health and wellbeing of refugee young people through education and training. Promotion and Education, 14 (3), 143–149.

3. Overview of range, scope and scale of MHPS issues facing UASC in Greece –

3.1 Scope of MHPSS issues

In the table below the prevalence of worrying signs according to UAC shelters' coordinators or other key-staff is presented (total cases reported; chronic and acute cases).[1]

Prevalence of worrying signs noticed by shelters' staff		chronic cases [f (%)] for 730 UAC (N=381)	acute cases [f (%)] for 730 UAC (N=684)	total cases (chronic+acute) for 730 UAC (N=1065)[2]
most frequently reported signs	least frequently reported signs			
Having nightmares and/or not being able to sleep		96 (13,2%)	48 (6,6%)	144 (19,7%)
Disrespectful behavior against people in the shelter		43 (5,9%)	93 (12,7%)	136 (18.6%)
Self-harming behavior (including suicidal behavior)		22 (3%)	59 (8,1%)	81 (11,1%)
Unusual crying and screaming		18 (2,5%)	65 (8,9%)	83 (11,4%)
Sadness (e.g. not talking, not eating, etc.)		25 (3,4%)	42 (5,8%)	67 (9,2%)
Spending less time with friends		22 (3%)	26 (3,6%)	48 (6,6%)
Violence against staff		6 (0,8%)	46 (6,3%)	52 (7,1%)
Violence against other children		15 (2,1%)	42 (5,8%)	57 (7,8%)
Aggressive behavior		11 (1,5%)	36 (4,9%)	47 (6,4%)
Substance abuse (drugs)		12 (1,6%)	30 (4,1%)	42 (5,8%)
Anti-social (isolating themselves)		20 (2,7%)	21 (2,9%)	41 (5,6%)
Substance abuse (alcohol)		4 (0,5%)	34 (4,7%)	38 (5,2%)
Panic attacks and related symptoms		13 (1,8%)	23 (3,2%)	36 (4,9%)
Involvement in illegal activities (looting, sex work/ prostitution, etc.)		18 (2,5%)	16 (2,2%)	34 (4,7%)
Disoriented behavior		12 (1,6%)	8 (1,1%)	20 (2,7%)
Attempt to commit suicide		6 (0,8%)	13 (1,8%)	19 (2,6%)
Victim of bullying due to ethnic origin and/or religion		11 (1,5%)	7 (1%)	18 (2,5%)
Being a victim of violence by other children		4 (0,5%)	12 (1,6%)	16 (2,2%)
Being a victim of violence by adults		3 (0,4%)	12 (1,6%)	15 (2,1%)
Sexual assault or exploitation by adults		2 (0,3%	11 (1,5%)	13 (1,8%)
Overt psychotic symptoms (hearing voices, becoming paranoid etc.)		5 (0,7%)	6 (0,8%)	11 (1,5%)
Victim of bullying due to sexual orientation		6 (0,8%)	2 (0,3%)	8 (1,1%)
Attack on people outside the shelter (other civilians)		0	8 (1,1%)	8 (1,1%)
Bullying against other children due to sexual orientation		2 (0,3%)	4 (0,5%)	6 (0,8%)
Bullying against other children due to ethnic origin and/or religion		1 (0,1%)	4 (0,5%)	5 (0,7%)
Sexual assault of other children		0	5 (0,7%)	5 (0,7%)
Committing crimes		0	5 (0,7%)	5 (0,7%)
Engaging in high risk sexual behavior		1 (0,1%)	3 (0,4,%)	4 (0,5%)
Victim of bullying due to gender		3 (0,4%)	0	3 (0,4%)
Recruitment of other children in illegal activities		0	3 (0,4%)	3 (0,4%)

[1] For every case where respondents provided a positive reply (*"yes, I noticed this sign in one at least UAC in the shelter"*) they were additionally asked to clarify whether this concerned a chronic situation (cases where UAC demonstrated the behavior/symptom continuously) or an acute event (cases where UAC demonstrated the behavior/symptom in a specific occasion with an acute character).

[2] It should be noted that more than one signs reported by shelters staff may concern the same UAC and this is why the total sum of the signs is higher (=1065) than the number of UAC (=730). Moreover, chronic and acute cases may also concern the same UAC.

Given that the scope of the assessment concerned the whole spectrum of mental health and psychosocial needs (not only 'severe' or diagnosed cases) and the fact that staff working in shelters (including Coordinators) are not necessary mental health professionals, staff were asked to provide information on whether they had noticed any of a number of worrying behavioral signs rather than to report officially diagnosed cases of mental disorders. The data collected were used as a basis for the discussions made with focus groups and the key-informants participating in the SSIs (Annex 5).

As a general observation, all of them had a more or less similar perception of the MHPS problems of UAC living in shelters but also those living in other contexts; mental health and health professionals working mainly with children in camps, for example, noted that among the most evident worrying signs to their personal experience were children's social isolation, withdrawal and unwillingness to participate in everyday activities. According to Human Rights Watch study (July, 2017) even cases of children who registered as adults and lived in camps reported experiencing similar psychological distress, including symptoms such as anxiety, depression, and insomnia. [1]

On the other hand, however, there were some cases where the MHPS needs of UAC were somewhat different as, for example, a shelter hosting younger children[2] or female UAC living in shelters or camps.[3]. In addition, it should be noted that some key-informants considered that specific worrying sings, such as delinquent behavior and involvement of UAC in sexual exploitation activities are under-reported either because shelters' staff is not aware of them or for other reasons. A child psychologist working with children in shelters and camps mentioned that *i*f he were to put the worrying signs in order, the top ones for sure would be withdrawal and isolation as well as nightmares and difficulties in sleeping. He added that children get isolated, they don't want to participate in activities; in his opinion this has a lot to do with the fact that children are very suspicious. According to him, there is a lot of self-harm happening in camps, mainly cutting and this concerns chronic cases (same children harm themselves again and again). Also, what's was different for him compared to the information we presented (i.e. from shelters) was that there is a lot of violent behavior from children towards children; not so much towards people working with them. Violence usually starts from sport or other group activities. He highlighted that there is also a lot of verbal violence but children do not report it to the staff and the staff can't always understand the issue if there is no interpreter available. UAC are cursing to each other while smiling in order for staff not to understand what is going on. The psychologist concluded that there is a lot of cyber bullying; children circulate naked pictures of other pictures by phone, e-mail and platforms such as Viber etc.

> *"In my opinion cases regarding participation in illegal activities and mainly prostitution seem considerably underreported"*
> *(Child psychiatrist)*

It is of note that during the FG discussions behaviors such as juvenile delinquency and substance abuse were reported more frequently in Athens and Thessaloniki than in smaller cities (Mytilene and Alexandroupolis).

In the context of a discussion with a 4-member group of the Service responsible for UAC placements in shelters nationwide (belonging to EKKA) on severe cases of MHPS problems of UAC, the research team asked

[1]Source: Human Rights Watch(July 19, 2017) "Greece: Lone Migrant Children Left Unprotected" Available at: https://www.hrw.org/news/2017/07/19/greece-lone-migrant-children-left-unprotected

[2] In the shelter hosting younger children school-related issues as well as issues relevant to child-parents' communication (e.g. intervention of parents in children's everyday life/cultural issues- while parents were already in other EU countries) were additionally reported.

[3] In a shelter hosting girls many cases of "hysteria" were reported (while this reporting might be somehow biased by gender stereotyping); moreover, a child psychiatrist working with children living in shelters and in camps noticed that often girls living in camps (including accompanied) referred for psychiatric support because they are angered and upset due to current living conditions, their separation from their families or other reasons.

for information regarding requests made by shelters for movement of UAC because of such problems; refusal of shelters to host specific UAC due to MHPS problems; and involuntary admissions to psychiatric departments for assessment with prosecutors' order following either requests of shelters or of other referees (such as police or RIS). Relevant data extracted from EKKA files (for the first semester of 2017) are as follows:[1]

- there were 58 requests for movement of equal number of UAC (due to MHPS problems) from a shelter to another structure. As a general observation, requests for movement of UAC from shelter to shelter increased during the last period not necessarily because MHPS problems increased but because this practice often facilitates the responsible prosecutors (often when shelters address the prosecutors for cases of UAC with severe MHPS problems, they suggest to shelters' staff to contact EKKA to move the child to another structure)
- there were ~10 cases where shelters refused to host a child because of severe MHPS problems
- there were ~20 cases where prosecutors ordered the clinical assessment with the question of potential involuntary admission of UAC in psychiatric departments following requests from shelters
- there were ~18 cases where prosecutors ordered the clinical assessment with the question of potential involuntary admission of UAC in psychiatric departments following requests from referees, such as police and RICs.

In the last two cases prosecutors' orders in some cases concerned the same UAC (multiple referrals). It should also be noted that in one) case of an UAC (often discussed during relevant debates) with up to 8 public prosecutor's orders for clinical assessment, most of these orders when scrutinized eventually were not ordering the assessment with the question of potential involuntary admission and treatment; all but one were rather simple orders granting permission to provide clinical services to the minor (since in the absence of a legal guardian, the public prosecutor fulfils that role). This contributed in the particular UAC not receiving appropriate treatment for several months. Given that, it is possible that such misconstrue may equally apply in other similar cases potentially resulting to similar implications.

Concerning the practice of moving the children from shelter to shelter, the coordinator of a shelter noted that the stress UAC already experience day by day becomes even more intense because, among others, their frequent movement from shelter to shelter as well as the insecurity they feel when reach or are close to come in age, given that currently there is no provision for transitional structures for young adults or shelters where they may stay as adults in general after their discharge from the shelters for UAC.

The Psychiatric Unit of an NGO since the beginning of its operation works with 55 UAC; four out of which have been hospitalized. The representative of the Unit commented "that if it weren't for the Unit providing weekly counseling sessions to them much more UAC would have been hospitalized; much more than 4."

Relevant data were also requested from the Child and Adolescent Psychiatric Department of a General Hospital. As there is no special registry for UAC, a list including 28 cases of refugee and migrant adolescents in general who were hospitalized in the hospital since 2011 was provided. Fifteen out of 28 adolescents were girls and were 13 boys; in ~10 cases the diagnosis was relevant with emotional disorders and in the remaining cases there were various diagnoses (such as anorexia nervosa, personality disorder and behavioral disorder). It was estimated that no more than 2 out of the 28 cases were UAC: it should be noted that these figures represent the totality of admissions for all immigrants living in Greece during these years (including those permanently residing with their families in the country for years). In addition, a representative of Ministry of

[1] Note: The information is not precise as data extracted from files for the needs of the current assessment (no statistical data/indicators are available on this subject).

Health (member of Steering Committee of the project) mentioned that he was aware for no more than 20 cases of UAC addressed to psychiatric departments for hospitalization nationwide although this was mentioned as a rough estimate.

Most and least frequently reported worrying signs

It occurs that the most frequent issues noticed by the personnel were that one fifth of UAC had nightmares and/or were not being able to sleep (mainly reported as *chronic* rather than *acute* cases); almost 1/5 of UAC displayed disrespectful behavior against people in the structure (reported mainly as *acute* cases), and that 1/10 of UAC shows self-harming behavior (including suicidal behavior). Less frequent, but nevertheless worrying, problems were related with behaviors such as sexual assault of other children (5 *acute* cases where recorded); committing crimes (5 acute cases); engaging in high risk sexual behavior (3 *acute* and 1 *chronic* case); and recruiting other children in illegal activities (3 *acute* cases were recorded).

> *"It was a period when children made the night day, but not because of stress..."*
> *(Shelter coordinator)*

Chronic and acute worrying signs

Acute reported cases in total constitute the ~65% of the total number of cases. For most of the individual signs, acute cases were reported more frequently than the respective chronic ones. "*Having nightmares and/or not being able to sleep*" is the only sign where chronic cases are considerably more than the acute ones while for some further worrying signs there are a few more chronic than acute cases (such as cases of involvement in illegal activities; victimization of bullying due to ethnic origin and/or religion; victimization of bullying due to gender; victimization of bullying due to sexual orientation and disoriented behavior). This may indicate that most of the worrying signs are distinct, isolated events rather than permanent conditions, with the exception of problems related to sleeping during the night. The later, however, as it was clarified during the FG discussions, is not necessarily relevant to *insomnia* due to nightmares but often intentional: UAC, for example, prefer to stay awake because they like to spend their night time in the web or due to special conditions such as the Ramadan period.

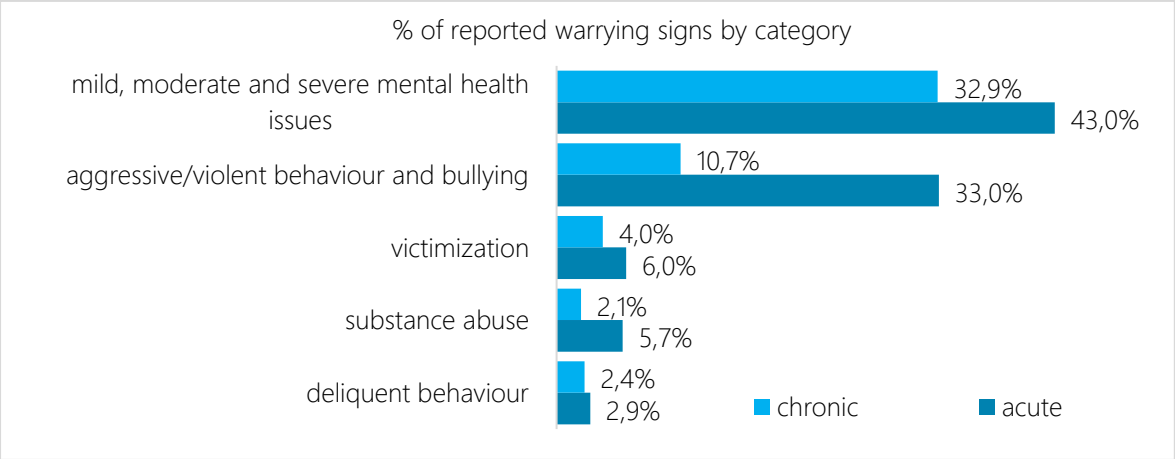
Spectrum of types of worrying signs

By grouping the reported worrying signs according to their nature in larger categories as presented in the figure below, it is observed that they are mainly (in ~75% of cases) relevant to mild, moderate and severe mental health issues (such as withdrawal, mental health and psychiatric problems, including the items: *spending less time with friends; isolating themselves; having nightmares and/or not being able to sleep; unusual crying and screaming; panic attacks and related symptoms; sadness e.g. not talking, not eating, etc.; self-harming behavior including engagement in high risk sexual behavior and suicidal behavior; attempt to commit suicide; disoriented behavior and overt psychotic symptoms like hearing voices, becoming paranoid etc.*) and in less than half of the cases (~44%) are related to aggressive, violent behavior and bullying (including the items: *disrespectful behavior against people in the structure; aggressive behavior in general; attack on people in the structure; attack on people outside structure namely other civilians; violence against other children; sexual assault of other children; recruitment of other children in illegal activities; bullying against other children due to ethnic origin and/or religion; against other children due to sexual orientation; against other children due to their gender*).

Frequency of reported signs relevant to delinquent behavior (committing crimes; involvement in illegal activities such as looting or involvement in acts of sexual exploitation etc.) and substance abuse (alcohol and drugs) is considerably lower (~5% and 8%, respectively) while victimization of UAC seems to concern one out of ten children. Lastly, in all groups of worrying signs, it is observed that acute cases are more than chronic

ones implying that appropriate changes in cases' administration while UAC hosted in the shelters may prevent acute problems from occurring.

A psychologist working in a shelter commented that a large proportion of UAC hosted in the shelter experience disorders under Axis I of the DSM-IV (American Psychiatric Association) such as dysthymia, depression, generalized anxiety disorder, and post-traumatic stress disorder. Moreover, abusive behaviour, passive aggression, acting out, refusal to comply with the rules and program of the shelter, denial of co-operation, despair, verbal aggression among UAC and staff are quite common. (S)he added that many children come to the shelter without knowing their rights, responsibilities and obligations within a European country while very often UAC are not aware in regard to the legal framework of the political refugee status.



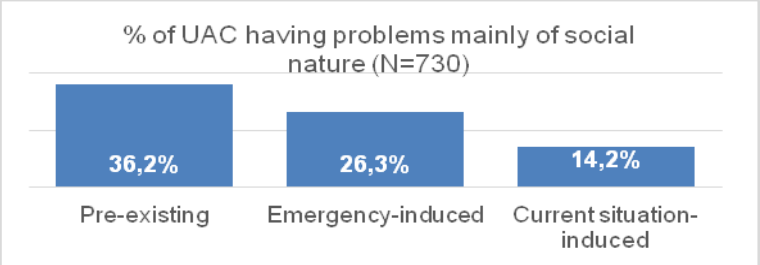
** cumulative percent exceeds 100% as it was possible for more than one worrying signs to refer to the same child*

One issue raised during interviews with mental health professionals in regard to the above estimations was the relative underrepresentation of withdrawn and depressive UAC in the population they encounter; this probably has to be attributed to the relative more attention paid by the shelters' caregivers to UAC with externalizing (aggressive etc.) behaviors in contrast to the internalizing ones. In addition to this, it was also noted that in many occasions when UAC were brought to hospital emergencies with the question of hospital admission (usually after an aggressive outbreak), there was apparently little prior relationship built among the adolescent and the caregivers. They commented that there is little apprehension of the vital and active role of the caregiver in any C&A treatment process mentioning that *sometimes caregivers don't speak to the UAC; they sometimes do not even know who they are. One clinician mentioned that "One time in one such clinical assessment the person accompanying the UAC said to me "I don't know him at all". How can they help those adolescent escape their rage? Do they think that "other" adolescents express less anger?"*

Pre-existing, emergency-induced and current situation-induced MHPS problems of UAC

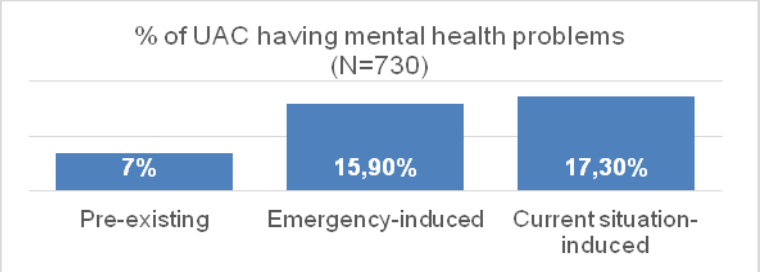
Mental health and psychosocial problems in emergencies are highly interconnected, yet may be predominantly social or psychological in nature. Professionals working in the shelters were asked whether, to their knowledge, there were children in the shelter having one or more problems of social/psychosocial or mental health/psychiatric nature. Information collected is presented below:

Concerning ***problems of social nature***, these could pre-exist (e.g. child belonging to an ethnic, social, religious or other group that is discriminated against or marginalized; living in poverty), be emergency-induced (family separation; violence, conflict, forced recruitment, destruction of homes and schools, loss of family members, forced displacement, disruption of social networks; vulnerability against victimization as trafficking) or could have occurred due to their current situation (overcrowding and lack of privacy in shelter/camp; not covered by traditional support mechanisms; aid dependency).



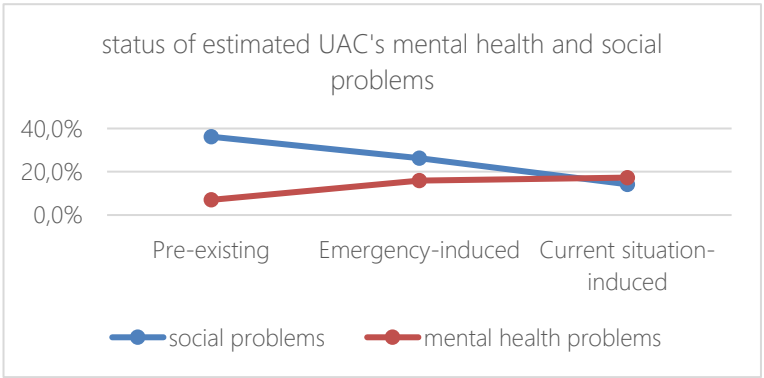
More than one third of UAC had already problems of social or psychosocial nature while living in their country of origin; such cases were reported in almost all shelters (33 out of 34). Moreover, for more than one fourth of UAC it was mentioned by staff in 24 shelters that they were facing emergency induced problems of social nature and for ~14% of UAC living in 14 shelters that were facing similar problems induced by the current situation.

Concerning *mental health problems*, these could also be pre-existing (e.g. diagnosed mental disorders; depression; substance abuse; self-harming incidents), emergency-induced[1] (e.g. grief; non-pathological distress; alcohol and other substance abuse; depression and anxiety disorders including PTSD) or induced by the current living conditions (anxiety due to living conditions (such as lack of privacy) or due to lack of information about asylum procedures etc.).



Staff from 18 shelters replied that to their knowledge almost 7% of UAC had pre-existing mental health problems; from the majority of shelters however (29 out of the 34) it was reported that almost 16% of UAC had emergency-induced mental health problems while staff from 24 shelters noted that even more UAC (~17%) had mental health problems induced by their current situation.

From a rough comparison of the status between psychosocial and mental health problems a different pattern is observed: pre-existing psychosocial problems (as defined above) were more prevalent than emergency- and current situation-induced; on the other hand, mental health problems induced by the current situation were more prevalent than emergency-induced and the pre-existing ones. Taking into account this information along with the types and prevalence of worrying signs it may be considered that at the present time the main problems of UAC are mainly acute cases of psychological nature induced either due to emergency or due to current situation where UAC living and usually concern behavioral aspects rather than severe psychiatric conditions. One social worker working with UAC living in various settings (shelters and camps) noticed that during her several years' experience in the field she wasn't able to remember even one diagnosis for an UAC relevant to psychosis.



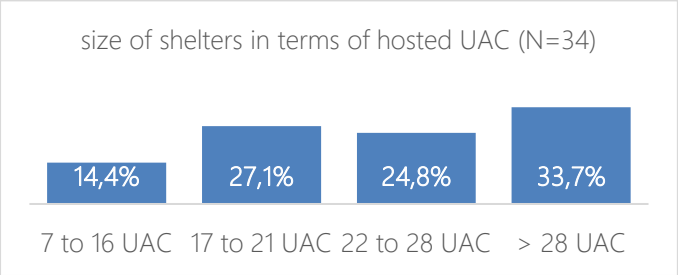
Concerning the more severe cases of mental health problems, according to a group of social workers working with UAC living in many shelters and camps, the most frequent diagnoses given in UAC are (following the

[1] Emergency-induced defined as in the following:
https://www.unicef.org/protection/what_humanitarian_health_actors_should_know.pdf

ICD-10: 2014) either mood (affective) disorders (specifically "*persistent mood [affective] disorders*" including cyclothymia, dysthymia, and other persistent mood [affective] disorders) or neurotic, stress-related and somatoform disorders (specifically "*reaction to severe stress, and adjustment disorders*" including acute stress reaction, post-traumatic stress disorder, adjustment disorders and other reactions to severe stress).

