MENTAL HEALTH AND PSYCHOSOCIAL WELL-BEING OF REFUGEE CHILDREN

An exploration of risk, resilience and protective factors in the post-migration context of Germany

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A thesis submitted in partial fulfilment of the requirement for the degree of

Master of Science in International Health

by

Teresa De Rosa

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Where other people's work has been used (from either a printed or visual source, or any other source), this has been carefully acknowledged and referenced according with academic requirements.
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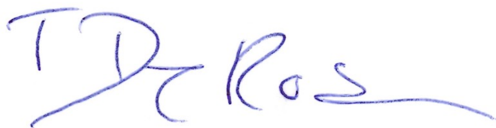
Signature: 

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List of Abbreviations

ARM	Accompanied Refugee Minors
AS	Asylum Seeker
AsylbLG	Asylum Seekers’ Benefits Act
BafF	German Association of Psychosocial Centres for Refugees and Victims of Torture *(Bundesweite Arbeitsgemeinschaft Psychosozialer Zentren für Flüchtlinge und Folteropfer)*
BAMF	Federal Office for Migration and Refugees *(Bundesamt für Migration und Flüchtlinge)*
CAP	Child and Adolescent Psychiatry
CEAS	Common European Asylum System
CRC	UN Convention on the Rights of a Child
CFCEU	Charter of Fundamental Rights of the European Union
ECEC	Early Childhood Education and Care
EU	European Union
GAP	General Adult Psychiatry
HCC	Hair Cortisol Concentration
HIC	High income countries
MHPSS	Mental Health and Psychosocial Support
NGO	Non-governmental organization
OECD	Organisation for Economic Co-operation and Development
PMS	Post-Migration Stressors
PPCT	Person-Process-Context-Time
PSCC	Psychosocial Care Centres
PTSD	Post-Traumatic Stress Disorder
PTSS	Post-Traumatic Stress Symptoms
RKI	Robert Koch Institute
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children’s Fund
URM	Unaccompanied Refugee Minors
WHO	World Health Organization

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Glossary

Asylum seeker – Someone who requests international protection, but whose application still has to be processed. Not every asylum seeker will ultimately be recognized as a refugee, but every refugee is initially an asylum seeker

Child – Every human being below the age of 18 years (1)

Coping strategies – An action, a series of actions, or a thought process used in meeting a stressful or unpleasant situation or in modifying one's reaction to such a situation (2)

Externalizing – Externalizing behaviours and disorders are characterized primarily by actions in the external world, such as acting out, antisocial behaviour, hostility, and aggression (2)

Internalizing – Internalizing behaviours and disorders are characterized primarily by processes within the self, such as anxiety, somatisation and depression(2)

Migrant – someone who is born abroad and moved to Germany (3)

Migration background – A person has a migration background if s/he or at least one of his/her parents did not acquire the German citizenship at birth (4)

Pre-school children – Children younger that obligatory school age, in Germany younger than 6 years old.

Protective factors – Characteristics associated with a likelihood of positive mental health outcomes or that reduce a risk factor's negative impact

Psychosocial distress – A type of stress that results from being overwhelmed by demands, losses, or perceived threats. It has a detrimental effect by generating physical and psychological maladaptation and posing serious health risks for individuals (2)

Refugee – Someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion (5)

Resilience – Following the American Psychological Association, "resilience is the process and outcome of successfully adapting to difficult or challenging life experiences, especially through mental, emotional, and behavioural flexibility and adjustment to external and internal demands" (6)

Risk factors – Characteristics associated with a higher likelihood of negative mental health outcomes

Unaccompanied Refugee Minor (URM) – Any child under the age of 18 who is physically separated from both parents (by death or other reason) and is an asylum seeker, recognized refugee, or other displaced person

Vulnerability – Susceptibility to developing a condition, disorder, or disease when exposed to specific agents or conditions (2)

Abstract

Since 2015, Germany hosts an unprecedented number of refugees. Refugees are exposed to risk factors that disproportionally increase the rate of mental health problems compared to the host countries' population. Around 40% of the refugees are children. The costs of not meeting the mental health needs of refugee children are high.

This thesis aims to identify and explore factors that influence mental health and the psychosocial well-being of refugee children in Germany; to analyse how these are interconnected; and to point out areas that need more research.

A literature review was performed and a modified version of Bronfenbrenner's person-process-context-time model was used to analyse data relevant to the German context.

A range of risk and protective factors affecting the child's mental health and psychosocial well-being were identified on four levels (individual/child, family, community and institution & policy). The main results were: access to good quality Early Childhood Education and Care (ECEC) is not only important for the refugee child's well-being but also of utmost importance for the integration of the whole family. Furthermore, parents play a crucial role in mental health and well-being of their children. Research into the life course of refugee children's mental health is urgently needed.

To meet the outlined challenges in addressing the complex needs of refugee children, Germany needs to adopt a more public health approach. This should include appropriate screening programmes for mental health issues on a larger scale. Furthermore, Germany needs to train mental healthcare professionals, including ECEC teachers and social workers.

Key words: refugee, children, mental health, Germany, ECEC

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Introduction

During the last 2 years I have been working in an outpatient clinic as a medical doctor in training for child and adolescent psychiatry and psychotherapy in Germany. In my consultation hours I am often confronted with refugee families whose elementary school children are referred to me through their teachers because of disruptive, self-control and conduct problems. My colleagues and I feel often overwhelmed as we are not trained to meet the complex needs of refugee children and their families, nor do we dispose of sensitive instruments for diagnostics, well trained interpreters or well established inter-sectoral collaborations.

Knowing that from a public health perspective, mental health is much more than what we provide as a psychiatrist and psychologist in our specialized hospitals and consultation rooms, knowing that instead of only focusing on the individual psychiatric concerns and symptoms, we must use ecological approaches that expand the focus from the individual to family, community and structural factors, I became interested in studying the social determinants of mental health in refugee children in Germany. Starting to gather information about the topic, I felt quite overwhelmed and frustrated to find out that so much research has been done during the last years and so many creative initiatives were formed and volunteers engaged, but so little of the knowledge is translated into structural clinical and public health practice and therefore good practice still depends on chance.

As a clinician I feel it is my duty to advocate for a migratory policy respectful of human rights, so that *traumatisation* does not continue in the resettlement country. I think that there are significant ways in which mental health institutions/psychiatrists can make a difference for refugee mental health, beyond the clinician’s commitment to good quality treatment. Psychiatrists may influence decision makers by providing information about mental health determinants in the post-migration environment and proposing protective social policies and promoting psychosocial interventions.

During the last two years, during the COVID-19 pandemic, many refugee children have been telling me that they are “stressed” or “feel depressed” because of school closures and limited social contacts. They were even more worried about their future because school closures meant less possibilities to learn the German language. Germany was one of the countries in Europe with the longest school closures and closure of leisure activities. Due to the COVID-19 pandemic, public health has been a part of our shared discourse in a way that it never has been before. Suddenly health is in the centre of everything. “Health in All policies” became reality. The importance of the public health system became visible.

In the following thesis I will review literature on the factors influencing mental health in refugee children in the post-migration context of Germany. I will give specific attention to pre-school children.

As the topic is very complex, I start with a rather extensive introduction for the better understanding and classification of the subject matter, first of all with the definition of “mental health” and “psychosocial well-being”.

1 Background

1.1 Mental health and psychosocial well-being

The World Health Organization (WHO) defines mental health as “a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community” (7). Mental health is more than the absence of mental illness. “Being mentally healthy during childhood includes reaching developmental and emotional milestones and learning healthy social skills and how to cope when there are problems” (8). Mental health is a fundamental part of children's overall health and has a complex relationship with their physical health (9).

The term “psychosocial” well-being emphasizes the socio-ecological perspective, embedding the more clinical term of “mental health” in a context, in which an individual exists and the relationship within that context (10).

1.2 Asylum seekers in Germany since 2015

Since the beginning of 2015, more than 5.6 million people have sought asylum in the European Union (EU). Germany is the largest receiver of asylum applications in the EU, hosting more than 2.1 million of them (11). Nearly 40% of asylum seekers (AS) in Germany are children. Since 2017 around 60% of the children are younger than 6 years old (12–18). More than 80% of the children came with their parents (19). The vast majority came from Syria, followed by Afghanistan and Iraq (12–18).

The share of AS accepted as refugees or entitled to asylum was ranging between 35% and 60% approximately between 2015 and 2021 (20).

Figure 1 and Table 1 summarise the age distribution of asylum seekers in Germany from 2015 to 2021.

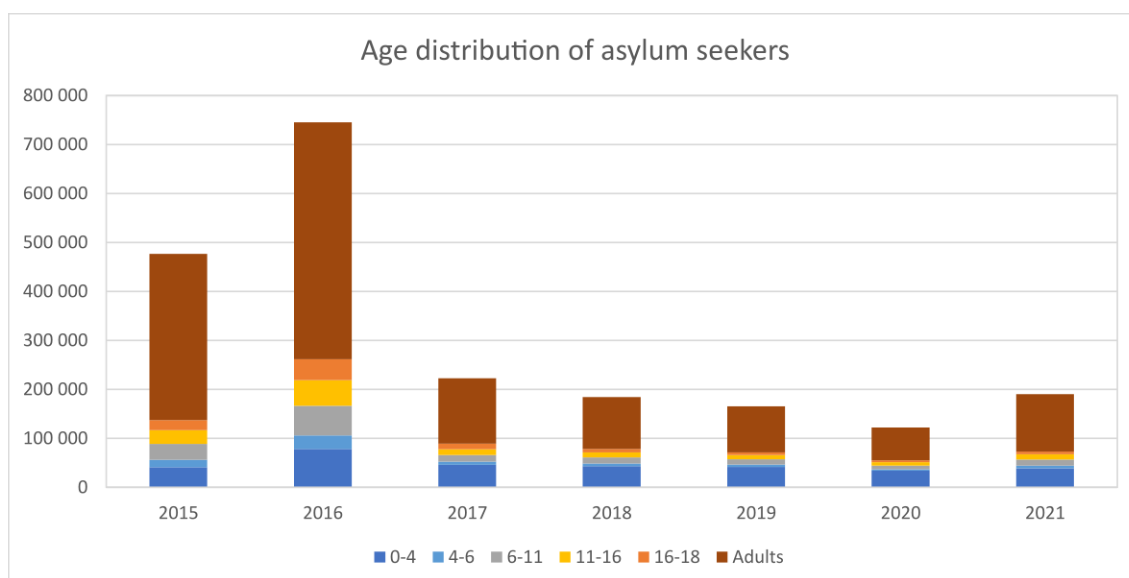

Figure 1: Age distribution of asylum seekers in Germany between 2015 and 2021 (12–18)

Age	2015	2016	2017	2018	2019	2020	2021
0-4	41 253	78 192	46 096	43 480	41 713	33 892	38 799
4-6	14 972	27 668	6 267	5 241	4 603	3 191	5 466
6-11	32 723	60 699	13 834	12 365	10 785	7 533	12 744
11-16	28 060	52 434	11 890	10 386	9 175	6 754	10 595
16-18	20 471	42 393	11 120	6 826	5 145	3 967	5 677
Adults	339 031	483 774	133 358	105 882	94 194	66 618	117 264
Total	**476 510**	**745 160**	**222 565**	**184 180**	**165 615**	**121 955**	**190 545**
Children (% of total)	28.9%	35.1%	40.1%	42.5%	43.1%	45.4%	38.5%
0-6 (% of total children)	40.9%	40.5%	58.7%	62.2%	64.8%	67.0%	60.4%

Table 1: Age distribution of asylum seekers in Germany between 2015 and 2021 (12–18)

1.3 Consequences of traumatic experiences on refugee children and prevalence rates of mental disorders

Children need secure, stable and positive environments to support their recovery from stressful experiences and to be able to play, learn and develop their full potential (21). However, refugee children coming to Germany during the last years fled from areas with ongoing war, armed conflicts or huge poverty. Many children have witnessed or experienced atrocities, were deprived of food and water, were separated from family and friends and experienced significant disruption of their daily lives. The latter included schooling (22–24).

During the process of migration they might have lived under poor conditions in refugee camps and might have experienced or witnessed domestic violence (25). After arriving in Germany new stressors, so called post-migration stressors (PMS), arise due to e.g. asylum insecurity, education in a new language and potentially the experience of exclusion and discrimination. As a consequence, refugee children and their parents are a vulnerable group to develop stress related mental health disorders. However, not every potential traumatic experience leads to the development of a mental disorder. Interpersonal traumatic events (e.g. interpersonal violence, rape) have a higher risk than natural disasters or accidents (26). Additionally, more than one traumatic experience is related to an increased risk for trauma and stress related disorder such as post-traumatic stress disorder (PTSD), depression and externalizing problems (22,27).

PTSD symptoms in adults and adolescents (28) include intrusive memories (e.g. unwanted distressing memories of the traumatic event, upsetting dreams or nightmares about the traumatic event, "flashbacks"), avoidance (avoiding of activities and situations reminiscent of the trauma), hyper-arousal (e.g. irritability, angry outbursts or aggressive behaviour, always being on guard for danger), and negative changes in thinking and mood (e.g. negative thoughts and hopelessness about the future, difficulty maintaining close relationships, feeling detached from family and friends, lack of interest in activities one once enjoyed).

Hans Keilson described that trauma does not disappear with the end of the war, it persists, can become chronic and can be intensified by renewed traumatic experiences (29). Trauma manifests via both biological and psychosocial mechanisms: frequent activation of the stress response system over a long period of time can lead to "toxic stress". Toxic stress can disrupt the development of the brain architecture and other organs. Exposure to traumatic experiences can also affect psychosocial functioning, which has negative effects on our coping abilities (30).

People who have experienced traumatic events can react very differently. A common psychological reaction is the development of a trauma-related disorder. This includes PTSD, depression, anxiety, psychosomatic or substance-related disorders (31). The full picture of PTSD is more often seen in adults than in children. Children react more often with developmental regressions or delays, with behavioural problems or with other post-traumatic stress symptoms (PTSS). PTSS is characterized by nightmares and sleep problems, bed-wetting, eating problems. somatic problems (e.g. stomach pain, headache), performance problems in school, concentration problems, social withdrawal, motor restlessness, oppositional-aggressive behaviour, problems forming attachment disruptive behaviour, impulsivity, and loss of interest in play (32,33).

One study showed that around half of refugee children experienced distress. In total, 40% of the children were impaired in their everyday life, including school and social interactions (23). Prevalence rates for PTSD vary greatly among studies. International studies reported mean prevalence rates of PTSD in refugee children between 22.71% and 36% (34–36). However, one consistent finding is that among refugee children, PTSD is more common compared to their non-refugee peers (37). In addition, prevalence rates for depression and anxiety disorders are higher compared to the global point prevalence of those disorders (34–

36). A systematic review from 2021 on the prevalence of depressive symptoms and symptoms of post-traumatic stress disorder among newly arrived refugees and asylum seekers in Germany (all ages) confirmed prevalence rates among refugees that exceed the prevalence rates in the general German population (38). This is in line with international reviews on refugee adults (39–41). It is important to note, that many (estimates are around 50%) of the children and adults who fled to Germany did not develop significant psychiatric symptoms and show remarkable resilience (42,43).

Dr. K. Stellermann-Strehlow is a child and adolescent psychiatrist working in Germany. She is an expert in refugee mental health and describes refugee children's reaction to severe stress as (44):

"Typical are strong emotional fluctuations, quick changes between anger, sadness, joy. We see children who have a strong need for control, always want to dominate in play and become aggressive. Sometimes this is simply a way to relieve tension, which can even be healing. Others bite their nails, twist their hair. Some children have diminished hearing abilities as in dangerous situations our ear only perceives the very high and the very low, threatening sounds - the deep growl of a predator, the shrill beeping of a siren. Normal conversations are simply tuned out. So it may be that children who are still afraid for their lives really don't hear when they are spoken to in the classroom, for example".

Reliable data on prevalence rates of mental health disorders among refugees living in Germany are difficult to find. Reasons for this are complex and include: inhomogenous definition of refugee (hence study inclusion criteria vary) in the epidemiological studies, lack of consensus on which research instruments and classifications should be used, differences in their cross cultural validity and the primary outcome chosen. Furthermore study samples tend to be small, non-representative and control groups are missing or differ between studies. Longitudinal data is hardly available.

Over the past few years, Germany has invested in research efforts focusing on refugees living in Germany. Even though the majority of refugee children are accompanied by their parents (accompanied refugee minors, ARM) most attention in research is given to unaccompanied refugee minors (URM) who are acknowledged to be particularly vulnerable (45–47). Two studies on pre-school refugee children (0-6 years old) in Germany found that around one third of the children showed symptoms indicative of PTSD (48,49).

1.4 Policy frameworks relevant to refugee children in Germany

The German government provides a framework through German law for the care of children in Germany, including refugee children. Germany has to adhere to the principles of European law. The overarching and guiding principle is the United Nations (UN) Convention on the Rights of a Child.

German law: German child and youth welfare law includes the principle that every young person has "a right to the promotion of his or her development and to education to become an independent and socially capable personality" (50). The right of access to offers and services

of child and youth welfare applies to all children in Germany regardless of their residence status (51).

