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Beyond reception

Recommendations from the Community of Practice for the Protection of Mental Health and Psychosocial Well-being of Migrant and Refugee Youth

Index

Coordination

Ivan Mei, Enza Roberta Petrillo, Fedora Gasparetti, Estella Guerrera, Silvia Li Quadri Cassini Finaurini, Paolo Vanni

Community of Practice

Child and Adolescent Neuropsychiatry Department - U.O.N.P.I.A. - Fondazione IRCCS Ca' Granda Ospedale Maggiore Policlinico of Milan: Paola Maffeis, Sofia Trezzi

Association Approdi: Delia Da Mosto, Irene

Esposito, Stella Kutrubis

Cooperative Insertion Disability Assistance Solidarity (CIDAS) (CIDAS): Marilù Parisi, Sarah Miclet

SaMiFo Center - Regional Healthcare Facility of ASL Roma 1: Silvia Capretti, Giancarlo Santone

Terres des Hommes: Federica Giannotta

PENC Centre: Maria Chiara Monti, Rosalia

Terrana

Catania Provincial Health Authority: Giuseppe Florio, Aldo Virgilio

Emilia-Romagna Region / Romagna Local Health Unit: Rosa Costantino, Tiziana Marzulli

Graphics

Roberta De Cristofaro

Thanks for the contributions provided in the development of this document

Europe and Central Asia Regional Office (ECARO): Maria Eleonora Benini, Laura Biscaglia, Paola Galassi, Emanuel Garavello, Chiara Garri, Maddalena Grechi, Valentina Iacovelli, Anna Lisa Pantusa, Giorgia Rocca.

Youth Sounding Board: Krishini Srikrishnamoorthy, Tetiana Yurchuk, Zeyad Hashem Mahmod Allderehmin, Cristina D'Agostino, Mohamed Hafez, Elshoery Elsayed Reda Mahmood Hashem, Qasim Mihammad, Sadman Sakib Mir, Saine Saidou, Shehara Galagamage, Mahmadou Korka Balde.

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Introduction

The Community of Practice

The **Community of Practice on Psychosocial Support and Mental Health Services for Migrant and Refugee Youth** includes services and professionals judged to be most involved in the mapping of psychosocial support and mental health services for adolescent and young migrant and refugee persons, carried out in 2022 by UNICEF.[1] With the Community of Practice, UNICEF wants to support, using community-based logic, the strengthening of the MHPSS system for adolescent and young migrant and refugee persons/young people through the activation of a community of experts and practitioners who systematically and regularly discuss operational or advocacy issues pertaining to Mental Health and Psychosocial Support of the migrant and refugee population based on their different experiences, needs, and wishes.

The objectives of the Community of Practice are as follows:

- To strengthen the capacity of staff working in the social and health care system and professionals through training needs analysis, knowledge capital transfer, tools and problem-solving strategies;
- To identify solutions and proposals regarding issues of specific programmatic and advocacy relevance;
- To share knowledge of the Community of Practice with decision makers who oversee policy and programme development in mental health and psychosocial support;
- To initiate and consolidate a work plan on the minimum MHPSS standards to be guaranteed within the reception system and the social and health service system.

At the time of publication of this document, the Community of Practice is made up as follows:

- Child and Adolescent Neuropsychiatry Department - U.O.N.P.I.A. - Fondazione IRCCS Ca' Granda Ospedale Maggiore Policlinico of Milan
- Approdi Association
- Cooperative Insertion Disability Assistance Solidarity (CIDAS)
- SaMiFo Center - Regional Healthcare Facility of ASL Roma 1
- Terres des Hommes
- PENC Centre
- Catania Provincial Health Authority
- Emilia-Romagna Region / Romagna Local Health Unit

This document was also produced in consultation with the Trapani Provincial Health Authority.

1 New Pathways. Good practices in psychosocial support and mental health for adolescents and migrant and refugee youth in Italy https:/ www. unicef.it/publications/new-pathways/

Background

Within the complex context of welcoming and integrating migrant and refugee children and youth, the identification, intake and effective referrals to mental health services, as well as interventions aimed at psychosocial well-being, are key pillars in ensuring appropriate support for people in vulnerable situations. In this context, this paper aims to offer recommendations and minimum intervention guidelines to improve these processes.

It is crucial to recognise that, in addition to interventions that respond to specific situations, it is of the utmost importance to focus on preventive interventions that act at different levels of the reception pathway. The implementation of preventive strategies can significantly contribute to reducing the risk of developing clinically relevant frameworks and can foster better social and cultural integration of migrant and refugee minors and youth.

This document is addressed to all professionals and actors in public and private services involved in the reception and integration process. The programmatic objectives of this document are not exhaustive and aim to provide basic intervention guidelines, taking into account territorial variations in services and procedures.

The work presented here closely complements other tools already established in the field, which proceduralise procedures for identification, intake and referral to social and health services including mental health services, including:

- The Operational Vademecum for Taking Charge of and Receiving Unaccompanied Foreign Minors;[2]
- The Vademecum for the detection, referral and taking charge of persons bearing vulnerabilities arriving in the territory and included in the protection and reception system;[3]
- The Reception and Integration System and unaccompanied foreign minors.[4]

2 https://www.interno.gov.it/sites/default/files/2022-08/24._vademecum_per_la_presa_in_carico_dei_minori_stranieri_non_accompagnati.pdf
3 https://www.interno.gov.it/sites/default/files/2023-06/vademecum.pdf
4 https://www.retesai.it/wp-content/uploads/2023/05/prot-Rapporto-MSNA-7-%E2%80%93-2023-Il-Sistema-di-Accoglienza-e-Integrazione-e-i-minori-stranieri-non-accompagnati.pdf

The operational principles that guide UNICEF's interventions

Protecting the Mental Health and Psychosocial Support (MHPSS) of children and adolescents is a global priority for UNICEF,[5] with a special focus on those in situations of vulnerability and risk. Interventions with the MHPSS approach have been progressively integrated into all UNICEF programs (protection, health, prevention and response to gender-based violence, education and promotion and participation of juveniles and young people), based on the peculiarity of the context and the needs identified with recipients and addressees, adopting the definition of MHPSS given in the Guidelines[6] of the Inter-Agency Standing Committee (IASC) on Mental Health and Psychosocial Support.

In the IASC Guidelines, the composite term **mental health and psychosocial support (MHPSS)** denotes any type of support, internal or external to a community, that **aims to protect or promote psychosocial well-being and/or to prevent or provide appropriate responses and treatment to mental health-related distress**. This term is widely validated and used internationally; it lays the foundation for the support system of a **multidisciplinary and integrated approach**, allowing a wide range of intervening actors to be united and coordinated to support individuals, groups, and communities, emphasising the need to converge and discuss diverse approaches and for complementary professionals in order to provide appropriate services in response to multidimensional wellness, health and care needs.

Mental health
is defined by the World Health Organisation as a state of well-being in which each individual realises his or her potential, can cope with normal daily stress, can work productively and fruitfully and is able to make a contribution to its community.

Psychosocial support
includes processes and actions that promote the holistic well-being of people in their social environment. These processes are aimed at facilitating the resilience of individuals, families and communities, respecting their independence, dignity, strategies and resources, promoting. The restoration of social cohesion and community infrastructure.

5 Mental Health and Psychosocial Technical Note: https://www.unicef.org/documents/mental-health-and-psychosocial-technical-note
6 Guidelines on Mental Health and Psychosocial Support in Emergency Settings, IASC 2007. https://interagencystandingcommittee.org/iasc-task-force-mental-health-and-psychosocial-support-emergency-settings/iasc-guidelines-mental-health-and-psychosocial-support-emergency-settings-2007

In accordance with the IASC Guidelines, and the main operational and theoretical reference tools produced by UNICEF at International level,[7] *all practitioners, workers and agencies working in the field* of mental health and psychosocial well-being support are bound by important **operational principles** that enunciate and guide interventions at every stage (needs assessment, design, implementation, monitoring, evaluation, research, advocacy, etc.). These operational principles can be summarised as follows:

1. Equity and basic human rights

Every mental health and psychosocial well-being service must promote the basic human rights of the individuals and groups they address. Furthermore, in accordance with the *Convention on the Rights of the Child*, all parties involved should ensure maximum equity, accessibility and availability of services to all users who need it, without any discrimination related to gender, age, language, cultural affiliation, or any other human dimension. In the specific area of interest for this research, MSNAs are considered a vulnerable group and should therefore be guaranteed dedicated channels that facilitate access to and use of services that take into account specific experiences including those related to gender issues.

2. Do no harm

The utmost care and attention is required to ensure that mental health and psychosocial support services do not cause and contribute, even unintentionally, to further distress, suffering, difficulty, disadvantage, or increased vulnerability to the person and groups they address. As the field of psychosocial intervention is sensitive and complex, the risk of causing harm is higher than in other areas. Therefore, careful assessment of possible risk factors before, during, and after service delivery and careful monitoring of the impact of the intervention on the psychosocial well-being and safety of the user are necessary.

3. Superior interest

In every decision-making process, public and private, judicial and administrative in nature or in other contexts, the principle of the best interests of the minor is a fundamental element and must be held in primary consideration. This principle is a relevant interpretive tool through the role of adults must be balanced with minors, within decision-making, protection, care and support processes that affect them. The best interest must take on an individual dimension, taking into account the circumstances of each minor in the case, especially in particularly delicate situations. This is in order to promote and ensure their well-being in terms of their primary material, and physical, educational and emotional needs.

4. Participation of individuals and groups targeted by interventions of mental health and psychosocial well-being

The involvement and consultation with people receiving services is fundamental to ensuring that interventions are consistent and effective with respect to identified needs. Furthermore, encouraging users to play an active role within the programmes ensures faster recovery, strengthening of personal resources, and greater capacity for self-determination, which are all fundamental aspects and preparatory to the consolidation of psychosocial well-being and empowerment. In the case of children, their voices, thoughts, and emotions should always be given the utmost consideration and taken as guiding elements of interventions. Taking an active role may require different amounts of time depending on the person's experiences, including gender and cultural context of belonging. Early marriages and pregnancies, for example, can affect the

7 Operational guidelines: Community-based Mental Health and Psychosocial Support in Humanitarian Settings: Three-tiered support for children and families, UNICEF 2018. https://www.unicef.org/reports/community-based-mental-health-and-psychosocial-support-guidelines-2019 UNICEF Global Multisectorial Operational Framework for Mental Health and Psychosocial Support of Children, Adolescents and Caregivers Across Settings. https://www.unicef.org/reports/global-multisectoral-operational-framework

perception of one's autonomous identity. Similarly, the social and gender norms a girl has been surrounded by, can influence her openness to sharing her opinions.

5. Building interventions on available resources and capacities, strengthening the existing systems, enhancing the resources of individuals, groups and communities that the services themselves address

This principle may involve mapping and evaluating community initiatives and services to support mental health and psychosocial support that are already in place, before new ones are established. In general, each intervention should address the identified needs and be compatible with these needs, including cultural, contextual, and user factors in order to be sustainable. Continuous capacity building and strengthening of female and male workers, and other stakeholders involved, should be a priority programmatic pillar of any intervention. A so-called 'community-based' approach, which is well exemplified by the recently developed UNICEF operational guidelines mentioned above, has gradually been gaining ground in recent years.


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6. Multi-level and integrated mental health support and psychosocial well-being

As noted above, the continuum of basic and psychosocial needs can be supported with a multiplicity of interventions, which in their diversity and distinctiveness involve different technical skills, but which act in an integrated and complementary way. This aspect is critical to avoid the creation of a fragmented system that is incapable of adequately capturing and responding to the complex needs of individuals and groups.

7. Inter-agency coordination and referral mechanisms

Given the vast area of services and the great multiplicity of figures working in different sectors to support mental health and psychosocial well-being (health, education and protection, to name just a few of the main ones), there is a need for effective and shared coordination mechanisms that make it possible to regularly exchange and compare among all stakeholders, locally, regionally and nationally. A good knowledge of services active in the area, by providers of the services themselves, is essential to be able to provide integrated support in able to respond to the continuum of the individual's needs and make timely and appropriate interventions. The IASC guidelines[8] includes several tools for mapping existing services, establishing effective inter-agency coordination mechanisms, and systematising dispatch mechanisms.

In line with the above-mentioned operating principles, it is important for organisations that operate in the area of mental health support and psychosocial well-being to equip themselves with safeguards to protect the minors served by their programmes. The same intake services and support can, in fact, create or exacerbate the risks to which children and adolescents are exposed,

8 https://www.mhpssmsp.org/en

The **Youth Sounding Board** (YSB) is a group of about 15 **UASCs** and **migrant and refugee youth** between the **ages of 15** and **19**, established within the framework of the Adolescent Wellbeing Programme, whose members are predominantly minors residing in shelter system facilities in Milan. From October 2023 to June 2024, the YSB met regularly every week at Terres des Hommes' Indifesa Hub, coordinated by a UNICEF worker, to reflect on the topic of **Mental Health and Psychosocial Wellbeing and analyse support services dedicated to migrants and refugees**, creatively contributing to the **proposal of solutions for their improvement**.

Gathering participants' voices, views, opinions, and experiences and comparing them with in-person focus groups made up of adolescent migrants in reception centres in Genoa and Ragusa, and with the results of online surveys on the topic of Mental Health, YSB identified **priority areas to focus on, collected information on existing services, and reported critical issues encountered regarding access**.

In addition to reporting the results of these observations and interactions to the Community of Practice, UNICEF will enhance the work of the Youth Sounding Board by producing a small adolescent-friendly vademecum, translated into multiple languages, intended to inform MSNAs in the reception system about basic concepts related to mental health and psychosocial well-being, the main support services available and the relevant professional figures, inside and outside the shelter system.

such as physical violence, sexual violence, sexual abuse and exploitation, emotional and verbal abuse, economic exploitation, failure to protect physical and emotional safety, neglect with respect to physical, emotional, and psychological needs, harmful cultural practices, and violations of privacy. *Child safeguarding* refers to measures taken, in terms of policies, procedures, and programmes, to ensure physical and emotional safety and to assess and reduce the risks of causing harm to children and adolescents with whom organisations come into contact, directly or indirectly, through their own work and that of staff and partners. In particular, with regard to sexual abuse and exploitation cases, the IASC Guiding Principles and related operational and theoretical tools, including those produced by UNICEF at international level, provide useful references for the creation of policies and mechanisms for reporting, investigation, and response.[9] When carrying out psychosocial support activities, it is essential that protection from sexual exploitation and abuse (PSEA) policies are enforced based on a zero-tolerance approach. Policies and related safety mechanisms - accessible, and possibly identified based on consultations with target persons -must be communicated effectively to all affected persons through different channels depending on the target population, including simplified messages for children.[10]

More information is available by accessing the Prevention of Sexual Exploitation and Abuse e-learning course.