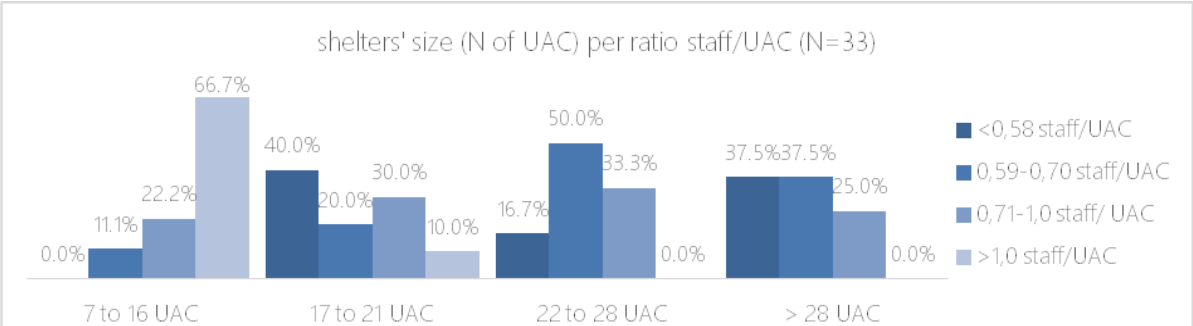
The above information on the most frequent diagnoses is in alignment with the personal histories of UAC and specifically with the main causes of separation of these children from their families, according to shelters' staff knowledge. Specifically, it was reported that in more than half of the cases UAC either traveled away from their countries for meeting caregivers/ other relatives in another country (usually in EU) (35.8%) or their caregivers/ families sent them away for their safety along with some members of their extended families or friends that afterwards were separated from the child (23.8%). Such cases identified in almost all shelters, regardless UAC or shelters' characteristics (in 33 and 27 shelters respectively. Moreover, in almost one out of 10 cases UAC lost their caregivers in the war (9.9%) and even fewer lost their caregivers during the trip from their countries to Greece (4.1%). Such cases were reported in 22 and 20 shelters, respectively. Almost 16% of UAC separated from their caregivers for other reasons (related, for example, to specific conditions e.g. to avoid recruitment in the army back in their countries, to avoid problems with police or justice, to go abroad for work and gain money to send back to family etc.) and for at least 10% of the cases shelters staff didn't provide any main cause of separation (that by itself representing a source of concern).

Size of shelters, staff/UAC ratio and prevalence of reported worrying signs



The smallest shelter hosted 7 UAC, the largest hosted 37 UAC while the mean number of UAC per shelter was 21.5 UAC (SD 7.6). Smaller shelters (7 to 16 UAC) hosted ~14% of the total UAC while larger shelters (>28 UAC) hosted ~34% of the total population of UAC. Given the information presented in the figure it is quite evident that the vast majority of UAC are placed in institutional-like residential units. In addition, as presented in the figure below, the ratio of staff/UAC in smaller shelters is higher in comparison with larger shelters, especially the ones hosting more than 21 UAC.[1] Specifically, regarding staff/hosted UAC ration, the lowest one was 0.4 staff/UAC and the highest was 1.63 staff/UAC; in 2 shelters the staff/UAC ratio was 1/1, in 7 shelters >1/1 and in 24 <1/1, implying significant differentiation in the operation mode between shelters.

[1] Apart from Coordinators, 498 persons were employed in the 33 shelters during the rapid assessment as caregivers, scientific staff, auxiliary staff or interpreters (for one shelter there was no information). Eight persons was the minimum while 30 persons was the maximum number of staff in a single shelter. The majority of the staff (38.2%) were caregivers (including educators pedagogues working also as caregivers); there was a shelter where nor caregiver neither pedagogue was employed. Scientific staff (including social workers, psychologists, teachers, sociologists, lawyers, nurses, social anthropologists, creative activities staff, child protection officers and medical doctors) was the second largest group of professionals (33.9%) working in all 33 shelters, followed by auxiliary staff (16.5%) including cooks, cleaning staff, drivers, guards, administrative staff, available in 21 out of the 33 shelters. Cultural mediators and interpreters represented the 11.4% of the total staff working in 23 out of the 33 shelters (10 shelters employed neither interpreter nor cultural mediator).



Considering the prevalence of the total reported acute cases it seems that there is a positive correlation with the size of the shelter ($r = 0.496$, $p = 0.003$) and a negative correlation with the staff/UAC ratio in the shelters ($r = -0.353$, $p = 0.044$). No significant correlations were observed in the frequency of reported chronic cases in regard to size and staffing of shelters.

Examining the wider categories of worrying signs two positive correlations were observed in regard to the size of shelters: the more UAC hosted in the shelter the more acute cases of aggressive and violent behaviors ($r = 0.428$, $p = 0.012$) as well as acute cases of withdrawal, mental health and psychiatric problems ($r = 0.366$, $p = 0.033$) were reported. On the other hand, a negative correlation between acute cases of mental health/ psychiatric problems and staff/UAC ratio is observed ($r = -0.376$, $p = 0.031$). From the above it is suggested that chronic cases of MHPS problems do not differentiate concerning size and staffing of shelters; concerning the reported acute cases, however, they appear to be fewer in smaller shelters with higher staff/UAC ratio.

4. Mapping of existing MHPSS and Child Protection (CP) framework for UAC in Greece

4.1 Legal framework and policy framework

The legal framework covering issues of the treatment of unaccompanied minors and victims of trafficking consists principally of either general provisos of the domestic civil and penal law on child protection as well as laws ratifying the relevant UN and EU conventions/ regulations/ directives. Though important steps have been made, the fact that "core" domestic law has not yet been modified towards a successful, effective and most of all comprehensive management of this vulnerable population, hinders the well-being, protection, access in public services and inclusion in the society of migrant and refugee children as well as victims of trafficking. One crucial issue which inevitably affects the treatment of UAS is also that regarding general legislative provisos for child protection in Greece there is considerable fragmentation as pieces of legislation on child protection have introduced several provisos in different points of time regulating the mandate action and capacities of different involved services[1] (Annex 6). These fragmented measures introduced and provided for by different laws and presidential decrees in the course of time sometimes result in contradictory or overlapping actions lacking coherence and consistency. Therefore, the necessity of a comprehensive unique piece of legislation (i.e. framework law) on child protection that has been raised in overall for child protection legislation in Greece is also relevant to the provision of effective and efficient protection to UAC as well.

In practice all "visible" children are able to have a place to sleep and eat, visit school or access the health system.[2] Nevertheless, there is no comprehensive legislative framework to cover all and every aspect of providing assistance to UAC as a vulnerable group of children from the moment they enter the Greek borders up to the global coverage of all their essential needs. This seems more applicable in securing that there are sufficient resources to bring about the measures provided by various laws (i.e. appointing legal guardian, providing medical and other assistance etc.). The inconsistency of services provided didn't seem to represent such a grave issue as long as the majority of UAC were able to continue their journeys to other EU countries passing through Greece; as long as this transit character of UAC passing through the country, several issues might be settled in an ad hoc manner. Even NGO's working with UAC rightfully put a strong focus initially on the asylum procedure (as the only legal available path of legalization UAC residence in third countries); however, especially since the closure of the Western Balkan channel other issues have to be addressed such as providing sufficient protection, access to essential services such as education, provision of mental health and psychosocial support but also identification and recognition of UAC potential victimization (i.e. as victims of human trafficking). Additionally, existing national legal framework requires additions and revisions that have been repeatedly indicated. This overall situation results in leaving a great number of children in limbo, especially **given the delays in the asylum procedure including family reunification procedure (Dublin III Regulation)**. In the context of the new situation of the last couple of years in which refugee and migrant flows have grown and borders towards other EU countries-destinations have been substantially narrowed, the changes in laws are indispensable for providing sufficient and timely protection measures for all children. Emphasis should be placed to the fact that they are children above all and since they are traveling on their own they are at risk of being exploited.

[1] ICH, unpublished work, 2017

[2] Law 2101/1992 "Ratification of the UN International Convention on the Rights of the Child" (for example art. 24 "access to health"; art. 27 "adequate standards of living", art. 28 "access to education"); specifically for the right of minor aliens who reside on Greek territory in education see Law 2910/2001, art. 40 "access of minor aliens in education"

At both international and European level the Convention on the Rights of the Child[1], together with other institutional documents, is the main guide when it comes on the protection and rights of children moving. The principles of the International Convention on the Rights of the Child are of great importance when unaccompanied minors. Regarding Greece and other EU countries, the Geneva Convention must be read combined not only with the Convention on the Rights of the Child, but with the Convention for the Protection of Human Rights and Fundamental Freedoms. Additionally, in the fight against trafficking, the Protocol to prevent, suppress and punish trafficking in persons, especially women and children, should be taken into account, supplementing the United Nations Convention against trans-national organized crime.[2] Particular provisos and selected articles of most significant laws on minor asylum seekers as well as for minor victims of trafficking are presented in Annex 7[3].

As indicated in a number of instances throughout the last years, one of the most important shortcomings of existing legal framework in Greece regarding UAC is regulating the guardianship institution which unfortunately is still due. That combined also with the lacking of provisos for alternative, non-residential placement of UAC (i.e. foster placement[4]) results in further complications allowing only for residential care placement combined with execution of temporary guardianship only by public prosecutors. Apart from all social implications of these shortcomings, such conditions applying complicate provision of mental health services to UAC when needed. Qua minors, UAC also are affected by existing provisos of national legislation on issues such as i.e. medical treatment. Therefore, given the above, formally whenever any UAC requires medical or other therapeutic assistance a written permission should be made available by the public prosecutor who holds the guardianship rights of the particular minor (often being the public prosecutor of the cross-border area in which the minor was firstly located by the Greek authorities). This legal requirement might not always be realized fully, especially in regard to either life threatening medical conditions or merely physical conditions requiring quite trivial medical intervention. However, these legal requirements might represent a crucial barrier when it comes to either chronic mental health conditions or mental health conditions for which and in virtue of them the child or adolescent refuses to receive the required assistance. For instance in one case of UAC which had challenging behavioral reactions, and the shelter's personnel asked for the UAC's involuntary admission to a mental health facility, for each and every time the minor was taken to a hospital to be assessed in the emergencies, there had to be a public prosecutor's written order to allow such medical examination (as matter of fact there had to be more than 8 such written orders).

[1] CRC General Comment 6 (2005)

[2] Papanastasiou, S., Ntafouli, M. & Kourtidou, D. (2016). (2016). The state of the children in Greece. Report: Children in danger. Hellenic National Committee for UNICEF, 2016.

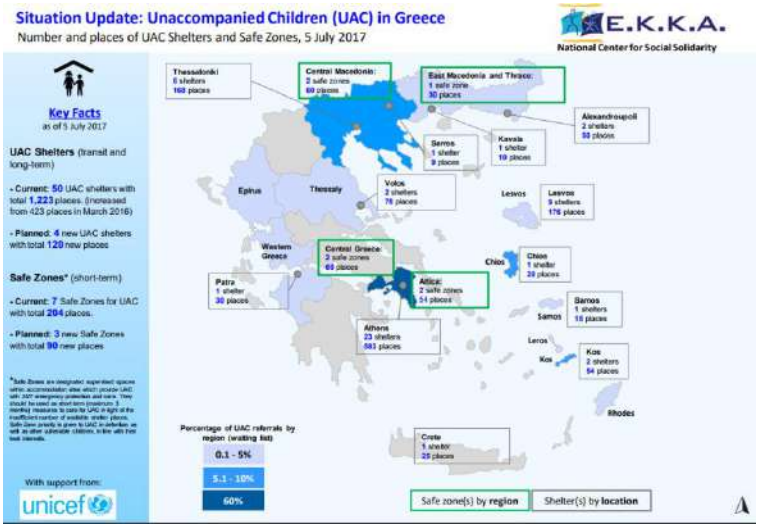
[3] Gyftopoulou A. (2016) The legal framework for unaccompanied minors victims of trafficking. In: children on the move - children at risk: from detection to intervention. Athens: ICH (in press)

[4] According to existing national legal framework, lawful guardians are entitled also to preform foster placements for minors under their custody.

4.2 Mental health & psychosocial institutions and services addressing the MHPSS needs of UAC

In July 2017 there were 50 shelters in which UAC reside. Moreover there were some more UAC in seven safe zones within camps. Most of these facilities are located in the greater Attica area, nearby Thessalonica, the Northern Aegean islands (Lesvos, Chios, Samos) with some additional few such residential facilities located in other areas.

Source: National Center for Social Solidarity & UNICEF. At: www.ekka.org.gr/files/ekka dashboard 5-7-2017.pdf



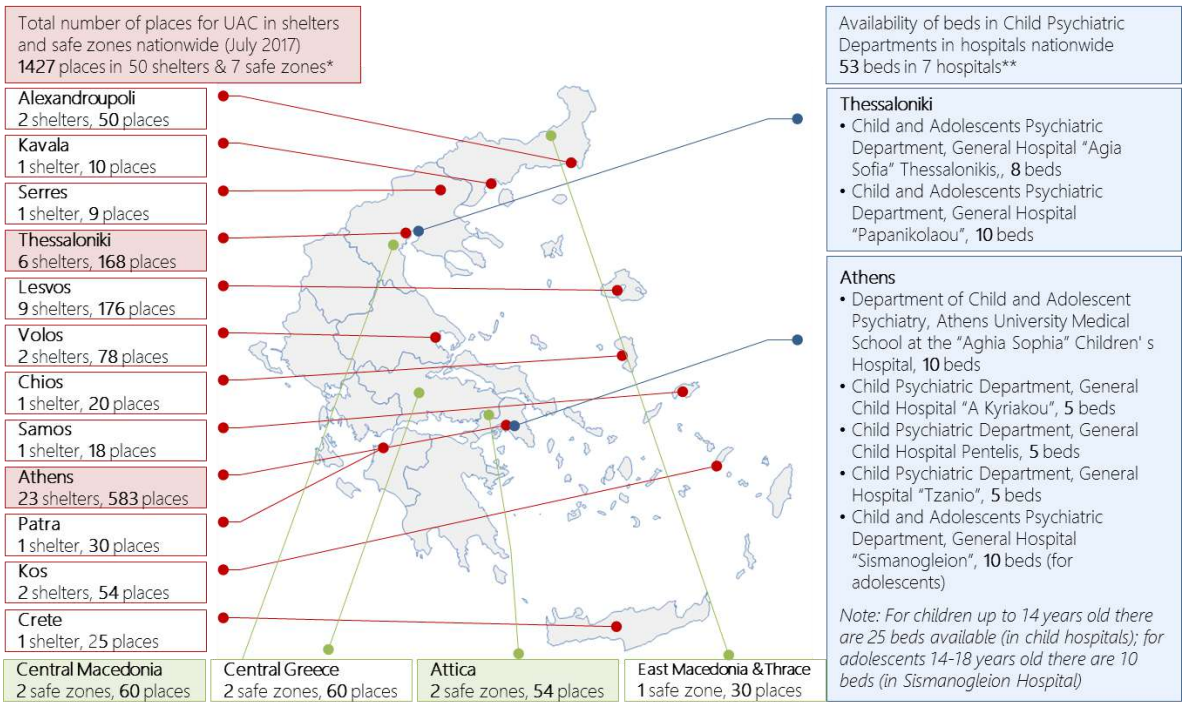
Naturally, in order to address their needs for MHPSS, UAC have to seek for assistance and support in services located in relative proximity. Overall, most of the existing MHPSS (not exclusively for UAC but in general for children and adolescents facing mental health issues of) are located in the greater Athens and Thessalonica areas; however, due to their workload, their availability for addressing specific challenges of UAC is limited. On the contrary, in Northern Aegean islands as well as in places such as Alexandroupolis or Crete, there is the additional issue of availability of MHPSS in general. More specifically, in the greater Athens area within the overall public sector there are currently available the following services:

1. Hospital Departments with inpatient units (for hospitalization): "Agia Sofia" Children's Hospital, "Aglaia Kyriakou" Children's Hospital, Pentelis Children's Hospital, "Zanneio" Hospital (Piraeus), "Sismanogleio" Hospital (adolescents' unit)
2. Hospital Departments without inpatient units: "G. Gennimatas" Hospital (adolescents' unit), "Asklepieio" Voulas Hospital
3. Mental Health Centers (ESY: NHS), Medico-pedagogic Centers (ESY: NHS), Centers for Children's Mental Hygiene (PEDY: NHS), Centers for Mental Hygiene (Center for Mental Hygiene and Research) and University of Athens' Mental Health Centers (community-oriented mental health services centers): C&A Community Mental Health Center of Pagrati (affiliated to "Evaggelismos" Hospital), C&A Mental Health Center of Agia Paraskevi (affiliated to "G. Gennimatas" Hospital), C&A Mental Health Center of Peristeri (affiliated to Athens' Psychiatric Hospital), C&A Mental Health Center of Attiki (affiliated to "Sotiria" Hospital), Medico-pedagogic Center of Athens (affiliated to Pentelis Children's Hospital), Medico-pedagogic Center of Pallini (affiliated to "Sismanogleio" Hospital), Medico-pedagogic Center of Nea Smirni (affiliated to Pentelis Children's Hospital), Medico-pedagogic Center of Neou Irakleiou (affiliated to Pentelis Children's Hospital), Athens Center for Children's Mental Hygiene, Athens Children's Center for Mental Hygiene, Athens Adolescent's Center for Mental Hygiene, Piraeus C&A Center for Mental Hygiene, Aigaleo C&A Center for Mental Hygiene, C&A Community Mental Health Center of Vironas.

Apart from the above, there are additionally, some other public sector services such as "Michalineio" Child Protection Center in Piraeus, 2 shelters for supported residential care for C&A with mental health issues ("Ormos" and "Spiti") affiliated with the "Sismanogleio" Hospital's adolescents unit and 7 Centers for assessment of educational disabilities operating within the context of Ministry of Education in the Attica region

(the later, however, having rather limited relevance to addressing UAC needs for MHPSS). Overall, there are currently around 35 operating hospital beds for children and adolescents in greater Athens from which a limited number could be used for involuntary hospitalization treatment. It should be also noted that these beds are serving a much greater geographical area than Attica region as such in the absence of available similar services in other regions of the country (i.e. Central Greece, Aegean islands etc.).

A similar situation in regard to the density of available MHPSS also applies for Central Macedonia region (including Thessalonica), with currently operating 8 public sector's units providing MHPSS for children and adolescents from which two are hospital departments with 18 available beds for inpatient treatment (again more or less serving the most of the regions of Northern Greece in virtue of the inexistence of similar services in some regions). Situation is much worse in other areas such as the Aegean islands where currently there is only one adult psychiatrist providing outpatient clinical services once a month in the islands of Lesvos and Chios with no further resources available. In other areas there is little or no capacity for inpatient care (limited capacity in the University Hospital in Heraklion, Crete, etc.).



* *Source: EKKA & UNICEF (July 2017) available at: http://www.ekka.org.gr/files/EKKA%20dashboard%205-7-2017.pdf*
** *Source: MoH, Special Committee for the Protection of Rights of People with Mental Disorders (14/5/2013) available at:* http://www.moh.gov.gr/articles/health/domes-kai-draseis-gia-thn-ygeia/c312-psyxikh-ygeia/1398-eidikh-epitroph-elegxoy-prostasias-twn-dikaiwmatwn-twn-atomwn-me-psyxikes-diataraxes?fdl=8836

The information above highlights the geographical inequalities in the distribution of services available for addressing needs for MHPSS in general, for the whole population (as most of the available services are concentrated in Athens and Thessalonica with entire regions remaining without coverage). Furthermore, it should be added that, even in areas where services exist, they are rather already overloaded due to the relative shortage in human resources- issue not always captured when just mentioning or listing existing services. For instance there are around 15 currently operating C&A mental health services of the public sector for the Attica region; however in most of them there are currently 1-2 C&A psychiatrists serving; that, in turn, makes the actual waiting time for a clinical appointment for follow up consultation to range from a few months to over one year in some occasions. In addition, often needs for inpatient admission are postponed in virtue of unavailability of vacant beds in one of the existing inpatient hospital units. Moreover, given the existing workload of the above units, it is rather doubtful whether they could address the perplexed issues of providing MHPSS to UAC in which treatment faces additional challenges (such as linguistic and cultural barriers),

especially regarding the long-term follow up. It is also doubtful for exactly the same reasons that these units could undertake comprehensive preventive actions with in situ visits to shelters, safe zones and other places of UAC residence, since most of the personnel currently serving has already a tight schedule with clinical appointments arranged. Therefore, existing MHPSS of the public sector faces severe difficulties in providing services to UAC due to their workload, barriers in UAC-related issues (and in general trans-cultural) mental health treatment as well as their inexistence in some regions.

Despite that - and in the absence of any alternative option - one considerable portion of cases of UAC requiring MHPSS is currently addressing mental health services for children and adolescents of the public sector for assessment or treatment. This is exclusively true in the rare occasions of UAC requiring hospitalization which is currently available only in a few Departments throughout Greece, mainly in child and adolescent Department of Sismanogleio Hospital and Agia Sofia Children's Hospital. These particular hospitals regularly provide services to adolescents, so it is only natural that UAC (who are, in their vast majority, adolescents) are addressed there. Sometimes UAC end up receiving treatment in adult psychiatric units of mental health hospitals such as Dromokaiteio. This particular addressing to these two hospital departments in Athens can be explained since these regularly provide services to adolescents and UAC in their vast majority are adolescents.

During the past years there have been a number of referrals to hospitals with the question of potential admission of UAC in mental health units. According to EKKA's estimations, for the first semester of 2017, these referrals (actually the prosecutors' orders made by shelters all over the country) were 20 and another 18 were made from other referees (such as police and reception and identification centers); some of these referrals concerned the same UAC. However, as illustrated from the interviews and the focus groups discussions of the current assessment, it seems that most of these requests for clinical assessment do not end up in hospitalization of the UAC under clinical examination or end up in an extremely short-term admission (up to 48 hours) after which the UAC is discharged. As responders said, in many occasions, there is no full-fledged mental health disorder but rather an emotional outbreak common to adolescents which the residential care "system" is not in position to handle. In other occasions, the problem lies in social circumstances or psychosocial issues (such as anger related with the status of the UAC, drug or alcohol abuse, involvement in delinquent activities etc.) which obviously cannot be addressed with admission or hospitalization of the adolescents. There were very limited cases of psychotic or other major mental health disorders which were eventually hospitalized for a considerable number of days. As the most of the UAC cases taken to C&A mental health units of hospital emergencies are cases of behavioral and emotional disturbances (according to the mental health professionals interviewed), there is an obvious question regarding follow up and long term treatment for both UAC and their caregivers; one of the most problematic findings from the interviews with key mental health professionals was that there is no systematic follow up after hospital admission and discharge or after clinical assessment with the question of potential admission of the UAC. In most occasions, mental health professionals have no idea about what happened to the UAC after their shorter or more extended contact with hospital or child and adolescent mental health services.

For the time being, and partly covering the limitations of the public sector when it comes to UAC MHPSS, there are several organizations specialized in providing such services; for example in the region of Attica the NGO BABEL SYN-EIRMOS provides psychological support and psychiatric care to a big number of UAC living in residential shelters while other NGOs are providing psychological support in situ in camps and safe zones.

