EU-MiCare
Training the EU Health Workforce to Improve Migrant and Refugee Mental Health Care

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Work Package n°2 – Conceptual Framework for covering mental health needs of migrants and refugees

COUNTRY PROFILE COMPILATION

Countries: Germany, Spain, Cyprus, Italy, Greece

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Introduction

In recent years, migration has emerged as one of the most significant global challenges, influencing economic, social, and cultural landscapes in numerous countries. The movement of people across borders, driven by various factors such as conflict, poverty, and climate change, has brought opportunities and challenges to various European countries involved. Although migrants and refugees are populations with high resilience, the literature establishes that psychosocial well-being among migrants and refugees is often compromised, due to prolonged trauma experienced at their country of origin, their journey, or country of destination (WHO, 2022). Despite increasing needs in receiving psychological support, migrants and refugees are often underrepresented in mental health services (McDonald et el., 2021; Bartolomei et al., 2016) while service providers report a lack in training opportunities that would help them deal with the needs of these populations.

The project EU-MiCare aims to address this issue by improving the mental health training of professionals and volunteers in contact with migrants and refugees. It aims at designing an extensive and innovative training program, catering to health professionals across diverse countries. This training program will equip them with essential skills and knowledge necessary to effectively manage the mental health challenges faced by migrant and refugee populations.

This report delves into the migration and psychosocial support landscape for migrants and refugees throughout the asylum process and beyond in five European countries: Germany, Greece, Cyprus, Italy, and Spain. These countries have been chosen for the EU-MiCare project due to their diverse experiences with migration and the varying approaches they have taken to address the mental health needs of migrants. The report will examine the various stakeholders involved in mental health and psychosocial support services for migrants and refugees in each of the selected countries. It will encompass governmental bodies, non-governmental organizations, community-based organizations, healthcare providers, and other relevant actors engaged in providing support during the asylum process. The primary objective of this report is to act as conceptual framework on how mental health and psychosocial support are addressed in these five European countries, which will serve as the foundation for an intervention that can address the unique context of each country.

Germany[1]

As one of the largest recipients of refugees in Europe, over the last few years, Germany has taken in more than 1.5 million people uprooted from their homes due to conflict, persecution, and violence. While providing a new home and opportunities for these individuals is undoubtedly an essential priority, the mental health and well-being of refugees are often overlooked. Depression, anxiety, post-traumatic stress disorder, and other mental health concerns are prevalent among refugees, and these issues often go untreated. This country profile report aims to highlight the mental health challenges experienced by asylum seekers, refugees, and other migrants in Germany and how the country has been addressing them. By delving into the experiences of refugees and the measures implemented by the German government and humanitarian organizations, this report aims to provide a comprehensive account of the mental health picture for asylum seekers and refugees in Germany.

Migrant & Refugees Demographic Characteristics

Number of Migrants/Refugees in Germany

The German authorities do not provide unique, reliable data on the number of people seeking and receiving asylum in the country. The two main data sources on the issue are the German Federal Ministry of the Interior (Bundesinnenministerium) and the German Statistical Office (Statistisches Bundesamt).

According to the German Federal Ministry of the Interior, as of June 30, 2023, there were around 1.57 million people living in Germany who had been granted protection (Mediendienst Integration, 2023). Around a third of them (31%) are minors. Around 67% of them have been living in Germany for more than six years. Their protection is granted in different ways: under the Geneva Refugee Convention (around 750.000 refugees), under Article16a of the German Basic Law (around 45.000 people), subsidiary protection (around 300.000 people), and around 180.000 people for whom a ban on deportation applies. Around 300.000 further people were granted protection due to various circumstances - for example, because they have a job or because they cannot be deported for humanitarian reasons. In addition to

[1] *This report has been compiled with the utmost care, based on reliable sources of information. Unless otherwise stated, the data contained within is accurate and up-to-date as of 20/01/2024. Updates to this report may not be made available past this date.*

them, another half a million people has either an open protection status or is officially obliged to leave after a rejected asylum application but is still in Germany for various reasons. In total, there are currently around two million people seeking protection.

In addition, the German Federal Ministry of Interior reports around one million refugees from Ukraine, who do not appear in the official statistics on asylum.

However, the numbers provided by the Ministry of Interior are based on the registrations in the Foreigners Central Registry (Ausländerzentralregister, AZR), which may, however, be outdated or incomplete. The Federal Statistical Office has therefore published a special analysis of the AZR data. According to this, around 3.1 million people seeking protection were living in Germany as of 31.12.2022 (Mediendienst Integration, 2023).

Ukrainian Refugees

Ukrainians are not submitted to the general asylum law (Mediendienst Integration, 2023) and therefore do not appear in the overall statistics. As of September 30, 2023, 1,099,905 refugees from Ukraine were registered in the Central Register of Foreigners (Ausländerzentralregister, *short AZR*). Amon them, 80% have a residence permit of temporary protection (Section 24 AufenthG).

Around 356,000 of the refugees from Ukraine registered in the AZR were children and young people under the age of 18, with most being of primary school age (38%). Approximately 700,000 refugees from Ukraine were adults, nearly 70% of them were women, 30% were men (Mediendienst Integration, 2023).

Special Reference to Minors & Adults

Refugees tend to be very young, with approximately 73% of asylum seekers who applied in 2022 being under 30 years old, and minors accounting for around 37% of asylum seekers. Among the Ukrainian refugees in Germany, around a third are minors (Mediendienst Integration, 2023).

Main Countries of Origin

The top main countries of origin for refugees in Germany include Syria, Iraq, Russian Federation and Afghanistan (subject to deportation ban). Among those applying for asylum in Germany in 2023, the main countries of origin were Syria, Turkey, Afghanistan, Iraq, Iran, Georgia, and Russia. However, their chances of receiving asylum vary consistently based on the country of origin: while citizens of Syria, Eritrea, Somalia, and Afghanistan have chances to be granted asylum over 70%, for citizens of Georgia, Russian Federation and Turkey the chances are low (Mediendienst Integration, 2023).

Top Asyl-Herkunftsländer 2023

Herkunftsland	Asylanträge	Schutzquote
Syrien	104.561	88,2%
Türkei	62.624	13,0%
Afghanistan	53.582	76,5%
Irak	12.360	25,0%
Iran	10.206	29,5%
Georgien	9.399	0,3%
Russische Föderation	9.028	9,1%
Somalia	5.773	77,4%
Eritrea	4.230	84,5%
Ungeklärt	4.299	57,2%

Tabelle: © MEDIENDIENST INTEGRATION 2024 • Quelle: BAMF, Aktuelle Zahlen zu Asyl 12/2023 • Daten herunterladen • Erstellt mit Datawrapper

Mental Health Issues

The issue of psychological well-being of migrants and refugees in Germany is of great significance since the country is one of the most popular destinations for refugees and migrants seeking asylum in Europe. However, given the high number of asylum seekers and refugees living in the country and the great increase within few years, there is no conclusive and consistent data on the prevalence rates of mental disorders among them. Although there is a great variety in the prevalence rates reported in the literature, all existing empirical evidence indicates that the rates of mental disorders among the asylum seekers and refugee population are significantly higher than in the German population in general (Hajak et al. 2021).

According to research, post-traumatic stress disorder (PTSD) and depression are the most common psychological disorders among refugees (Steel et al. 2009; Steel et al. 1999; Boettcher et al. 2021). Studies

have shown that PTSD and depression are more prevalent in refugee populations compared to host populations. In Germany, for example, there was a prevalence of 40% for PTSD in a sample of asylum seekers (Gäbel et al. 2006). Similarly, a sample of Syrian citizens holding residence permits for Germany showed that 14.5% of the participants suffered from depression (Georgiadou et al. 2018).

These mental health issues often result from traumatic experiences related to war, conflict, persecution, and displacement. These experiences can cause significant psychological distress, leading to symptoms such as flashbacks, nightmares, avoidance behaviors, sadness, loss of interest, and feelings of hopelessness. However, in addition to traumatic events before and during migration, also the so-called post-migration stressors can have a great influence on mental health. Adapting to the new environment includes potential socioeconomic, social, and interpersonal stressors, as well as migration-related barriers to legal residence in the resettlement country (Hajak et al. 2021). In the following, some contextual factors extracted from several articles included in the systematic review by Hajak and colleagues (2021) will be discussed.

Factors Affecting the Psychological Wellbeing in Migrant/Refugee Population

Each step of the refugee trajectory has its own characteristics and potential mental health consequences. While trauma-related factors seem to explain more variance in rates of PTSD, post-migration appears to particularly influence rates of mood and anxiety disorders (Schick 2016). Recent research suggests, therefore, that mental health problems of refugees and asylum seekers are best captured by models integrating pre- and post-migration factors (Schick 2016). This section aims to identify some main contextual factors affecting the psychological well-being of migrants and refugees in Germany.

Pre-Migration and Trauma and Post-Traumatic Stress Disorder (PTSD)

A review of several studies conducted on asylum seekers and refugees in Germany highlights that between 50 and 85% of asylum seekers and refugees report experiencing at least one traumatic event either in their home countries or during their journey to Germany (Hajak et al. 2021). Traumatic events can be unmet basic needs for survival, such as regular access to water and food, shelter and medicine;

fearing for one's life, the death of a loved one, and forced separation from family; witnessing acts of violence, bombing and shooting, living in a war zone; imprisonment, and living in a refugee camp. (Hajak et al. 2021).

These traumatic experiences are a major risk factor for the development of mental disorders such anxiety disorder, depression, and post-traumatic stress disorder PTSD. Not everyone experiencing traumatic events develops a mental disorder, although the greater the exposure to traumatic events, the more pronounced the symptoms of mental disorders, especially depression and anxiety disorders (Kaltenbach et al. 2018).

Asylum Status

One of the most pressing post-migration stressors for asylum seekers and refugees in Germany is an insecure asylum status. The process of applying for asylum and the waiting period until the status is secured can greatly affect the applicants´ mental health well-being. In the first half of 2023, on average, an asylum procedure took 6.6 months between application and decision. However, the duration of the procedure can vary greatly depending on the country of origin: While procedures for people from Moldova and some "safe countries of origin" such as Albania or Montenegro take 2-3 months, they can take 13-16 months for people from Nigeria or Senegal (Mediendienst Integration). Awaiting the outcome of the legal proceedings, either for the initial asylum application or after an appeal against a negative decision, is associated with significantly higher levels of psychological distress and lower life satisfaction compared to the positive response of having a refugee or asylum status (Walther et al. 2021). Symptoms of depression and PTSD among those who are waiting for a decision or receive a rejection are higher compared to those whose residence permit is secured (Hajak et al. 2021). Along this line, a further study (Raghavan et al. 2013) found out that being recognized as a refugee and obtaining a secure status has the greatest effect in reducing the severity of symptoms among asylum seekers.

Family

Separation from the family is identified as a predictor of mental health deterioration among asylum seekers and refugees in Germany (Hajak et al. 2021). This is in line with several international studies showing how refugees isolated from their families were more likely to report psychiatric disorders such

as depression and PTSD (Steel et al. 2006; Steel et al. 2002; Schweitzer et al. 2006). The ongoing worry about the lives of family members left behind is a major factor affecting the psychological well-being of refugees (Nesterko et al. 2020). Refugees coming from a conflict or post-conflict setting, like a war zone, can show greater symptoms of mental health issues. Not only is there the worry of one's family members but also about the homeland and fellow citizens. Additionally, the separation from family and long-standing relationships in the home country, which in mostly Asian and African countries are the biggest social support for individuals, puts refugees and newly arrived migrants at risk of social isolation (Hajak et al. 2021).

Accommodation

A further factor associated with the psychological wellbeing of migrants and refugees is the housing situation. According to a study by El Khoury (2018) the quality of residence affects mental health up to 20%. Living in a shared asylum accommodation or even in emergency accommodations like airport halls, containers, or schools, increases mental health issues while private accommodations or shared apartments can offer a better life quality and also decrease the risk of discrimination experienced in initial reception facilities (Walther et al. 2021). More so, living in independent accommodation relates to a higher quality of life resulting in better mental well-being. These results from the German context are in line with international research showing that living in shared institutions is connected to poor mental health amongst refugees (Silove et al. 2017).

Occupation and Economic Insecurity

Occupation such as work, school or apprenticeship is a protective factor for mental health and well-being and is significantly associated with fewer depressive and PTSD symptoms and better overall mental health (Hajak et al. 2021).

However, asylum seekers in Germany face restrictions in accessing the job market. For instance, people in the asylum procedure are completely banned from working for the first three months. The work ban is extended to six months (for asylum seekers with underage children) or nine months (for asylum seekers without underage children) as long as they live in a reception center. At the same time, asylum seekers are obliged to live in a reception center (see §§ 47 and 61 of the Asylum Act) and therefore cannot avoid

the work ban during this time (ProAsyl). After the period of the work ban, asylum seekers are usually only granted a work permit for employment after approval by the immigration authority. This is, in turn, linked to bureaucratic hurdles, extended waiting time etc.

A similar situation is experienced by those holding a so-called "toleration" (Duldung). When living in a first reception centre, they are banned from working for the first six months (§ 61 para. 1 AsylG). Restrictions on access to work, unemployment, economic challenges, high bureaucratic hurdles in the recognition of certificates and diplomas, often lead to involuntary inactivity and cause feeling of loss of agency, status and being undervalued. Not being able to work due to legal restrictions also causes financial instability, which affects the ability to access adequate housing, healthcare, and education. Concerns about economic stability and uncertainty about the future can cause anxiety, depression, and even feelings of hopelessness (Walther et al. 2021).

Language

Language barriers may limit the individual's ability to access health care services, educational opportunities, and employment, which can further contribute to poor psychological well-being. Most refugees struggle with the German language, which affects their ability to communicate and integrate within German society.

Steel et al. (2002) found poor host language proficiency to be one of the most significant risk factors for mental disorders. Similarly, Hajak and colleagues (2021) indicate that better German language skills reduce the level of psychological distress and increase life satisfaction, especially among men. Language barriers can make it difficult for refugees to access mental health resources, exacerbating feelings of isolation and anxiety and pre-existing mental health issues.

Integration

Integration and mental health are tightly linked. Germany expects refugees to successfully integrate - particularly in terms of learning the language and reaching financial independence. This is for all, but especially for those struggling with mental health issues, very challenging. In fact, a close association between integration difficulties and psychological symptoms has been underlined (Schick et al. 2016).

Conversely, spending more time with German natives and better German skills have been associated with higher levels of life satisfaction and lower levels of psychological distress, particularly among women (Walther et al. 2021). Also, less participation in activities such as German language courses or sports is associated with more psychological symptoms (Hajak et al. 2021).

Discrimination and Cultural Differences

Migrants and refugees in Germany are often faced with discrimination, racism, and prejudice especially in working life, on the housing market, when accessing goods or services, and at public offices or authorities (Antidiskriminierungsstelle des Bundes, 2016). Discrimination can express in several forms: From unfriendly behavior and the denial of services to verbal and physical hostility (Amadeu Antonio Stiftung 2020). Also, the political landscape - with the uprising of the right-wing party of AfD (Alternative für Deutschland) – plays an important role.

Experiences of discrimination have a great influence on their well-being and their behavior: They can lead to resignation or the restriction of one's own behavior as well as sadness, anger or even aggression. Furthermore, experiences of discrimination harm refugees' participation in society, for example by making access to housing and the labor market more difficult (Antidiskriminierungsstelle des Bundes, 2016). Facing stereotypes and discrimination, especially common for Muslim asylum seekers and refugees, can cause frustration and have a traumatic effect, threatening their ability to adapt to life in Germany (von Haumeder et al. 2019).

Confrontations with stereotypes and discrimination can be both frustrating and an obstacle to positive psychological adaptation (Hajak et al. 2021). The level of perceived discrimination was also associated with psychological distress, particularly depressive and GAD symptoms (ibid.).

Barriers

Asylum seekers and refugees encounter a series of legal und bureaucratic barriers in accessing mental health provisions, as described in the next paragraphs. In addition to them, a further major barrier can be identified as the fear of exclusion, stigmatization, and feelings of shame that are associated with mental health issues (Kantor et al. 2017). This is especially true in the Arabic world, where seeking psychotherapeutic care is often seen as a weakness and failure (Chowdhury 2016). Additionally, many

people lack knowledge about mental health, including symptoms and treatment options (Bajbouj et al. 2021; Boettcher et al. 2021).

To overcome these barriers, it is important to increase awareness and knowledge about mental health, reduce stigmatization, and improve access to healthcare and information. Additionally, providing support and education to those who may be hesitant to seek psychotherapeutic care can help break down barriers.

Access to Healthcare for Asylum Seekers and Refugees in Germany

Legislation Regulating Access to Healthcare

The German health care system is an insurance-based system. Most people - included all who work as employers - are insured by one of the statutory insurance companies. However, in order to be accepted into the insurance companies some requirements must be fulfilled, e.g. a residence permit. This means that for asylum seekers in the first 18 months upon their arrival as well as migrants without legal status the membership in a health insurance is precluded.

Access to health care for asylum seekers and refugees depends on the length of residence in Germany and the residence status. As soon as they apply for asylum, and in the first 18 months upon their arrival in Germany, asylum seekers receive social benefits according to § 3 AsylbLG and health care provisions according to §§ 4 and 6 AsylbLG. Persons with a so-called “toleration permit” (Duldung) as well as persons who are by the law obliged to leave the country and are not in possession of a “toleration permit” (e.g., migrants without legal status) also fall under the AsylbLG. Holders of specific residence permits and persons who have filed a follow-up asylum application or a confirmatory application are also included in the scope of application. In contrast, refugees who are required to leave the country and who have already been granted international protection by another member state of the European Union are expressly excluded from receiving benefits. They should only receive so-called “bridging benefits” for a maximum of two weeks, with entitlement only once within two years. Further benefits are to be granted only in cases of special hardship.

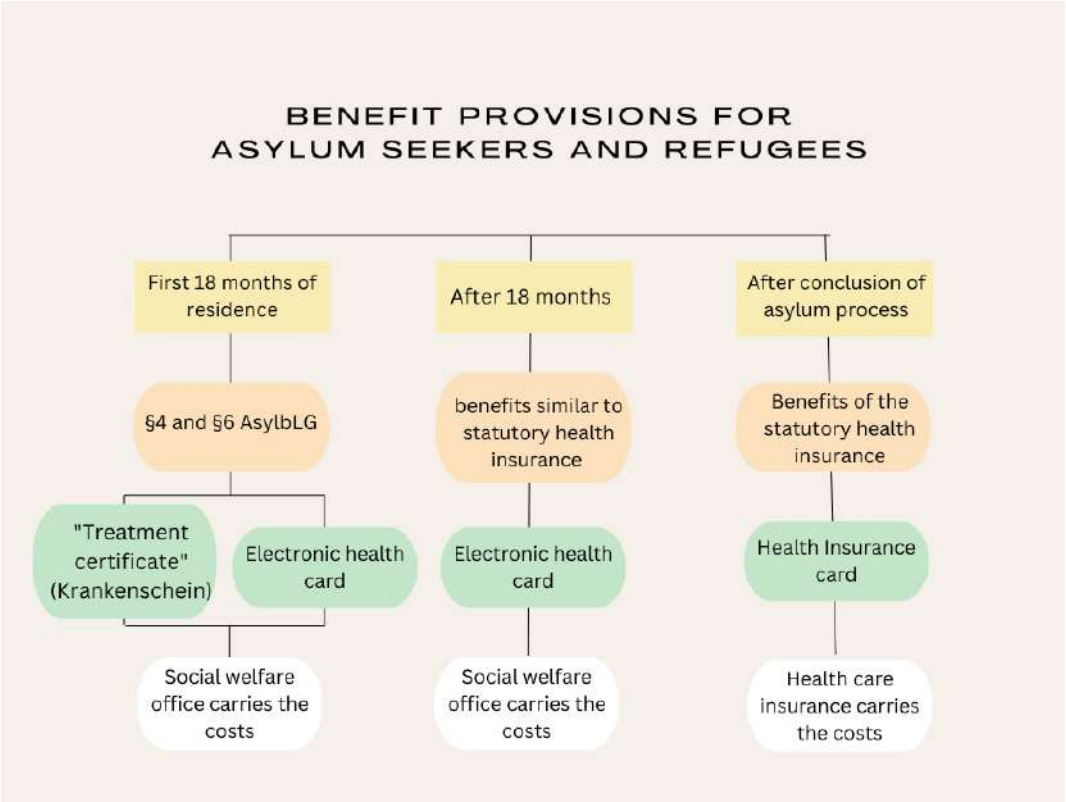
Spouses, life partners and minor children of the persons in question are also entitled to benefits under the AsylbLG, even if they themselves do not fall into the above-mentioned residence categories. Unaccompanied children and adolescents are given priority for benefits under Book VIII of the Social Code.

Health care provisions within AsylbLG are limited and include only "necessary" treatments of "acute illnesses and pain conditions"[2]. Provisions on health care in general (and mental health too) are regulated by §4 and §6 AsylbLG. Following §4 the health treatment must be “necessary”, for an “acute” and “painful” condition to be financed. Based on §6 AsylbLG, further benefits to ensure subsistence or health can be applied for in individual cases. The granting of these "optional" benefits is at the discretion of the responsible authority. Because of the fussiness of these definitions and the lack of a detailed catalogue of foreseen treatments, authorities (especially social welfare offices) have a great leeway in the decisions of which health care treatment shall be financed and carried out. However, in the case of persons with special needs as defined by the EU Reception Directive (e.g., victims of human trafficking, persons with mental disorders and persons who have suffered torture, rape or other serious forms of psychological, physical or sexual violence), the discretion is usually reduced, and the necessary health benefit must be granted (BAfF 2020).

After 18 months of residence, the legal framework is regulated by § 2 AsylbLG and the benefits guaranteed are similar to those granted by the statutory health insurance.

If an employment subject to compulsory insurance is taken up (and it fully covers one's own needs and, if applicable, and those of the family) or if recognition is granted in the asylum procedure, then the entitlement to asylum seeker benefits no longer applies. These persons are covered by statutory health insurance and the restrictions mentioned here do not apply.

[2] Provisions during pregnancy and childbearing are covered entirely by the AsylbLG.



Implementation and financing of healthcare for asylum seekers

During the first 18 months, the costs of health care treatment are carried by the responsible social welfare office (Sozialamt). Within the federal framework provided by the AsylbLG, the individual federal states or even municipalities regulate specific aspects of the health care provisions for asylum seekers. In some cases, asylum seekers can access health care through a so-called “sickness certificate” or “treatment certicate” (Krankenschein). This certificate must be applied for at the social welfare office prior to each visit to the doctor. Furthermore, this certificate is valid only for a short period of time (a quarter of a year) and, if expired before the treatment was carried out – for example due to longer waiting times for specialized medical visits – must be requested again at the responsible authorities. A problematic aspect of the “treatment certificate system” is that the social welfare office staff called to decide on the assumption of costs normally has no medical background and can therefore not always rightly evaluate the need of treatment from a medical point of view (Mohammed et al. 2022).

In the last years, some federal states and autonomous communities have introduced an electronic health card for asylum seekers (eGK). Although this card looks like the insurance card people receive when becoming "full" members of a health insurance, the provisions covered by it remain limited to those foreseen in the Asylum Seekers Benefits Act. However, asylum seekers in possession of a health card do not need to request the "treatment certificate" at the social welfare office anymore and can access health care directly. The health card simplifies access to health care by removing barriers to utilization and eliminating extensive bureaucratic hurdles. By that, it also reduces the delays in treatment that can be expected when applying for a "treatment certificate". Especially chronically ill asylum seekers can benefit of the simplified access to health care. When in possession of the health card, asylum seekers only rarely need to visit the social welfare offices - for example, in the case of services requiring approval and language mediator costs (Lindner 2022; Rolke et al. 2020).

After 18 months of stay, the legislative framework applying is analog to the "Social assistance benefits" (Sozialhilfeleistungen, SGB XII). The range of health care provisions guaranteed to asylum seekers is wider than the one of the AsylbLG as they are entitled to provisions similar to those of the insured persons of the statutory health insurance (GKV). However, this is still a "transitory stage": the social welfare office remains the cost bearer and asylum seekers do not enjoy a full membership in a health insurance company. Access to health care services occurs only via an electronic health card (the option of a "treatment certificate" is no longer possible).

As soon as the asylum process is completed and asylum seekers receive a residence permit, they become full members of the statutory health insurance. Since health insurance is compulsory in Germany, refugees are entitled to receive the benefits of the statutory health insurance. However, language mediation costs are not covered by the entitlement to benefits of the GKV-insured, an important aspect regarding mental health services.

Refugees without legal status experience a very difficult access to health care. In theory, the Asylum Seekers Benefits Act (AsylbLG) applies also to migrants and refugees without legal status, and they could benefit of the (limited) provisions guaranteed in §4 and §6. However, because of §87 of the Residence Act, all authorities (including the social welfare office) are obliged to report the data of persons without legal residence status to the foreigner's authority. This means that when contacting the responsible authorities to receive the necessary documents to access health care (e.g., "treatment certificate"),

migrants without legal status could be faced with deportation. This *de facto* hinders access to health care whenever public authorities are involved. Migrants and refugees without legal status cannot enter the health insurance system either as they lack the necessary residence permit. Refugees without legal residency status are therefore largely excluded from health care system and are mostly dependent on voluntary or charitable help of organizations and volunteering medical personnel. However, in the last years, some improvements have been made by some municipalities in guaranteeing access to health care to this population. In Berlin and further cities, for example, a responsible "clearing office" has been established by the city government. The task of this office is to offer counseling to migrants without legal residency and investigate if they can possibly receive a residence permit and/or be included in the health insurance system. If the requirements are missing but the person needs medical treatment, the office issues an anonymous health insurance voucher which can be used to cover the costs of treatment without having to fear any negative legal consequence. The obligation to report does not apply to medical staff in doctors' offices or hospitals so that migrants without legal status do not have to fear deportation when requesting medical help. However, when accessing treatment without a clear cost bearer, they must pay the treatment costs out of their own pocket and – especially in the case of major treatments or longer stays in hospital- face the risk of receiving very expensive bills.

Different Implementation across Federal States in Germany

Although the Asylum Seekers Benefits Act applies nationwide in all Germany, it leaves a great deal of room for interpretation and entails many undefined legal terms (Schammann 2015; Hillmann 2017). The insufficient normative concreteness of the AsylbLG, the federal character of asylum policy in Germany as well as the different party-political constellations at the state level concur to create a differentiated landscape of implementation across the single federal states. In fact, the federal states are the key decision-makers in asylum policy when it comes to implementing medical care under the AsylbLG. To this end, they have, among other things, each enacted their own refugee reception laws and ordinances and introduced cost reimbursement procedures.

As a result, access to health care for asylum seekers varies widely across the federal states. In some states, more regulatory-restrictive policies apply ("treatment certificates" according to AsylbLG §§ 4 and 6 with necessary frequent visits to the social welfare office), while in other states more liberal-permissive policies (eGK for asylum seekers with a range of services, that go beyond AsylbLG §§ 4 and 6) are in use.

These differences imply different opportunities for asylum seekers and different administrative procedures and costs for the authorities (cf. Schammann 2015).

The financing of health care for asylum seekers in Germany is carried out by various actors (federal government, the states, and the municipalities) (Bookmann et al. 2018) As long as asylum seekers reside in the (first) reception facilities of a federal state, the latter are directly responsible for accommodation and for bearing the costs of medical care. After the transfer to the districts, independent cities or municipalities, these are responsible for the implementation of the AsylbLG. Until the conclusion of the asylum procedure, it is therefore mainly the federal states and municipalities that must bear the costs of housing and medical care.

Mental Health Services in Germany

Psychiatric and psychotherapeutic care in Germany is composed of outpatient, semi-inpatient, inpatient, and complementary services (Deutsche Gesellschaft für Psychiatrie und Psychotherapie, Psychosomatik und Nervenheilkunde 2022). Most people with mental illness are treated on an outpatient basis, and in many cases the primary care physician is the first point of contact for those affected. Waiting times for a psychotherapy place with a specialist, medical or psychological psychotherapist can last weeks to months. In addition to that, there are significant differences between the federal states and between rural and urban regions (ibid.)

Inpatient treatment of people with mental illnesses is provided by many specialist clinics and departments at general hospitals, including numerous university hospitals. In addition, there are numerous clinics for psychosomatics that offer inpatient care as well. In recent decades, hospital beds and lengths of stay have been massively reduced, while the number of inpatient treatment cases has risen sharply. In addition, the services offered are not yet optimally coordinated - which poses further problems for patients with few personal resources.

Access to Mental Healthcare for Asylum Seekers and Refugees

The legal framework regulating the access and financing of outpatient psychotherapies for refugees is very complex. Several factors (e.g. residence status, length of stay in Germany and employment status) influence on the possibility of a therapy being financed and with whom it can be carried out.

In many places, refugees *de facto* cannot access the standard mental health care system and are not adequately cared for. The main reasons for this are bureaucratic hurdles, lack of language mediation, limited capacities of professionals and the associated long waiting times, and reservations on the part of doctors and psychotherapists about treating refugees with traumatic experiences play a role (Mohammed et al. 2022). In addition, therapists often lack the expertise to deal with the special needs of refugees (Flory et al. 2016). A further key issue for mental health care is, next to the treatment itself, the provision of language mediation/interpretation, which is also hard to receive.

Psychotherapy during the asylum procedure

During the first 18 months of residence, access to psychotherapy or counseling is difficult, as mainly emergency and acute treatments are provided. While §4 of the AsylbLG states that the necessary medical treatment is to be granted for the treatment of “acute illnesses and pain conditions”, §6 states that other benefits can be granted on an individual base if “they are indispensable to safeguard health”. The social welfare office must assess and approve treatment as necessary. Following the law, for a health provision (e.g., psychotherapy) to be granted and financed, it is sufficient to meet one of the two conditions stated in the corresponding paragraphs.

In practice, however, the relatively open formulations of the law often lead to uncertainty among the administrative staff about which services are covered by the law and should be financed. As a result, many health provisions, including psychotherapy, are rejected. Newest data by the Nationwide working group of the Psychosocial Centers for Refugees and victims of torture (BAfF e. V. 2022) report that the rejection rate for therapy applications at the Social Welfare Office (15.3%) was significantly higher than the rejection rate when applying for therapy at a statutorily health insurance (2.6%).

European directives (especially the so-called "Reception Directive”) also foresee the right of refugees to appropriate medical care, including psychotherapy. The Reception Directive is especially important for asylum seekers with special needs and states the provision of "necessary medical and other assistance, including, if necessary, appropriate psychological care." According to Art. 21 of the Directive, asylum seekers with special needs (also called “especially vulnerable refugees”, besondere schützbedürftige Geflüchtete) include, for example, minors, unaccompanied minors, disabled persons, elderly persons, pregnant women, single parents, persons with serious physical illnesses, persons with mental disorders and persons who have suffered torture, rape, or other serious forms of psychological, physical, or sexual

violence. LGBTIQ+ refugees are not explicitly named in this (non-exhaustive) list, but in the view of both the German government and NGOs and advocacy groups, they are also understood to be a particularly vulnerable group with specific needs.