9 https://psea.interagencystandingcommittee.org/
10 Examples of communication materials are available on the IASC website: https://psea.interagencystandingcommittee.org/resources?f%5B0%5D=type_of_publication%3A336

Guiding principles for supporting survivors of gender-based violence

1. **Safety**: the safety of the survivor of violence and others, such as her children, family members, and caregivers, must be the top priority for all actors. People who report an incident of gender-based violence or a history of abuse are often at high risk of further violence by the perpetrators themselves or others.
2. **Confidentiality**: confidentiality reflects the belief that people have the right to choose to whom they will or will not tell their story. Maintaining confidentiality means not disclosing any information at any time to any party without the informed consent of the person concerned. Confidentiality promotes safety, trust and empowerment.
3. **Respect**: the person who is a survivor of violence is the main actor, and the role of the people who support them is to facilitate their recovery and provide them with resources for solving their problems and meeting their needs. All actions taken should be guided by respect for the person's choices, wishes, rights and dignity.
4. **Non-discrimination**: survivors of violence should receive fair and balanced treatment regardless of age, gender, race, religion, nationality, ethnicity, sexual orientation, or any other characteristics.

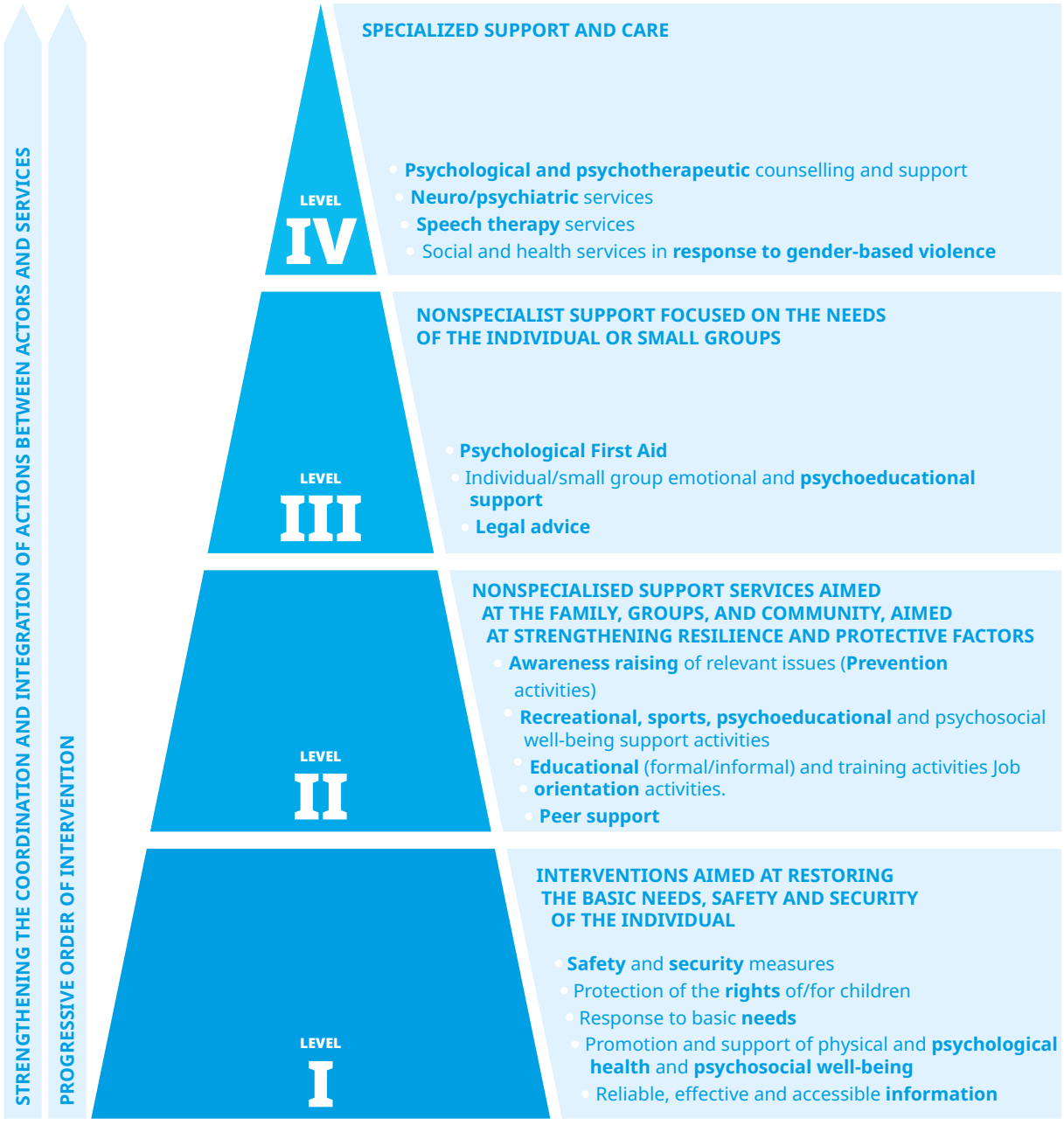
For further study: The Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming, Inter-Agency Standing Committee, 2019

The IASC MHPSS model

The IASC Guidelines frame MHPSS interventions on 4 levels, which are represented within a pyramid, as shown in the figure below.

The pyramid of interventions to support MSNAs

Any intervention respects the principle of **non-harm**, **dignity** and **best interests of the child/children** and adopts **cultural-linguistic mediation** as a building block of any intervention



Each of the 4 levels of intervention is designed to address certain needs. As we move from the base of the pyramid to the top, these needs become progressively more intense and require the services provided to pay more attention to individual dimensions and require more sophisticated specialised skills.

Level 1: Interventions aimed at ensuring basic needs, safety (actual and perceived) and security of the person. All necessary considerations and arrangements must be put in place to ensure full respect for human dignity, involvement of and attention to the best interests of minors.
This approach, which remains valid for every level of MHPSS intervention, is also intended to be emphasised and promoted in the services that focus on meeting *basic needs* (food, hygiene materials, medical care, clothing and blankets, a protected place to live, safe and reliable protective measures for an unaccompanied minor, etc.). **The safety of the person is likewise an indispensable prerogative and therefore, with regard to minors, implies a physical, emotional and relational environment that is protective, supportive, predictable and consistent**.
Included at this level are *dissemination of* critical *information* for accessing services and *awareness-raising actions* about aspects pertaining to: basic human rights, guiding principles of the Convention on the Rights of the Child, multidimensionality of psychosocial well-being, etc.

Level 2: Direct family, group, and community support interventions that aim to restore and/or strengthen individual resilience, protective factors (individual and group), and functional coping strategies. Within this level are the majority of unfocused, nonspecialised psychosocial well-being support interventions. These are *services that are structured and have predefined goals*, look at the needs of the group and aim to strengthenconnections between people and social support networks by replacing or strengthening family or community support systems that were present in the past and changed as a result of emergencies or migration movements.
For example, work with adolescent(s) at this level could include group workshops aimed at strengthening self-esteem coping strategies, ability to manage emotions and conflict situations, etc. Also included in this category is **support between peers**, awareness-raising actions (against stigma, discrimination, gender stereotypes, etc.), recreational, sports and educational activities (which must include MHPSS components), psycho-socioeducational interventions, formal and informal education services, etc. It is important to arrange both activities in mixed groups (age, gender, culture), as well as separate activities. The multiplicity of interventions that are found at this level are referred to generically as **nonspecialist psychosocial support, and imply structured services which are tailored to the target group (based on gender, age, culture, etc.).**

Level 3: Focused support interventions that address the specific needs of the individual or a small group of people with common or similar experiences, needs or problems. Again, these are activities, individual or group, structured with predefined goals, led by staff with *specific skills* but not necessarily clinical training. These services can be provided by professional educators and other figures with skills in educational, paedagogical, and psychological fields (including active and empathic listening skills, providing emotional support, adopting age-appropriate supportive communication techniques, etc.).

Level 4: Supportive interventions and specialised care. At the top of the pyramid, we find clinical and medical services that require more attention to the experience and history of the individual and need specialised expertise, including psychological, psychotherapeutic, neuropsychiatric, psychiatric, neurological support, etc.
Overall, the four levels of support emphasise

the connection between services that strengthen the individual's resilience in the host community and the local area inclusion (Levels I and II), services that improve the coping mechanisms of specific vulnerable groups within the broader population (Level II), and the focused services aimed at individual needs (Levels III and IV), which may also include specialised interventions (Level IV).

Thus, the operational paradigm of mental health and psychosocial support is proposed as an organic response to the fragmented nature of intervention models put in place by actors outside the health sector who deliver services conventionally ascribed to psychosocial well-being, and health sector actors who conventionally oversee clinical mental health interventions.

From the perspective of service providers, therefore, the MHPSS definition aims to "harmonise in a dimension of interdisciplinarity, the three pivotal figures in psychosocial action, psychiatrists, psychologists and social workers, each interacting with the others but with their own specific tasks distributed in the various phases of intervention, excluding mono-disciplinary and isolated approaches that experience has shown to be reductive and inappropriate" (Castelletti, 2008, p.7[11]). In addition to the professional figures mentioned above, other professionals such as educators, health workers and volunteers are also considered relevant.

The arrow in the pattern diagram, which runs upwards from the base of the pyramid, indicates the priority of the interventions, i.e., the progressive direction in which services should be delivered. This should not be misinterpreted as a hierarchy of importance among services; **rather, it suggests opting for services at the upper levels of the pyramid only after having already attended to and met the needs related to the levels below. In this way, the intervention is more likely to be effective, and the number of individuals in need of focused services, dedicated resources, and support in the long term will decrease as one moves up towards the top of the pyramid**. At the same time, people with significant mental health conditions may be referred to Level 4 services as they need specialised support and care.

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11 The Guidelines on Mental Health and Psychosocial Support in Emergency Settings, Paolo Castelletti, 2008, http://www.psicologiperipopoli.it/files/Numero%202%20Cas.pdf.

Intervention models for prevention and response to psychosocial care and support needs

Emotional needs and experiences, especially those related to **complex experiences** such as forced migration, as perceived by migrant and refugee minors and youth are not always externalised in ways that can be easily decoded by shelter workers or the closest reference figures. Often, minors and the adults in their care need to be supported and guided in understanding their most delicate emotional states (which are sometimes very painful), and the possible psycho-physical and relational reactions related to them. This action to support psychosocial needs and well-being rests on two types of intervention.

Prevention and promotion interventions. The goal is the **strengthening** of the acquired state of **psychosocial well-being** and the enhancement of **individual and environmental resources** that support and facilitate the ability to effectively manage developmental challenges and adaptation processes. This category includes all services of consolidation of the person's life skills and strengths (at the level of cognitive-intellectual skills, emotional-relational skills, etc.), fostering social connections of trust and support (among peers, in a family unit, with adult figures of reference, etc.) and, with respect to adults caring for minors, their ability to provide reliable and effective parental care.

Support and care interventions. These are interventions provided in **response to a condition of emotional distress**, psychological suffering, or-in more severe cases, in the presence of an overt psychological disorder or psychopathology. Emotional suffering may take forms that are not always clearly recognisable and, sometimes, may be hidden behind to behaviours that would seem to communicate mixed messages. Professionals (e.g., educators, community coordinators, social workers, psychologists and psychologists, etc.) and other possible caregivers (parents, guardians, teachers or internship tutors, sports coaches or entertainers in social-recreational centres, etc.) **should master the tools to be able to decipher the behaviour of girls, boys and adolescents and readily identify signs of distress and possible emotional distress. These manifestations of distress, if recognised and properly handled by trained professionals, can have a less significant impact on the mental health of the child/children**. Identifying early warning signs and assessing their complexity allows targeted and rapid referrals to specialist services so as to avoid exacerbation of the symptomatology or to avoid it becoming chronic and the activation of overly burdensome intensive interventions. In the case of increased vulnerability, more attention to "stress-related" needs is also needed in the receiving environment to support formal care pathways and facilitate adaptation processes related to post-migration.

Systemic challenges identified by the Community of Practice

In relation to this paper, the Community of Practice has noted significant challenges that need ad hoc interventions aimed at strengthening psychosocial well-being and mental health and responding appropriately to conditions of emotional distress, psychological suffering or psychological disorders and psychopathologies. These challenges, as well as the proposed interventions, were highlighted in three stages of the reception pathway: Access to the territory, Access to services, Taking charge.

Access to the territory

This phase includes entry into the territory by landing, landing or tracing, the emergency, extraordinary and first reception phases in government facilities, and the transfer phase to first and second reception.

Challenges noted

- Inappropriate and non-continuous linguistic-cultural mediation or that carried out by staff who, due to gender or other characteristics, is not conducive to fiduciary engagement for the emergence of specific vulnerabilities
- Accelerated deterioration of ill states and early application of psychiatric treatment
- Unstructured and organised care settings to promote psychosocial well-being significantly undermine emotional health and resilience of the resident(s)
- Early identification of risk signals and psychological/psychosocial vulnerabilities and structures potentially causing further risks to the physical and emotional safety of the people received
- Absence of safe and confidential spaces conducive to the emergence of risks and vulnerabilities in the interview phase
- Lack of structuring of space and time in facilities
- Lack of resources for accompaniment to territorially competent health services

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Access to services

Barriers to accessing MHPSS services

Challenges noted

- Absence/lack of interview for orientation or screening purposes, aimed at identifying signs of psychological/psychosocial vulnerability
- Absence/lack of established practices to bring together all stakeholders involved in case management
- Lack of harmonised procedures and tools for sharing the information in a secure manner in accordance with the principle of confidentiality

- Lack of health information about the person accessing services
- Stigma and prejudice towards mental health needs

Barriers to accessing services

- Difficulties in obtaining residency for those who are not housed in the SAI
- Type of pathology: public mental health services have increasingly narrowed access criteria based on severity of pathology
- Age: services are lacking for the group of people under legal age
- Physical and/or mental vulnerabilities are not compatible with the criteria for access to certain facilities, particularly when there is substance use/abuse, or when placement in a residential facility is necessary and with the presence of round-the-clock caregivers and operators
- Lengthy hospitalisations in the most severe cases in unsuitable wards, even up to 6 months long, due to the difficulty of locating suitable communities
- Shortage of therapeutic facilities or, in these facilities, shortage of sufficient places to meet the identified needs

Intake

Challenges noted

- Marked clinical and/or mental distress patterns associated with deviant behaviour and substance use/abuse
- Clinical pictures and/or emotional-psychological distress associated with the experience of survivors of gender-based violence, abuse or exploitation, or other highly destabilising and potentially traumatic episodes
- Clinical and/or mental distress pictures associated with early pregnancy
- Lack of awareness of minors regarding aspirations related to the migration project
- Overburdening of the National Health Service and lack of adequate services for taking in load of migrant people
- Shortage of public psychotherapy services
- Lack of support for reception staff to manage mental suffering

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The recommendations of the Community of Practice

These recommendations are geared towards providing targeted guiding principles on the delivery of services and interventions to protect and support the psychosocial well-being and mental health of migrant and refugee children and youth, with an emphasis on prevention and early detection of psychosocial vulnerabilities and promotion of psychosocial well-being in settings such as first aid facilities, extraordinary and emergency reception facilities and governmental first reception facilities, also including the delicate phase of transfer to and between first and/or second reception centres.