5. Rapid assessment of MHPS Services response for UAC

5.1 Response of existing services to the MHPSS needs of UAC

To outline the current response to MHPS needs of UAC within and outside shelters, participants in focus group discussions were asked "*In general, what are you/ your colleagues doing to identify and help children in acute incidents of mental disorders? In cases of UAC with chronic mental problems? In cases of UAC with psychosocial needs?*" Moreover, they were asked about where they are usually seeking for help (services, professionals etc.). Lastly, they were asked about the extent to which they were satisfied from the current response to these needs of UAC. Similarly, key-informants participating in semi-structured interviews were asked about the cases of UAC they work with, whether they feel that the response of their services is adequate and what are the main problems they deal with.

Ability of shelters to respond to MHPSS needs

General case management

Concerning the response to psychosocial needs of UAC, representatives of all shelters replied that they manage all cases internally, relying on their own resources. Staff of shelters and in particular social scientists undertake cases relevant to UAC everyday concerns, integration with life in shelters and relationships of children with one another and/or staff members but also cases of educational and other activities-related issues.

Regarding mental health difficulties in most of the cases it was reported that they are also manageable within shelters, in some cases with the support of services outside the shelters. Adequate shifts (especially during night time) was one of the practices that seemed to be effective for the response of a variety of mental health and/or psychosocial needs of UAC such as the particularly frequent issue of the lack of sleep during the night (in some cases due to nightmares but usually because of other reasons including the option of UAC to spend their night time in the web or due to special conditions such as the Ramadan period): in this case, for example, living in the shelter means involvement of children in many activities during the day in order for them to need to sleep during nighttime.

The coordinator of a shelter commented that UAC are minors who are primarily experiencing post-traumatic stress, depression, anxiety disorders and, in some cases, some personality disorder. He added that sometimes use of alcohol or other substances is closely associated with these disorders and that self-destructive or aggressive behaviour is, in specific cases, manipulative." Sometimes, however, it was suggested that shelters need time in order to manage effectively cases even the ones that could be considered as "difficult". The general coordinator for a number of shelters stated that "*…For us the situation has changed very much … Last summer (i.e. 2016) it was one of the most difficult periods. Many shelters opened at this time and received children from the camp of Idomeni. These children came after 3.5 months of waiting while living in a crowded environment - 12,000 people – with increased delinquency. They were children who waited when they would leave for their destination, children who wanted to stay in the camp with the people they already knew. When they came to the shelters they were "on the railings". Then 15 out of 30 children had post-traumatic stress and they had continuously panic attacks. One child was in crisis and another 6-7 were significantly affected. Now, a year later, this is not the case. A lot of work has already been done with children and they are in a much better situation … children who suffered from panic attacks now almost never have crises … but we should have patience*".

In some cases, shelters' staff provided a more optimistic picture of MHPSS needs of UAC, considering that UAC in their majority are easily and quickly adapted to the current living conditions. They noted that from

time to time UAC experience major emotional fluctuations but of short duration; by observing the daily life in the shelter staff noted that although during their admission UAC are often frightened and confined to themselves, after a period of time they open up with both the staff and the other children. Even though in some cases reactive behaviour and negativity is expressed by specific children, such incidents can be handled adequately by the staff taking into account apart from cultural differences the fact that UAC are in the transition developmental stage of puberty.

It is of note, however, that in some cases, even severe mental health problems may have not received the required response because UAC are quite silent and do not create problems in shelters' everyday life; in a shelter hosting girls/older girls it was mentioned that there were no self-harm incidents in the shelter, maybe some cases of depression. It was added that often these people have very bad histories which however are very common in their countries; the professional brought up the example of a girl talking about her rape and the fact that the girl was considering that rape is something that happens all the time to everybody"

Social workers working on EKKA were asked about requests for movement of children because of psychiatric problems relevant to suicidal and self-harming behaviour and attempted suicides. According to them, they receiveno requests for movement of children after suicide attempts adding that actually there is no reason to ask to move the child to another shelter since none of the shelters have psychiatric services within them. They mentioned that the only case to consider movement is when the shelter is located in a small city where there is no child psychiatrist and the child must go to a city where they can receive the services of a child-psychiatrist. They explained that in such psychiatric cases attended by a psychiatrist and concerning also medication, there is no point for asking for a move as after a period of time these children become eventually functional. They concluded stating that they would consider the movement of an UAC only if there are reasons in the environment of the particular shelter that influence negatively the child's symptomatology.

Cases managed by shelters with the support of EKKA: the practice of moving UAC to another shelter

Social workers from the EKKA commented about the requests for movements of UAC from a shelter to another shelter: "*Now, we are going to discuss issues that are serious and, to my opinion, are observed in almost all the shelters… In some cases (i.e. 58 during the first semester of 2017) we receive a request to move a child from a shelter for some reason as, for example, because staff cannot handle the child or because there is "a clique" creating problems that staff want to break it down to avoid further episodes, etc. From our part, we are trying to examine any request as unique: for example, was the request submitted because the life of the child is at risk or it was because the child does not follow the rules of the shelter and staff is not able to handle it? Afterwards we proceed with the request depending on the case -the reason justifying the request for movement and the current system's ability (available places at the time). We generally know that the requests for moving a child to another shelter have also the subjective criterion of the professional who submit the request and how s/he perceives the case. We do not always have full information but we know that things are usually a little harder than the shelter staff says after submitting such a request.*

In some shelters, for example, was reported that cases of UAC with delinquent behavior (e.g. thefts) were often more than one at the same time; they usually manage these cases internally; there were, however, some cases of older persons who systematically refused to cooperate and comply with the rules; in these cases the support of prosecutor was asked, mainly for remove the person from the shelter.

Regarding the outcome of the movements, it was noted that there have been cases of children who, when they moved to another shelter, have gone too well while there were also movements in which issues were again raised. Professionals considered that the outcome depends on the case. Given the sheltering system constraints, namely the availability of places, and to meet the requests for movements of UAC, the practice

of mutual movements of two children with problems who live in two shelters is also applied: "*we have already tried it and in some cases it works, as both children were better; in other cases however the mutual movement was not so successful. The adaptation of a child does not depend only on the child: it depends on the dynamics of the shelter and the rotation of the staff, all of them play a role…"*

Acute cases managed within shelters with support from external services

According to professionals working with UAC, often staff in shelters have to deal with children having behaviours that they are not able to handle such as cases when *"…the child breaks everything, knocks the other children around, coming out in the neighbourhood and stoning the people…"*. Often these children are diagnosed by child psychiatrists with a behavioural disorder. P*ersonnel in the shelters, however, are not experts and therefore they ask from the child psychiatrists to provide them with step by step instructions, namely what they should do if the child does this or that, how to react… If this is a psychiatric problem, then the child psychiatrist is more specialized than the social worker or the psychologist working in the shelter… often UAC with such behaviour simply leave the shelter "in white paper""*

As far as behavioral disorders are concerned, "*some psychiatrists prescribe medication and others do not, some feel that the cause is the environment that the child is living now, and others that the cause is that the child has been through very difficult situations*" said another social worker; "*These are the incidents that shelters' staff cannot catch from somewhere to deal with; when a child discharged from the hospital often the psychiatrists recommends "external psychiatric monitoring" is necessary and they do not give more instructions to the social workers of the shelter on how to manage the child…"*

On the same issue a child and adolescents' psychiatrist commented: "*to my opinion and the opinion of my colleagues, we have been often confronted with a tendency to psychiatrisise situations which are natural reactions of adolescents in terribly pressing living conditions, additional to their recent difficult experiences… and does not stop there. Personnel in shelters do not think that we have not yet allow these children to sit down, settle and reflect what has been done in their lives. We are still in a situation we call them "ah, tomorrow you should go for an interview", they go for the interview and we say "ah, your interview is cancelled, you should schedule a new appointment" and so on. We tell them "you cannot work, you cannot go to school, you cannot do anything" and at the same time "you cannot leave, you have to stay here". This is, of course, a situation that is shaped not only by the staff of the shelters but by the whole system including children's families that often say "did you find him I was telling you? (i.e. smuggler)". It is very difficult for these children to have to comply with the requests of their families while at the same time we treat them as if they were alone …"*. Moreover, people working with UAC in shelters or camps "*often do not know that when adolescents get better, then they may become violent and start the reaction against them. Instead of accepting "thank you", as shelters' staff expect, they accept back violence. These people, however, are like parents, they represent power and must show stability … but they are often not so, but they are very friendly with children and the roles are confused…"*

Referral of UAC with mental health problems to community based services

There are cases involving self-harm behavior and substance abuse by the UAC; if proved that caregivers are not able to help UAC sufficiently then the child referred to external services, operated by either the public sector or an non-for-profit NGO (such as Babel mental health center) in order for the child to receive more specialized support. There is currently no standard protocol or referral mechanism to provide for appropriate steps or for the registering of such referrals. It should be noted that almost all representatives of shelters located in Athens mentioned that refer UAC specifically in Babel; they are generally satisfied from the quality of services they receive but often noted that because of the number of cases appointments with child psychiatrists, for example, need a waiting of at least two weeks. Strengthening of services like Babel was

suggested by many professionals. Moreover, often shelters' personnel suggested the hiring of interpreters in at least some hospitals as they are necessary; in a specific case a social worker accompanied a child to hospital; when the MD realized that the person was social worker and not interpreter said "*What I'm supposing to do with you? I need an interpreter in order to talk with the child and his family; if this is not possible, just go*".

A child psychiatrist mentioned practical difficulties that she and her colleagues faced concerning the referrals of UAC living in shelters as well as in camps: "*last year, when Greece was a passage and there was a high flow of population, we did not know if we would see the child again and felt a lot of pressure to do something, to make a good contact, to provide a good advice, etc. even from the very first session that might have been unique. While there are appropriate and weighted psychiatric tools, their use is time consuming… sessions have already enlarged and now they last for 1.5 hour and this because children have so much to say: what has happened to them, complaints about how we have faced them … they want to tell what happened in the camp, what happened until they made the request, until to go to the appointment and not to lose their turn and much more …*"

When a mental health professional working with UAC in shelters was asked "*how many of the cases you treated you consider that is not possible to continue to live in a shelter and should be removed and placed elsewhere*" she replied "*none; on the contrary all these children can be helped by living with support in shelters with the prerequisite that they will not rejected and that will receive some interest by the meaning of mobilization. If they just left be there, it makes no sense. They must be given some prospect, albeit small, with short interventions*."

A child and adolescents' psychiatrist stressed that "*shelters are an amazing tool for this population. During their trip they did it with raised adrenaline. When they sit down and reflect on what happened to them, then the problems begin. If instead of shelters they were going to foster families, again they would be the same - tensions, reactions, etc. Shelters can help adolescents rebuild their personality. Along the way, all the problems, anger, depression, anger will come out. If the philosophy is that "it will be difficult with these children" then the staff will be able to manage them better. It should also be known from the outset that the problems that will arise are not necessarily psychiatric: one child will be more difficult, another more foolish, another aggressive and another more shy…. And there will always be the black sheep. And if this child leaves, then another will take his place. This is an issue that we are discussing with colleagues in shelters, which are constantly influenced by children's behaviour. Anyway, we have to bear in mind that until now as a state, politics, authorities, etc., we are not credible to this population. Even shelters are not "consistent" with opening and closing and staff turnover. Nevertheless, we ask these children to be consistent … They feel, however, they are benefiting from being delinquent and in addition have the feeling of omnipotence with which they have achieved so far… Indeed, children who dare, even though they have more practical problems, are in a better position than those who withdrawn*".

Referral of UAC with psychiatric problems for involuntary hospitalization

More severe cases, usually cases of UAC with diagnosed mental disorders and especially those at an acute phase are those that almost all shelters are not able to respond adequately to and, therefore, they refer UAC to more specialized services such as child and adolescent psychiatric departments of public hospitals.

Involuntary hospitalization in psychiatric units

Legislation: *"Involuntary hospitalization of children and adolescents is a practice that is run by the juvenile prosecutor for children up to 18 years of age. In accordance with the Internal Regulation of the Prosecutor's Office, the Prosecutor of Minors has the responsibility to investigate the conditions and to initiate the involuntary treatment of minors under the statutory terms. In practice, the rationale of Law 2071/92 and in particular Articles 95 (conditions for hospitalization) and 96 (conditions of involuntary hospitalization) are followed. In this law, there is no mention of children and adolescents. There is no other relevant legislation. Article 98 states, inter alia, that "inconvenient conditions of hospitalization should serve the needs of treatment", "in all cases and during hospitalization, respect for the personality of the patient must be demonstrated"*[1]

Ethics: *According to the Code of Ethics of the Child Psychiatric Society of Greece-Association of Children and Adolescents "Each hospital unit needs to provide "therapeutic environment" conditions, to ensure the participation of parents in the treatment and to be connected with community based structures in order to ensure the continuity of community life. " ... "Psychiatric hospitalization has a specific duration, cannot exist to cover welfare needs or care of individuals, it is not a "suppressive method" and becomes inactive if no "therapeutic environment" is provided". "Hospitalization in asylum-type structures is scientifically outmoded, potentially pathogenic and seems to violate the child's fundamental rights for personal development and participatory life". "Involuntary hospitalization follows the rules established by the state for its realization".*[1]

Standards: *"There should be separate facilities for the mental care of children and adolescents, because children and adolescents may experience fear and cowardice if they are hospitalized in an adult section". Moreover, WHO considers 6-8 psychiatric beds for children in hospitals per million of population are needed and even more for adolescents"*[2]

[1] MoH, Special Committee for the Protection of the Rights of People with Mental Disorders (2013). Psychiatric Hospitalization of Adolescents. Available at: http://www.moh.gov.gr/articles/health/domes-kai-draseis-gia-thn-ygeia/c312-psyxikh-ygeia/1398-eidikh-epitroph-elegxoy-prostasias-twn-dikaiwmatwn-twn-atomwn-me-psyxikes-diataraxes?fdl=8836

[2] WHO (2005). Mental Health Policy and Service Guidance Package: Child and Adolescent Mental Health Policies and Plans Available at: http://www.who.int/mental_health/policy/Childado_mh_module.pdf

Referral process for involuntary psychiatric assessment of UAC

- Coordinator of the shelter or other person in charge (depending where the child lives) communicates with the prosecutor (who is the guardian of the child) providing a description of the case along with a request to order the involuntary admission in a psychiatric service for assessment and investigation of the conditions for involuntary hospitalization (according to the art. 95 of Law 2071/1992), namely whether the UAC suffers from a mental disorder from which becomes dangerous against self or others; from which he/she has impaired judgment; and which is anticipated to improve by hospital admission and treatment.

- In cases that the conditions are satisfied (following the provisions of art. 96.1-5 of Law 2071/1992), namely are documented with written diagnoses by two psychiatrists/child-psychiatrists or one psychiatrist and a medical doctor with relevant specialty, the prosecutor order the involuntary admission of the UAC in an appropriate facility (that satisfies the conditions according to the Law 2071/1992.

- In cases that the conditions are not satisfied (art. 96.6-9) and the request for involuntary hospitalization is not accepted, then the UAC discharged from the hospital and other alternatives are explored (e.g. movement of the child in another shelter via the EKKA, referral to other services for psychiatric support etc.).

In rare occasions (according to EKKA's data ~20 referrals nationwide for the first semester of 2017 some of which concerning the same minor), UAC was involuntarily taken for clinical assessment with the question of potential admission to an inpatient psychiatric hospital unit following a respective prosecutor's order (upon a request of shelters' personnel when the case is not possible to be handled internally within the shelter).

Often the experience of shelters' staff accompanying UAC to psychiatric departments of hospitals are not positive; according to the professionals, in a specific case the Director of the Psychiatric Hospital in Athens was not cooperative at all complaining about the staff bringing the UAC there and for asking for a prosecutor's order in the first place adding that on that day the hospital had refused hospitalization to more severe cases, such as people with Alzheimer. In that specific case the child eventually was not admitted for hospitalization.

In another case a child was addressed eight times (following a prosecutor's order) to a psychiatric hospital but none of the times was admitted because it wasn't considered that he needed hospitalization (while according to shelter's staff it wasn't feasible for the UAC to stay in the shelter); however, as already mentioned in that case most of the prosecutor's order were eventually proven not to refer the UAC with the question of involuntary admission but were rather simple permissions to provide voluntary clinical services (this fact being quite indicative of the confusion prevailing in legal provisions' execution in practice).

Another incident reported by the staff of a shelter located in Thessaloniki: an UAC in the context of a crisis harmed himself; staff took the child to the hospital and explained that apart from the obvious injury he may needed a psychiatric assessment and he had to be also examined on what they had eaten (probably something inedible); hospital referred the child to another hospital where a child psychiatrist was on duty without checking any of the other physical problems (injury, stomach). In the second hospital there was no x-ray machine available and they sent the UAC and the professional back to the first hospital. Again, the hospital referred the child to another hospital where basic care was provided for the hand injury.

In Alexandroupoli when an UAC needs to be admitted in a psychiatric clinic s/he should be transferred to Thessaloniki because no such services are available in the city.

In Lesvos there are some services (including a Child Psychiatric Service) but the Child Psychiatrist is not always there; usually no problems are observed in the response of services to mental health needs of UAC (as apart from child psychiatrist some psychologists also work in the same service). In other cases they addressed the hospital. When needed, child psychiatrist assessed children and prescribed medication. Such cases (often UAC with depression) are manageable within shelters. It was mentioned, however, that sometimes there are difficulties with some medical doctors working in the hospital when UAC are taken there for physical health problems; one social worker said that when she accompanies a child in the hospital often medical doctors say *"oh, you again…"*.

Some participants in the discussions suggested the planning and development of specialized structures for hosting UAC with severe mental health problems; other participants –even working in the same shelters- had a quite a different opinion as they consider that this would be a new form of institutionalization; in one case a psychologist said that if such shelters/units were created, half of the total number of UAC would be placed in these structures as these children have considerably more problems than the general population and this is not the solution. Other participants suggested the development of new services that would support UAC with problems while living in the shelters (except for very severe and "dangerous" cases) or strengthening the already existing services to this direction.

Professionals highlighted that the refugee crisis was unprecedented situation for everybody working currently with UAC and that almost none of them had the necessary previous experience. The Coordinator of multiple shelters noted additionally that due to the opening of numerous shelters during the past and the need of a high number of social workers to be recruited, it was very difficult at that time to find skilled and experienced personnel to hire, especially in areas other than Athens; therefore, ongoing training of younger social workers is necessary. A lawyer from another shelter noticed that in the beginning everything was done quickly due to necessity; however, she added, even today, there are no common methodologies for handling cases of UAC with exceptional mental health and psychosocial needs; the administration is currently adapted per case. Professionals in a FG concluded that now it's time to proceed with planning of more appropriate services.

In the question about the quality of cooperation with public hospitals the general coordinator of multiple shelters mentioned that cooperation is not always an easy task because often hospital are overloaded, adding that there is a lack of multicultural experience as well as lack of specialized interpreters on mental health issues;

therefore the treatment of UAC is not adequate. She stated that sometimes even the access is not easy and that there is a Psychiatric Unit for Children and Adolescents that could support some of the children but up to now she didn't make it to admit children there. She provided the example of a smaller city where there were two cases of children with severe psychiatric conditions but it was not able to hospitalize them because it was understaffed; initially the hospital hired an exclusive nurse and the shelter covered the other two shifts. Finally, when hospital could no longer pay for the nurse, the solution was to tie down the children during the third shift.

Ability of mental health and psychosocial support services to respond to MHPSS needs of UAC

Concerning mental health issues it was discussed that further community based mental health services are mainly required especially for the effective administration and follow up of psychiatric cases (including acute cases): many different options were expressed regarding such cases such as provision of in-patient care (outside of the shelter) in already existing structures for the general population (child hospitals psychiatric units for children or youth) or in newly developed structures especially for UAC (because the already existing ones will probably not be appropriate for UAC due to a number of limitations they face: lack of recourses, lack of experience in the particular children's population; lack of interpreters and respective capacities); provision of out-patient care (inside shelters) with the support of either already existing public community based mental health services (such as the Health-educational centers) or by strengthening already existing relevant services (in terms of staff including interpreters) and development of new services were no child-mental health/psychiatric service exist (in smaller cities such as Alexandroupolis there is a lack of available services such as child-psychiatric department/unit in public hospitals and they should refer the respective cases in other cities e.g. in Thessaloniki).

Below opinions of key-informants, shelters' coordinators and staff are presented on the issue of the creation of a specialized psychiatric service for UAC; some of them are supportive while others are not.

Need for creation of a specialized psychiatric service for UAC	
Supportive opinions	Non supportive opinions
- *"It is true that all shelters have children with diagnoses such as behavioural disorder. In all shelters there were children who were hospitalized and went well. What we are concerned with is the intensity of behaviours and the fact that the shelter can in no way manage this tension. I would say there is a need for a small specialized structure. This structure –I don't know whether it will be psychiatric or not, but it will certainly be small, let's say for 8 persons, but it should be staffed with experienced and skilled professionals who will be able to treat children with such behaviours. And we do not mean behaviour such as "the child does not follow the rules" but for aggressive persons, who are fighting"* - *"The number of UAC hosted in the shelter with an anxiety disorder-relevant diagnosis has increased and more UAC are currently being treated by a child psychiatrist of the organization and receive medication to manage their stress. …The lack of specialized structures to take care of severe cases of mental disorders that are not manageable by existing structures is a problem."*	- *"This should not be an option. During the past year the cases in Attica Region in need for hospitalization were about 20. It will lead to even more institutionalization of these children and after their recharge what will happen? Will they go back to the shelters they came from? They will be stigmatized; they will be very embarrassed of the whole experience and especially by the fact that the police came to the shelter and escorted them to a mental health facility. Shelters personnel should be "strengthened" in handling such cases. They should receive training and they should have structured professional supervision."* - *"I'm certain that the solution is not the creation of a structure especially for UAC with mental health problems. We are supposed to be living in a country that is promoting deinstitutionalization. There has been so much planning, so much budget has been allocated to this, for example with "Psychargos". You cannot close psychiatric hospitals and then open new ones for refugees! If a structure of this type was to open, it would get immediately full of children and then what? Open*

- *"UAC have very complex needs of psychological and psychosocial nature… There is an urgent need for specialized care for some specific difficult cases requiring individualized intervention that exceeds the potential of a 25-person structure. Unfortunately, the psychiatric structures of the country are not able to undertake the responsibility of these cases (often due to lack of knowledge and 'mood'), and this has as result that children not receiving the care they need and end up like "balls" between the structures. Staff training on intercultural psychiatry issues would help, as diagnosis of disorders is often complicated by the different cultural contexts"*
- *"There is a lack of structures for undertaking care of acute cases as well as restricted governmental structures and services for supporting of psychiatric cases of UAC. In addition, the number of non-governmental services specialized in migrant and refugee population is also restricted and therefore not able to provide timely care for mental health problems and as a result waiting lists are long enough and namely access is restricted."*

even more such structures? Immigrant flows, including UAC, are once again reaching the high levels of last year. At the same time there is a decrease in UAC leaving Greece for other EU countries"

- *"For me it has to do with what one means by "psychiatric hospitalization". Has it a therapeutic purpose or is it a way of detaining children for who you don't want to proceed with police or other legal ways or for children you cannot control?"*
- *"Not all cases benefit from psychiatric hospitalizations; in Greece we tend to believe that all mental health cases should be hospitalized for one, two, three years or more. But this is not a therapeutic procedure!"*
- *"In this subject I propose that shelters should be small in size and have a community character. Within such shelters UAC with psychiatric problems can reside together with other UAC, given that there will be staff specialized in handling such cases."*

An alternative was suggested by a coordinator of multiple shelters for UAC: *"I would not suggest the creation of units for psychiatric or for delinquency cases; I would propose the creation of structures for short-term intensive intervention where case workers will take care of children with delinquent behavior who are very entangled. A 2-month intervention program could be planned and, after its completion the child would return to the shelter where lived before. As far as psychiatric incidents are concerned, the shelters can manage them internally with systematic support from a psychiatrist. And, of course, shelters should have more staff and accommodate up to 15 children, with 30 difficult. For children, however, with delinquent behaviour I do not know what else can be done…"*

Good practices concerning MH Services

Already existing: Almost all representatives (coordinators and staff) of shelters located in Athens mentioned that from time to time they addressed Babel, an NGO that provides psychiatric services to migrant and refugee population and, specifically, to child and adolescents migrants and refugees (as in this specific organization there is also the facility of interpretation and cultural mediation in various languages). A Child Psychiatrist specialized to adolescence from the specific organization that provided care in numerous cases of UAC with mental health difficulties considered that almost all cases she treated were children able to continue living in the shelters with the appropriate support with the prerequisite that shelters are well-staffed and able to provide individual care to these children. The problem concerning the specific organization is that there are a lot of requests and due to workload the waiting time for appointments is too long. Shelters' representatives suggested to strength such organizations providing services to multiple shelters, as Babel, in terms of human and other resources.