If special needs are present, authorities cannot by law refuse suitable and necessary psychotherapy. However, in practice such applications are nevertheless often rejected.

If treatment has been approved, in most of the cases the waiting period for a therapy is long. In the first 18 months of residence, therapy can be carried out by therapists with or without health insurance approval (Kassenzulassung). The costs of treatment are covered by the social welfare office after psychotherapists in private practice or in in psychosocial centers apply for it. In the first 18 months of their stay, most asylum seekers and refugees are treated in one of the 47 psychosocial centers for refugees and torture victims (PSZ) across Germany. There, psychosocial, therapeutic, and other low-threshold support services are available in a mostly interdisciplinary team. Admission is granted via a waiting list system. PSZs have their own pool of language mediators.

After 18 months of residence, the legal framework changes and asylum seekers have the right to benefits analogous to those granted by a health insurance. This implies that they can be treated only by psychotherapists who are licensed by the health insurance (Kassenzulassung). Especially in some regions, because of the very high demand and/or the scarce number of psychotherapists licensed by the health insurance – a further option becomes useful. This foresees psychotherapists to apply for a special authorization that enables them to treat asylum seekers (Ermächtigung). This measure should improve the possibility of access treatment for asylum seekers and increase the offer of therapy. Furthermore, psychotherapeutic outpatient departments of universities can be a contact point in the search for a therapist (BAfF, 2020).

A further barrier to access to mental health care for asylum seekers and refugees is language. In fact, many of them need the assistance of an interpreter for receiving psychological treatment. The financing of interpreters during the first 18 months can be applied for at social welfare offices within the framework of the AsylbLG. In practice, however, it has been shown that processing often takes many months. Furthermore, according to the experience of the Psychosocial Centers for Refugees and Victims of Torture (PSZ) in Germany, only 58% of applications for the assumption of language mediation costs are decided positively.

After 18 months, costs for language mediation are not covered anymore, as they do not belong to the catalogue of provisions granted by the statutory health insurances, on which the provisions in this phase of asylum process are oriented.

For unaccompanied minors, special regulations about the financing of health care apply. In the case of therapies, the responsible authority depends on whether the need of a therapy arises from a "mental disorder requiring treatment", a "disruption in the education process" or a "mental disability". In case of a mental disorder requiring treatment, the costs are normally covered by the statutory health insurance. Otherwise, the costs are covered by the youth welfare office.

Psychotherapy after obtaining a residence permit

After obtaining a residence permit, refugees enter the statutory health insurance (either when an employment is taken up or the persons receives social benefits following SGB II). If the membership in the health insurance derives from employment, also spouse and children of the worker are entitled to receive the same benefits.

With membership in a health insurance, psychotherapeutic treatment can be obtained only from psychotherapists approved by the health insurance. In order to ease the access to mental health care provisions, an additional path to therapy has been established through a procedure called "reimbursement procedure" (Kostenerstattungsverfahren). This allows to receive psychotherapy from a therapist not licensed by the health insurance (BAfF 2020).

Discrimination of Asylum Seekers and Refugees

The experiences and needs of refugees are heterogeneous, as is the case with people who have not experienced flight. For those affected, a flight experience is a significant and potentially traumatic experience, but the consequences for the individuals, their families, communities, and societies are very diverse and context dependent (BAfF 2022). All in all, the meaning and impact of a flight experience on individuals are influenced by their life realities prior to flight (e.g., health conditions, social roles, social and professional involvement, traumatic experiences, political persecution, etc.), their experiences during the flight (e.g., duration, escape routes, intensity of threat and violence) and the conditions in the destination country (e.g., personal safety, accommodation, residence status, development opportunities, etc.) (e.g. Patel 2003).

The experiences of asylum seekers in Germany differ greatly depending on their residence status. People who quickly obtain an unlimited settlement permit or at least a temporary residence status (e.g., persons granted asylum, refugees under the Geneva Convention, refugees with subsidiary protection, or refugees protected by a national ban on deportation) have good opportunities to activate their self-healing potential, in part because they can develop new life perspectives in safety. These are good preconditions for coming to terms with the flight experiences and the arrival in a new society (BAfF 2022).

Of the nearly two million people seeking protection in Germany in 2020, only 280,715 had a permanent settlement permit, which secures a long-term perspective in Germany. More than one million had a temporary residence permit, which allows regular access to education, social services, health care and the labor market, but residence is not secured in the long-term. The situation of persons without secure residence (e.g., without legal status or just a "toleration permit") is much more difficult. In 2020, a total of 459,100 persons (23% of all protection seekers) were in Germany without a secure residence status, of whom 215,960 had an open protection status, i.e., they were still in the asylum procedure, and a further 243,140 persons who had been rejected and were therefore considered obliged to leave the country (Statistisches Bundesamt 2021). The latter, however, often stay in Germany for many more years without a secure residence status in order to fight for their right to asylum. Their living situation is characterized by adverse conditions such as years of waiting for a secure residence perspective, cramped living conditions in shared accommodation, lack of or limited education and work permits, lack of or limited access to integration and language courses, and restricted access to health care (BAfF 2022).

Especially people who have experienced severe violence and torture and, in addition, have no secure prospects of staying in Germany are exposed to at great risk of not recovering well from their physical and psychological ailments, but on the contrary, to suffer from protracted psychosocial stresses (Bittenbinder & Patel 2017; Winkler et al. 2019). Furthermore, the opportunities for social participation and access to social and health services are particularly limited and associated with hurdles for these individuals.

For many years, the BAfF together with many other actors has been reporting the discrimination and exclusion of refugees in Germany, especially regarding their health care (Baron & Flory 2020; BAGFW 2020; BPtK 2018; ProAsyl 2017; Razum et al., 2016). Professionals in the field underline that Germany does not grant the human right to health equally to all individuals and therefore does not fulfill its obligations under international treaties regarding discrimination-free and comprehensive health care, free of discrimination (for more detail, see Baron & Flory 2018).

The current report of the Federal Anti-Discrimination Agency of Germany (Bartig et al. 2021) clearly points to discrimination mechanisms in health care. The following areas of discrimination have been identified:

(1) **Institutional exclusion**, such as exclusion from the right to health through the Asylum Seekers' Benefits Act.

(2) **Lack of expertise in migration-specific aspects** by health care professionals.

The health care system is insufficiently prepared to deal with (cultural) diversity and especially the needs of refugees. Only in isolated cases there are health care facilities offering treatment that do justice to the cultural diversity in society. One of the reasons is that the handling of cultural diversity in the treatment of patients does not play a central role in the training of physicians and psychotherapists. Also, the complex psychosocial needs of people who have survived war and violence are not addressed. Thus, people with uncertain residency status and survivors of violence and torture often encounter health care staff who do not have the necessary knowledge and skills to deal with their specific needs. This can lead to misunderstandings and frustration on both sides and, in the worst case, prevent necessary treatment (BAfF 2022).

(3) **Prejudice in the interactions** between health care professionals and refugees.

Refugees are sometimes exposed to prejudice and racial devaluation in their everyday life. This is very stressful for those affected and has a negative impact on their well-being and health (Schouler-Ocak et al. 2021; Kluge et al. 2020; Sequeira 2015; Velho 2011). In the context of health care, prejudice can lead to people not being heard, their needs not being taken seriously[3], or in the worst cases, treatment being denied (BAfF 2022).

(4) **Lack of accessibility in health care**, oft due to the lack of access to language mediation/interpretation for people with little or no knowledge of German.

[3] In the so-called “Afro Census”, the first comprehensive study on black, African, and Afro-diasporic living realities in Germany, which has been carried out online in 2020, two thirds of the respondents (66.7%, n = 2,108) agreed with the statement "My doctor does not take my complaints seriously" (Aikins et al. 2021).

As for outpatient care, the number of doctors and psychotherapists able to offer their treatment in languages other than German is limited and they are difficult to find. Hospitals sometimes offer to organize language mediation and to finance it through hospital budgets, but in practice it is common that acquaintances, relatives or even children must help with translation (Karger et al. 2017). Interpretation during a health care appointment (or a therapy) requires great organization, is time consuming and often doctors and psychotherapists do not know how to organize and finance it.

(5) **Lack of reliable data on refugees' health and needs**

Until recently, data on refugees' health has not been included in the most important nationwide surveys and only rudimentary data on their health was available.

Necessary Interventions

Hanewald et al. suggest a so-called two-step approach including a broad screening that detects mental health risks at an early stage in addition to the physical examination. In case of a positive diagnosis quick and appropriate (medical) action should be taken. The main point however is to take a holistic approach by considering the social, political, legal and financial impacts when treating refugees (Hanewald et al. 2022).

The BAfF, the umbrella organization under which the 47 psycho-social centers main providers of mental health provisions to asylum seekers and refugees in Germany are organized, had redacted a list of necessary interventions for improving health and well-being among refugees and asylum seekers. These include:

- Upon arrival, quicker registration and placement in an accommodation providing sufficient privacy and opportunities for social interaction.
- Asylum seekers and refugees should have the same access to medical and psychosocial care as people with statutory health insurance.
- Improving of the transcultural competencies and sensitity towards (cultural) diversity in institutions providing social, legal, and healthcare services
- Targeted counseling within the first few weeks, which helps to identify special resources, needs, and protection requirements.

- Access to needs-based multi-professional help for people who have experienced violence and torture
- Easier access to education, labor market, social and health care, language mediation

In conclusion, several factors affect the psychological well-being of migrants and refugees in Germany, including trauma and PTSD, discrimination and social exclusion, acculturation, language barriers, and economic challenges. So, after the arrival of refugees, certain factors can help improve their mental well-being. These include the necessity for education, screening for mental health, psychoeducation regarding mental health, early contact with language and cultural mediators, a more flexible residence law, availability of language mediators with covered costs, more knowledge about psychological problems by decision-makers, and extended support by interpreters. Additionally, concepts and considerations around working with lay people, such as Narrative Exposure Therapy (NET), group psychoeducation, and E-mental health, can be effective.

To address the mental health needs of migrants and refugees, it is essential to provide culturally sensitive and trauma-informed mental health services that are tailored to meet the specific needs of the target group. A wide range of culture and trauma-sensitive diagnostic and therapeutic procedures are needed, along with new mental health care models with fast and low-threshold access to diagnose, prioritize and treat refugees. Community-based mental health services and concepts of humanitarian aid or emergency medicine that address situations where a quick response is required in an environment with limited resources within a prioritization system can also be effective. Importantly, factors such as granting a residence permit, perceived social support, safe environment to profit from available resources, participation in everyday life, freedom of movement, access to the labor market, address discrimination and social exclusion through social integration policies, and providing independent refugees opportunities with active members of the communities of refugees can promote mental well-being.

Main providers of mental health provisions to asylum seekers and refugees

The 47 psycho-social centers (PSZ, psychosoziale Zentren) across all Germany are the main providers of mental health provisions to asylum seekers and refugees. The centers are organized under the umbrella

organization called “BAfF”. These centers do not belong to the “standard” mental health services and have a mixed financing (public, donations etc.). The psycho-social centers have been focusing on the support of traumatized refugees, victims of torture and particularly vulnerable and/or mentally ill refugees.

They offer a wide range of support services including diagnostics/clearing, crisis intervention and stabilization, as well as psychosocial or psychological counseling. To their further offers belong social counseling, the preparation of expert reports especially on health status for the asylum procedure, individual psychotherapies, legal counseling on asylum, the identification of refugees in need of “special protection”, group psychotherapy or other group activities promoting social contacts. Other services include support during the visits to the authorities, coordination of language mediators and volunteers, and additional services to promote social participation (e.g., mentoring). In addition to that, the psycho-social centers offer training for professionals for improving their competence in working with traumatized refugees (BAfF 2022).

Because of the above-mentioned barriers in the access to mental health care, the psychosocial centers are key actors in the provision of mental health for refugees. The clients of the PSC often include people with special (protective) needs, for example as a result of experiences with torture, human trafficking and/or persecution on the basis of sexual orientation and/or gender identity. Many PSC clients have a precarious residence status, i.e., they are waiting for the result of an asylum procedure or only have a temporary “toleration permit” (Duldung), which leaves open the possibility of being deported at any time. The PSCs give priority to people with a precarious residence status, as they experience severely limited access to standard health care.

Nonetheless, although spread all over the country, also psychosocial centres can be hard to reach for asylum seekers and refugees living in the countryside, who have often to travel many kilometres to receive treatment in the centres.

The BAfF conducts an annual online survey of all member centres to obtain data on the care of refugees in the psychosocial centres (PSCs). This is the only regularly scheduled and nationwide survey of data on the psychosocial care of asylum seekers and refugees.

In 2020, a total of 19,352 clients were served in the centres (decrease of 25.5% compared to the year before, due to the Covid-19 pandemic). Almost two thirds (65.5%) of the clients were in the asylum-

seeking process, hold a “toleration permit” or had no legal residence status. Only about a quarter (27.9%) had a relatively secure residence status, i.e., a residence or settlement permit. In comparison, three quarters (75.3%) of all refugees in Germany had a relatively secure residence status. In 2020, the clients of the PSCs came from over 100 different countries. The ten most common countries of origin were: Afghanistan, Syria, the Russian Federation, Iran, Iraq, Nigeria, Guinea, Turkey, Somalia, and Eritrea.

Benefits accorded to Ukrainian refugees

Since the Ukraine crisis many refugees from Ukraine have sought protection in Germany. While it has been regarded highly positive how quick the government provided structures for Ukrainian refugees concerning accommodation, legal status, health care and labour market access, refugees from other countries have noticed the difference in treatment. Migrants from Ukraine receive faster and less bureaucratic assistance. They have improved access to education and employment opportunities, as well as better healthcare options. However, it can be seen as a positive development from the German government to have improved its processes of integration since the great arrival of refugees from Syria in 2015.

Cyprus[4]

Migrant and Refugee Demographic Characteristics

Cyprus is an island located in the Eastern Mediterranean, covering a total area of 9251 km^2. According to the Statistical Service of Cyprus (2019), the total population is 888,000. Currently, there is a growing number of recently arrived refugees and adult migrants. In 2002 the Government of the Republic of Cyprus, took over refugee protection responsibilities from UNHCR. From January through to the end of September 2022, some 16,705 persons have applied for asylum (Country Report Cyprus: Asylum Information Database., 2021). Based on the EMN annual report 2021 on Migration and Asylum, 69,120 registered refugees and migrants entered the borders of Cyprus (Eurostat, 2022 ; Country Report Cyprus: Asylum Information Database., 2021). Currently there are 27,725 applications pending at the Asylum Service and another 8,013 appeals pending at the International Protection Administrative Court (IPAC). As of now, there are 16,301 persons registered as refugees or subsidiary protection beneficiaries. In addition, some 110 refugees under UNHCR's mandate reside in the northern part of the island (Eurostat, 2022).

From January to September 2022, 665 unaccompanied/separated children (UASC) applied for asylum in the Republic of Cyprus. Another 396 applied in 2021; 451 in 2020; 565 in 2019; 259 in 2018; 221 in 2017; and 220 in 2016. Almost half of the 3000 applicants were from Syria. Children with refugee or protected status are not recorded separately; however, 117 unaccompanied minors were accounted for in 2016 (Gravani, Hatzopoulos, & Chinas, 2021). Based on the latest reports, from January to September 2022, some 665 unaccompanied/separated children applied for asylum. The majority of these children arrived by sea, with origin from the Syrian Arab Republic ("Cyprus-Fact sheet Sept 2022" , 2022; "Europe Accompanied, Unaccompanied and Separated © UNICEF - LESVOS MISSION Overview of Trends January to December 2021", 2021). In addition, the table below presents the actual number of unaccompanied

[4] *This report has been compiled with the utmost care, based on reliable sources of information. Unless otherwise stated, the data contained within is accurate and up-to-date as of 23/05/2023. Updates to this report may not be made available past this date.*

children hosted in each shelter as of the end of 2020 (this is the latest information since data were not provided for 2021) (Country Report Cyprus: Asylum Information Database., 2021).

Unaccompanied children in shelters in 22020			
Shelter	City	Number of residents	Capacity
Male Youth Home (HfC)	Nicosia	35	42
Male Youth Home (HfC)	Larnaca	Not operating	25
Male Youth Home (HfC)	Larnaca		20
Female	Larnaca	19	20
Female	Limassol	11	20

Cyprus possesses a crucial place geographically. As a crossroad between Europe, Asia and Africa, migrants and refugees come from all these 3 continents, resulting in a huge variety of the origin of refugees and migrants. More specifically, the top countries of origin of new asylum-seekers in Cyprus through September 2022 were Syria, Nigeria, Democratic Republic of the Congo, Pakistan, Bangladesh, Afghanistan, Somalia, Cameroon, India, Nepal, as well as Ukraine. (Gravani, Hatzopoulos, & Chinas, 2021). Almost half of the 3000 asylum applicants were from Syria (Gravani, Hatzopoulos, & Chinas, 2021)

Factors affecting the psychological wellbeing of migrant/refugee populations

There are several factors that affect the psychological wellbeing of migrant and refugee populations. Based on a field observational study which was conducted in a refugees' camp in Cyprus, researchers observed a higher level of self-blame among migrants and refugees who were rescued when part of their families was left behind. As a result, an immediate danger and intense emotions (e.g., anger) were born, developing beliefs that Cyprus has nothing to offer to them, when at the same time feeling "trapped" in an island increased those feelings (CODECA, 2022; BPtK, 2021).

In some of the key literature and policy papers concerning refugees in Cyprus, such as the National Strategy for Lifelong Learning 2014–2020 (Directorate General for European Programmes, Coordination and Development (DGEPCD), n.d.), the Education and Training Monitor: Cyprus, and the policy paper on the integration of students with migrant background to the Cyprus Educational System (Ministry of Education and Culture (MoEC), 2016), there is a striking absence of any substantial reference to adult

migrants or to the notion of multiculturalism, intercultural education, or the integration of non-native adult learners, which are in the leading factors that affect the psychological wellbeing.

Furthermore, an analysis of the Cypriot social integration strategy and reception conditions for migrants shows that there are some considerable constraints in relation to the official policies, which reduce the likelihood of setting the foundations for the creation of an intercultural country (CODECA, 2022). As a result, the mental health of migrants and refugees is affected since the sense of security is low. In addition to that, the process to access the labour market is not straightforward for migrants in Cyprus. Applicants and beneficiaries of international protection, non-EU nationals and EU nationals, enter the labour market with different procedures (CODECA, 2022) which are more complicated and limited.

It has also become evident that there are no formal governmental strategies or mechanisms in place to promote social integration. When it comes to accessing services and becoming self-oriented, newly arrived migrant groups usually face problems which in time minimize their chance of meaningful interaction with their host societies (CODECA, 2022; Country Report Cyprus: Asylum Information Database., 2021).

Mental health difficulties

Unfortunately, in Cyprus, there are no official data from epidemiological studies available regarding the prevalence of mental disorders amongst refugees, but expert experience suggests a high demand for services among this population. (BPtK, 2021)

There are main cultural differences concerning mental health difficulties. Specifically, applicants and beneficiaries of international protection, as well as non-EU nationals (low skilled workers), are facing important hindrances and restrictions compared to other migrant groups (EU nationals and highly skilled migrant workers). It can be argued that this results in these groups not developing a feeling of belonging. There are certain gaps and omissions that prevent active participation in the society, thus increasing the likelihood of the phenomenon of social exclusion and isolation. (CODECA, 2022).

Mental health services

The public mental health sector under the supervision of the Central Mental Health directory of the Ministry of Health is responsible for providing the therapeutic care of refugees in Cyprus. (BPtK, 2021) Currently, there is only one institution offering specialized psychological support to victims of abuse, torture, and trauma. The Future Worlds Centre operates these support programs through funds of the United Nations Voluntary Fund for the Victims of Torture (Country Report Cyprus: Asylum Information Database., 2021). Residents of the Kofinou Center, the main reference centre for newly arrived migrants and refugees, receive psychological and sociological counselling once per month.

There is a provision for part of the budget of each Ministry, including the Ministry of Health, for emergencies, which may bear the cost for the mental health care of refugees. Also, the European Coordination Section of the Ministry of Health has received funds from the European Union for the care of asylum-seekers/refugees. The burden falls for the government to fund it via its health care plans (BPtK, 2021).

Legislation regarding the use of mental health services

Currently, there is only one NGO, the Cyprus Refugee Council, offering specialized social and psychological support to victims of torture and gender-based violence, operating through the funds of United Nations Voluntary Fund for the Victims of Torture (UNVFVT) and the EU. During 2021, 118 persons received relevant services. (Country Report Cyprus: Asylum Information Database., 2021)

The legal framework that has been set-up to regulate migrant flows dates from the British Colonial era: Law 13 of 1952, covering aspects of their residence, such as entry, stay and departure. The main laws that regulate the residence of migrants and refugees in Greek Cypriot territory, following European and international standards, define education as one of the basic rights of these populations (Gravani, Hatzopoulos, & Chinas, 2021). The national legal framework for refugees provides restricted benefits during the first 15 months of their sojourn in Germany, as regulated in §§ 4 and 6 of AsylbLG (Asylum Seekers Benefits Act).

Italy[5]

Introduction

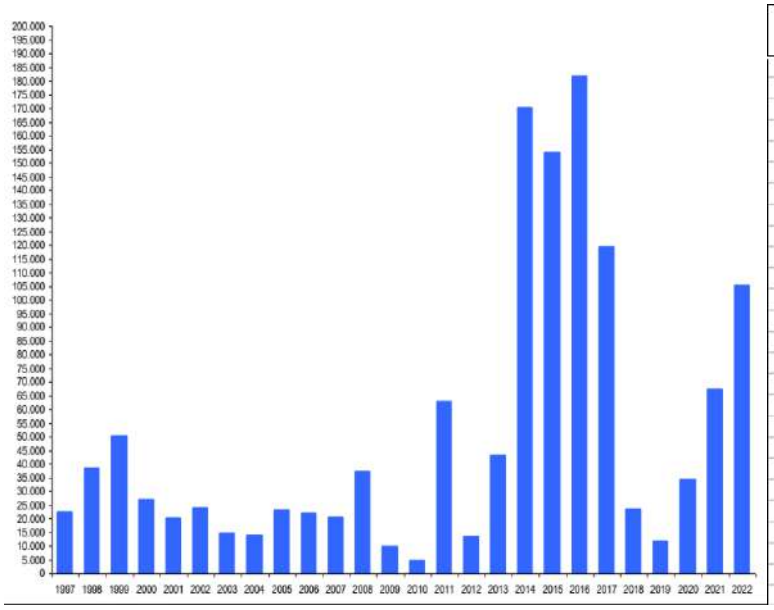
Preliminary note: In many cases, it is difficult to collect accurate data both because of the inherent complexity of the phenomena and because different sources (governmental, non-governmental, and scientific) sometimes adopt different methods for counting and listing, or consider periods that are not directly comparable. In order to present a picture as faithful to reality as possible and to offer useful indications for the purposes of the report, several complementary criteria have been adopted: a) whenever the data agree with each other, or can be traced back to a single reliable source, they are reported as presented in the sources cited; b) in the event of discrepancies or variations over time, a weighted average has been applied and the data are reported rounded off with a margin of error of 1%; c) data take into account the latest available updates as of April 2023, including where relevant a comparison with previous years, to account for ongoing trends.

Migration routes to and through Italy

Although migration routes rise and fall, depending on geopolitical, economic, and diplomatic factors, Italy represents persistently a primary arrival and passage country for migrants and refugees since several decades (Papavero, 2023; ISTAT, Rapporto Annuale 2022, 2022; ISTAT, Storia demografica dell'Italia, 2023). Due to its geographic position, the main path of irregular migration flows remains the sea, even though it is an extremely risky course in which thousands of people may lose their lives a year. The so-called Central Mediterranean Route is generally the itinerary of the greatest influx and, in the last years, also the deadliest one worldwide (IOM, Missing Migrant Project, 2023; Consilium, 2023). It can be divided into two carrier routes, from Tunisian and Libyan, to which a few people from Algeria (from the Western Mediterranean Route) are added to a small extent. In addition, the flow through the Adriatic-Ionian and Egyptian routes has grown considerably in the last decade, conveying part of the migrants and refugees from the broader Oriental Mediterranean Route (ARCI P.C., 2021; IOM, WORLD MIGRATION REPORT

[5] *This report has been compiled with the utmost care, based on reliable sources of information. Unless otherwise stated, the data contained within is accurate and up-to-date as of 29/04/2023. Updates to this report may not be made available past this date.*

2022, 2022; IOM, Displacement Tracking Matrix, 2023; Astuti, Bove, Brambilla, & al., 2020; Chiodi & Coletti, 2021).



1997	22.343	
1998	38.134	70,7
1999	49.999	31,1
2000	26.817	-46,4
2001	20.143	-24,9
2002	23.719	17,8
2003	14.331	-39,6
2004	13.635	-4,9
2005	22.939	68,2
2006	22.016	-4,0
2007	20.455	-7,1
2008	36.951	80,6
2009	9.573	-74,1
2010	4.406	-54,0
2011	62.692	1322,9
2012	13.267	-78,8
2013	42.925	223,5
2014	170.100	296,3
2015	153.842	-9,6
2016	181.436	17,9
2017	119.369	-34,2
2018	23.370	-80,4
2019	11.471	-50,9
2020	34.154	197,7
2021	67.040	96,3
2022	105.140	56,8

Figure 1: Arrivals by Sea in Italy - Tables from 'Sbarchi e accoglienza di migranti in Italia negli anni 1997-2022'; edited by G. Papavero - Statistics Department Fondazione ISMU, January 2023

Flows by land are also present, although in significantly smaller proportions. In this case, it is actually impossible to have precise statistics, also due to the state's failure to track this phenomenon. Data on entry from land borders, and in particular along the Balkan route at the border with Slovenia, are sporadically and unsystematically disseminated through official national or international reports. However, it may be indicative to consider that during periods of large influxes in the last years, estimates range from an average of 80 people per day to peaks of 200. A very rough percentage estimate puts the average overland flow at around 10-12% of the annual total. (ISMU, XXVII Rapporto sulle migrazioni 2021, 2022; MAECI, 2023). In any case, land flows have become a numerically significant phenomenon only in recent years, mainly as a result of conflicts in the Middle East and Eastern Europe. In fact, since the beginning of the current conflict in Ukraine, the number of refugees choosing Italy as their arrival country and reaching it by land has grown considerably. This has come on top of the variable, but essentially uninterrupted flow of migrants and refugees arriving from the Balkan route since 2015-16 (Gorza, La Frontiera Alpina del Nord Ovest, 2022; Chiodi & Coletti, 2021).

Anyways, it is also important to stress that for a significant number of migrants and refugees, Italy doesn't represent the desired ultimate destination – plausibly it applies in higher proportions to migrants and refugees arriving by land. Basically, Italy itself is the site of several irregular migration routes overland to central and northern EU countries – without considering legal transfers to other European countries, granted for instance through the new relocation agreements from 2018, or family reunification procedures. – Unfortunately, even in this case it is impossible to collect statistics, since the Dublin III Regulation (No. 604/2013) requires migrants to apply for asylum in the country of first arrival and, therefore, prohibits free transition. Nevertheless, a comparison of the figures between yearly arrivals and asylum applications at the Italian and European levels can help paint an indirect rough picture of the real situation. Although in the last two decades, Italy has often ranked first or second in Europe in terms of the number of arrivals, on average it has often remained fourth or fifth among Member States in terms of the number of asylum and protection applications. (EUROSTAT U. , 2022) In particular, excluding arrivals in previous years, between 2015 and 2022 the total difference between new arrivals in Italy and successful applications for asylum and international protection amounts to about 70,000 people – considering also the number of persons directly relocated for expulsion – (MdI, Quaderno Statistico per gli anni 1990-2020, 2021; Papavero, 2023; Statista, Number of immigrants who arrived by sea in Italy from 2014 to 2021, 2023; ISMU, Sbarchi e accoglienza di migranti in Italia negli anni 1997-2022, 2023). Bearing in mind that the submission of applications can be months or years late, that the assessment procedures can take several months, and that not all new arrivals are recorded, this reference figure is considerably underestimated. Furthermore, the number of rejections by other European countries at the Alpine borders should also be considered, as well as the so-called "Dubliners" phenomenon, i.e., migrants and refugees who have crossed borders and are intercepted through the Eurodac network in third countries (often France, the Netherlands, Germany, and Sweden) and then brought back to Italy. These phenomena emerge typically at times of "overwhelming flows" and in both cases, the figures can reach into the tens of thousands per year (Statista, Migration routes via Italy to Europe - Statistics & Facts, 2021; MSF, Mal di Frontiera, 2018; Gorza & Moschella, Il rapporto sulla rotta Nord-Ovest delle Alpi, 2021; StC, Nascosti in piena vista, 2022; IOM, Displacement Tracking Matrix, 2023).

Figure 2 Main migrant and refugee routes involving Italy, based on 2015-2022 data from (Idemudia & Boehnke, 2020; IOM, WORLD MIGRATION REPORT 2022, 2022; Astuti, Bove, Brambilla, & al., 2020)

Pivotal Concept and Strengths of the Italian Reception System

Tracing the evolution of the Italian reception and assistance system for migrants and refugees, Geraci & Mazzetti (2019) show how Italy has over time aimed to regulate and to structure a system of protection for those who apply for it of great political and social significance. Even from a health point of view, Italy has an important tradition in the protection of immigrants and refugees. Since 1995, policies and norms have considered the foreign population, even in conditions of social fragility and legal weakness, defining a highly inclusive legal body. In this respect, health policies have been guided mainly by two principles: «1) full equality of rights and duties, regarding health and welfare rights, between Italian citizens and legally present foreign citizens, with full coverage by the public health system; 2) broad protection and assistance possibilities also for irregular migrants, with particular reference to women and children and the area of infectious diseases.» (Marcera, 2013) Precise health policies on migrants' health have been outlined through legislative measures that were stabilised at the end of the 1990s and merged into an organic law known as the 'Consolidation Act on Immigration' (MdI, Testo unico sull'immigrazione 2023, D.Lgs. n.

286/1998 aggiornato con le modifiche apportate, da ultimo, D.L. n. 34/2023, 2023). The guidelines that are still valid today can be traced back to this law and subsequent regulatory measures.

The roots of the current Italian reception system were laid between 2002 and 2005, conceiving it on two levels: First reception and Second reception. The entire process was designed to accompany and support migrants and refugees from the first moment of arrival until their full integration into Italian communities once their right to asylum or special protection has been recognised. (Schiavone, 2023; FIS, 2021).