In such contexts, psychosocial and mental health support interventions for minors and youth migrants are aimed at fostering:

- **SAFETY**: To create a sense of safety -physical, emotional, psychological, and relational -right from the initial reception settings by providing emotional support and appropriate resources.
- **CONNECTION**: From the outset, promote opportunities for discussion, group and effective relationship building among the minors and with caregivers, ensuring their inclusion and accessibility to minors and youth who differ in age, gender, culture of origin, presence of disabilities, and other characteristics, including by monitoring participation in exchange events.
- **COPING**: developing coping strategies to help minors and youths adapt to the reality of post-access shelter facilities and cope with stress and possible emotional and psychological distress.

The model shown here is based on the realisation that much of the healing from exposure to chronic stress and trauma can occur in nonclinical settings.[12]

12 Trauma Informed Care -TIC, Bath, 2016

At a general level, these interventions are articulated with the following macro areas of reference in mind.

Prevention and management of the onset of acute psychosocial stress

- Implement prevention interventions to reduce the risk of impairing the psychosocial well-being and mental health status of children, with a focus on the early arrival stages.
- Provide operators with effective operational tools to manage psychosocial emergency situations and ensure the safety of minors.
- Implement interventions that promote an empathetic approach to children and young migrants, avoiding any form of dehumanisation, threat to their well-being, and potential retraumatisation, if prior trauma is present.

Reducing risk factors and strengthening protective factors

- Identify and reduce risk factors, including contextual factors, that may affect the psychosocial well-being and mental health of and migrant children.
- Strengthen protective factors, including those related to the hosting environments, to create safer and more conducive contexts for the recovery and/or strengthening of psychosocial well-being.

Identification of vulnerable situations, reporting of them, and specialised support

- Establish and systematise procedures and tools to quickly and effectively identify cases of greatest vulnerability among minors, allowing immediate access to the specialised support required.
- Implement training programmes for male and female operators aimed at the early identification of the signs of vulnerable situations and their referral to specialised services.

The reception system

The arrangements for the reception of and asylum seekers in Italy are regulated mainly by Legislative Decree No. 142/2015, the decree implementing Directive 2013/33/EU on standards for the reception of applicants for international protection.
Its regulations have been amended several times over time, including in 2023 those introduced by Decree-Laws No. 20/2023 (the so-called Cutro Decree) and No. 133/2023 (containing changes regarding the reception of MSNAs).
The reception system is outlined below, dividing the stages of reception among the different facilities that comprise it. A focus will be devoted later to the reception of underage persons.

1. The reception system

First aid facilities

According to Article 10ter of Legislative Decree No. 286/1998 (Consolidation Act on Immigration), a foreigner who enters the territory illegally, including as a result of rescue at sea, is taken to special facilities called "crisis points" (hotspots). Migrants stay at these facilities for the time strictly necessary for the establishment of first aid operations, material and health care, and for identification procedures.

Ten hotspot facilities are currently operating in Italy, in Lampedusa, Trapani, Pozzallo and Taranto.

Government Reception Centres

After completing the initial operations at hotspots, migrants are transferred to government reception centres regulated by Article 9 of Legislative Decree No. 142/2015.

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These are facilities located throughout the country, established to meet the needs of first reception and for the completion of the operations necessary to define the legal position of the foreigner who has expressed the desire to seek asylum in Italy (when these have not been completed at the hotspots).

In the event that the availability of places in the centres referred to in Article 9 is temporarily exhausted, due to large and close arrivals of applicants, reception may be arranged by the Prefect, after consulting the Department for Civil Liberties and Immigration of the Ministry of Interior, in temporary facilities, specifically set up for this purpose, after assessing the health conditions of the person applying for international protection, also in order to ascertain the existence of special reception needs. Within government first reception centres, food, shelter, and minimum services are provided. However, the reform introduced by the Cutro Decree has reduced the services offered to the people received, which to date are limited to health care, social assistance and linguistic-cultural mediation.

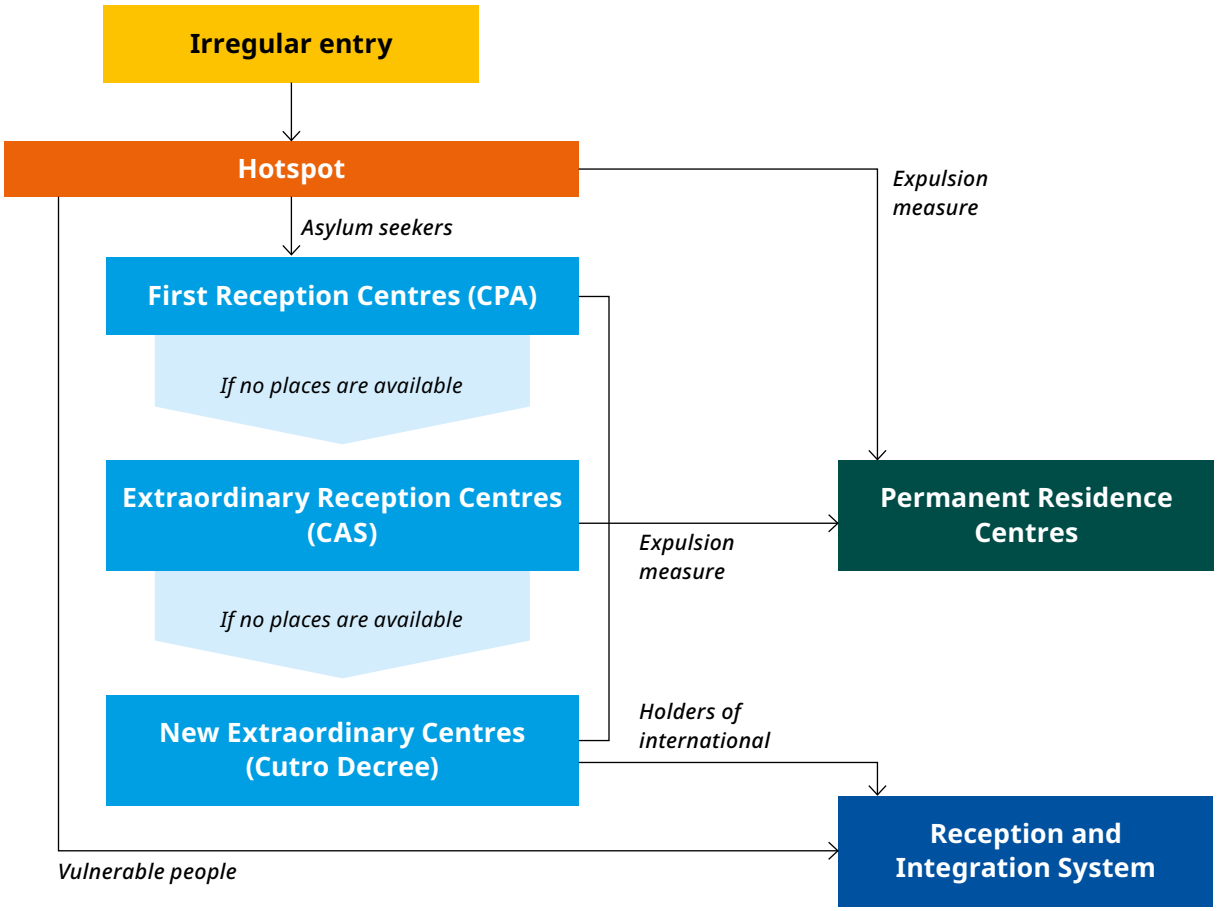
DL 20/2023, known as the Cutro Decre, also introduced a third type of extraordinary reception facility, activated by the Prefectures, where people can be received in the event of unavailability of places in the previously mentioned facilities. The normative reference of these facilities is now found in paragraph 2-bis of Art. 11 of Legislative Decree No. 142/2015. Within these facilities, services are further reduced, and other than material reception, people can only benefit from health care and linguistic-cultural mediation (thus social assistance is not included).

Reception and Integration System (SAI)

Unlike government centres, which are managed exclusively by the Ministry of the Interior, SAI is coordinated by the Central Service, the management of which is assigned to the National Association of Italian Municipalities (ANCI) with the operational support of the Cittalia foundation. Ownership of the projects is assigned to local authorities, which, on a voluntary basis, activate and implement reception and integration projects. The reference standard for SAI facilities is Article 1-sexies of Decree-Law No. 416/1989. Reception within the SAI is dedicated to holders of international protection, who are (generally) transferred here after the initial reception phase in government facilities.

However, there are some categories of individuals who are allowed to enter the SAI even if they do not hold protection: these are unaccompanied foreign minors (MSNA), people who have special conditions of vulnerability or those who have entered Italy through "humanitarian corridors" or similar systems, and finally, in view of specific regulations, Ukrainian and Afghan asylum seekers. Reception is organised into two distinct levels: the first level, reserved for asylum seekers, within which material, legal, health and language assistance is provided. The second level services are reserved for protection holders and also include, in addition to to those at the first level, job integration and guidance services.

Reception system



2. Reception of unaccompanied and separated children

The reception system for minors is also governed by the Legislative Decree No. 142/2015 (and in particular Article 19), which contains specific rules introduced and amended by Law No. 47/2017 (Zampa Law) and most recently by Decree-Law No. 133/2023.

The resulting system distinguishes between a first and second reception and establishes the principle that an unaccompanied minor may under no circumstances be detained or received at centres of stay for repatriation (CPR) and government reception centres.

The initial reception phase

The reception of Unaccompanied and Separated Children (UASC) is based first and foremost on the establishment of governmental first reception facilities (so-called FAMI centres) for the rescue and immediate protection needs of all unaccompanied minors. As specified in Article 19 of Legislative Decree no. 142/2015, "for the needs of rescue and immediate protection, unaccompanied minors shall be received in governmental facilities of first reception intended for them [...] for the time strictly necessary, however, not exceeding forty-five days, to identification, which must be completed within ten days, and to age determination, if any." First reception facilities are activated by the Ministry of the Interior, in agreement with the local authority in whose territory the facility is located, according to the needs of that territory, taking into account the extent of arrivals at the border or tracing, and managed by the Ministry of the Interior with funding from the Fund for Asylum Migration and Integration (FAMI).

The second reception phase

For the continued care of the minor, again Article 19 of Leg. No. 142/2015 stipulates that all unaccompanied minors should be received primarily within the framework of the Reception and Integration System (SAI), and in particular in projects specifically designed for this category of vulnerable individuals. Paragraph 2-bis of Art. 19 of Legislative Decree No. 142/2015 specifies that, in choosing where to place the minor, their needs and characteristics should be taken into account, in relation to the type of services offered by the care facility.

Emergency reception

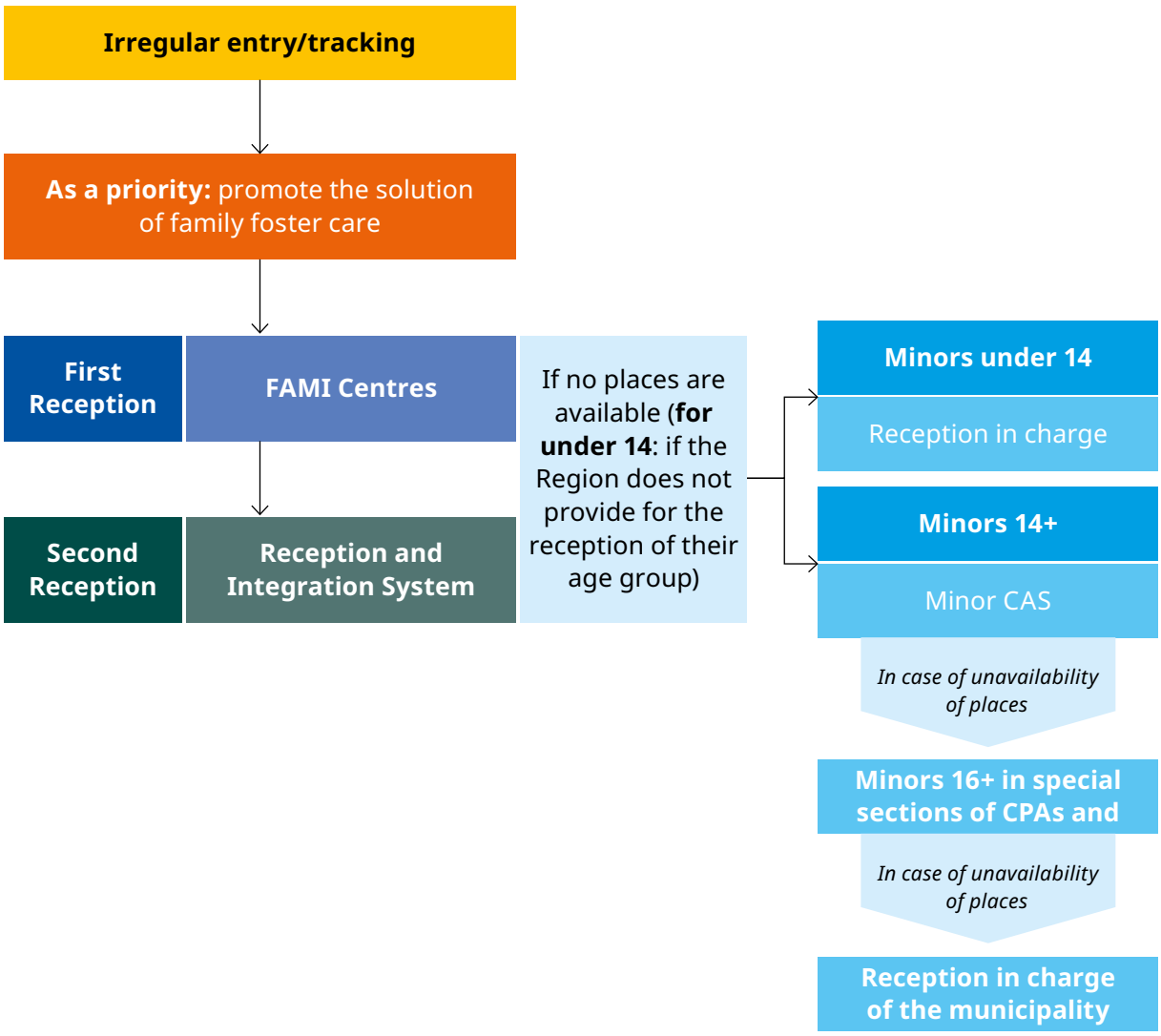
In addition to the basic structure of the reception system for minors, in two separate phases between FAMI centres and the SAI, the regulatory framework also provides for reception in other facilities considered as emergency reception solutions. The emergency facilities can replace the reception of both FAMI and SAI centres, and their activation and use was recently amended by Decree-Law No. 133/2023, which in turn amends paragraph 3-bis of Article 19 of the Reception Decree (Legislative Decree No. 142/2015).