Newly developed: A good practice identified was by PRAKSIS, namely the development of the Child Psychiatric Department, an "external" mental health service for the UAC's shelters in Attica. The "internal" hiring of mental health professionals to work in the shelters as an alternative might present some merits but it also bears some

additional problems (i.e. confusion of roles, recognition of mental health professionals as identical to the caring environment by the suffering UAC etc.). However, obviously, this was possible to be developed by the particular NGO in virtue of the number of shelters it currently operates; on the contrary, a similar structure could be a less cost efficient choice for other NGOs on the field handling smaller numbers of UAC; in those cases, providing for an independent such structure with appropriate recourses for greater regions (i.e. Attica, Thessalonica or Northern Aegean) might be an alternative option.

Distinct roles of professionals: an advantage of Units such as The Child Psychiatry Unit of Praksis

"From the beginning the Unit was built to create a clear division of roles for the professionals working with UAC. In all shelters there are 1 or more psychologists who are the reference persons for some the UAC; these persons cannot be responsible for psychotherapy and counseling sessions with the child. Let's say that a native child in Greece has parents who are psychologists; would they have counseling sessions with the child? No way!

Also, except for limited and very urgent cases, the personnel of the Unit do not visit UAC in the shelters. The very fact that UAC have to get out of their shelter (in some cases they need to travel for 1-2 hours) implies a "procedure", a commitment; this commitment should be perceived as part of the therapeutic process."

We are past the "emergency" state of the refugee problem so we need to change how we tackle UAC mental health. In reality we are responsible for secondary prevention. What we do, not only us but also Babel and all organizations providing mental health support to UAC, is being the "wave-breakers" for hospitalizations.

Right now we see 55 UAC. Out of these UAC only 4 have been hospitalized since the beginning of the operation of the Unit. I can assure you that if it weren't for the Unit providing weekly counseling sessions to them much more UAC would have been hospitalized. Not all of them obviously, but much more than 4."

In another occasion, the NGO "ARSIS" recruited a child and adolescent psychiatrist to work along with other personnel in a shelter for UAC. This was reported to make easier the management of mental health issues especially the more severe ones (i.e. arranging for admission in a case of an UAC requiring hospitalization) as well as facilitated follow up of minors under treatment. However, confusion over the "external" or "internal" function of the mental health professional was not always avoided; this also was reported in some other instances with clinical psychologists working in shelters for UAC. Moreover, it is doubtful whether for the UAC themselves such professionals are recognized as a part and parcel of the caring setting (viz. "as if" parental caregivers) or as therapeutic resources, the former probably limiting the capacity for providing "lege artis" therapeutic services.

5.2 Key challenges, primary gaps and identified good practices

Long delays in asylum seeking (or other relevant) procedures

Issue/gap: According to data published by the Asylum Service of Ministry of Immigration Policy in July 2017, (for the period Jan 2013 – Jun 2017) 2,887 out of the 4,669 requests for asylum of unaccompanied minors were examined; moreover, from the 2,887 cases only 319 UAC received refugee status and 87 additional received the status of subsidiary protection; the remaining cases were either canceled for various reasons or rejected. In this later case the usual practice is for UAC to ask re-examination of the request which means additional waiting time.[1]

There also delays in relocation and reunification processes often influenced by factors such as the increase of the arrivals in specific periods; slow down on family reunification transfer due to technical difficulties and changes in decisions about the number of refugees other countries receive; and border closures in countries to the north.

Challenge: Concerning their *length of stay* in the 34 shelters that provided information, the majority (~63%) of the UAC were living in the shelter for longer than 3 months, ~24% for 1-3 months and ~13% for less than one month. No differences were observed in the length of stay in regard to the size of the shelters. UAC received information concerning the progress on legal procedures for their cases from multiple and often contradictory sources including lawyers (also those working in shelters); the dedicated members of the guardianship network; staff of shelters; family members; other UAC; other adult refugees and migrants and, often, smugglers.

Progress on legal procedures and services for UAC MHPSS needs.

A common finding among all structures hosting UAC was that *waiting* and uncertainty were the main trigger for many mental health difficulties. Specifically, waiting for a reply in their request for asylum or family reunification, waiting for the green light to go make UAC to experience every single day of stay in Greece as a fail; Professionals noted that at least the procedures for asylum seekers should be simplified.

Mental health and social welfare professionals working with UAC within shelters and in community based services recognized that developments on legal procedures of UAC are very relevant to mental health difficulties (especially with acute incidents of aggressive or violent behavior but also of withdrawal and depressive behavior)/ Commenting on mental health difficulties of UAC a professional working mainly in camps noted that children are very suspicious because they have been through a lot and have followed many routes within the system before they come to a shelter/camp. He added that he believes that many promises were made to them and they were not met so now it's impossible for UAC to trust what they hear. He concluded that UAC tend to forget what they hear, because nothing is important for them anymore and that they currently seem very sad and want to invest in nothing".

> "Waiting time for receiving reply in a request for asylum seeking is very large while the procedure for family reunification lasts for many months. Because of such long-term waiting times UAC experience continuously increased stress, anxiety and agony resulting in acute cases of children's aggressive behavior against self or other people"
> (Shelter Coordinator)

Moreover, apart from the delays, differences in progress and outcome among UAC legal cases is a major stressor for UAC, while "news" for individual cases are communicated among the UAC and often are the reason for rumors and arguments among UAC. An adolescents' psychiatrist noticed that «*the way the children are informed is wrong –often they consider that once they entered in a shelter, then their case will be delayed.*

[1] Source: http://asylo.gov.gr/wp-content/uploads/2017/07/Greek_Asylum_Service_Statistical_Data_GR.pdf

There is a trend to circulate mainly "success stories" where the children said "once I left the shelter I arrived where I wanted"…"

A psychologist of another shelter said that "*very often children consider that personnel here in the shelter are responsible for the delays as well as for negative developments in their legal cases because they want to keep them in Greece*" and that many times this is the reason for disrespectful behavior of UAC against staff of shelters. In another cases it was noted that "*the decision of Germany to accept fewer UAC per month led to longer delays for some children*"; "*children's disappointment due to additional delays while they already had a positive reply in their request makes them to want some way to go to Athens considering that things will be easier*" said on the same issue a social worker of a shelter located in a smaller city.

Objectively, however, long delays have additional consequence for UAC; many of them are close to 18 years old and they come of age while waiting for some developments; in such cases persons that come of age, in Mytilene for example, should move from shelters for UAC to other structures for people 18+ (with more independent living conditions) and this is an additional change in their life. A child psychiatrist noted that "*there are bigger issues over and beyond our capacity that are directly and indirectly influencing the mental health of UAC. When we talk about MHPSS for UAC we cannot ignore that EU countries close their borders. It is not up to us to fix it but it is the most important issue. Some of the UAC have families elsewhere and they cannot reach them".*

The increased stress of UAC due to their current situation of "uncertainty" was pointed out from many professionals working in the field that cause mental health problems and acute problematic behaviors: "*The current situation is clearly abusive for UAC. The more they stay in Greece like that, the worse the situation will get. They remain in a transit destination for months and months. Then some of them get one or two rejects for asylum or family reunification and need to be sent back to their countries of origin… It is not ok to work with UAC for months to emphasize in their socialization, in tackling their isolation, in building their resilience and then have them sent back to their countries."*

A Social Worker based on her experience with multiple shelters commented on that issue: *"indeed, often children consider that people from the shelters are responsible for the delays in their cases. It's something I expect because the role of personnel in shelters is a bit contradictory in the eyes of the children; I mean they are caregivers and at the same time the ones who "guard" them… so children will not think "it is the agreement between EC and Turkey", instead they will express their discomfort and anguish against the person they see every day…"*

Here there is a contradiction that should be solved: because shelter for UAC is the most stable environment they have so far since the journey has begun, children invest on this environment to make their cases go on. Despite from the beginning people from shelters make it clear that they are not involved in the legal procedures; lawyers (among the most important persons in their lives) and social workers make it clear. On the other hand it is difficult for a child after all difficulties s/he has had to elaborate this information and accept that "these people are responsible for me but at the same time are not involved in my legal request at all"… the misinformation among children, families, smugglers and so on makes the situation even more complex.

Concerning UAC living in camps, the Coordinator of a shelter noted "long-term (often for many months) residence of minors in detention centers (such as in Moria) often either creates or exacerbates any existing psychosocial difficulties. Children who had no similar symptoms previously after their residence in detention centers experienced panic attacks, hysterical crises, self-harm episodes and nightmares. The main problem at borders is the lack of integration policies for children, especially concerning integration in education; opportunities for recreational and educational activities are scarce and this enhances the tiredness and frustration of children while inaction can lead to nervousness and thus aggressive behaviour."

Age of UAC

Issue/gap: often results of age assessment procedures are not accurate; in many cases staff of shelters as well as key-informants noted that they consider that there are many young adults living in shelters along with minors. This constitutes the opposite phenomenon of what was noticed by Human Rights Watch, namely that unaccompanied migrant children are being incorrectly identified as adults and housed with unrelated adults.[1] In both cases minors are vulnerable to abuse and do not receive the appropriate care.

> *"an important issue is child status, namely whether and to what extent children's declared ages correspond to their real ages and how this affects their psychosocial profile, their development and their social integration" (Coordinator of a shelter)*

Challenge: The vast majority (91.8%) of the 730 UAC living in 34 shelters were boys. From the 670 boys 91.9% were the older ones (>14 years old) while 8.1% were younger ones (<14 years old)[2]

Thirteen out of 34 shelters hosted in total 308 male residents, 276 of which were >14 years and 32 were <14 (ratio younger/older UAC 2,5/23,7); there were cases of shelters hosting 31 or 27 older and only 1 younger boy. Fifteen out of 34 shelters hosted in total 326 male residents aged 14-18 years old (half of shelters from 25 to 30 residents).[3]

During the focus group discussions, staff of shelters mentioned that they consider that many of the UAC maybe older than 18 years old, sometimes minors who come of age while in the shelter and in other cases people who were >18 when placed; in this later case persons probably claim to be minors following the advice of other people (including smugglers and other migrants) in the RICs for having the rights and entitlements of minors such as accommodation in the respective shelters, legal aid, and other services. In addition, given that there is a chronic shortage of space for unaccompanied children, placements of young adults in shelters implies longer waiting list for UAC.

> *"It is very important that age assessment is done appropriately from the first service the person contacts, usually the reception and identification service… afterwards, it's very difficult for a shelter to "close the door" to any person who is registered as 16 even in cases they are actually 25 years old … shelter has the obligation to undertake their care and host them" (Social Worker working in multiple shelters)*

Age of residents and response of MHPSS Services: Often child status/age of UAC emerged as an issue directly related to MHPSS necessary services given that MHPSS needs of young adults are not the same with the ones of children.

Hosting two or three 13 or 14 years old UAC along with many older residents, some of them most likely over 18, is a major difficulty for some shelters. The example of a 14 year old boy who was transferred from a camp to a shelter was mentioned. He said to the social worker that he was told that he would go to a house where there are other children and he would be better than in the camp but in the shelter everybody was older. He was wondering "*Why did they lie to me? What am I going to do here?*" The coordinator of a shelter thought that the two younger children in the shelter did not feel safe and mentioned that she is was worried about them.

Staff in some shelters noticed that it is difficult to work equally and adequately with the whole population of the shelter and that they feel that their shelter miss an *identity*; their initial planning (including involvement of

[1]Source: Human Rights Watch(July 19, 2017) "Greece: Lone Migrant Children Left Unprotected" Available at: https://www.hrw.org/news/2017/07/19/greece-lone-migrant-children-left-unprotected

[2] There were also 60 girls (8.2% of the total number of UAC); 41 (68%) were >14 years old and 19 (32%) were younger than 14.

[3] From the remaining 6 shelters 1 hosted exclusively girls and 5 mixed population (boys and girls, older and younger).

volunteers) concerned children and is not the appropriate one for older residents: "*The interaction is difficult. I came here to work with a group of children and instead I feel that I am within a group of peers; …and what about the school? If someone is most likely close to 25 years old to what class should I try to place him? Shelters are not able to choose who will host. Therefore, improvement of age assessment procedures is a necessity or, otherwise, more effective scheduling of placements among the shelters; anyway, child protection means to avoid placement of a child 14 years old along with a group of young adults*". In many cases personnel of shelters are often confused when designing activities, interventions, rules for the cohabitations etc. because the approach of children is different than the approach of young adults. These remarks become more relevant in the context of time: given the fact that some of the adolescents placed in shelters have grown to adulthood over time (while procedures for relocation etc. takes more time than anticipated), the mixture of ages of residents in UAC shelters is becoming more and more perplexed.

A child psychiatrist working with UAC living in shelters and in camps expressed also her concerns for UAC with psychiatric problems saying that she feels lucky that she has experience in adult psychiatry too so she can have counseling sessions with UAC who are in reality adults. She added that, nevertheless, problems arise when it comes to medication since she needs to prescribe it according to the actual age of the person.

Similarly, social workers working with multiple shelters commented "*you know, it happened to us to see the picture of a person and to discuss that the person do not seem to be a child, is not a minor, he looks to be at least 30 years old… we called back to the referee and the answer was that "it's because of the specific picture"… however, more attention should be given on this issue. These people came from countries where even 16 year old boys considered as "men" and often their families send them to Europe to work; as you understand in cases the persons are in reality over 18 it's not easy to treat them as children*". They stressed the need for more effective implementation of age assessment procedures and for a harmonized approach of competent agencies (i.e. RIS and Asylum Service).

Suggestions

The proper procedure to be followed for a precise age assessment as soon as the person arrives in the country (i.e. in the reception and identification services) as provisioned in the relevant Ministerial Decision (2013) setting out a "multidiscipline approach to age assessment" that does not rely solely on appearance or medical or dental examinations but also in interviews with social welfare and mental health professionals.

Mental health professional working mainly in camps noted that there is a clear need for the creation of structures for young adults since, according to him, nearly all UAC currently residing in shelters will be adults by next year. He added that even if they won't be "unaccompanied children" anymore, they will be "unprotected adults" needing support and this could be in the form of structures/houses with a psychosocial rehabilitation and work integration character.

Human Rights Watch also suggests that those who are determined to be over 18 should be accommodated in special housing for young adults and given access to adequate services, including psychosocial support and mental health services.

An adolescents' psychiatrist stressed also the discontinuity regarding cases of UAC who come of age while waiting for asylum as well as the cases of children who eventually granted with the refugee status (once this happens the UASC is not anymore unaccompanied refugee and therefore s/he should leave the shelter and go to a shelter for children-refugees, if there is a place available -otherwise s/he will become a homeless minor refugee). In both the above cases children believed that they are «unwanted»; feeling often leading to MHPS problems.

Sharing of information among services working with the same UAC

Issue/gap: A common finding among shelters hosting UAC was the lack of adequate information concerning children psychosocial and mental health history. The information accompanying the UAC when placed in a shelter (from another shelter or from a camp etc.) is quite restricted (as for example, why the child left his/her home/country, what s/he expected to achieve coming to Greece, how the whole situation influenced him/her, whether s/he has mental health issues). To this end, the shelter should assess all newcomers in order to collect some information for their histories.

"our permanent requests concern: ID file of UAC; standard operational procedures; legislative framework for shelters; and guardianship" (General coordinator of shelters for UAC)

EKKA is already aware on this issue often raised by shelters' personnel. EKKA representative noted that the information following the UAC depends per case on who makes the referral for an unaccompanied child to be included in the system for accommodation in a shelter. In any case, however, social workers from the national service for placement of UAC in shelters noted that no social histories of children can be shared in written with staff of shelters or other professionals because of specific restrictions posed by the National Authority for the Protection of Personal Data.

Challenges: The psychologist of a shelter recognized that it is very important for the information on a child to be shared among the professionals working with the child. In regards to identification of mental health and psychosocial needs of UAC, participants in the discussions often mentioned that this is one of the main weaknesses of the system: every time that an UAC is placed in a shelter (either from first reception centers or from other structure –e.g. camps or shelters) social workers should take UAC's social history and mental health professionals (psychiatrist, psychologist) should proceed with the assessment of his/her mental health. This practice of having to repeat their story again and again is not of benefit for the UAC but is necessary because usually the history of the child does not follow him or her. An adolescents' psychiatrist noted "*They (i.e. people from camps or shelters) often send us children who have already spoken with so many people. Instead of this being useful, it confuses children and makes them think "what history they want to hear about me" because, as you know, they often come to get a certificate or a paper on asylum. They have heard, for example, "he said that you are not asleep the night and you will go sooner from Chios to Athens"; the result is the child to confuse us or the opposite … In general, there is no sharing of information and this is traumatic because the child constantly tells his/her story and rehearses the traumatic experiences.*"

According to the staff of shelters, information especially for MHPS issues of children is not shared because everybody worries that a child with a history of mental health problems will not be accepted to the structure where s/he is placed while at the same time, changing of living conditions (e.g. changing of shelter) is often considered that will help the child to resolve some problems. Social workers from EKKA explained: "*Let's take it from the beginning: First of all, it has to do with where the request for housing of the child has been made. Police, for example, says "we arrested this person that day" and provides demographic information. NGOs that usually have a Social Service have the ability to get a better and more complete history of the child (the quality of history depends, of course, on the professional and his/her experience, the interpreter, the communication, the language, etc.). From NGOs we receive usually more information about the child concerning the country of origin, the reasons why s/he left the country, about the trip, etc. The Reception and Identification Centers, which are another source of referral, use usually a standard document with tick-boxes, unless they consider for a child that s/he should be seen by the psychosocial group (usually from an NGO). The standard document gives us an idea about the child but not detailed information. Anyway, quality of information for UAC from RICs depends on the period we are looking at (when we have a large inflow, there is no time for them to get more information and histories are more typical). In addition, quality of information has to do with the child: s/he has just arrived*

in Greece and s/he has in front of him/her two strangers, a social worker and one interpreter asking him/her to provide them with personal information… So, depending on the referral, the information accompanying the UAC and reaches the EKKA may be from very detailed to just the demographics. In any case, however, we are not allowed to share this information in written because the authority for the protection of personal data forbids it."

Currently applied practices

Avoidance of multiple interviews: In the camp located in Skaramanga a child protection team working with unaccompanied and accompanied refugee children released a set of instructions for professionals working with children; they recommend to relevant parties, among others, to avoid multiple interviews with the children living in the camp.

Preparatory work with professionals: An adolescents' psychiatrist working with UAC living in shelters and in camps, recognizing the problem of the multiple interviews often due to lack of information sharing and relevant experience of shelters' personnel, explained how she and her colleagues trying to deal with this issue: "*after the referral but before the first contact with the child we are trying to work with people from shelters, the person of reference, the lawyer or the guardian as if they were family or parents of the child; following such a preparatory work we decide whether there is a need to talk to the child too. Often we realize that we have to do with a member of the staff who is in panic because a child showed confidence and during a discussion they had s/he confessed that "I had thought to commit suicide in the past"; in such cases the person does not think that the child is doing better (because when the child relaxes s/he talks for personal issues) but thinks "s/he needs a psychiatrist"; then s/he stops to talk with the child and addressed to us*". In such cases it was suggested that personnel working with UAC should be further trained and sensitized on issues relevant to adolescents' behaviors rather than additional interviews of children.

Adoption of screening and follow-up procedures for mental health issues: A child psychiatrist mentioned that it was among their priorities to set up a system to screen all new-coming UAC for mental health issues, and then perform a follow-up evaluation after 3 months planning to use WHO tools.

Strengthen the role of EKKA in information sharing via networking of relevant stakeholders: In the context of a FG discussion with shelters' coordinators the development of a protocol was suggested or even of an electronic system for UAC-specific accompanying information; specifically it was proposed that EKKA, during the process of placing an UAC, could communicate to social service/ professionals of the shelters somewhat more detailed information on the children, especially those identified having mental health or special psychosocial problems.

As for the shelter to shelter communication it was also suggested that it should be more comprehensive (e.g. common protocols for initial assessment in first reception centers or camps) as currently shelters often avoid to share information of UAC re-allocated in other shelters in order to avoid negative replies (as usually the UAC leave a shelter because there are problems there). Social workers working with placements of UAC in shelters nationwide said: *"our service is able to network relevant services per UAC such as previous with current shelter and source of referral with the shelter. In cases that we realize that there are some difficulties we are contacting the Social Services of shelters and provide them information that will be useful for them but not in written. We are actually in open communication with the shelters, especially concerning children who have been involved with the system in some way –often because of their behaviour. When needed, we bring in contact social workers of the referral with social workers in shelters; to our opinion they should be always in contact; however this happens only in specific cases. We are trying to support this contact because professionals from the source of referral know the*

> *"to our opinion social workers from shelters should always be in contact with social workers from services make the referrals"*
> (Social Workers, EKKA)

child… Our service has a main weakness -we are not able to have personal opinion for children as we never see the children; we have a very comprehensive idea for the system as a whole (number of UAC, number of shelters, of available places and so on) but no direct information for specific cases. We prioritize the vulnerability of children on the basis of information we receive from the sources of referral and afterwards we proceed in their placements in shelters."

MHPS problems of UAC related to practical difficulties

Issue/gap: There is a problem with public services response when it comes to UAC day-to- day life and aspects influencing their mental health and well-being. People working in services are confused or unaware of the legal framework or sometimes they do not want to implement what is prescribed.