Currently, First Reception is – theoretically – divided into three types of collective centres: Hotspots, First Reception Centres (CPA), and Permanence and Repatriation Centres (CPR). Hotspots are centres where migrants and refugees are collected upon arrival in Italy. Here they receive initial medical treatment, undergo health screening, are pre-identified, and photographed, and can apply for asylum or protection (most of them do so). After an initial assessment, people applying for asylum and protection are transferred – supposedly within 48 hours – to CPA, where they are held for the time necessary to find a solution in the Second reception. Otherwise, in the few cases where people do not apply for asylum, they are led to the CPR, where they are administratively detained, for a maximum of 90 days, with the view to being repatriated, together with those who under other circumstances receive expulsion proceedings (d.lgs. 142/2015, art. 9 (Openpolis, Come funziona l'accoglienza dei migranti in Italia, 2023)).

Once they have passed through Hotspots and CPA, asylum and protection seekers are assigned to Second reception, which – theoretically, beyond emergency situations – should be based exclusively on the Reception and Integration System (SAI). In this case, it is mostly no longer a question of mass collection centres, but of placements, as targeted as possible, – 85% of cases are flats, 6,5% small centres – according to the availability and particularities of local entities' projects. Each SAI is in fact based on a project submitted by the municipalities and approved and financed by the state. The projects must mandatorily be contracted to non-profit organisations implementing the basic principle of the system: integrated reception, which implies the establishment of a local network (with third sector organisations, volunteers, but also other stakeholders) to take care of an all-round integration in the local community, to be achieved through social, educational, work, and cultural inclusion activities. Refugees and beneficiaries of subsidiary protection can stay in the SAI placements for six months, extendable by another six months, during which they are accompanied to find independent accommodation. In addition to the accommodation, the managing bodies are called upon to provide a series of goods and services: cleaning and environmental hygiene (which are also carried out by the guests in self-management); food (breakfast

and two main meals, better if self-managed by the guests); kitchen equipment; clothing, linen and products for basic personal hygiene; a telephone card and/or recharge card; a season ticket for urban or extra-urban public transport based on the characteristics of the area. Here, asylum and protection seekers also receive legal, health and language assistance. As soon as the right to special protection is officially recognized, protection holders have access to services more explicitly aimed at social integration (civil registration, obtaining a tax code, registration within the national health service, insertion in school for all minors, socio-cultural and sports activities, etc.) and job orientation. Finally, similar assistance is provided to asylum holders through further integration paths launched by the same host local administrations (Openpolis, 2023; Colombo, 2022; FIS, 2021).

It is significant to note that the basic concept of the SAI originated in a decentralised reception network involving municipalities and third-sector organisations, spontaneously engaged in the experimentation of reception experiences already active in 1999. It was, therefore, a bottom-up good practices system, which was then institutionalised through Law 189/2002 becoming a national system. By virtue of this, not only is it a model that has already been calibrated and proven effective, but it has also been the bearer of a particular deontological, social, and organisational culture of reception that still largely characterises this specific context. On this basis, a corpus of different stakeholders (coordination and administration personnel, social workers, psychologists, social assistants, legal operators, interpreters and cultural mediators, Italian language teachers, etc.) has developed over the last two decades, accumulating vast methodological experience and specific knowledge. Moreover, the same spirit of the initiative has given rise to some realities of excellence in the territorial sphere, sharing a transcultural and all-embracing approach to care and assistance, as well as targeted transversal training (SIMM, La SIMM informa, 2020; Cioppi & Seu, 2022; TNIA, 2022).

Structural Weaknesses of the Italian Reception System

However, twenty years after the institutionalisation of the two-level reception system modelled on the SAI, as a flagship, Italy has not been able to truly promote and take advantage of its core principles and innovative approach on a large scale yet. This resulted in a *de facto* non-implementation of the system at a national level. It derived rather into a limited, fragmented, and unbalanced development of the different efforts and structures involved. Most of the sector's expertise at all levels agrees in attributing the serious deficiency of planning and practical implementation to conflicting attitudes towards migration and weak

political will, both in terms of centralised governance and local availability (EC.europa, 2018; Schiavone, 2023; ActionAid, 2023; DLCL, 2015; Re.Co.Sol, 2021; Openpolis, Il sistema a un bivio, 2020; TNIA, 2022; ASGI, Caritas, Emergency, & al., 2022).

In this regard, the long-standing crucial issue of the opening of new SAI is exemplary of the limitations inherent to the implementation of the Italian reception system, as well as of the socio-political controversy surrounding the topic of migration in Italy – with more than one parallel to the political debate at European level. – In fact, although each SAI is financed with state funds, the initiative for new integration projects is left to the local administrations. These, however, for the most part, have always remained reticent to put themselves forward – currently, only around 23,2% of all local administrations are available to host a reception centre or an integration project (ActionAid, 2023). Such a situation sometimes is due to the logistical or material impossibility of organising suitable initiatives, but also often either because of political culture or, anyways, for reasons of electoral consensus. In any case, the obvious main consequence was and is the persistent impossibility of redistributing migrants and refugees to be taken into care, thus, overwhelming first-level facilities and exacerbating reception and integration conditions in the second level (Schiavone, 2023).

As far back as the first decade of the Reception System, the slow growth of the network of SAI projects and its consequences has come on top of intrinsic imbalances of the migratory phenomenon (e.g. for purely geographical reasons hotspots and CPAs are inevitably more concentrated in southern regions) and structural idiosyncrasies of the country (e.g. differences in resources and human capital between regions, different regional administrative models, especially in the field of health, etc.) Therefore, major humanitarian organisations and expertise have denounced the inadequacies of the Italian reception, especially regarding health and social care, since its first decade (MSF, Anatomia di un fallimento, 2005; Angeli, 2006; MSF, Al di là del muro., 2010; MSF, Rapporto CAR, 2014).

Afterwards, starting with the Arab Spring and the civil war in Syria in 2010-2011, the radical and sudden increase in refugee arrivals forced on the one hand a reaction with extraordinary measures that further distorted the process of the reception system. On the other hand, it deeply impacted the public perception of the migration phenomenon and, consequently, the Italian socio-political context. On the first point, the most significant legacy of that emergency time has been the creation of the Emergency Reception Centres (CAS). These services are basically hybrid forms between CPA and SAI: 1) they can be either mass centres or targeted accommodation; 2) in case of need, they receive migrants and refugees

directly from the Hotspots or even directly instead of them. Moreover, they can be contracted out also to for-profit organisations. It is important to bear in mind that, although “indispensable” at the time of their introduction to respond to the emergency, these types of centres have proven to be averagely incapable of providing an adequate and quality reception, care, and integration service. This is both by its own nature and by its contiguities. In fact, CAS are expected to provide for a variety of different needs within proportionally reduced facilities and with limited time and material resources. Therefore, they do not have the possibility to support migrants and refugees until their full integration into the citizenship system and the social texture of the territory. Moreover, the massive intervention of for-profit organisations, especially large ones, favours a levelling of services following economic logic and to the detriment of migrants' and refugees' wellbeing. (DLCL, 2015; FIS, 2021).

Concerning the impact of the refugee crisis on public opinion, Italy – like many other European countries (EC.europa, 2018) – has seen a radicalisation of narratives on the migration phenomenon and the increase of disinformation because eighter of media infodemic or of political instrumentalization. Concurrently, on a political level, there has been a proliferation of new decree-laws that have reshaped the Consolidation Act on Migration several times in a few years. Depending on the political line prevailing at the time, the main aims have been to try establishing new forms of migrant and refugee management centres - besides those mentioned above, many other forms have overlapped in the meanwhile: CPSA, CARA, CID, CIE, SPRAR, SIPROIMI, etc. – and, correspondingly, to expand or reduce forms of protection and asylum (Colombo, IL SISTEMA DI ACCOGLIENZA DEI MIGRANTI IN ITALIA, SPIEGATO PER BENE, 2022). According to many commentators and experts, this unstable context aggravated and highlighted another structural weakness: the inability of Italian governments – from any political party – to look beyond the moments of acute crisis and to recognise migration movements as systemic and mostly “ordinary” phenomena, and thus to equip itself structurally for it. Hence, the paradox of the so-called “permanent emergency” (Valbruzzi, 2019; Coresi, 2022; Openpolis, L’emergenza che non c’è, 2022) and the persistent lack of planning to provide Italy with a chain of services capable of responding effectively to both ordinary situations and moments of crisis. (SIMM, SItI, & ISS, DICHIARAZIONE DI ERICE su ‘LA SALUTE DEI MIGRANTI. UNA SFIDA DI EQUITA’ PER IL SISTEMA SANITARIO PUBBLICO’, 2022; ASGI, Caritas, Emergency, & al., 2022; ActionAid, 2023; TNIA, 2022).

Finally, it is worth pointing out that this lack of planning and systemic vision of the migration phenomenon is also reflected in the failure to implement basic training programmes for health

professionals. It should be noted that the “legally” resident foreign population in Italy grew between 2002 and 2022 from 1.3 to 5.2 million, i.e., 8-9% of the total population (ISTAT, Storia demografica dell'Italia, 2023). At the same time, there has been a steady fluctuation over the years in the presence of 'irregular' foreigners, whose estimates ranged from highs of 760,000 to lows of 250,000 (ISMU, Stime stranieri irregolari ISMU, 1991-2021, 2022). Nevertheless, it was only in the wake of the refugee crises of the last decade that a few university courses were created that focused on a transcultural, ethnological or migration perspective in academic training courses in medicine, nursing, psychology, or psychiatry. In any case, these have remained very few, present in only a few universities, optional and occasional. The many relevant training offers that have been produced in recent years, including those of the institutions of excellence on migration, have remained prerogative of the third sector. Therefore, limited in resources, in the continuity, and subject to the principle of voluntariness on the part of both providers and participants.

The restrictive drift of the Italian Reception System in recent years

Over the last few years, the flawed political logic of the permanent emergency has degenerated on the whole into a re-orientation towards more restrictive policies of reception and social control: less concerned with the well-being and the integration of migrants and refugees, but more with the “Italian security”, as well as with the hasty, rough, or even rejecting management of this “pressing issue” (Openpolis, La sicurezza dell'esclusione, 2020; Valbruzzi, 2019; MPE, CPR, Hotspot e altri luoghi di confinamento, 2021). The already fragile and distorted Italian Reception System has consequently suffered a setback, on numerous levels, in the opposite direction to the original reception and integration concept.

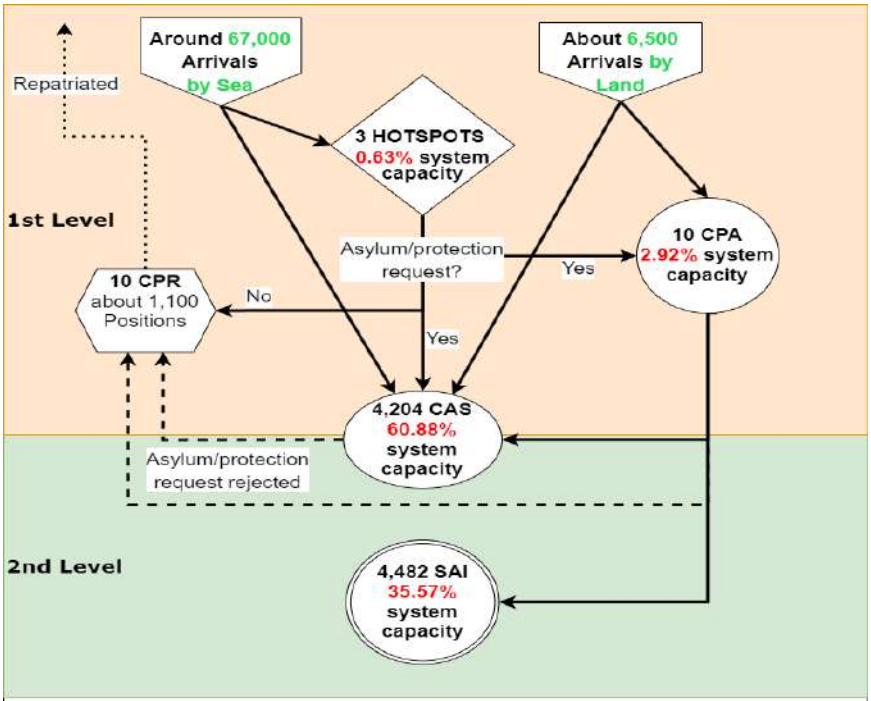
First, since the CAS were centres designed just for emergencies, – to be resorted to only in the event of overcrowding in the SAI – they have turned into permanent services, stabilising their specific weight within the reception and integration system in a majority role (DL 113/2018 and DL 53/2019, the so-called 'Security Decrees'). The latest data available on the various types of centres are from 2021 and speak of approximately 59,500 available positions in CAS out of a total of 97,670 throughout Italy, i.e., a proportion of 61% of the entire Italian Reception System (ActionAid, 2023). This happened even though the average of new arrivals has drastically dropped since 2018: an average of about 156,000 yearly between 2014-

2017 – when the CAS started to spread – against an average of "only" 35,000 between 2018-2021 (Statista, Number of immigrants who arrived by sea in Italy from 2014 to 2021, 2023). Diametrically, the places in the ordinary SAI have reduced in absolute terms – 1,137 positions were lost between 2018 and 2021 – and the SAI centres have acquired a specific weight of just 35.5% within the whole system (ActionAid, 2023).

Secondly, it is significant that the positions lost in recent years have been in a higher percentage (more than 50%) in small and medium-sized CAS and SAI, which are structurally more effective in terms of services to the people hosted and impact on the host communities (ActionAid, 2023). Instead, it was invested in the concentration of migrants and refugees mostly in mass structures for hundreds of people (often in large metropolises and managed by large private companies), which are less functional and suitable for reception and integration but make it easier to keep people under control. The fact that it is to all intents and purposes a deliberate abandonment of the initially pursued model of widespread reception, in favour of security and control management, is also evident from the lack of internal redistribution toward the integration process. Indeed, while political and public discourse continued to fear collapse due to an alleged "overload of the reception system"; in reality between 2018 and 2021 the average number of free, unused positions in the system was around 29,000, a third of these in the SAI (O&A, 2023). In other words, the system does not collapse because of the sheer number of people but rather breaks down because of internal obstructions and obstacles based on a underlying reluctance to integration policies.

Thirdly, most of the last governments have directly or indirectly implemented rejection propaganda and policies. The resources allocated to integration services have been progressively reduced (from 35€ to 26€ per capita/per day), redirecting part of those resources to the expansion of CPR and the construction of new similar detention centres. - the last measure in this sense is of the government currently in charge, 01/01/2023, L. 197/2022, realised on the instrumental basis of an official declaration of a 'state of emergency' (Openpolis, Aumentano le previsioni di spesa per i Cpr, 2023; O&A, 2023; DPC, 2023). However, the investment of millions in CPR seems to be aimed only at expanding their capacity and spreading them across the territory, not at improving the "administrative" detention conditions. Yet, since 2017, there has been a steady increase in reports from NGOs monitoring the treatment of migrants and refugees, about the recurring violation of human rights in CPR and the serious impact on the psychological and physical health of people who find themselves transiting

through them. Indeed, with administrative detention, irregular migrants are *de facto* detained as if they were in a prison, and indeed in conditions that are often worse, without the guarantees and protections provided by the prison system. (MSF, Fuori Campo. Secondo Rapporto, 2018; CILD, 2021; CdP, 2022; ASGI, Il libro nero del CPR di Torino, 2021; Altreconomia, 2023; ASGI, Report sulla visita al Centro di Permanenza per il Rimpatrio (CPR) di Palazzo San Gervasio, 2022).



Italian Reception System at 12/31/2021

Centres	Facilities	No. Positions	% S. Capacity	Abs. Attendance	% R. Attendance
Tot.	8,699	97,670	100%	77,435	79.28%
Hotspots	3	611	0.63%	398	65.14%
CPA	10	2,849	2.92%	2,065	72.48%
CAS	4,204	59,466	60.88%	50,495	84.91%
SAI	4,482	34,744	35.57%	24,497	70.51%
CPR	10	1,100	-	-	-

Figure 3: Snapshot of the Italian Reception System according to the latest count of 2021. The data were composed by deriving them from (ActionAid, 2023; ISMU, XXVII Rapporto sulle migrazioni 2021, 2022; CILD, 2021; CdP, 2022).

Moreover, protective rights have been restricted or, at least, their recognition has been made in fact more difficult to achieve. In this sense, it is worth considering the case of 'special protection'. Similar forms of protection exist in 18 European countries and are addressed, among others, to those who were at risk of being subjected in third states to torture, inhuman or degrading treatment, or persecution for reasons of race, sex, sexual orientation, gender identity, language, nationality, religion, political opinion, personal

or social conditions. The Italian special protection has been abolished, reintroduced, and amended several times over the past five years. The latest amendment (the so-called 'Decreto Cutro') rectified by the Italian Senate on 04/20/2023 (MdI, Testo unico sull'immigrazione 2023, D.Lgs. n. 286/1998 aggiornato con le modifiche apportate, da ultimo, D.L. n. 34/2023, 2023) effectively excludes (except in special cases) those who need protection for psychophysical reasons or serious calamities in their origin countries; moreover, it deletes the part concerning the protection based on the consideration of the family ties of the person and his/her effective social integration in Italy. Finally, it makes the following integration process impossible for future holders of this type of protection by preventing the conversion of protection into a work permit (Spena, 2023).

More significant, however, is the fact that even before this formal restriction, the process of obtaining this type of protection had already been hampered *de facto* by the practices of the police headquarters and the inefficiency of the public administration, which prevents the fulfilment of procedures for regularisation on the territory (Tiberio, 2023; Ambrosini, 2023). To this example can be added many others, ranging from the so-called "criminalisation of solidarity" – i.e., the new set of legal obstacles and penalties for the third sector dealing with migrants and refugees (L.A.W., 2023; ASGI, Country Report: Italy, 2022) – to many forms of discrimination (often on ethnic, religious, or national grounds) perpetuated by institutions, which in fact treat the various groups of migrants differently – it is meaningful that the Ukrainian refugees who arrived in Italy in 2022 are not usually counted in the statistics under the general category 'refugees', and that only 20 per cent of them were referred to CPA and CAS centres, while 80 per cent were relocated with special support by family members and compatriots (UNHCR, Italy, Factsheet December 2022, 2023; UNICEF, RAPPORTO ANNUALE 2022, 2023; ASGI, Country Report: Italy, 2022). Essentially, there is currently a dense network of informal obstacles and hostile practices in Italy that pushes many migrants and refugees towards illegality, stigmatisation, and marginalisation, further restricts access to essential services and care, and discourages the intervention of the third sector (TNIA, 2022).

Finally, it is also important to point out that the general domestic drift into a more hostile and rejecting attitude towards migrants and refugees is also reflected in the level of foreign migration policies in recent years. In fact, Italy soon aligned itself with the rest of the major European countries in the so-called 'externalisation of borders to third countries' policy after the beginning of the Syrian crisis. This resulted in a temporary reduction of sea flows, however, at the cost of brutally worsening the situation of migrants

and refugees stranded for years in the countries of departure, especially on the Central Mediterranean Route (ASGI, L' ESTERNALIZZAZIONE DELLE FRONTIERE E DELLA GESTIONE DEI MIGRANTI, 2019; AI, 2021; MPE, La Tunisia non è né un paese di origine sicuro né un luogo sicuro di sbarco, 2023).

Migrant and Refugee Demographic Characteristics

In this report, the terms 'migrant' and 'refugee' are used as umbrella terms, in accordance with their common usage in Italy and in the international context. However, to get a better idea of the demographic characteristics of the foreign population in the Italian context, it may be useful to start by distinguishing four main legal statuses, as well as by focusing on the special cases of unaccompanied minors and of the temporary protection.

Legal Statuses and Regulations

Regular migrant: Migrants are people who change their residence and move to another country without being forced to do so and can safely return to their country. In Italy, they are defined as 'regular' when they are EU citizenship, or in case they hold a regular residence permit, issued by the competent authority based on a pre-established reason, generally for study, work, or family reunification (MdI, Il rilascio del permesso di soggiorno, 2023). Mostly, the following periods of validity of the residence permit are provided for:

- up to six months for seasonal work, and up to nine months for seasonal work in sectors requiring such extension (circular prot. 47457 of 5.12.2016);
- up to one year for attending a course for study or vocational training that is obviously documented (circular prot. 106051 of 16.10.2018)
- up to two years for self-employment, for permanent employment and for family reunification.

Foreigners who come to Italy for visits, business, tourism, and study for periods not exceeding three months do not have to apply for a residency permit, but rather for a declaration of presence. Whereas foreigners who apply for a residency permit for a period of no less than one year are required to sign an integration agreement with the Italian State, whereby they undertake to sign specific integration objectives to be achieved during the period of their residency. In addition, these long-terms permits can be renewed – if the necessary status, economic and/or integration requirements are met – and entitle the person to apply for family reunification. The latter presupposes two requirements: a) an

accommodation (even if different from one's own) that meets the necessary hygienic, sanitary and housing requirements; b) a minimum annual income of no less than the amount of the social allowance for the current year, increased by half for each family member to be reunited after the first. Family reunification can be addressed in the following cases (INPS, Ricongiungimento famigliare - Scheda, 2023):

- the spouse who is not legally separated and not less than 18 years of age;
- minor children, including those of the spouse or born out of wedlock, who are unmarried, on condition that the other parent, if any, gives his/her consent;
- dependent children of major age, if they cannot permanently provide for their own living needs due to their state of health condition resulting in total disability;
- dependent parents, if they have no other children in their country of origin or provenance, or parents aged 65 or over, if their other children are unable to support them for documented serious health reasons.

Refugee: In international law, 'refugee' is the legally recognised status of a person who has left his/her country and found refuge in a third country, «in justified fear of being persecuted on account of his/her race, religion, nationality, membership of a particular social group or political opinion, is outside the state of which he/she is a national and is unable or, owing to such fear, unwilling to seek the protection of that state.» (Art. 1, Geneva Convention, 1951) A person who, «being stateless and being outside his/her State of domicile as a result of such events, cannot or, owing to the fear mentioned above, does not wish to return there», is also considered a refugee. Italy incorporated the definition of the convention in L. 722 of 1954. Refugee status entails the application of two principles:

- non-extradition: a foreigner who is to stand trial in his/her own country for political offences may not be extradited from the territory of the State that has granted him/her asylum; in Italy this principle is affirmed by Article 10 of the Constitution;
- non-expulsion: recognition of political refugee status prevents expulsion from the territory of the State, an act that would place him at the mercy of the authorities of his State of origin.

Once refugee status has been granted, the foreigner may apply to the Immigration Office for an asylum residence permit. The residence permit for asylum is valid for five years and is renewable. For refugee status holders, half the time is allowed for applying for Italian citizenship by naturalisation: they will therefore be able to apply for it after only 5 years of residence in Italy. Furthermore, holders of asylum

permits may apply for family reunification to allow their family members to enter Italy, without having to prove that they meet the accommodation and income requirements for holders of other types of residence permits (INPS, PERMESSO DI SOGGIORNO PER ASILO POLITICO , 2023).

Beneficiary of humanitarian protection: It defines a person who is not recognised as a refugee because he/she is not a victim of direct persecution but is nevertheless recognized as person in need of protection and assistance because he/she might suffer violence if returned or expulsed, or because he/she is particularly vulnerable from a medical, psychological, or social point of view. In Italy, there are two main forms of humanitarian protection, one international at the European level, and one specifically national (although 18 of the 27 Eu countries have similar protection forms):

- Subsidiary protection: institutionalised at European level, it is granted when there is a proven risk of suffering serious harm if returned to his/her country of origin. Serious harm is defined as: death sentence or execution, torture or other inhuman treatment, serious and individual threat to life resulting from indiscriminate violence in situations of internal or international armed conflict.

Holders of subsidiary protection status are granted a residence permit for subsidiary protection valid for five years, renewable after verification of the conditions that permitted the granting of subsidiary protection. (INPS, IL PERMESSO DI SOGGIORNO PER PROTEZIONE SUSSIDIARIA, 2023).

- Special protection: it can be issued when neither the requirements for political asylum nor those for subsidiary protection are met. Requirement is that there is a risk that refusing him/her may subject him/her to persecution on the grounds of race, sex, sexual orientation, gender identity, language, nationality, religion, political opinion, personal or social conditions. Furthermore, all situations in which there are reasonable grounds to believe that the foreigner, in the event of expulsion, risks being subjected to torture, or inhuman or degrading treatment or systematic and serious violations of human rights are protected. Finally, it expressly excludes the possibility of expelling a foreigner if this would lead to a violation of the right to respect for one's private life.

The special protection residence permit generally is valid for two years. Its renewal is subject to a reassessment of the situation by the Territorial Commission. However, in case of serious calamities as application ground, it is valid for only six months, renewable only one time (Spena, 2023).

Both forms of humanitarian protections give right to apply for family reunification. However, as for migrants present for other reasons, the person must prove that the accommodation and income requirements are met (INPS, Ricongiungimento famigliare - Scheda, 2023).

Asylum seeker: defines a person who has already applied for refugee status or the other two forms of protection and is awaiting a response. Until then, the person is entitled to stay legally in the country even if he/she has entered irregularly or without identity papers. The status of asylum seeker provides rights and obligations similar to those granted to those who subsequently obtain any form of asylum or protection. In particular:

- be informed in an understandable language;
- contact the UNHCR;
- remain in Italy;
- receive an identification document;
- receive free healthcare;
- have access to public education;
- work, starting two months after registration of the request;
- receive a place in a reception centre.

However, this transitional status does not give direct possibility for family reunification, nor can it be converted directly into a work permit (MdI, Diritti e doveri dei richiedenti asilo, 2023).

UASC: UASC refers to minors who do not have Italian or European Union citizenship and who are for any reason in the territory of the State, or who are otherwise subject to Italian jurisdiction, without the assistance and representation of their parents or other adults legally responsible for them according to the laws in force in the Italian legal system.

Law 47/2017 establishes that unaccompanied foreign minors are entitled to rights in the field of child protection on an equal footing with minors of Italian citizenship. Moreover, it provides for a unitary system throughout the national territory for the reception, identification, age assessment and protection of UASC, guaranteeing first and foremost their right to health, education and hearing in administrative proceedings concerning them. Protections for the right to health and education of children are also strengthened, with simpler procedures for registration in the national health service (S.S.N.) and the school system. Among the instruments indicated by the law for the protection of the child's best interests

is the establishment of the figure of the voluntary guardian. Furthermore, two other aspects of special care are significant. On the one hand, the maximum time during which minors can reside in first reception facilities before being transferred to SAI projects, is defined as 30 days. On the other hand, if suitable family members are found to take care of the UASC, this solution must be preferred to community placement.

Finally, Legislative Decree 142/2015 states that in the application of reception measures, the best interests of the child take priority, to ensure living conditions appropriate to the child's age, regarding the child's protection, well-being and development, including social development. It is necessary to listen to the child, considering his/her age, degree of maturity and personal development, also with a view to learning about previous experiences and assessing the risk of the child being a victim of human trafficking, as well as to verify the possibility of family reunification, once provided it corresponds to the best interests of the child. (MLPS, Normativa e pubblicazioni MSNA, 2023; StC, IL SISTEMA NORMATIVO A TUTELA DEI MINORI STRANIERI NON ACCOMPAGNATI, 2019; UNICEF, RAPPORTO ANNUALE 2022, 2023).

Temporary Protection: it is an exceptional form of protection that provides immediate protection for people who have been displaced from Ukraine since 24 February 2022, following the invasion by Russian armed forces. The Decree of the President of the Council of Ministers of 28 March 2022 regulated temporary protection in Italy (transposing the EU implementation of 4 March 2022). Refugees are issued by the police headquarters with a residence permit, which allows registration with the National Health System and access to work, study, and welfare measures. Art. 1 of the DL. of 2 March 2023 stipulated that the residence permits issued to beneficiaries of temporary protection from Ukraine would remain valid until 31 December 2023 – unless revoked should the state of emergency in Ukraine end sooner – and is then renewable by the police headquarters from 6 months to 6 months for one year.

If no accommodation is available, one can take advantage of accommodation within the network of CAS and SAI centres or in other forms of reception provided by the State, such as temporary accommodation (hotels, accommodation facilities and religious institutes) or accommodation within the widespread reception system. Otherwise, if an independent accommodation has been found, including with relatives, friends, and host families, one is entitled to a subsistence contribution of €300 per month. In addition, a contribution of EUR 150 per child per month may be granted for each dependent child. The contribution is granted for a maximum duration of three months.

At present, there is no possibility of converting temporary protection into a residence permit for work. The residence permit for temporary protection allows in any case to carry out employment (including seasonal employment) or self-employment, attend a vocational training course, do an internship, and access other active labour policy measures, under the same conditions as Italian citizens. For recruitment and other procedures, only the receipt of the application (if still waiting for the permit to be issued) is valid, as well as the Italian tax code that is assigned when applying for the permit (MdI, Opuscolo informativo Protezione temporanea in Italia, 2023).

Structure and Characteristics of the migration flows over the last years

Looking at the structure of migratory flows over the last decade, a two-sided picture emerges. On the one hand there has been a greater rootedness in the territory of migrants who arrived in past decades, and on the other a significant change in new migratory flows arriving. This last aspect is particularly relevant regarding non-EU migrants and refugees. Specifically, three main phenomena stand out: a) an unprecedented contraction of flows for work and economic reasons, (i.e., of what made up a large portion of regular migrants until 2010); b) a substantial stability of those for family reunification (linked to stabilisation processes in the territory), which has remained the main trend; c) a sudden increase in arrivals of people seeking international or humanitarian protection (ISTAT, Rapporto Annuale 2022, 2022).