In essence, if reception cannot be provided within the FAMI or SAI centres, the prefect may order the activation of temporary accommodation facilities dedicated exclusively to unaccompanied minors, with a maximum capacity of fifty places for each facility. Reception in these temporary facilities cannot be arranged for minors under the age of fourteen and is in any case limited to the time strictly necessary for transfer to SAI facilities.

Should there be no vacancies in the temporary facilities for minors, Decree-Law No. 133/2023 introduces (again by amending paragraph 3-bis of Article 19 of Legislative Decree No. 142/2015) the possibility for the prefect to order the reception of a minor not younger than sixteen years of age in a dedicated section in reception facilities for adults (referred to in Articles 9 and 11 of Legislative Decree No. 142/2015), for a period, however, not exceeding ninety days, extendable by a maximum of an additional sixty days.

Lastly, if there are no places available in any of the aforementioned facilities, Paragraph 3 of Article 19 stipulates that "the care and reception of the minor shall be temporarily ensured by the public authority of the municipality where the minor is, subject to the possibility of transferring the child to another municipality, according to the guidelines set by the Coordination Table referred to in Article 16, giving priority consideration to the best interests of the child."

Reception system for unaccompanied and separated children



Gender-based violence guidelines

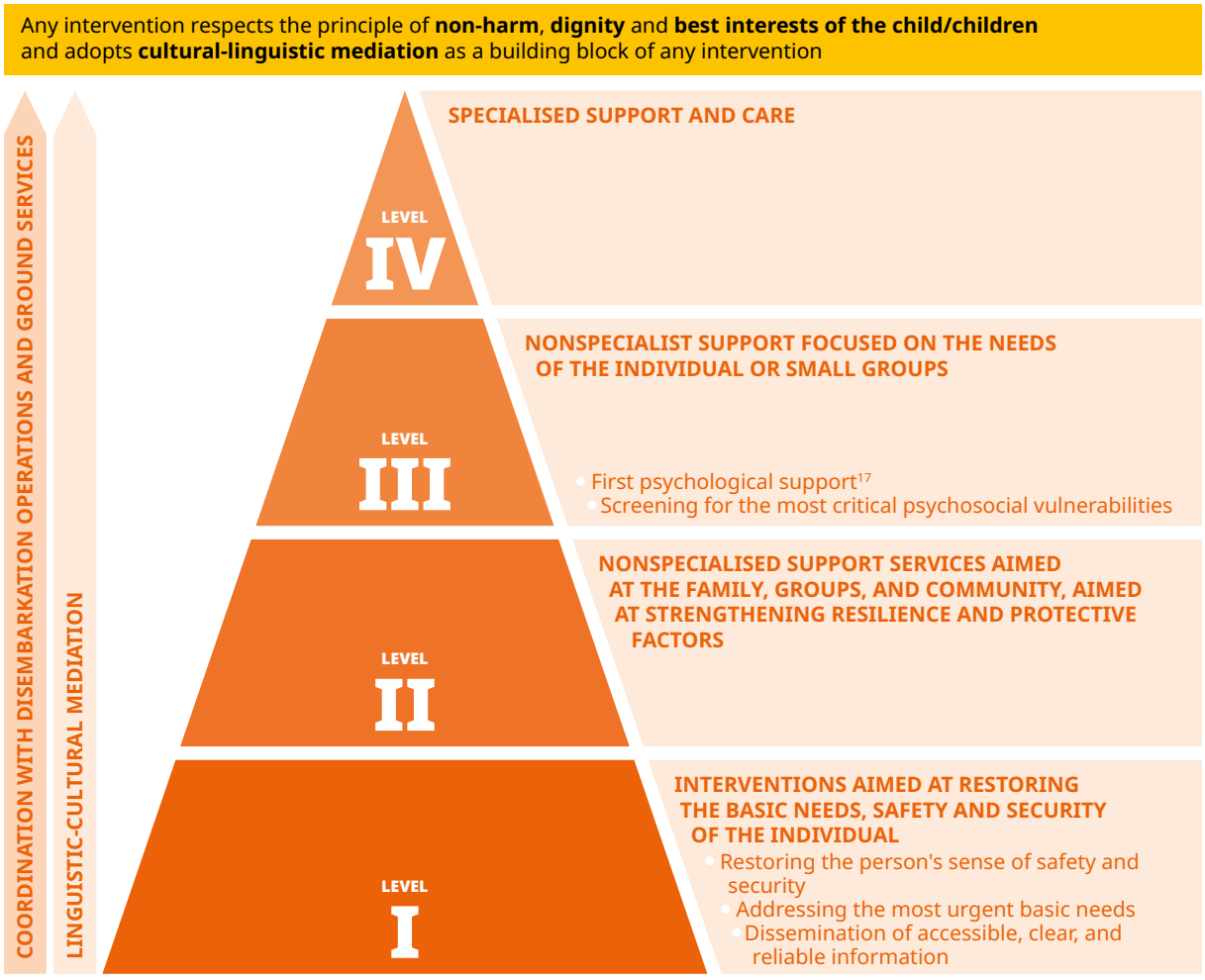
It is recommended that practitioners, workers and agencies working in the area of mental health and psychosocial wellness support and programmes to support migrant and refugee populations, work within the following guidelines and tools when supporting survivors of gender-based violence and other forms of violence, abuse and exploitation.

- Guidelines for early recognition of victims of female genital mutilation (FGM) or other harmful practices. (Parsec Research and Social Interventions Association; Coop. Soc. Parsec; University of Milan-Bicocca; A.O. San Camillo Forlanini; Nosotras Onlus and Associazione Trama di Terre, 2018).[13]
- National Guidelines for Health Authorities and Hospital Authorities on Relief and Socio-Health Care for Women Victims of Violence (DPCM, O.J. No.24, 30-1-2018).[14]
- Guidelines for the planning of care and rehabilitation interventions as well as treatment of mental disorders of holders of refugee status and subsidiary protection status who have experienced torture, rape or other serious forms of psychological, physical or sexual violence (issued by the Ministry of Health, 2017).[15]
- Guidelines for carrying out prevention, care and rehabilitation activities for women and girls already subjected to female genital mutilation practices (Issued by the Ministry of Health, 2007).[16]

13 https://www.pariopportunita.gov.it/media/2090/linee-guida_-it.pdf
14 https://www.gazzettaufficiale.it/eli/id/2018/01/30/18A00520/sg
15 https://www.salute.gov.it/portale/documentazione/p6_2_2_1.jsp?id=2599
16 https://www.salute.gov.it/imgs/C_17_pubblicazioni_769_allegato.pdf

Section 1
Access to the territory

Post-rescue navigation / Operations at sea



Navigazione post-soccorso / Operazioni in mare: interventi essenziali da garantire

The period between rescue operations at sea and disembarkation operations at assigned ports is critical in order to be able to reduce the risk that the stressful conditions to which rescued people are subjected and have been subjected to previously, result in the onset of symptoms of profound psychological distress, with manifestations likely to occur onboard or in the days immediately following disembarkation.

The people rescued all potentially present a vulnerable condition, considering the stressful and potentially traumatic experiences experienced:

- On route from the country of origin to the country of embarkation;
- In the country of embarkation;
- In the hours or days spent at sea prior to rescue operations, particularly when these occur after a shipwreck.

To this basic vulnerability framework, we must add the operational context factors that characterise the days of post-rescue and

17 More details at the box on page 33 et seq.

pre-landing navigation, such as overall sailing times, space available onboard, specialised personnel, and an effective system of coordination with the agencies in charge and directly involved in disembarkation operations. Assuming this multidimensional perspective, it is therefore necessary to implement interventions that are aimed primarily at reducing risk factors and strengthening protective factors in accordance with the "do not harm" principle.

At a general level, at this very early stage, there is a need to strengthen coordination mechanisms between the post-sea rescue navigation period and landing operations in assigned ports, with the aim of carrying out an initial screening of vulnerabilities, ensuring proper passage of information to dedicated personnel at the dock, and increasing the sense of safety of minors and young migrants. Furthermore, it is crucial to raise awareness of the need to consider, onboard and upon disembarkation, through specific protocols and procedures, not only the medical and health aspects related to physical health, but also to consider mental health as essential, to be approached in a culturally sensitive manner.

Responses to basic needs, safety, security

The first 48 hours after the sea rescue are critical and are dedicated to carrying out interventions aimed at meeting:

- basic needs;
- security needs;
- the individual's needs for protection.

During this time, unless severe psychiatric symptoms occur that need to be taken care of by onboard health personnel or, when possible, by mental health specialists, and for which evacuation may be required, it is deemed appropriate to implement only interventions aimed at meeting the aforementioned needs.

Regarding safety and security needs, whenever possible, it is recommended that those rescued be divided onboard by gender, avoiding separation of the mother-child household, thereby increasing the sense of security of people, particularly women, who are often potential victims and have previous experiences of gender-based violence. The gender breakdown also encourages the emergence of vulnerabilities declared by the people themselves to the crew with whom they are in contact. It is also considered necessary that reliable, effective reporting be implemented onboard and that it be accessible with respect to rights and reception pathways and procedures. Given the stressful conditions to which people onboard are subjected, it is deemed necessary to make the disclosure while avoiding providing information that might create expectations that are then unfulfilled in the early post-landing period.

To ensure the safety of those rescued, de-escalation, crisis management and containment interventions should be implemented onboard.

The presence of language-cultural mediation professionals is essential the whole time while sailing to the assigned ports. It appears necessary to have language mediators and mediators onboard vehicular referrals. For the people rescued, the support given by these professionals and the ability to receive and understand information is a primary safety factor.

Screening for the most critical psychosocial vulnerabilities

During the course of the days spent onboard, indicators of psychological distress may emerge at various times; they can be observed directly by the crew, particularly during medical screenings, but also during any activity carried out on board. Such indicators can also be manifested directly by the people themselves. It is therefore necessary for crew personnel to be trained:

- to recognise the main indicators and needs related to mental health;
- in Psychological First Aid (PFA), if it can be carried out in vehicular languages and by primarily language-cultural mediation professionals;
- to manage self-injurious and heterolesive behaviours, read aggression, and de-escalate emotionally and behaviourally critical situations.

In order to be able to carry out even minimal psychological and psychosocial vulnerability screening operations, moments of interaction and exchange between crew personnel and rescued persons should be encouraged as much as possible. In particular, carrying out everyday activities, such as eating meals together, allows crew personnel to more effectively establish a trusting relationship and observe and identify any signs of stress.

Where it is possible to have specialised mental health personnel and where conditions on board make it possible, it is important that any certifications pertaining to the person's mental health status and/or any conditions related to victims of torture and violence be issued. Such information can be forwarded to the appropriate agencies for disembarkation and reception, thereby facilitating access to specialised services ashore.

Coordination with landing operations and shore services

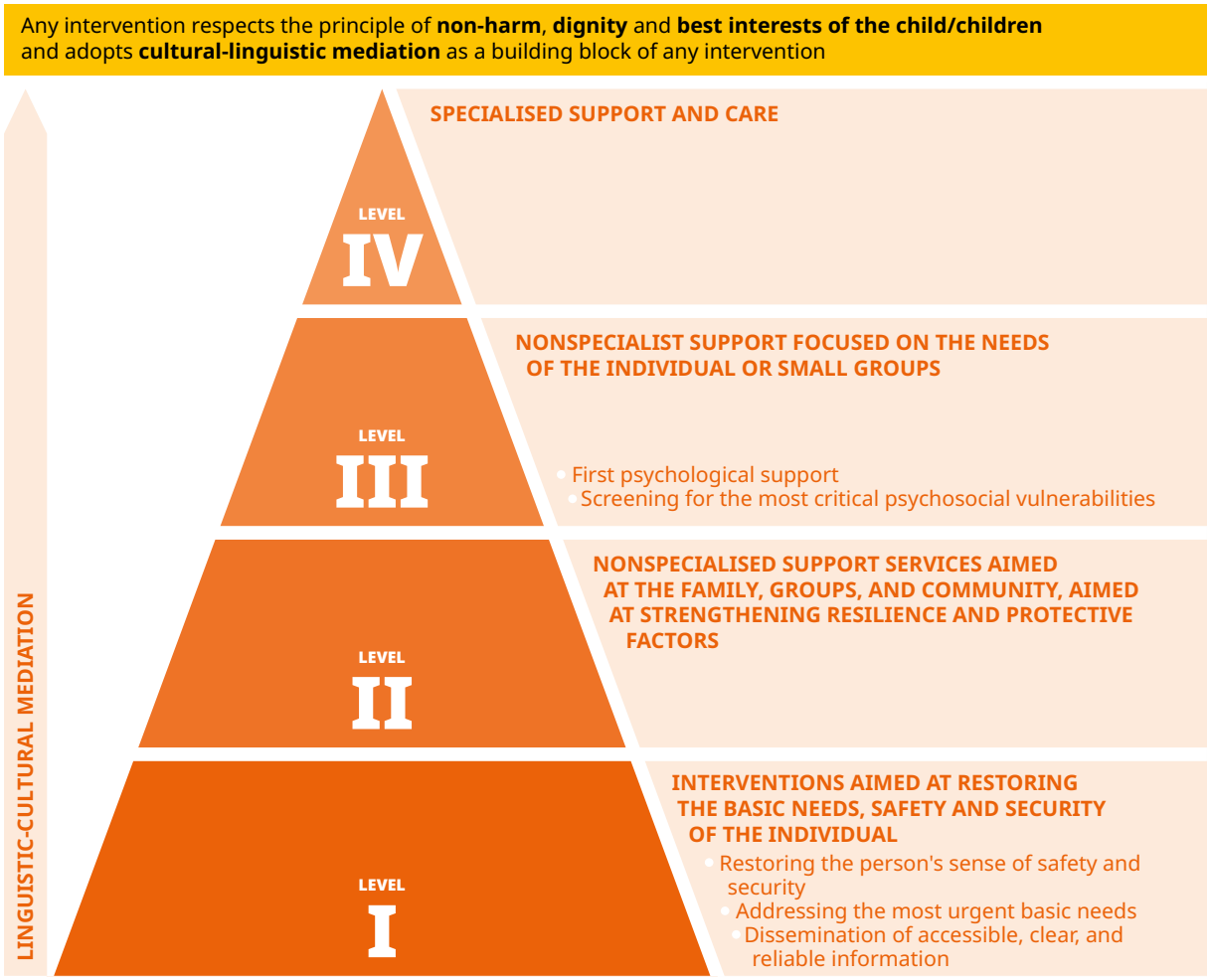
To effectively address the intake of people with mental health issues, it is essential to coordinate closely with local authorities and service providers in the area. This coordination is essential to ensure that those who have undergone assessments or reports onboard receive the necessary assistance once ashore.

In this context, it is crucial to establish a consistent and homogeneous agreement that applies to all landing territories. Such an agreement should clearly outline how information and situations should be handled once they reach land. This ensures that there is consistent and standardised intake, thereby reducing the risk of discrepancies and inefficiencies at the various ports of debarkation.