Challenge: During focus group discussions as well as interviews with key-informants, a recurring subject was the practical problems that UAC have to face; these issues affecting their day to day life and adding up to their stress are, indicatively, related to acquiring AMKA number, registration at school, parental/guardian consent in various cases for practical everyday issues such as buying SIM cards, money transfer from families to UAC, participation in community sport clubs or other activities, etc. In addition to the stress these situations put upon UAC, they also require extended amount of time from the professionals working in shelters who need to visit, for example, several KEPs in order to make it possible for an UAC to acquire AMKA or various schools in order to find a school principal who will accept the UAC in their school. At the same time, especially outside Athens, shelter professionals tend to accept this situation as a "necessary evil" because they want to maintain good or at least undisturbed relationships with the local communities. A teacher in Lesvos mentioned that she had three negative replies from schools before she was able to find a school that would accept an UAC as a student. She added that school principals are confused, they don't know what is needed, whether it's ok for UAC to enroll during the school year, what vaccinations they need to have had in advance. She also mentioned that in her experience it's not always about confusion; principals may just feel pressured by parents (of native students) and they don't know how to deal with it. As mentioned by a social worker in Thessaloniki area *"We know that we shouldn't accept no for answer, we know it's bad for the children; but what can we do? We have to live in this neighborhood; we don't want to disturb them"*.

A shelter professional in Athens stated *"It is not ok to have to look for the "good" social service, for the "good" KEP. It is not ok to have to look for the "good" school principal to enroll UAC to schools. It is not ok for hospitals to interpret the law whichever way they want to"*. She added *"Regarding practical issues, it is very hard to make an appointment with public hospitals- we cannot call 1535 directly, we need to go through the National Health Operation Centre (NHOC) and this is not practical. NHOC is really busy… they call us back after 2 weeks to let us know that they arranged an appointment for 3 months later. This way they step upon an already bad and difficult situation (UAC in need of medical assistance) and make it even more stressful for both the child and the staff.*

Good practice: No specific good practices on the topic were recorded. However, common request from professionals working with UAC was the preparation of a brief document/guide with clear directions providing solutions to practical barriers, common for all shelters for UAC to be shared among them but also to be distributed (stating, for example, in a simple way but also citing the relevant legislation what documentation is needed for registration in school).

Services for hosting young adult refugees

Issue/gap: The absence of shelters for hosting young adults for a transition period for mainly a) the ones who have lived in shelters as minors and came of age during their stay there and also b)the ones identified as >18 based on a secondary age assessment

Challenge: Since most of the UAC are adolescents, the ones being over 17 years old come of age during their stay in the shelter. Since they are not minors anymore, there is a gap on what shelters should do with them. In some cases they are sent to camps, in other cases they remain in the shelter together with adolescents or younger children.

Apart from the challenges occurring as well as the potential risks of adults-children cohabitating within the same structure, the above mentioned situation keeps behind young adults when it comes to their day to day life and in acquiring the skills for living independently in Greece or another EU country. As a psychologist working with UAC mentioned: *"There is a clear need for the creation of structures for young adults. It is my perception that nearly all UAC currently residing in shelters will be adults by next year. Sure they won't be "unaccompanied children" anymore but they will be "unprotected adults" needing support. These should be structures/houses with a psychosocial rehabilitation and work integration character".*

Good practices: No good practices were recorded in the issue. During focus group discussions and interviews with key informants the development of new services was suggested; these new services should have a "transitional" character and address mainly the age group of young adults (e.g. >18-23), targeting the real needs of this special age group instead of treating them as minors, as, for example, provide them with options for young adults' education (e.g. vocational training in order at a later time to be able to find some employment).

Guardianship-related issues

Issue/gap: Given the particular characteristics of unaccompanied children as well as their numbers, the effective exercise of guardianship functions by temporary or permanent guardians becomes particularly difficult, resulting in children not being able to enjoy the protection and rights enshrined in the Convention on the Rights of the Child.

Challenge: As mentioned in previous chapter one of the most important shortcomings of the existing legal framework in Greece is the regulation of the guardianship institution for UAC which unfortunately is still due. This combined also with the lacking of provisos for alternative, non-residential placement of UAC (i.e. foster placement[1]) results in further complications allowing only for residential care placement combined with execution of temporary guardianship only by public prosecutors. At the same time trying to partly cover the legislation gaps there exist the "Members of Guardianship Network" (i.e. METAdrasi) acting as informal guardians in several cases. These persons are not guardians in any legal sense but acting under public prosecutors (still being the temporary guardians for UAC) in order to represent children for specific acts such as the asylum procedure, medical care, education.

Several MHPS-related issues deriving with the complex guardianship situation emerged during the field work. In some cases the roles of shelters professionals and "Members of Guardianship Network" are confused and it is not rare for them to disagree when it comes to decisions concerning the UAC. Even in the cases where they don't have disagreements there is often confusion regarding responsibilities and timelines (e.g. who is going to make doctor appointments and when) or regarding informing or misinforming the UAC in subjects related to their asylum procedure.

When it comes to the prosecutor as the formal guardian of an UAC several problems were also reported; Prosecutors were in many cases "overloaded" with UAC so they did not have the time to personally deal with UAC's issues. It was also often mentioned that prosecutors did not want to take the responsibility for children they don't even know. As a teacher in Lesvos mentioned, in one case the prosecutor did not sign the consent

[1] According to existing national legal framework, lawful guardians are entitled also to preform foster placements for minors under their custody.

form for several UACs to participate in a school day-trip. As a result UAC were excluded from their classroom trip and felt discriminated. She added *"School and school trips in particular are all about socialization…Just imagine how they [the UAC] felt when we had to tell them that they cannot go the trip with their classmates"*. In another case, the Prosecutor failed to sign the documents for UAC to be able to participate in the football championship for which they had been preparing for months.

Good practices: No good practices were recorded in the issue.

MHPS problems of UAC related to policy or general societal aspects

Issue-gap: Apart from the issues covered above there appear to be broader policy or society-related issues.

Policy-level problems One of the most highlighted issue is the lack of a competent authority responsible for UAC-related issues. It is of critical importance, that if a responsible Authority charged with the duty for the protection of minors is not established, well-staffed and running – which would eventually lead to the development of the necessary protection framework – no institutional steps may be taken towards desirable direction, i.e.: the creation and step by step upgrade of a structured system for the protection of minors (including those in need of MHPSS).

One specific issue mentioned had to do with the limited funds provided for UAC, for example for children's pocket money. Though not directly related to mental health, funding of shelters has a huge indirect impact on UAC's MHPSS through several pathways related to number of shelters, of personnel and of available services. As mentioned by a professional in Athens "*Not all solutions can be cost-free or cheap! There need to be funds if we want to really tackle the problem; volunteers and recreational activities cannot solve the problem. Sure the government says "There is no money" and we know it's true. But then they ask from us to come up with solutions that are not costly. This can be a never-ending discussion: they say to us "Do something to find cheap solutions", we say to them "Do something to find money"*.

For example, in most cases UAC have no pocket money at all and this creates all kind of MHPSS-related problems.

Challenge: As highlighted by a psychiatrist working with UAC "*When they have no money at all it means that they can't be independent. They go out for a walk, for a coffee and all they have is the bus ticket that the NGOs provide for them… As a result the get sad and also angry with the staff because sometimes they believe that NGO' have EU funding for UAC pocket money but don't give money to the UAC"*. It was also mentioned by several professionals that the absence of pocket money makes UAC much more vulnerable in participating in illegal activities putting them sometimes in really risky situations.

Challenge: It was also reported that *"All UAC should be able to enroll to school but currently there are not enough places in multicultural schools and reception classes in other schools are not always available (even when there is a provision by law). There need to be more places, more teachers…this takes some funding"*.

Society-related problems: Often the discussion focused on mental health difficulties induced by the current situation and especially in the negative attitude of the community against UAC.

Challenge: There were several cases mentioned in which UAC were victims of racist behaviors. For example, there was a health professional in a hospital located in Athens who didn't want to provide care to an UAC because of his origin; a priest in an church in a smaller city who asked "documentation" of Christianity in order to give to the child the holy communion; police officers who arrested and led UAC in custody because they didn't have on them their original papers but just copies; habitants in a neighborhood who complaint to the local authorities about UAC sitting in a park *"where families go"*.

Participants suggested that preventive interventions at a community level are necessary including sensitization/ informational activities with the communities/ services in order to prevent bad experiences of UAC and, as already mentioned, the production of short but clear material (leaflets/ booklet etc.) to inform public services regarding UAC rights (e.g. responsibilities of mental health units of hospitals, of health services, of police e.g. that UAC can have copy of their papers rather than the prototypes along with them when outside of the shelter).

Education

Issue/gap: Education is not always an option for UAC.

Challenge: Education was consistently mentioned as a MHPSS related issue need especially for areas where reception classes and/or cross-cultural classes in schools are not adequate or doesn't exist at all; some UAC go to school but face difficulties with the language and therefore their assessment by respective services (e.g. by KEDDY for learning or other difficulties) are not feasible especially considering that validated assessment tools for children deriving from specific countries are now widely available. A problem that was mentioned often were the difficulties of enrolling UAC in school (either due to practicalities or because there were no available places in reception classes or there was no cross-cultural school).

Professionals from different backgrounds and in different geographical areas seemed to agree on the significance of school attendance for UAC. In Lesvos a teacher mentioned: "*The importance of school for refugee children is dual: the most important thing is that they are finally getting into a routine, even if it's for a few hours per day. Adolescents in shelter spend all night awake; then they sleep all day. They move around like they have no purpose, nothing to do. With school they wake up and need to be at some place every day. At the same time, school offers them a means to achieve their final goal; almost all of them want to get out of Greece. They feel they need to learn new things and especially English*".

From several reports the majority of UAC seem to enjoy going to school. "*We hear that children are angry or violent in the shelters… We have a completely different picture at school. They seem to really respect school, the place, the procedure*" mentions a teacher in Lesvos. A psychologist in Athens agrees: "*…Children are really suspicious and skeptical and don't want to accept help in their day-to-day life. They are very negative towards interventions and services addressed only to refugees. However, when it comes to services concerning everyone they tend to be positive and accept them. Take school for example; they want to go to school, they are very positive, they enjoy it*".

Good practice: NGO Iliaktida run a number of shelters for UAC in Lesvos created an alternative cross-cultural educational center addressing UAC who weren't able to attend existing schools for various reasons. This maybe is a good practice to be considered especially in areas where there are no appropriate educational structures for UAC.

Shelters

Standards of operation

Challenges/Suggestions: A lot of discussion on current response of shelters to MHPSS needs of UAC focused on operational aspects of shelters. Currently each shelter develops and applies its own procedures to handle mental health or psychosocial problems of residents in a more or less effective way; participants in discussions suggested that development and application of common operational standards for all shelters for UAC and evaluation methods are necessary and directly relevant to effective response to MHPSS needs of UAC. Such standards can, for example, be related to shelter characteristics: concerning the size of shelters it was suggested that smaller shelters (hosting up to 15-16 persons) are better-operating in comparison with large

shelters (e.g. hosting 30-40 persons), regardless the number of personnel. Other opinions were relevant to the staff composition such as the suggestion each shelter to have a physician on call (staff or volunteer) in order to make the decision whether an UAC needs to go to secondary health units (hospitals) or not. As for the geographical distribution, it was suggested that shelters may be distributed more equally throughout Greece (in other words avoid concentration in specific cities such as Athens, Mytilene) in order for the hosted UAC to receive better services (in terms of quality and timeliness) for mental health/ health/ educational and other issues; to be easier for them to integrate in local societies and to protect them more effectively from being involved in illegal networks and activities.

Placements

Generally the shelters are designed to accept all nationalities. However it has been noticed that Afghanis and Pakistanis are in constant tension. On the other hand, several shelters host different nationalities and are doing well. In paper, there is no provision for this. As EKKA representatives mentioned: *"… Administratively there is no provision for this issue and the child should be accommodated. I will put the child where there is an available place and not where he/she will cause no tension. It is a dynamic, fluid situation; what positions there are available, where they are located, how many vulnerable children I have to place. But I have to protect them and accommodate them where there is a place … even if the shelter would not receive it, not to create tension. At the same time, we try to protect each shelter as much as we can, when it's possible"*

A psychologist mentions: "*There is certainly still a large number of UAC in camps. However, in no way I consider shelters to be "perfect places" especially in the way that they are currently operating. There are no standards of operation and no evaluation; everyone does whatever they think fits best to the situation. Nevertheless I believe that their work is very, very difficult. They are certainly in need of any kind of support and professional supervision"*.

Shelters' structure

Population of UAC: In many cases representatives of shelters mentioned that they worry for the physical and mental health of younger children (up to 15 or 16 years old) hosted in their shelters, often representing one or two minors among 20 or 25 older UAC. Providing that younger UAC are considerably fewer than the older ones, it was suggested the revision of the age criterion for placements from $\geq$14 years old to $\geq$16 old (in this way it would be ensured that more of the younger UAC will be placed separately from the older ones).

Capacity building: Almost every participant in the FGDs mentioned that initial and ongoing training of UAC shelters' personnel is necessary as well as relevant material covering a variety of subjects such as practical issues, legal issues, cultural issues etc.; in 2014 NGO Arsis developed a is a *Methodological Guide for Reception, Support and Protection of UAC living in Residential Care*. Among the main sections of the Guide included the legal framework for the shelters for UAC and for the rights of UAC; services of primary social care; services provided within service; and service and community. According to the Arsis Coordinator for the Shelters of Central and Northern Greece *"this Guide consists the basic tool upon which every member of Arsis shelters' personnel "build on" in his/her everyday work with UAC"*. It would be a good practice to build upon this guide in cooperation with Arsis, by updating its content and add necessary material and information for UAC MHPSS needs and services with the contribution of all relevant stakeholders and the revised version being used by all organizations run UAC shelters.

Composition of teams: In a few FGDs staff (coordinators/ caregivers/ interpreters) with the same ethnic background as the UAC (e.g. ex-UAC asylum seekers who decided to remain in Greece) participated; according to shelters' representatives it seems that it is a good practice to have among the staff people that know how UAC think, their culture particularities and, of course, their mother tongue.

Appropriate staffing/ not frequent movement

Apart from standards for the shelters' operation a number of suggestions that discussed were relevant to the personnel working with UAC: first a need was noted for clarification of roles among caregivers, guards/security staff, educators and other personnel (e.g. cooks). Capacity building needs were also stressed and specifically the need for common and systematic training of personnel (including social scientists, caregivers/guards/pedagogues, supportive personnel) on a range of issues following a common training module for newcomers (initial training) and for existing personnel (continuous training); the content of such a training should include -among others- cultural issues related to countries of origin of UAC, legal issues (related to UAC relocation, family reunion, asylum seeking, re-assessment of age, guardianship), other issues as first aids etc. In this way frequent misunderstandings could be avoided as for example cases where professionals mentioned that they did not consider UAC self-harm incidents as severe because they think it's cultural for UAC with specific ethnicities. Apart from trainings, professional supervision for social scientists as well as for the care givers were discussed in order for them to respond adequately in UAC MHPSS needs within the shelter. It was mentioned that there are difficulties in finding and recruiting appropriate personnel (e.g. SWs in northern Greece), that often shelters are under-staffed and shifts especially during the nights have one instead of 2 at least caregivers/ guards/ pedagogues and that there is a continuous flow of personnel among shelters (while personnel should remain for appropriate time intervals in a structure and not to move very often disrupting the relationships that they developed with the UAC).

Definition of roles among shelter's staff

Some organizations focus mainly in the pedagogical character of the shelter and the critical role of the pedagogues/caregivers who are at the same time the persons of reference for UAC; they also stress the importance of the rules for the cohabitation (such as rules about the time the children should be in the shelter and the time of sleeping) and focus on the prevention of mental health problems through the establishment of very strong relationships and bonds between UAC and his/her pedagogue –practice implying that frequent turnover of personnel of the shelter is generally avoided. When difficulties are more complicated, pedagogues/ caregivers involve mental health professionals working in the shelters (usually psychologists). This may happen when, for example, children asking for drugs in order to sleep or calm; in such cases mental health professionals apply relaxing techniques in the context of weekly individual or group sessions. It was mentioned by several professionals that "*… guards should be outside the door, they should not have any other role*".

In addition it appears to be more beneficial for the UAC with increased mental health needs when they receive psychotherapy/counselling from psychologists from services outside their shelter As stated by professionals working in such service: "*The service is built primarily to create a clear division of roles for the professionals working with UAC. In all shelters there are 1 or more psychologists who are the contact persons for some the UAC; these persons cannot be responsible for psychotherapy and counseling sessions with the child. Let's say that a native child in Greece has parents who are psychologists; would they have counseling sessions with the child? No way!*

…Also, except for limited and very urgent cases, the personnel of the Unit do not visit UAC in the shelters. The very fact that UAC have to get out of their shelter (in some cases they need to travel for 1-2 hours) implies a "procedure", a commitment; this commitment should be perceived as part of the therapeutic process."

Capacity building of staff

The need of systematic and possible common training of personnel (including social scientists, caregivers/guards/pedagogues, supportive personnel) on a range of issues following a common training

module (probably) was a recurrent issue in all discussions. They expressed the need for training for newcomers (initial training) as well as for existing personnel (continuous training)

The content of the training should include among others cultural issues related to countries of origin of UAC, legal issues (related to UAC relocation, family reunion, asylum seeking, re-assessment of age, guardianship), other issues as first aids etc. (example: self-harm: many professionals do not consider it very serious because they think it's cultural for UAC with specific ethnicities)

Accordingly, apart from the professionals in shelters, training of professionals in other positions, such as referrals, is also needed.

Good practice: As an example the Child Psychiatry Unit of Praksis visits all Praksis shelters every 2 weeks. Emphasis is given in strengthening professionals in general but also in handling specific cases. These visits are not like lectures; they are discussions through which professionals are trained. In each meeting they bring up new cases to talk about irrespectively of whether or not they will be referred to the Unit.

6. Conclusion

One should bear in mind that there is nowadays a growing body of evidence documenting the increased incidence of mental health and psychosocial issues in UAC resettling from low income to high income countries[1],[2]. These issues are not only related with traumatic experiences (which are anyway a predominant determinant of psychopathology in this population[3]) but also with present state hardships as well as adjustment problems in the new social environment and its challenges for UAC[4]. Given also the fact that the most of the UAC are in adolescence this often gets perplexed with behavioral and emotional challenges of that age[5]. It has also been demonstrated that adolescent UAC face additional barriers in using health services and especially MHPSS in virtue not only of linguistic and cultural differences but also due to prevailing perceptions of all involved parties (their own perceptions on mental health issues and treatment as well as on accessibility of MHPSS[6], professionals' attitudes on their problems and potential capacities for cure, caregivers perspectives on prioritization of their needs).

In Greece, where the "core" domestic laws has not yet been modified towards a successful, effective and most of all comprehensive management of this vulnerable population, the well-being, protection, access in public services and inclusion in the society of migrant and refugee children is severely hindered. One crucial issue which inevitably affects UAC's MHPSS is also that regarding general legislative provisos for child protection in Greece there is considerable fragmentation as pieces of legislation on child protection have introduced several provisos in different points of time regulating the mandate action and capacities of different involved services. These fragmented measures introduced and provided for by different laws and presidential decrees in the course of time sometimes result in contradictory or overlapping actions lacking coherence and consistency. Therefore, the necessity of a comprehensive unique piece of legislation (i.e. framework law) on child protection that has been raised in overall for child protection legislation in Greece is also relevant to the provision of effective and efficient protection to UAC as well.

By following a mixed methodology based on desk review, the completion of an online form and focus group discussions with shelter coordinators and staff as well as semi-structured interviews with key-informants, findings from this assessment suggest that the majority of UAC currently living in shelters in Greece face more or less similar MHPSS issues; some of them pre-exist and others are emergency-induced. The more the UAC stay in Greece their psychosocial problems appear to decrease while their mental health problems increase. The most common experienced problems appear to be difficulties in sleeping at night, aggressive behavior towards the shelters' staff and self-harming behaviors followed by sadness, isolation and withdrawal leading often to unwillingness to participate in everyday activities. Less frequent but nevertheless worth noticing problems were the sexual assault of other children, committing crimes, engaging in high risk sexual behavior,

[1] Guruge S., Butt H., (2015). A scoping review of mental health issues and concerns among immigrant and refugee youth in Canada: Looking back, moving forward, Can J Public Health. 2015 Feb 3; 106(2): e72-8.

[2] Marquardt L., Krämer A., Fischer F., Prüfer-Krämer L., (2016). Health status and disease burden of unaccompanied asylum-seeking adolescents in Bielefeld, Germany: cross-sectional pilot study, Trop Med Int Health. 21(2):210-8.

[3] McGregor L.S., Melvin G.A., Newman L.K., (2015). Differential accounts of refugee and resettlement experiences in youth with high and low levels of posttraumatic stress disorder (PTSD) symptomatology: A mixed-methods investigation, Am J Orthopsychiatry. 2015 Jul; 85(4):371-81.

[4] Joshi P.T., Fayyad J.A., (2015). Displaced Children: The Psychological Implications, Child Adolesc Psychiatr Clin N Am. 2015 Oct; 24(4):715-30.

[5] Hirani K., Payne D., Mutch R., Cherian S., (2016). Health of adolescent refugees resettling in high-income countries, Arch Dis Child. 2016 Jul; 101(7):670-6.

[6] Majumder P., O'Reilly M., Karim K., Vostanis P., (2015). "This doctor, I not trust him, I'm not safe": the perceptions of mental health and services by unaccompanied refugee adolescents, Int J Soc Psychiatry. 2015 Mar; 61(2):129-36.

and recruiting other children in illegal activities. Findings also reveal that certain behaviors such as juvenile delinquency and substance abuse were reported more frequently in Athens and Thessaloniki than in smaller cities (Mytilene and Alexandroupolis). Regarding the more severe cases of mental health problems, the most frequent diagnoses given in UAC are either mood (affective) disorders (specifically "*persistent mood [affective] disorders*" including cyclothymia, dysthymia, and other persistent mood [affective] disorders) or neurotic, stress-related and somatoform disorders (specifically "*reaction to severe stress, and adjustment disorders*" including acute stress reaction, post-traumatic stress disorder, adjustment disorders and other reactions to severe stress). From these it occurs that shelters' staff has to mainly deal with specific events/ outbursts rather than with chronic mental health problems /psychiatric disorders.

Taking into account this information along with the types and prevalence of worrying signs seems that currently the main problems of UAC are primarily acute cases of psychological nature induced either due to emergency or due to current situation where UAC live and usually concern behavioral aspects rather than severe psychiatric conditions. Size of shelter and ratio of professionals per UAC appear to influence the manifestation of MHPSS problems; results suggested that although chronic cases of MHPS problems do not differentiate among shelters of different size and staffing, the reported acute cases seem to be fewer in smaller shelters with higher number of staff/UAC ratio.

Regarding management of MHPSS cases, findings indicate that, in most cases, they are managed internally, within shelters; staff of shelters and in particular social scientists undertake cases relevant to UAC everyday concerns, integration with the life in shelters and the relationships of children with other children and/or staff members but also cases related to educational and other activities issues. Sometimes, staff of shelters asks for the support of services outside the shelters. Cases involving self-harm behavior and substance abuse by the UAC were also reported; when proved that caregivers are not able to help UAC sufficiently then the child is referred to external services operated by either the public sector or non-for-profit NGOs such as Babel mental health center in order for the child to receive more specialized support. It should be noted that almost all representatives of shelters located in Athens mentioned that refer UAC specifically in Babel; they are generally satisfied from the quality of services they receive but often noted that because of the number of cases appointments with child psychiatrists, for example, need a waiting of at least two weeks. There is neither an effective referral system to provide for appropriate steps nor a system for registering cases of UAC referred to MHPSS.

