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Assessing the plight of young unaccompanied refugees

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In their article, currently available in *Swiss Medical Weekly*, Lorenzo Campisi et al. [1]. show that, in their study population, young first- and second-generation migrants had a lower engagement in risk behaviours than natives of a comparable group. Their results are reassuring, even if migration remains an important risk factor for psychological health. Their work helps us to avoid stereotypes, and to gather more information about the migrant population, as research in the field is not always consensual. They also underline how the environment in which these young persons are placed, as well as the opportunities it offers, are better determinants of health than migrant status in enhancing risk behaviours.

This conclusion is particularly relevant in the situation of unaccompanied refugee minors (URMs, refugees under the age of 18 years without a legal representative in the country in which they stay). When their number rose very quickly in Switzerland at the end of 2015 (in the canton of Vaud, the number of minor refugees increased from its usual level of 50–70 to around 270 in November 2016), some important problems became clearer. In November 2016, a local newspaper reported 7 suicide attempts in a foster home in the canton of Vaud [2]. In total, 8 suicide attempts and 15 acts of self-mutilation, involving 16 patients, were reported in 2016 in facilities for URMs in the canton. This is also a concern in other cantons [3] and at an international level [4]. Political authorities and the Service of Public Health were questioned about this situation and were asked what could and should be done to decrease the risk associated with such mental health distress.

To answer this question, a working group was set up and additional funds were allowed by the Service of Public Health, with the objectives to: (1) gather information on this particularly vulnerable population, (2) identify the different professionals working with URMs, (3) better understand their role and their interactions, and (4) propose solutions for improvement.

What specific needs were identified?

1. Improvement of the detection of psychological distress, as well as access to child and adolescent psychiatric care. URMs present two important factors of vulnerability, as they combine the difficulties linked to their age group (transition to adulthood, impulsivity due to developmental changes of their brain) with those of their migrant status (being away from their families, traumatic experiences before, during and after their migration, uncertainty about their future legal status). As a consequence, URMs are particularly at risk for psychological disorders, such as depression, anxiety disorders and posttraumatic stress disorder [5–7]. They also have barriers to accessing psychological care (limited knowledge of the Swiss healthcare system, language and communication difficulties, different perceptions or fear of psychological care). Furthermore, the important increase in arrivals since 2015 has quickly saturated the existing psychiatric network. Finally, reaching a psychiatric diagnosis can be difficult, as adolescents tend to express psychological distress differently from adults, with actions (risky behaviours, substance abuse and violence) rather than expressions of emotion, such as sadness.
2. Coordination of the multiplicity of professionals involved with these minors (educators, curators, teachers and healthcare workers). As for other potential high-needs, high-costs populations (who cumulate complex medical, behavioural, health and social problems [8]), the more professionals involved, the greater the risk of "falling through the cracks" of our healthcare system. It results in avoidable complications, as well as consuming a disproportionate amount of resources. In March 2017, political initiatives from the various cantons asked the Swiss government for more resources for the asylum domain, notably because specific expenses for URMs were not covered [9]. Minors have specific needs and specific rights. This brings more costs for dedicated foster homes, education, supervision in the homes by educators, and curatorship. Two

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different approaches have been proposed to improve the management of high-needs, high-costs populations: complex case management and specialised primary care clinics [8]. The second is considered as more efficient, as it is based on specialised structures for high-needs, high-costs populations, gathering multidisciplinary personnel in the same place and enabling more individualised attention.

3. Reinforcement of the educational framework in foster homes and equality of treatment with minors in other foster homes. In the canton of Vaud, structures for migrants benefited from fewer educators per minor compared with other structures. Furthermore, distress of the educational staff in the foster homes was reported, increasing sickness leave and resignations in the teams. School absenteeism and missed appointments (social or medical) are also important problems for URMs.
4. Questioning of the follow-up after minor migrants turn 18. When they turn 18 years old, URMs have to leave their foster homes for adult infrastructures. This means they also leave the close supervision/mentorship of their educators and curators for the more distant supervision of social workers. For many URMs, depending on their origin, their right to stay in the country stops suddenly at age 18, and they have to give up their professional training without being able to complete their education.

What concrete actions have been planned to improve the situation for unaccompanied refugee minors in the canton of Vaud?

1. Making unaccompanied refugee minors into accompanied refugee minors. Until recently, the parental function was split between different professionals (curators, educators), which brings difficulties in identifying a referent, especially for healthcare workers. It was decided to better identify one or two referents among the social or administrative team. This measure is also recommended by United Nation High Commissioner for Refugees concerning the federal centres [10].
2. Training and better supervision for educators. Educators need a good comprehension of the psychological perspective of the minors in relationship to migration, culture, the asylum procedure and administrative issues. A better understanding of the difficulties brings better opportunities to help them. Therefore, two specific training programmes have been planned. One specifically for curators, educators and teachers (five modules of a half-day each) and a second dedicated to all persons working with a URM (four consecutive days). Finally, educators would probably benefit from support from a psychiatrist on a regular basis and this would therefore be recommended.
3. Setting up a mobile team. After the events of 2016, it was observed that minors who showed signs of psychological distress often didn't recognise their need for help and refused psychological healthcare, or failed to keep to follow-up when it was started. Thus, a mobile team, with psychiatrists and nurses was organised, with the possibility to intervene directly where the minors live, in foster homes. An intervention can be requested by educators, the school, or healthcare workers when they notice difficulties. A specific procedure was developed so that the staff on the field (including the emergency services, whom URMs consult frequently, particularly at night and on the weekends) know whom to call in which situation.

URMs present with specific and complex challenges. We have the responsibility, just as for other vulnerable populations, to adapt our social and healthcare system to provide equity of treatment and to offer them a positive environment in which they can develop. Hopefully, this will lower the engagement of URMs in risk behaviours, just as the young migrants included in the study described by Campisi et al.

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