Finally, referral pathways need to be created at each port of landing. These pathways should provide clear guidance on which actors should be involved and what minimum procedures should be ensured during the landing phase. Having a well-defined protocol allows for more efficient and humane management of incoming people, ensuring that they receive the care and support they need immediately, thus reducing the stress and trauma associated with their arrival.

Active collaboration with local associations in the landing areas is another key pillar of this process. These organisations are often at the forefront of assisting survivors of torture, violence or trafficking. Reporting these people early on to local associations and ensuring that they are properly taken care of can make a significant difference in their path of welcome and integration.

Disembarking, Landing, Tracking



Landing, landing, tracing: essential interventions to ensure

Dissemination of accessible, clear and reliable information

It is necessary to implement a humanising reception process that respects and protects the fundamental rights and dignity of migrant children and youth during the disembarkation and subsequent reception phases (according to the *Humanitarian Principle and Imperative*[18]), **which supports their primary and secondary needs and that protects and strengthens their mental, physical, and psychosocial health and well-being, designed from an integrated perspective**. This process requires up-to-date, accessible, reliable, and clear baseline information to be provided to the children at each stage, respecting their right of participation (*Art 12.*

18 In line with the *Principle of Humanity*, one of the four fundamental Humanitarian Principles (along with Neutrality, Impartiality, and Independence), which establishes the Imperative to "...prevent and alleviate in all circumstances the suffering of men, in order to enforce respect for the human person and protect their life and health...." The four Humanitarian Principles were originally enshrined by the International Red Cross and Red Crescent Movement at the 20th International Conference of the Red Cross in October 1965, and were later adopted by the United Nations General Assembly (Resolutions 46/182 and 58/114) as a common reference-guide for all actors working in humanitarian and emergency contexts. By adopting the universal principles outlined in the *'Humanitarian Charter,'* the European Union reaffirms its commitment in fulfilling the *Humanitarian Imperative* and thus to take all necessary action to ensure that human suffering caused by conflict or other disasters is alleviated, and that the rights to protection and assistance of civilians affected by such circumstances are safeguarded and protected. https://ec.europa.eu/echo/files/evaluation/watsan2005/annex_files/Sphere/SPHERE3%20-%20The%20Humanitarian%20Charter.pdf

of the UN International Convention on the Rights of the Child and Adolescent[19]) and to strengthen their sense of security and capacity for self-determination from the very first stage of entry into the territory, and through each subsequent stage of the reception process.

In order to ensure the above, provision can be made during operations in dock or in the immediate aftermath for the distribution of brochures in the language spoken by the people, containing general and understandable information on the fundamental rights of children, the figure and role of the guardian, the role of the Juvenile Court, and the reception system. Within this framework, however, it is important to consider the needs of illiterate people.

First Psychological Support

Adopt Psychological First Aid (PFA), applicable in individual and group/community emergencies and crises, offering **human and emotional** as well as **practical support**, from appropriately trained caseworkers. The tool requires adaptation in terms of content and delivery methods, as well as specific skills, depending on the age,[20] gender, and cultural characteristics of the person or group targeted. Furthermore, it is essential to ensure basic support and provide information while maintaining a person-centred approach and avoiding making interventions that may cause further harm. This consideration applies to all situations, with particular attention to people in a vulnerable state, including survivors of gender-based violence.[21]

19 UN International Convention on the Rights of the Child and Adolescent, https://www.salute.gov.it/portale/saluteBambinoAdolescente/dettaglioContenutiSaluteBambinoAdolescente.jsp?lingua=italiano&id=2599&area=saluteBambino&menu=vuoto#:~:text=La%20Convenzione%20sui%20diritti%20dell,vigore%20il%202%20settembre%201990.

20 Considering persons of minor age, we recommend using this resource: https://resourcecentre.savethechildren.net/document/save-children-psychological-first-aid-training-manual-child-practitioners/

21 UNICEF, UNHCR, IOM (2020). How to provide initial support to survivors of gender-based violence. Pocket Guide: https://www.unhcr.org/it/wp-content/uploads/sites/97/2020/11/GBV-Pocket-Guide.pdf

Psychological first aid

What is it and what are its goals?

Psychological First Aid, *PFA*, is a **step-by-step guide to offering humane, timely emotional support** to a person, adolescent or young person who is going through a more or less intense difficult situation. It is effective in **protecting the person(s) in need from additional stress** and **helping them to make an informed decision**, and **more easily and quickly access** required **services**.

Who can deliver it and what skills are required?

The PFA is a critically important resource for every practitioner, both specialists and non-specialists. Although the title may be misleading, **it is not a clinical tool and one does not need to be a mental health specialist to use it**. To deliver PFA requires, in addition to knowledge of the method, a foundation of skills in communication and empathic listening, *skills in communicating effectively with diverse age groups, including minors, people of varied backgrounds and cultural affiliations, people in vulnerable situations, and people of different genders*.

Any professional who works **in contact with people in acute stressful circumstances, or who are in an individual or group crisis situation, including children and youth**, should be familiar with PFA: educators, teachers, social workers, linguistic/cultural mediators, tutors/guardians, sports coaches, physicians, nurses, paediatricians, facilitators of social-recreational groups, legal counsellors, volunteers, rescuers, and shelter workers, to mention just a few of the categories involved.

When is it appropriate to use it?

Some of the circumstances under which PFA can be used:

- An explicit request for help from the person in distress;
- When unusual behaviour and/or the more or less explicit expression of discomfort is noticed;
- When an account of a painful experience related to a difficult period or abuse and violence is received.

PFA can be used with anyone who has experienced an acute stressful event, even if there are no signs of distress. This can occur in a variety of settings: school, a counselling centre, an oratory, a recreational club, an educational, cultural, or sports centre, a hospital, as well as a wide variety of other formal and informal settings.

PFA helps practitioners consolidate fundamental skills for coping with crisis situations or immediate support needs, in an experienced and effective manner, sensitively and competently.

What does it consist of?

The PFA is structured in four phases, each with specific characteristics, actions and goals:

In order to effectively put PFA into practice and for the risks associated with its misuse or even harmful use to be mitigated, the practitioner must have in-depth knowledge of all four stages of which it consists and, as a foundational premise to all subsequent steps, be adequately *prepared*. The preparation phase implies **up-to-date knowledge** also relative to critically important information, **services of various nature** and any other **procedural and spatial references** that can help the person meet the most urgent needs.

What are the goals of psychological first aid?

- To equip practitioners who *do not have purely psychological and clinical skills* with key knowledge and skills to **effectively manage a crisis** or emergency **situation**, whether individual, group or community-based.
- To offer **comfort and** immediate **emotional relief**, to help the person feel calmer.
- **Strengthening the sense of security**.
- Helping the person identify and address **basic and safety needs**, especially the most urgent ones.
- To restore **a sense of order and control** over one's emotions and the situation.
- To provide a **protected and confidential space for empathic listening** in a respectful manner.
- Providing **practical support and** relevant **information** without being intrusive, and protecting the person's right to choose.
- To facilitate **free, informed and conscious decision making** (self-determination skills).
- To facilitate or expedite contact and/or **access to** required **services**.

How to integrate it with other interventions?

PFA is a valuable tool for **containing and managing a situation of crisis and intense distress**. It is most effective when provided in the **immediate aftermath** of the incident or event that triggered or contributed to the crisis condition. While valuable and effective in achieving the aforementioned goals, PFA **is not a long-term support and treatment tool** and, therefore, does not replace other more intensive forms of support with clinical/therapeutic purposes. **One of the big advantages of PFA is that it acts as a bridge**: it offers immediate relief and helps the person access the required services. The person involved in a situation of crisis or severe emotional distress does not always express such a need, but if there is a hint of a need for specialised help or another service, **the professional should be equipped to understand this need and facilitate connection and access to support needed**. Furthermore, the PFA includes coping strategies that can be implemented by the provider to manage his or her reactions to working with people in distress.

Where to learn more about Psychological First Aid?

To learn more about PFA and its use, we recommend referring to module 4 of the asynchronous online training *'Integrated Support for Adolescence and Transition to Adulthood,'* developed by UNICEF in collaboration with the CNOP Childhood and Adolescence Working Group, CNOAS and FEDERPED, available free of charge at the link: https://italy.learningpassport.org/ (you must create an account to access the training and other content on the platform).

Linguistic-cultural mediation

It is of paramount importance for services to be stably staffed with appropriately trained linguistic-cultural mediators and mediators who know how to apply Psychological First Aid (PFA) and the basic elements of intervention to protect and support the mental health and psychosocial well-being of the people served, with particular attention to to the most vulnerable groups. This preparation enables them to play a key role of qualified support to both the other members of the working team and the persons assisted, in supportive interventions and in the eventual management of psychosocial emergencies in which an acute distress, major difficulties, or an individual or group crisis situation arises, impacting emotional, psychophysical, or social-relational well-being.

The presence of mediators with linguistic-cultural mastery of the target languages, who regularly update their knowledge of the languages they work with, is essential. This enables communication between staff and those being assisted and means they can convey the linguistic nuances and specific cultural content reported by and about migrant children, thus contributing to more effective and informed support. Mediation figures play a key role in that they are bearers of experiential knowledge built both in the context of origin but also often through the migration process.

Furthermore, it is crucial to ensure the presence of linguistic-cultural mediation also when accompanying children and minors to social and health services, in the case of referrals or specific needs. This not only facilitates access to services, but also ensures that the path to support is accompanied by trusted and culturally competent figures. In order to adequately accompany minors to access basic, social-health and specialised services in the territory, **it is essential that linguistic-cultural mediators receive adequate training, in-staff support and supervision**.

Linguistic-cultural mediation in supporting underage migrants and refugees

How to

- **Ensure the principle of participation for the child(ren) being supported**
  - Know the Rights of Childhood and Adolescence and inform the child/children about their rights with language appropriate to age, gender, cultural background, ability, etc.
  - Take action so that the minor can feel safe and valued in expressing his/her point of view
  - Promote child/children's consultation practices and ensure that their views are taken into account
  - Help to create safe, secure, non-judgmental and accessible spaces of active and empathetic listening to the needs of the child/children
- **Use age-appropriate language in coordination with other professionals with whom you collaborate**
  - Be aware of one's communication style (verbal, nonverbal and paraverbal communication)
  - Ensure information accessibility and adaptation of communication to different skills, in the presence of disabilities and specific individual characteristics
  - Know how to adapt language and structure of communication to underage people
  - Promote the adoption of communication modes appropriate to the child/children by the other professionals as well
- **Working in a multidisciplinary team involving parental figures or caregivers**
  - Know the resources and limitations of one's role in the team and the roles and responsibilities of other professional(s)/caregiver(s) involved
  - Support the sharing and convergence of goals among professionals/caregivers, family members, and caregivers according to an approach that places the person at the centre
  - Adopt facilitation strategies that also include and involve parental figures and caregivers
  - Know how to ask for support and activate colleagues in the case of specific needs or difficulties
- **Working within an institutional framework, including structured services**
  - Know the function of the MLC within the institutional framework
  - Know how to cooperate with practices, languages, and models of intervention that may differ from one's own
  - Be advocates for positive change in the best interest of the child/children
  - Support and contribute to the processes of deconstructing stereotypes, prejudices, and cultural biases present in the system

Skills and Knowledge Needed

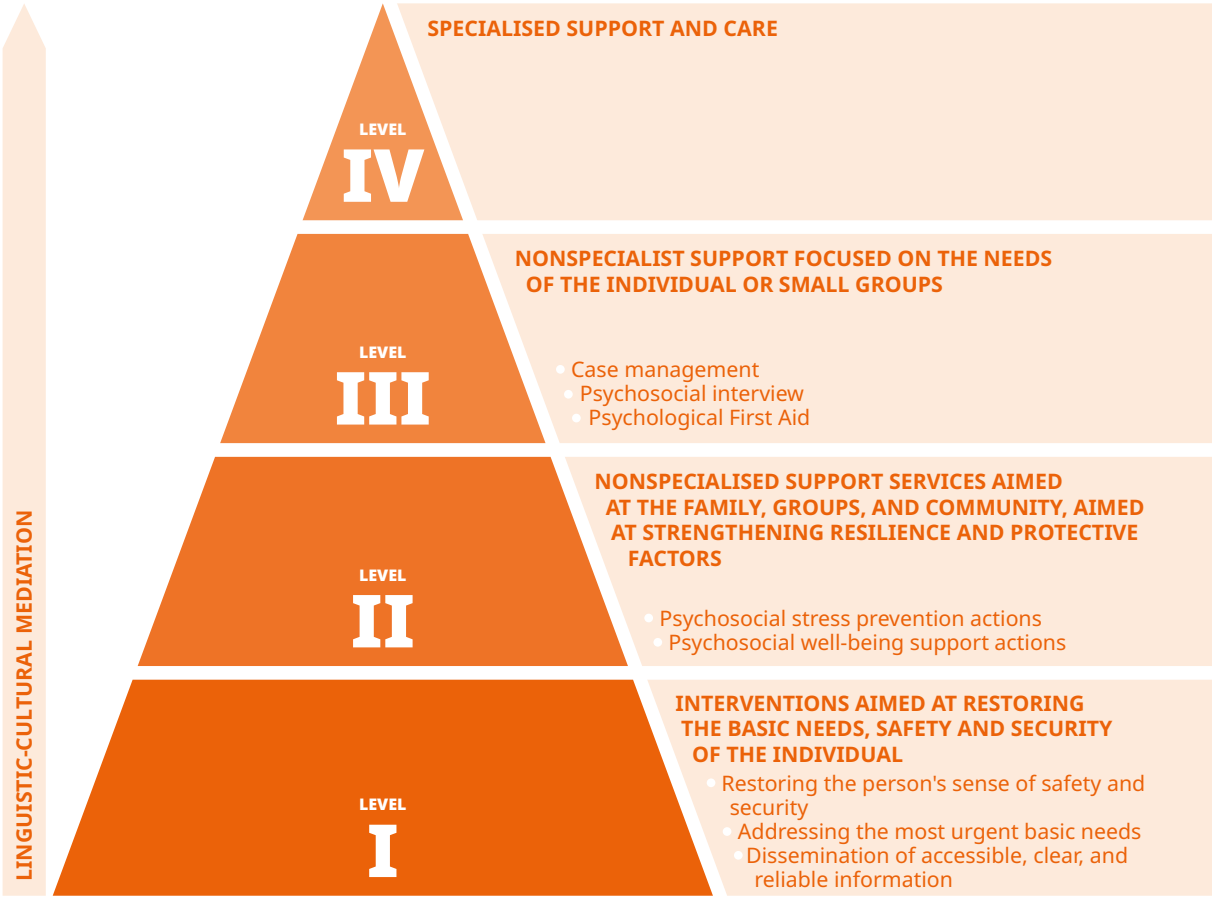
Addressing critical issues related to the reception of migrant children, the promotion of their psychosocial well-being, and the prevention and management of marked vulnerability frameworks requires a real commitment to providing **comprehensive and ongoing training to the staff involved, as well as regular supervision and debriefing**. This includes a number of key aspects such as communication geared towards providing emotional support and recognising any conditions that require dedicated interventions, cross-cultural approach, and behavioural de-escalation strategies, with a **specific focus on Psychological First Aid (PFA)**.