More severe cases, usually cases of UAC with diagnosed mental disorders and especially those at an acute phase are those that almost all shelters are not able to respond adequately and, therefore, they refer UAC to more specialized services such as child and adolescent psychiatric departments of public hospitals. In rare occasions (less than 20 referrals nationwide for the first semester of 2017 some of which concerning the same individual), prosecutors' orders are issued for involuntary clinical assessment of UAC with the question of potential psychiatric hospital admission (upon a request of shelters' personnel when the case is not possible to be handled internally in the shelter). Throughout the last years though only a few UAC were eventually hospitalized within the context of the aforementioned procedure; some of which only for a few days since at its most these cases were cases of emotional and behavioral disturbances rather than a stricto sensu mental disorder cases.

Further to that, there seems to be a challenging situation regarding follow up of cases of UAC requiring MHPSS. In some cases clinicians providing treatment ignored what happened to UAC after their discharge. In other cases reported there residential care facilities refusing to take the UAC back after discharge. There was limited information of efforts dedicated to relapse prevention in cases of UAC with mental health or psychosocial issues including caregiving personnel's involvement in the treatment. Obviously there is a gap in

procedures applied in terms of formalizing appropriate steps to be taken from identification of an issue and referrals to follow up and long-term individualized care plans for UAC with such issues.

Apart from the issues related purely with mental health conditions and problems, the findings of this assessment also highlight a wide range of challenges that indirectly affect UAC's mental health and well-being. As mentioned by nearly all participants, long delays in asylum seeking (or other relevant) procedures in combination with UAC being misinformed by various "significant others" (e.g. parents/relatives back home or another EU country, peers, traffickers etc.) adds up on the stress, sadness and withdrawal of UAC. Sometimes it triggers aggressive behaviors and in some cases self-harm and even suicide attempts. Another issue raised was that age assessment procedures are often not effective; in many cases staff of shelters as well as key-informants noted that they consider that there are many young adults living in shelters along with minors leaving the former not able to receive age-appropriate care and services and the latter potentially vulnerable to abuse. In addition, the absence of shelters for hosting young adults for a transition period for mainly a) the ones who have lived in shelters as minors and came of age during their stay there and also b) the ones identified as >18 based on a secondary age assessment makes the situation even more difficult when it comes to finding options for older UAC/young adults.

Moreover, practical problems making harder the life of UAC and clearly affecting their mental health were also recorded. First, there appears to be a problem in public services response when it comes to UAC; people working in services are confused or unaware of the legal framework or sometimes they do not want to implement what is prescribed. Also, a recurring theme by participants during the assessment were the fact that education is not always an option for UAC often due to limited resources in public school, bureaucracy, as well as confusion regarding UAC's right of enrolling to school. The confusion in the legal framework regarding UAC's guardianship resulting to various limitations in options for UAC everyday life was also highlighted by the majority of the participants in the assessment.

Furthermore, the results of this assessment suggest that operational aspects of shelters need to be reconsidered. Currently each shelter develops and applies its own procedures to handle mental health or psychosocial problems of residents in a more or less effective way; it was suggested that development and application of common operational standards for all shelters for UAC and evaluation methods are necessary and directly relevant to effective response to MHPSS needs of UAC. Lastly, with regards to shelters operation the need of training new as well as older professionals and provide them with professional supervision was a consistent finding in all focus group discussions.

Taken together, findings suggest that although many steps forward have been made in handling MHPSS needs of UAC, there are still much more to be done. Given the conditions leading them to leave their home countries, the hardships they faced prior to their entering Greece as well as their present state it is expected that all the traumatic circumstances represent potential risk factors for them developing in due course a series of psychosocial and mental health issues. The fact that they are still staying in Greece despite their initial planning and wishes make them even more vulnerable MHPSS-related problems highlighting at the same time the imperative need for a more comprehensive approach when it comes the response of the relevant services.

7. Recommendations

Problem statement

As expected there is a considerable burdening of UAC compared to general children's population in terms of reported frequencies of mental health signs and symptoms as well as psychosocial conditions requiring clinical attention; this fact results in greater recognition of the necessity for taking action to improve access of UAC in MHPSS for addressing such challenges[1].

While the most highlighted type of issues seems to be aggressive behavior and the like, the reported prevalence of withdrawn types of symptoms is even higher and could represent a threat to the mental health of UAC in due course: for instance from shelters' reports it seems that an 11% of UAC manifests aggressive behavior versus almost 33% withdrawn and depressive one.

Most reported conditions refer to symptoms, behaviors or reactions; the overtly opened psychiatric disorders' cases were reported in relatively lower frequencies. Resulting from this, preventive actions are of paramount importance for abstracting current under-threshold conditions becoming clinical disorders.

Ways forward

To address such challenges a series of measures could substantially improve current situation. Although these measures can be linked to one another, they can be better illustrated as clustered in the following dimensions[2]:

Primary Care

This dimension is the most essential since preventing UAC from manifesting mental health disorders or challenging behaviors as well as addressing premorbid conditions, under-threshold symptoms and "soft" signs could be the most effective strategy to tackle the issue. Moreover, it is well documented that addressing such mental health challenges at an early stage is more cost-efficient and prevents further implication which otherwise might appear. Applying a comprehensive approach for primary prevention would entail:

- *Promoting early detection and identification of UAC with mental health and psychosocial issues:* a comprehensive capacity building program for all scientific and care-giving personnel of residential care shelters could improve their ability to trace UAC with related issues; this is especially important for internalizing mental health symptoms and signs which were found to be predominant from the data collection within the context of this assessment. Training schemes for shelters' personnel should be developed by Ministries involved with technical assistance from the respective scientific community,
- *Raising awareness of UAC for mental health issues and availability of effective care:* as it has been documented UAC might have limited health literacy, reproduce stereotypical perception on mental health disorders and their potential treatment, mistrust mental health services or be discouraged by bureaucratic or administrative procedures in accessing MHPSS[3]; consequently, addressing these issues might improve substantially the collaboration between UAC and respective services and increase assistance seeking from their behalf. A separate module on such mental health promotion and awareness raising program should be on substance and alcohol abuse and one on exploitation and victimization provided by specialized

[1] UNHCR/UNICEF, (2017). The Way Forward to Strengthened Policies and Practices for Unaccompanied and Separated Children in Europe, p. 25.

[2] http://www.euro.who.int/en/health-topics/Health-systems/public-health-services/policy/the-10-essential-public-health-operations/epho5-disease-prevention,-including-early-detection-of-illness2

[3] Majumder P., O'Reilly M., Karim K., Vostanis P., (2015). ibid.

agencies in an age and culture appropriate mode. Awareness raising programs should be developed by authoritative Ministry and conducted by various agencies with respective capacities.

- *Enhancing opportunities for structured learning and social inclusion:* given the psycho-traumatic nature of the relative alienation experienced by UAC in relation the host society[1], all measures promoting their social inclusion may contribute to reducing feelings of anger, frustration, isolation and helplessness, which if unchecked, could evolve into full-fledged mental health conditions. Resulting from this, and in accordance with UNHRC/UNICEF pan-European recommendations[2] and UNHRC recommendations for Greece[3] all measures to encourage school attendance, vocational or informal education, sports, leisure and other social activities of UAC would contribute to minimizing the individuals to eventually exhibit conditions requiring clinical attention. To that end, structured programs providing with daily activities could be of paramount importance since according to reports a considerable number of unaccompanied adolescents have a relatively unstructured daily schedule with little or no activities to engage them with. As mentioned in previous chapters, Pharos School-Based Education Program for Refugee Children in the Netherlands and Changing Cultures Program for Refugee Youth (Australia) could serve as examples of good practice on the topic. Moreover, legal reform for appointment of legal guardianship would enhance all social inclusion activities to be tailor-made to individual inclinations, capacities and needs of the UAC. Furthermore, a respective legal reform for allowing for lawful foster placement is expected to improve situation as it is well-established that institutional residential settings (such as the current shelters) or even more camps (like in the safe zones) rather increase than decrease psychiatric morbidity. On the contrary applying foster placement as an alternative to residential care could provide a more supportive setting and a reparatory experience to these minors which in turn is documented that could reduce late onset mental health disorders' occurrence[4].
- *Expanding the range of options for community based care:* Legal reform to support the development of community-based alternatives to residential care, including foster care, supported independent living and other modalities, should be pursued. It is well-established that institutional residential settings (such as the current shelters) or even more in sites (like in the safe zones) increase rather than decrease psychiatric morbidity. On the contrary applying community-based care through for example foster placement as an alternative to residential care could provide a more supportive setting and a healing experience for UAC which in turn could reduce late onset mental health disorders' occurrence.
- *Strengthening relationships of trust between UAC and caregivers:* strengthening human relationships with caregivers can contribute substantially in minimizing manifestations of mental health issues or challenging behaviors but also in managing such conditions if occurring. To that end a comprehensive training scheme for UAC care-giving personnel should be developed in order to promote strengthened relationships of trust between UAC and caregivers – this could focus on dealing with cultural differences, working with traumatized children, and addressing challenging behaviors of adolescents, among other issues. Relatedly, developing operating procedures clarifying the distinct roles and functions of professionals employed in

[1] Joshi, P. T., & Fayyad, J. A. (2015). Displaced Children. Child and Adolescent Psychiatric Clinics, 24(4), 715-730.
[2] UNHCR/UNICEF, (2017). ibid.
[3] UNHCR -Bureau for Europe: UNHCR Recommendations for Greece in 2017. Available at: http://www.unhcr.org/publications/operations/58d8e8e64/unhcr-recommendations-greece-2017.html
[4] Bowlby, J. (1951). Maternal care and mental health. Bulletin of the World Health Organization. Geneva, Switzerland: WHO.
Berens, A. E., & Nelson, C. A. (2015). The science of early adversity: is there a role for large institutions in the care of vulnerable children?. The Lancet, 386(9991), 388-398.
Rutter, M. (1998). Developmental catch-up, and deficit, following adoption after severe global early privation. Journal of Child Psychology & Psychiatry, 39(4):465– 476.

shelters is of paramount importance. Such operating guidelines could augment current SOPs and could be delivered in comprehensive training schemes to shelter personnel.

- *Addressing key triggers or risk factors of psychopathological manifestations*: as many of the acute or chronic externalizing behaviors are reported to be related with current status events (such as asylum seeking application procedures, delays, bureaucratic obstacles etc.), improving the overall system of care for UAC could contribute also in minimizing their needs for MHPSS support. For instance, improving timing of procedures, in detail explanation of their nature and their perplexities in advance might reduce expressed emotional reactions. To that end developing operating procedures regarding the actual functions of professionals currently employed in shelters is of paramount importance. Such operating guidelines could augment current SOPs and could be delivered in comprehensive training schemes to shelters' personnel. Moreover, the appointment of full-fledged legal guardians could also help in a global and coherent but also individualized coverage of UAC's needs for minimizing current status induced behavioral challenges.

Secondary Care

This dimension is of paramount importance for tackling the problems once mental health disorders or challenging behaviors eventually arise. It should be noted that measures included at this level should target to the totality of UAC facing mental health and psychosocial issues and not just the few ones requiring hospitalization in virtue of the one or the other such condition. Therefore, outpatient, community-based services should be the main focus of efforts to prevent mental health conditions to worsen. However, in order for such services to be available in practice, one has to take into consideration all practical issues currently representing barriers to utilization of existing MHPSS by the UAC. Therefore, such an approach should include:

- *Developing a streamlined and comprehensive system of referrals to hospitals:* in many occasions confusion over legal requirements for clinical assessment of UAC or provision of clinical services to them, especially in cases involuntary ones create additional barriers to timely and effective addressing of their mental health issues. For instance distinguishing simple granting permission of legal custodian to provide clinical service from involuntary assessment and/or treatment should be clear to all involved parties. Legal reform for appointing guardians could resolve the issues of custodian permission for providing therapeutic services. However, even without that reform in place, standardizing the procedures in the aforementioned two distinct cases could be made in collaboration with the hierarchy of public prosecutors and the government and in turn made know to all operators and agencies involved in UAC's residential care. EKKA could lead this effort qua coordinating body having also other monitoring functions on UAC.
- *Providing accessible and appropriate MHPSS to all UAC in need:* Comprehensive, specialized mental health services should be made available for cases of UAC requiring treatment and support; these services should secure continuity of care and capacity in dealing with particular issues (cultural diversity, volatility in UAC's status, linguistic barriers etc.)[1]. These should be mostly community – based services with adequate recourses for continuous support and provision of treatment as well as for undertaking extensive preventive interventions in most of the currently known places of UAC's residence. Given the current workload of existing public sector C&A mental health outpatient services it is extremely doubtful whether these could undertake this additional burden. Therefore, developing such specialized units at least in the three main geographical areas in which most UAC currently reside (Athens, Thessalonica, and Northern Aegean islands) seems as an alternative with much better potential for success in addressing the issue at stake. The same goal could be achieved by supporting existing specialized services when already operating

[1] APA, (2010). Report of the APA task force on the psychosocial effects of War on children and families who are refugees from armed conflict residing in the United States (http://www.apa.org/pubs/info/reports/refugees-full-report.pdf)

(i.e., such as BABEL in Attica Region) in order to enhance their capacity to deal with increased needs in provision of MHPSS to UAC.

- *Actively involving caregivers in the delivery of treatment schemes:* any effective treatment scheme for children and adolescents cannot be effective unless it also includes regular consultation with caregivers (qua "as if" parents since fulfilling the parental functional role) in order for them to facilitate change for the better for the minor having mental health issues. As a result, engaging personnel (reference person optimally) in a comprehensive treatment scheme for any individual UAC should be mainstreamed and standardized as a practice in cases of UAC having mental health and psychosocial issues[1]. As in similar issues raised in the primary prevention dimension, these could be also included in comprehensive training for shelters' personnel.
- *Addressing gaps in availability of necessary MHPSS services including geographical inequalities:* as becoming apparent in chapter 3, there is currently an overall shortcoming in currently available resources of MHPSS for children and adolescents in Greece. For instance, outpatient, community-oriented mental health services are already behind optimal ratio per reference population; that issue could be better addressed by developing focused units for providing mental health services to UAC in Athens, Thessalonica and Northern Aegean. Inpatient C&A mental health care is also behind optimal standards: WHO recommends a ratio of 6-8 available hospital beds per 1.000.000 population with additional ones for adolescents[2] while in Greece figures are still behind that target. Also geographical allocation of these resources is not even since for example in the entire Northern Aegean region there is currently no availability for hospitalization of acute cases. Therefore, prioritizing to cover existing geographical inequalities (i.e. by developing a small C&A psychiatric unit with some limited inpatient capacity in the region of Aegean islands) could contribute in avoiding long-distance referrals of UAC to Athens or Thessalonica (sometimes even for just a short-term admission in a hospital unit). Ministry of Health should review the current situation examining options to strengthen the capacity of providing community based C&A mental health services in the Northern Aegean region as well as regarding capacity of inpatient care especially for adolescents nationally.

Tertiary Care

Safeguarding continuity of care and enhancing efforts for avoiding relapses is of paramount importance for any comprehensive strategy for prevention and control of mental health issues of any particular population group including UAC. Such an approach should include:

- *Developing individualized care plans for UAC with MHPS issues:* such plans should be drafted individually for each UAC with respective issues by specialized MHPSS, inpatient units in cases there will be a necessity for admission for a period of time, caregivers (shelters etc.) and legal guardians (provided that some such legal reform will come into effect in due course) but also involving the minor him-/her-self. Given the extended prior experience of such individuated care plans in both mental health and child protection services such plans should better be written, provided by a standardized modus operandi and regularly revised by involved parties[3]. Drafting such individualized tailor-made action plans should be included in

[1] APA, (2010). ibid.

[2] Source: http://www.moh.gov.gr/articles/health/domes-kai-draseis-gia-thn-ygeia/c312-psyxikh-ygeia/1398-eidikh-epitroph-elegxoy-prostasias-twn-dikaiwmatwn-twn-atomwn-me-psyxikes-diataraxes?fdl=8836

[3] See also related recommendations in Digidiki V & Bhabha J (2017). Emergency Within an Emergency: The Growing Epidemic of Sexual Exploitation and Abuse of Migrant Children in Greece. FXB CENTER FOR HEALTH & HUMAN RIGHTS | HARVARD UNIVERSITY. Available at: https://cdn2.sph.harvard.edu/wp-content/uploads/sites/5/2017/04/Emergency-Within-an-Emergency-FXB.pdf)

the supplementary operating guidelines and in the training curricula for shelters' personnel developed and supervised by the authoritative Ministry.

- *Securing a comprehensive and quality follow up system of mid- and long- term treatment of UAC with MHPSS needs:* one of the most important findings of the current assessment is the relative low level of follow up in care of UAC in need of MHPSS. In many occasions continuity of care was not safeguarded and treating clinicians lost traces of UAC they had provided with services; in other instances, UAC had to change residential care facilities in virtue of an admission to a child and adolescents inpatient unit with considerable administrative difficulties in finding a new placement for these minors. The often discussed solution of a "segregated" system of shelters for UAC with mental health and psychosocial issues seems as ethically problematic but also ineffective and inefficient; anyway, there are too many UAC which either already have manifested or are at immediate risk of manifesting some or other mental health issue or challenging behavior, thus, any such structures will soon be full without resolving the problem as such (see box). Consequently, solution to the problem in hand could be given by a two-folded strategy, namely on one hand strengthening all residential care system for being able to handle such issues (thus, not developing "increased/intense support" shelters but rather upgrading capacities of all shelters to become such) and on the other developing specialized community-based units for UAC which could dedicate the required attention to such cases and follow them up.

On the proposed solution of developing specialized residential care shelters for UAC with MHPS issues

Findings of the current assessment were not supporting that could represent an effective solution. This is so because on one hand, the overall figures of UAC eventually hospitalized were quite limited with several of them being discharged only a few days after their admission; from these very few had stricto sensu mental health disorders (such as i.e. psychotic disorders) while in most of the cases what was predominant source of concern was behavioral and emotional disturbances in virtue of psychosocial conditions (such as drug or alcohol abuse or anger for some occurrence typically related with the current status of the adolescent; in some other occasions the initiating events might be simply temper outbreaks manifested in adolescence). On the other hand, if one attempts to address the aforementioned issues (mood and anger behaviors in adolescence related with substances' abuse or disappointing life events in adolescence) by admitting UAC in specialized residential care units, then the number of places required for those unit should be represent a considerable proportion of the totality of the UAC; thus, soon enough, any residential care shelter developed will be full with more requests for admission unsatisfied. Additionally, this focus on externalizing symptoms of this particular vulnerable population tends to underestimate the internalizing symptoms (withdrawal, depression, inhibited behavior) which according to the reports of the shelter coordinators represent the majority of observed symptoms currently. Therefore, it seems much more effective and cost efficient to employ a different strategy to tackle the problem by accepting its reality instead of denying it, viz. instead of developing segregated shelters for UAC with behavioral issues to enhance the capacity of the entire residential care system to address challenges of UAC's behavior (which should be regarded as given in that population group). In order to do so, shelters should be further supported by developing (i) extensive training programs for the caregiving and scientific personnel, (ii) comprehensive early detection and intervention mental health promotion programs for the UAC conducted by specialized services to the shelters, (iii) a specific monitoring scheme for duties and recommended practices in organizing daily life in the shelters and (iv) accessible, specialized in the peculiarities of that target group and external to the shelters' system MHPSS to undertake ongoing support of the caregiving role of the residential care system and provision of clinical services in cases of expressed psychopathology as well as follow up of cases in collaboration with the residential care staff. The later (viz. the provision of specialized clinical services in an outpatient basis) seems currently rather challenging to be delivered by existing resources of the public mental health sector. This so because on one hand, C&A mental health services of the public sector currently face already a substantial workload (on several occasions having to restrain to official certification of disorders for social insurance, schools and other agencies, not having adequate resources to provide lege artis medium- and long- term treatment) making delivery of care in the UAC population rather fragmented; on the other hand the development of such specialized units at a regional level (for supporting all shelters within the region) could be a rather cost-efficient option (requiring, thus, only a few such units to de developed). Moreover, such an option can also provide opportunities for a comprehensive monitoring of the situation (while specialized residential care shelters will only be able to provide data for their own residents) and in case of a radical change in the current situation (in regards to figures of UAC to be served) they could easily differentiate their function to serve wider societal needs for MHPSS.

- *Establish measures to ensure continuity of care of children who leave care, including cases of UAC coming into adulthood:* age assessment should be improved for the shelters not having to provide mental health services to a heterogeneous mixture of residents with gravely differentiated needs; however, since a lot of the UAC are adolescents when located by Greek authorities, there should be some proviso for care (and respective proviso for mental health services to then when required) for young adults (i.e. adolescents entering adulthood while in the system off shelters). Therefore, improving re-assessment mechanisms to be operating in practice but also providing for specialized residential care for young adults with mental health issues who entered the country as minors but came into adulthood might provide substantial help in addressing perplexed issues currently faced by shelters' personnel and providers (age mixture of population; adults who cannot be treated under the schemes of C&A mental health services etc.); to that end developing networks between community-based mental health services specialized in immigrants and refugees issues of either adults or children and adolescents could secure continuity of treatment and comprehensive care.

Horizontal Actions

Horizontal actions which cut across all levels of response should include:

- *Developing a national information management mechanism for case-based registering and monitoring of UAC in need of MHPSS support:* the current situation as depicted by this assessment apart from other issues reveals the shortcomings on monitoring and surveillance of mental health and psychosocial issues reported to UAC. This issue could be better addressed if some central mechanism (possible EKKA qua referral and coordinating agency of the entire efforts for UAC) could undertake the role of serving as a reference point to all related issues at a case-base level. This would facilitate follow up of individual cases but also provide accurate and ongoing aggregative data to inform decision-making at a timely manner[1].
- *Promoting participation of UAC (and where possible caretakers of similar ethnic or cultural background) in all levels of decisions concerning them including effective response to MHPSS support needs:* participation of minors in all decisions concerning them is a principle of all contemporary children's rights policies also provided by the UN CRC. Accordingly, using the aforementioned awareness raising and mental health promotion programs at the collective and the action plan designing schemes at the individual level would service these principals but also strengthen the capacity of the system to help individual UAC to overcome their hardships and distress. Moreover, at the level of ethnic community participation, involvement of people from the same country in the care of UAC seems to improve communication between the residential care system and the residents, thus, allowing for earlier identification of issues as well as facilitate those issues addressing[2].
- *Establishing Standard Operating Procedures for UAC residential care which include protocols for addressing acute of chronic mental health issues of residents:* as illustrated in the material presented in the current assessment, insofar there are quite big differences in provision of care, activities and relationships but also responses of the residential care system to UAC and their potential mental health and psychosocial issues. Standardizing care provided and formalizing responses to challenging conditions or behaviors would assist all involved parties including residential care providers and their personnel and the UAC themselves.
- *Clarifying accountabilities of public sector services for the relevant subject matter from top level (Ministries) to first-line service.*

Last but not least: as emerging from the interviews of professionals, there should be some equal proviso for services for accompanied minors: these minors also suffer from increased rates of mental health problems and their access to appropriate and intensive mental health services is quite questionable and fragmented.