European law: The Charter of Fundamental Rights of the European Union (CFCEU) obliges EU Member States to take the best interests of the child as a primary consideration in all measures affecting a child (Art. 24 (2) CFCEU). European directives on asylum procedures, assign children to the group of those in particular need of protection and endow them with special rights. The Reception Directive sets minimum standards at the European level for the reception of asylum seekers, which include, among other things, the consideration of gender and age-specific aspects. The Directive provides for adequate spaces according to the needs of children and requires that the standard of living must be appropriate to the child's physical, mental, spiritual, moral and social development (Art 23 (1) 2013/33/EU). The best interests of the child are to be taken into account by, among other things, ensuring the well-being and social development and guaranteeing the safety of the children (Art. 23 para. 2 2013/33/EU) (52) .

The UN Convention on the Rights of a Child (CRC) applies to every person under the age of 18 years. The life and development of children are protected according to four central principles (1):

1. No child may be discriminated against, explicitly also not "because of the status [...] of his or her parents, guardians or family members" (Art. 2 CRC).
2. The best interests of the child must be given priority in all measures affecting the child (Art. 3 CRC).
3. The development of each child must be ensured to the fullest extent possible (Art. 6 CRC).
4. Children must be heard and involved in all matters that affect them (Art. 12 CRC).

2 Problem Statement and Justification

2.1 Problem statement

Which are the key factors influencing mental health and psychosocial well-being of refugee children in Germany, and how to better meet their needs.

The influx of refugees has soared in Germany since 2015, and while today Germany hosts a unprecedented high number of refugees (11), it is expected that the numbers will further increase over the next few years (53,54).

Refugees are exposed to severe risk factors that disproportionally increase the rate of mental health problems compared to the host countries' population. This is well established in national (38,48,49) as well as in international literature (34,39). Pre-school children represent the majority of children and are a particularly vulnerable group (30,55) but have been largely neglected in research (30,48).

As many as one third of refugee children in Germany fulfil diagnostic criteria for PTSD (49), and overall mental distress was shown in up to 50% of them (23).

Although a number of measures have been taken both at the national and local level to better address the mental health and psychosocial well-being needs of refugee children, there is much room for improvement (56,57).

The costs of not meeting the mental health needs of refugee children are high. Mental health problems are a barrier to integration and can have long term impact on the migrant overall quality of life from the medical perspective (58), as well as deep social and economic repercussions both for the individual and the host country (59,60).

In particular poor mental health in children is likely to lead to problems in learning, self-regulation, emotional adaptability and relating to others (32); it negatively affects friendships, family relationships, education attainment and employment prospects. Moreover, poor mental health is a strong predictor for substance abuse and violence, and is also linked to poor reproductive and sexual health (61–65).

The impact is not only on individuals but also on their families and on the society as a whole (66).

2.2 Justification

The mental health and psychosocial needs of refugee children are complex and can not be solely addressed as a medical problem.

There is evidence that traumatic experiences during the various phases of migration (pre-flight and during flight) have an important impact on refugee children's mental health and psychosocial well-being (34,49). Furthermore, there is a growing body of evidence showing that post-migration circumstances might have an even greater impact. A number of studies on

adult refugees found that post-migration stressors have an equal or even greater influence on psychopathology than pre-migration experiences (67). Data is not available on children refugees, but abundant anecdotal evidence points to even stronger consequences of post-migration circumstances on the mental health and psychosocial well-being of refugee children.

Among the factors that influence mental health and the psychosocial well-being of refugee children and their parents, many have been explored and reviewed in international literature, with a number of them being context specific (68,69). In recent times in Germany and internationally, the impact of post-migration stressors on refugees' mental health has received more attention (58,70,71). However the research in Germany is still fragmented and mainly focuses on specific aspect of the problem, e.g. access to medical care (72) or living conditions in refugee accommodations (73,74).

Although the discussion is starting to focus on a more comprehensive view of the problem, we still know very little about the complex interactions that can affect the mental health and psychosocial well-being of refugee children who arrived in Germany since 2015.

There is increasing evidence that many of the post-migration stressors are directly affected by institutions, policies, measures and the German society as a whole (70,71,75). And specifically regarding resilience, there is now widespread agreement that resilience is not a given personal unmodifiable characteristic but it can be shaped by the availability of supportive environments (76).

Considering all of the above, the high number of refugees living in Germany and the predicted continued influx of refugees in the near future (already this year because of the war in Ukraine) (53,54), it is of the utmost importance for all stakeholders to improve our understanding of refugees mental health and their specific psychosocial needs, in order to prevent what is preventable, to address what needs to be addressed, and to limit the negative impact for the individual, their family and the society as a whole.

3 Objectives

The thesis aims to identify and explore factors that influence mental health and the psychosocial well-being of refugee children in Germany; to analyse how these are interconnected; and to point out areas that need more research. This is done using a modified version of the socio-ecological framework of Bronfenbrenner (68,77).

The overall objective of this thesis is to contribute to the development of a comprehensive theoretical conceptual framework for addressing the needs of refugee children in Germany, which could be used to define priorities, formulate guidelines, and help to recognize synergies that could be used to for intervention to most effectively influence the mental health of refugee children.

Specific objectives

This conceptual framework will be used to explore and analyse factors influencing mental health and psychosocial well-being of refugee children in Germany on the:

- institutional and policy level
- community level
- family level
- individual/child level

As well as to formulate recommendations for key stakeholders addressing factors affecting mental health in refugee children on all of the four above mentioned levels, referring to existing knowledge and good practice examples.

Specific attention is given to pre-school children, as those represent the majority of refugee children in Germany and are a particularly vulnerable group.

4 Methods and theoretical approaches

4.1 Methodology

For the literature research I used a three-step approach. First, I screened the online databases PubMed and Medline using the following key words : Germany, refugee, and asylum seeker. Articles published in peer reviewed journals, published in English or German between 01/2015 and 03/2022 were screened for relevant information. In a second step, I screened the below listed institutional and government websites and online available official reports relevant to my thesis. In a third step, I used a more targeted approach in grey literature, using google scholar and google search engine for specific factors. The search terms used were taken from two international literature reviews that focused on factors that affected children's mental health and psychosocial well-being (68,69). Relevant factors identified in these reviews were used as key words in the present thesis.

As this thesis focuses on the situation in Germany, the web based search included German key words. Further publications were obtained by going through the references of the retained publications. Data specific for the German context is lacking. Therefore, data from international research studies focusing on refugee children was also taken into account.

Databases and search engines

PubMed	https://pubmed.ncbi.nlm.nih.gov/
Medline	https://www.medline.com/
Google Scholar	https://scholar.google.com/
Google search engine	https://www.google.com/

Institutional, government and other relevant websites

WHO	https://www.who.int/
UNHCR	https://www.unhcr.org/
UNICEF Germany	https://www.unicef.de/
European Commission	https://ec.europa.eu/info/index_en
Robert Koch Institute	https://www.rki.de/EN
Federal Office for Migration and Refugees (BAMF)	https://www.bamf.de/EN
Federal Ministry for Family Affairs, Senior Citizen, Women and Youth (BMFSFJ)	https://www.bmfsfj.de/bmfsfj/meta/en
German Association of Psychosocial Centres for Refugees and Victims of Torture (BafF)	https://www.baff-zentren.org/english/
German Society of Psychiatry and Psychotherapy (DPGGN)	https://www.dgppn.de/en
German Institute for Youth Human Services and Family Law (DIJuF)	https://dijuf.de/en/

4.2 Theoretical approaches

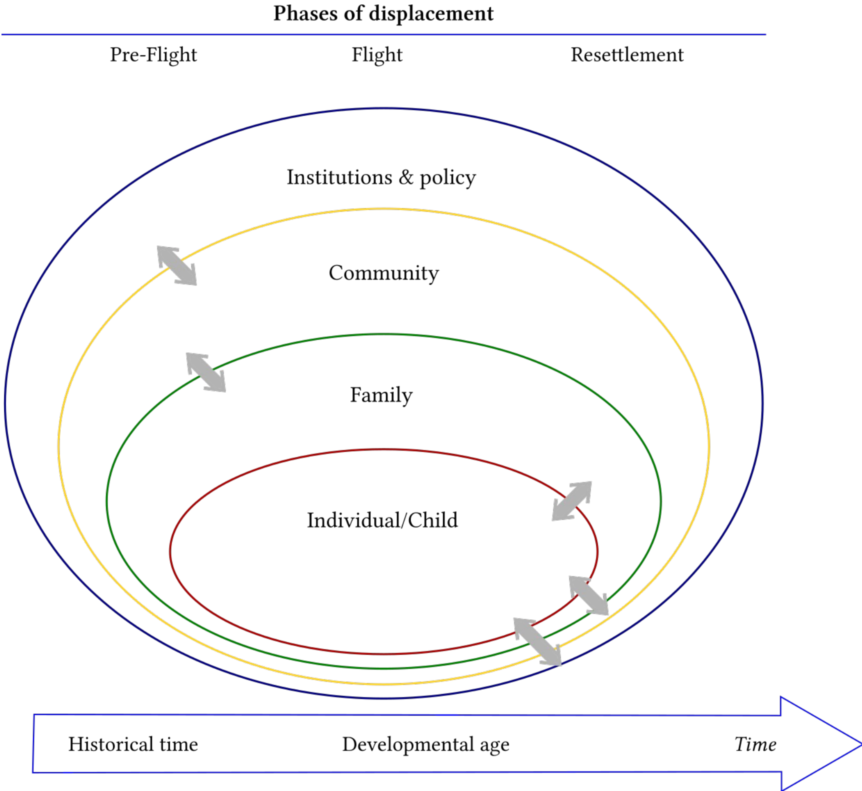

Figure 2: Conceptual framework from Bronfenbrenner

Displayed is a modified conceptual framework from Bronfenbrenner (77), showing how the social environment affects the child's development. Arakelya and Ager adapted the model to the refugees experience, using it to analyse the risk and protective factors on refugee children's mental health (68). The four different levels as indicated by the red, green, yellow and blue circles interact with each other, indicated by the grey arrows. The blue arrow at the bottom indicates the historical time and developmental age in which the child's life course is embedded.

In 2021 Arakelya and Ager (68) published a multi-layered socio-ecological model, used to analyse factors relevant to mental health and psychosocial well-being of refugee children. The model is an adapted version of Bronfenbrenner's person-process-context-time (PPCT) model (77).

One of the core propositions of PPCT is the complex interplay between various factors operating on different levels. These include the individual/child, family, community and institutional & policy level. In this multi-level approach, the levels are not independent from each other but influence and interact with each other. Another relevant element of PPCT is the time trajectory represented by 'historical time' and 'developmental age'. The child's life course is embedded in and shaped by both. The 'historical time' refers to the circumstances and events happening and the 'developmental age' refers to the actual developmental stage of a child.

5 Results

The Bronfenbrenner's PPCT conceptual framework (77) allowed to successfully explore and analyse the different risk and protective factors affecting children's mental health and psychosocial well-being in Germany. Figure 3 displays the main results of this thesis.

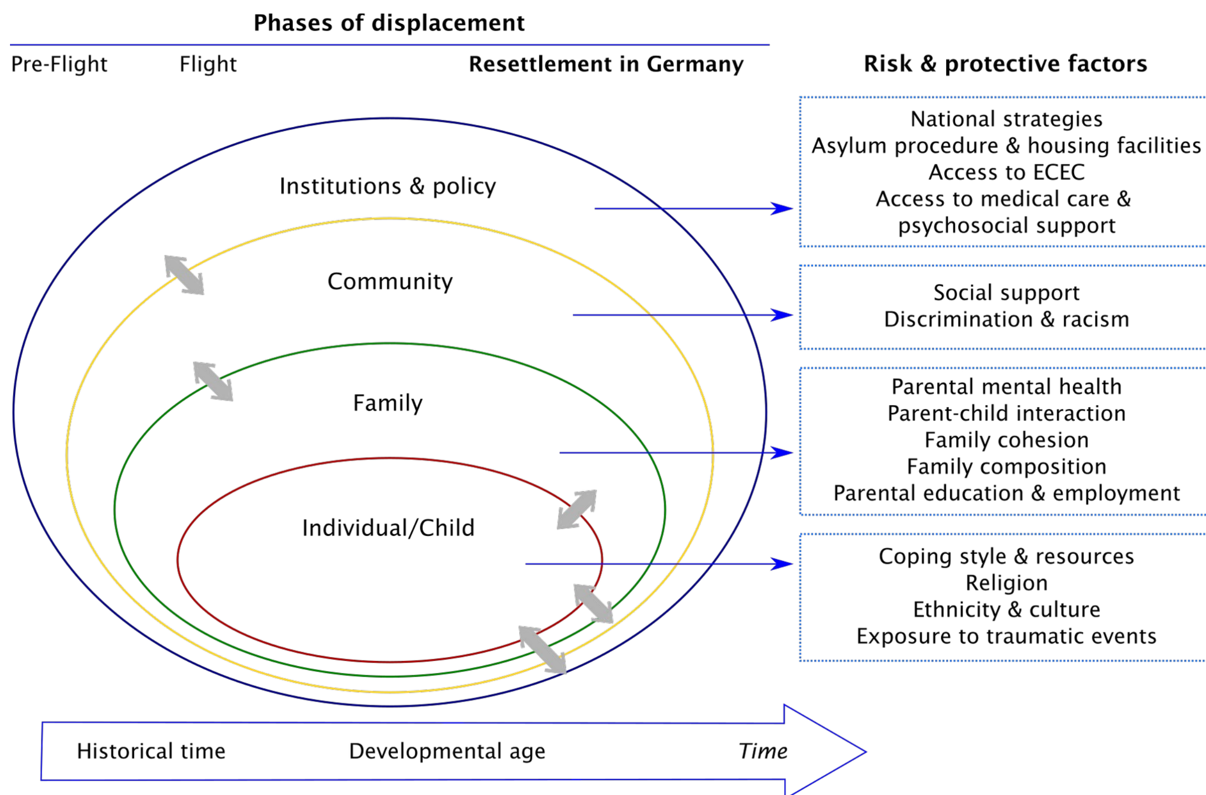

Figure 3: Risk and protection factors of refugee children's mental health and psychosocial well-being in Germany

Based on the modified conceptual framework from Bronfenbrenner, the results of this thesis are summarized here. For each level, the main identified risk and protective factors are listed in the boxes on the right size.

5.1 Institutions and policy level

The key institutions and policy factors identified that affect the mental health and psychosocial well-being of pre-school refugee children in Germany are: **National strategies**, **asylum procedure and housing facilities, access to Early Childhood Education and Care (ECEC)** and **access to medical care and psychosocial support.**

National strategies

The German Federal Government issued a new Global Health Strategy in October 2020 (78). Germany emphasises multilateralism and global health in all policies. This is underlined by the government's commitment to health as a fundamental human right and the committed to the United Nations Sustainable Development Goals.

Despite a large influx of refugees to Germany, refugees' health is not sufficiently addressed on various levels in Germany's public health system. The above described Global Health Strategy does not mention refugees and Germany was criticised by Knipper *et al.* to "leave migrants behind" (79).

A paper by the European Migration Network, published in July 2022, reports that Germany is amongst 14 member states that do not have a relevant national strategy or policy that references migrants' and refugees' mental health. The Network also pointed out that Germany was one of 9 member states who did not involve migrants in drafting policies and strategies on access to mental health (80).

A report about the current situation of refugee and forced migration studies in Germany (81), published by Kleist and colleagues in 2019, identified the following challenges to addressing health issues of refugees in Germany: lack of exchange between all relevant stakeholders (decision makers, politicians, institutions, media and other social actors); lack of common knowledge basis in relation to the needs of refugees; barriers in efficiently communicating with each other; lack of centralised and harmonized research activities.

The lack of data on refugees' health strongly indicates that refugees are overlooked in the health care system. E.g. the Robert Koch Institut (RKI) health monitoring programme did not collect data on refugees in nationwide surveys. However, there is a trend to collect data on health issues in refugees; e.g. the PriCare research project was initiated. It collects routine medical data on all refugees living in reception centres to provide more reliable information on their health situation (82). Furthermore, the RKI aims to systematically collect data on migrant status in their annual health monitoring (83).

In addition to the lack of reliable data on the health of refugees and migrants, several studies point to the lack of health care professionals expertise with regard to migration-specific aspects of health (84). Systematic approaches are lacking on how to integrate cultural competence and global health at German-speaking medical schools into medical curricula (85). In a survey of 523 medical students, 70% of the students surveyed answered that they are too little prepared and almost 85% would like more information on the (medical) treatment of refugees (86).

Some health care facilities have started to address the specific needs of refugees and are aiming to make their services more accessible to a culturally diverse population (87). However the process of implementing guidelines still has a long way to go (88).

Asylum procedure and housing facilities

The asylum procedure is regulated by a national law, the Asylum Act (89). In addition, the regulations of the Common European Asylum System (CEAS) apply (90). The asylum

procedure is carried out by the Federal Office for Migration and Refugees (BAMF). Parents can present their own grounds for asylum for their child. If they do not do so, the same reasons apply as for the parents (91).

AS are distributed to the different Federal States in Germany via a distribution system which is laid down there. The 16 Federal States are responsible for the accommodation and social care of AS. The implementation varies considerably from State to State. This leads to great differences in *quality/spatial structures* of housing and services and staff availably. The same implementation differences apply to the minimum standards for the protection against violence in refugee accommodations, that were developed on national level (92).