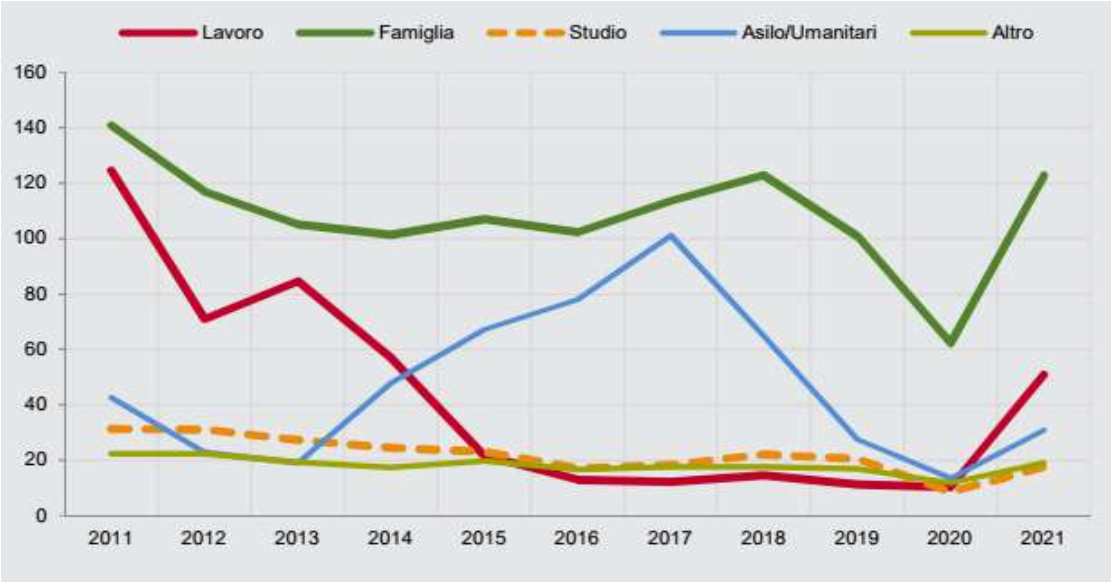


Figure 4: New residence permits issued in the year by reason. Years 2011-2021 (absolute values in thousands, for work in red, for family reunification in dark green, for study in orange, for asylum/protection in blue, for other reasons in light green). Graph from 'Rapporto Annuale 2022', edited by ISTAT, July 2022.

According to the most-up-dated ISTAT annual report: «The flows of people seeking international protection have contributed to the transformation of this Italian migration scenario also because, in the case of this type of migration, the South of Italy has played an even more relevant role as a land of first arrival. The flows of asylum seekers arrive from different countries than those from which the flows to Italy traditionally came, and with very different characteristics and migratory projects than those of labour or family migrants. Between 2011 and 2021, a total of about 516,000 permits were issued for asylum-related reasons. Growing rapidly since 2013, in 2016 and 2017 permits issued for these reasons peaked, accounting for more than 30% of new issuances. Subsequently – from 2018 onwards – there was, however, a steady decline in new permits issued for international protection reasons, both in absolute terms and as a share of total issuances [because of political choices and the pandemic international context (Covid-19)]. During 2021, there was [again] an upturn in the issuance of new permits (a total of almost 242,000) and new asylum documents also returned to growth: almost 31,000 were issued.

The migratory flows of people seeking protection have also led to a change in the rankings of the main citizenships, which have changed significantly in correspondence with political crises and conflicts in different parts of the world. Between 2016 and 2017, for example, there was a peak in the number of Nigerians who jumped to the top of the list in terms of the number of arrivals; this dynamic is to be traced above all to the humanitarian crisis of the period, which then, at least in part, receded in the following years; a similar trend, albeit with smaller numbers, can also be seen for arrivals from Mali. More constant over time, although with less evident peaks, was the growth in arrivals from the Indian subcontinent (India, Pakistan, and Bangladesh), only partially attributable to the search for international protection.

Asylum flows are inflows in which, generally, the share of women and minors is very small, although in recent years the presence of minors has increased. Focusing on 2021, most of the nearly 31,000 new documents were granted to citizens of Pakistan (6,090 new permits issued), followed - but at a distance - by citizens of Bangladesh (almost 5,000 permits) and Nigeria (over 3,000). During 2021, the flows of people seeking protection from Africa (Egypt, Mali and Ivory Coast) also returned to relevance, while entries from Latin American countries (especially Venezuela and Colombia), which had played a primary role in 2020, lost relative importance. Arrivals from the Indian subcontinent continued, and Afghanistan

rose in the top ten countries for number of entries for protection requests. With the return to growth of arrivals from Africa, the share of men in the total number of new entries for asylum is also increasing; in 2020 it was at 76.2% while in 2021 it was at 80.2%. Among the top ten communities by number of entries for this reason only Georgia sees a clear prevalence of women (82.3%). Women represent about 40% of asylum seekers from Nigeria and 31.3 per cent among those arriving from Côte d'Ivoire. The male predominance is, however, clear: for three communities in the top ten it is around 99% and for Mali it is over 97%. The share of minors arriving for asylum has also significantly increased compared to the past: they were just over 3% in the 2016 flows, in 2021 they represent on average 9.5% of inflows for protection-related reasons (with a slight decrease compared to 2020). For some communities, the presence of minors is particularly relevant: for citizens of Nigeria, El Salvador, Afghanistan and Peru, the share of persons under 18 in the total inflows in 2021 exceeds 23%» (ISTAT, Rapporto Annuale 2022, 2022).

Migrants and refuges in 2022 and early 2023

2022 then represented a new peak in arrivals both due to the new conflict in Ukraine and following the previous year's upward trend in landings from Africa. Concerning the first case, 173,638 new refugees have arrived (53.2% women, 18.3% men, 28.5% minors). Of these, 167,802 have applied and received temporary protection (CIR, 2023). The Ukrainian refugees resulted in a net increase of 75% of the existing community (UNHCR, Italy, Factsheet December 2022, 2023). Currently, however, it is not possible to make reliable predictions about how this situation will develop. It is true that after only a few months, a (small) number of Ukrainian refugees have already left either to return home or to other countries. At the same time, the Ukrainian community in Italy is a long-standing presence, well rooted in the territory – although significantly skewed towards the female gender – and therefore capable of facilitating paths of integration (ISTAT, Rapporto Annuale 2022, 2022).

As far as new arrivals by sea are concerned, the more than 105,100 people who arrived on Italian shores in 2022 – of them 13,386 were UASC – represent an overall increase of almost one third compared to the total in 2021. (MdI, Cruscotto statistico giornaliero 31-12-2022, 2022). Based on the identification processes carried out so far, the composition mostly appears to confirm recent trends regarding Africa the Indian subcontinent, and the Middle East:

Egypt	20,542	20%

Tunisia	18,148	17%
Bangladesh	14,982	14%
Syria	8,594	8%
Afghanistan	7,241	7%
Côte d'Ivoire	5,973	6%
Guinea	4,473	4%
Pakistan	3,188	3%
Iran	2,326	2%
Eritrea	2,101	2%
Others	17,561	17%
Total	**105,129**	**100%**

Anyway, of all these people, only about 77,200 (of which 1,660 UASC) have already applied for asylum or some form of protection. Moreover, measuring these figures together with the 45,200 first-time asylum applicants in 2021, it emerges that only 34.6% of the applications were already examined, resulting in still 80,005 asylum seekers on Italian territory at the end of 2022 (EUROSTAT, 2023).

Also, it is worth to point out that the increasing trend of new arrivals by sea seems to continue in early 2023: in the first three months there have already been more than 33,400 arrivals, – in 2022 on the same date they were "only" 8,432 – including around 7,200 minors (3,142 UASC), fleeing from the Middle East and North Africa, Sub-Saharan Africa, Central and South Asia (MdI, Cruscotto statistico giornaliero 15-04-2023, 2023):

Côte d'Ivoire	5,568	17%
Guinea	4,208	12%
Pakistan	3,412	10%
Tunisia	2,764	8%
Egypt	2,685	8%
Bangladesh	2,339	7%
Cameron	1,590	5%
Syria	1,330	4%

Mali	1,053	3%
Burkina Fasu	966	3%
Others	7,565	23%
Total	**33,480**	**100%**

Finally, several CAS centres were reopened to accommodate the growth in arrivals. As of 04/15/2023, the state of the reception system is as follows:

MIGRANT PRESENCE IN THE RECEPTION SYSTEM				
	Hotspots	CAP & CAS	SAI	Total presence
No. Tot	1,485	78,746	34,741	114,972

The special case of UASC

The issue of UASCs deserves a separate brief discussion. In general, although presence in absolute terms as well as differentiation by country of origin are variables that change over time, from the study of trends in recent years, three constants characterising UASC can be identified: age, gender composition, and tendency towards non-traceability. In fact, this group follows constantly a certain trend line, since the majority of UASC are between 15 and 17 years old (currently about 70% of them, but often over 90%). Moreover, this migration phenomenon almost exclusively involves male minors (often over 80-90% of them). – Concerning the underage girls, it has been noted that, in most cases, the UASC coming from West and sub-Saharan African countries are victims of trafficking for prostitution. – Finally, this sub-group generally shows a high percentage (sometimes thousands in absolute values) of "untraceable" minors, i.e., who leave the reception facilities and whose traces are lost. In fact, many minors, especially those who could apply for international protection, make themselves unavailable to continue their journey to northern European countries, with the desire to reunite with their families or their diasporas. In general, for many minors, staying in the Italian reception system is perceived as an obstacle on the road to socio-economic autonomy, especially in the presence of a strong family mandate, as in the case of North African minors (CeSPI, Primo Rapporto: 2020, 2020).

«The migration phenomenon of Unaccompanied Foreign Minors in Italy has become increasingly important over time. […] Similarly, to what happened to the presence of migrants in absolute terms, the presence of foreign minors arriving alone has intensified following the Arab revolutions that from Tunisia, in December 2010, rapidly spread to Egypt, Libya, Syria and other countries in the region. […] During 2014 there was a significant increase in the number of admissions, connected to the significant increase in the flows of entry by sea. [...] According to Viminale data, 70,547 unaccompanied foreign minors arrived on Italian shores between 2014 and 2018.» (CeSPI, Primo Rapporto: 2020, 2020) After a significant decrease in arrivals in 2019 (-43%) and during the years of the covid-19 pandemic, the trend started to grow again markedly. At the end of 2021 there were 11,159 UASC in Italy. (CeSPI, Secondo Rapporto: 2021, 2021) Then, the presence of unaccompanied minors almost doubled over a year, in large part due to the war in Ukraine, reaching more than 20,000 at the end of 2022. (ISMU, Unaccompanied foreign minors in 2022 in Italy., 2023) Finally, as of March 2023, 19,640 UASC were reported to be present on Italian territory: 85,4% males and 14,6 females (MdI, REPORT MENSILE MINORI STRANIERI NON ACCOMPAGNATI (MSNA) IN ITALIA, 2023). The last Ministry of the Interior's monthly report (03/31/2023) also shows the following graph on their main citizenships:

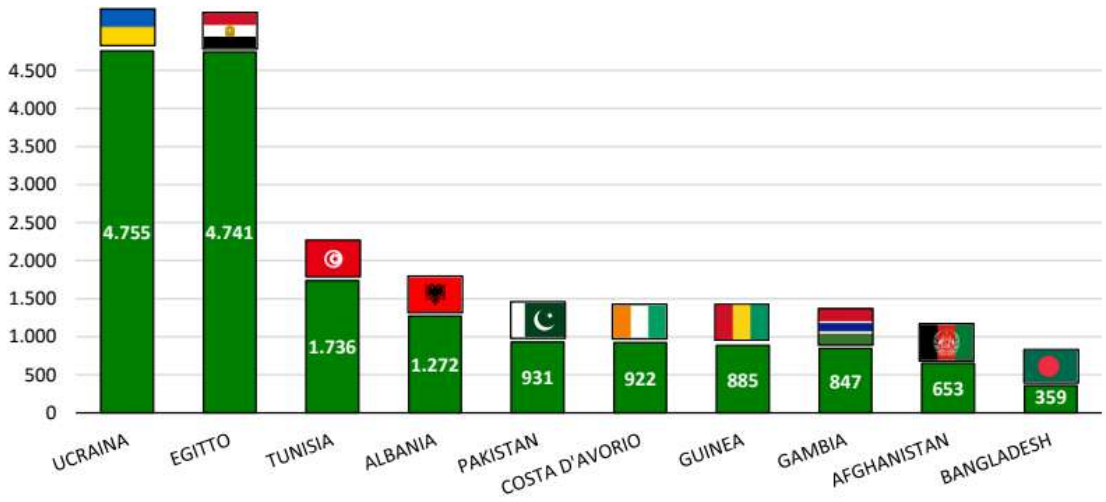


Figure 5: UASC BY CITIZENSHIP (absolute values). Graph from 'REPORT MENSILE MINORI STRANIERI NON ACCOMPAGNATI (UASC) IN ITALIA. Dati al 31 Marzo 2023' Edited by lavoro.gov.it, MdI 2023

General dimensions of the foreign population in Italy

The latest estimates (based, in turn, on census statistics in 2022) suggest a 3.9% increase in the number of foreigners residing in Italy as of 1 January 2023, giving a total figure between 5,050,176 and 5,213,699 persons (ISTAT, Rapporto Annuale 2022, 2022; ISTAT, Indicatori Demografici - anno 2022, 2023). Of these, more than 3.5 million are non-EU citizens (68,3%). These general figures include both adults and minors of all four main statuses mentioned above: regular migrants, refugees, beneficiaries of international protection, and asylum seekers. Despite the surge in arrivals reported over the past two years, these figures are to be seen within a stable trend of the foreign presence over the last ten-twelve years, which is only slightly increasing overall.

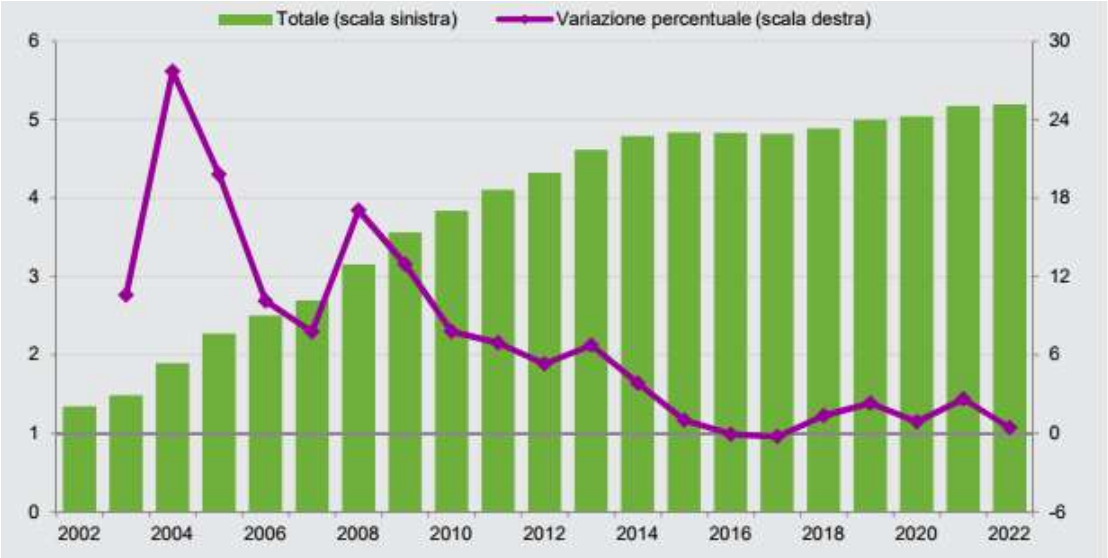


Figure 6: Resident foreign population in Italy. Years 2002-2022 (absolute values in millions on the left scale and annual percentage change on the right scale). Graph from 'Rapporto Annuale 2022', edited by ISTAT, July 2022.

However, in order to fully understand the real numerical extent of migration presence and, at the same time, the possible influences on health determinants, two peculiarities of the Italian context must be considered: A) the complex dynamic between acquisitions of citizenship and second generations of migration; B) the complex relationship between the presence of so-called irregular migrants and their turnover in and out of the group of legal resident foreigners.

A) According to the latest available statistics, between 2011 and 2020 more than 1.2 million people acquired Italian citizenship. Also, it can be estimated that on 1 January 2021 the new citizens by acquisition of citizenship residing in Italy were about 1.6 million. Therefore, from this point of view, it can be considered that the overall population with a migratory background (both foreigners and Italians by acquisition of citizenship) the population of foreign origin has reached between 2021 and 2022 the quota of almost 6.8 – 6.9 million residents (ISTAT, Rapporto Annuale 2022, 2022).

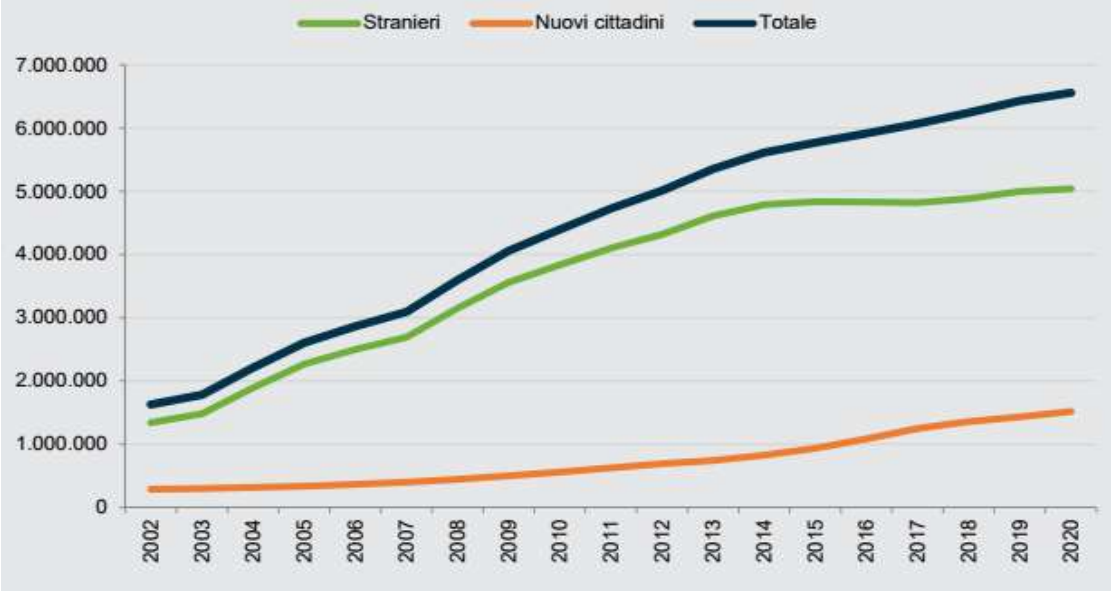


Figure 7: Foreigners and new citizens resident in Italy. Years 2002-2020 (absolute values, foreigners in green, new citizens in orange, total in blue). Graph from 'Rapporto Annuale 2022', edited by ISTAT, July 2022.

However, while it is important to consider this wider pool of people with a migration background, the classification of 'foreigners/Italians', in this case, is not a homogenous category and can be misleading in some circumstances, especially regarding the conditions, identity, or degree of integration of people. To better understand this, it is necessary to look at the distortions caused by the citizenship law concerning migration. Indeed, L. 91/1992 states that those whose parents (even if only their father or mother) are Italian citizens automatically acquire Italian citizenship at birth: actually, anyone who is the child of an Italian citizen according to the principle of *jus sanguinis*, whereas where one is born does not matter. Those born in Italy from both foreign citizens can apply for Italian citizenship at the age of 18 by proving that they have resided in Italy continuously since birth. The same law also says that Italian citizenship can be acquired by those who have resided in Italy for at least 10 years by proving that they meet the

requirements of income (which remain discretionary but are in fact applied in many cases) and regularity of residence (G2, 2023). This legislative basis – criticised by most non-governmental organisations dealing with migration – has the main consequence that a considerable number of second generations of migrants are officially considered 'foreigners' even though they were born and raised in Italy. At the same time, there are several people (however small) who are officially considered Italian even though they have just arrived in Italy and their degree of integration is minimal.

The latest survey in this regard found that, as of 1 January 2018, there were approximately 1.316 million second-generation minors, including both “foreigners” and “Italians by hereditary transmission”. Of these, 991,314 were born in Italy (75,3%) and 325,181 were born abroad (24,7%). But of those born in Italy, as many as 78.5% (777,940) are still officially considered foreigners. While of those born abroad, 80.9% are considered foreigners and 19.1% are already naturalised Italians (ISTAT, Identità e percorsi di integrazione delle seconde generazioni in Italia, 2020). Although integration pathways are, in any case, individual and personal processes, it is plausible to assume that, not only minors already naturalised Italians, but also a large proportion of those considered 'foreign' born in Italy are significantly closer in identity, material conditions and degree of integration to Italian minors born of both Italian parents – though not in terms of recognition of rights and discriminatory experiences. This assumption seems to be confirmed, among others, by some surveys directly carried out in secondary and high schools (Openpolis, L’inclusione delle seconde generazioni e il ruolo della comunità educante, 2022). Ultimately, it is important to consider the complexity of this picture in approaching the overall figure of 5,050,000 or more resident foreigners, as well as in addressing the 1,600,000 and more new citizenships acquired in recent years.

B) The second peculiar factor influencing the population with migratory background present in the Italian territory is the impact of the irregular foreign presence. This is to be understood both in terms of the dynamics that characterise its formation, and in the extent of the constant turnover with the number of legally resident foreigners, also due to distortions in migration policies (MDP, 2022). According to the latest estimates, currently there are in Italy around 600,000 – 700,000 irregular migrants. Anyway, it is in fact a constantly present group, although with significant variations in quantity over the years: from the 1990s until nowadays the estimated average number of irregular migrants has been around 400,000, with lows of 140-160,000 and peaks of 750,000. More specifically, between 2010 and 2023, irregular migrants

made up between 6 and 9% of the entire population with a migratory background in Italy (ISMU, Stime stranieri irregolari ISMU, 1991-2021, 2022).

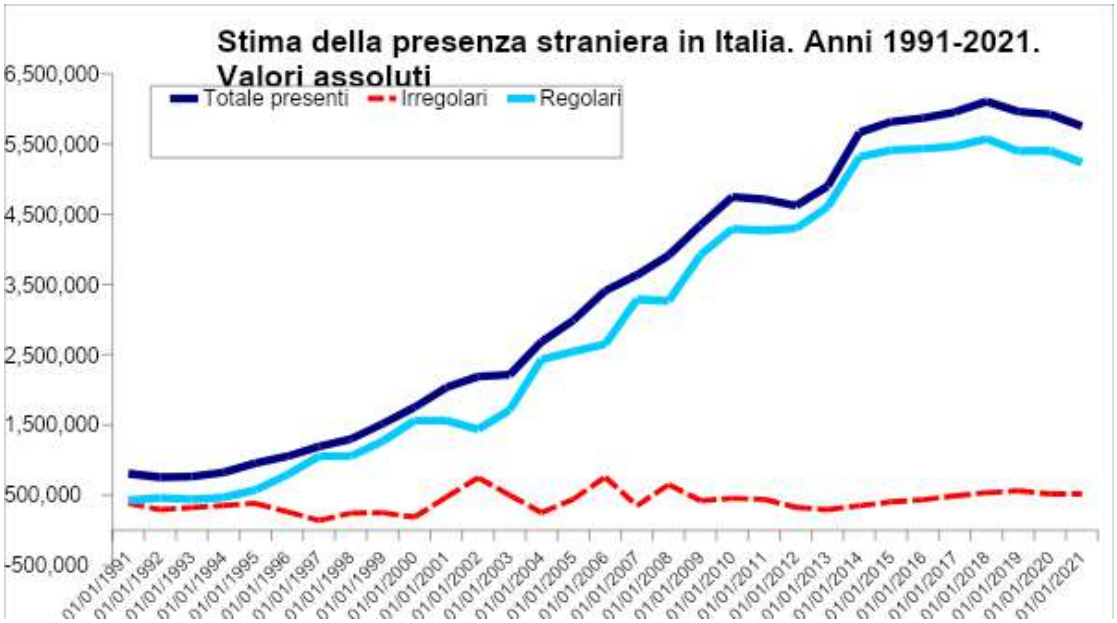


Figure 8 Estimated foreign presence in Italy. Years 1991-2021. (Absolute values: regular in light blue, irregular in red dashed, total in dark blue.) Graph from 'Stime stranieri irregolari ISMU, 1991-2021', edited by ISMU, 2022.

Apart from the relatively small percentage of people who are not immediately intercepted upon arrival in Italy, – for instance with false documents or without crossing at an official border crossing point – there are several processes that can lead a person to belong to the group of irregular migrants. Generalising a little, first, there are a few people who for various reasons do not apply for asylum/protection or do not get identified right at the level of hotspots and first reception. Usually, either they manage to get away from the centres without leaving traces – as in the above-mentioned case of several UASC – or more often they are transferred directly to the CPR with the prospect of repatriation. Nevertheless, the mechanisms for repatriation are structurally limited and historically unable to process the volume of people with an expulsion order or an illegal status. According to data collected since 2017, an average of about 4,800 people passes through CPR centres every year, but in fact just under half (48-49%) actually end up being repatriated. Almost all others (47%) are discharged on a legal basis (e.g. because the 90-day administrative detention period expires), but remain *de facto* illegally on the territory (Palma, de Robert, & Rossi, 2022; ISMU, Transiti nei CPR e Rimpatri anni 2016-2022, 2022).

Anyway, most of the irregular migrants are people who only subsequently lose their regular status and residence permit. Sometimes this happens within a relatively short-medium period (from a few months to two years). For example, in the case of people who obtain a seasonal work or short-term study permit and then, willingly or unwillingly, are not in a position to convert it into a long-term permit. Or in the case of asylum seekers to whom at the end of the verification process refugee status or humanitarian protection are denied. – This case occurs quite often: according to data presented by the Ministry of the Interior, from 2015 to 2021, out of a total of 515,640 asylum/protection applications, the average number of denials was 58% (MdI, Quaderno Statistico per gli anni 1990-2020, 2021; MdI, Confronto dati anno 2020 - 2021, 2022). – In other situations, the period of permanence may last several years: ranging from cases where long-term work permit or humanitarian or subsidiary protection is not renewed, up to extreme cases, such as those of some young second generations of migration who, once they reach the age of majority, are denied not only citizenship but also a residence permit due to insufficient income requirements or to bureaucratic formal flaws (G2, 2023). Non-compliance of administrative practices can be also the indirect cause of the irregular status. Indeed, various situations have been reported in which people have lost their jobs for this reason and consequently drifted out of regular circuits (Mangano, 2016; MSF, Fuori Campo. Secondo Rapporto, 2018; MEDU & UNHCR, Rapporto Margini, 2022). Moreover, in recent years it has frequently happened that changes in migration policies have reduced the types of protection, even changing the ongoing regular status of people (ISPI, I nuovi irregolari in Italia, 2018; ISPI, Fact-checking: migrazioni 2021, 2021).

Obviously, the ways of reacting to the condition of irregularity are extremely varied and individual. Anyway, it is worth noting that bureaucratic and judicial failures and obstacles cause that in many cases no expulsion order is officially formulated. Even more significant is the fact that even when this occurs, the expulsion decisions that are followed by actual voluntary or forced repatriation are a minority. According to last available data, between 2018 and 2021, out of 107,368 expulsion orders, only 21,366 people had returned to their country of origin through voluntary or forced repatriation, i.e., one fifth of the total (CdC, 2022; ISMU, Transiti nei CPR e Rimpatri anni 2016-2022, 2022). Ultimately, in many cases, people who lose their residence permit for whatever reason remain (at least for a certain time) in Italy. Yet, the main consequences of irregular status are of course the worsening of access to health, educational, supplementary, and civic services (in a good number of cases also housing), as well as the impossibility of working legally. These conditions not only push people into social marginalisation, but

often put them at risk of labour exploitation. In this sense, the phenomenon of *caporalato* (illegal recruitment) is exemplary: since decades it has been connoting the exploitation of people, especially in the agro-food chain – according to last data, more than 10,000 people (mostly from Romania, Morocco, India, Albania, Senegal, Pakistan and Nigeria) scattered in more than 150 illegal settlements – and only recently it has begun to be countered by statal interventions that try to coordinate all the stakeholders involved (ANCI, 2022; MLPS, Piano triennale di contrasto allo sfruttamento lavorativo in agricoltura e al caporalato 2020 - 2022, 2020).

To complete this picture, it is important to consider that there are also mechanisms that possibly return people to regular status – actually, it is not unusual for migrants and refugees to enter and leave the "official" Italian system more than once. Although no structural procedures are foreseen in this regard; in reality, over the last decades the political practice has been established – on all sides – of resorting to regularisation measures. In a first phase, official general amnesties were used, every 2-4 years, to (re)integrate the foreign presence that had inevitably leaked out of the reception system and remained on the margins of society. In more recent years, recourse has been rather had mainly to the so-called annual 'flow decrees' – which have just become three-yearly with the latest amendment of 2023. – These, in theory, should establish from time to time the quotas for the admission of new foreigners from abroad, but in fact present the features of a sort of disguised amnesty. The real difference is that these are rather stringent amnesties, dedicated only to certain economic sectors or professions (e.g. domestic helpers and carers), in order to address the great need for regularisation in a targeted manner. In both cases, however, they are technically procedures that allow people who meet certain criteria to self-disclose their irregular position by applying for a residence permit for work reasons, anchoring the requirements mainly to existing work relationships or job-seeking or third-party sponsorship (Colucci, 2020; ASGI, Caritas, Emergency, & al., 2022; ASGI, Diritto, CILD, & al., 2020).

In conclusion, to adherently approach the reality of the population with a migrant background in Italy, it is necessary to consider that two dimensions, the regular and the irregular, have existed for decades, coexisting in parallel, but with numerous points of contact and mutual transition over the time.

Demography of the resident foreign population

Beyond the most recent flows discussed above, the most up-to-date statistical data on the composition and demographic characteristics of the foreign population resident in Italy are those collected by the

ISTAT census at the beginning of 2022. The following are some tables elaborated from the same data and edited by TuttItalia.it.