[1] Also a key recommendation in UNHCR/UNICEF, (2017). ibid.
[2] Vostanis, P. (2016). New approaches to interventions for refugee children. *World Psychiatry*, *15*(1), 75-77

ANNEXES

Annex 1 Invitation to provide UAC MHPS Needs data (example)

RAPID ASSESSMENT OF MHPSS FOR UASC IN GREECE

Θέμα: Πρόσκληση στη συλλογή δεδομένων για την εκτίμηση αναγκών ψυχικής υγείας και ψυχοκοινωνικών προβλημάτων ασυνόδευτων παιδιών στην Ελλάδα

Αγαπητέ/Αγαπητή Επαγγελματία

Αναμφισβήτητα η τρέχουσα προσφυγική και μεταναστευτική κρίση συνιστά έκτακτη ανάγκη και, ως τέτοια, δημιουργεί ένα ευρύ φάσμα προβλημάτων τόσο για τα ίδια τα άτομα που τη βιώνουν, όσο και για το πλαίσιο που αναλαμβάνει την υποδοχή και τη φροντίδα τους,. Τα ασυνόδευτα παιδιά που φτάνουν στην Ελλάδα ανήκουν σε μια ιδιαίτερα ευάλωτη ομάδα και αντιμετωπίζουν πολλαπλά προβλήματα (που είτε προϋπήρχαν και ενισχύονται λόγω της κατάστασης, που προέκυψαν αποκλειστικά από την μετακίνηση των παιδιών ή που προκύπτουν καθημερινά από τις τρέχουσες συνθήκες διαβίωσης). Ως εκ τούτου, πέραν των κοινών προβλημάτων, κάθε ασυνόδευτο παιδί μπορεί να αντιμετωπίζει και επιπλέον ιδιαίτερες δυσκολίες, για την αντιμετώπιση των οποίων απαιτείται διαφορετικού τύπου υποστήριξη. Επιπρόσθετα, πρακτικά ζητήματα -όπως η δυσκολία στην επικοινωνία- συχνά καθιστούν την απόκριση των υπηρεσιών στα προβλήματα των ασυνόδευτων παιδιών μη- επαρκή.

Η παρούσα πρόσκληση συνεργασίας συνιστά ένα από τα πρώτα βήματα για τη συστηματική και συνολική εκτίμηση των αναγκών όσον αφορά υπηρεσίες ψυχικής υγείας και ψυχοκοινωνικής υποστήριξης για ασυνόδευτα παιδιά στην Ελλάδα, στο πλαίσιο πρωτοβουλίας Rapid Assessment of Mental Health and Psychosocial Needs and Services for UASC in Greece της UNICEF. Για να προχωρήσουμε σε αυτή την εκτίμηση, ωστόσο, θα πρέπει προηγουμένως να γνωρίζουμε τα γενικά χαρακτηριστικά του προβλήματος, να έχουμε, δηλαδή, μια –έστω έμμεση- καταγραφή όσον αφορά την ψυχική υγεία και τα ψυχοκοινωνικά προβλήματα των ασυνόδευτων παιδιών (αφού, όπως ήδη γνωρίζετε από την προσωπική σας ενασχόληση, επί του παρόντος δεν υπάρχουν διαθέσιμες πληροφορίες για τον τύπο, τη συχνότητα και τη βαρύτητα ψυχοκοινωνικών προβλημάτων και προβλημάτων ψυχικής υγείας των ασυνόδευτων παιδιών στη χώρα).

Στις παρούσες συνθήκες, οι επαγγελματίες πρώτης γραμμής που εργάζονται σε δομές που φιλοξενούν και φροντίζουν ασυνόδευτα παιδιά είναι η πιο έγκυρη πηγή για την παροχή τέτοιου είδους πληροφοριών. Για το λόγο αυτό απευθυνόμαστε σε εσάς και σας προσκαλούμε να συμμετέχετε στην προσπάθεια καταγραφής των αναγκών που αφορούν την ψυχική υγεία και τα ψυχοκοινωνικά προβλήματα των ασυνόδευτων παιδιών, συμπληρώνοντας την σχετική φόρμα (online) με όσο το δυνατόν περισσότερες πληροφορίες όσον αφορά τα παιδιά που φιλοξενούνται στη δομή όπου εργάζεστε. Γνωρίζοντας, βέβαια, ότι πολύ συχνά τα ασυνόδευτα παιδιά δεν φέρουν μαζί τους επίσημα έγγραφα που να περιλαμβάνουν πληροφορίες για την πρότερη κατάστασή τους (περιλαμβανομένων και θεμάτων ψυχικής υγείας), στις περισσότερες από τις παρακάτω περιπτώσεις καλείστε να παρέχετε πληροφορίες "*από ό,τι γνωρίζετε*", το οποίο μπορεί να σημαίνει από προσωπική παρατήρηση, βάσει πληροφορίας από τρίτη πηγή (όπως άλλα παιδιά) κλπ. Ως εκ τούτου, συστήνεται η συμπλήρωση της φόρμας να γίνει σε κάθε δομή από επαγγελματία ή ομάδα επαγγελματιών που λόγω της

επαγγελματικής τους ιδιότητας ή για όποιον άλλο λόγο έχουν πιο συστηματική επαφή με τα παιδιά και πιο ολοκληρωμένη εικόνα για τα προβλήματά τους (το οποίο μπορεί να διαφέρει από δομή σε δομή).

Οι πληροφορίες που θα συλλεγούν από όλες τις σχετικές δομές θα χρησιμοποιηθούν ως βάση για την ανάπτυξη πρωτοκόλλων για ομάδες εστιασμένων συζητήσεων (focus group discussions) αλλά και συνεντεύξεων, διαδικασίες στις οποίες θα κληθούν να συμμετέχουν εκπρόσωποι των σχετικών δομών φιλοξενίας και φροντίδας. Στόχος αυτών είναι ο προσδιορισμός των πρακτικών που εφαρμόζονται επί του παρόντος για την ικανοποίηση ψυχοκοινωνικών αναγκών και την αντιμετώπιση προβλημάτων ψυχικής υγείας, την αναγνώριση κενών ή αδυναμιών των υφιστάμενων υπηρεσιών να ανταποκριθούν ικανοποιητικά στις ανάγκες του συγκεκριμένου πληθυσμού. Από τα αποτελέσματα των συζητήσεων αναμένεται να προκύψουν καλές πρακτικές που θα μπορούσαν να εδραιωθούν αλλά και συστάσεις για αποτελεσματικότερη διαδικασία σχεδιασμού υπηρεσιών. Για το λόγο αυτό **η προθεσμία για τη συμπλήρωση της φόρμας ορίζεται σε ορίζοντα μιας εβδομάδας (έως Τετάρτη, 24 Μαΐου 2017)**.

Για την ενημέρωσή σας, οι πληροφορίες που θα συλλεγούν από όλες τις δομές θα παρουσιαστούν συγκεντρωτικά. Η ταυτοποίηση συγκεκριμένων δομών –και ιδίως συγκεκριμένων παιδιών- δεν θα είναι δυνατή και οι μεμονωμένες απαντήσεις ανά δομή θα παραμείνουν εμπιστευτικές. Σε περίπτωση που χρειάζεστε επιπλέον διευκρινίσεις ή θέλετε να προτείνετε επιπλέον όρους εμπιστευτικότητας, μη διστάσετε να επικοινωνήσετε μαζί μας [Γ Νικολαΐδης, Συντονιστής Μελέτης (gnikolaidis@ich-mhsw.gr), Μ Σταύρου, ερευνήτρια (myrtostavrou@gmail.com), και Α Ντιναπόγιας, ερευνητής (dinapogias@gmail.com)].

Σας ευχαριστούμε εκ των προτέρων για τη συμμετοχή σας

Γιώργος Νικολαΐδης, MD, MH, MSc, PhD
Συντονιστής της Μελέτης

Ηλεκτρονική διεύθυνση φόρμας: https://ee.kobotoolbox.org/x/#YBxK

Annex 2 Focus Group Protocol, Discussion Guide & Informed Consent

Suggested Methodology for conducting FGs

Background: Focus group discussions are going to be conducted as a way to gain more in-depth information for UAC MHPSS needs and response of services, after preliminary information has been obtained (from shelters Coordinators via a short tool, see Annex II).

In this protocol included the questions to be used in focus group discussions with professionals (see Annex III) who are expected to have in-depth knowledge of the target-population, namely UAC in Greece.

AIM: to learn from professionals working with UAC about MHPS problems of the specific population and to collect information on current MHPSS response, good practices applied and weaknesses

- 8 groups (4 FGs minimum; 8 FGs targeted value) * 6 professionals minimum – 8 maximum;
    - 3 groups: coordinators of UAC shelters in Attica Region
    - 5 groups: front line professionals working in UAC infrastructures in Attica Region and Islands Northern Aegean Region and Thessaloniki
    - *Eligible participants are the professionals described in Annex III*

Planning the Focus Groups

- *Preparation of invitation letters* including a brief description of the objectives of the discussion and of the procedure (including the preparation, namely MHPS needs data collection)
- *Scheduling of the venue & the dates*
- *Send invitations to participants (and confirmation of participation via phone)*
- *Preparation of informed consent forms (to be signed by participants the day of discussion)*

Focus group results

- *Outcome of FGs' discussion*
    - *Drafting recommendation according to FG results on planning appropriate services for the response to MHPS needs of UAC*

Overview of FGs

	Suggested Process & Organization
Method	Group session
Group size	6-8 participants per session + 2 moderators
Session duration	120 min
Time	10 – 26 May 2017
Place	Institute of Child Health (Fokidos 7, Athens) OR TBD
Participants	~ 18-24 Coordinators of Shelters for UAC (Attica Region) ~ 30-40 Personnel of Shelters for UAC (Athens, Lesvos, Chios or Alexandroupoli. Thessaloniki)
Recruitment of participants	Written invitations and further communication via phone where needed
Participants preparation	Short description of the FGs' discussion subject & topics
Eligible participants	First line practitioners and professionals, if opted so, also include UAC shelters' coordinators and other key personnel
Number of Groups & participants	8 groups min 48- max 62 participants (in total)
Moderator(s)	Moderator: coordinate the discussion Co-moderator: administrative tasks (including minutes recording)
Other material	Invitation letters & short informational document (e.g. infographic)
Data to be collected	Qualitative
Data collection	Electronically recorded and written minutes
Analysis of data	Descriptive analysis of repeated issues, comments and suggestions Presentation of selected quotations (words, sentences, expressions)
Reporting	Brief description of aim and method of FG Presentation of results and references for any specific suggestion or proposed recommendation made by participants in the context of the final report of the rapid assessment.

Note: for the SSIs will be used the same protocol (namely the same discussion topics. The process, however, is expected to has a maximum duration of 60 min (as only one professional/ stakeholder will participate in the interview).

FOCUS GROUP DISCUSSION [120 MIN PER GROUP]

Introduction of participants [05 min]

Briefing of info-graphic (presenting initial data collected in advance) [10 min]

Opening of the Discussion

TOPIC 1: OVERALL FRAMEWORK OF DISCUSSION [25 min]

As the participants get prepared for the discussion, the moderator asks the following questions:

1. First, I would like to ask you about mental health and psychosocial problems of children in the structures where you are working; do these data adequately present the needs of children you are working with?

   Prompts
   - *Do you like to add some information you think is missing concerning mental health needs of children? What about psychosocial needs?*
   - *Do you have personal experience of children having such kind of needs?*

TOPIC 2: CURRENT RESPONSE TO MHPS NEEDS OF UAC (INTERNAL/EXTERNAL RESPONSE) [40 min]

1. In general, what are you/ your colleagues/ structure doing right now to identify and help / respond children
   - in acute incidents of mental disorders?
   - with chronic mental problems?
   - with chronic psychosocial needs?

   Prompts
   - *Where are you seeking usually for help? (services/ professionals etc.)*
   - *Are there practices that you usually apply when responding to psychosocial needs of children other than UAC but you don't apply in the case of UAC?? If yes, are there specific practical or other reasons for this (e.g. language barriers)?*
2. Are you satisfied from the current response to these needs of UAC? What do you think is working adequately (if any)?

Prompts

how timely is usually the response? How effective is usually the support?

Especially concerning referrals to hospital or special care units?

What about referral back to shelters from hospitals (after hospitalization, do shelters taken children back?

TOPIC 3: STRENGTHS & WEAKNESSES IN RESPONSE TO MHPSS & SUGGESTIONS FOR IMPROVEMENTS [40 min]

1. What more could be done to help unaccompanied children who suffering
   - acute incidents of mental disorders?
   - chronic mental problems?
   - chronic psychosocial needs?
   - in other urgent cases (e.g. sexual violation; drugs abuse)?
2. In your opinion what kind of support services is needed to be created (or expanded) in order to meet sufficiently MHPSS needs of UAC?
   - In terms of the type of needs/problems?
   - In terms of workload?

Closing

Informed consent

Dear Participant,

Our team (names) is currently working for a UNICEF's project aiming to assess Mental Health and Psychosocial Needs and Services for UASC in Greece. We have been working in this subject only for a few weeks. Currently, we are talking to UASC shelters' coordinators and other personnel who we believe know a lot about the unaccompanied children hosted in various settings in Greece. In this group discussion we would like to ask you about mental health and psychosocial needs and services of these children. We would also like to ask how you and your colleagues deal with such problems and needs, whether the available services are sufficient and if additional help may be needed.

Our aim is to learn from your knowledge and experience, so that we will be better able to provide information to authorized parties including Ministries for planning support services. We cannot promise to give you support in exchange for this interview. At the moment we are here only to ask questions and learn from your experiences. You are free to take part or not. Information provided will be aggregated and anonymized in final presentation and thus individual responses will be kept confidential. If you choose to participate, we can assure you that any information is going to be collected following the respective ethics rules such as non-identification of any children or specific structure. We cannot give you anything for taking part but we would greatly value your time and responses. Also, you can withdraw from the discussion at any time.

Do you have any questions? Would you like to be interviewed?

1. Yes

2. No

Name: _____

Signature: _____

Shelter: _____

Date: _____

Annex 3 Focus Group Discussions (FGDs)

7 FGDs with a total of 46 participants (shelters' personnel)

1. *Personnel SOS Villages, Athens (5+2 facilitators)*
2. *Personnel Iliaktida, Lesvos (9+2 facilitators)*
3. *Personnel, Arsis, Thessaloniki (8+2 facilitators)*
4. *Personnel, Arsis, Thessaloniki (5+2 facilitators)*
5. *Personnel, Arsis, Alexandroupolis (6+2 facilitators)*
6. *Personnel, Arsis, Alexandroupolis (4+2 facilitators)*
7. *Personnel, Praxis, Athens (9+2 facilitators)*

3 FGDs with a total of 17 Coordinators of Shelters hosting UAC

1. *Coordinators representing 4 Shelters in Athens (4+2 facilitators)*
2. *Coordinators representing 5 Shelters in Athens (5+2 facilitators)*
3. *Coordinators representing 8 Shelters in Mytilene (8+2 facilitators)*

Annex 4 Semi-structured Interviews (SSIs) and Steering Committee Members

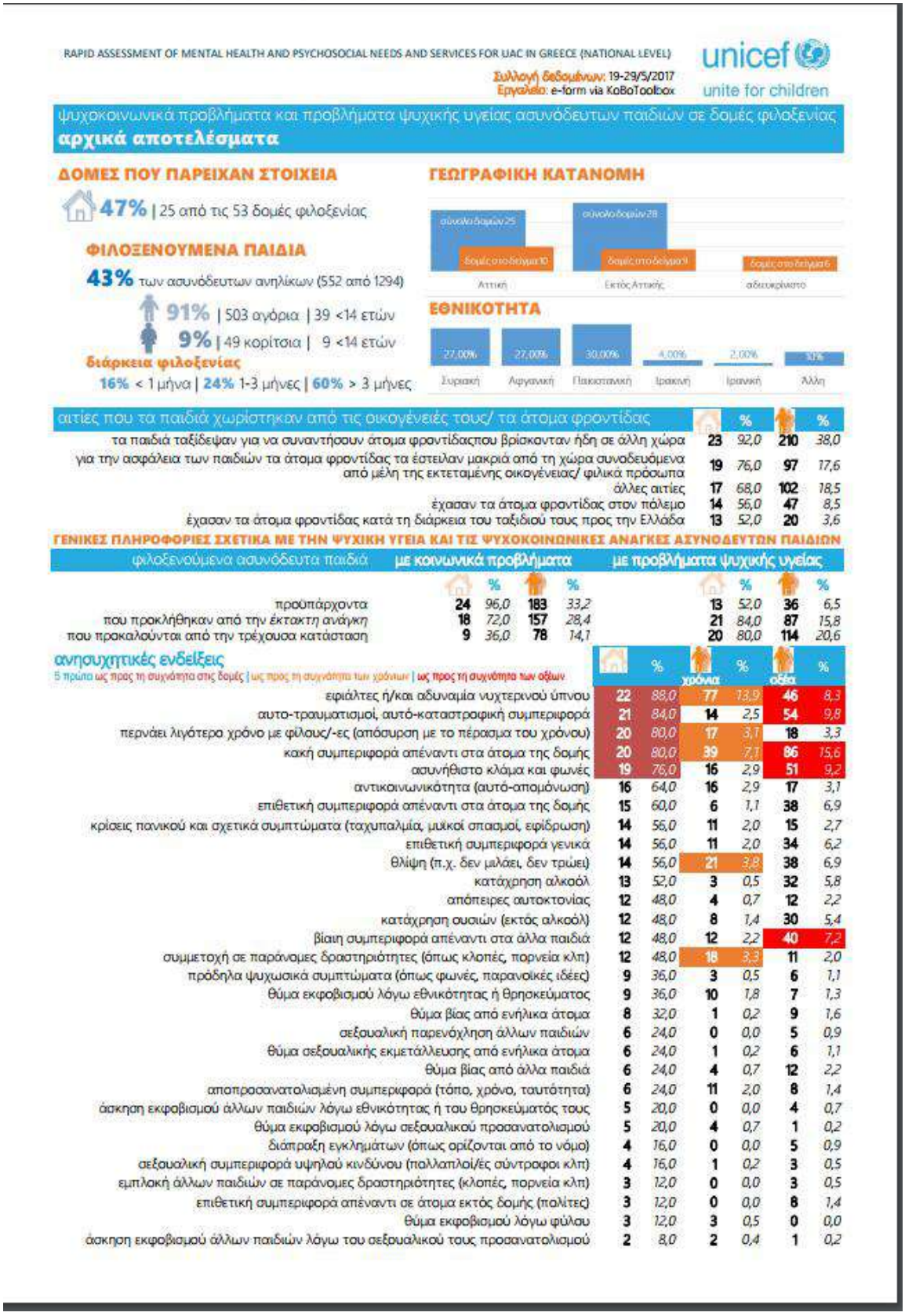
List of key-informants

1. *Child Psychiatrist (Arsis)*
2. *Lawyer (Network for Children's Rights)*
3. *Child Psychiatrist Director of C&A psychiatry Department (Sismanogleio Hospital)*
4. *Child Psychiatrist specialized in juveniles (Babel)*
5. *Social Worker, Coordinator of Arsis Shelters in Central and Northern Greece*
6. *Social Psychologist (Network for Children's Rights)*
7. *Educator (Iliaktida's School)*
8. *Social Worker, Coordinator of INEDIVIM Shelter*
9. *Pediatrician (Network for Children's Rights)*
10. *Child Psychiatrist (Child Psychiatric Service Department of Praxis)*
11. *Four Social Workers, Service for placement of UAC in shelters nationwide (National Center for Social Solidarity-EKKA)*

Members of Steering Committee of the Rapid Assessment

a. *Ioannis Avranas, Ministry of Labour, Social Insurance and Social Solidarity*
b. *George Giannopoulos, General Secretary, Ministry of Health*
c. *Christos Hombas, Director, National Center for Social Solidarity*
d. *Mariella Michailidou, UNICEF*
e. *George Moschos, Deputy Ombudsman in charge of Children's Rights*
f. *Ioannis Papachristodoulou, UNICEF*
g. *Michalis Papantonopoulos, Ministry of Health*
h. *Lina Sipitanou, Ministry of Labour, Social Insurance and Social Solidarity*
i. *Dimitra Soulele, Child Rights Monitoring Expert at the Ombudsman's Office*
j. *Alkis Souliotis, Ministry of Migration Policy*
k. *Vasileios Theodorou, Ministry of Health*
l. *Galit Wolfensohn, UNICEF*

Annex 5 Infographic with preliminary data



RAPID ASSESSMENT OF MENTAL HEALTH AND PSYCHOSOCIAL NEEDS AND SERVICES FOR UAC IN GREECE (NATIONAL LEVEL)

Συλλογή δεδομένων: 19-29/5/2017
Εργαλείο: e-form via KoBoToolbox

unicef
unite for children

ψυχοκοινωνικά προβλήματα και προβλήματα ψυχικής υγείας ασυνόδευτων παιδιών σε δομές φιλοξενίας
αρχικά αποτελέσματα

ΔΟΜΕΣ ΠΟΥ ΠΑΡΕΙΧΑΝ ΣΤΟΙΧΕΙΑ

47% | 25 από τις 53 δομές φιλοξενίας

ΦΙΛΟΞΕΝΟΥΜΕΝΑ ΠΑΙΔΙΑ

43% των ασυνόδευτων ανηλίκων (552 από 1294)

91% | 503 αγόρια | 39 <14 ετών

9% | 49 κορίτσια | 9 <14 ετών

διάρκεια φιλοξενίας

16% < 1 μήνα | **24%** 1-3 μήνες | **60%** > 3 μήνες

ΓΕΩΓΡΑΦΙΚΗ ΚΑΤΑΝΟΜΗ

ΕΘΝΙΚΟΤΗΤΑ

αιτίες που τα παιδιά χωρίστηκαν από τις οικογένειές τους/ τα άτομα φροντίδας		%		%
τα παιδιά ταξίδεψαν για να συναντήσουν άτομα φροντίδαςπου βρίσκονταν ήδη σε άλλη χώρα	23	92,0	210	38,0
για την ασφάλεια των παιδιών τα άτομα φροντίδας τα έστειλαν μακριά από τη χώρα συνοδευόμενα από μέλη της εκτεταμένης οικογένειας/ φιλικά πρόσωπα	19	76,0	97	17,6
άλλες αιτίες	17	68,0	102	18,5
έχασαν τα άτομα φροντίδας στον πόλεμο	14	56,0	47	8,5
έχασαν τα άτομα φροντίδας κατά τη διάρκεια του ταξιδιού τους προς την Ελλάδα	13	52,0	20	3,6