Refugee accommodations

The Federal States are responsible for the accommodation and social care of asylum seekers, which is regulated via the Asylum Seekers' Benefits Act (AsylbLG). The benefits under the AsylbLG are intended to secure the physical *subsistence* minimum (e.g. needs for food, accommodation, clothing and health) and the socio-cultural subsistence minimum, that should secure participation and personal needs (93). The average duration of the asylum process was 6.6 months in 2021 (94)

In general, after arriving to Germany, AS live in initial reception centres. Afterwards they move to collective accommodation and decentralised accommodations. AS are obliged to live in a reception centres until a decision is made on their asylum application or in the event of rejection, until they leave the country. For children and their parents a maximum stay of up to six months applies (Section 47 (1) Asylum Act (95)). AS are not free to choose their place of residence in Germany for the duration of the asylum procedure.

The effects of the asylum procedure on children's mental health are widely unknown. One study in refugee children (average age of 17 years) found that clinically significant symptoms of psychological distress declined significantly after asylum was guaranteed (71). From an adult perspective, extended uncertainty about the asylum application outcome and fear of deportation significantly deteriorate the mental health in adult refugees in Germany (70,96,97). Indirectly this will affect the mental well-being of their children (see Section 5.3).

The type of accommodation upon arrival has a major impact on the well-being of refugee children. Reports indicate that some young children are spending months or even 1-2 years in so called reception centres, which are collective accommodations (73). Living in collective accommodations influences all areas of life: personal safety, health, education, privacy and participation. Collective accommodations rarely offer facilities for parents to prepare home-cooked meals for their children; rather they are offered ordered food that might not take into account specific food preferences of the child. Furthermore, refugee parents report that they and their children don't feel safe in collective accommodations. Reasons include: sanitary facilities and personal rooms that cannot be locked from the inside (hence increasing the risk of sexual violence) and children who are woken up by security guards patrolling the facility at night. Furthermore, some report that they are in fear of attacks by right-wing extremists (73,98,99). In a German-wide study, 10% of the staff working in collective

accommodations reported that children living there were victims of violence (99). Reports also point to increased intra-family violence in refugee families, particularly in families with substantially high stress levels (e.g. worry for safety of families back home, loss of a family member, uncertainty in relation to their residential status) (100).

Parents report that their children have hardly any opportunity to play, to learn and interact with peers or relax. The noise level in collective accommodations is constantly high. Furthermore, collective accommodations rarely have a daily structure addressing children's needs, play activities are ad hoc and without qualified personnel. Collective accommodations are often located on the outskirts the city so that access to playgrounds and interaction with locals is limited. Young children become aggressive easily, cannot sleep and start to bed-wet. Symptoms of people already experiencing mental illness were exacerbated, those who are not already ill become ill (73).

Access to Early Childhood Education and Care (ECEC)

According to the German law all children have the legal right to access ECEC on their first birthday (101). While some federal states allowed refugee children to enrol in ECEC upon their arrival, others grant access only after they move into private accommodations (102).

Evidence of benefits of high quality ECEC for vulnerable children is ample (103). ECEC is seen as an important instrument to mitigate the risks refugee children face, due to experienced adversities, on their psychosocial, cognitive and physical development (104). Furthermore access to ECEC is important because it provides refugee children with a sense of normality, let them regain a daily structure and stability (105). ECEC gives children the opportunity to acquire social and language skills, which are fundamental for their further integration (106) starting with the opportunity to succeed in school (107). Furthermore, ECEC can also play an important role in the integration of the family as a whole (102).

Although the children are legally entitled to ECEC, availability and quality are reported to differ widely (108). Data from representative samples of refugees shows that children are significantly under-represented among the 0-3 age group in ECEC (109). In addition to the lack of available places, complex and inflexible registration procedures and prioritisation policies might disadvantage refugees (e.g. prioritisation of families where both parents work). Furthermore refugee parents are reported to have insufficient guidance and support navigating the complex ECEC service. Additional barriers include language issues, cultural unfamiliarity and lack of trust in the system (110). Also the often forced mobility of refugee families makes it difficult for the families to settle down (104). On the other side, teachers report lack of specific training and resources to provide refugee children with adequate support (111) Even when resources are made available, such as online tools, the teachers experience a lack of supervision and counselling/guidance on individual cases (112).

In Germany, children are required to start school when they are around 6 years old. In Germany, the relation between socio-economic background of the parents and the child's educational success is more pronounced than in other OECD countries (113). Children with a migration background tend to perform less well compared to non-migrant children.

Furthermore, their future employment and socio-economic status is lower than that of their non-migrant peers (114).

Studies show that ECEC participation of refugee children substantially affects the social integration of their mothers. This is mostly via their mother's language acquisition (102).Women are less likely than men to participate in language and integration courses. This is usually explained by their care responsibilities, and the lack of access to ECEC (115). Delay in language acquisition has been shown to slow integration, especially into the labour market (116).

Access to medical care and psychosocial support

Access to health care is limited during the approval process for asylum. AS have a right to emergency care, services during pregnancy and child birth, check-up for children and vaccination (117). Access to mental health care services is not included unless the individual was identified as being a "vulnerable person" or access was granted on a case-by-case basis depending on individual assessments carried out by social welfare agencies and public health authorities (72,118).

However, those in need ("vulnerable person") are often not identified during the obligatory initial health examination upon arrival in Germany. This physical exam is mainly intended to identify and treat communicable diseases (89). In addition, lack of mental health screening tools, lack of systematic procedures and lack of specific responsibilities are barriers to the identification of "vulnerable individuals". This is especially detrimental for children who develop symptoms that might be overlooked by a non-professional. Studies showed that parents sometimes underestimate especially internalizing symptoms in traumatized children (119,120).

Furthermore, the German system distinguishes between URMs and ARMs. While it is routine for URMs to be looked after by social workers, this is much less common for ARMs (47). According to German law, each individual refugee minor has to undergo a comprehensive health check which addresses the social, educational, medical and psychosocial needs. However, in practice this is only the case for URMs.

Mental health screenings are not routinely carried out in Germany. Even if they were performed, there is a lack of validated trauma and mental health tools, especially for refugees below the age of 6 years e.g. (121,122) and diagnostic criteria might not appropriately provide a developmentally sensitive classification of PTSD in young children (119). Mental health screenings are discussed controversially in Germany e.g. (56,123) and applied differently on an international level (124). Furthermore, training in Child and Adolescent Psychiatry (CAP) and training in General Adult Psychiatry (GAP) are two totally separated specialisations in Germany which do not share a common trunk (125).

Refugee children who have access to mental health services might be reluctant to use them due to fear of stigma; fear and mistrust of services; lack of information on mental health and service providers lacking cultural responsiveness (126). This finding is in line with my own experience working as a child and adolescent psychiatrist. Parents reported that they were

afraid that child protective services might take their children away when behaving badly (e.g. aggressive behaviour).

The EU Commission noted that: “insufficient access to healthcare services can be a major obstacle to integration and inclusion, affecting virtually all areas of life, including employment and education” (127).

Providing access to medical care is regulated differently between Federal States and municipalities within Federal States. In some municipalities, the paper work requirements are extremely complex and burdensome than in others, practically hampering an easy access to health care, even when access is guaranteed. In some cases, refugees might be denied medical services as the decision whether a symptom requires medical attention is made by a non-medical professional (118).

Refugees often face delayed mental health diagnoses, treatment, and care (128). Compared to the German native population, data shows that refugees have poorer overall health with lower utilization of the health care system (129).

Furthermore, the following barriers to accessing the regular health care provision structures were identified and described by the German Association of Psychosocial Centres for Refugees and Victims of Torture (BafF) (130), and additional resources are listed below:

- Language and cultural barriers (131,132)
- Difficulties in getting access to interpreters or no coverage of the costs
- Although short intensive training for interpreters in child and adolescent mental health exist, the number of translators with special training is quite limited (133)
- Discrimination in health care centres (134)
- Unwillingness of doctors and psychotherapists in health care facilities to deal with specific billing modalities for refugees (135,136)
- Poor communication and lack of networking between youth welfare offices, doctors (137) psychotherapists, counselling centres and lawyers and other relevant stakeholders
- Interruption of diagnostic and therapeutic processes due to asylum-related reassignments and changes of residence
- Limited accessibility due to the the isolated housing situation in refugee accommodations, and delayed or missing reimbursement of travel costs
- Lack of information about which benefits refugees are entitled to and how to access them in the German health care system
- Limited capacity of health care centres and availability of psychotherapy. Since the Covid pandemic waiting time for a psychotherapy doubled and many symptoms exaggerated (138)

Most of these barriers not only exist in Germany but also in other European countries as stated by the European Migration Network in July 2022 (80). Specifically in regard to access to mental health services, refugees in Germany mentioned concerns about confidentiality, lack of trust and potential stigmatization (139). In addition to fear of stigmatization from others, the feeling of shame was increased in Syrian refugees with moderate PTSD symptoms in Germany (140).

These barriers to appropriate treatment for refugees in regular care provision structures can lead to misdiagnosis (98,141), increased used of emergency care (142) and chronicity of illnesses due to non-recognition or non-treatment of illnesses. Quantitative data on these barriers are scarce because people do not access the health system(143).

There are currently 47 psychosocial care centres (PSCC) in the BAfF that are committed to the medical, psychotherapeutic and psychosocial care and rehabilitation of victims of torture and other serious violations of human rights (144). These centres provide specialized multi-professional services for refugees. However, due to their rather low numbers and insufficient financing, they are only able to meet some of the refugee's needs (145).

5.2 Community level

Social support

Several international systematic literature reviews found that supportive relationships are central for the emotional well-being of refugee children (68,69,146). Social support can be provided by different persons within the child's environment: e.g. friends, teachers, neighbours or other adults. It is well known that the younger the child, the more important are the parents or other primary caretakers.

Arekelyan and Ager state "it appears that the mental health effects of relationships and supports are complex, contested and context-specific" and "refugee children clearly distinguish between the type of relationships they have with a host community (peer, adults) and those sharing a common ethnic and refugee background", with the latter providing a sense of belonging and social cohesion (68). A study conducted in Germany indicated that children with a migration background are important gatekeepers who provide refugee children with access to social networks (147). A study from Müller and colleagues found that lower social support in the host country and poorer German language proficiency was associated with higher levels of psychological distress in refugee minors (47). The importance of being able to speak the dominant language of the host country for the well-being of refugee children is in line with international literature.

Even though education and mental health are closely interrelated, the mental health of refugee children in ECEC has been largely neglected in research in Germany. One study in ECEC found that mental health needs were restricted to specific domains associated with externalizing behaviours such as aggressive behaviour, problems with other peers, or attention problems (148). Furthermore ECEC teachers report that refugee children might not want to invite playmates to their homes, or their parents do not want them to do so, because they are ashamed of their poor living conditions (112). But also a lack of behavioural

regulation skills, due for example to PTSS, can lead to problems in group environments (149).

“Willkommenskultur” – welcome culture

The BAMF defines welcome culture through active help and social support for integration in community activities and to prevent social isolation. The goal is to give refugees the feeling of being welcome, as well as practical orientation assistance (220). Heckmann (218) points out that a welcoming culture is characterized by openness and acceptance. In doing so, he assumes that the welcome culture can be expressed on four different levels. These include the individual, the interpersonal, the organizational and the the societal level. "To be welcome" creates, according to Gill (221). the social basis for the development of trust.

An important *social construct* in Germany related to refugees is the so called “Willkommenskultur”. Institutions provide e.g. platforms and support private initiative to create an active network of people for welcoming the refugees and helping their integration in local life. There are countless volunteers, NGOs and grassroot organisations in Germany who try to help refugees with all the barriers they face. These are quite successful when they exist. In a representative survey on 4321 adults in Germany, the feeling of being “welcome” had an indirect positive effect on the mental health of the refugees through life satisfaction as a mediator (75). For children, no specific data was found on this subject.

Discrimination and racism

On the negative side, it is a well established fact in literature that discrimination, stigmatisation, exclusion in the society at large and at ECEC and school in particular are serious elements that undermine the well-being of refugee children. Although it is widely known, to this days I could not find a study that quantifies the negative effect on children’s mental health. Discrimination and everyday racism have a negative impact on children worldwide (150). Refugees are often exposed to prejudice and racial devaluation in everyday life, in the educational environment but also in institutions. This is very stressful for them and has a negative impact on their well-being and health (151–155). In the context of health care, prejudice can lead to individuals not being heard, their needs not being taken seriously or treatment being denied (73). Refugees in Germany particularly often experience discrimination in working life, in the housing market, in access to goods or services and at agencies and authorities (156).

Findings from an ongoing study that looks at institutional racism in ECEC in post-migration Berlin are: lack of materials that reflect social plurality, ECEC staff sometimes downplays racist incidents and that children reproduced racist attitudes. Children’s migration background, e.g. different physical appearance, was the reason why they were excluded from play and birthday parties, which caused some of them to become aggressive and other withdrawn (157).

5.3 Family level

Characteristics of refugee families who arrived in Germany over the past few years

- refugee families have an above-average number of children in comparison to the local population (219)
- the majority of refugee children is younger then six years old
- around 30 000 refugee children are born each year in Germany
- the employment rate of refugees is lower compared to the general population; the employment rate of women with refugee background is particularly low

Parental mental health, parent-child interaction, family cohesion

The role of family on the mental health of refugee children in Germany is not well understood, yet. Research on this topic in the particular German context is sparse. However, there is data available from research studies from other countries. These international studies consistently show that family plays a leading role in the mental well-being of refugee children.

These are compilations of the findings: Resilience is strengthened when children grow up in an secure and reliable environment (158). The child's own ability to self-regulate often depends on the emotional condition of the parent (159,160). Studies show that healthy family communication and a low level of conflict makes families a helpful resource to overcome stressful events (161). Furthermore parents are not only the first to detect and assess the stress or need in children but also the ones who can initiate seeking help, treatment and therapy (162). Positive parenting practices have a positive effect on externalizing (163) and internalizing (164) problems after traumatic events. Social support from a spouse promotes positive parenting and reduces the risk of child maltreatment (165).

Research consistently shows that parental mental health problems in refugees have a negative effect on their children's mental health (166–170). Destabilising family dynamics in the phases before, during and after the flight reduce the protective effects of family (159). Refugee adults in Germany report that they are impaired because of past events experienced, worries about family members left behind, uncertainty of legal status, lost of agency and isolation in refugee accommodations. These feelings of powerlessness, meaninglessness, lack of control over the future and passivity negatively impact their mental health (96). Adverse living conditions are shown to increase the risk of family conflict (160). Family stress affects care and parenting behaviour and increases intra-family violence (25). In studies, war-traumatization in parents is linked to increased intra-family violence against women (171) and children (172). Excessive alcohol consumption, particularly in war-traumatized men, appears to be a crucial risk factor for this (171,173). Parents with a trauma history and post migratory difficulties are described to use more negative parenting practices such as harsh parenting which is linked to higher levels of child mental health problems e.g. conduct problems, hyperactivity, and peer problems (168). Children who already show signs of mental health problems, e.g. emotional and behaviour problems, are at particularly high risk of experiencing maltreatment at home (174) as parents might be overwhelmed with the challenging behaviour and respond out of helplessness and lack of knowledge with threats and violence (175).

Figure 4 outlines the relationships between traumatizing experiences, mental stress, and family violence.

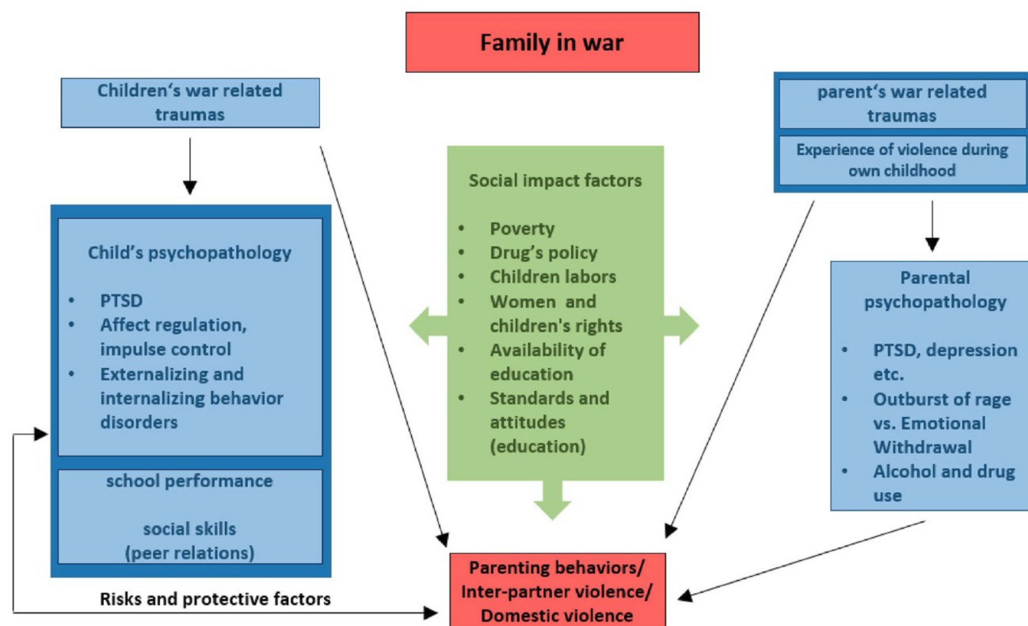

Figure 4: Links between social, individual and familial parameters and domestic violence (175,222)

Also, there is very little data on mental health on pregnant refugee women (176), evidence shows that perinatal mental health disorders affects mother-infant attachment (177). In Germany we only know that asylum seeking women are at higher risk of abortive outcomes and stillbirths and show a tendency towards higher postnatal complication in comparison to resident women (178), but we do not know about their mental health status.