EUROPE	Area	Males	Females	Total	%
Romania	European Union	467.255	616.516	1.083.771	21,54%
Albania	Central Eastern Europe	215.58	204.407	419.987	8,35%
Ukraine	Central Eastern Europe	50.032	175.275	225.307	4,48%
Moldova	Central Eastern Europe	38.948	75.966	114.914	2,28%
Poland	European Union	18.933	56.048	74.981	1,49%
North Macedonia	Central Eastern Europe	28.059	25.384	53.443	1,06%
Bulgaria	European Union	18.226	30.979	49.205	0,98%
Kosovo	Central Eastern Europe	20.791	16.273	37.064	0,74%
Russian Federation	Central Eastern Europe	6.901	30.081	36.982	0,74%
Germany	European Union	12.602	20.382	32.984	0,66%
Serbian Rep.	Central Eastern Europe	15.29	16.052	31.342	0,62%
Francia	European Union	11.412	17.323	28.735	0,57%
UK	European Union	13.575	14.78	28.355	0,56%
Spain	European Union	8.824	17.593	26.417	0,53%
Bosnia-Herzegovina	Central Eastern Europe	11.227	10.007	21.234	0,42%
Turkey	Central Eastern Europe	10.972	7.958	18.93	0,38%
Croatia	European Union	7.722	8.032	15.754	0,31%
Byelorussia	Central Eastern Europe	1.723	7.088	8.811	0,18%
The Nederland	European Union	3.748	4.619	8.367	0,17%
Slovakia	European Union	1.904	5.945	7.849	0,16%
Svitzerland	Other European countries	3.228	4.418	7.646	0,15%
Hungary	European Union	1.995	5.603	7.598	0,15%
Greek	European Union	3.33	3.563	6.893	0,14%
Portugal	European Union	2.977	3.606	6.583	0,13%
Austria	European Union	1.89	4.213	6.103	0,12%
Belgium	European Union	2.52	3.251	5.771	0,11%
Czech Rep.	European Union	871	4.3	5.171	0,10%
Lithuania	European Union	955	4.04	4.995	0,10%
Ireland	European Union	1.617	1.73	3.347	0,07%
Slovenia	European Union	1.627	1.564	3.191	0,06%
Sweden	European Union	1.029	2.004	3.033	0,06%
Leetonia	European Union	496	2.235	2.731	0,05%
Montenegro	Central Eastern Europe	900	1.042	1.942	0,04%
Denmark	European Union	748	1.106	1.854	0,04%

Finland	*European Union*	366	1.209	1.575	0,03%
San Marino	*Other European countries*	760	528	1.288	0,03%
Estonia	*European Union*	198	965	1.163	0,02%
Norwegian	*Other European countries*	440	584	1.024	0,02%
Malta	*European Union*	283	436	719	0,01%
Cipro	*European Union*	104	174	278	0,01%
Luxemburg	*European Union*	125	138	263	0,01%
Island	*Other European countries*	62	86	148	0,00%
Principate of Monaco	*Other European countries*	23	13	36	0,00%
Città del Vaticano	*Other European countries*	14	12	26	0,00%
Liechtenstein	*Other European countries*	8	10	18	0,00%
Andorra	*Other European countries*	4	5	9	0,00%
Total EUROPE		**990.294**	**1.407.543**	**2.397.837**	**47,66%**

AFRICA	*Area*	**Males**	**Females**	**Total**	**%**
Morocco	*North Africa*	228.481	191.691	420.172	8,35%
Egypt	*North Africa*	92.658	47.664	140.322	2,79%
Nigeria	*West Africa*	68.742	50.693	119.435	2,37%
Senegal	*West Africa*	81.345	29.418	110.763	2,20%
Tunisia	*North Africa*	62.031	36.971	99.002	1,97%
Ghana	*West Africa*	32.634	15.646	48.28	0,96%
Côte d'Ivoire	*West Africa*	18.892	9.493	28.385	0,56%
Gambia	*West Africa*	20.989	837	21.826	0,43%
Mali	*West Africa*	19.05	958	20.008	0,40%
Algeria	*North Africa*	11.464	6.534	17.998	0,36%
Cameron	*Central Southern Africa*	8.174	6.839	15.013	0,30%
Burkina Faso	*West Africa*	9.595	4.572	14.167	0,28%
Guinea	*West Africa*	10.218	1.578	11.796	0,23%
Somalia	*East Africa*	6.388	1.982	8.37	0,17%
Eritrea	*East Africa*	3.493	3.082	6.575	0,13%
Ethiopia	*East Africa*	2.624	3.734	6.358	0,13%
Togo	*West Africa*	3.631	1.811	5.442	0,11%
Mauritius	*East Africa*	2.212	2.835	5.047	0,10%
Capo Verde	*West Africa*	1.278	2.416	3.694	0,07%
D.R. of Congo	*Central Southern Africa*	1.702	1.733	3.435	0,07%
R. of Congo	*Central Southern Africa*	1.384	1.429	2.813	0,06%
Libya	*North Africa*	1.802	840	2.642	0,05%
Kenya	*East Africa*	896	1.59	2.486	0,05%

Benin	*West Africa*	1.56	903	2.463	0,05%
Sudan	*North Africa*	1.891	553	2.444	0,05%
Guinea Bissau	*West Africa*	2.07	220	2.29	0,05%
Sierra Leone	*West Africa*	1.528	465	1.993	0,04%
Niger	*West Africa*	1.314	335	1.649	0,03%
Madagascar	*East Africa*	426	1.084	1.51	0,03%
Tanzania	*East Africa*	531	663	1.194	0,02%
Liberia	*West Africa*	933	211	1.144	0,02%
Angola	*Central Southern Africa*	566	542	1.108	0,02%
Mauritania	*West Africa*	560	171	731	0,01%
Sud Africa	*Central Southern Africa*	286	420	706	0,01%
Burundi	*East Africa*	255	396	651	0,01%
Uganda	*East Africa*	249	324	573	0,01%
Ruanda	*East Africa*	241	316	557	0,01%
Gabon	*Central Southern Africa*	244	220	464	0,01%
Chad	*Central Southern Africa*	344	78	422	0,01%
Mozambique	*East Africa*	139	213	352	0,01%
Seychelles	*East Africa*	107	232	339	0,01%
Zambia	*East Africa*	116	139	255	0,01%
Zimbabwe	*East Africa*	89	136	225	0,00%
Equatorial Guinea	*Central Southern Africa*	103	88	191	0,00%
Central African R.	*Central Southern Africa*	112	56	168	0,00%
Sud Sudan	*North Africa*	81	30	111	0,00%
Malawi	*East Africa*	26	39	65	0,00%
Namibia	*Central Southern Africa*	6	21	27	0,00%
São Tomé e Principe	*Central Southern Africa*	11	16	27	0,00%
Djibouti	*East Africa*	13	11	24	0,00%
Botswana	*Central Southern Africa*	5	9	14	0,00%
Eswatini	*Central Southern Africa*	7	6	13	0,00%
Lesotho	*Central Southern Africa*	6	4	10	0,00%
Comroe	*East Africa*	3	4	7	0,00%
Total AFRICA		**703.505**	**432.251**	**1.135.756**	**22,58%**

ASIA	*Area*	**Males**	**Females**	**Total**	**%**
China	*East Asia*	152.332	147.884	300.216	5,97%
India	*South Central Asia*	94.736	67.756	162.492	3,23%
Bangladesh	*South Central Asia*	113.368	45.635	159.003	3,16%
Philippine	*East Asia*	68.771	90.226	158.997	3,16%

Pakistan	South Central Asia	96.571	37.611	134.182	2,67%
Sri Lanka	South Central Asia	57.002	51.067	108.069	2,15%
Georgia	West Asia	3.565	19.342	22.907	0,46%
I.R. of Iran	West Asia	7.203	6.806	14.009	0,28%
Afghanistan	South Central Asia	11.466	2.081	13.547	0,27%
Japan	East Asia	1.786	5.069	6.855	0,14%
Syria	West Asia	3.626	2.483	6.109	0,12%
Iraq	West Asia	4.764	1.279	6.043	0,12%
Thailand	East Asia	552	4.897	5.449	0,11%
Lebanon	West Asia	2.624	1.458	4.082	0,08%
South Korea	East Asia	1.524	2.029	3.553	0,07%
Indonesia	East Asia	463	2.593	3.056	0,06%
Kirghizstan	South Central Asia	423	1.523	1.946	0,04%
Kazakhstan	South Central Asia	316	1.608	1.924	0,04%
Israeli	West Asia	972	798	1.77	0,04%
Nepal	South Central Asia	991	701	1.692	0,03%
Vietnam	East Asia	507	1.068	1.575	0,03%
Jordan	West Asia	884	554	1.438	0,03%
Armenia	West Asia	589	798	1.387	0,03%
Palestine	West Asia	893	353	1.246	0,02%
Uzbekistan	South Central Asia	320	783	1.103	0,02%
Azerbaijan	West Asia	471	435	906	0,02%
Taiwan	East Asia	167	431	598	0,01%
Malaysia	East Asia	273	231	504	0,01%
Myanmar	East Asia	119	209	328	0,01%
Yemen	West Asia	159	104	263	0,01%
Mongolia	East Asia	63	173	236	0,00%
Singapore	East Asia	50	153	203	0,00%
Cambogia	East Asia	63	134	197	0,00%
Saudi Arabia	West Asia	98	44	142	0,00%
Timor Est	East Asia	16	71	87	0,00%
North Korea	East Asia	27	46	73	0,00%
Tajikistan	South Central Asia	34	33	67	0,00%
Kuwait	West Asia	42	24	66	0,00%
Turkmenistan	South Central Asia	16	49	65	0,00%
Laos	East Asia	13	47	60	0,00%
Qatar	West Asia	32	5	37	0,00%
Bhutan	South Central Asia	13	10	23	0,00%

Bahrein	*West Asia*	12	10	22	0,00%
UAE	*West Asia*	13	7	20	0,00%
Oman	*West Asia*	11	7	18	0,00%
Maldives	*South Central Asia*	13	1	14	0,00%
Brunei	*East Asia*	1	2	3	0,00%
Total Asia		**627.954**	**498.628**	**1.126.582**	**22,39%**

AMERICA	*Area*	**Males**	**Females**	**Total**	**%**
Perú	*Central and South America*	39.899	54.232	94.131	1,87%
Ecuador	*Central and South America*	29.424	37.166	66.59	1,32%
Brazil	*Central and South America*	14.274	33.044	47.318	0,94%
Dominican Rep.	*Central and South America*	11.444	17.368	28.812	0,57%
Cuba	*Central and South America*	6.405	15.094	21.499	0,43%
El Salvador	*Central and South America*	8.661	11.947	20.608	0,41%
Colombia	*Central and South America*	7.487	11.538	19.025	0,38%
USA	*North America*	6.341	8.155	14.496	0,29%
Bolivia	*Central and South America*	5.071	7.853	12.924	0,26%
Venezuela	*Central and South America*	4.347	7.686	12.033	0,24%
Argentina	*Central and South America*	4.797	5.725	10.522	0,21%
Mexico	*Central and South America*	1.579	3.188	4.767	0,09%
Honduras	*Central and South America*	1.042	2.081	3.123	0,06%
Chile	*Central and South America*	1.303	1.71	3.013	0,06%
Canada	*North America*	794	1.193	1.987	0,04%
Paraguay	*Central and South America*	503	1.311	1.814	0,04%
Uruguay	*Central and South America*	458	712	1.17	0,02%
Dominica	*Central and South America*	410	666	1.076	0,02%
Guatemala	*Central and South America*	315	590	905	0,02%
Nicaragua	*Central and South America*	252	523	775	0,02%
Costa Rica	*Central and South America*	169	354	523	0,01%
Haiti	*Central and South America*	149	187	336	0,01%
Panama	*Central and South America*	94	240	334	0,01%
Jamaica	*Central and South America*	59	69	128	0,00%
Trinidad e Tobago	*Central and South America*	10	29	39	0,00%
Guyana	*Central and South America*	8	10	18	0,00%
Barbados	*Central and South America*	7	10	17	0,00%
Bahamas	*Central and South America*	7	9	16	0,00%
Antigua e Barbuda	*Central and South America*	6	6	12	0,00%
Belize	*Central and South America*	6	5	11	0,00%

Saint Lucia	*Central and South America*	4	7	11	0,00%
Grenada	*Central and South America*	5	4	9	0,00%
Saint Kitts e Nevis	*Central and South America*	4	3	7	0,00%
Suriname	*Central and South America*	2	5	7	0,00%
Saint Vincent e Grenadine	*Central and South America*	2	3	5	0,00%
Total America		**145.338**	**222.723**	**368.061**	**7,32%**

OCEANIA	*Area*	**Males**	**Females**	**Total**	**%**
Australia	*Oceania*	567	854	1.421	0,03%
New Zeeland	*Oceania*	158	160	318	0,01%
Samoa	*Oceania*	18	21	39	0,00%
Papua Nuova Guinea	*Oceania*	19	12	31	0,00%
Fiji	*Oceania*	9	14	23	0,00%
Tonga	*Oceania*	7	6	13	0,00%
Salomon Island	*Oceania*	0	5	5	0,00%
Vanuatu	*Oceania*	1	3	4	0,00%
Kiribati	*Oceania*	2	0	2	0,00%
Island Marshall	*Oceania*	1	0	1	0,00%
Micronesia	*Oceania*	1	0	1	0,00%
Palau	*Oceania*	0	1	1	0,00%
Total Oceania		**783**	**1.076**	**1.859**	**0,04%**

Stateless persons	**Males**	**Females**	**Total**	**%**
Total Stateless persons	**328**	**293**	**621**	**0,01%**

According to the ISTAT annual report 2022: «The different communities in Italy follow different patterns of integration. The specificities partly depend on the different degree of maturity reached by the presence on the territory. [However, the] migratory projects developed by the many citizenships present in Italy are multiple, over and above the average duration of the community's presence, since very often they also respond to the living conditions and political and social stability in the country of origin. One very important difference concerns the gender structure of the foreign presence, which is overall balanced: the gender ratio is 95 women for every 100 men. However, the overall balance conceals strong imbalances within the different communities. This is the case, for example, with some Eastern European citizenships that are strongly unbalanced in terms of women, such as Ukrainian and Russian citizenships for which the

female component exceeds 75% of the total presence. More balanced is the gender ratio for Romanian citizenship for which women still account for almost 58% of residents (as of 1 January 2021). Other communities, such as Bangladesh, Egypt and Pakistan, are, on the other hand, unbalanced in favour of men, with the percentage of women between 28% and 34%.»

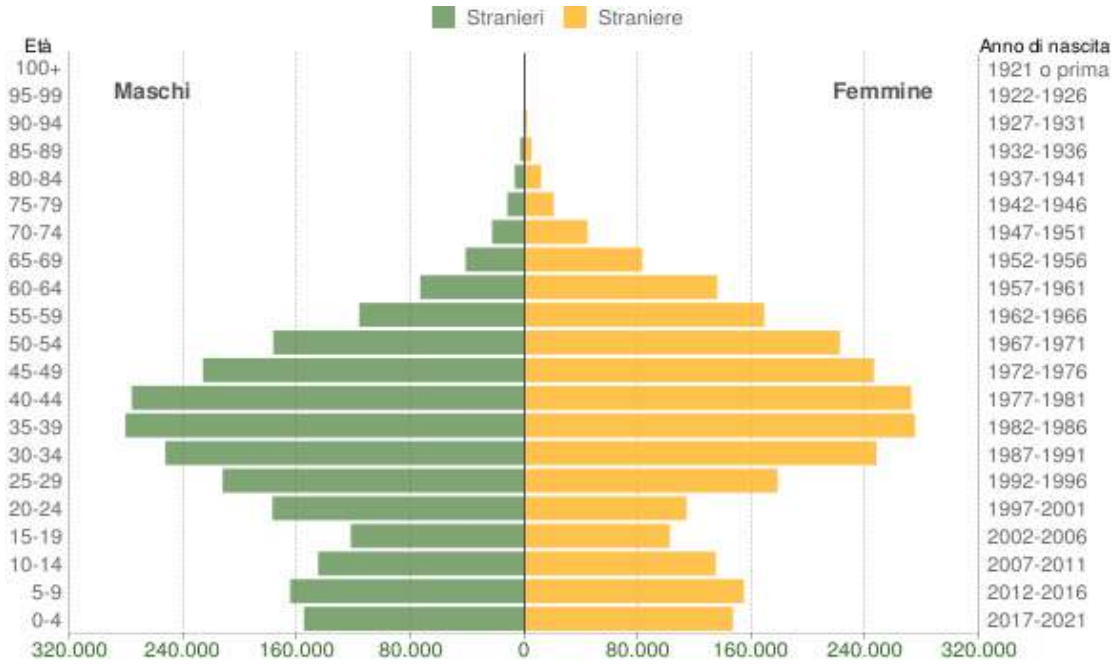


Figure 9: Distribution of the foreign population by age and gender (males in green, females in yellow). Data elaborated from (ISTAT, Rapporto Annuale 2022, 2022), edited by TuttItalia.it, 2023.

The largest age group is that of 30-44 year olds, with an incidence of 30.9%. In general, almost 2 out of 5 non-EU foreigners (37.3%) are under the age of 30 and almost 7 out of 10 (68.2%) under the age of 45, while the over 45s do not even reach a third of the total (31.8%). The great predominance of young people also influences the marital status of this segment of the population, which in 3 out of 5 cases (59.6%) is made up of unmarried persons (single and single, amounting to more than 2,121,000 people), while the remainder is represented almost entirely by married persons (1,405,000, or 39.5% of the non-EU). The 18,000 widowed, the approximately 12,000 divorced and the more than 5,000 separated only come close to 1% of the total» (ISS, I numeri, 2022).

Factors affecting the psychological wellbeing in migrant/refugee populations

It is extremely difficult to provide an exhaustive and precise picture of the factors influencing the mental health status of migrants and refugees. «Determinants of health include a variety of individual, social, and environmental factors that can cause poorer health outcomes among refugees and migrants compared with host populations. The determinants are highly interconnected and often interdependent. Many researchers consider the displacement and migration process to be a determinant in itself. Refugees and migrants are affected by the same determinants that affect the rest of humanity. However, their migratory status can add a layer of complexity that, when combined with other determinants, makes them particularly vulnerable to specific health risks, thereby affecting their overall health. [Given this premise, it is also important to consider that] social determinants disproportionately affect populations that are most vulnerable. When exploring the health of refugees and migrants, it is the social determinants of health (rather than diseases or medical conditions themselves) that explain most of their poor health outcomes. Key social determinants include income and social protection, level of education, unemployment, and job insecurity, working conditions, food insecurity, housing and basic amenities, early childhood development, social inclusion and non-discrimination, conflict, and access to affordable health services of good quality (WHO, World report on the health of refugees and migrants, 2022).

Regarding mental health, a general approximation can be attempted by distinguishing the determinants with the (likely) greatest impact in the period before and during the migratory movement from those that are more relevant once they have reached the Italian territory. Anyways, it is important to bear in mind that this is not a rigid distinction.

Mental health stressors before and during migration

The review of the scientific literature underlying the above quoted 'World report on the health of refugees and migrants' (WHO, World report on the health of refugees and migrants, 2022) shows that, from a global perspective, migrant populations are not inherently less healthy than host populations and has no less healthy behaviours in the first instance. This overview also confirms the non-existence, to a significant extent, of ‘import diseases’ among migrants in Italy, which had already emerged in a previous

report on the European Region (WHO, Report on the health of refugees and migrants in the WHO European Region, 2018). These data, referring to the overall epidemiology, had partially proven to be valid in the psychiatric field as well: hospitalization rates for mental diagnoses among migrants in Italy were particularly low despite what might have been expected due to the presence of risk factors related to the migration experience.

To this regard, many studies, including in the field of psychology, conducted between the 1990s and the mid-2110s had highlighted the so-called "healthy migrant effect." Basically, the finding that most «migrants leave their countries healthy, which is quite obvious, if one considers how challenging the migration route generally is, and how it requires good health to cope» (Geraci & Mazzetti, 2019). Unfortunately, the change in migration flows to Italy in the last decade – see the previous chapter – have begun to transform this picture. Indeed, more and more people are leaving fleeing desperate situations of grave danger. WHO's General Director himself, presenting the latest report, also said that this trend is likely to continue in the coming years due to the increase of interconnected factors such as conflict, climate change, sociopolitical instability, and inequality (ISS, Salute dei migranti: un nuovo report OMS, 2022). Thus, among the first pre-migratory stressors influencing mental health – particularly of refugees and displaced people – can be the following most significant (CSI, 2021; WHO, World report on the health of refugees and migrants, 2022; T. & H., 2020; Uphoff, Robertson, & Cabieses, 2020; Beiser & Hou, 2001; Allen, Balfour, Bell, & Marmot, 2014; Arega, 2017; Idemudia & Boehnke, 2020):

- traumatic events (conflict, human rights violation, sexual violence);
- reduced/impossible access to healthcare;
- reduced/impossible access to primary services, including education;
- pre-migration mental disorders.

In addition to these, there are peri-migratory factors related to the migration process itself as well as to the route to be taken. First, the detachment from the family environment and from one's own community can be, as losing social and psychosocial support networks, a factor of significant psychic suffering (Sanfelici, Wellman, & Mordeglia, 2021; Blackmore, Boyle, Fazel, & al., 2020; Morina, Akhtar, Barth, & Schnyder, 2018). Secondly, a number of generally relevant stressors can be highlighted with regard to the impact of the route travelled (CSI, 2021; WHO, World report on the health of refugees and migrants, 2022; Al-Hourani, Azzam, & Jaber, 2019; Allen, Balfour, Bell, & Marmot, 2014; Arega, 2017; Jamaluddine, Sahyoun, & Choufani, 2019; Napier, Oldewage-Theron, & Makhaye, 2018; UNHCR, Vulnerability

Assessment of Syrian Refugees in Lebanon, 2020; Idemudia & Boehnke, 2020; Angeletti, Ceccarelli, Bazzardi, & al., 2020):

- duration of the travel;
- economic capabilities;
- food insecurity;
- absence of drinking water;
- absence of comfortable accommodation;
- (re)traumatising events;
- enforced detention.

Starting for this background, some specificities are worth pointing out in the specific case of migratory flows to Italy. Unfortunately, no conclusive studies are yet available concerning the large number of refugees that have recently arrived from Ukraine, but some contingencies typical of the routes by sea and the Balkan can be highlighted. As mentioned previously, in the last years the Central Mediterranean Route has proved to be the deadliest one, leading to the constant need for rescue operations by sea – sometimes carried out mostly by NGOs and even obstructed by the Italian governments themselves, thus, aggravating the conditions of the rescued people (OHCHR, 2021). In addition to this, the constant flow of migrants and refugees from sub-Saharan and West Africa, as well as those from the Middle East via North Africa, must first and foremost pass through territories characterised by poverty and political instability, including conflict. In this context, a dense criminal network dedicated to kidnapping, extortion, and human trafficking has taken root over the years between Tunisia, Libya and Egypt, resorting also to torture, exploitation, sexual violence and other brutal practices. Moreover, there have been increasing reports from international non-governmental organisations on how this criminal dimension has become synergistically integrated with arbitrary detention and coastal control practices implemented by the local authorities. Unfortunately, the aforementioned European policy of borders externalisation – particularly the agreements made and renewed by Italy since 2017 – has played a decisive role in exacerbating this vicious circle. (AI, 2021; ARCI P.C., 2021; ASGI, L' ESTERNALIZZAZIONE DELLE FRONTIERE E DELLA GESTIONE DEI MIGRANTI, 2019; Idemudia & Boehnke, 2020; MPE, La Tunisia non è né un paese di origine sicuro né un luogo sicuro di sbarco, 2023; StC, Nascosti in piena vista - frontiera sud, 2023; MEDU, The Torture Factory, 2020). This set of criticalities means that currently, regardless of pre-migratory conditions and reason for leaving, many migrants and refugees already present trauma, psychopathological elements

or conditions of extreme psychic vulnerability right upon arrival in Italy, anticipating the so-called 'exhausted migrant effect', thus, counteracting the healthy migrant effect (Angeletti, Ceccarelli, Bazzardi, & al., 2020; Aragona, Salvatore, Mazzetti, & al., 2020) The same policy of externalisation has also had repercussions on the Balkan route, in a context less characterised by the presence of entrenched criminal activities, but still systemically marked by episodes of harassment and intentional violence – typical are the so-called 'informal rejections' through violence – as well as by conditions of deprivation and indigence. The recent Covid-19 pandemic has also led to a significant worsening of temporary accommodation and transit situations, exacerbating the already widespread feelings of anxiety, intimidation and isolation, with further serious impacts on mental health (Chiodi & Coletti, 2021; Astuti, Bove, Brambilla, & al., 2020; ICS, 2021; BVMN, The black book of pushbacks - Volume I, 2020; BVMN, The black book of pushbacks - Volume II, 2020).

Given these basic elements, it is useful to consider then other cross-cutting mental health determinants in the context of the pre- and peri-migratory phase. Regarding gender and sex, the latest WHO report highlights some main patterns impacting differently females, males, and generally LGBTIQ+ people. About the heightened health risks for women and girls: (Redden, Safarian, Schoenborn, & al., 2021; Shorey, E., & Downe, 2021; Im, Swan, & Isse, 2020; Usta, Masterson, & Farver, 2019; NIzrane, Ossewaarde, & Need, 2019; Oliveira, Keygnaert, do Rosário Oliveira Martins, & Dias, 2018; UNICEF, Uncertain Pathways: How gender shapes the experiences of children on the move, 2021; WHO, World report on the health of refugees and migrants, 2022):

- unique challenges and vulnerabilities, such as unique privacy and security challenges in accessing water, sanitation and hygiene services and facilities, including for menstrual hygiene management;
- many displaced and refugee women are in their prime childbearing years. Thus, eir health requires additional medical services for prenatal, labour, and delivery, and postpartum care. – Particularly, war exposure and daily stress can affect the general mental health of mothers and, thus, increase the risk of negative parenting behaviour, contributing to poorer psychosocial outcomes for children;
- female refugees and migrants faced high levels of sexual and gender-based violence, which is linked to trauma, poor mental health outcomes, and increased vulnerability to suicide and self-harm;
- practices such as female genital mutilation (FGM) and early marriage can drive girls to migrate in order to seek safer places.

On the other hand, regarding the specific stressors on mental health among men and boys, the following has been highlighted: (Mundy, Foss, Poulsen, & al., 2020; R., D., L., & O., 2017; Liebling, H., & L., 2020; L., E., & Rolland, 2020; P., S.M., Pessotti Aborghetti, & P., 2021; Belanteri, Hinderaker, & Wilkinson, 2020):

- A greater exposure to the risk of physical violence, including torture, beatings and imprisonment – often as a result of political violence or driven by state actors. – These can result in a high burden of post-traumatic physical and psychological morbidity, as well as a poorer quality of life and social isolation;
- An often-ignored rate of sexual violence (lower compared to females, but still present). - In the Mediterranean zone has happened that 28% of sexual assault survivors reported were men. Most of them had experienced it during the migration period rather than in their country of origin.

«LGBTIQ+ refugees and migrants face unique risks and vulnerabilities as a result of their sexual orientation, gender identity, gender expression and sex characteristics, similar to LGBTIQ+ people among the host population. However, migratory status adds an additional layer of complexity.» (WHO, World report on the health of refugees and migrants, 2022) During the pre- and peri-migration period these are mostly (E., Hatzenbuehler, Berg, & al., 2017; Golembe, Leyendecker, Maalej, & al., 2020; Hopkinson, Keatley, Glaeser, & al., 2016; Alessi, Kahn, Greenfield, & al., 2020; Kostenius, Hertting, Pelters, & C., 2021; Clark, Pachankis, Khoshnood, & al., 2020; Rosati, Coletta, Pistella, & al., 2021):

- In the African Region these groups lack social support, face stigma and discrimination, and experience limited access to and poor treatment from local health services more often than the average of the other population. – In a study emerged that 40% of the men who have sex with men (MSM) from several migrant originated countries indicated that their reason for migration was to affirm their sexual orientation;
- Displaced MSM and transgender women tend to present higher levels of psychiatric comorbidities compared with their counterparts in the host population as a result of experiencing both displacement- and stigma-related stressors;
- Compared with other migrants, transsexual and transgender individuals experienced higher levels of violence, including sexual and psychological violence.

Age constitutes another significant cross-cutting factor in the initial stages of migration. Although there are fewer studies on the older migrant and refugee population, it is significant to note that recent changes in migration flows due to catastrophic events, famine and violent conflicts are leading an increasing

number of this target population to move. Most studies to date, however, have focused on minors. On the one hand, evidence shows that immigrant pre-adolescents are more exposed to psychopathological risk multi-factors than native peers. (Riva, Nachinovich, Brivio, & al., 2018) On the other hand, «UASC from the WHO African Region and WHO Eastern Mediterranean Region migrating to Europe often follow the Central Mediterranean Route or Eastern Mediterranean Route. However, the Central Mediterranean Route is particularly dangerous (Brauzzi & V., 2022)s for UASC as they are more likely not only to travel alone but also to be exploited, spend more time in transit, and have limited access to protective systems.» (WHO, World report on the health of refugees and migrants, 2022) Other elements related to the particularly high risk of developing psychological problems among UASC are (UNICEF, Harrowing Journeys: Children and youth on the move across the Mediterranean Sea, at risk of trafficking and exploitation, 2017; UNICEF, Buone pratiche di supporto psicosociale e salute mentale per adolescenti e giovani migranti e rifugiati in Italia, 2022; Brauzzi & V., 2022; Longobardi, G., & Prino, 2017):

- physical or psychological abuse in pre-migration time – moreover, a study on UASC in Italy (coming from Egypt, Albania, Senegal, Bangladesh, Gambia, Morocco, and Mali) reported that more than half were sexually abused before or during their migration.
- forced labour, reported by almost 50% of them passing through the Central Mediterranean Route;
- the effects of forced separation from the family, death of a family member and/or lack of social support.

Mental health stressors in the Italian context

"Pre-migration trauma does predict mental disorders and PTSD, but the post-migration context can be an equally powerful determinant of mental health. Moreover, post-migration factors may moderate the ability of refugees to recover from pre-migration trauma" (Hynie, 2018). However, it is only in recent years that a more substantial number of studies have begun to emerge on post-migration mental health determinants, – especially in the medium and long term – showing that especially social, economic, and environmental determinants, as well as access to health care, seem to play a predominant role. (IOM, WORLD MIGRATION REPORT 2020, 2020; Allen, Balfour, Bell, & Marmot, 2014; CSI, 2021; M., D., M., & S., 2012) Even more recent and few are the studies on the positive and negative effects of different reception systems, particularly the Italian one. Yet, the evidence gathered so far by this line of research seems to

indicate that even the primary and first reception phase can play a decisive role in the worsening of migrants' and refugees' mental health – in accordance with what has been reported in other European contexts. (Nante, Gialluca, & De Corso, 2016; Barbieri, Visco-Comandini, Pirchio, & al., 2020; Crepet, Rita, A., & al., 2017; Hajak, Sardana, Verdeli, & Grimm, 2021) Starting from this frame, an attempt is hereunder made to outline the available relevant findings, also giving an account of the indications from international studies on comparable contexts.

Bearing in mind the current structural weaknesses and practical distortions of the Italian reception, it is significant to firstly point out that the actual conditions under which the primary reception process takes place are often inadequate. Indeed, despite the existence of specific protocols, guidelines, and recommendations on mental health at least since 2017, – see chapter 5 – the situations in Italian Hotspots, CAP and CAS are often variously characterised by environmental stressors, deprived conditions, and structural limits, such as: strong overcrowding; geographic and social isolation of the facility; unsuitability of massive facilities; lack of training of all stakeholders (not only health professionals); qualitative and/or quantitative lack of necessary staff; difficulty accessing the National Health System; difficulty accessing psycho-social and/or legal support; episodes of social degradation, violence and illegality; and very long stay. These daily life elements may affect migrants' and refugees' mental health as stressors and re-traumatising experiences, crucially contributing to the emergence of the Pervasive PTSD profile characterised by the symptoms highest severity, to higher prevalence of distress related to health problems, as well as to psychological disorders such as somatization disorder, psychotic disorder, anxiety disorder, and depression (Barbieri, Visco-Comandini, Pirchio, & al., 2020; Minihan, Liddell, Byrow, & al., 2018; Crepet, Rita, A., & al., 2017; Marchetti, Preziosi, & Zambri, 2023).