Training should span several areas, including:

- communication in its various aspects: *verbal, nonverbal and paraverbal*. Special attention should be paid to communication geared towards providing **empathic listening and basic emotional support**, to the recognition of significant and/or acute states of suffering and emotional distress, enabling staff to acquire essential skills to recognise and respond to the needs of those who have suffered stressful, highly destabilising and potentially traumatic experiences;
- the ability to **detect signs of distress and suffering** (such as insomnia, difficulty concentrating, various physical and psychosomatic disorders, etc.) and potential signs of post-traumatic stress disorder (PTSD), while also recognising possible differences in symptom manifestation based on age, gender and cultural background;
- knowledge of **protective factors of mental health and psychosocial well-being** of children and risk factors which could threaten or further undermine the psychosocial well-being of the youths, including dynamics related to primary and secondary traumatisation;
- to **identify and manage self-injurious and heterolesive behaviours**, it is essential that skills be acquired in reading aggression, de-escalation of emotionally and behaviourally critical situations, and emotional regulation and anger management;
- **practical tools and organisational policies of self-care** and prevention, recognition and management of burn-out, vicarious trauma and compassion fatigue, to preserve staff well-being;
- **cultural humility**, or awareness and acceptance of cultural differences, is a key aspect that needs to be incorporated into training and encouraged in support sessions and supervision of staff carried out on a regular basis;
- appropriate methods of **referral to services**, ensuring staff are able to connect individuals with specialised services in a timely manner when required;
- the implementation of **Psychological First Aid (PFA)** practices to respond effectively and immediately to psychosocial emergencies;
- recognition, prevention, and response strategies to gender-based violence (types and forms) from a culturally sensitive perspective and related basic principles.

Emergency reception and first reception

Any intervention respects the principle of **non-harm**, **dignity** and **best interests of the child/children** and adopts **cultural-linguistic mediation** as a building block of any intervention



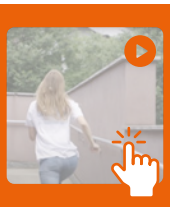
Emergency shelter and first reception: essential interventions to be guaranteed

The reception of minors and young migrants in facilities at the stage prior to placement in first and/or second reception should include and take into consideration the following elements:

- Ensure that even short stays of minors are characterised as much as possible by interventions that satisfy **minimum quality standards, a structuring of time, and by the presence of planning** through, for example, the implementation of psychosocial, guided and structured group activities.

Spaces meeting the needs of UASC

- Ensure the presence of **safe and dedicated physical spaces for minors**, particularly those who are unaccompanied, divided by gender and in mixed modes, and taking into consideration the specific needs of each individual and group, such as needs related to age, gender, cultural background, disabilities, possible specific vulnerability situations, etc.



Access to information

- Ensure **effective, inclusive, reliable, accessible, and user-friendly information** to help the adjustment process, to strengthen children's capacity for self-determination, and to increase their sense of security. With regard to the reception spaces, it is essential to be able to ensure the availability of adapted information, directions, and signage that are understandable and accessible to everyone. In addition to the written form, it is necessary to provide for the use of of **visual aids and facilitation strategies for communication**.
- **Ensure** the presence of mechanisms for **reporting abuse and exploitation situations that are safe and accessible for underage persons** and of mechanisms and tools to collect feedback from children and youth about the programmes and services provided.
- **Identify and act early in cases of vulnerability**, through case management activities in close collaboration with social and health services in the relevant territory and Prefecture.

In such contexts, it is essential to have not only properly trained and equipped first receptionists and operators, but also to ensure the presence of **stable and trained resources for linguistic-cultural mediation**.

Furthermore, it is recommended to provide **case management** skills to ensure coordination with organisations and entities working with the same group of beneficiaries, so as to ensure continuity in the case of referrals to services in the area.

Finally, provision should be made for **a multidisciplinary team** specialised in supporting minors and children with psychosocial vulnerability.

Disability, rights and discrimination

Migrant and refugee persons with disabilities, particularly female and underage persons, are one of the groups identified in the **Vademecum for the detection, referral and referral of persons bearing vulnerabilities arriving in the territory and included in the protection and reception system**,[22] as they may be at greater risk of protection, need specific support, in the path of reception and to access dedicated support and assistance services.

In the definition of the *UN International Convention on the Rights of Persons with Disabilities*,[23] "persons with disabilities, at any age, include those who have long-term physical, mental, intellectual or sensory conditions that in interaction with various barriers may prevent their full and effective participation in society on an equal basis with others."
The Convention promotes combatting the discrimination and human rights violations that people with disabilities may face when they live in a stigmatising environment that is not adapted to their needs. Article 6 of the Convention explicitly mentions how women and girls with disabilities are exposed to multiple discrimination, and the need to implement specific measures to ensure their full development, progress and empowerment.

The World Health Organisation[24] highlights how disability is an experience inherent in human beings: all people, at some point in their lives, temporarily or permanently, may experience a condition of disability.

In this view, which moves beyond the medicalised approach towards a social view, the living environment and social context have an enormous impact on the experience of disability. Inaccessible environments -physically, communicatively, relationally, socially, economically, politically, etc. - create barriers that hinder the full and effective inclusion and participation of people with disabilities in society on an equal basis. The main discrimination that people with disabilities experience is termed "ableism": an entrenched and systemic attitude of negative perception and devaluation that perpetuates stereotypes and prejudices (implicit and explicit) towards people with disabilities. Over the years, activism by organisations and people with disabilities has consolidated the current of Disability Studies,[25] a broad and non-universal discipline of studies that deals with this issue from a social, cultural, political, rights-related perspective. Disability studies moves from the evidence of the discrimination that citizens and citizens experience, accompanying and supporting their claims, for the right to affirm their identity, to self-determination, and for complete equality in society. It is important to remember that people with disabilities do not constitute a homogeneous group, but present more or less specific risk and protective factors in relation to other individual, social and contextual characteristics. Depending on the disabilities they have, women and girls may be more exposed to gender-based violence and have greater difficulty in accessing services and resources, in-person and digital, thus requiring specific support measures to ensure their safety and full enjoyment of basic rights and freedoms. In emergency situations, these risks can be exacerbated by separation from parents or caregivers, as well as the absence of other networks of proximity and support and essential aids and medications.

22 https://www.interno.gov.it/sites/default/files/2023-06/vademecum.pdf
23 https://www.lavoro.gov.it/temi-e-priorita/disabilita-e-non-autosufficienza/focus-on/Convenzione-ONU/Documents/Convenzione%20ONU.pdf
24 https://www.who.int/health-topics/disability#tab=tab_1
25 https://disabilitystudies.uniroma3.it/

Prevention actions

In the context of early care facilities, it is essential to implement **targeted prevention activities to foster the creation of a safe [26] and reassuring environment** in which minors are guaranteed access to guidance information for their reception and integration paths, developing meaningful relationships and effective coping strategies.

To this end, the organisation of group psychosocial, cultural and recreational-educational activities facilitated by staff is recommended of reception and supported by the presence of linguistic-cultural mediation figures, both specially trained. **This approach aims to promote the psychosocial well-being of minors in an integrated manner, providing them with tools and practical ways to deal with the challenges associated with reception and the new cultural reality**. The combination of group psychosocial activities and cultural mediation helps to create an **inclusive environment** tailored to the specific needs of children in care.

Whether it is possible to carry out this type of activity depends on the space, furnishings, tools available, and the organisation of the time and daily routine of the people accommodated.

At the preventive level, in temporary reception spaces, it is preferable to favour group activities over individual activities that could be implemented in dedicated spaces and times or for people who express a special need.

The implementation of activities should take into consideration the following general standards.

Standards towards participating persons

- Self-determination: ability to freely join in with activities without being obligated
- Low threshold: offer simple and understandable messages within activities
- Attention to privacy and informed consent

Space-related standards

- Security
- Availability of large spaces suitable for group activities
- Adequacy of indoor and outdoor spaces
- Adequacy from an intersectional perspective (gender, age, etc.).
- Caring for the environment as an "enabling environment" for well-being and mental health

Standards related to timing

- Continuity: activities are offered in a structured way and spread over time
- Predictability: activities allow you to get a clear idea within the day
- Repeatability and recursiveness, so as to create a meaningful and familiar time structure within the days

26 In the context of this document, a safe environment is considered to be a place that does not present risks of any kind to the physical, mental health and psychosocial well-being of the child/children. An environment that aims to protect and promote the rights, safety, health and well-being of the boy and girl, and in respect and consideration of individual characteristics such as age, gender, cultural and linguistic affiliation, etc., is a safe environment. Specific to care facilities, facilities are considered safe if they have in place measures to prevent and respond to possible risks, including policies to protect against abuse and exploitation and codes of conduct, and operate according to minimum quality standards and referenced operating procedures. Measures to mitigate and respond to possible threats to the safety and psychosocial well-being of and for minor girls cover the physical location, items made available for the user(s), regulatory and logistical aspects inherent in the management of daily activities, personnel employed, activities conducted, etc. The exposure of girls to risks of gender-based violence must especially be taken into account when assessing the safety of the reception facilities (e.g., housing and separate toilet facilities and ensuring privacy conditions, facilities and staff, including women, responsible for security, information and access to support services, etc.).

Standards related to personnel

- Continuous presence of linguistic-cultural mediators to cover all language needs
- Appropriate training for staff at the centres
- A minimum team dedicated to basic reception with dedicated functions should be identified within the centres to mitigate the high variability of the context (staff turnover, variability of groups) and as a stable point of reference for the people housed there;
- Use a team of figures from within the facility for psychosocial activities (or for some components of the activities; do not outsource them only to external staff or consultants who come once to the facility)
- Internal figures must be able to accommodate boys and girls and must be adequately trained in certain issues, so as to represent a stable and competent internal point of reference (e.g., trained in legal issues, orientation, disclosures, etc.).
- Facility workers also with different training (e.g., social workers, psychologists properly trained and with nonverbal work skills).

Regarding the operational tools that can be used, especially with regard to structured psychosocial activities, some examples are given below:

- Expression and Innovation Kit for Adolescents, originally Adolescent Toolkit for Expression and Innovation: https://www.unicef.it/media/kit-di- expression-and-innovation-for-adolescents-a-precious-tool-psychosocial/
- I support my friends: https://www.unicef.org/ documents/i-support-my-friends
- TeamUP: https://resourcecentre.savethechildren.net/document/teamup-support-refugee-children-worldwide/

Three types of activities which can be implemented are also recommended next, accompanied by the main reference contents and methodologies.

In any case, it is recommended to avoid activities that involve in-depth study of the personal history of the participants and related high-emotional-impact events and that cannot be concluded within the term of people's stays in the shelter.

Basic information sessions

Conduct group information sessions broken down by age group and gender. **Important to check the understanding of the information** received by the beneficiaries.

Contents
- operation of reception and integration system
- reception procedures (Guardian, Juvenile Court, etc.)
- paths to schooling in Italy
- access to health care (services, health registry)
- legal notice
- photosignal
- Italian culture and geography
- actors operating in the very first reception
- self-care
- support services and useful numbers

Methodology
- group information sessions
- audiovisual material
- unaided augmentative communication
- augmentative assisted communication
- information booklets in the relevant language
- multilingual signage
- accommodation of group sessions, for participants with disabilities

Coping strategies

To carry out individual and/or group psychoeducation sessions, specific to age groups, gender and adapted to and for participants with disabilities, with the aim of consolidating knowledge related to the prevention, promotion, maintenance or recovery of states of well-being.

Contents
- self-care
- sleep and rest
- power supply
- psychoeducation
- well-being and digital security
- physical and mental health
- lifestyles for physical and mental health
- self-perception of well-being levels

Methodology
- group information sessions
- lightweight micro-video
- unaided augmentative communication
- augmentative assisted communication
- information booklets in the relevant language
- multilingual signage

Cultural, recreational-educational and leisure activities

Set up spaces where people can freely engage in recreational-educational and sports activities.

Contents
- sports activities
- recreational-educational, creative and artistic activities
- spiritual and religious practices

Methodology
- free organisation of activities
- supervision by facility staff
- free-use spaces with internet access

Case Management

In the context of caring for migrant children, **it is crucial to establish clear, efficient and rapid procedures for referral to specialised services in the area in order to handle early signs of psychosocial vulnerability**. This implies a **preliminary action of mapping** the network of services at local level and **close collaboration with support networks** and specialised services to ensure immediate and appropriate intake of identified cases.

It is important for the activation of case management skills to be promoted in two specific contexts: in **prefectures**, to govern the transfer to the reception centres, and in **emergency and temporary reception facilities pre-transfer to first and second reception**. The managing bodies of the reception facilities must have such a case management function. The same figure may serve as a focal point for receiving reports of suspected abuse and exploitation, ensuring confidentiality and tertiarity in the handling of reports.

The role of caseworkers and case managers should include observation activities and accompaniment to services, playing an important function in ensuring that the minors receive all the necessary support in a timely, integrated and coordinated manner.

The stable and continuous presence of staff who have case management skills and responsibilities is essential to ensure adequate follow-up, while weekly meetings between caseworkers and shelter workers facilitate the sharing of any observations made.

In order to ensure stability within the referral mechanisms in the territory, it is necessary to involve local social and health services in their various articulations. Sending minors with obvious psychosocial vulnerabilities to the relevant territorial services is an essential step, thus ensuring that they receive specialised care, which should be harmoniously integrated with nonspecialised psychosocial support and any other intervention provided.

Finally, it is critical to ensure follow-up of the child/children upon their return to the facility, thus contributing to an integrated and individualised continuity of care.

Voluntary guardianship

Since its introduction with Law 47/2017, the institution of **voluntary guardianship** guarantees unaccompanied minors **a form of legal representation and individual support inspired by the principle of the best interests of the child**. This form of active citizenship allows ordinary people who are at least 25 years old to attend a training course sponsored by the Regional Guarantors for Children and Adolescents, at the end of which they can apply for inclusion in special lists at the Juvenile Courts responsible for pairings and appointments.

Although the system is still being perfected today, **the role of guardians and custodians is crucial in the processes of social inclusion and transition to adulthood for protected persons**: in addition to dealing with bureaucratic procedures, guardians and custodians are responsible for listening to their opinions and aspirations, involving them in any course of action that affects them and acting as a "bridge" with services to be activated in the area, based on their specific needs and plans for the future.

In this area, UNICEF is supporting **the strengthening of the voluntary protection system** through five specialised support and counselling desks in the Trieste, Rome, Reggio Calabria, Catania and Palermo districts, according to three lines of intervention:

- Promoting **a sustainable model of peer-to-peer support and continuing education**, based on the needs of beneficiaries, **with a focus on gender-based violence issues and mental health and psychosocial support** (for access to the free e-learning course on the best interests of the child for guardians: https://italy.learningpassport.org/);
- Consolidating an **inclusive inter-institutional network of coordination and confrontation of guardianships**, among the actors of the protection system of unaccompanied minors at local level;
- Raising awareness in local communities through **storytelling and sharing of personal experiences of voluntary guardianship** from the perspective of guardians and protected persons.