Ruf-Leuschner et at studied a group of 41 refugee mothers and their 11 to 18 year old children in Germany with regard to the trans-generational transmission of trauma sequelae and found no direct association between the severity of maternal PTSD symptomatology and the children's PTSD symptomatology, depressiveness and anxiety, but a positive association between the severity of maternal PTSD symptomatology and intra-family violence experienced by the children (179).

Furthermore, roles within the family can be affected. Children might take over more adult roles when parents are mentally ill (169).

Family composition

Living with at least one biological parent has a positive effect on children’s mental health while being separated from immediate family members is a risk factor (69). Even short-term separation from family members was associated with mental health problems among young male refugees in Germany (27). In Germany, URM show a higher prevalence rate of mental health issues compared to ARM (47).

As previously outlined, the mental health of parents is a relevant factor for the well-being of the refugee children. On the parental level, worrying about family left behind is associated with psychological distress. On the other hand, living with your child in Germany was associated with higher life satisfaction of adult refugees (180). Having children was identified to be the primary source of motivation to overcome difficulties, they gave a sense of meaning and helped enduring sacrifices and hardships (96).

Germany's family reunification policies are more restrictive than most Western European/OECD countries in terms of the delays and eligibility restrictions. E.g. adult siblings are only allowed to join the family members living in Germany in exceptional cases (114).

The COVID-19 pandemic has further intensified the mental health risks for migrants and refugees, particularly those living in precarious housing and employment conditions. It has exacerbated pre-existing stressors, with migrants feeling further from home and from their support networks (182). Furthermore, family reunification was even more difficult due to border and travel restrictions (183).

Parental education and employment

Parental education and regular occupation in adults are linked to less psychological distress and more life satisfaction (96,102,184) in Germany. The direct impact of parental education and employment on children's mental health in Germany is not known. International literature on the topic is scarce and shows mixed results (68) but parent's education, educational resources at home, parents involvement in schooling and family socioeconomic status of migrants and native children are important determinants for children's achievement in school in Germany (185).

Studies suggest that there might be a bidirectional relation between mental health and integration. E.g. Mental health problems will negatively affect the possibility to join the workforce and on the other hand having no work will have a negative effect on mental health. This can lead to economic hardship of the family and create more tension (58)

Higher socioeconomic status of adult refugees in the home country was associated with a slightly better subjective health status after migration. However, the difference in health satisfaction between refugees of high and low socioeconomic status became much smaller after migration (186). Due to the pandemic the positive trend in the labour market integration of refugees has been interrupted: significantly more people from countries of origin for asylum lost their jobs and the acquisition of language and education has been interrupted or slowed down. Women with refugee experience seem to be particularly affected by the negative consequences as they work more than other immigrant groups in jobs, which are particularly affected by job losses and at the same time they bear the heavier burden in terms of housework and childcare (187).

5.4 Individual/child level

A review of international literature by Arakelyan and Agar found eight different factors influencing mental health and psychosocial well-being of refugee children. These are: ***age***, ***gender***, **coping style**, **religion**, **ethnicity** and **national identity**, **acculturation style** and ***risky behaviour*****r**. Furthermore, they **exposure to traumatic events** in the pre-flight and flight phase as an important risk factor (68). My review of a number of studies found that these are all certainly relevant factors but there is no substantial data to support this in the specific context of Germany. Here I present what is actually available at the German level.

Coping style and resources

There is a growing body of literature on coping styles and resilience in adult refugees in Germany e.g. (96,188,189) but not much is known about children. An interview study on 20 children between 6 and 12 years of age in a refugee accommodation in Germany found that these children showed a broad range of internal protection factors, especially when confronted with racism and exclusion in school. Despite their traumatic experiences, the children in the sample did not develop PTSD. Differently from the common assumption in resilience research which sees long term friendships as a protective factor, in the case of refugee children it was a positive resource to be able to built friendships rapidly and overcome losses quickly. This capacity made them resilient to relationship breakups that they cannot control (190). A study on young refugees showed that using more palliative emotion regulation, social support, and avoidance coping was linked to higher well-being independently of the refugee minors' age or gender (191). In an international literature review avoidant coping strategies were found as a risk factor on children's mental health (69).

Meyeringer, a child and youth psychotherapist working with refugee children in Berlin, identified the following resources to be helpful: perceived security, stability of material resources, strong belief systems and sense of purpose, positive outlook on the future, positive sense of self-worth, openness, adequate stress coping strategies, focus on own goals (192).

Religion

For the moment there are hardly any studies focusing on religion in relation to refugee children's mental health and well-being in Germany. However, it is known that religion can be both, a coping mechanism but also a risk factor that creates tensions, when the main religious believes of the refugee's culture clashes with the main religious believes of the receiving country. Based on my own experience working as a medical doctor in CAP, I saw first hand that religious beliefs were both protective and harmful for mental health of refugee children. E.g. when religion strictly forbids suicide, this could be a protective factor. On the other hand it could also make it more difficult for them to talk about suicidal ideation.

Ethnicity and culture

Having a different physical appearance, e.g. skin colour, compared to the average physical appearance in the peer group might be a stressful experience for children and lead to exclusion (157).

Culture can affect the way in which people describe their symptoms and the meaning people give to mental illness and the way they make sense of it and cope with it (193). An example is nonsuicidal self-injury. It is often used in children to regulate emotions. The way it is performed might vary based on the cultural background. E.g. in Western society nonsuicidal self-injury is often done by cutting the skin. Children from the Middle East instead hit their hands or heads against a wall or hit themselves (194).

Exposure to traumatic events

Children experiencing multiple and prolonged exposure to traumatic events have a higher risk to develop PTSS or PTSD and show more severe symptoms (22,27). In a study in refugee minors in Germany the number of traumatic events experienced was significantly associated with severity of PTSD symptoms and guilt related distress, which was linked to greater suffering and functional impairment (22). Another study in Germany showed that exposure to violent family separation was particularly significant in predicting internalizing symptoms (27). A study with children below the age of five in Germany found that maternal hair cortisol concentration (HCC), PTSS and affection played a major role in understanding children's HCC and PTSS, whereas children's flight experiences did not show relevant effects (33).

So far longitudinal studies are scarce (184) and inconsistent. A systematic review on longitudinal studies of PTSD among refugee youth found that symptoms and diagnoses of PTSD are relatively consistent over time (195). A prospective cohort study on asylum seeking children in Germany found a significant decline of psychological distress after 1 year, but symptoms still remained on a high level (71). This is in line with a long term (8-9 years) follow up study on refugee children in Denmark (196). A study on adult refugees in Germany showed no significant change in PTSD symptoms over the course of 1 year (184). Following Kaltensbach's review of international evidence on adults, findings of longitudinal studies in refugee populations vary immensely. Results range from improving to unchanging to aggravating mental health symptoms over time (184).

Experts report that PTSD, when existing over a longer period of time, becomes chronic in 30% of cases, whereas with adequate treatment it will last on average 36 months and without adequate treatment 64 months (197).

6 Discussion

This thesis focuses on the analysis of risk and protective factors affecting the mental health and psychosocial well-being of refugee children in Germany, with special attention to pre-school children. This is of particular importance as Germany experienced an enormous influx of refugees from Syria, Afghanistan and Iraq since 2015 and pre-school children represent the majority of children who arrived.

The protective and risk factors operate on various levels and are part of one conceptual framework described in Figure 2. In the following, the **main results** are discussed in the context of current literature, with practical implications and good practise examples.

ECEC is an important protective factor for mental health and the psychosocial well-being of refugee children and their families

Access to good quality ECEC has a positive effect on refugee children's mental health and psychosocial well-being by meeting important needs (e.g. providing a daily structure and stability) (105), promoting the children's development and reducing inequalities between them and their local peers(e.g. through facilitating language acquisition) (106). Furthermore, ECEC is an important driver for future success in school (107).

Additionally, it plays an important role for the integration of the family into the German society. The successful integration is facilitated by particularly refugee mothers being able to attend language classes, while their children are being cared for in ECEC (102). This increases the mothers' chances to join the regular work force in Germany (116).

In addition to access to ECEC, its quality is important. As shown in Section 5.2, ECEC might be a source of negative experiences in cases when e.g. the children are not adequately supervised by trained staff. Refugee children and their families might experience exclusion and racism, which might have a negative impact on their mental health and psychosocial well-being. In Germany there is a general shortage of ECEC places. Refugee parents who are dependent on child care might not dare to point out racism or inequalities that they and their children might experience.

Practical implications

Participating in ECEC creates opportunities for social encounters, for facilitating reduction in prejudice between parents of refugee and non refugee children and for supporting the building of inclusive communities. Furthermore, ECEC staff could play an important role in the early detection of psychological symptoms, and in guiding parents to find adequate help for their children should they need it. Therefore, high quality training standards and supervision of ECEC staff is crucial.

The pathway to entering the ECEC system varies between different Federal States or even on a city level. The complexity of the system is a relevant barrier for refugee children. As children attending ECEC are below the compulsory school age, gaps in services and obstacles

to access may be invisible at the policy level. Policy makers need to address the lack of available places, the demand for high quality training and the complexity of the registration process, as well as the barriers to ECEC. on the side of the refugee parents.

According to German law, every child has "a right to the promotion of his or her development and to education to become an independent and socially capable personality" (50). Having access to child-friendly spaces is an important factor for the healthy development of a child. The concept of child-friendly spaces was initially developed by the United Nations Children's Fund (UNICEF) to provide a safe space for children to play, learn and experience a sense of normality in times of crisis (e.g. at the outskirts of war zones). These spaces may provide the children with a sense of structure (e.g. daily routine), psychosocial support, and a sense of security. Furthermore, the trained staff running theses spaces may identify children that are particularly stressed and that require professional help. Over the years, the concept has proven to be very effective in a range of contexts and is now implemented in non-emergency situations as well. To show how child-friendly spaces can be implemented in a variety of settings in Germany, UNICEF launched a study in three refugee accommodation centres to document promising practices in different circumstances and contexts (198). In order to meet the demands and rights of the refugee children, Germany initiated several support programmes on a national level (e.g. "Kita-Einstieg" and "Sprach-Kita"). However, wide-spread implementation is lacking and programmes are will not continue in 2023. This is mainly due to the lack of adequately trained staff, limited financial resources, and the short funding period of these programmes (199–201).

"**Kita-Einstieg**" (ECEC Entry): a programme that works with families in collective accommodations who are unfamiliar with the German ECEC system. This programme promotes services that prepare families to access ECEC services and strives to reduce barriers for underserved families at a local level (201).

"**Sprach-Kita**" (Language ECEC): a programme which provides language education in ECEC to allow refugee children and other disadvantaged children to reach more equal opportunities with their peers (202).

Parental mental health issues have a substantial negative impact on the children's well-being

Mental health issues of refugee children's parents have a negative impact on their children's mental health and psychosocial well-being (166–169). Reasons include: an increase of intra-family violence (168,172,173), the use of more negative parenting practices, such as harsh parenting (168,174), or the inability of the parents to provide an environment that meets the children's needs (25,58). Reasons for the latter might include mental health issues of the parents due to the trauma they experienced in the past and the stress they face because of PMS. All of this is linked to higher levels of mental health problems in children. Furthermore, we know that perinatal mental health disorders negatively impact mother-infant attachment (177).

Evidence for the above stems mostly from international research. We do not have data regarding e.g. prevalence of intra-family violence in refugee families in Germany. So far we

just have data that points in the direction that PMS increases the probability of intra-family violence (25,100).

The negative effect of parental mental health issues on children's mental health is well in line with established evidence from non-refugee populations. However, prevalence rates indicate that refugee parents are disproportionally affected by mental health problems in comparison to the general German population (69).

This makes refugee children especially vulnerable. A key area to invest in in order to protect the mental health of refugee children is the mental health of their parents. In Germany, this is challenged by the disconnect between GAP and CAP, the lack of screening for mental health issues after arriving in Germany, and the barriers (described in detail in Section 5.1) to mental health services.

Frounfelker and colleagues described that "interventions that represent an added burden for the parents or caregivers may be counterproductive, as are parenting courses, which are often perceived as reflecting the prejudices and normative practices of the host society. For these reasons, embedding early-childhood interventions within extended social networks, schools, and the larger community is beneficial". Given the relationship between family functioning and mental health of parents and children, interventions situated in families that target the well-being of entire refugee families are needed (30). However, so far, although knowing the importance of processes on the family level (such as family relationships, communication, and resilience) little attention has been given to interventions for refugee children that address such family dynamics (203).

As the negative effect of parental mental health problems on children's mental health is a universal problem, some GAPs in Germany offer programmes to meet the needs of this families (e.g. out patient groups for pregnant women with mental illness, mentor programmes for children with mentally ill parents) (204). Furthermore, federal subsidised research is carried out to evaluate intervention that could reduce the negative impact of the parental mental illness on the child (205). Even though this topic got more attention during the last decade, there is still considerable need to improve collaborations between different stakeholders, e.g. the health care sector, the youth welfare system and other support systems in Germany (206). In the existing programmes, no specific attention is given to refugee parents and barriers they might experience to this programmes.

Practical implications

Professionals that regularly come in contact with refugee families, such as general practitioners, midwives, gynaecologists and paediatricians could play a crucial role in the identification of mental health problems and stressful family situations. Therefore these professionals would need specific training on the topic and clear referral pathways to psychiatric and psychotherapeutic care systems have to be set up. Furthermore, research should pay attention to the specific needs of refugee families, when looking on implementation of programmes. However, this needs first have to be identified.

Experience of and coping with trauma is an important factor for the mental health of refugee children

As described in chapters 1.35.45.35.2, experiencing trauma may have a negative impact on the mental health of a child. Some may develop PTSS which is characterized by e.g. aggressive behaviour and the inability to concentrate. This may impair the child's learning capacity and lead to exclusion in group environments, e.g. ECEC. Furthermore, parents might not be well equipped to deal with their child's behavioural issues. Studies indicate that children who already show signs of mental health issues, e.g. emotional and behaviour problems, are at particularly high risk of experiencing maltreatment at home. Parents might be overwhelmed with the challenging behaviour and respond with threats and violence due to the feeling of helplessness. Thus PTSS has a wide impact on the direct family and in return on the child itself (e.g. lack of positive social encounters) and might create a vicious cycle.

Data on the prevalence and life course of PTSS in refugee children in Germany is still lacking 1.3. Also data an coping styles and resources (individual and contextual) that help refugee children to become more resilient 5.4 is lacking.

Practical implication

Early detection of psychological symptoms in refugee children are important so they can develop their full potential. Refugee parents and other adults that come regularly in contact with refugee children, e.g. ECEC teachers, must know about the symptoms and have low threshold access to diagnostic and treatment. Therefore barriers mentioned in Section 5.1 need to be addressed. Additionally, more research is needed into the mental health needs of refugee children in ECEC programmes (148), as ECEC programmes play such an important role for refugee children.

The massive impact of pre-resettlement traumatic experiences calls for trauma-focused treatments. Good evidence does exist for trauma-focused treatments in refugee children such as narrative exposure therapy, child-centred play therapy and trauma-focused cognitive-behavioural therapy (207,208). Efforts are made to systematically compare different methods (209). Other innovative therapies, such as the Trauma Systems Therapy for Refugees, which focuses on both, the child and it's social environment context, seem to be effective not only in reduction of psychological symptoms but also the engagement for refugee children in services (210). Lack of personnel might need innovative methods, it might be useful to take a stepped care approach similar to the one in Mental Health and Psychosocial Support (MHPSS) (10). Implementing new tools, however, would require more evaluative research and a major shift in service models.

Example: In refugee-accommodations in Hamburg a child-and adolescent psychiatrist offers a regular consultation hour and a low threshold parent group about child development, offering parents and children direct help and referring them to other specialists if necessary (211).

Research into the life course of mental health and psychosocial well-being of refugee children is urgently needed

So far, longitudinal studies on refugee children's mental health in general, and specifically in Germany are lacking 5.4. Particularly the needs of pre-school refugees are not well understood. Children born to refugee parents in Germany receive the status of a refugee. Currently, we do understand well which factors are the most relevant for the mental health of a child, i.e. do children born in Germany to refugee parents have the same risk of developing a psychiatric disorder compared to children who have actively fled a country. Furthermore, we need more research into the most vulnerable time periods in a child's life in order to adjust our support systems to be delivered at the most effective time points.

Furthermore, we do not know much about factors shaping the resilience of refugee children in Germany. As resilience is a dynamic process driven by time and context specific variables it is more complex than the balance between risk and protective factors. Studies of resilience in refugee children show that although there are some universal resilience processes, resilience in young refugees has substantial variability (203).

Lack of national strategies

As described in chapter 5.1 mental health of refugee is not sufficiently addressed on various levels of the public health system in Germany. In contrast to other countries, e.g. Canada (212) and England(213) , Germany does not have a nationally representative public health body (214) nor a national strategy or policy that refers to migrant/refugee mental health. Furthermore, research on refugee an forced migration studies in Germany is fragmented and exchange between relevant stakeholders is lacking.