Without the possibility of offering an exhaustive picture, studies directly referring to the Italian context have highlighted some specific, partially mirrored, positive and negative determinants (facilitators/barriers) of migrants' and refugees' mental health. Among the first are (Griffiths, Tarricone, Berardi, & al., 2017; Tessitore, Parola, & Margherita, 2022; CSI, 2021):

- language skill of patients;
- involvement of patients' family;
- voluntary services;
- organisation of the mental health system;
- specialist cultural psychiatric services.

In contrast, the following negative determinants were highlighted (Griffiths, Tarricone, Berardi, & al., 2017; CSI, 2021; Marchetti, Preziosi, & Zambri, 2023; Crepet, Rita, A., & al., 2017; Zambri, Marchetti, Colaceci, & al., 2020):

- patients' perceptions;
- lack of family support;
- poor funding of the mental health system;
- cultural knowledge of mental health workers;
- language skill of mental health workers.

In addition to the general importance of implementing mental health and support services, from this framework emerges the particular importance of training in ethnopsychiatry and transcultural psychiatry, as well as the fundamental role played by cultural mediators.

Finally, it is useful to complement this overview with two significant gender-related patterns involved in the first reception process. The latest WHO thematical report (2022) highlights that «LGBTQI+ people seeking refugee status [...] reported suffering negative psychological impacts while completing the refugee claims process. Reasons for this included re-traumatization while recounting experiences of violence and persecution, compressed service timelines leading to mental health and identity crises, and the additional burden of proving that they are members of a sexual or gender minority as part of the process.» On the other hand, «because men are not traditionally recognized as a vulnerable subgroup in the same way as women or children, the needs of men may be overlooked or neglected along the migration journey, particularly those relating to the provision of health services. […] Cases of sexual violence among refugee and migrant boys and men are often underreported as a result of social and cultural stigma and the belief that men cannot be raped. […] Many met negative attitudes in health care providers and staff, such as disbelief and lack of empathy, and were subjected to humiliating comments from service providers with xenophobic and homophobic misconceptions of male-on-male sexual violence.» (WHO, World report on the health of refugees and migrants, 2022; Chynoweth, Buscher, & Zwi, Characteristics and Impacts of Sexual Violence Against Men and Boys in Conflict and Displacement: A Multicountry Exploratory Study, 2020; Chynoweth, Buscher, Martin, & Zwi)

Mental health difficulties

«From the various studies (e.g., Morina et al., 2018) regarding the health status of refugees, a great difficulty in estimating the prevalence of psychopathologies in this population has emerged; in fact, reviews show a very wide variation, ranging from 3% to 88% for post-traumatic stress disorder (PTSD) and from 5% to 80% for depression. These data were confirmed by a review conducted in 2018 (Morina et al., 2018), which found large differences not only regarding the prevalence rates of mood disorders, but also for alcohol dependence disorders and psychotic symptoms, concluding that these widely varying results are caused by a lack of studies on the subject. […] A recently published study (Henkelmann et al., 2020) conducted a systematic review and meta-analysis regarding the prevalence of self-reported and diagnosed disorders in samples of adult refugees, children and adolescents resettled in high-income countries. In particular, anxiety disorders, depressive disorders and post-traumatic stress disorder were assessed. The study, analysing a total of 66 items, estimated that 1 in 3 refugees had a diagnosis of depression and post-traumatic stress disorder, while the presence of anxiety disorders was estimated to be 1-2 refugees in every 10. These data suggest frequent mental suffering that could hinder individuals' functioning and consequently their adaptive capacities (UNHCR, 2019; Edlund et al., 2018).» (Andrei Mitroi, 2023)

Given the complexity of the migration phenomenon and the relatively small number of studies on the prevalence of psychological disorders and problems in the migrant population in Italy, four excerpts of the main results available are given below for comparison, trying to outline a mixed picture.

1. cross-sectional study on mental health and discrimination among migrants from Africa: «Participants were 293. The prevalence of depression, anxiety, and PTSD was: 12.1%, 12.1%, and 24.4%. Only 7.2% declared not to be discriminated. Among significantly associated factors, waiting to be in possession of temporary permits and discrimination were associated with all mental outcomes. Being (or having parents from) Sub-Saharan Africa increased the likelihood of discrimination. A relevant prevalence of mental illnesses was reported.» (Voglino, Gualano, Lo Moro, & al., 2021)
2. descriptive study on the frequency and correlates of psychological distress and psychiatric disorders in asylum seekers and refugees resettled in an Italian catchment area: «109 asylum seekers or refugees were recruited. The frequency of traumatic events experienced was very high. More than one-third of the participants (36%) showed clinically relevant psychological distress, and one-fourth (25%),

met the criteria for a psychiatric diagnosis, mainly PTSD and depressive disorders. In multivariate analyses, time after departure, length of stay in the host country and number of traumatic events were independent factors associated with psychological distress and psychiatric disorders.» (Nosè, Turrini, Imoli, & al., 2017)

3. descriptive study on mental health and trauma in asylum seekers in a first reception facility: «among 385 individuals who presented themselves for a MH screening during the study period, 193 (50%) were identified and diagnosed with MH conditions. Most were young, West African males who had left their home-countries more than a year prior to arrival. The most common MH conditions were post-traumatic stress disorder (31%) and depression (20%). Potentially traumatic events were experienced frequently in the home country (60%) and during migration (89%). Being in a combat situation or at risk of death, having witnessed violence or death and having been in detention were the main traumas. Lack of activities, worries about home, loneliness, and fear of being sent home were the main difficulties at the AS centres.» (Crepet, Rita, A., & al., 2017)

4. cross-sectional study on the prevalence of psychotic symptoms among Romanian immigrants living in very poor conditions: «Sixty-eight subjects were evaluated. More than 80% had left Romania for economic reasons. 57% exceeded the four-point GHQ-12 threshold of potential mental disorder and 19% scored positively at the Psychosis Screening Questionnaire. [In conclusion,] this community of immigrants living in deprived conditions showed a high prevalence of distress and psychotic symptoms, related to health problems. Preventing excess of psychosis among immigrants and ethnic minorities in critical socio-economic conditions should mean, first and foremost, facilitating social integration and access to primary care.» (Tarricone, Atti, Salvatori, & al., 2009)

Legislation regarding the presence and use of mental health services

By law, Italy guarantees health care to all migrants with or without regular status, and irregular migrants are entitled to urgent and essential preventive or curative care. However, there exist barriers to accessing care for refugees and migrants, even when they are entitled to receive such care. In 2013 a national referral centre for transcultural mediation in the health system was established (WHO, World report on the health of refugees and migrants, 2022). Moreover, «on 24 April 2017, the Decree of the Ministry of Health on "Guidelines for the planning of assistance and rehabilitation interventions as well as for the treatment of mental disorders of holders of refugee status and subsidiary protection status who have

been subjected to torture, rape or other serious forms of psychological, physical or sexual violence" was published in the Official Gazette with the relevant schemes for the various health interventions to be carried out. [...] The guidelines, [...] aim to protect applicants for international protection who are in a particularly vulnerable condition at any stage of their protection process and wherever they are hosted, creating the conditions so that victims of traumatic events can effectively access the procedures provided for by the norm and their condition can be adequately protected.» (Geraci & Mazzetti, 2019) Unfortunately, the fundamental problem of translating directives and recommendations into practice remains.

Greece[6]

Summary

Since the onset of the Syrian civil war in 2011, Greece has been a primary entry point for refugees and migrants seeking to enter Europe. The country has faced a significant reception crisis, with hundreds of thousands of people arriving on its shores, primarily via the Aegean Sea from Turkey. Greece implemented various policies to address the migration crisis, such as setting up reception and processing centres on certain islands and signing the EU-Turkey agreement (March 2016). However, these policies have been criticized for contributing to poor mental health outcomes among refugees and asylum seekers, human rights violations, and inadequate support and assistance for refugees and migrants. While the Greek governments has also attempted to improve conditions for migrants and refugees, such as providing housing and financial assistance and integration programs, these policies have been poorly implemented, resulting in overcrowded and unsanitary conditions and issues with integration.

Many refugees have been stranded in Greece for years, with limited access to healthcare, education, and other basic necessities. According to findings, refugees face various stressors during different stages of the migration process, such as armed conflict, violence, poverty in the country of origin, the process of migration, including the risk of death, physical exhaustion, and lack of healthcare and the isolation, discrimination, and marginalization in host country. Multiple studies have shown that refugees in Greece are at a high risk of experiencing mental health problems, with a significant proportion of them experiencing symptoms of mental health disorders such as depression, anxiety, and post-traumatic stress disorder (PTSD). Studies have also shown that refugee minors are at higher risk of experiencing mental health problems than their non-refugee peers. In addition, refugees screened positive for anxiety and felt oppressed by stressful events such as poverty, isolation, marginalization, and changes in family structure.

[6] *This report has been compiled with the utmost care, based on reliable sources of information. Unless otherwise stated, the data contained within is accurate and up-to-date as of 01/06/2023. Updates to this report may not be made available past this date.*

The trauma they have experienced, as well as the uncertainty and lack of stability of living in a refugee camp or temporary housing, can have a significant impact on their mental well-being. Studies have also shown that refugee minors are at higher risk of experiencing mental health problems than their non-refugee peers. However, most refugees are not routinely screened for psychopathology and mental illnesses.

In order to face the reception crisis and the refugees' mental health needs, Greece created a legislative framework about the use of mental health services by refugees but the actual access to these services remains limited due to lack of funding, resources, bureaucracy and trained personnel. There have been reports of long wait times, limited availability of specialized care, and discrimination. In order to fill the gap, several NGOs and international organizations operate in Greece to provide mental health care services to refugees and support them in accessing the public health care system.

It is important to note that available research data on the crisis have many methodological limitations, hindering the development of effective policies and interventions to address it. Language and cultural barriers can make it difficult for researchers to effectively communicate with refugees and to gain their trust. Other challenges include the self-referential nature of research, difficulty distinguishing symptoms from reactions to stressful situations, and logistical issues in conducting research in the context of a humanitarian crisis, including issues related to safety, access to resources, and the need to work within the constraints of government and NGO policies and protocols.

Introduction

The movement of refugees and immigrants to Europe, and especially to Greece, is one of the greatest human tragedies. The massive influx of migrants and refugees has created a reception crisis with multiple ramifications for all stakeholders. The reception crisis in Greece has been a complex and multifaceted issue that has presented numerous methodological challenges and controversies. With thousands of refugees and migrants arriving on Greek shores in search of

safety and a better life, the Greek government and international aid organizations have faced significant logistical and ethical challenges in aiding these vulnerable populations. Furthermore, the reception crisis has been subject to intense political and media scrutiny, with conflicting narratives and opinions on how best to respond to the crisis. These methodological challenges and controversies have further complicated efforts to address the reception crisis in Greece, highlighting the need for careful consideration and nuanced approaches to addressing this pressing issue.

It is important to stress that available research data on the reception crisis in Greece have-reportedly-many methodological limitations that have been highlighted by NGOs on various occasions. These limitations span from inaccurate representation of the real numbers of refuges to difficulty documenting their journey, serviced provided and needs due to constant forced relocation. This further exacerbates the problem of understanding/gauging the scope of the crisis and hinders the development of effective policies and interventions to address it.

Migrant and Refugee Demographic characteristics

In the last decade, Greece has become the host country for many refugees and migrants, who have arrived by crossing the Mediterranean Sea by boat or cross country traveling via Turkey. Because of wars and other dire circumstances, many people seek for a new place to continue their life (United Nations High Commissioner for Refugees, 2018). For some people, Greece is just a transit country, for others it can be their new home. Greece – due to its geographical position between three continents and because of its extensive coastline comprising a significant part of the external sea borders and part of the land borders of the European Union (EU) and the Schengen area – is the main entry and transit point to the European territory for incoming third-country nationals, i.e. asylum seekers, refugees and migrants, who cross the Greek-Turkish land borders in the area of Evros and the sea borders in the Aegean Sea.

This situation is known with the term 'migrant crisis'. While immigration via Greece substantially decreased following the EU-Turkey agreement, the closure of Turkish borders has drastically increased the length of stay of refugees at the Greek entry locations. Upon arrival, refugees generally reside in camps, which, even though originally designed as short-stay structures, became long-stay facilities.

Only in the first week of 2023, the Hellenic Coast Guard stopped 32 boats carrying 1108 people (https://ecre.org/).

Migrants

Definition: Migrants are the people who change their residence and move to another country but they are not forced to i.e., study migrants, work migrants.

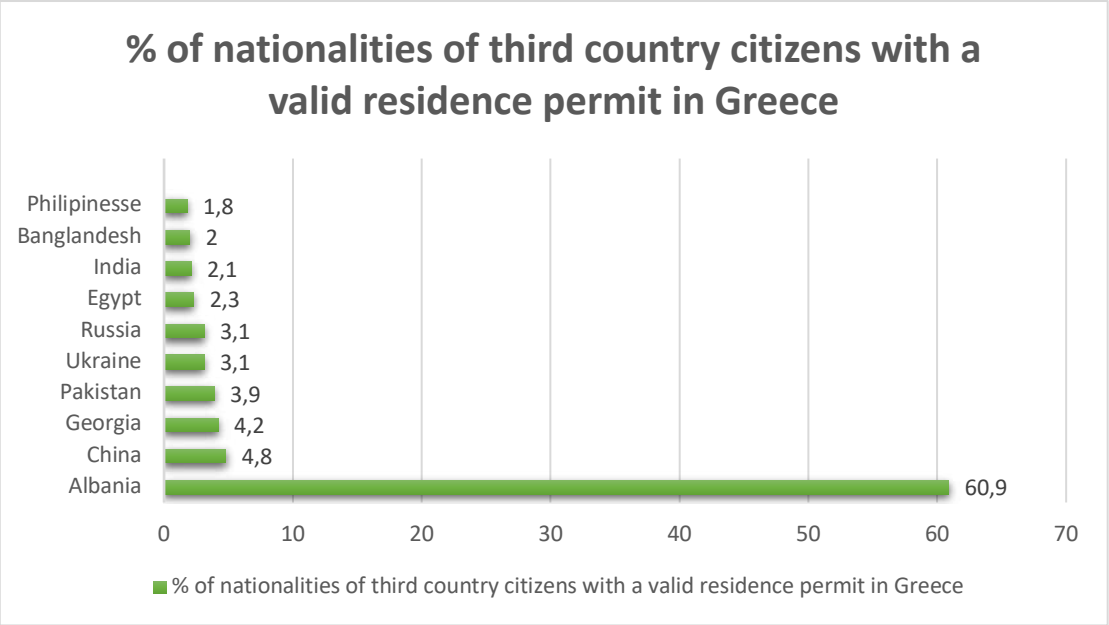
According to the latest data of the Greek Ministry of Migration and Asylum, in November 2022, there are 754.141 regular migrants. We can observe **a 31% reduction** on the valid residency permission, but there is an **103% increase** in the residency permit request in relation to 2021. There are no statistical data about people who arrived Greece irregulary.

Table 1. Number of Migrants living in Greece

Migrants	
EU countries	221.967
Non-EU countries	471.198
Beneficiaries of international protection	60.976
Total	754.141

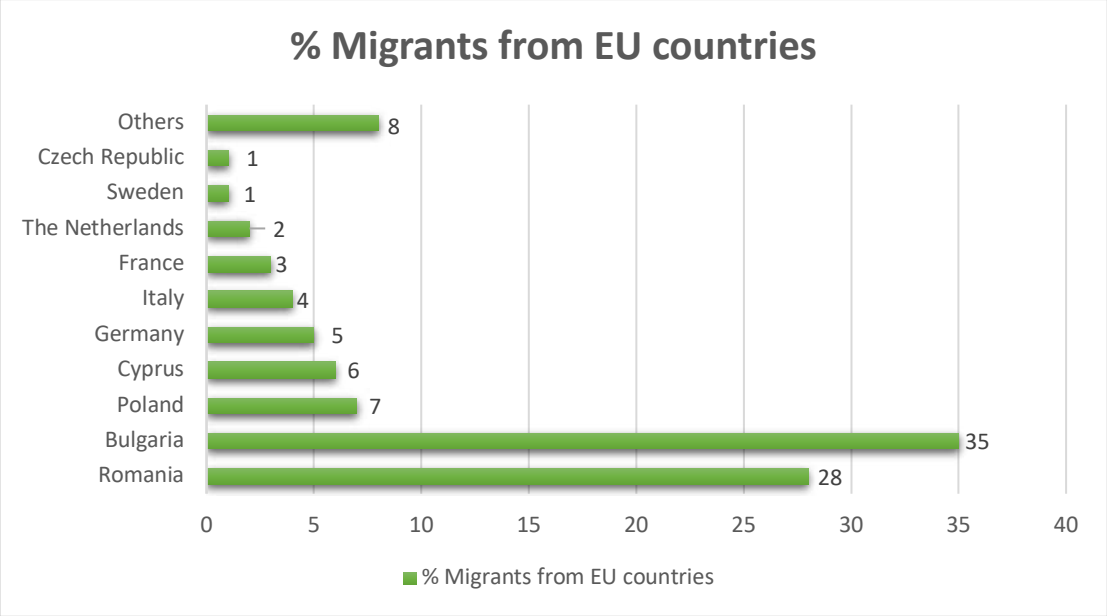
In Table 1, it is shown the percentage of Migrants from EU countries. In Graph 1, there is percentage of nationalities of non-EU citizens with valid residence permit in Greece according to the latest data of the Ministry of Migration and Asylum.

Graph 1. Percentage of Nationalities of non-EU citizens with valid residence permit in Greece



The main 10 nationalities from non-EU countries that have valid residency permit is shown in Graph 2. With respect to initial grant requests filed within 2020, the main countries of origin of immigrants for which have been issued residence permits were Albania, China and Pakistan. However, for the requests submitted in 2021 permits have mainly been issued for nationals of Albania, Georgia and Pakistan.

Graph 2. Percentage of Migrants from EU countries



The most requests are from the Region of Attica and Macedonia-Thrace.

For initial grant requests that have been filed in the first 10 months of 2022 and residence permits have been issued, ahead of the nationals of Albania, Russia and China (see the number of residency permission in Table 2.) The most requests are from the Region of Attica and Macedonia-Thrace.

Table 2. Number of Requests and Renewals of Residence Permits

Migrants' Requests for Residence Permit

New Requests	231.834
Renewal of residence permit	690.075
Total	941.909

Asylum Seekers

"Asylum seeker is an individual who is seeking international protection. In countries with individualized procedures, an asylum-seeker is someone whose claim has not yet been finally decided on by the country in which the claim is submitted. Not every asylum-seeker will ultimately be recognized as a refugee, but every refugee was initially an asylum-seeker" (https://www.unhcr.org/449267670.pdf)

The census data of the Greek Asylum Service concern asylum applications and asylum decisions. The data is examined by gender, age and nationality of asylum seekers. In particular, data on the asylum applications of unaccompanied minors are analysed. The data are presented as sets of years, where past years are compared with the current year.

In December 2022, Greece has reported 28.055 asylum requests (27% are for unaccompanied minors, 56% for 18-24 years old and 17% 35-64 years old). In 2022, compared with 2021 Greece has shown 20% increase of minors' asylum requests. According to UNHCR Greece, 67% were asylum-seekers and 33% were recognized refugees. In their majority, they came from Afghanistan (34%), Syria (13%), the Democratic Republic of Congo (9%), and Somalia (8%). Seventy-five per cent were men and 25% women.

The final decisions about requests from 01/01/2022 till 31/10/2022 are 33 % positive, 36% negative and 31% decision which concerns other administration process. 97% has been given recognition as refugees and the 3% has been given subsidiary protection.

According to Medicines Sans Frontiers (MSF) report (2021), 61% of asylum seekers reached out services, during a difficult bureaucratic process, 52% of asylum seekers are living in apartments which are offered by the ESTIA project and 26% at hotspots, although refugees with mental health problems are not beneficiaries of ESTIA project. Unfortunately, the Greek authorities decided to terminate the project in December 2022.

In the following table, the situation of residency change is described:

Table 3. Residency change in December 2022

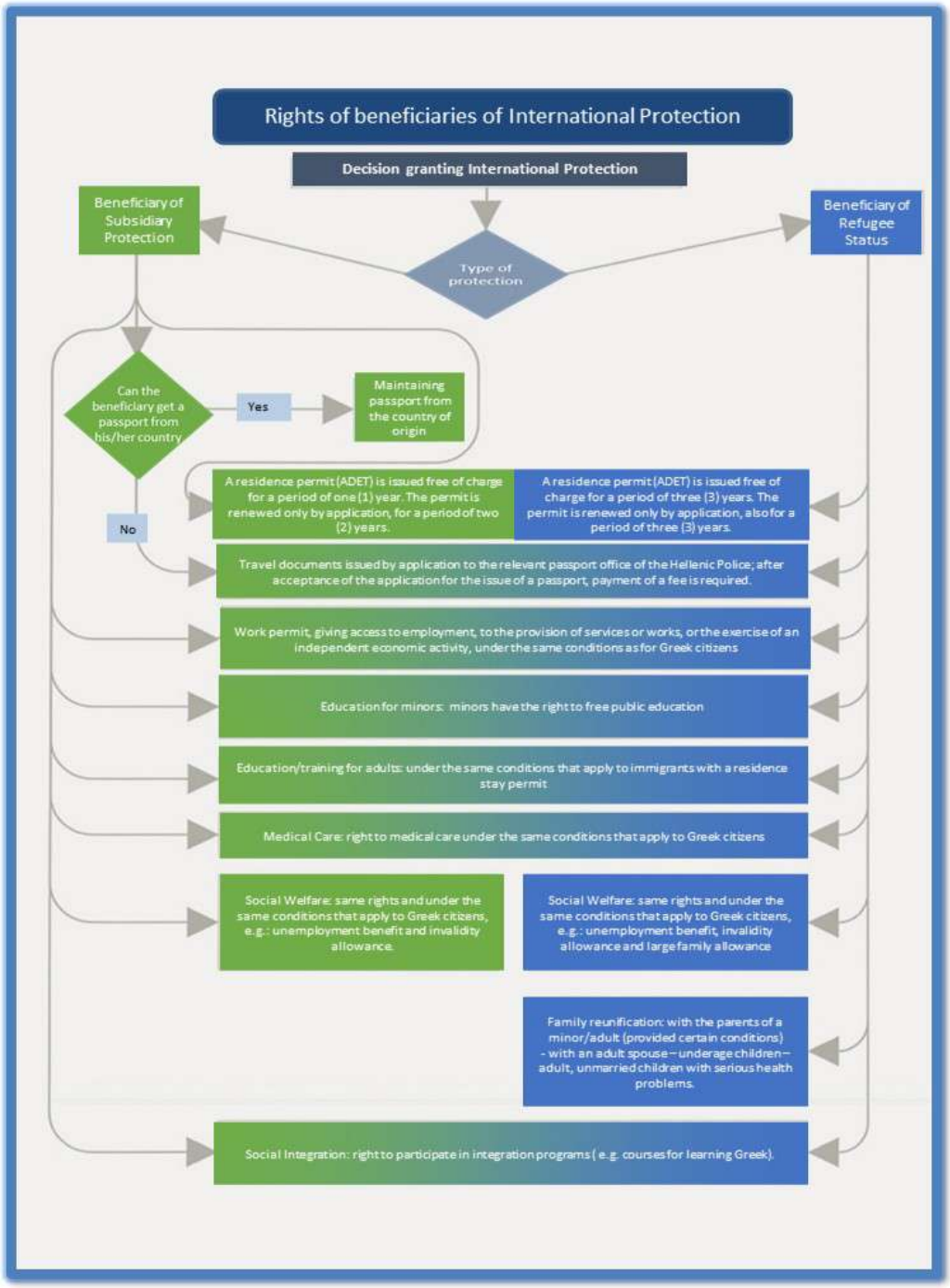
Forced deportations and returns of non-EU citizens based on European agreements	211
Voluntarily Departures through IOM	286
Voluntary departures to the country of origin	130
Departures to another EU country based on Dublin Agreement	39
Departures of minors	14

Refugees

A refugee is someone who has been forced to flee their home and cross an international border because of war, violence or persecution, often without warning. They are unable to return home unless and until conditions in their native lands are safe for them again. If someone is granted refugee status, they can apply for family reunification under certain criteria. Beneficiaries of subsidiary protection do not have this right (see below Image 1. Rights of beneficiaries of International Protection).

There are two ways to reach Greece: by sea and by land. The refugees and asylum seekers have landed mainly on the islands of the Aegean Sea: Lesvos, Chios, Samos, Leros, Kos, Simi, and Tilos. The most common causes of such population movements are the long-term conflicts and violence in countries such as Syria, Afghanistan, Iraq, South Sudan, and Sudan. According to recent data, in 2022, 16.538 refugees have fled their countries to travel to Greece (10.924 sea arrivals and 5.614 land arrivals). Compared to 2021, there was a **2% reduction of refugee's arrival** in 2022, which contrasts with a 16.5% increase in refugees in 2021 compared to 2020. Another data refers that there is **54% decrease of refugees who live in Greece** (16% decrease of those who live on islands). By the end of 2022, more than 86,600 refugees and asylum seekers were in Greece (refugees from Ukraine represent 25 per cent)

Image 1. Rights of beneficiaries of International Protection



Source: Ministry of Migration & Asylum

According to data retrieved from https://data.unhcr.org/, 5.435 refugees have fled their countries to travel to Greece (5.307 sea arrivals and 128 land arrivals) and 1.953 deaths and missing people have been reported in 2022. Till March 2023, 3.293 refugees have fled to Greece (2.827 sea arrivals and 466 land arrivals).

Table 4 shows the statistical data on the number of Refugees residing on the islands in December 2022 as published by the Ministry of Civil Protection.

Table 4. Number of Refugees in December 2022.

	Lesvos	*Chios*	*Samos*	*Leros*	*Kos*	*Others*
Number of Refugees	1631	509	1057	478	965	20

In 2022, many refugees have left Greece due to a variety of reasons. In October, 680 refugees departed and 1.714 arrived in Greece.

Ukrainian Refugees

In March 2022, the Russian war on Ukraine started. The war made many people to flee from Ukraine and move to other EU countries, including Greece.

Up until 31/10/2022 Greece had 20.418 cards for temporary protection permit for Ukrainian refugees, 69% women and 31% men. 7% were issued without date. According to the latest data, retrieved from https://www.consilium.europa.eu/en/infographics/ukraine-refugees-eu/ as of January the 4th 2023, there are **20.955 refugees from Ukraine living in Greece**.

Unaccompanied minors in Greece

According to UNICEF (2020) 1/3 of refugees arriving through Mediterranean routes are children and adolescents. Specifically, the Greek Ministry of Migration and Asylum announced that in January 2023, the number of children that live in Greece is **2.624**. More details are referred below:

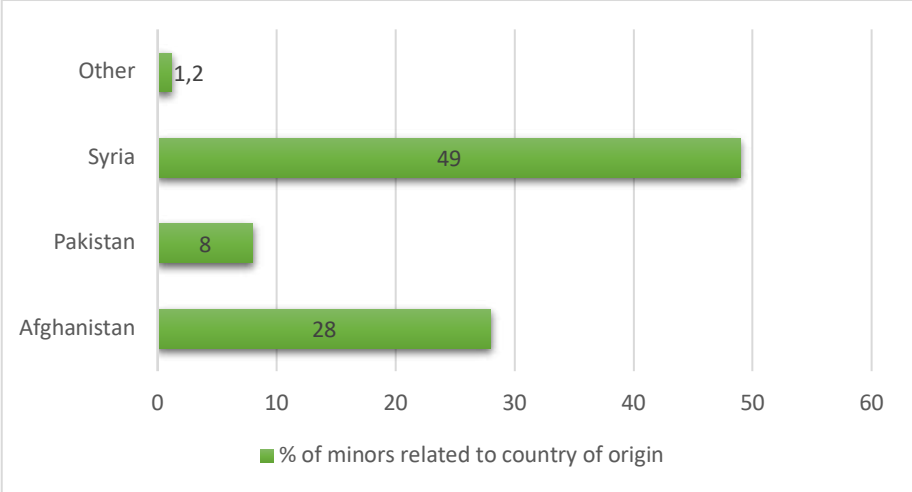
- 85% Boys and 15% Girls
- 7% <14 years of age
- 1.736 in Accommodation Centres
- 241 children in Supported Independent Living Apartments (SIL)
- 214 in Emergency Accommodation Facilities
- 389 in Reception and Accommodation Centres
- 44 children in Open Accommodation Facilities

Number of places:

- 2,272 places in Accommodation Centres (Shelters/SIL)
- 240 places in Emergency Accommodation Facilities

The countries minors fled from are shown in Graph 3.

Graph 3. Percentage of unaccompanied minors related to country of origin in December 2022



Factors affecting the psychological wellbeing of migrants and refugees

Migrants and refugees often face various problems and stressors which can take place at various stages of the migration process and are referred below:

Pre-migration

The life before migration can play an important role in refugees' mental health. The lack of opportunities for education and development, the exposure to armed conflict, violence, poverty and/or persecution are some of the factors that can affect migrants' mental health (WHO,2020).

Migration

One main factor that affects the psychological mental state of refugees and migrants is the process of migration itself. Many refugees have left their homes, they have experienced trauma and death and during their trip to a safe shelter they may have risked their lives. Numerous people have risked or lost their life on boats. The way these people travel to a country and the attitudes and processes of the host country can affect their physical and mental health e.g., causing anxiety. The refugees and asylum seekers are physically exhausted and the provision of healthcare is an emergent need.

Unaccompanied minors report prolonged exposure to violence and lack of a sense of security (Giannakopoulos & Anagnostopoulos, 2016). The increased risk of poor mental health among the refugees and asylum seekers seems to be closely linked with anxiety before and after emigration but also with the procedure for seeking asylum itself. Immigrants and refugees usually undertake dangerous journeys leaving their country of origin.

The host country situation & culture

Migrants and asylum seekers in Greece, many of whom are children, face tremendous mental health problems related to war, trauma, forced migration, and other factors. People compelled or even forced to abandon their home country or their permanent residence and seek shelter in a foreign country experience a "culture shock". Culture shock is conceived as a serious, acute, and sometimes chronic affective reaction to a new environment. Cultural differences and potential cultural conflicts between the refugees and host country citizens can lead to feelings of isolation, discrimination, and marginalization which can contribute to the development of mental health issues (Kontaxakis, et al., 2010).

Additionally, the reception crisis has exposed divisions within Greek society, with some Greeks expressing resentment towards refugees and others advocating for greater compassion and support. As a result, much of the burden of supporting refugees has fallen on NGOs and international organizations, who have been forced to fill the gaps left by the Greek state.