For more information, you can visit the dedicated web page: https://www.unicef.it/media/alternativecare/

Individual psychosocial interview

In the stages prior to initial placement, beginning immediately after the initial intake phase, it is crucial to provide for the intervention of specialised multidisciplinary teams capable of conducting in-depth observations and assessments, enabling timely referral to the services required. The use of cross-cultural criteria is essential to implement observations and screening that take into account the multiple cultural and linguistic dimensions of migrant minors in order to identify accurate signs of psychological and psychosocial vulnerability.

Ensuring the early identification of children with signs of high risk of acute stress/illness or imminent deterioration of their health status and psychosocial well-being, and their immediate referral to specialised territorial services is a key step. This process must be guided by a **cross-cultural reading and a solid awareness of any individual and/or cultural preconceptions and stereotypes**, to avoid the use of the Western model of mental health, combined with limited cross-cultural awareness, causing a distorted reading of the child's distress or difficult situation, with the risk of creating **stigma** towards the symptoms the person expresses, or of "overpathologising," generalising symptomatology or arbitrarily and/or without the necessary expertise applying certain diagnostic criteria (e.g., all minors with migrant backgrounds suffer from trauma or PTSD).

When conducting individual psychosocial interviews, teams must be adequately informed and trained with regard to the topic of **disabilities** and the emerging **neurodiversity** paradigm to ensure **fairness and nondiscrimination** in observation, assessment and support, towards people with disabilities, including non-visible disabilities, and specific developmental conditions, including neurodevelopmental disorders.

Specialised services in psychosocial well-being and mental health need to be mapped and **their** accessibility by migrant minors **and refugees** needs to be **ascertained**.

Early detection of vulnerable situations should take place in direct connection with specialised services, ensuring timely intake.
The use of attention criteria makes it possible to assess the need for support in the next stage of reception, where ongoing intake and intervention planning is possible.

To ensure continuity of care, efficient document collection is recommended to avoid future repetition of interviews with the child/children, ascertainments, and consequent negative impact on the child/children (according to the principle of *'do no harm'*). Furthermore, the development of a comprehensive report card, including biographical information, personal medical history, gender, and language helps to provide a comprehensive and personalised overview for each individual. It is essential that the right to privacy/confidentiality and sharing with other professional(s) based on a need-to-know basis be ensured at every stage, including through the development of information management procedures.

Intersectionality

Intersectionality[27] is a lens through which overlapping or intersecting social identities and related systems of oppression, domination or discrimination are analysed.
The concept of intersectionality was coined in 1989 by jurist and activist Kimberly Crenshaw. It is "a metaphor for understanding the ways in which different forms of inequality, nonequity, and disadvantage combine to create obstacles that cannot be understood and defined uniquely, that is, using single structures and categories of social justice."[28]

The intersectional perspective highlights how each person possesses different subjective characteristics, which interact at multiple levels in defining his or her social identity.
These characteristics are inseparable from each other: gender, age, disability, physical and mental health condition, sexual and relational orientation, nationality, ethnicity, culture and language, family and social status, religion, etc.

There can, therefore, be multiple levels of exclusion of an individual within a community: the person may be discriminated against based on the overlapping and intersection of his or her multiple social identities, which are stigmatised within the specific social, cultural, and institutional context.

For example, a female minor with a disability who comes from a migration background may find herself more exposed to discrimination, based on gender, age, disability, nationality, language, and culture. In such cases, this is referred to as **intersectional discrimination**.

Multiple discriminations, especially if systemically rooted, expose the person to severe conditions of exclusion, difficulty in accessing equal opportunities, as well as the supportive services and interventions they need, impacting levels of psychosocial well-being and physical and mental health, exacerbating any prior conditions of vulnerability, and increasing the risk of experiencing abuse and violence.

27 Crenshaw, Kimberle. "Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color." Stanford Law Review, vol. 43, no. 6, 1991, pp. 1241–99. JSTOR, https://doi.org/10.2307/1229039
28 https://www.youtube.com/watch?v=ViDtnfQ9FHc

Gender-Based Violence - Mapping and toll-free number

Where the person brings up an experience of violence or reports a risk in this regard and therefore specialised care is needed, a mapping of anti-violence centres in the territory can be found here https://www.1522.eu/mappatura-1522/. It is important to keep abreast of where to find specialised services and their accessibility also in terms of age, gender, legal status, languages, etc.

People also have access to the national anti-violence number 1522, which is active 24/7 and is answered in **Italian, English, French, Spanish, Arabic, Farsi, Albanian, Ukrainian, Russian, Portuguese, and Polish**. The telephone operators provide an initial response to the needs of survivors of violence, offering information and guidance regarding social and health services in the area, supporting the emergence of the demand for help. Cases of violence that have an emergency nature are received with a specific technical-operational procedure shared with the Police Forces.

Also available is the anti-trafficking hotline 800 290 290, active 24/7 throughout the country, to encourage the emergence of the phenomenon and support victims of trafficking and exploitation, offering information regarding possibilities for help and assistance and putting them in touch with territorial social welfare services. The number is answered in several languages.

Transfer

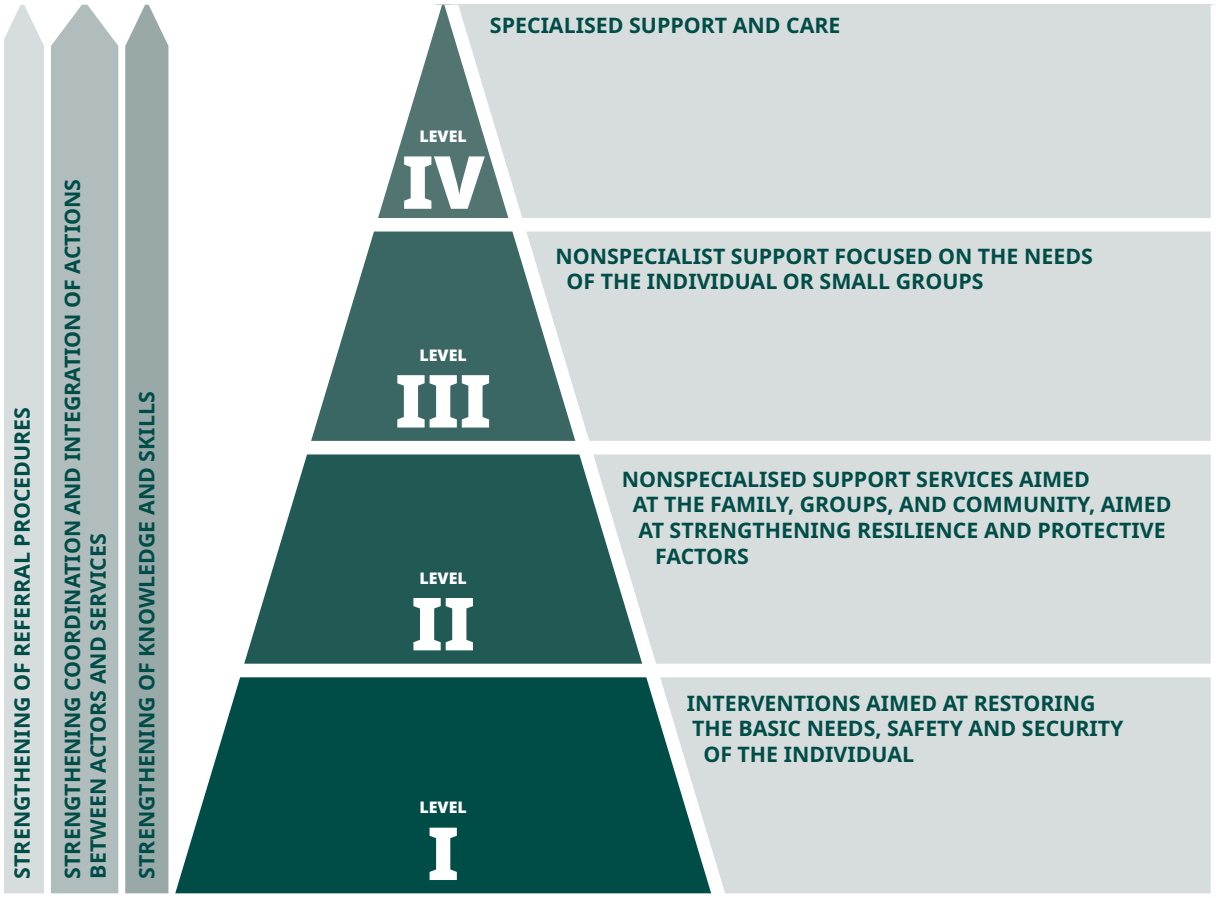
The transfer phase assumes an essential role, constituting a **crucial link** between the needs that emerged in the initial reception phase, the interventions implemented, and the pathways of support and integration in contexts of greater stability, such as those of first and second reception.

Prominent elements of this process include:

- Targeting territories where specialised services are available online with the needs identified in previous psychosocial assessments, or to areas where risk factors related to specific issues are fewer or absent.
- The case manager assumes a key role in this context, recording the assessments, requirements, and interventions
- Implemented in the social record, passing on this information to the receiving facilities intended for relocation, in line with an information management protocol.
- Prior to transfer and as part of multidisciplinary case assessment, it is crucial to provide a multidisciplinary assessment unit in the local health care services. This unit should adopt a more complex case management methodology, involving a stable multidisciplinary team, especially in emergency settings.
- Ensuring the stable connection between the social and health components is essential for integrated caretaking that takes into account the person's needs and is able to adapt to changes and the evolution of his or her situation.

Section 2
Access to integrated and quality services

Strengthening a multilevel governance system to foster the structuring of accessible, informed, and competent services



To ensure effective care of migrant and refugee children and youths, **synergistic interaction** is crucial **and interdisciplinary** among professionals working in each institution and decision-making level involved. Only by using this approach can **individual needs and the preventive dimension** in psychosocial intervention be put **at the centre**, thus promoting more effective coordination between the reception system and social and health services at national, regional and local levels.

To this end, it is considered essential to promote **the activation and/or to strengthen** permanent coordination tables of interdisciplinary programming involving both services and institutions, and any other relevant entities in the area for the integrated and multidimensional management of services.

Through such a coordinating table, an **integrated interdisciplinary working model** is promoted, which involves regular interinstitutional meetings with various stakeholders, enhancing multidimensionality and strong integration between thematic and specialised services.

When establishing, activating or strengthening such tables, territorial specificity should be assessed, adopting different governance models and facilitating communication between the Prefecture and the Departments of Social and Health Services.

Where numerous local authorities are to be involved, the involvement of ANCI as the single point of contact for all municipalities pertaining to that territory is appropriate.

Specifically, it is deemed necessary at the coordination tables to ensure the representation of the aforementioned actors through the mandatory participation of:

- ASL general contact person;
- ASL liaison for mental health;
- ASL addiction liaison;
- ASL liaison for minors and adolescents;
- Referent of public health facilities;
- referents of third sector actors delivering health services;
- Contact persons of the Educational Communities.

The goal of this coordination system is the multidimensional and integrated management of services, with a particular focus on work themes closely related to mental health and psychosocial support and a focus on the following general aspects:

- Emergence of health needs in the territory;
- Sharing of information related to the current intake practices put in place by services to benefit people, with a focus on best practices;
- Analysis and reading of the migration phenomenon through the sharing of information about changes in phenomena related to people's health;
- Emergence of critical access to services at the territorial level, in order to ensure access to services and respect for the right to health;
- Cooperation with institutional participatory initiatives of male and female minors and migrant and refugee youths.

At a more operational level, the coordination table should include interventions aimed at:

- Creating a network of actors who will take action to facilitate the intake and referral of specific cases;
- Bringing out the training needs of the network and the support needs of practitioners and workers in order to plan appropriate support interventions;
- Finding operational solutions, e.g. assign 2 cases per month and give an operational response;
- The development of tools for risk observation and assessment, shared among relevant departments;
- The construction of an interdepartmental dispatch procedure, through the use of the aforementioned tools;
- The analysis of the training needs of the actors participating in the table.

Examples of screening tools that can be used by specialist and nonspecialist personnel are given in Section 3 of this document. These tools assume their greatest effectiveness and functionality when placed within interdepartmental collaboration procedures.

Strengthening knowledge and skills

All people who come into contact with juveniles and migrant and refugee youths in the reception process, can play an important role in observing and detecting possible vulnerabilities. Properly sensitised and trained, social workers, guardians, Italian teachers, psychologists, doctors, social workers, sports coaches, etc., play a critical role in the process of accessing mental health and psychosocial wellness support services.

In order to ensure knowledge and skills strengthening that takes into account professionalism and different levels of contact and intervention, two levels of mental health and psychosocial support skills and knowledge strengthening should be provided: awareness raising and training.

Awareness raising

Outreach efforts are a crucial pillar in efforts to promote the inclusion and well-being of migrant and refugee youths. Their fundamental goal is to challenge and overcome prejudices, fears, and biases that, unfortunately, too often hinder integration and support required. They are multifaceted initiatives, acting on multiple fronts to achieve tangible and meaningful results.

Since these are wide-ranging interventions, the target audience can be considered all those who come into contact with migrant and refugee children/youths, such as:

- Teachers and school staff
- Legal guardians and volunteers
- Coaches and contact persons for sports activities
- Law enforcement personnel (Local Police, State Police, Carabinieri)
- Cultural and family spaces
- Active citizenship groups
- Juvenile Court Staff
- Trade associations of professionals and professional bodies
- Associations and third sector organisations active in territories where minors are present
- Faculty students (Medicine, Law, Midwifery, Social Services)
- Secondary school students (e.g. co-management moments in schools in which boys and girls are invited to speak)

The **objectives** of these outreach actions can be summarised as follows:

- To reduce prejudices, fears, biases, and stigma related to migration and child and youth migrants and refugees
- To increase the basic knowledge needed to detect signs of stress and offer help to troubled children

The **topics** recommended to be addressed during these interventions are as follows:

- Right to health and well-being of migrant and refugee children and youth
- Bias, prejudice and discrimination
- Intersectionality
- Migration in adolescence and young adulthood, with special reference to unaccompanied foreign minors
- Services and network present at local level to support well-being and mental health of migrant and refugee youths
- Signs of distress

At the methodological level, after appropriate consensus and preparation, it is recommended to include migrant and refugee minors and youths in the outreach activities, thereby ensuring compliance with the principle of participation.

Training

Ongoing training modules should be provided to ensure ongoing and up-to-date training, ensuring that issues related to the reception and management of complex mental health and psychosocial support cases are covered in depth. This integrated approach aims to enhance preparedness and sensitivity, ensuring better understanding and management of the mental health needs and psychosocial support for migrant youths throughout the reception and integration journey.