Looking on the European level, Germany is not alone expressing concerns about its public health competencies and infrastructure for research and teaching (215).

Examples:

Nationally coordinated projects, such as the immigrant and refugee mental health project in Canada (216) and a national research agenda on mental health for refugees, as the one of Australia (217), could, amongst others, help to address knowledge gaps and priorities research.

Main limitations of the study

It is of note that studies and publications, especially from NGOs focus on the negative aspects of mental health in refugees in order to identify areas that require improving. Relevant aspects that already work well tend not to receive equal attention. This might cause a bias in assessing the needs of refugees in Germany and might create an impression of the situation that is worse than it is in reality.

Current evidence is largely based on cross-sectional studies without comparison groups, which preclude firm conclusions on the direction of associations between presumed factors of influence and outcomes.

Furthermore, many studies used are of rather small sample size and differ widely in instruments and classifications used, their cross cultural validity and primary outcomes. Most important, studies vary greatly in how populations are defined as refugees. This made it sometimes impossible to differentiate between AS and refugee.

As Germany's 16 Federal States differ substantially in the implication of specific laws and guidelines, as well as in financial resources, the situation of refugee families does differ widely.

7 Conclusion and Recommendations

Germany witnessed a tremendous influx of refugees in 2015. Of these, approximately 40% were children. Mental health and psychosocial needs of this vulnerable populations are often not met as key factors influencing them are not identified or sufficiently addressed. This varies substantially between Federal States and municipalities.

Bronfenberenner's conceptual framework worked well to identify, explore and analyse the different risk and protective factors affecting children's mental health and psychosocial well-being in Germany on all 4 levels (individual/child, family, community, and institution & policy).

Interventions that reduce risk factors and promote resilience on one level will have an effect. However, due to the interdependencies of factors affecting mental health and psychosocial well-being, multi-layered interventions are needed, focusing on the individual and the context.

Furthermore, Bronfenbrenner's conceptual framework points to the potential of interventions on one level to have influence on other levels and thus possibly to synergise effects.

ECEC is an important protective factor for mental health and psychosocial well-being of refugee children and their families. According to German law, every child has a right to access to ECEC services after its first birthday. However, there is a shortage of available places and the access pathways are complex and often a barrier for refugee parents (e.g. due to language and cultural barriers). Germany has addressed this problem with specific programmes targeting refugee families ('Kita Einstieg' and 'Sprach-Kita'). However, these programmes were not implemented nationwide, are not sufficiently financed and will run out by the end of the year 2022.

The conceptual framework emphasises the crucial role of the family on refugee children's mental health and psychosocial well-being and calls for interventions on this level. Appropriate interventions have yet to be evaluated.

Parental mental health problems have a substantial negative impact on the children's well-being. Hence, strategies focusing on mental well-being of children need to include the parental mental health and their attitudes towards accessing mental health care services.

Some of the factors influencing mental health are universal and well in line with established evidence from non-refugee populations (e.g. the effect of parental mental health on children's mental health), thus addressing them might not only help refugees but strengthen public health for all children in Germany.

Experience of and coping with trauma is an important factor for mental health and psychosocial well-being of refugee children. Early detection of mental health problems, regular check ups and access to adequate low threshold treatment is necessary. Furthermore, known risk factors have to be reduced and mental health and psychosocial well-being promoted. ECEC teachers, as well as midwives, general practitioners and other adults,

refugee families come regularly in contact with, should play an important role in the early detection of mental health problems as well as in the promotion of mental health and psychosocial well-being.

Appropriate treatment options for mental health problems do exist. Germany has to reduce barriers affecting access to these treatment options, as long-term consequences of mental health problems have a huge impact on the individual, their family and the German society.

To meet the above outlined challenges in addressing the complex needs of refugee children, Germany needs to adopt a more public health approach. This should include appropriate screening programmes for mental health issues on a larger scale, stepped care, task sharing, and task shifting. The latter methods were developed in global mental health and have previously proven to be successful. Furthermore, Germany needs to train both mental healthcare professionals and ECEC teachers and social workers, who can incorporate the approach in their daily work. The public health sector should play a leading role in this.

So far, longitudinal studies on refugee children's mental health in general, and specifically in Germany are lacking. Particularly the needs of pre-school refugees are not well understood. We need more research into the most vulnerable time periods in a child's life in order to adjust our support systems to be delivered at the most effective time points. Furthermore, we do not know much about factors shaping the resilience of refugee children. As resilience is a dynamic process driven by time and context specific variables, it is more complex than the balance between risk and protective factors. A national research agenda could help to address knowledge gaps and coordinate the required tasks from each stakeholder.

7.1 Recommendations

Improve access to high quality ECEC services

- Provide ECEC places for all children, including refugee children. This requires an increased funding of ECEC from both the German government and the local authorities;
- Simplify access to ECEC for refugee families. It is recommended that the local authorities promote services that prepare families to access ECEC services and to reduce barriers for refugee families;
- Improve quality of ECEC, train staff on meeting the psychosocial needs of refugee children, provide extra staff for language training for non native speakers;
- Use ECEC services as a platform for social encounters and facilitating reduction in prejudice between parents of refugees and non-refugees;

Decreasing barriers to mental health services

- Provide low threshold psychoeducation of parents on early symptoms of mental health issues of their children;

- Provide easy access to mental health professionals outside of the psychiatric institutions, e.g. through regular consultation hours in community accommodations;

Early detection and treatment of mental health issues

- Implement appropriate screening for mental health issues in adult and children refugees upon arrival in Germany;
- Provide regular follow-ups for vulnerable refugees;
- Provide sufficient mental health care to refugees with a psychiatric disorder. This will require training of mental health professionals in treating trauma-related disorders;
- Close gap between GAP and CAP through joint outpatient clinics and joint training programmes;

Research

- Research designs are needed that enable longitudinal investigations of the individual, community and societal context.
- Develop a national research strategy with all important stakeholders, including refugees.

References

1. United Nations. *Convention on the Rights of the Child*. Nov 20, 1989. https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-child

2. *APA Dictionary of Psychology*. https://dictionary.apa.org/ [Accessed 10th August 2022].

3. Bundeszentrale für politische Bildung. *Migrant*. https://www.bpb.de/kurz-knapp/lexika/glossar-migration-integration/270612/migrant/

4. *Bevölkerung_Migration und Integration*. https://www.destatis.de/DE/Themen/Gesellschaft-Umwelt/Bevoelkerung/Migration-Integration/_inhalt.html?__blob=publicationFile

5. Refugees UNHC for. *What is a refugee?*. UNHCR. https://www.unhcr.org/what-is-a-refugee.html [Accessed 10th August 2022].

6. American Psychological Association. *Resilience*. https://www.apa.org/topics/resilience [Accessed 26th July 2022].

7. World Health Organization. *Promoting Mental Health*. Geneva: World Health Organization; 2004. https://public.ebookcentral.proquest.com/choice/publicfullrecord.aspx?p=4978588 [Accessed 20th July 2022].

8. Centers for Disease Control and Prevention. *Children's Mental Health*. https://www.cdc.gov/childrensmentalhealth/features/mental-health-children-and-parents.html [Accessed 25th July 2022].

9. American Psychological Association. *Children's mental health*. https://www.apa.org/topics/child-development/mental-health [Accessed 25th July 2022].

10. Carll EK. *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*. American Psychological Association; 2008. https://doi.org/10.1037/e518422011-002. [Accessed 4th August 2022].

11. Eurostat. *Asylum and first time asylum applicants - annual aggregated data (rounded)*. 2022. https://ec.europa.eu/eurostat/databrowser/view/tps00191/default/table?lang=en

12. Bundesamt für Migration und Flüchtlinge. *Das Bundesamt in Zahlen 2015: Asyl, Migration und Integration*. 2016 Sep. https://www.bamf.de/SharedDocs/Anlagen/DE/Statistik/BundesamtinZahlen/bundesamt-in-zahlen-2015.pdf

13. Bundesamt für Migration und Flüchtlinge. *Das Bundesamt in Zahlen 2016: Asyl, Migration und Integration*. 2017 Aug. https://www.bamf.de/SharedDocs/Anlagen/DE/Statistik/BundesamtinZahlen/bundesamt-in-zahlen-2016.pdf

14. Bundesamt für Migration und Flüchtlinge. *Das Bundesamt in Zahlen 2017: Asyl, Migration und Integration*. 2018 Aug. https://www.bamf.de/SharedDocs/Anlagen/DE/Statistik/BundesamtinZahlen/bundesamt-in-zahlen-2017.pdf

15. Bundesamt für Migration und Flüchtlinge. *Das Bundesamt in Zahlen 2018: Asyl, Migration und Integration*. 2019 Aug. https://www.bamf.de/SharedDocs/Anlagen/DE/Statistik/BundesamtinZahlen/bundesamt-in-zahlen-2018.pdf

16. Bundesamt für Migration und Flüchtlinge. *Das Bundesamt in Zahlen 2019: Asyl, Migration und Integration*. 2020 Aug. https://www.bamf.de/SharedDocs/Anlagen/DE/Statistik/BundesamtinZahlen/bundesamt-in-zahlen-2019.pdf

17. Bundesamt für Migration und Flüchtlinge. *Das Bundesamt in Zahlen 2020: Asyl, Migration und Integration*. 2021 Sep. https://www.bamf.de/SharedDocs/Anlagen/DE/Statistik/BundesamtinZahlen/bundesamt-in-zahlen-2020.pdf

18. Bundesamt für Migration und Flüchtlinge. *Das Bundesamt in Zahlen 2021: Asyl*. 2022 Feb. https://www.bamf.de/SharedDocs/Anlagen/DE/Statistik/BundesamtinZahlen/bundesamt-in-zahlen-2021-asyl.pdf

19. UNICEF. *Geflüchtete und migrierte Kinder in Deutschland: Ein Überblick über die Trends seit 2015*. 2020 Dec [Accessed 4th August 2022]. https://www.unicef.de/blob/178376/af4894387fd3ca4ec6259919eefdde2d/gefluechtete-und-migrierte-kinder-in-deutschland-2015-2018-data.pdf [Accessed 4th August 2022].

20. Statista. *Gesamtschutzquote: Anteil der als Flüchtling oder asylberechtigt anerkannten Asylbewerber in Deutschland von 2005 bis 2022*. https://de.statista.com/statistik/daten/studie/452067/umfrage/gesamtschutzquote-der-asylbewerber-in-deutschland/

21. Snider L, Hijazi Z. UNICEF Community-Based Mental Health and Psychosocial Support (MHPSS) Operational Guidelines. In: Song SJ, Ventevogel P (eds.) *Child, Adolescent and Family Refugee Mental Health: A Global Perspective*. Cham: Springer International Publishing; 2020. p. 101–119. https://doi.org/10.1007/978-3-030-45278-0_7. [Accessed 7th August 2022].

22. Stotz SJ, Elbert T, Müller V, Schauer M. The relationship between trauma, shame, and guilt: findings from a community-based study of refugee minors in Germany. *European Journal of Psychotraumatology*. 2015;6(1): 25863. https://doi.org/10.3402/ejpt.v6.25863.

23. Gavranidou M, Niemiec B, Magg B, Rosner R. Traumatische Erfahrungen, aktuelle Lebensbedingungen im Exil und psychische Belastung junger Flüchtlinge. *Kindheit und Entwicklung*. 2008;17(4): 224–231. https://doi.org/10.1026/0942-5403.17.4.224.

24. BundesPsychotherapeutenKammer. *BPtK-Standpunkt: Psychische Erkrankungen bei Flüchtlingen*. 2015 Sep [Accessed 6th December 2021]. https://www.bptk.de/wp-

content/uploads/2019/01/20150916_bptk_standpunkt_psychische_erkrankungen_fluechtlinge.pdf [Accessed 6th December 2021].

25. Fegert JM, Diehl C, Leyendecker B, Hahlweg K, Wissenschaftliche Beirat. *Aus Kriegsgebieten geflüchtete Familien und ihre Kinder: Entwicklungsrisiken, Behandlungsangebote, Versorgungsdefizite*. 2017 Sep p. 6. https://www.bmfsfj.de/blob/119734/9715f720b0090d71d4cbe797586a9cec/kurzgutachten-gefluechtete-familien-data.pdf

26. Myles P, Swenshon S, Haase K, Szeles T, Jung C, Jacobi F, et al. A comparative analysis of psychological trauma experienced by children and young adults in two scenarios: evacuation after a natural disaster vs forced migration to escape armed conflict. *Public Health*. 2018;158: 163–175. https://doi.org/10.1016/j.puhe.2018.03.012.

27. EL-Awad U, Reinelt T, Braig J, Nilles H, Kerkhoff D, Schmees P, et al. Polytraumatization in young male refugees from the Middle East and its association with internalizing and externalizing symptoms. *Child and Adolescent Psychiatry and Mental Health*. 2021;15(1): 75. https://doi.org/10.1186/s13034-021-00428-9.

28. Mayo Clinic. *Post-traumatic stress disorder (PTSD) - Symptoms and causes*. Mayo Clinic. https://www.mayoclinic.org/diseases-conditions/post-traumatic-stress-disorder/symptoms-causes/syc-20355967 [Accessed 4th August 2022].

29. Keilson H. *Sequential Traumatization in Children: A Clinical and Statistical Follow-up Study on the Fate of the Jewish War Orphans in the Netherlands*. 1992.

30. Frounfelker RL, Miconi D, Farrar J, Brooks MA, Rousseau C, Betancourt TS. Mental Health of Refugee Children and Youth: Epidemiology, Interventions, and Future Directions. *Annual Review of Public Health*. 2020;41(1): 159–176. https://doi.org/10.1146/annurev-publhealth-040119-094230.

31. Baron J, Flory L, Krebs D. *Versorgungsbericht: Zur psychosozialen Versorgung von Flüchtlingen und Folteropfern in Deutschland*. 2016. https://www.baff-zentren.org/wp-content/uploads/2017/02/Versorgungsbericht_3-Auflage_BAfF.pdf

32. Pacione L, Measham T, Rousseau C. Refugee Children: Mental Health and Effective Interventions. *Current Psychiatry Reports*. 2013;15(2): 341. https://doi.org/10.1007/s11920-012-0341-4.

33. Lembcke H, Buchmüller T, Leyendecker B. Refugee mother-child dyads’ hair cortisol, post-traumatic stress, and affectionate parenting. *Psychoneuroendocrinology*. 2020;111: 104470. https://doi.org/10.1016/j.psyneuen.2019.104470.

34. Blackmore R, Gray KM, Boyle JA, Fazel M, Ranasinha S, Fitzgerald G, et al. Systematic Review and Meta-analysis: The Prevalence of Mental Illness in Child and Adolescent Refugees and Asylum Seekers. *Journal of the American Academy of Child & Adolescent Psychiatry*. 2020;59(6): 705–714. https://doi.org/10.1016/j.jaac.2019.11.011.

35. Bronstein I, Montgomery P. Psychological Distress in Refugee Children: A Systematic Review. *Clinical Child and Family Psychology Review*. 2011;14(1): 44–56. https://doi.org/10.1007/s10567-010-0081-0.

36. Kien C, Sommer I, Faustmann A, Gibson L, Schneider M, Krczal E, et al. Prevalence of mental disorders in young refugees and asylum seekers in European Countries: a systematic review. *European Child & Adolescent Psychiatry*. 2019;28(10): 1295–1310. https://doi.org/10.1007/s00787-018-1215-z.

37. Perkonigg A, Kessler RC, Storz S, Wittchen HU. Traumatic events and post-traumatic stress disorder in the community: prevalence,risk factors and comorbidity: Post-traumatic stress disorder in the community. *Acta Psychiatrica Scandinavica*. 2000;101(1): 46–59. https://doi.org/10.1034/j.1600-0447.2000.101001046.x.

38. Hoell A, Kourmpeli E, Salize HJ, Heinz A, Padberg F, Habel U, et al. Prevalence of depressive symptoms and symptoms of post-traumatic stress disorder among newly arrived refugees and asylum seekers in Germany: systematic review and meta-analysis. *BJPsych Open*. 2021;7(3): e93. https://doi.org/10.1192/bjo.2021.54.

39. Blackmore R, Boyle JA, Fazel M, Ranasinha S, Gray KM, Fitzgerald G, et al. The prevalence of mental illness in refugees and asylum seekers: A systematic review and meta-analysis. Spiegel P (ed.) *PLOS Medicine*. 2020;17(9): e1003337. https://doi.org/10.1371/journal.pmed.1003337.

40. Peconga E k., Høgh Thøgersen M. Post-traumatic stress disorder, depression, and anxiety in adult Syrian refugees: What do we know? *Scandinavian Journal of Public Health*. 2020;48(7): 677–687. https://doi.org/10.1177/1403494819882137.

41. Fazel M, Wheeler J, Danesh J. Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. *The Lancet*. 2005;365(9467): 1309–1314. https://doi.org/10.1016/S0140-6736(05)61027-6.

42. Attanayake V, McKay R, Joffres M, Singh S, Burkle F, Mills E. Prevalence of mental disorders among children exposed to war: a systematic review of 7,920 children. *Medicine, Conflict and Survival*. 2009;25(1): 4–19. https://doi.org/10.1080/13623690802568913.