ΓΕΝΙΚΕΣ ΠΛΗΡΟΦΟΡΙΕΣ ΣΧΕΤΙΚΑ ΜΕ ΤΗΝ ΨΥΧΙΚΗ ΥΓΕΙΑ ΚΑΙ ΤΙΣ ΨΥΧΟΚΟΙΝΩΝΙΚΕΣ ΑΝΑΓΚΕΣ ΑΣΥΝΟΔΕΥΤΩΝ ΠΑΙΔΙΩΝ

φιλοξενούμενα ασυνόδευτα παιδιά	με κοινωνικά προβλήματα				με προβλήματα ψυχικής υγείας			
		%		%		%		%
προϋπάρχοντα	24	96,0	183	33,2	13	52,0	36	6,5
που προκλήθηκαν από την έκτακτη ανάγκη	18	72,0	157	28,4	21	84,0	87	15,8
που προκαλούνται από την τρέχουσα κατάσταση	9	36,0	78	14,1	20	80,0	114	20,6

ανησυχητικές ενδείξεις

5 πρώτα ως προς τη συχνότητα στις δομές | ως προς τη συχνότητα των χρόνων | ως προς τη συχνότητα των αξόνων

		%	χρόνια	%	οξέα	%
ειφιάλτες ή/και αδυναμία νυχτερινού ύπνου	22	88,0	77	13,9	46	8,3
αυτο-τραυματισμοί, αυτό-καταστροφική συμπεριφορά	21	84,0	14	2,5	54	9,8
περνάει λιγότερο χρόνο με φίλους/-ες (απάσυρση με το πέρασμα του χρόνου)	20	80,0	17	3,1	18	3,3
κακή συμπεριφορά απέναντι στα άτομα της δομής	20	80,0	39	7,1	86	15,6
ασυνήθιστο κλάμα και φωνές	19	76,0	16	2,9	51	9,2
αντικοινωνικότητα (αυτό-απομόνωση)	16	64,0	16	2,9	17	3,1
επιθετική συμπεριφορά απέναντι στα άτομα της δομής	15	60,0	6	1,1	38	6,9
κρίσεις πανικού και σχετικά συμπτώματα (ταχυπαλμία, μυϊκοί σπασμοί, εφίδρωση)	14	56,0	11	2,0	15	2,7
επιθετική συμπεριφορά γενικά	14	56,0	11	2,0	34	6,2
θλίψη (π.χ. δεν μιλάει, δεν τρώει)	14	56,0	21	3,8	38	6,9
κατάχρηση αλκοόλ	13	52,0	3	0,5	32	5,8
απόπειρες αυτοκτονίας	12	48,0	4	0,7	12	2,2
κατάχρηση ουσιών (εκτός αλκοόλ)	12	48,0	8	1,4	30	5,4
βίαιη συμπεριφορά απέναντι στα άλλα παιδιά	12	48,0	12	2,2	40	7,2
συμμετοχή σε παράνομες δραστηριότητες (όπως κλοπές, πορνεία κλπ)	12	48,0	18	3,3	11	2,0
πράδηλα ψυχωσικά συμπτώματα (όπως φωνές, παρανοϊκές ιδέες)	9	36,0	3	0,5	6	1,1
θύμα εκφοβισμού λόγω εθνικότητας ή θρησκεύματος	9	36,0	10	1,8	7	1,3
θύμα βίας από ενήλικα άτομα	8	32,0	1	0,2	9	1,6
σεξουαλική παρενόχληση άλλων παιδιών	6	24,0	0	0,0	5	0,9
θύμα σεξουαλικής εκμετάλλευσης από ενήλικα άτομα	6	24,0	1	0,2	6	1,1
θύμα βίας από άλλα παιδιά	6	24,0	4	0,7	12	2,2
αποπροσανατολισμένη συμπεριφορά (τόπο, χρόνο, ταυτότητα)	6	24,0	11	2,0	8	1,4
άσκηση εκφοβισμού άλλων παιδιών λόγω εθνικότητας ή του θρησκεύματός τους	5	20,0	0	0,0	4	0,7
θύμα εκφοβισμού λόγω σεξουαλικού προσανατολισμού	5	20,0	4	0,7	1	0,2
διάπραξη εγκλημάτων (όπως ορίζονται από το νόμο)	4	16,0	0	0,0	5	0,9
σεξουαλική συμπεριφορά υψηλού κινδύνου (παλλαπλοί/ές σύντροφοι κλπ)	4	16,0	1	0,2	3	0,5
εμπλοκή άλλων παιδιών σε παράνομες δραστηριότητες (κλοπές, πορνεία κλπ)	3	12,0	0	0,0	3	0,5
επιθετική συμπεριφορά απέναντι σε άτομα εκτός δομής (πολίτες)	3	12,0	0	0,0	8	1,4
θύμα εκφοβισμού λόγω φύλου	3	12,0	3	0,5	0	0,0
άσκηση εκφοβισμού άλλων παιδιών λόγω του σεξουαλικού τους προσανατολισμού	2	8,0	2	0,4	1	0,2

Annex 6 National Legislation on Child Protection in Greece

(ICH, unpublished work, 2017)

2017	**Draft Law (announced)** *(the aim of this draft law is the development of two national registries: the first one for children –living currently in institutional care- to be adopted or placed in foster care and the second registry for candidate foster and/or step parents. Both registries should operate by a national authority responsible for adoptions and placements in foster care; this authority will proceed with coupling of the two registries in a transparent way and taking into account the rules for privacy of personal data)* (for the above description see: www.dikaiologitika.gr)
2016	**Draft Law** on *"prerequisites for placement of minors into residential care or foster family from and to EU Member States on the basis of Law 56 of the Council Regulation (EC) 2201/2003 (November 27, 2003) on jurisdiction and the recognition and enforcement of judgments in matrimonial matters and in matters of parental responsibility for children of both spouses Regulation (EC) 1347/2000)"*
2015	**Law 4356/2015 (GG A 181/24-12-2015)** *"Cohabitation agreement, exercise of rights, penal and other provisions"*
2014	**Ministerial Decision Δ27Γ.Π.οικ./22560/891/ 2014:** *Keeping of a National Registry for Foster Parents of Minors* **Decision ref. no. Δ27/οικ.34481/1526/2014:** *Prerequisites for foundation and operation of Child Protection Unites by Legal Entities of Private Law [repealed].* **PD 113/2014:** *Organization of Ministry of Labour, Social Security and Welfare* **Law 4267/2014:** *Combating of child's sexual abuse and exploitation and child pornography and miscellaneous related provisions.*
2013	**Law 4109/2013:** *Urgent regulations of the Ministry of Environment, Energy and Climate Change and other provisions.* **Law 4216/2013:***Council of Europe Convention on Action against trafficking*
2012	**Law 4055/2012:** *Fair trial and reasonable duration of trial. In art. 17 (on cases of voluntary jurisdiction)*
2011	**Law 3961/2011:** *Modification of Law 3126/2003 for Penal Responsibility of Ministers and other issues (Art. 8states that National Center for Social Solidarity maintains and operates the National Registry for Child Protection)* **Decision 49540/2011:** *Coordination of Actions and Child Protection Services* **Law 4025/2011:** *Reconstruction of Social Solidarity and Rehabilitation, Restructuring NHS and other provisions* **Law 4020/2011:** *Convention of 19.10.1993 on the international jurisdiction, applied law, recognition, implementation and cooperation in regards to parental responsibility and measures for children's protection*

2010	**Law 3838/2010:**	*Modern provisions on Greek nationality and the participation of ethnic Greeks and legally residing immigrants and other arrangements*
	Law 3852/2010:	*New Architecture of Self-Administration and Decentralized Administration – The Program Kallikrates.*
	Law 3860/2010:	*Improvements of penal legislation for minor offenders, prevention and treatment of minors' victimization and criminality*
	Law 3868/2010:	*Upgrade of National Health System and related issues under the responsibility of Ministry of Health and Social Solidarity*
	Law 3875/2010:	*Ratification and implementation of the UN Convention against transnational organized crime and its three Protocols; miscellaneous related provisions*
2009	**PD 86/2009:**	*Organization and implementation of the institution for child's foster care*
	Law 3765/2009:	*Ratification of Convention of Hague on Protection of Children and Co-operation in Respect of Inter-country Adoption.*
2008	**Law 3527/2008:**	*Ratification and implementation of the Council of Europe Convention for the protection of children against sexual exploitation and abuse, measures for the improvement of living conditions and decongestion of detention centers; miscellaneous provisions*
	Law 3699/2008:	*On special education of persons with disabilities or special educational needs*
	Law 3718/2008:	*Art.20 replaces the art. 7 of the Law 2447/1996 in regards to the placement of a child to candidate adoptive parents before the completion of the social research)*
	Law 3727/2008:	*Ratification of the Lanzarote Convention of the Council of Europe on the Protection of Children against Sexual Exploitation and Sexual Abuse.*
	PD 55/2008:	*Organization of Institute of Social Protection and Solidarity*
2007	**Law 3625/2007:**	*Ratification of the Optional Protocol to the Convention on the Rights of the Child on the sale of children, child prostitution and child pornography; miscellaneous related provisions.*
2006	**Law 3500/2006:**	*Combating Intra-Family Violence*
	PD 22/2006:	*Organization of National Center for Social Solidarity*
	Joint Min. Dec. 33165/2006:	*Establishment of Socio-Medical Centers*
	Joint Min. Dec. 139491/2006:	*Requirements for free hospital and medical care of Greek and foreign citizens*
	Joint Min. Dec. 92798/2006:	*"Readjustment of the amount of provided financial support to foster families and way of payment of the Social Care units, Anarrotirio Pentelis, Pedopolis "Aghios Andreas" Kalamaki, Center Infant 'Mother'"*
2005	**Law 3386/2005:**	*Entry, Residence and Social Integration of third-country nationals on Greek Territory*
	Law 3370/2005:	*Organization and Operation of Public Health Services and other issues.*
	Law 3344/2005:	*European Convention for Human Rights and Fundamental Freedom (as modified by Legal Decree 53/1974; Law 1705/1987; Law 2400/1996)*
2004	**Min Decision Π1α/Γ.Π.οικ.74349/2004** "Determination of the amount of provided financial support to foster families and way of payment of the Social Care units, Anarrotirio Pentelis, Pedopolis "Aghios Andreas" Kalamaki, Center Infant 'Mother'**"**	

2003	**Law 3094/2003:**	The Ombudsman and other provisions
	Law 3106/2003:	*Reorganization of the National System of Social Care*
	Law 3137/2003:	*Convention (2.10.1973) on the applied law and obligations related to child support obligations*
	Law 3172/2003:	*Organization and modernization of Public Health Services and other provisions*
	Law 3171/2003:	*Convention (2.10.1973) on recognition and implementation of decisions related to child support obligations*
	Min Decision Π1α/Γ.Π.οικ.86970/2003	"Continuation of implementation of social-welfare programs of the National Organization of Social Welfare (PIKPA, EOP) in the context of the institution of foster parents and of support of families in crisis in particular by Social Care Units of Pe.S.Y.P"
	Law 3189/2003:	*Reform of Penal Legislation for minors; miscellaneous provisions*
	PD 233/2003:	*Protection of and assistance to the victims of the crimes referred to articles 323, 323A, 349, 351 and 351A of the Penal Code*
2002	**Law 3064/2002:**	*Measures to Combat Trafficking in Human Beings, Sexual and Economic Exploitation, and Child Pornography*
	Law 3080/2002:	*Optional Protocol to the Convention on the Rights of the Child on the involvement of children in armed conflict*
2001	**AY 19353/2001:**	*Definition of prerequisites, organization, operation of principles as well as the details for the programs of hosting families (art. 9 Law 2716 1999)*
2000	**PD 36/2000:**	*Organization of Ministry of Justice*
	PD 95/2000:	*Organization of Ministry of Health and Welfare*
1999	**Law 2716/1999:**	*Development and Modernization of Mental Health Services*
	Law 2776/1999:	*Correctional Code*
	PD 226/1999:	*Agencies and organizations responsible for conducting social research in child adoptions and for the preparation and realization of adoptions*
1998	**Law 2619/1998:**	*Ratification of the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine*
	Law 2646/1998:	*Development of the National Social Care System and other provisions*
	PD 63/1998:	*Employment of minors in prohibited works*
1997	**Law 2462/1997:**	*Ratification of the International Convention on Civil and Political Rights*
	Law 2502/1997:	*Ratification of the European Convention on the Exercise of Children's Rights*
	Law 2514/1997:	*Convention on Implementing the Schengen Agreement*
	PD 180/1997:	*Abolishment of Papagou Institution for Minor Female and Korydallos Institution for Minor Male operating under Ministry of Justice*
1996	**Law 2447/1996:**	*Adoption, Tutelage of a minor, Sponsorship of minor and Judicial assistance (ratification of the draft Law and incorporation into the Civil Code Part A, art. 3-11, 49-54, 57-58, 60, Part B).*
1995	**Law 2298/1995:**	*Design and implementation of Detention Policy and other provisions*

1993	**PD 337/1993:**	*Definition of conditions and prerequisites for placement of children in foster families*
1992	**Law 2082/1992:**	*Reorganization of Social Welfare and Introduction of New Methods of Social Welfare*
	Law 2101/1992:	*Ratification of the UN International Convention on the Rights of the Child*
	Law 2102/1992:	*Ratification of the UN International Convention on the Civil Aspects of International Child Abduction*
	Law 2104/1992:	*European Convention on Recognition and Legal Guardianship of Children*
Before 1992	**PD 141/1991:**	*Competences of organs and official activities of the personnel employed with the Ministry of Public Order; organizational issues under which the Hellenic Police protect children from all risks they may be exposed to*.
	PD 95/1987:	*Restructuring, establishment, organization and operation of services of Attica General Police Directorate*
	Law 1702/1987:	*European Convention on Legal status of children born out of wedlock*
	Law 1431/1984:	*Regulation of issues of child protection social welfare services and other provisions*
	Law 1426/1984:	*Social European Charter*
	Law 1049/1980:	*Convention of the Council of Europe on Adoption of Children*
	PD 49/1979:	*On issues related to operation of Juvenile Service*
	Law 378/1976:	*Establishment of Juvenile branch by Juvenile Courts and related issues*
	PD 56/1974:	*First additional protocol to Convention for the protection of Human Rights*
	Reg.D. 71/1973:	*On compulsory primary education of juvenile reformatories and their affiliation to the Ministry of National Education and Religious Affairs*
	Law 2792/1954:	*On the organization of the Probation Service by Juvenile Courts*
	Law 2329/1953:	*European Convention for the Protection of Human Rights and Fundamental Freedoms*
additionally	**Greek Constitution**	Art. 9:*1,* Art. 21:*1, 3,* Art. *28:1*
	Civil Code:	articles 1510-1518 (regulation of parental care and custody exercising) 1532, 1533, 1536, 1537, 1538, 1542-1588 (adoption), 1589-1654 (guardianship); and 1655-1665 (on the institution of foster care of children)
	Code of Civil Procedure articles 735, 739, 740, 742, 744, 752, 758, 776, 796, 797 and 691:*2, 4*	
	Penal Code:	article 232A on "Violation of court decisions", article 323A on "Trafficking in human beings", article 324 on "Abduction of minors", article 348A on "Child pornography", article 351 on "Pandering"; article 352A:4, articles 122, 123
	Code of Penal Procedure article 45A	

Annex 7 Presentation of the most significant legislative provisos for minor asylum seekers and victims of trafficking

Minor asylum seekers can remain legally in Greece until their request is considered. Recognized refugees have the right to legal residence for a period of three years which can be renewed (Presidential Decree 141/2013, paragraph 24). There is also the possibility that when an application for international protection is rejected (in Asylum Service or Appeal Authority) and the competent decision authorities suspect that the conditions for granting a residence permit for humanitarian reasons are met, they refer the case to Ministry of the Interior, in accordance with article 19 A par. 1 f of L. 4251/2014, as amended by Law 4332/2015. Otherwise, a minor with the assistance of his or her guardian, representative or lawyer could claim a residence permit for humanitarian reasons, as set out in L. 4251/2014, as amended by Law 4332/2015, as a guest in housing structures. For unaccompanied minors (residence permit for two years and renewed for two years at a time, or as a minor who has proven protection measures and is hosted by institutions or other legal entities of public interest, in the case that their return to a safe environment is impossible (Article 19 A (2) (a)). In any case, under Greek practice, minors are not expelled, as there are no guarantees provided by the law, that such a decision serves the best interests of the child (Law 3907/2011 which incorporates Directive 2208/115 / EC of the European Parliament and the Council on common rules and procedures in Member States for returning illegally staying third-country nationals).

Law 4375/2016 on the Organization and Operation of the Asylum Service, the Appeal Authority, the Reception and Identification Service, the establishment of the General Secretariat for Reception, the adaptation of the Greek Legislation to the provisions of Directive 2013/32 / EU of the European Parliament and of the Council on common procedures (Recast), provisions on the work of beneficiaries of international protection and other provisions (as amended by Article 86 of Law 4399/2016). Special provisions for minors, inter alia:

Article 36, paragraphs 8-10

- A minor under 15 applies for international protection by a representative
- A child over 15 years of age can apply in person
- The minor's spokesperson or representative of the shelter hosting the minor can apply for asylum on behalf of the minor if he / she considers that he / she needs international protection

Article 45

- Appointment of a Guardian for the representation of the child before the authorities and the asylum application procedure and for the safeguarding of his or her interests and human rights,
- Informing of the minor about the asylum process and the asylum interview in a language that he/she understand.
- An interview specially tailored to the needs and age of the child

Article 46

- The detention of unaccompanied minors of international protection should be avoided.
- In exceptional cases, they are kept as a last resort for the shortest period of time until they are transferred to an appropriate hosting structure
- The period of detention cannot exceed 25 days except in exceptional cases that can be extended for another 20 days

PD 141/2013, Adaptation of Greek legislation to the provisions of Directive 2011/95 / EU of the European Parliament and of the Council on the requirements for the recognition and status of aliens or stateless persons as beneficiaries of international protection, Refugees or persons enjoying subsidiary protection and the content of the protection afforded (recast)

Article 28

- Access to the education system under the conditions applicable to Greek citizens

Article 30

- Assistance in matters of social assistance

Article 31

- Access to medical treatment under the conditions applicable to Greek citizens

Article 32

- The competent department of the General Secretariat of Welfare takes all necessary measures to represent unaccompanied minors by appointing a commissioner or assigning responsibility to an organization concerned with the care and protection of minors or other appropriate form of representation
- To meet the needs of minors
- The opinion of the minor is taken into account according to his or her age and maturity
- An effort to identify other members of his family more quickly while respecting the confidentiality required in situations where the life or integrity of the minor or his or her relatives is threatened

PD 220/2007, Adaptation of Greek Legislation to the provisions of Council Directive 2003/9 / EC on minimum standards for the reception of asylum seekers in the Member States

Article 9

- Access to the education system under the same conditions as for Greek citizens
- Access should not be delayed beyond three months from the time the asylum application is received. This period may be 1 year, when specific language training is provided to facilitate access
- When access is not possible, all appropriate measures must be taken
- Access to secondary education is not restricted solely to the reason of adulthood

Article 12, paragraph 1

- Provide material reception conditions to have a standard of living that ensures health, meet living needs and protect their fundamental rights.

Article 13

- Housing with trained staff and confidentiality for all information

Article 14

- The necessary medical care is provided free of charge

Article 19, paragraph 1

- The competent authorities shall immediately take appropriate measures with regard to unaccompanied minors to ensure their necessary representation
- To this end, the competent authorities shall inform the Prosecutor of Minors and, where there is no, the District Attorney, who acts as a temporary guardian and takes the necessary steps to appoint a minor's guardian

Regarding smuggling the Committee on the Rights of the Child stresses that children who arrive unaccompanied in a foreign country if they have not already been victims of exploitation in their country of origin or during their trip are in any case at risk of becoming victims at all times (CRC / GC / 2005/6, see also DSB 34, 35, 36 and 6). It is a fact that trafficking in human beings is often confused with the smuggling of immigrants, as in both cases there may be humiliating, degrading conditions and human rights abuse. However, in immigrants' smuggling the person willingly pays for the transfer (or abandonment) to another country of which he is not a national; this relationship with the trafficker is almost commercial and usually ends

with the completion of the journey. Instead, in human trafficking, there is no freedom of the individual and the purpose of the perpetrator is to exploit the person himself, namely his work, his sexual freedom, or the organs of his body, always violating human rights. Also, in this case the victim may have arrived in the country legally or illegally. There are frequent cases where third-country nationals believe that they will simply cross the country's borders illegally to find work and eventually end up being trafficked and abused by traffickers or other, intimate and non-human beings (see also UNHCR 2006[76], UNODC 2014[77]).

Especially for juvenile victims it is foreseen that recruitment, transportation, accommodation or reception of a child for the purpose of exploitation constitute trafficking of human beings, even if there is a consensus of the child (a. 3 §3 of the Palermo Protocol). The consent of a child is in no way taken into account in the evidence of a trafficking offense against him or her. If there is any doubt about whether the victim is a minor or not, but they can be considered to be under 18, then they are considered minors and are provided with all the special protection measures until their actual age is established (Law 3875/2010 modifying the P No 233/2003). In any case, when the trafficked victim is an unaccompanied minor, the Prosecutor's Office takes all necessary steps to identify his or her nationality and establish the fact that he / she is not accompanied and makes every effort to identify his / her family as soon as possible. The Office immediately receives the necessary measures to ensure the legal representation of the minor and, if involved in the criminal justice system, its representation in this context. Where no family is found or repatriation is not in the best interest of the child, the Advocate-General or, in the absence thereof, the Prosecutor of the Prosecutor's Office may order any appropriate measure to protect him or her until the court has conclude to a decision, to which the minor must address within 30 days, in order to have the appointment of a Commissioner in accordance with the Civil Code (Law 4251/2014, paragraph 49).

When the minor victims of the offences against personal and sexual freedom or the economic exploitation of sexual life is asked to testify before a probation officer or judicial officer, they are examined in the presence of a psychologist or child psychiatrist who has been appointed to prepare the minor to testify (CPC 226 A). The mental health expert proceeds to some meetings with the minor and provides his / her opinion on his / her perceptual capacity and mental condition to see whether the minor is able to testify. The testimony of the minor is documented and where there is the possibility, it can be registered in an electronic audiovisual way in order to avoid the physical presence of the child in the next stages of the criminal proceedings. Accordingly, there is a specific provision for victims of trafficking and trafficking who are asked to testify whether they are minors or are adults (PK 226 B).

In addition, the minor victim of the abovementioned offences is subjected to a specific examination of his or her mental and physical condition in order to assess whether there is a need for treatment (PK 352 A). In accordance with Article 39 of the International Convention on the Rights of the Child, each Member State must take all appropriate measures to facilitate the physical and psychological recovery and social reintegration of the child. In addition, by asking the legislator to protect the privacy of the minor, a right enshrined in the International Convention on the Rights of the Child (Article 16), but also to guarantee his own security (ISSF 6), he penalizes anyone who has leaked data which could lead to the disclosure of the identity of the minor victim throughout the criminal proceedings (CP 352B).

[76] UN High Commissioner for Refugees – UNHCR. (2006) *UNHCR Guidelines on international protection: The application of Article 1A(2) of the 1951 Convention and/or 1967 Protocol relating to the Status of Refugees to victims of trafficking and persons at risk of being trafficked,* available at: http://www.unhcr.org/443b626b2.html

[77] UN Office on Drugs and Crime – UNODC. (2014) *Global Report on Trafficking in Persons 2014*, United Nations publication, Sales No. E.14.V.10