The reception crisis has brought new needs, which must be undertaken by already heavily weakened services, especially at primary healthcare level. For instance, lack of personnel, organizational dysfunctions and cultural limitations may affect the level of access and quality of mental health services, for both the local population as well as for immigrants.

For the unaccompanied minors and children, the situation was slightly better. In June 2022, 72% of children had access to schools, meaning that they are entitled to enroll even if they are undocumented. However, one of the major challenges facing migrant and refugee children in Greece is the difficulty of integrating into the Greek school system. Many migrant and refugee children face language barriers, cultural differences, and a lack of resources and support, which can make it difficult for them to succeed in school.

Attitudes towards refugees and migrants

The way the local population treats the refugees can play an important role to their psychological wellbeing. Greeks' concerns and suspicion are related to various factors, such as

the limited financial resources for confronting the reception crisis, the capacities of the local authorities to manage the flows and the emerging security and issues (Dixon et al., 2019). In addition, xenophobia can lead to racism and social exclusion, which, in turn, leads to mental instability of the marginalised groups. Racism and xenophobia play an important role in the psychological health and well-being of migrant and refugee children.

Social and demographic characteristics

Gender can also be a factor in the mental health of refugees. Women, in particular, are at increased risk of experiencing sexual and gender-based violence by men, which can have a significant impact to their mental health. Also, they might be in an increased risk to develop depression, anxiety, and PTSD.

In terms of country of origin and legal status:

- Adult refugees from war-torn countries may be more likely to experience PTSD, while adult refugees from countries where there is a high prevalence of sexual violence may be more likely to experience mental health problems related to this type of violence.
- Unaccompanied minors from Syria, Afghanistan, and Somalia may be at a higher risk of experiencing mental health problems, including depression, anxiety, and PTSD, compared to UAMs from other countries. The authors suggest that the high prevalence of mental health problems among UAMs from these countries may be related to experiences of trauma and violence in their home countries and during their migration journey, as well as difficulties adapting to a new cultural and social context (Niemiec & Oikonomidou, 2019)
- Asylum seekers have a higher level of PTSD and depression/anxiety symptoms compared to refugees. (Stathopoulou & Robjant, 2019).

In terms of gender:

- According to MSF, female refugees do not receive the same treatment as male. This can be caused by cultural stereotypes about gender and the fact that health services are being populated by a majority of Greek male doctors. Gender disparities exist in the mental health care

provided to refugees in Greece, with female refugees experiencing lower quality care and greater barriers to accessing services. Female refugees in Greece are more likely to experience barriers to accessing mental health care, including stigma, cultural norms, and language barriers. The authors suggest that these gender disparities may be related to gender-based violence, which is more prevalent among female refugees, and the fact that mental health care services are often designed with men in mind. (Michail & Vagenas, 2019)

- Females among the refugee population in Greece may be at a higher risk of experiencing mental health problems than males.
- Additionally, the study found that female refugees in Greece are more likely to present with symptoms of anxiety and depression, while male refugees are more likely to present with symptoms of PTSD. This may be due to differences in the experiences of male and female refugees, with women being more likely to experience gender-based violence and discrimination, and men being more likely to have experienced direct violence and conflict.
- More men are taking part in researches than women, which is mainly due to cultural and other reasons for this sample, as males are possibly more likely to agree in being interviewed or take part in a research study in general.

It is important to note that these findings cannot be generalised to all refugees. Every individual has different experiences and resilience levels. In addition, every refugee should be approached with a trauma-informed care, taking into account the specific context, such as specific vulnerabilities, cultural background and the different experiences that led them to become a refugee.

Policies about reception and integration of migrants/refugees, as factors that might affect psychological wellbeing

Greece as a country has transformed from sender to receiver and during migrant crisis was forced to develop policies about migration. Policies about reception and processing and integration immensely affect refugees' psychological well-being. Although Greece has introduced various policies, measures and approaches to address the migration crisis in recent years, the

high numbers of refugees/migrants, the increased level of needs in conjunction with the lack of financial resources, hinder their effectiveness.

Greece is a party to the 1951 Geneva Convention and 1967 Optional Protocol and its asylum law is bound with the European Union Standards. One of the main policies has been the establishment of reception and processing centres, also known as "hotspots," on the islands of Lesbos, Chios, Samos, Leros, and Kos. These centers were set up to register and fingerprint migrants and refugees, and to determine their eligibility for asylum. However, **these centres have been heavily criticized being part of a more general deterrence policy adopted and applied by the Greek state which can significantly contribute to poor mental health among refugees and asylum seekers.** Additionally, the lack of privacy and the lack of access to appropriate mental health services can further exacerbate mental health problems among refugees in hotspots. the prolonged waiting periods and uncertainty surrounding the asylum process can also contribute to poor mental health outcomes among refugees in hotspots, which can cause serious mental health difficulties (Vlachou, 2019).

Another policy that has been implemented is the EU-Turkey agreement, also known as the "EU-Turkey deal," which was signed in 2016. This agreement aims to disrupt the flow of refugees and migrants to Europe by returning those who do not qualify for asylum in Greece back to Turkey. However, this agreement has also been criticised for human rights violations, and for putting migrants and refugees at risk of being returned to countries where they may face persecution. There were two choices that Greece could opt for to face the large numbers of migration flows: closing the borders or restricting their intake policies or requesting more external aid (UNHCR, 2016). In general, Greece has followed a policy of containment and deterrence, seeking to prevent refugees and migrants from entering the country and encouraging them to move on to other European countries. This has involved a range of measures, including border closures, the construction of barriers and fences, and the use of military and police forces to patrol the borders and deter crossings.

At the same time, the Greek government has struggled to provide adequate support and assistance to refugees and migrants who are already in the country. Many have been housed in overcrowded and unsanitary conditions, with limited access to basic services such as healthcare, education, and legal support. The Greek government has also faced criticism for its handling of asylum applications, with many refugees and migrants facing long delays and inadequate support in the application process. According to a report by Human Rights Watch (HRW) published in January 2021, Greece's migration policies have led to human rights violations, including the "systematic use of illegal pushbacks and violence against migrants and asylum seekers." The report also criticized the Greek government for its inadequate support and assistance for refugees and migrants, and for failing to uphold their rights to asylum and protection.

The Greek government has also sought to improve conditions for migrants and refugees living in Greece, with measures such as providing housing and financial assistance, as well as integration programs for those granted asylum. However, there are huge discrepancies between the written policies and their implementation in real life. The housing options in particular, remain inadequate and overcrowded, with reports of people living in inhumane and unsanitary conditions. The issues with integration are also paramount. Waiting for residence permit appears to be a marker for post-migration stress. As a result, a great number of refugees remain on Greek islands either waiting for their asylum application to be accepted or because the limited financial resources could not ensure their safe return to Turkey (Velentza, 2018).

The situation in “HotSpots”

When refugees arrived to Greece, especially to Greek islands, they are gathered in camps called “Hotspots”. The “hotspot approach” was first introduced in 2015 by the European Commission in the European Agenda on Migration as an initial response to the exceptional flows. It was a solution for Member States, which were facing disproportionate migratory pressures at the EU’s external borders and was presented as a solidarity measure. The initial objective of the “hotspot approach” was to assist Italy and Greece by providing comprehensive and targeted operational support, so that the countries could fulfil their obligations under EU law and identify, register and

fingerprint incoming migrants, channel asylum seekers into asylum procedures. The hotspot approach was also expected to contribute to the implementation of the temporary relocation scheme, proposed by the European Commission in September 2015. Therefore, according to the Greek law L 4375/2016, that was introduced in April 2016, the reception process will be undertaken at the hotspots. The reception process includes: identification, asylum procedure or return.

Five hotspots, under the legal form of First Reception Centres – now Reception and Identification Centres (RIC) – were established in Greece on Lesvos, Chios, Samos, Leros and Kos. During 2021, on Samos, Leros and Kos, the RIC have been converted into 'Closed Controlled Access Centres of Islands (CCACI)'. The situation in hotspots has impacted refugees' mental health. Refugees who live in the hotspots face overcrowded spaces, security issues, lack of access to adequate healthcare, sanitation, and food. Upon arrival in Greece, many are placed in camps with limited access to school and mental health services, and report high rates of attempted suicide, panic attacks, anxiety and aggressive outbursts (Hermans et al., 2017; Médecins Sans Frontières, 2018). For example, the "HotSpot" in Chios, like many other refugee camps, is located in a remote area, far from the town centre, therefore far away from the available mental health services- which according to several studies- hinders the access to necessary mental health support (e.g., Hynie, 2018).

After the EU-Turkey Statement, refugees arriving on the Eastern Aegean islands were systematically and indiscriminately detained. This differs from the "geographical restriction" on the island. Detention refers to the practice of confining individuals, including refugees and migrants, to a particular location or facility, often without their consent or legal justification. In the context of refugees and migrants in Greece, detention is often used to refer to the practice of holding individuals in overcrowded and unsanitary conditions, with limited access to healthcare, sanitation, and other basic needs.

Geographical restrictions, on the other hand, refer to policies or practices that limit the movement of refugees and migrants to a particular geographical area. In the case of Greece, the

geographical restrictions on the islands mean that refugees and migrants who arrive on the islands must remain there while their asylum applications are being processed, often in overcrowded and inadequate facilities. This policy is designed to prevent refugees and migrants from moving to mainland Greece or other EU countries while their asylum claims are being considered.

Such measure was imposed either de facto, under the pretext of a decision restricting the freedom within the premises of the RIC for a period of 25 days, or under a deportation decision together with a detention order. The long-term stay in hotspots is experienced as detention which can be harmful to their well-being especially for minors. During, the pandemic, to prevent the spreading of the virus, people who arrived to the Eastern Aegean Islands have been subjected to a 7-day, 10-day or 14-day quarantine period, during which they were not allowed to exit the facility. Another restriction is that people can leave the island only if the asylum procedures come to an end.

It is important to note that both detention and geographical restrictions on refugees and migrants can have significant negative impacts on their mental and physical health, as well as their ability to access legal support and other basic needs. Additionally, these practices may be in violation of international and national human rights laws, including the right to freedom of movement and the right to seek asylum.

Policies about Ukrainian Migration

The recent Ukrainian crisis has showed that the country of origin plays an important role in the way the local population will treat refugees. For example, Greece was more openminded and welcoming to the Ukrainian refugees, which can be attributed to the fact that they are EU citizens, caucasian and Christians. In March 2022, the EU activated the **temporary protection directive**, an EU emergency scheme used in exceptional circumstances of a mass influx to:

- provide **immediate and collective protection** to displaced persons
- reduce pressure on the national asylum systems of EU countries

Rights under the temporary protection scheme include a residence permit, access to the labour market and housing, medical assistance, and access to education for children.

The EU policy for Ukrainian refugees has transformed the process of identification and integration and made it easier, so in this case the reception policies which are shown below, were not a risk factor for Ukrainians. According to a recent report by the Greek Council for Refugees and Save the Children (2022) they are able to enter Greece without visa and once registered, they are given social security and tax numbers that allow them to access the labour market, healthcare, housing and food support.

Integration policies as a factor which affects refugees' mental health

Social integration is a process that entails mutual accommodation by third-country nationals (migrants, applicants, or beneficiaries of international protection) and Greek residents. Successful social integration leads to peaceful co-existence, respect for diversity and social cohesion.

According to the National Integration Strategy of 2019, the main objectives of the Greek model for social integration are:

- Create and maintain an open society that respects diversity.
- Protect the rights and outline the obligations of third-country nationals in a non-discriminatory manner that ensures social equality.
- Foster interaction, collaboration, dialogue and constructive criticism between culturally or ethnically diverse communities, promulgating democracy and equality.
- Promote diversity, tolerance and social cohesion.
- Motivate all individuals to protect the common good and encourage the contribution of all individuals to the development of the country.
- Access to necessary services and goods.

- Access to education, work, civic participation and participation in the political life.

Greek integration policies for refugees can have a significant impact on their mental health. The integration process can be challenging for refugees as they may face language barriers, cultural differences, discrimination and difficulty finding employment. Additionally, the uncertainty and lack of stability that comes with living in a refugee camp or temporary housing can also contribute to mental health issues. The Greek government has implemented various policies to support the integration of refugees, including language classes, job training programs, and housing assistance. However, these programs are often underfunded and understaffed, which can lead to delays and difficulties in accessing services. Integration policies in Greece that are restrictive or that do not take into account the specific needs and cultural backgrounds of refugees can lead to feelings of isolation, discrimination, and marginalisation, which can contribute to poor mental health outcomes. Policies that promote social and economic integration, such as language classes and job training, can have positive effects on the mental health of refugees in Greece (Papadopoulou, 2020).

Overall, the Greek government has struggled to effectively address the reception crisis in the country, and the policies implemented have been implemented with mixed results. There have been criticisms of the poor living conditions in the reception and processing centres, as well as concerns about the human rights implications of the EU-Turkey agreement. At the same time, efforts have been made to improve the lives of migrants and refugees in Greece, but it is difficult to say that these efforts have been successful, as the situation is constantly changing and evolving.

Mental health challenges

It is difficult to provide specific statistical data on the mental health of refugees in Greece, as data collection and research in this area is limited. However, studies have shown that refugees in Greece are at high risk of experiencing mental health problems.

Main Mental Health Problems

A study conducted in 2016 by the Greek Ministry of Health and the World Health Organization (WHO) found that over half of all refugees in Greece were experiencing symptoms of mental health disorders, such as depression, anxiety, and post-traumatic stress disorder (PTSD). Another study conducted by the UN refugee agency (UNHCR) in 2018 found that among the refugee population in Greece, 70% of children and adolescents, and over 50% of adults reported symptoms of psychological distress. A more recent study conducted by the Mental Health Centre for Asylum Seekers, Migrants and Refugees in Greece, in 2020, found that nearly 80% of the asylum seekers who were assessed were suffering from at least one mental disorder, such as depression, anxiety, PTSD, or adjustment disorder. In 2022, the most common diagnoses in adults globally and in Greece were anxiety and stress-related disorders as well as emotional disorders (Fylla et al., 2022, Patanè et al., 2022). Here is a list of some common mental health disorders and their definitions among adults among the refugee population in Greece:

- Post-traumatic stress disorder (PTSD): A condition that can develop after experiencing or witnessing a traumatic event, such as war, violence, or displacement. Symptoms can include flashbacks, nightmares, avoidance of reminders of the trauma, and increased anxiety and distress. Exposure to trauma is high in Syrian refugees and occurs at all stages of the journey. Among refugees in Greece, 31–77.5% experienced at least one violent event in Syria (mainly bombings), 24.8–57.5% during the journey to Greece (mainly beatings), and 5–8% in the Greek settlement (mainly beatings). (Hazma et al.,2021). In Greece, there is no official data for PTSD prevalence, except for a study concerning children survivors of a ship wreck where 52% were found to have PTSD as opposed to 3% in the general school population. PTSD is the most severe psychopathological condition for people who fled a war zone, i.e., such as the Syrian civil war. Make shift boats from Syrian conflict zones, are at risk of having had or developing PTSD due to their experiences of war and the trauma of the migration process itself.
- Depression: Depression rates are higher among immigrants and refugees than in the general population due to their living conditions. Barriers remain to accessing specific health services, such as specialist psychological and mental care; women care; child care and victim of violence car.
- Anxiety: A condition characterized by excessive worry and fear about a variety of situations or events. Symptoms can include panic attacks, sweating, and a rapid heartbeat.

- Somatoform disorders: A condition in which physical symptoms are present, but there is no underlying physical cause. These symptoms can be used as a way to express psychological distress or emotional problems.
- Substance abuse: Some refugees may turn to substance abuse as a way to cope with the trauma and stress they have experienced. This can lead to addiction and other problems.

In addition, refugees screened positive for anxiety and felt oppressed by stressful events such as poverty, isolation, marginalization and changes in family structure (Ben Farhat et al.,2018). In 2022, mental health conditions emerged as the most common health problems among people staying at migrant camps (56.3%) (Farmakioti et al., 2022). Between 31% and 78% of refugees reported having experienced at least one incident of sexual or physical violence (Ben Farhat, 2018). 19% of beneficiaries who visited a psychologist in Athens, Thessaloniki and Lesvos referred self-harm and 22% suicidal ideation (12% suicidal attempt) (Fylla et al., 2022). According to Lavdas et al. (2023) life in the camp with associated inactivity, and uncertainty for the future, was perceived as a crucial risk factor for psychological distress. Female participants referred gender-based and domestic violence as risk factor and males highlighted conflict and persecution.

It is worth noting that these studies were conducted in different time periods and may reflect different contexts and population. Also, it is important to keep in mind that these studies are based on self-reported data, which may not fully represent the mental health conditions of all refugees in Greece. While specific data on the mental health of refugees in Greece is limited, multiple studies have shown that refugees in Greece are at a high risk of experiencing mental health problems, with a significant proportion of them experiencing symptoms of mental health disorders such as depression, anxiety, and PTSD.

Minors Mental Health Problems

Minors, or children and adolescents are particularly vulnerable when it comes to mental health problems among refugees in Greece. The trauma they have experienced, as well as the uncertainty and lack of stability of living in a refugee camp or temporary housing, can have a significant impact on their mental well-being. Although mental disorders are quite widespread

among refugees, most of them are not routinely screened for psychopathology and mental illnesses (Theofanidis et al., 2022).

Studies have shown that refugee minors are at higher risk of experiencing mental health problems than their non-refugee peers. A study conducted by the UN refugee agency (UNHCR) in 2018 found that among the refugee population in Greece, 70% of children and adolescents reported symptoms of psychological distress. A more recent study conducted by the NGO Save the Children in 2020, found that more than 80% of the children in refugee camps in Greece suffered from symptoms of psychological distress, such as nightmares, bedwetting, and difficulty sleeping. The study also found that more than half of the children had symptoms of depression and anxiety.

Here is a list of some common mental health disorders of minors among the refugee population in Greece:

- Post-traumatic stress disorder (PTSD): A condition that can develop after experiencing or witnessing a traumatic event, such as war, violence, or displacement. Symptoms can include flashbacks, nightmares, avoidance of reminders of the trauma, and increased anxiety and distress.
- Depression: A mood disorder characterized by feelings of sadness, hopelessness, and a loss of interest in activities. Symptoms can include changes in appetite and sleep, fatigue, and difficulty concentrating.
- Anxiety: A condition characterized by excessive worry and fear about a variety of situations or events. Symptoms can include panic attacks, sweating, and a rapid heartbeat. More than three-quarters of the respondents aged over 15 years were diagnosed with an anxiety disorder and required referral for mental health evaluation. (Fahrar B., 2018)
- Adjustment disorder: A condition that can develop when an individual has difficulty adjusting to a major change or stressor, such as moving to a new country or living in a refugee camp. Symptoms can include depression, anxiety, and difficulty functioning.
- Sleep disturbance

- Externalizing behaviours

(Fazel et al., 2012; Savin et al., 2005)

During 2022, it was found by Fylla et al., that the most common diagnoses in minors were:

- Anxiety
- Stress-related disorders
- Developmental disorders

Children and adolescents may also face additional challenges, such as difficulty adjusting to a new culture, language barriers, and difficulty accessing education. These challenges can make it difficult for them to form connections and relationships, which can further exacerbate mental health problems. The trauma that minors have experienced can also have long-term effects on their mental health. For instance, children who have witnessed violence or been separated from their families may be at a higher risk of developing PTSD, depression, and anxiety. According to Nye (2018), children who live in refugee camps are at high risk of attempting suicide.

In addition, refugee children face family separation, detention, limited access to education and recreational activities, trafficking, and security problems. It is recognized that they are exposed to a wide range of risks, such as sexual violence, and physical and psychological harm. Sexual exploitation is increasingly observed in many public places, such as parks, squares, and bars. In these places, particularly teenage boys are sexually abused by older men in exchange for money (Freccero et al., 2017).

Possible cultural differences and somatization issues

Cultural differences can also play a role in the mental health of refugees in Greece. Many refugees come from cultures where discussing mental health issues is stigmatised, and seeking help for mental health problems is not widely accepted. This can make it difficult for refugees to access mental health services and may lead to somatization, where mental health issues are expressed through physical symptoms rather than emotional or psychological symptoms.

Somatization is a common phenomenon among refugees and immigrants, as they may not have the cultural or linguistic resources to understand and express their mental health problems. In some cultures, mental health issues may be perceived as a personal weakness, and people may not be willing to talk about them or seek help. Moreover, the trauma that refugees have gone through such as war, persecution, and displacement, can also lead to somatization. Trauma can manifest itself in physical symptoms, such as headaches, stomach aches, and fatigue, which can make it difficult to diagnose and treat mental health disorders.

Due to cultural and linguistic barriers, migrants may be unwilling or feel unable to seek help, and those who are eager to do so are often not aware of the services available to them. Pregnant women present commonly with somatic symptoms and are left in social isolation. In general, they tend to prefer practical help instead of pharmacological interventions (Iliadou et al., 2019). Refugees and asylum seekers may maintain a negative attitude towards mental health services because of dissuasive experiences in their country of origin. The refugee population is often not accustomed to receiving mental health services since, for instance, in the Arabic world, a small amount of the annual governmental budget is spent on mental health. Cultural differences in beliefs about mental health and access to mental health services can make it difficult for refugees to receive appropriate care. This highlights the importance of culturally sensitive approaches to mental health care for refugees in Greece (Kostakopoulou, 2018).

As the reception crisis in Greece continues, healthcare providers face the challenge of caring for a diverse population with unique cultural backgrounds and experiences. One of the key issues facing refugees in Greece is the potential for cultural differences to affect their physical and mental health. For many refugees, their beliefs about health and illness may be vastly different from those held by healthcare providers in Greece (Kontaxakis, 2015). This can lead to misunderstandings and mistrust between refugees and healthcare providers, making it difficult for providers to effectively diagnose and treat patients.

Another issue that healthcare providers may encounter is somatization, which is the experience of physical symptoms as a result of psychological distress. According to data from the United

Nations High Commissioner for Refugees (UNHCR), as of 2021, more than 70% of the refugee population in Greece has experienced some form of trauma. Many of these refugees may somatize their symptoms, making it difficult for healthcare providers to identify and treat the underlying mental health issue. This can be further complicated by cultural and language barriers, which can impede communication between refugees and healthcare providers.

It is important for healthcare providers to be culturally sensitive and aware of these potential issues when working with refugee populations in Greece. Providers should take the time to understand the cultural beliefs and experiences of their patients, and should work to build trust and open communication with them. Additionally, providers should be trained to recognize the signs of somatization and be prepared to refer patients to mental health professionals for further assessment and treatment.

In conclusion, the reception crisis in Greece presents unique challenges for healthcare providers. By understanding the cultural beliefs and experiences of refugees, and being aware of the potential for somatization, healthcare providers can more effectively and sensitively care for this population and ensure that they receive the best possible care.

Mental health services

The mental health promotion and prevention has been a central focus over the last years. After the economic crisis, the situation of mental health services has worsened. On the other hand, the high refugee and immigrant flows overwhelmed Greece, that did not have the necessary infrastructure to welcome them. The rights of migrants to healthcare and education are interlinked with their integration into society and their right to live a normal life. Thus, health and education policies cannot be missing from the overall crisis management strategy (Vozikis et al., 2021). In the sector of national insurance and social protection, migrants have the same rights as Greek citizens only if they have legal documents of residency in Greece, otherwise, they can only have access to medications and relevant services exclusively in emergency and life-threatening cases. According to Article 33 of the National Law 4368/2016 asylum seekers are entitled to free

access to healthcare systems. People who belong to vulnerable social groups such as pregnant women, elderly, unaccompanied children, people who has survived from torture, people with disabilities and those who come from conflict areas has the right to health care including psychological care and support (Law, No.141/2013,2013).

Even if the laws give free access for people under international protection, this access is limited in practice, due to financial crises and Greek National Health System and due to lack of translators and social workers. For example, according to UNHCR Greece, 2020, in Samos Island there was only one doctor for a dense of population.

Greece has no specialized mental health services for refugees and no interpreter is offered by mental health institute (few interpreters untrained). In fact, in most camps, primary healthcare (PHC) is generally ensured by army doctors and international and Greek NGOs, and these play a critical role in delivering healthcare services in all sites. Since recently, medical services were provided mainly by a general practitioner and a nurse. Gynaecologists (preferably female), midwives, dentists, psychologists, and psychiatrists were lately included in the camp clinics (De Paoli, 2018). According to Farmakioti (2022), refugees are not satisfied with the access to primary health care (physician, paediatrician, midwife, psychologist, and antenatal and perinatal care), while access to a psychologist was assessed as minimum or non-existent.

Governmental Mental Health Services

There are various organizations and agencies in Greece that provide mental health services and support to migrants and refugees. These services include counselling, therapy, and medication. The Greek Ministry of Health and the Ministry of Migration and Asylum are responsible for providing these services, which are supported by the European Union and the United Nations. The Governmental Organizations which provide mental health services are listed below:

- **The Ministry of Health:** The Ministry of Health is responsible for the overall management and funding of the National Health System (NHS) which provides mental health services to refugees and other residents of Greece.

- **The National Centre for Social Solidarity (EKKA)**: EKKA is responsible for the coordination of social welfare services provided by the Greek state, and also offers mental health support to refugees and migrants.
- **Local MMHUs (Mobile Mental Health Units) which are involved in MHPSS:** An example of MMHU is referred in Fylla et al. (2022) and it is about MMHU in Chios. The MMHU-Ch delivers services in rural areas of the regional unit of North-East Aegean, more specifically on 3 islands on the borders: Chios, Oinousses, and Psara. The provided services include diagnosis and individualized treatment, such as pharmacotherapy and psychotherapeutic interventions, as well as enhancement of patients' social skills, family support, and community-based programs. All services are free of charge. There was a high percentage (20.7% adults and 21% children) where the request was cancelled with no appointment ever taking place.
- **EODY:** The programme "PHILOS – Emergency health response to reception crisis" is a programme of the Greek Ministry of Health, implemented by EODY. It's a new approach of the Greek Republic to address on the reception crisis, by fulfilling the sanitary and psychosocial needs of people living in the open camps. The programme is funded by the Asylum, Migration and Integration Fund (AMIF) of EU's DG Migration and Home Affairs.
- **AEMY:** The Anonymous Company of Health Units SA (AEMY SA) is the implementing body of the action "Development of the services provided in the Pre-departure Detention Centers for Foreigners" with MIS code 5010510, which is funded by the Ministry of Health and is part of the National Asylum, Migration and Integration Fund Programme. AEMY S.A. function as a provider of medico-pharmaceutical services and psychosocial diagnosis, based on the provisions of Law 4461/2017 and the establishment and operation of the Pre-Departure Detention Centers for Foreigners (PRO.KEK.A.), where a significant number of foreigners live, whose detention is temporary and do not have the possibility to stay in the country and there is an obligation to be sent back to the countries of origin.

It is important to note that the mental health services provided by these organizations may vary over time depending on funding and other factors e.g., EODY and AEMY should provide

psychosocial services in reception/hospitality/pre-departure centres, etc. but they do it from time-to-time.

Mental Health Services for Refugees by NGOs

Unfortunately, the Greek State alone cannot provide the needed services to refugees. NGOs try to fill the gap in the map of mental health services. Their funding comes from programs assigned to them by states and supranational bodies such as the United Nations (UN) or the European Union. According to the Article 81/c of Law on Foreigners and International Protection, refugees and asylum-seekers can benefit from the services of NGOs (L 2828/1983). Some examples of NGOs:

- **Medecins Du Monde Greece:** Medecins Du Monde have implemented the project "Open Minds: Promoting mental health and well-being in community". Through the project, several unaccompanied minors as well as minor children of refugee and immigrant families received services for dealing with their mental health problems by:
  - Ensuring access to free and quality mental health services
  - Psychosocial support
  - Referrals to secondary health care structures and
  - Social welfare
  - Individual sessions and social history download
  - Awareness actions for the approach to the mental health sector
- **Babel Day Centre** is a mental health unit for migrants and refugees operating in Athens under "Syn-eirmos" management. As a mental health unit is funded and supervised by the Greek Ministry of Health. They offer a range of services including:
  - Mental health assessments: This includes screenings for conditions such as depression, anxiety, and post-traumatic stress disorder (PTSD)
  - Psychological support: This includes individual and group counseling for refugees who have experienced traumatic events such as war, persecution, or displacement.
  - Community-based mental health: This includes support for individuals and families in the form of workshops, community-based activities, and education on mental health issues.

- Social support: This includes assistance with housing, education, and employment for refugees and migrants.
- Referral services: This includes connecting refugees and migrants with specialized mental health services and other community resources as needed.
- **ARSIS**: ARSIS is an NGO based in Athens and Thessaloniki while it has developed structures and accommodation facilities in many cities of Greece such as Alexandroupoli, Volos, Kozani and the region of Epirus. They provide support and assistance to vulnerable youth, including refugees and migrants. They offer a range of services, including:
- Mental health support: This includes counselling and therapy for youth who have experienced traumatic events such as war, persecution, or displacement.
- Social support: This includes assistance with housing, education, and employment for youth.
- Educational and vocational training: This includes programs to help youth acquire the skills and knowledge needed to find work and integrate into Greek society.
- Health and well-being, including access to health care and other services that promote physical and mental well-being.
- Recreational and cultural activities: This includes programs that provide youth with opportunities for socialization, self-expression, and cultural exchange.
- Legal support: This includes assistance with navigating the legal system and resolving issues related to immigration and asylum.
- **Klimaka- Ioalos Project:** Iolaos project is running by Klimaka Organization and is funded and supervised by the Ministry of Health. "Iolaos" was designed and operates, providing a range of multifaceted support and care services to refugees facing mental disorders and serious psychosocial problems. The program consists of the **"IOLAOS" Day Centre** and the **Psychosocial Rehabilitation Unit - "IOLAOS"** Guesthouse. **The Day Centre** provides a range of services to refugees with mental disorders and serious psychosocial problems like psychiatric care and follow-up, individual (intercultural) counselling, referral-link to relevant health, welfare,

employment, legal support etc. agencies, providing support in the asylum process and in integration, education of students and health professionals.