43. Gäbel U, Ruf M, Schauer M, Odenwald M, Neuner F. Prävalenz der Posttraumatischen Belastungsstörung (PTSD) und Möglichkeiten der Ermittlung in der Asylverfahrenspraxis. *Zeitschrift für Klinische Psychologie und Psychotherapie*. 2006;35(1): 12–20. https://doi.org/10.1026/1616-3443.35.1.12.

44. Hörnlein K, Stellermann-Strehlow K. Kinder im Krieg: ‘Wir sehen viele körperliche Reaktionen bei geflüchteten Kindern’. *Die Zeit*. Hamburg; 2022. https://www.zeit.de/zeit-magazin/leben/2022-05/kinder-krieg-flucht-trauma-kinderpsychiaterin [Accessed 6th August 2022].

45. Bean T, Derluyn I, Eurelings-Bontekoe E, Broekaert E, Spinhoven P. Comparing Psychological Distress, Traumatic Stress Reactions, and Experiences of Unaccompanied Refugee Minors With Experiences of Adolescents Accompanied by Parents. *Journal of Nervous & Mental Disease*. 2007;195(4): 288–297. https://doi.org/10.1097/01.nmd.0000243751.49499.93.

46. Möhrle B, Dölitzsch C, Fegert JM, Keller F. Verhaltensauffälligkeiten und Lebensqualität bei männlichen unbegleiteten minderjährigen Flüchtlingen in Jugendhilfe einrichtungen in Deutschland. *Kindheit und Entwicklung*. 2016;25(4): 204–215. https://doi.org/10.1026/0942-5403/a000206.

47. Müller LRF, Büter KP, Rosner R, Unterhitzenberger J. Mental health and associated stress factors in accompanied and unaccompanied refugee minors resettled in Germany: a cross-sectional study. *Child and Adolescent Psychiatry and Mental Health*. 2019;13(1): 8. https://doi.org/10.1186/s13034-019-0268-1.

48. Buchmüller T, Lembcke H, Busch J, Kumsta R, Leyendecker B. Exploring Mental Health Status and Syndrome Patterns Among Young Refugee Children in Germany. *Frontiers in Psychiatry*. 2018;9: 212. https://doi.org/10.3389/fpsyt.2018.00212.

49. Soykoek S, Mall V, Nehring I, Henningsen P, Aberl S. Post-traumatic stress disorder in Syrian children of a German refugee camp. *The Lancet*. 2017;389(10072): 903–904. https://doi.org/10.1016/S0140-6736(17)30595-0.

50. Bundesministerium der Justiz. *SGB VIII § 1 Recht auf Erziehung, Elternverantwortung, Jugendhilfe*. Sozialgesetzbuch Jun 26, 1990. https://www.gesetze-im-internet.de/sgb_8/__1.html

51. Bundesministerium der Justiz. *SGB VIII § 6 Geltungsbereich*. Sozialgesetzbuch Jun 26, 1990. https://www.gesetze-im-internet.de/sgb_8/__6.html

52. European Parliament. *Charter of Fundamental Rights of the European Union*. C 364 Dec 18, 2000. https://www.europarl.europa.eu/charter/pdf/text_en.pdf [Accessed 6th August 2022].

53. *Latest Asylum Trends*. European Union Agency for Asylum. https://euaa.europa.eu/latest-asylum-trends-asylum [Accessed 8th August 2022].

54. *Sharp rise in asylum applications in Germany*. InfoMigrants. https://www.infomigrants.net/en/post/37803/sharp-rise-in-asylum-applications-in-germany [Accessed 8th August 2022].

55. Berg A, Lachman A, Voges J. Infant Mental Health in Africa. In: *Understanding Uniqueness and Diversity in Child and Adolescent Mental Health*. 2018. p. 167–193. https://doi.org/10.1016/B978-0-12-815310-9.00007-1.

56. vom Felde L, Flory L, Baron J. *Identifizierung besonderer Schutzbedürftigkeit am Beispiel von Personen mit Traumafolgestörungen. Status quo in den Bundesländern, Modelle und Herausforderungen.* 2020 Jun. https://www.baff-zentren.org/wp-content/uploads/2020/11/BAfF_Reader_Identifizierung.pdf

57. Gewaltschutz in Unterkünften für geflüchtete Menschen. : 6.

58. Walther L, Rayes D, Amann J, Flick U, Ta TMT, Hahn E, et al. Mental Health and Integration: A Qualitative Study on the Struggles of Recently Arrived Refugees in Germany. *Frontiers in Public Health*. 2021;9: 576481. https://doi.org/10.3389/fpubh.2021.576481.

59. König H, Rommel A, Thom J, Schmidt C, König HH, Brettschneider C, et al. The Excess Costs of Depression and the Influence of Sociodemographic and Socioeconomic Factors: Results from the German Health Interview and Examination Survey for Adults (DEGS). *Pharmacoeconomics*. 2021;39(6): 667–680. https://doi.org/10.1007/s40273-021-01000-1.

60. DGPPN. *Basisdaten Psychische Erkrankungen*. 2022. https://www.dgppn.de/_Resources/Persistent/be8589427bb02b67f5592b73cbb4d32cde26d0be/Factsheet_Kennzahlen%202022.pdf [Accessed 8th August 2022].

61. *Mental Health | Healthy People 2020*. https://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Mental-Health [Accessed 8th August 2022].

62. Lereya ST, Patel M, dos Santos JPGA, Deighton J. Mental health difficulties, attainment and attendance: a cross-sectional study. *European Child & Adolescent Psychiatry*. 2019;28(8): 1147–1152. https://doi.org/10.1007/s00787-018-01273-6.

63. Hebebrand J, Anagnostopoulos D, Eliez S, Linse H, Pejovic-Milovancevic M, Klasen H. A first assessment of the needs of young refugees arriving in Europe: what mental health professionals need to know. *European Child & Adolescent Psychiatry*. 2016;25(1): 1–6. https://doi.org/10.1007/s00787-015-0807-0.

64. *Mental Health and Substance Use Co-Occurring Disorders | MentalHealth.gov*. https://www.mentalhealth.gov/what-to-look-for/mental-health-substance-use-disorders [Accessed 8th August 2022].

65. Hope H, Pierce M, Johnstone ED, Myers J, Abel KM. The sexual and reproductive health of women with mental illness: a primary care registry study. *Archives of Women's Mental Health*. 2022;25(3): 585–593. https://doi.org/10.1007/s00737-022-01214-y.

66. *Understanding Mental Health as a Public Health Issue*. https://publichealth.tulane.edu/blog/mental-health-public-health/ [Accessed 8th August 2022].

67. Hynie M. The Social Determinants of Refugee Mental Health in the Post-Migration Context: A Critical Review. *The Canadian Journal of Psychiatry*. 2018;63(5): 297–303. https://doi.org/10.1177/0706743717746666.

68. Arakelyan S, Ager A. Annual Research Review: A multilevel bioecological analysis of factors influencing the mental health and psychosocial well-being of refugee children. *Journal of Child Psychology and Psychiatry*. 2021;62(5): 484–509. https://doi.org/10.1111/jcpp.13355.

69. Scharpf F, Kaltenbach E, Nickerson A, Hecker T. A systematic review of socio-ecological factors contributing to risk and protection of the mental health of refugee children and adolescents. *Clinical Psychology Review*. 2021;83: 101930. https://doi.org/10.1016/j.cpr.2020.101930.

70. Walther L, Fuchs LM, Schupp J, von Scheve C. Living Conditions and the Mental Health and Well-being of Refugees: Evidence from a Large-Scale German Survey.

Journal of Immigrant and Minority Health. 2020;22(5): 903–913. https://doi.org/10.1007/s10903-019-00968-5.

71. Müller LRF, Gossmann K, Hartmann F, Büter KP, Rosner R, Unterhitzenberger J. 1-year follow-up of the mental health and stress factors in asylum-seeking children and adolescents resettled in Germany. *BMC Public Health*. 2019;19(1): 908. https://doi.org/10.1186/s12889-019-7263-6.

72. Razum O, Bozorgmehr K. Restricted entitlements and access to health care for refugees and immigrants: The example of Germany. *Global Social Policy*. 2016;16(3): 321–324. https://doi.org/10.1177/1468018116655267.

73. Baron J, Flory L, Krebs D. *Living in a box. Psychosoziale Folgen des Lebens in Sammelunterkünften für Geflüchtete Kinder*. 2020 [Accessed 5th November 2021]. https://www.baff-zentren.org/wp-content/uploads/2020/05/BAfF_Living-in-a-box_Kinder-in-Ankerzentren.pdf [Accessed 5th November 2021].

74. Lewek M, Naber A. *Kindheit im Wartezustand: Studie zur Situation von Kindern und Jugendlichen in Flüchtlingsunterkünften in Deutschland*. 2017. https://www.unicef.de/informieren/aktuelles/presse/2017/studie-fluechtlingskinder-in-deutschland/137440

75. Keller AM, Hajji R. Die psychische Gesundheit von Geflüchteten in Deutschland: Zur Rolle der Lebenszufriedenheit als Mediator zwischen dem Gefühl „willkommen zu sein“ und der psychischen Gesundheit. *Prävention und Gesundheitsförderung*. 2021;16(4): 354–360. https://doi.org/10.1007/s11553-021-00833-0.

76. World Health Organization. Regional Office for Europe. *Building resilience: a key pillar of Health 2020 and the Sustainable Development Goals: examples from the WHO Small Countries Initiative*. World Health Organization; 2017. https://apps.who.int/iris/handle/10665/338752 [Accessed 6th August 2022].

77. Bronfenbrenner U, Evans GW. Developmental science in the 21st century: Emerging questions, theoretical models, research designs and empirical findings. *Social Development*. 2000;9(1): 115–125. https://doi.org/10.1111/1467-9507.00114.

78. German Federal Government. *Global Health Strategy of the German Federal Government*. Report number: BMG-G-11125, 2020 Oct p. 44. https://www.bundesgesundheitsministerium.de/service/publikationen/details/global-health-strategy-of-the-german-federal-government.html

79. Knipper M, Bozorgmehr K, Offe J, Orcutt M. Germany’s new global health strategy: leaving migrants behind. *The Lancet*. 2021;397(10268): 20–21. https://doi.org/10.1016/S0140-6736(20)32546-0.

80. European Migration Network. *Mapping of mental health policies for third-country national migrants*. 2022 Jul [Accessed 16th July 2022]. https://www.bamf.de/SharedDocs/Anlagen/EN/EMN/FlashInformSyntheseberichte/Inform/emn-inform-psychische-gesundheit-migrant-innen.html [Accessed 16th July 2022].

81. Kleist J, Engler M, Etzold B, Mielke K, Oltmer J, Pott A, et al. *Flucht-und Flüchtlingsforschung in Deutschland. Eine Bestandsaufnahme*. 2019 Jan. https://www.researchgate.net/publication/334327865_Flucht-und_Fluchtlingsforschung_in_Deutschland_Eine_Bestandsaufnahme

82. Jahn R, Rohleder S, Qreini M, Erdmann S, Kaur S, Aluttis F, et al. Health monitoring of refugees in reception centres for asylum seekers: Decentralized surveillance network for the analysis of routine medical data. *Journal of Health Monitoring*. 2021;6(1): 30–52. https://doi.org/10.25646/7865.

83. Kajikhina K, Schumann M, Sarma N, Lampert T, Santos-Hövener C. Konzepte für ein migrationssensibles Gesundheitsmonitoring. *Journal of Health Monitoring*. 2019;4(3): 51–68. https://doi.org/10.25646/6071.

84. Koch E. Spezialstationen für die psychiatrisch-psychotherapeutische Behandlung von Flüchtlingen – Kontra. *Psychiatrische Praxis*. 2016;43(3): 132–133. https://doi.org/10.1055/s-0042-103662.

85. Mews C, Schuster S, Vajda C, Lindtner-Rudolph H, Schmidt LE, Bösner S, et al. Cultural Competence and Global Health: Perspectives for Medical Education – Position paper of the GMA Committee on Cultural Competence and Global Health. *GMS Journal for Medical Education*. 2018;35(3): Doc28. https://doi.org/10.3205/zma001174.

86. Tillmann J, Krämer A, Fischer F. Medizinische Ausbildung zur Versorgung von Schutzsuchenden – Quantitative Bestandsaufnahme und Bedarfserhebung unter Medizinstudierenden in Deutschland. *Zeitschrift für Flüchtlingsforschung*. 2018;2(1): 163–174. https://doi.org/10.5771/2509-9485-2018-1-163.

87. LVR-Stabstelle Inklusion - Menschenrechte - Beschwerden. *LVR-Diversity-Konzept*. 2021 Jun. https://www.lvr.de/de/nav_main/derlvr/aktionen/vielfalt_diversity/vielfalt_diversity.jsp

88. Mohammed L, Karato Y. *Flucht & Gewalt. Psychosozialer Versorgungsbericht Deutschland 2022*. 2022. https://www.baff-zentren.org/wp-content/uploads/2022/07/BAfF_Versorgungsbericht-2022.pdf

89. Federal Ministry of Justice. *Asylum Act*. Mar 11, 2016. https://www.gesetze-im-internet.de/englisch_asylvfg/englisch_asylvfg.html

90. European Commission - Migration and Home Affairs. *Common European Asylum System (CEAS)*. https://home-affairs.ec.europa.eu/pages/glossary/common-european-asylum-system-ceas_en [Accessed 27th July 2022].

91. Bundesamt für Migration und Flüchtlinge. *Familienasyl und Familiennachzug*. https://www.bamf.de/DE/Themen/AsylFluechtlingsschutz/FamilienasylFamiliennachzug/familienasylfamiliennachzug-node.html

92. Bundesministerium für Familie, Senioren, Frauen und Jugend. *Mindeststandards zum Schutz von geflüchteten Menschen in Flüchtlingsunterkünften*. 2021 Apr.

https://www.bmfsfj.de/bmfsfj/service/publikationen/mindeststandards-zum-schutz-von-gefluechteten-menschen-in-fluechtlingsunterkuenften-117474

93. Bundesministerium des Inneren und der Heimat. *Asyl- und Flüchtlingspolitik in Deutschland*. Bundesministerium des Innern und für Heimat. https://www.bmi.bund.de/DE/themen/migration/asyl-fluechtlingsschutz/asyl-fluechtlingspolitik/asyl-fluechtlingspolitik-artikel.html?nn=9392666 [Accessed 27th July 2022].

94. Bundesamt für Migration und Flüchtlinge. *Aktuelle Zahlen*. 2021 Dec. https://www.bamf.de/SharedDocs/Anlagen/DE/Statistik/AsylinZahlen/aktuelle-zahlen-dezember-2021.pdf

95. Bundesministerium der Justiz. *AsylG § 47 Aufenthalt in Aufnahmeeinrichtungen*. Asylgesetz Sep 2, 2008. https://www.gesetze-im-internet.de/asylvfg_1992/__47.html

96. Walther L, Amann J, Flick U, Ta TMT, Bajbouj M, Hahn E. A qualitative study on resilience in adult refugees in Germany. *BMC Public Health*. 2021;21(1): 828. https://doi.org/10.1186/s12889-021-10817-6.

97. Nutsch N, Bozorgmehr K. Der Einfluss postmigratorischer Stressoren auf die Prävalenz depressiver Symptome bei Geflüchteten in Deutschland. Analyse anhand der IAB-BAMF-SOEP-Befragung 2016. *Bundesgesundheitsblatt - Gesundheitsforschung - Gesundheitsschutz*. 2020;63(12): 1470–1482. https://doi.org/10.1007/s00103-020-03238-0.

98. Schouler-Ocak M, Kurmeyer C. *Study on Female Refugees Repräsentative Untersuchung von geflüchteten Frauen in verschiedenen Bundesländern in Deutschland*. 2017. https://female-refugee-study.charite.de/

99. Christ S, Meininghaus E, Röing T. ‘All day waiting’: Konflikte in Unterkünften für Geflüchtete in NRW. *BICC Working Paper*. 2017;3. https://nbn-resolving.org/urn:nbn:de:0168-ssoar-61651-8

100. Fachberatungsdienst Zuwanderung, Integration und Toleranz im Land Brandenburg. *Gewalt in den Gemeinschaftsunterkünften für Asylsuchende im Land Brandenburg Situationsanalyse*. 2016 [Accessed 7th August 2022]. https://www.menschen-in-dresden.de/wp-content/uploads/2016/01/Situationsanalyse-Gewalt-in-Gemeinschaftsunterk%C3%BCnften-f%C3%BCr-Asylsuchende-im-Land-Brandenburg.pdf [Accessed 7th August 2022].

101. Bundesministerium der Justiz. *SGB VIII § 24 Anspruch auf Förderung in Tageseinrichtungen und in Kindertagespflege*. Sozialgesetzbuch Jun 26, 1990. https://www.gesetze-im-internet.de/sgb_8/__24.html

102. Gambaro L, Neidhöfer G, Spieß CK. *The effect of early childhood education and care services on the social integration of refugee families*. Report number: 1828, 2019. https://www.econstor.eu/handle/10419/206633

103. Melhuish E, Ereky-Stevens K, Petrogiannis K. *A Review of Research on the Effect of Early childhood Education and care (ECEC) upon Child development*. Report number: FP7-SSH-2013–2, 2015.

https://ecec-care.org/fileadmin/careproject/Publications/reports/new_version_CARE_WP4_D4_1_Review_on_the_effects_of_ECEC.pdf

104. Park M, Katsiaficas C, McHugh M. *Responding to the ECEC Needs of Children of Refugees and Asylum Seekers in Europe and North America*. 2018 Apr. https://www.migrationpolicy.org/research/responding-ecec-needs-children-refugees-asylum-seekers-europe-north-america

105. Lanfranchi, A. Kinder aus Flüchtlingsfamilien: nicht jedes Trauma traumatisiert. *systeme*. 2006;20(1): 82–102.

106. European Commission. *Action Plan on the integration of third country nationals*. COM/2016/0377 Jun 7, 2016. https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX:52016DC0377

107. von Bibra S. Begleitete minderjährige Flüchtlinge: Die vergessenen Kinder. *Münchner Ärztliche Anzeigen*. 2019;108(15): 4–6.

108. Spiess K, Berger EM, Groh-Samberg O, Krappmann LF. *Overcoming Disparities and Expanding Access to Early Childhood Services in Germany: Policy Considerations and Funding Options*. Report number: IWP-2008-03, 2008 Oct. https://www.un-ilibrary.org/content/papers/25206796/22

109. Gambaro L, Liebau E, Peter FH, Weinhardt F. Viele Kinder von Geflüchteten besuchen eine Kita oder Grundschule: Nachholbedarf bei den unter Dreijährigen und der Sprachförderung von Schulkindern. *DIW Wochenbericht*. 2017;84(19): 379–386.

110. Textor MR. *Flüchtlingsfamilien*. Das Kita-Handbuch. https://www.kindergartenpaedagogik.de/fachartikel/soziologie/526/

111. Baisch B, Lüders K, Meiner-Teubner C, Riedel B, Scholz A. *Flüchtlingskinder in Kindertagesbetreuung. Ergebnisse der DJI-Kita-Befragung „Flüchtlingskinder“ zu Rahmenbedingungen und Praxis im Frühjahr 2016*. 2017. https://www.dji.de/veroeffentlichungen/literatursuche/detailansicht/literatur/25737-fluechtlingskinder-in-kindertagesbetreuung.html

112. Textor MR. *Flüchtlingskinder in der Kita*. Das Kita-Handbuch. https://www.kindergartenpaedagogik.de/fachartikel/kinder-mit-migrationshintergrund/2386/ [Accessed 28th July 2022].

113. OECD. *Country Note: Programme for international student assessment (PISA) results from Pisa 2018 - Germany*. 2018. https://www.oecd.org/pisa/publications/PISA2018_CN_DEU.pdf

114. Salden S, Hertlein J. Is It Fair? The German Education System and Its Stumbling Blocks for Adolescents. In: Watzlawik M, Burkholder A (eds.) *Educating Adolescents Around the Globe*. Cham: Springer International Publishing; 2020. p. 116–147. https://doi.org/10.1007/978-3-030-37900-1_7. [Accessed 4th August 2022].

115. Menke, K, Klammer U. Mehr Geschlechtergerechtigkeit – weniger soziale Gerechtigkeit? Familienpolitische Reformprozesse in Deutschland aus intersektionaler

Perspektive. *Sozialer Fortschritt*. 2017;66(3–4): 213–228. https://doi.org/10.3790/sfo.66.3-4.213.

116. Brücker H, Kosyakova Y, Vallizadeh E. Has there been a “refugee crisis”? New insights on the recent refugee arrivals in Germany and their integration prospects. *Soziale Welt*. 2020;71(1–2): 24–53. https://doi.org/10.5771/0038-6073-2020-1-2-24.

117. Bundesministerium der Justiz. *AsylbLG § 4 Leistungen bei Krankheit, Schwangerschaft und Geburt*. Asylbewerberleistungsgesetz. https://www.gesetze-im-internet.de/asylblg/__4.html

118. Razum O, Wenner J, Bozorgmehr K. Wenn Zufall über den Zugang zur Gesundheitsversorgung bestimmt: Geflüchtete in Deutschland. *Das Gesundheitswesen*. 2016;78(11): 711–714. https://doi.org/10.1055/s-0042-116231.

119. De Young AC, Landolt MA. PTSD in Children Below the Age of 6 Years. *Current Psychiatry Reports*. 2018;20(11): 97. https://doi.org/10.1007/s11920-018-0966-z.

120. Cohen JA, Scheeringa MS. Post-traumatic stress disorder diagnosis in children: challenges and promises. *Dialogues in Clinical Neuroscience*. 2009;11(1): 91–99. https://doi.org/10.31887/DCNS.2009.11.1/jacohen.

121. Scheeringa MS, Zeanah CH, Cohen JA. PTSD in children and adolescents: toward an empirically based algorithma. *Depression and Anxiety*. 2011;28(9): 770–782. https://doi.org/10.1002/da.20736.

122. Gadeberg AK, Montgomery E, Frederiksen HW, Norredam M. Assessing trauma and mental health in refugee children and youth: a systematic review of validated screening and measurement tools. *European Journal of Public Health*. 2017;27(3): 439–446. https://doi.org/10.1093/eurpub/ckx034.

123. Borho A, Morawa E, Erim Y. Screening der psychischen Gesundheit von syrischen Geflüchteten in Deutschland: Der Refugee Health Screener. *Zeitschrift für Psychosomatische Medizin und Psychotherapie*. 2022; OA68_1. https://doi.org/10.13109/zptm.2022.68.oa1.

124. Magwood O, Kassam A, Mavedatnia D, Mendonca O, Saad A, Hasan H, et al. Mental Health Screening Approaches for Resettling Refugees and Asylum Seekers: A Scoping Review. *International Journal of Environmental Research and Public Health*. 2022;19(6): 3549. https://doi.org/10.3390/ijerph19063549.

125. For the Milestone Consortium, Russet F, Humbertclaude V, Dieleman G, Dodig-Ćurković K, Hendrickx G, et al. Training of adult psychiatrists and child and adolescent psychiatrists in europe: a systematic review of training characteristics and transition from child/adolescent to adult mental health services. *BMC Medical Education*. 2019;19(1): 204. https://doi.org/10.1186/s12909-019-1576-0.

126. Place V, Nabb B, Gubi E, Assel K, Åhlén J, Hagström A, et al. Perceived barriers to care for migrant children and young people with mental health problems and/or neurodevelopmental differences in high-income countries: a meta-ethnography. *BMJ Open*. 2021;11(9): e045923. https://doi.org/10.1136/bmjopen-2020-045923.

127. European Commission. *Action plan on Integration and Inclusion 2021-2027*. COM/2020/758 Nov 24, 2020. https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A52020DC0758

128. Führer A, Niedermaier A, Kalfa V, Mikolajczyk R, Wienke A. Serious shortcomings in assessment and treatment of asylum seekers' mental health needs. Doering S (ed.) *PLOS ONE*. 2020;15(10): e0239211. https://doi.org/10.1371/journal.pone.0239211.

129. Biddle L, Menold N, Bentner M, Nöst S, Jahn R, Ziegler S, et al. Health monitoring among asylum seekers and refugees: a state-wide, cross-sectional, population-based study in Germany. *Emerging Themes in Epidemiology*. 2019;16(1): 3. https://doi.org/10.1186/s12982-019-0085-2.

130. Bundesweite Arbeitsgemeinschaft Psychosozialer Zentren für Flüchtlinge und Folteropfer e.V. *Was sind die Barrieren im Zugang zur gesundheitlichen Versorgung?*. BAfF-Zentren. https://www.baff-zentren.org/faq/was-sind-die-barrieren-im-zugang-zur-gesundheitlichen-versorgung/ [Accessed 7th August 2022].

131. Metzner F, Reher C, Kindler H, Pawils S. Psychotherapeutische Versorgung von begleiteten und unbegleiteten minderjährigen Flüchtlingen und Asylbewerbern mit Traumafolgestörungen in Deutschland. *Bundesgesundheitsblatt - Gesundheitsforschung - Gesundheitsschutz*. 2016;59(5): 642–651. https://doi.org/10.1007/s00103-016-2340-9.

132. Karger A, Lindtner-Rudolph H, Mroczynski R, Ziem A, Joksimovic L. „Wie fremd ist mir der Patient?“: Erfahrungen, Einstellungen und Erwartungen von Ärztinnen und Ärzten bei der Versorgung von Patientinnen und Patienten mit Migrationshintergrund. *Zeitschrift für Psychosomatische Medizin und Psychotherapie*. 2017;63(3): 280–296. https://doi.org/10.13109/zptm.2017.63.3.280.

133. Hodes M, Gau SF, de Vries PJ. *Understanding uniqueness and diversity in child and adolescent mental health*. London: Academic press; 2018.

134. Bartig S, Kalkum D, Le HM, Lewicki A. *Diskriminierungsrisiken und Diskriminierungsschutz im Gesundheitswesen – Wissensstand und Forschungsbedarf für die Antidiskriminierungsforschung*. 2021 Jul. https://www.antidiskriminierungsstelle.de/SharedDocs/downloads/DE/publikationen/Expertisen/diskrimrisiken_diskrimschutz_gesundheitswesen.html

135. Mohammed L, Karato Y. *Sprachmittlung in der psychotherapeutischen und psychosozialen Versorgung*. 2021. https://www.baff-zentren.org/wp-content/uploads/2022/03/Sprachmittlung-in-der-psychotherapeutischen-und-psychosozialen-Versorgung_Ergebnispapier-2022.pdf

136. Ute Hausmann. *Sprachmittlung in der psychiatrisch-psychotherapeutischen Versorgung von Geflüchteten in Baden-Württemberg. Bestandsaufnahme und Bedarfsanalyse*. 2020 Mar. https://www.refugio-stuttgart.de/files/daten/20_Doku_Sprachmittlung.pdf

137. Universitätsklinikum Hamburg-Eppendorf. *Endbericht wissenschaftliches Gutachten_ 'Therapieangebote für psychisch traumatisierte, von Gewalt betroffene Kinder und Jugendliche in Deutschland'*. 2017 Jan.

https://www.bundesgesundheitsministerium.de/themen/praevention/kindergesundheit/kindergesundheit.html

138. Plötner M, Moldt K, In-Albon T, Schmitz J. Einfluss der COVID-19-Pandemie auf die ambulante psychotherapeutische Versorgung von Kindern und Jugendlichen. *Die Psychotherapie*. 2022; https://doi.org/10.1007/s00278-022-00604-y.

139. Byrow Y, Pajak R, Specker P, Nickerson A. Perceptions of mental health and perceived barriers to mental health help-seeking amongst refugees: A systematic review. *Clinical Psychology Review*. 2020;75: 101812. https://doi.org/10.1016/j.cpr.2019.101812.

140. Bär J, Pabst A, Röhr S, Luppa M, Renner A, Nagl M, et al. Mental Health Self-Stigma of Syrian Refugees With Posttraumatic Stress Symptoms: Investigating Sociodemographic and Psychopathological Correlates. *Frontiers in Psychiatry*. 2021;12: 642618. https://doi.org/10.3389/fpsyt.2021.642618.

141. Maier T, Schmidt M, Julia M. Mental health and healthcare utilization in adult asylum seekers. *Swiss Medical Weekly*. 2010; https://doi.org/10.4414/smw.2010.13110.

142. Wenner J, Razum O, Schenk L, Ellert U, Bozorgmehr K. Gesundheit von Kindern und Jugendlichen aus Familien mit ungesichertem Aufenthaltsstatus im Vergleich zu Kindern mit und ohne Migrationshintergrund: Auswertung der KiGGS-Daten 2003–06. *Bundesgesundheitsblatt - Gesundheitsforschung - Gesundheitsschutz*. 2016;59(5): 627–635. https://doi.org/10.1007/s00103-016-2338-3.

143. Baron J, Flory L. *Versorgungsbericht. Zur psychosozialen Versorgung von Flüchtlingen und Folteropfern in Deutschland. 6. Aktualisierte Aufgabe*. 2020. https://www.baff-zentren.org/wp-content/uploads/2020/10/BAfF_Versorgungsbericht-6.pdf

144. Bundesweite Arbeitsgemeinschaft Psychosozialer Zentren für Flüchtlinge und Folteropfer e.V. *Hilfe vor Ort*. BAfF-Zentren. https://www.baff-zentren.org/hilfe-vor-ort/ [Accessed 10th August 2022].

145. Karato Y, Mohammed L. *Datenlage zur psychosozialen Versorgung von Überlebenden von Krieg, Folter und Flucht in Deutschland*. 2021 Dec p. 16. https://www.baff-zentren.org/wp-content/uploads/2022/01/Datenbericht-Versorgung-BAfF-2019.pdf

146. Fazel M, Reed RV, Panter-Brick C, Stein A. Mental health of displaced and refugee children resettled in high-income countries: risk and protective factors. *The Lancet*. 2012;379(9812): 266–282. https://doi.org/10.1016/S0140-6736(11)60051-2.

147. Andresen S, Neumann S, Schneekloth U. How Children in Germany Experience Refugees: A Contribution From Childhood Studies. *Child Indicators Research*. 2021;14(5): 2045–2064. https://doi.org/10.1007/s12187-021-09828-x.

148. Buchmüller T, Lembcke H, Ialuna F, Busch J, Leyendecker B. Mental Health Needs of Refugee Children in Specialized Early Education and Care Programs in Germany. *Journal of Immigrant and Minority Health*. 2020;22(1): 22–33. https://doi.org/10.1007/s10903-019-00896-4.

149. Hahnefeld A, Sukale T, Weigand E, Münch K, Aberl S, Eckler LV, et al. Survival states as indicators of learning performance and biological stress in refugee children: a cross-sectional study with a comparison group. *BMC Psychiatry*. 2021;21(1): 228. https://doi.org/10.1186/s12888-021-03233-y.

150. Metzner F, Adedeji A, Wichmann MLY, Zaheer Z, Schneider L, Schlachzig L, et al. Experiences of Discrimination and Everyday Racism Among Children and Adolescents With an Immigrant Background – Results of a Systematic Literature Review on the Impact of Discrimination on the Developmental Outcomes of Minors Worldwide. *Frontiers in Psychology*. 2022;13: 805941. https://doi.org/10.3389/fpsyg.2022.805941.

151. Yeboah A. Rassismus und psychische Gesundheit in Deutschland. In: Fereidooni K, El M (eds.) *Rassismuskritik und Widerstandsformen*. Wiesbaden: Springer Fachmedien; 2017. p. 143–161. https://doi.org/10.1007/978-3-658-14721-1_9.

152. Schouler-Ocak M, Bhugra D, Kastrup MC, Dom G, Heinz A, Küey L, et al. Racism and mental health and the role of mental health professionals. *European Psychiatry*. 2021;64(1): e42. https://doi.org/10.1192/j.eurpsy.2021.2216.

153. Kluge U, Aichberger MC, Heinz E, Udeogu-Gözalan C, Abdel-Fatah D. Rassismus und psychische Gesundheit. *Der Nervenarzt*. 2020;91(11): 1017–1024. https://doi.org/10.1007/s00115-020-00990-1.

154. Verelst A, Spaas C, Pfeiffer E, Devlieger I, Kankaapää R, Peltonen K, et al. Social Determinants of the Mental Health of Young Migrants. *European Journal of Health Psychology*. 2022;29(1): 61–73. https://doi.org/10.1027/2512-8442/a000097.

155. Viazminsky A, Borho A, Morawa E, Schmitt GM, Erim Y. Perceived discrimination among Syrian refugees in Germany and its associations with mental health. *Global Public Health*. 2022; 1–14. https://doi.org/10.1080/17441692.2022.2026449.

156. Federal Anti-Discrimination Agency. *Risks of discrimination for refugees in Germany*. 2016 Dec. https://www.antidiskriminierungsstelle.de/SharedDocs/downloads/EN/publikationen/factsheet_en_Diskriminierungsrisiken_fuer_Gefluechtete_in_Dtschl.pdf

157. Bostanci S. *Rassismus an Kitas: 'Eltern dürfen die Verantwortung nicht alleine tragen'*. https://mediendienst-integration.de/artikel/eltern-duerfen-die-verantwortung-nicht-alleine-tragen.html [Accessed 29th July 2022].

158. Daud A, af Klinteberg B, Rydelius PA. Resilience and vulnerability among refugee children of traumatized and non-traumatized parents. *Child and Adolescent Psychiatry and Mental Health*. 2008;2(1): 7. https://doi.org/10.1186/1753-2000-2-7.

159. Pinto Wiese EB, Burhorst I. The Mental Health of Asylum-seeking and Refugee Children and Adolescents Attending a Clinic in the Netherlands. *Transcultural Psychiatry*. 2007;44(4): 596–613. https://doi.org/10.1177/1363461507083900.

160. Lechner C, Huber A. *Ankommen nach der Flucht: die Sicht begleiteter und unbegleiteter junger Geflüchteter auf ihre Lebenslage in Deutschland: Bericht*. München: Deutsches Jugendinstitut; 2017.

161. Khamis V. Posttraumatic stress disorder and emotion dysregulation among Syrian refugee children and adolescents resettled in Lebanon and Jordan. *Child Abuse & Neglect*. 2019;89: 29–39. https://doi.org/10.1016/j.chiabu.2018.12.013.

162. Measham T, Guzder J, Rousseau C, Pacione L, Blais-McPherson M, Nadeau L. Refugee Children and Their Families: Supporting Psychological Well-Being and Positive Adaptation Following Migration. *Current Problems in Pediatric and Adolescent Health Care*. 2014;44(7): 208–215. https://doi.org/10.1016/j.cppeds.2014.03.005.