- **KETHEA:** KETHEA is a legal entity under private law, under the supervision of the Ministry of Health that offers therapeutic services to persons with addiction problems. One of its units **("Mosaic")** is addressed to foreigners living in Greece who face such problems. In the recent years Mosaic staff works in camps for asylum seekers delivering primary and secondary prevention services.
- **The Hellenic Red Cross (HRC)**: HRC is a humanitarian organization that provides a range of services to vulnerable groups, including refugees and migrants. The services include psychological support. Mental health assessment, health promotion, referral services, support for self-care and empowerment.
- **SOLIDARITY NOW:** SOLIDARITY NOW is a non-profit organization that offers various services to refugees, including mental health services. They provide psychosocial support to refugees, which includes counselling and therapy, as well as group activities and workshops to promote mental well-being. They also work to raise awareness about the mental health needs of refugees and advocate for increased access to mental health services for this population. Additionally, SOLIDARITY NOW may collaborate with other organizations that provide mental health services to refugees, such as local hospitals or clinics, to ensure that refugees have access to the care they need.
- **The United Nations High Commissioner for Refugees (UNHCR) Greece:** UNHCR Greece offers mental health services to refugees as part of their overall support and assistance program. This can include providing access to mental health professionals, such as psychologists and psychiatrists, who can offer individual and group counselling, therapy, and other forms of support to refugees. Additionally, UNHCR Greece may provide psycho-social support activities, such as recreational and educational programs, to help refugees cope with their experiences and build resilience. They may also work with local organizations to ensure that refugees have access to the mental health services they need, including those that are culturally and linguistically appropriate. Additionally, UNHCR Greece may also provide training and support to staff and

volunteers working with refugees, to help them identify and respond appropriately to mental health needs.

- **METADRASI:** METADRASI offers support and assistance to refugees and migrants in Greece. They may offer a range of services, including mental health services. METADRASI may provide counselling and therapy, as well as group activities and workshops to promote mental well-being for refugees and migrants. They may also work to raise awareness about the mental health needs of refugees and migrants and advocate for increased access to mental health services for this population. Additionally, METADRASI may collaborate with other organizations that provide mental health services to refugees and migrants, such as local hospitals or clinics, to ensure that they have access to the care they need. They may also provide training to staff and volunteers working with refugees and migrants, to help them identify and respond appropriately to mental health needs.
- **Social EKAB (Social Ambulance Service):** Social EKAB is a Greek organization that provides emergency medical and social services to refugees and migrants through the project "Nefeli" and "Kallisti". The services include psychological support, mental health assessment, social support, medical management, community mental health, referral services.
- **EPAPSY:** EPAPSY (National Organization for the Provision of Health Services) is a Greek public organization that provides mental health services to the population, including refugees and migrants. In response to the reception crisis in Greece, EPAPSY has taken a leading role in providing mental health support to refugees. EPAPSY operates a number of mental health clinics and mobile units across Greece, which provide a range of services, including counseling, psychotherapy, and medication management. These services are available to refugees and migrants, as well as Greek citizens, and are provided free of charge. EPAPSY has also been involved in efforts to address the unique mental health challenges faced by refugees, such as trauma and anxiety related to displacement, persecution, and violence. The organization has developed specialized programs and interventions aimed at addressing these challenges, including group therapy sessions and art therapy programs.

- **BRF:** Boat Refugee Foundation provides medical and psychosocial (emergency) care and stands up for the rights of people on the run. Since 2015, they have been working on various hotspots in Greece.
- **IRC:** The International Rescue Committee (IRC) Hellas started operating in Greece in 2015, on the island of Lesvos, in response to the unprecedented number of refugees arriving on the island at the time.
- **Intersos Hellas:** INTERSOS is present in Greece since March 2016 with the aim of providing holistic support and long-term durable solutions as a response to the migration crisis. They provide access to information, services, rights and orientation and they try to promote peaceful coexistence between host and hosted communities.
- **FenixAid:** Fenix provides asylum seekers and refugees on Lesvos legal aid and representation, as well as protection and case management, and mental health support.
- **Home Project:** "The HOME Project" is a non-profit organization based in Greece that provides support and assistance to unaccompanied refugee minors. Their aim is to ensure that vulnerable children who have been forced to flee their homes due to conflict, persecution, or other crises have access to the basic necessities of life, such as shelter, food, healthcare, and education. The organization operates several shelters and safe houses across Greece, where they provide accommodation, support, and care for unaccompanied minors. They also offer a range of services and programs designed to help these young people integrate into society, including language and vocational training, counselling and mental health support, and legal assistance.
- **Praksis:** PRAKSIS is a non-governmental organization (NGO) based in Greece that provides humanitarian aid and support to vulnerable populations. PRAKSIS has been working extensively with refugees and asylum seekers since the onset of the reception crisis in Greece in 2015. The organization operates several programs and services specifically designed to support and assist refugees and asylum seekers who have fled their countries due to conflict, persecution, and other crises.
- **Medicins sans Frontiers:** Médecins Sans Frontières (MSF), also known as Doctors Without Borders, is an international medical humanitarian organization that provides emergency

medical care and assistance to people affected by conflict, epidemics, disasters, or exclusion from healthcare. MSF has been working with refugees in Greece since 2015, providing medical assistance and healthcare services to refugees who have fled their countries due to conflict, persecution, and other crises**.** In Greece, MSF operates several medical clinics and mobile units that provide primary healthcare, sexual and reproductive healthcare, and mental healthcare services to refugees living in refugee camps and urban settings. The organization's medical teams also provide emergency care and referrals to hospitals and specialized care facilities when needed.

- **MVI:** Medical Volunteers International offers refugees free medical care since 2016. Medical Volunteers works in Thessaloniki, in Lesvos (since March 2017) and Athens (since May 2017).
- **SOS Children Villages:** SOS Children's Villages is an international non-governmental organization (NGO) that provides care and support to vulnerable children around the world. The organization operates in more than 135 countries, including Greece, where it provides support to children and families in need. In "Child-Friendly Spaces" in Athens and Thessaloniki (and on the islands of Lesbos and Crete) they provide refugee children with psychosocial support and education. Furthermore, they offer shelter to unaccompanied minors, and help reunite them with their families.
- **Smile of the Child:** The Smile of the Child is a non-govermental organization that provides essential support and assistance to refugees in Greece. Its programs and services aim to meet the immediate needs of refugees, including emergency response, child protection, education, healthcare, and shelter. The organization's work is crucial in ensuring the well-being and protection of refugee children and families who have been forced to flee their homes due to conflict, persecution, or other crises.
- **Melissa Network:** The Melissa Network is a Greek non-governmental organization that supports refugee and migrant women in Greece. The organization's mission is to empower women and promote gender equality by providing a range of services and programs designed to meet the specific needs of refugee and migrant women. The Melissa Network provides a range

of programs and services to support refugee and migrant women in Greece, including language classes and integration programs, legal support, counseling and psychosocial support, healthcare services and vocational training for economic empowerment.

- **Greek Council for Refugees:** The Greek Council for Refugees (GCR) is a Greek non-governmental organization that provides legal and social assistance to refugees, asylum seekers, and stateless persons in Greece. The organization's mission is to protect and promote the rights of refugees and other vulnerable populations, and to advocate for their inclusion and integration into Greek society.
- **etc**

However, access to mental health services remains a challenge for many migrants and refugees in Greece. There is a shortage of mental health professionals who speak the languages of the refugees and migrants and understand the cultural context. This makes it difficult for refugees and migrants to access mental health services, and many are reluctant to seek help due to lack of trust, lack of information and fear of stigmatization.

In addition, there have been reports of inadequate mental health services provided in detention centres, where refugees and migrants are held while their asylum applications are processed. The conditions in these centres can exacerbate mental health problems, and there are often insufficient resources to provide adequate mental health care.

Overall, while there are efforts being made to provide mental health services to migrants and refugees in Greece, access to these services remains a challenge. Language and cultural barriers, lack of trust and information, poor living conditions, and limited resources are all factors that make it difficult for refugees and migrants to access the mental health care they need.

Legislation regarding the use of mental health services

Greece has a complex legislative framework that governs the use of mental health services by refugees. The country has been a major point of entry for refugees and migrants fleeing conflict

and persecution in the Middle East and Africa, and the government has struggled to meet the needs of this vulnerable population.

In Greece, **the Ministry of Health is responsible** for providing healthcare to registered refugees. According to Greek legislation, all individuals, including refugees, are entitled to access public healthcare services. **The Greek National Health System (NHS) provides primary and secondary care, as well as hospital care.** Article 33 of Law 4368/20161 provides free access to medical and pharmaceutical services provided by the Greek Health System to the uninsured and to members of "vulnerable social groups". This includes refugees, asylum-seekers (from the moment they express their will to apply for asylum) and minors irrespective of their legal status, including unaccompanied children and children without legal residence in Greece. One of the main aims behind this legislation was to ensure free access to health services to an estimated 2,5 million people who lost their social insurance during the severe economic crisis and to "vulnerable groups".

The process for accessing healthcare for refugees involves registering with the local health centre and obtaining a European Health Insurance Card (EHIC). This card is valid for the duration of their stay in Greece and allows them to access public healthcare services. Refugees are also eligible for a special card (named AMKA) that grants them access to additional services and benefits. However, despite these legal protections, access to mental health services for refugees in Greece remains limited. This is due in part to a lack of funding and resources, as well as a lack of trained personnel to provide these services. As a result, many refugees do not receive the mental health care they need, leaving them at risk of developing serious mental health problems such as PTSD, depression and anxiety. In addition, sometimes refugees face difficulties with the procedures required to obtain a social security number (AMKA) because it is not translated in Greece or due to bureaucracy (Kotsiou et al., 2013), which is obligatory for accessing healthcare services in Greece, except for emergencies (European Public Health Alliance, 2020).

In July 2019, the Greek Government suspended the issuance of Social Security Number (AMKA) for asylum seekers and undocumented migrants, thus blocking free access to healthcare services

and pharmaceutical treatment. In addition, post-traumatic stress disorder is no longer considered as one of the vulnerability categories examined during the asylum process, while detention measures have been extended. As of 24 September 2019, out of the 14,079 asylum-seekers hosted in ESTIA accommodation, 16% did not have AMKA. (Estia, n.d.)

There have been reports of difficulties in accessing healthcare for refugees in Greece, particularly in terms of long wait times and limited availability of specialized care. There are also concerns about discrimination and language barriers, which can make it difficult for refugees to navigate the healthcare system. Despite these challenges, several NGOs and International organizations operate in Greece to provide health care services to refugees and support them in accessing the public health care system.

Article 55 of the IPA, introduced a new a Foreigner's Temporary Insurance and Health Coverage Number (PAAYPA), replacing the previous Social Security Number (AMKA). In Greece, the government has recently introduced a new Personal Identification Number for Asylum Seekers and Beneficiaries of International Protection (PAAYPA) to replace the previous Social Security Number (AMKA) for refugees. The PAAYPA is aimed at simplifying the process of accessing healthcare and other public services for refugees, and ensuring they have the same rights and benefits as Greek citizens. According to the Greek Ministry of Migration and Asylum, the PAAYPA will be issued to all refugees who have been granted international protection in Greece, including those who have been granted asylum, subsidiary protection, or humanitarian protection. The number will be used as a unique identification for refugees and will be required for accessing public services, including healthcare, education, and employment.

The introduction of PAAYPA is part of the Greek government's efforts to improve the integration of refugees into society and to ensure they have access to the same rights and benefits as Greek citizens. The move is also in line with the EU's Common European Asylum System, which aims to ensure that all refugees have access to the same rights and benefits across the EU. PAAYPA is also expected to reduce the administrative burden on refugees, as they will no longer need to carry multiple documents with them when accessing public services. According to the Greek

Ministry of Migration and Asylum, the PAAYPA will make it easier for refugees to access healthcare, education, and other public services, and will also make it easier for the government to track and monitor their integration into society.

It is worth noting that, according to the Greek Council for Refugees (GCR), it will also help to reduce the discrimination and mistrust towards refugees, as it will grant them legal and social recognition. GCR also stresses that PAAYPA should be issued as soon as possible and should be accompanied by the necessary information and support for refugees to fully understand the new system and to use it properly (Greek Council for Refugees).

However, some technical and bureaucratical problems with using PAAYPA have risen.

- Those who received a negative asylum decision and their PAAYPA was deactivated but later lodged a subsequent application.
- Those who have received a positive decision to their asylum application but do not have an asylum seeker card (e.g., because they are in detention), are recognized refugees who have been returned from other EU Member States and have never received residence permits in Greece, persons whose protection status had been revoked but who later received a (new) protection status but also those who received a positive asylum decision following a subsequent asylum application" (rsaegean.org)

In recent years, there has been a growing awareness of the need to improve access to mental health services for refugees in Greece, and a number of organizations have stepped in to fill the gap. For example, the International Medical Corps (IMC) has been working to provide mental health services to refugees in Greece, through the provision of specialized counseling and psychotherapy. The organization also provides training and support to local health professionals to help them better understand the needs of refugees.

Despite this legal framework, access to mental health services for migrants in Greece remains limited. This is due in part to a lack of funding and resources, as well as a lack of trained personnel to provide these services. In addition, the migration context in Greece is still very challenging and many migrants experience several barriers that hinder their access to healthcare services, including mental health services.

In summary, Greece has a comprehensive legislative framework that recognizes the importance of providing mental health services to migrants, but the actual access to these services remains limited. The existing framework guarantees the rights of migrants to receive equal and high-quality healthcare services, including mental health services, but the implementation of this framework is challenged by a lack of funding, resources and trained personnel. NGOs and other civil society organizations have stepped in to fill the gap left by the government, by providing mental health services to migrants in Greece.

Possible differences based on the legal status and time of arrival

The use of mental health services by refugees can vary depending on the time of their arrival and their legal status.

Time of arrival

Refugees who arrive early in a crisis may have better access to mental health services than those who arrive later. This is because early responders, such as humanitarian organizations, are often better equipped to provide mental health services to refugees than the host country's government. Additionally, early responders may be more prepared to deal with the mental health needs of refugees, because they have more time to plan and coordinate their response.

However, for those who arrive later, the situation can be different. They may find that the resources and support available have been depleted, and the focus has shifted from emergency response to longer-term rehabilitation and integration. As a result, they may have more difficulty accessing mental health services. Additionally, if the crisis continues for an extended period of time, the host country may become overwhelmed and unable to provide adequate mental health services to all of the refugees.

In addition, the differences based on time of arrival can be obvious during the period 2018-2019. Refugees who arrived in Greece before 2019 have been granted asylum under the old asylum system, where they were issued with an AMKA number which granted them access to public services, including healthcare services.

However, for refugees who arrived in Greece after 2019, the asylum system has changed. They are granted a PAAYPA number which grants them access to public services, including healthcare services. The PAAYPA number is aimed at simplifying the process of accessing healthcare and other public services for refugees, and ensuring they have the same rights and benefits as Greek citizens.

As a result, refugees who arrived before 2019 and have an AMKA number have more comprehensive access to mental health services than those who arrived after 2019. Although the PAAYPA number grants the same rights and benefits, the process of issuing it, along with the necessary information and support, is not always efficient and smooth. This might lead to difficulties in accessing mental health services for some of the recently arrived refugees.

It is worth noting that, according to the Greek Council for Refugees (GCR), the newly arrived refugees have limited access to mental health services, as they are often not included in the public healthcare system and face language barriers and discrimination when trying to access healthcare services.

Legal status

The legal status of asylum seekers and refugees in Greece can affect their access to mental health services. For example, asylum seekers and refugees who are not registered with the authorities may be unable to access mental health services, as these services are often linked to legal residency. Additionally, the study found that the quality of mental health services available to refugees can vary depending on their legal status, with those in detention centers or hotspots often having limited access to mental health services, while those living in urban areas may have better access (Papadopoulos, 2018).

It is important to note that the use of mental health services by refugees is affected by a complex interplay of factors, such as the availability of mental health services, cultural and linguistic barriers, the refugees' own understanding of mental health, and their personal

experiences of violence and trauma. Furthermore, the legal status of a refugee should not be the only determinant factor of access to mental health services.

Possible differences based on the location of the camp

There are several differences in the use of mental health services by refugees in Greece based on the location of the camp. For example, refugees living in urban areas may have better access to mental health services than those living in rural or remote camps. Additionally, refugees living in camps that are run by non-governmental organizations (NGOs) may have better access to mental health services than those living in camps run by the government. Furthermore, refugees living in camps that are overcrowded and have poor living conditions may be more likely to experience mental health issues and have a harder time accessing mental health services.

Another difference is that the level of services provided in camps run by NGOs may be higher than that of government-run camps, as NGOs often have more resources and funding to provide mental health services. Additionally, the quality of services provided can vary depending on the qualifications and training of staff working in the camp. It's worth noting that the situation in Greece regarding refugee camps is complex and dynamic, the above information should be taken as a general overview, and the specific conditions of each camp may vary (Papadopoulos, 2020).

Possible differences based on the country of origin

The use of mental health services by refugees in Greece can also vary based on their country of origin. Cultural and linguistic barriers can play a significant role in the use of mental health services by refugees from different countries. For example, refugees from countries where there is a strong stigma attached to mental illness may be less likely to seek help for mental health problems than refugees from other countries. Additionally, refugees from countries where there is a lack of understanding or knowledge about mental health may have difficulty accessing mental health services or may not understand the services that are available to them.

Additionally, refugees from certain countries may have experienced different types of trauma and violence, which can affect their mental health in different ways. For example, refugees from

war-torn countries may be more likely to develop post-traumatic stress disorder (PTSD) than refugees from other countries. Similarly, refugees from countries where there is a high prevalence of sexual and gender-based violence may be more likely to experience mental health problems related to this type of violence.

Most of the barriers are related to language, culture, and lack of information about the healthcare system in the host country. Linguistic and cultural differences make it more difficult to assess and manage these problems (Kotsiou, et al., 2018). Furthermore, cultural and traditional beliefs, practices and values also play an important role in the mental health of refugees. For example, refugees from certain cultures may prefer traditional healing practices, rather than seeking help from mental health professionals, which may hinder their access to mental health services.

The significance of country of origin is obvious in the legal status of Ukrainian and non-Ukrainian refugees. Currently, Ukrainians benefit from the unprecedented implementation of the Temporary Protection Directive, which allows Ukrainian refugees to reside, seek employment, and attend school in the EU for three years, no official asylum approval necessary.

Possible differences based on the age

The legislation regarding the use of mental health services by refugees in Greece takes into account age differences to some extent. The main piece of legislation that governs the provision of mental health services to refugees in Greece is the Law on the Rights and Protection of Victims of Torture, which provides for the provision of specialized mental health services to victims of torture and other forms of violence, including refugees. This law recognizes the importance of providing specialized mental health services to children, who may be particularly vulnerable to the effects of trauma and violence.

Additionally, the Law on the Reception and Integration of Migrants and Refugees, passed in 2016, recognizes the rights of children to receive equal and high-quality healthcare services, including mental health services. This law also acknowledges that children, who are a particularly

vulnerable group, have special needs and require specific protection measures to be taken, such as providing appropriate accommodation, education, and healthcare services. Under international human rights law, the right to health includes the right to access health facilities, goods and services free from discrimination. Amnesty International calls on the Greek authorities to urgently take action to ensure that asylum-seekers, unaccompanied children and children born in Greece whose parents have irregular status can access free healthcare through the National Health System, in line with national legislation and Greece's obligations under EU and international law (GCR,2021).

However, despite these legal protections, access to mental health services for children refugees in Greece remains limited. This is due in part to a lack of funding and resources, as well as a lack of trained personnel to provide these services. This may result in children refugees not receiving the mental health care they need, leaving them at risk of developing serious mental health problems such as PTSD, depression and anxiety.

In addition, the law requires the establishment of specialized units within the healthcare system to address the specific needs of children, such as child-friendly spaces and specialized counseling services. However, these units are not always operational and may not be fully equipped to provide the necessary services.

Conclusion

Greece is a country that has been impacted greatly by the reception crisis, with thousands of individuals fleeing war, persecution, and other forms of violence in their home countries. With this influx of refugees, there has been a significant increase in the need for mental health services among this population.

Mental health services for refugees in Greece are provided mainly by non-governmental organizations (NGOs), either local or international, which operate time-to-time and short-term projects. On the other hand, the access to mental health services provided by the Greek State can be limited due to a lack of resources and funding. The Greek state currently finances a total

of four structures that were all founded many years ago (the Day Center and the "Iolaos" Hostel of Klimaka was founded in 2001 and at that time the responsibility for their operation was held by the Hellenic Council for Refugees, the Mosaic of KETHEA and Babel). No state structure has the capacity to properly receive foreigners for the reasons mentioned in the text below.

Additionally, language barriers, lack of trust in the health care system, lack of knowledge of available services, lack of access to services in remote locations, and financial constraints are also major limitations to the use of mental health services by refugees in Greece.

The Greek government has recognized the need for mental health services for refugees and has implemented several initiatives to address this need. In 2016, the Ministry of Health and the Ministry of Migration Policy established a National Action Plan for the Health Care of Migrants and Refugees, which includes provisions for mental health care. Additionally, the Greek government has also signed the Mental Health in Europe Action Plan, which aims to improve access to mental health care for vulnerable populations, including refugees. Unfortunately, none of the plans have been implemented.

The legislation for the provision of mental health services to refugees in Greece is in line with the EU legislation and the International human rights standards. The Greek Asylum Service is responsible for the referral of asylum seekers to mental health services. The Greek National Health System is responsible for the provision of mental health services to recognized refugees and other migrants with legal residence.

In conclusion, Greece has dealt many barriers in order to . This is primarily due to lack of resources, language barriers, lack of trust in the health care system and lack of knowledge of available services. It is essential that the Greek government continues to invest in mental health services for refugees and that efforts are made to ensure that mental health services are accessible and affordable to all refugees, regardless of their legal status or location.

It is essential that appropriate mental health services are made available to refugees, including access to culturally and linguistically appropriate care, in order to address the high levels of

mental health need among this population. Additionally, efforts should be made to ensure that mental health services are accessible and affordable to all refugees, regardless of their legal status or location. This can be achieved by providing interpreting services, increasing awareness of mental health services among refugees, and ensuring that mental health services are available in all refugee camps and other locations where refugees reside (WHO, 2018).

Spain[7]

Migrant and Refugee Demographic characteristics

As all socio-demographic analyses of migration reiterate, in less than 20 years (1980-2000), Spain went from being a country of emigration to a country of immigration. The change of sign of the migratory balance in the middle of this decade due to emigration flows, plus the combined effect of a notable return of former Spanish emigrants and the first international immigration flows to Spain became one of the driving phenomena of Spanish population growth in the first decade of the 21st century (González et al., 2010).

According to the National Statistics Institute (INE), the total number of immigrants in Spain in 2020 was 5,434,153 with no difference by sex (50.05% women versus 49.9% men). By nationality, 94.0% of Spaniards were born in Spain, compared to 9.4% of foreigners. By age, 14.9% of the population is under 16 years old, 35.0% is between 16 and 44 years old, 30.1% is between 45 and 64 years old, and 20% is 65 years old or older.

Of the total number of migrants, 34.5% were from the European Union (27), with a minimal difference between women (49.9%) and men (50.0%), which could be due to work-related reasons. The largest number of migrants by nationality were Romania (667,378), Italy (252,008), Bulgaria (122,375) and Germany (111,937).

With regard to the ages of immigrants coming to Spain according to Statistics of the Continuous Register, INE (2018), the percentages are obtained from 14 % of the total number of immigrants. Therefore, 0-15 years old are 413,141 people (6%), between 16-44 years old are 3,617,664 (21%), between 45-64 years old are 1,866,690 (14%) and 65 years old and over are 489,409 (5%).

[7] This report has been compiled with the utmost care, based on reliable sources of information. Unless otherwise stated, the data contained within is accurate and up-to-date as of 25/01/2024. Updates to this report may not be made available past this date.

Table 1. National Immigrant Survey, Sex, Total, Reasons for relocation

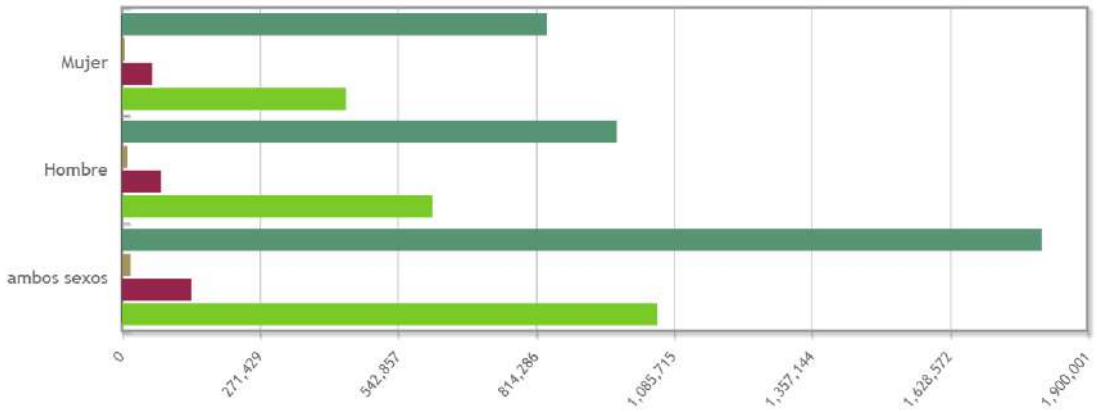


Table 1 shows the migration flow to Spain by reason of unemployment (aquamarine green); political reasons (orange); religious reasons (green) and quality of life (burgundy). The data are segregated by sex.

Factors affecting the psychological wellbeing in migrant/refugee population

The migrant population is exposed to worse socioeconomic conditions, greater mental health problems and lower consumption of medicines (Malmusi & Ortiz-Barreda, 2014). Despite the fact that the immigrant population has a lower prevalence of chronic diseases, a worse self-perception of health is observed, which stands out in women and who stay longer (Perreten et al., 2010).

According to a published study on the perspective of migrant people on access to health care (Ruiz-Azarola et al., 2020) in relation to the entry to the health system, the main barriers to access are administrative procedures, in addition to the lack of information about the necessary procedures to be able to receive health care, since, there is not a great deal of information from the institutions about these situations.

Legal requirements, lack of job opportunities, difficulties in meeting basic social needs and accessing social services, housing, cultural and language barriers, hostile acculturation attitudes and discrimination are only a few of the many problems that migrants have to face in the host country according to current literature.

Mental health difficulties

According to an article published by Achotegui (2016) in relation to the mental health of immigrants in the 21st century, it is noted that immigrants suffer from the same mental disorders as the rest of the population, as mental disorders are universal. Migration-related issues include those related to the impact of migration on public health, as migrants may be subjected to multiple forms of discrimination, violence and multiple forms of discrimination, violence and exploitation, which often directly affect their physical and mental health. Achotegui's research opened up a different approach to the mental phenomenon in the immigrant population, coining the term "Ulysses Syndrome", to account for the syndrome of the immigrant with chronic and multiple stress; which corresponds more to a symptomatology typical of a process of adaptation to the host society, which can generate psychopathology.

In Spain, the people most at risk of suffering from mental and neurological disorders are those who emigrate to live and work in another country and end up living in exploitative and isolated conditions, as well as those who seek refuge from hunger, violence and political unrest. In these cases, when they arrive at the place of refuge, they often find themselves in a situation of lack of information, unemployment and homelessness, which increases the risk of social exclusion and rejection by the native population (Irarrázaval. M & Armijo, 2016). Risk factors for mental and neurological disorders differ according to the stage of the journey in which the individual is in the process of preparing for the journey. Among migrants, fear, anxiety, hunger, family loss and economic conditions, as well as bereavement, depression, trauma, separation from family and breakdown of social support stand out. In the asylum process, repatriation difficulties, non-hospital conditions, unemployment and food shortages stand out, and during the resettlement

process, social isolation, acculturation problems, prejudice, language barriers and marginalisation (Vilar Peyrí & Eibenschutz Hartman, 2007).

According to several studies (Elgorriaga, 2011; Hidalgo et al, 2009) immigrant women present higher levels of stress and discomfort than men and show more psychological disturbances that may be due to role overload, jobs without contracts and exhaustive schedules, etc. (Patiño and Kirchner, 2008).

Mental health services

There are different types of access to mental health services for immigrants or refugees; immigrants, regardless of the regulation of their situation in Spain (residence permit...), have the right to health care and therefore, to psychological assistance. However, the mental health services and counselling services mostly used by immigrants and refugees are those provided by the different non-governmental organizations and NGOs in agreement with the different public administrations. These include those offered by recognized institutions such as:

1. CRUZ ROJA
2. MÉDICOS SIN FRONTERAS
3. ACCEM
4. CESAL
5. CEAR
6. ACNUR
7. KIFKIF
8. FUNDACIÓN ACSAR
9. RED ACOGE
10. ONG RESCATE
11. ASOCIACIÓN KARIBÚ

In relation to the available mental health services for immigrants in Spain, it should be noted that there is a lack of sufficiently in-depth research on the subject. Despite this, a study on the perception and experiences in the access and use of health services in the immigrant population

has been glimpsed (Bas-Sarmiento et al., 2015). The main difficulties encountered are language barriers (little use of Spanish and therefore difficult communication), the application of technical terms, waiting times, a clear lack of knowledge of current legislation and the administrative procedures necessary to be able to stay in Spain indefinitely.

Legislation regarding the use of mental health services

With regard to the health care problems of immigrants, since the approval of the General Health Law (LGS) in 1986 and the entry into force of the General Public Health Law (33/2011), there has been a major expansion in its scope of coverage, to include in practice the integration of undocumented immigrants through the Organic Law on the Rights and Freedoms of Foreigners in Spain (4/2000). Considering that the route by which undocumented immigrants could access healthcare was through registration (Fuentes et al., 2015), immigrants have the same right as any other Spanish citizen to the national health system regardless of their time in Spain, origin or administrative situation.

Conclusion

Migration has undeniably shaped the fabric of European societies, with an increasing number of migrants and refugees seeking safety, opportunities, and better lives within the continent. The psychological impact of migration, especially during the asylum process, presents a critical concern for both individuals seeking refuge and host countries. Addressing the mental health and psychosocial support needs of migrants and refugees is a crucial aspect of creating an inclusive society that upholds the human rights of all living in Europe. While all five countries have recognized the importance of addressing mental health issues among migrants and refugees, their responses have been each shaped by unique historical, cultural, and political contexts. EU-MiCare is an innovative project whose purpose is to develop an extensive training program for health professionals that can facilitate addressing obstacles to mental healthcare and psychosocial support for migrants and refugees. Thus, this report accompanied by the mapping of training opportunities and relevant initiatives in the partner countries and the qualitative report on the focus group discussions with health professionals, will provide the foundation from which each country's training will develop.

As Europe continues to witness migratory movements, ensuring the well-being of those seeking a new life in foreign lands remains a collective responsibility, and the findings of this report can contribute significantly to that ongoing effort. As the asylum process continues to shape the lives of migrants and refugees across Europe and globally, it is essential to prioritize mental health and psychosocial support to foster resilience and well-being among those seeking refuge. By understanding the existing stakeholder landscape and drawing from evidence-based initiatives, this report seeks to provide a solid foundation for the development of tailored interventions that can contribute to the empowerment and uplifting of the mental well-being of displaced individuals across these diverse five European countries. Ultimately, the insights gained from this report will contribute to the creation of an extensive and innovative training program for health professionals that will equip them with essential skills and knowledge necessary to effectively manage the mental health challenges faced by migrant and refugee populations.

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