163. Qouta S, Punamäki RL, Miller T, El-Sarraj E. Does war beget child aggression? Military violence, gender, age and aggressive behavior in two Palestinian samples. *Aggressive Behavior*. 2008;34(3): 231–244. https://doi.org/10.1002/ab.20236.

164. Sriskandarajah V, Neuner F, Catani C. Parental care protects traumatized Sri Lankan children from internalizing behavior problems. *BMC Psychiatry*. 2015;15(1): 203. https://doi.org/10.1186/s12888-015-0583-x.

165. Sim A, Fazel M, Bowes L, Gardner F. Pathways linking war and displacement to parenting and child adjustment: A qualitative study with Syrian refugees in Lebanon. *Social Science & Medicine*. 2018;200: 19–26. https://doi.org/10.1016/j.socscimed.2018.01.009.

166. Eruyar S, Maltby J, Vostanis P. Mental health problems of Syrian refugee children: the role of parental factors. *European Child & Adolescent Psychiatry*. 2018;27(4): 401–409. https://doi.org/10.1007/s00787-017-1101-0.

167. Sim A, Bowes L, Gardner F. Modeling the effects of war exposure and daily stressors on maternal mental health, parenting, and child psychosocial adjustment: a cross-sectional study with Syrian refugees in Lebanon. *Global Mental Health*. 2018;5: e40. https://doi.org/10.1017/gmh.2018.33.

168. Bryant RA, Edwards B, Creamer M, O'Donnell M, Forbes D, Felmingham KL, et al. The effect of post-traumatic stress disorder on refugees' parenting and their children's mental health: a cohort study. *The Lancet Public Health*. 2018;3(5): e249–e258. https://doi.org/10.1016/S2468-2667(18)30051-3.

169. Dalgaard NT, Montgomery E. The transgenerational transmission of refugee trauma: family functioning and children's psychosocial adjustment. *International Journal of Migration, Health and Social Care*. 2017;13(3): 289–301. https://doi.org/10.1108/IJMHSC-06-2016-0024.

170. Betancourt TS, Yudron M, Wheaton W, Smith-Fawzi MC. Caregiver and Adolescent Mental Health in Ethiopian Kunama Refugees Participating in an Emergency Education Program. *Journal of Adolescent Health*. 2012;51(4): 357–365. https://doi.org/10.1016/j.jadohealth.2012.01.001.

171. Saile R, Neuner F, Ertl V, Catani C. Prevalence and predictors of partner violence against women in the aftermath of war: A survey among couples in Northern Uganda. *Social Science & Medicine*. 2013;86: 17–25. https://doi.org/10.1016/j.socscimed.2013.02.046.

172. Catani C. Krieg im Zuhause – ein Überblick zum Zusammenhang zwischen Kriegstraumatisierung und familiärer Gewalt. *Verhaltenstherapie*. 2010;20(1): 19–27. https://doi.org/10.1159/000261994.

173. Saile R, Ertl V, Neuner F, Catani C. Does war contribute to family violence against children? Findings from a two-generational multi-informant study in Northern Uganda. *Child Abuse & Neglect*. 2014;38(1): 135–146. https://doi.org/10.1016/j.chiabu.2013.10.007.

174. Sriskandarajah V, Neuner F, Catani C. Predictors of violence against children in Tamil families in northern Sri Lanka. *Social Science & Medicine*. 2015;146: 257–265. https://doi.org/10.1016/j.socscimed.2015.10.010.

175. Fegert JM, Leyendecker B, Hahlweg K, Prayon-Blum V, Scientific Advisory Council of the Federal Ministry of Family Affairs, Senior Citizens, Women and Youth. Psychosocial problems in traumatized refugee families: overview of risks and some recommendations for support services. *Child and Adolescent Psychiatry and Mental Health*. 2018;12(1): 5. https://doi.org/10.1186/s13034-017-0210-3.

176. Boyle JA, Willey S, Blackmore R, East C, McBride J, Gray K, et al. Improving Mental Health in Pregnancy for Refugee Women: Protocol for the Implementation and Evaluation of a Screening Program in Melbourne, Australia. *JMIR Research Protocols*. 2019;8(8): e13271. https://doi.org/10.2196/13271.

177. Nonnenmacher N, Noe D, Ehrenthal JC, Reck C. Postpartum bonding: the impact of maternal depression and adult attachment style. *Archives of Women's Mental Health*. 2016;19(5): 927–935. https://doi.org/10.1007/s00737-016-0648-y.

178. Bozorgmehr K, Biddle L, Preussler S, Mueller A, Szecsenyi J. Differences in pregnancy outcomes and obstetric care between asylum seeking and resident women: a cross-sectional study in a German federal state, 2010–2016. *BMC Pregnancy and Childbirth*. 2018;18(1): 417. https://doi.org/10.1186/s12884-018-2053-1.

179. Ruf-Leuschner M, Roth M, Schauer M. Traumatisierte Mütter – traumatisierte Kinder?: Eine Untersuchung des transgenerationalen Zusammenhangs von Gewalterfahrungen und Traumafolgestörungen in Flüchtlingsfamilien. *Zeitschrift für Klinische Psychologie und Psychotherapie*. 2014;43(1): 1–16. https://doi.org/10.1026/1616-3443/a000237.

180. Gambaro L, Kreyenfeld M, Schacht D, Spieß CK. Lebenszufriedenheit von Geflüchteten in Deutschland ist deutlich geringer, wenn ihre Kinder im Ausland leben. *DIW Wochenbericht*. 2018; https://doi.org/10.18723/DIW_WB:2018-42-2.

181. Löbel LM, Jacobsen J. Waiting for kin: a longitudinal study of family reunification and refugee mental health in Germany. *Journal of Ethnic and Migration Studies*. 2021;47(13): 2916–2937. https://doi.org/10.1080/1369183X.2021.1884538.

182. World Health Organization. *ApartTogether survey: preliminary overview of refugees and migrants self-reported impact of COVID-19*. Geneva: World Health Organization; 2020. https://apps.who.int/iris/handle/10665/337931

183. *Germany: Covid-19 impacts Family Reunification Procedures | European Council on Refugees and Exiles (ECRE)*. https://ecre.org/germany-covid-19-impacts-family-reunification-procedures/ [Accessed 9th August 2022].

184. Kaltenbach E, Schauer M, Hermenau K, Elbert T, Schalinski I. Course of Mental Health in Refugees—A One Year Panel Survey. *Frontiers in Psychiatry*. 2018;9: 352. https://doi.org/10.3389/fpsyt.2018.00352.

185. Özdemir M, Bayram Özdemir S. Why Do Some Immigrant Children and Youth Do Well in School Whereas Others Fail?: Current State of Knowledge and Directions for Future Research. In: Güngör D, Strohmeier D (eds.) *Contextualizing Immigrant and Refugee Resilience*. Cham: Springer International Publishing; 2020. p. 51–72. https://doi.org/10.1007/978-3-030-42303-2_4. [Accessed 12th April 2022].

186. Bauer JM, Brand T, Zeeb H. Pre-migration socioeconomic status and post-migration health satisfaction among Syrian refugees in Germany: A cross-sectional analysis. Spiegel PB (ed.) *PLOS Medicine*. 2020;17(3): e1003093. https://doi.org/10.1371/journal.pmed.1003093.

187. Kosyakova Y. *Auswirkungen der Maßnahmen zur Eindämmung der Corona-Pandemie auf die Arbeitsmarktintegration von geflüchteten Frauen_ Working Paper*. 2021 Feb. https://www.netzwerk-iq.de/fileadmin/Redaktion/Downloads/Fachstelle_Einwanderung/Publikationen_2021/Minor_FE_WP-Corona-Arbeitsmarktintegration-gefl%C3%BCchtete-Frauen_2021.pdf

188. Zbidat A, Georgiadou E, Borho A, Erim Y, Morawa E. The Perceptions of Trauma, Complaints, Somatization, and Coping Strategies among Syrian Refugees in Germany—A Qualitative Study of an At-Risk Population. *International Journal of Environmental Research and Public Health*. 2020;17(3): 693. https://doi.org/10.3390/ijerph17030693.

189. von Haumeder A, Ghafoori B, Retailleau J. Psychological adaptation and posttraumatic stress disorder among Syrian refugees in Germany: a mixed-methods study investigating environmental factors. *European Journal of Psychotraumatology*. 2019;10(1): 1686801. https://doi.org/10.1080/20008198.2019.1686801.

190. Verlinden K. Resilient refugee children in a refugee shelter in Germany -preliminary results from an interview study. In: *World Congress of Sociology*. Toronto; 2018. https://www.researchgate.net/publication/332935180_Resilient_refugee_children_in_a_refugee_shelter_in_Germany_-preliminary_results_from_an_interview_study

191. Nilles H, Kerkhoff D, Demir Z, Braig J, Schmees P, Rueth JE, et al. Coping of Young Refugees in Germany: Relations to Gender, Age, and Gender Role Attitudes. *European Journal of Health Psychology*. 2022;29(1): 15–25. https://doi.org/10.1027/2512-8442/a000094.

192. Meyeringh J. *Individuelle Belastungsfaktoren junger Geflüchteter*. https://www.deutscher-verein.de/de/uploads/vam/2017/f-1734-17/dipl-psych._meyeringh_individuelle_belastungsfaktoren_junger_gefluechteter.pdf

193. Reis R, Crone MR, Berckmoes LH. Unpacking Context and Culture in Mental Health Pathways of Child and Adolescent Refugees. In: Song SJ, Ventevogel P (eds.) *Child,*

Adolescent and Family Refugee Mental Health. Cham: Springer International Publishing; 2020. p. 37–51. https://doi.org/10.1007/978-3-030-45278-0_3.

194. Gholamrezaei M, Heath N, Panaghi L. Non-suicidal self-injury in a sample of university students in Tehran, Iran: prevalence, characteristics and risk factors. *International Journal of Culture and Mental Health*. 2017;10(2): 136–149. https://doi.org/10.1080/17542863.2016.1265999.

195. Tam SY, Houlihan S, Melendez-Torres GJ. A Systematic Review of Longitudinal Risk and Protective Factors and Correlates for Posttraumatic Stress and Its Natural History in Forcibly Displaced Children. *Trauma, Violence, & Abuse*. 2017;18(4): 377–395. https://doi.org/10.1177/1524838015622437.

196. Montgomery E. Trauma and resilience in young refugees: A 9-year follow-up study. *Development and Psychopathology*. 2010;22(2): 477–489. https://doi.org/10.1017/S0954579410000180.

197. Schnyder U. *Posttraumatische Belastungsstörung (PTBS) - Prognose*. https://www.neurologen-und-psychiater-im-netz.org/psychiatrie-psychosomatik-psychotherapie/stoerungen-erkrankungen/posttraumatische-belastungsstoerung-ptbs/prognose [Accessed 8th August 2022].

198. *Child-friendly spaces and services for refugee and migrant children in Germany_ A Case Study*. https://www.gewaltschutz-gu.de/fileadmin/user_upload/PDFs/CFS_Broschre_E_0608219.pdf

199. *Bundesregierung beendet Bundesprogramm „Sprach-Kitas“ – Kinderbetreuung – Bayerisches Landesportal*. https://www.bayern.de/bundesregierung-beendet-bundesprogramm-sprach-kitas-kinderbetreuung/ [Accessed 10th August 2022].

200. Ostendorf E. *Pressemitteilung: Ende des Bundesprogramms Sprach-Kitas ist ein schwerer Schlag für Kita-Träger*. Deutscher Kitaverband. 2022. https://www.deutscher-kitaverband.de/pressemitteilung-ende-des-bundesprogramms-sprach-kitas-ist-ein-schwerer-schlag-fuer-kita-traeger/ [Accessed 10th August 2022].

201. Jugend B für F Senioren, Frauen und. *Kita-Einstieg - Frühe Chancen*. https://www.kita-einstieg.fruehe-chancen.de. https://www.kita-einstieg.fruehe-chancen.de/ [Accessed 9th August 2022].

202. Bundesministerium für Familie, Seniore, Frauen und Jugend. *Bundesprogramm Sprach-Kitas Weil Sptache der Schlüssel zur Welt ist.* https://sprach-kitas.fruehe-chancen.de/ [Accessed 1st August 2022].

203. Fazel M, Betancourt TS. Preventive mental health interventions for refugee children and adolescents in high-income settings. *The Lancet Child & Adolescent Health*. 2018;2(2): 121–132. https://doi.org/10.1016/S2352-4642(17)30147-5.

204. *Kinder psychisch kranker Eltern - LVR-Klinik Köln*. https://klinik-koeln.lvr.de/de/nav_main/fachgebiete___behandlungsangebote/besondere_angebote/kinder_psychisch_kranker_eltern/kinder_psychisch_kranker_eltern_1.html [Accessed 10th August 2022].

205. Internetredaktion RBL. *COMPARE - Risikobewertung bei Kindern psychisch kranker Eltern - DLR Gesundheitsforschung*. Deutsche Zentrum für Luft und Raumfahrt e.V. - DLR Gesundheitsforschung. https://www.gesundheitsforschung-bmbf.de/de/compare-risikobewertung-bei-kindern-psychisch-kranker-eltern-7281.php [Accessed 10th August 2022].

206. Wiegand-Grefe S, Klein M, Kölch M, Lenz A, Seckinger M, Ziegenhain U. *KInder psychisch kranker Eltern „Forschung“*. p. 98.

207. Ruf M, Schauer M, Neuner F, Catani C, Schauer E, Elbert T. Narrative exposure therapy for 7- to 16-year-olds: A randomized controlled trial with traumatized refugee children: KIDNET for Traumatized Refugee Children. *Journal of Traumatic Stress*. 2010;23(4): 437–445. https://doi.org/10.1002/jts.20548.

208. Schottelkorb AA, Doumas DM, Garcia R. Treatment for childhood refugee trauma: A randomized, controlled trial. *International Journal of Play Therapy*. 2012;21(2): 57–73. https://doi.org/10.1037/a0027430.

209. Velu ME, Martens I, Shahab M, de Roos C, Jongedijk RA, Schok M, et al. Trauma-focused treatments for refugee children: study protocol for a randomized controlled trial of the effectiveness of KIDNET versus EMDR therapy versus a waitlist control group (KIEM). *Trials*. 2022;23(1): 347. https://doi.org/10.1186/s13063-022-06178-z.

210. Benson MA, Abdi SM, Miller AB, Heidi Ellis B. Trauma Systems Therapy for Refugee Children and Families. In: Morina N, Nickerson A (eds.) *Mental Health of Refugee and Conflict-Affected Populations*. Cham: Springer International Publishing; 2018. p. 243–259. https://doi.org/10.1007/978-3-319-97046-2_12. [Accessed 7th August 2022].

211. Nitschke-Janssen M. Bedeutung traumatherapeutischer Versorgung geflüchteter Familien unabhängig vom Aufenthaltstitel. *Trauma - Zeitschrift für Psychotraumatologie und ihre Anwendungen*. 2020;18(3): 18–30.

212. Canada PHA of. *Public Health Agency of Canada*. https://www.canada.ca/en/public-health.html [Accessed 10th August 2022].

213. *Public Health England*. GOV.UK. https://www.gov.uk/government/organisations/public-health-england [Accessed 10th August 2022].

214. Plümer KD. *Germany*. Organization and financing of public health services in Europe: Country reports [Internet]. European Observatory on Health Systems and Policies; 2018. https://www.ncbi.nlm.nih.gov/books/NBK507327/ [Accessed 10th August 2022].

215. *Public health in Germany structures, developments and global challenges: statement*. 2015.

216. *Immigrant and Refugee Mental Health Project - Portico*. https://irmhp-psmir.camhx.ca/ [Accessed 10th August 2022].

217. Colucci, E, Minas, H., Swarc, J., Paxton, G., Guerra, C. E. *A mental health research agenda for people of refugee background in Australia: a consensus study*. p. 30.

218. Heckmann F. Willkommenskultur was ist das, und wie kann sie entstehen und entwickelt werden? In: *Bundeskonferenz der Integrationsbeauftragten von Bund, Ländern und Kommunen*. Bamberg: efms; 2012. http://www.efms.uni-bamberg.de/pdf/efms%20paper%202012_7.pdf

219. Bujard M, Diehl C, Kreyenfeld M, Spieß CK, Wissenschaftliche Beirat für Familienfragen. *Familien mit Fluchthintergrund: Aktuelle Fakten zu Familienstruktur, Arbeitsmarktbeteiligung und Wohlbefinden*. 2019 Sep. https://www.bmfsfj.de/resource/blob/140756/d9b5173da1eca339f2507a4c60bcffdd/familien-mit-fluchthintergrund-aktuelle-fakten-data.pdf

220. Bundesamt für Migration und Flüchtlinge. *Willkommenskultur*. https://www.bamf.de/DE/Themen/Integration/AkteureEhrenamtlicheInteressierte/EhrenamtlichesEngagement/Willkommenskultur/willkommenskultur-node.html [Accessed 22nd July 2022].

221. Gill N. The suppression of welcome. *Fennia - International Journal of Geography*. 2018;196(1): 88–98. https://doi.org/10.11143/fennia.70040.

222. Catani C. *Familie im Krieg. Transgenerationale Weitergabe von Gewalt und psychische Gesundheit im Kontext von Krieg und Verfolgung.* TU Braunschweig, Institut für Psychologie; 2016 Apr 20; Braunschweig.