Cross-cutting themes

- Strengthening the cross-cultural competencies of staff working with migrant and refugee children and young people
- Ethnopsychology and ethnopsychiatry and culturally sensitive approach
- Promoting regular specialised training informed by a culturally sensitive perspective on fundamental principles and gender-based violence
- Burn-out, vicarious trauma and compassion fatigue
- Psychological First Aid

Receptionists

- Train in the general assessment of psychosocial well-being levels in the service into which they operate, through assessment of the service/facility's ability to ensure an "enabling environment" for psychosocial well-being and mental health
- Train in the detection of risk signs and management of cases with marked vulnerability, facilitating appropriate referral to services.
- Training on assessment and screening tools
- Child Safeguarding Training

Linguistic and cultural mediators

- Strengthen skills at using supportive strategies, improving communication techniques and familiarising with Psychological First Aid.
- Train about the psychosocial needs of girls and boys and different interventions to support their well-being and mental health.
- Prepare training interventions tailored to the specific health and social service of the system of care with which mediators interface
- Train about specific topics related to gender-based violence, child protection, trafficking, Child Safeguarding and PSEA

With a view to complementarity, it must be ensured that linguistic-cultural mediation professionals have access to individual forms of psychological support for the management of any personal difficulties related to the mediation role, critical issues in the relationship with the person assisted or complexity in working with professionals within the service.

Furthermore, it seems appropriate to ensure that these professionals can access training with recognition of remuneration for the hours of training.

Social and health workers

- Co-training between reception workers and social and health services in the same area, with a multidisciplinary and focused approach to understanding and addressing the challenges related to migration and reception, to psychosocial well-being and interdisciplinary management of migration challenges.
- Training on assessment and screening tools
- Ensure continuous technical supervision for all workers involved in the delivery of social and health services, regardless of their role and field of work
- Provide mandatory training for health care providers within annual training plans

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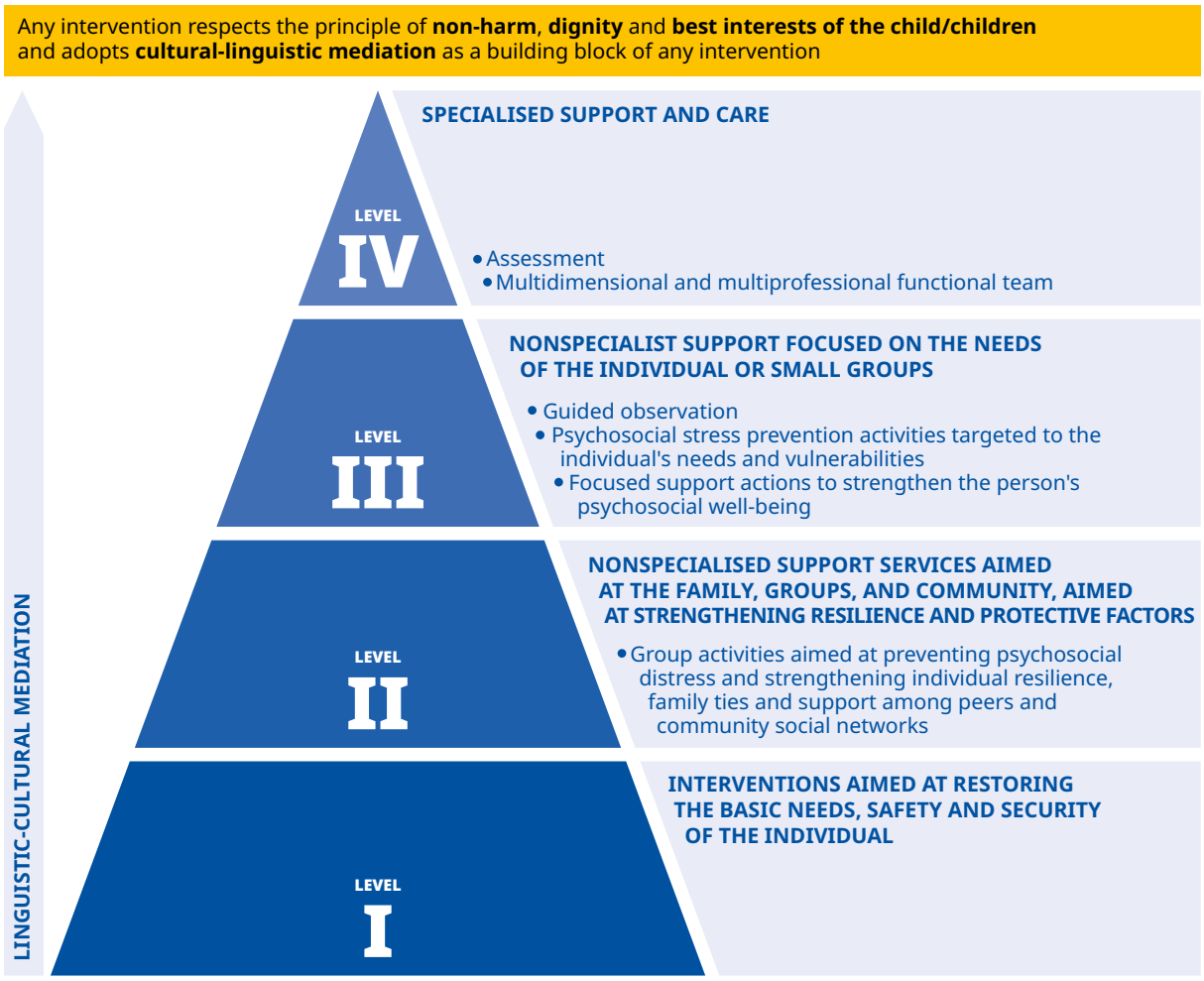
Section 3
Integrated Care



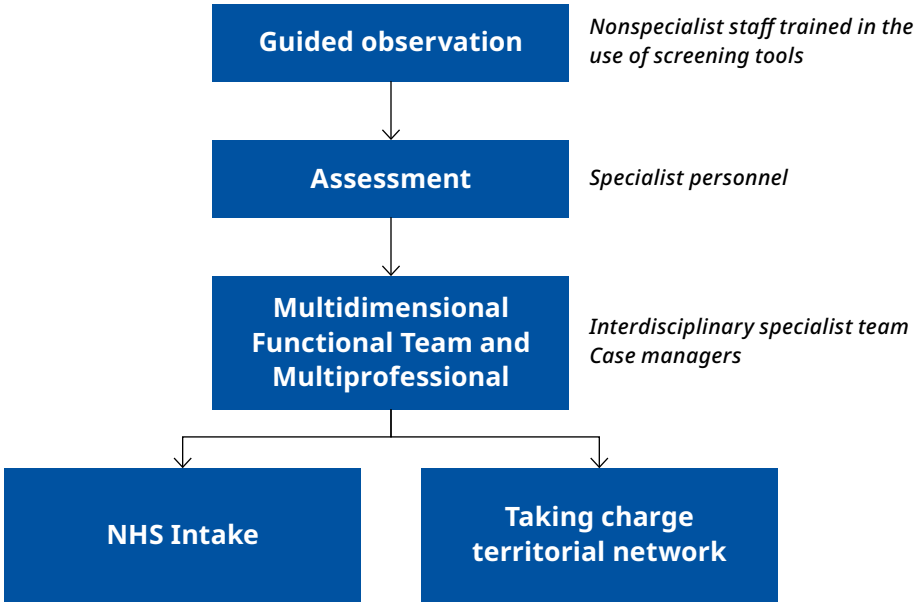
Integrated care: essential interventions to be guaranteed

To ensure adequate care for migrant and refugee youths throughout their journey, it is essential to structure tailored interventions that consider psychosocial challenges that may arise along the way. These interventions should integrate preventive strategies aimed at reducing the risks associated with their migration experience. Furthermore, it is crucial to implement programmes that not only protect but also promote the psychosocial well-being of each migrant child, paying special attention to their individual needs and the most vulnerable groups.

An approach respecting the principle of self-determination of migrant youths requires actively involving them in decisions that affect their mental health and psychosocial well-being. This direct involvement allows them to express their needs and preferences, thus contributing to a more informed migration path that respects their perspectives.

In conclusion, it is crucial to adopt a holistic approach that takes into account the specific challenges and opportunities of migrant youths, promoting their psychosocial well-being through interventions that are personalised, inclusive, and respectful of their decision-making autonomy.

The integrated intake process should follow a model involving the following steps:



Guided observation

- Promote the use of a comprehensive, systematic, cross-cultural grid aimed at observing risk signals, including indicators related to mental health, psychosocial well-being, and the adaptation process.
- Train practitioners and operators to use the observation grid effectively to intervene early when faced with signs of risk.

In the contexts of the first and second reception, it is essential that actions are carried out to observe people in their living contexts in order to detect any difficulties: indeed, a condition of psychological distress does not always emerge in a specialised setting, but much more often in everyday life contexts such as reception facilities.

Facility staff who interact with minors and migrant and refugee youths in various capacities, particularly reception workers and caregivers, social workers and educators, can play a key role, if properly trained, in identifying individuals who show basic signs of risk and obvious signs of distress and in subsequently sending them to services for a more in-depth assessment. It is to be avoided that such personnel, however trained, carry out more in-depth assessments as there is a risk of pathologising the person.

The training of practitioners, referred to in Section 2 of this document, serves precisely to sharpen observational and referral skills to the relevant specialist services.

Grid for Observing Signs of risk (GOSR)

The Grid for Observing Signs of Risk[29] is a non-diagnostic tool for early identification of signs of mental health risk in unaccompanied foreign minors housed in second reception facilities. The tool is aimed at activating **early interventions** in favour of the mental health of unaccompanied foreign minors and preventing or limiting as much as possible emergency room admissions, sudden discharges from the communities themselves, interruptions of ongoing projects and other painful events that often have a retraumatising value for the children themselves. It is not a diagnostic tool and its purpose is not to obtain a diagnosis. It guides educational observation in three areas: behaviour, adjustment and history, with a focus also on any resources the person may have. This grid is completed by the operators of the aforementioned second-care facilities after a stay of at least one month and is attached to the first request for neuropsychiatric counselling, as well as discussed in dedicated network meetings. It is suggested that it be used even in the absence of a request for neuropsychiatric counselling in order to reduce the negative impact of operator turnover and facilitate the discussion of cases within the teams.

29 https://www.codiciricerche.it/codici-uploads/2020/10/Quaderno-della-ricerca-Febbraio-2021_compressed.pdf

Assessment

Assessment involves actions to detect and assess signs of distress, situational stress and acute stress, carried out by specialist personnel, such as psychologists, psychiatrists and neuropsychiatrists, by conducting a clinical interview accompanied by the use of screening tools. This intervention represents a phase of initial contact and connection with the person, who, depending on the assessment made, can subsequently access the necessary specialised support.

Conducting a clinical interview involves **exploring the following areas as a minimum**:

- Sleep and nutrition
- Continuity of contact with family members in the country of origin
- Family presence in the host country
- Friendly relationships on the ground
- Carrying out recreational - sports, cultural, school, recreational activities
- Social Retreat
- Possible migration-related projects: work, study, etc.
- Possible use of substances and drugs
- Focus on aspects of protection that may result in the activation of specfic measures such as involvement of the judicial authority, services for people surviving gender-based violence, trafficking and victims of torture, etc.

It is essential that the information gathered during the assessment be returned to the network for possible activation of specialised support pathways implemented by the National Health Service and/or specialised private social actors.

If access to such services is not possible in the appropriate manner and timeframe in the target area, it is recommended to encourage access to remotely available services such as HERE4U: https://www.unicef.it/media/alle-roots-of-resilience-here4u-and-psychosocial-support-youth-refugees/

Refugee health screener (RHS-15)

The RHS[30] is an instrument originally designed and validated for the investigation of common mental health issues and symptoms in refugee and asylum seeker populations. The instrument has the advantage of being appropriate for different social and health service settings because it can be administered by interview or self-administration and is available in several languages. The RHS is an instrument consisting of 13 items on a 5-step Likert scale (0 "not at all" to 4 "very much") aimed at investigating active symptomatology in the area of Post-Traumatic Stress Disorder (PTSD), depression, somatisation and anxiety symptoms. An additional item (item 14) and a "stress thermometer" (item 15 - from 0 "no stress, everything is fine" to 10 "extreme stress, worse than ever") investigate respondents' coping skills and reaction to stress.
In the City of Milan, a specialised team uses this in the first and second reception facilities for an initial assessment of newly placed people, along with a clinical interview.

30 https://www.sciencedirect.com/science/article/pii/S2666623523000272

Methodological guidance on the administration of screening instruments

- Clearly introduce and check understanding of what the objectives of the interview and the use of screening tools are, with the cooperation of the appropriately trained linguistic-cultural mediation staff to actively collaborate with throughout the interview.
- Monitor the person's emotional states during the interview with respect to any particular themes that emerge.
- Always involve the person and make them feel heard.
- At the end of the interview, take time for closure by explaining the next steps and monitoring the person's emotional states, for example by using the Stress Thermometer (RHS-15).
- Ensure follow-up by involving the staff of the receiving facilities in order to activate monitoring actions related to the person's well-being, so as to foster continuity beyond the clinical intervention in the interview.

Multidimensional and Multiprofessional Functional Team

- Establish a Multidimensional and Multiprofessional Functional Team to manage the most complex cases
- Ensure effective communication and close collaboration among unit members for comprehensive and individualised assessment

Multidimensional and multiprofessional assessment makes it possible to define the tasks of the different professionals involved in the therapeutic, care and rehabilitation pathway while maintaining a holistic and systemic approach to the person. The team has the task of ensuring the drafting and implementation of the person's Individual Action Plan (IAP) with a view to co-responsibility within the integrated social and health network.

Depending on the specific needs of the person in question, the Multidimensional and Multiprofessional Functional Team is made up of professional figures, both clinical and non-clinical, all of whom have an ongoing relationship with the person regarding his or her pathway or who have a role in referral regarding the therapeutic-rehabilitation pathway. Examples of health and social professions that can make up the team include the following: child psychiatrist/neuropsychiatrist, developmental psychologist, health specialist for specific activities and needs (e.g., addictions), nurse, physical therapist, social worker (social worker, receptionist, community educator), cultural-linguistic mediator, guardian. Based on the needs identified, it is important to provide an adequate presence of female staff.

In conjunction with intake, it is critical to define who plays the role of case manager as a point of reference for the beneficiary, with the aim of providing a linking and verification function of the pathway. Through this function, it is possible to ensure effective communication and close collaboration among the members of the integrated network for a comprehensive and personalised assessment. The professionalism identified may change according to the evolution of the therapeutic-rehabilitation project of the person in question and depending on the organisational contexts in which they operate.

The evaluation of the Multidimensional and Multiprofessional Unit can have two types of outcomes:

1. Detection of vulnerabilities that DO NOT REQUIRE an NHS intake BUT an intake in psychosocial care by the territory's integrated social and health network.
In this case, integrated caretaking is territorial, and mental health care and psychosocial support may be entrusted to specialised private social actors. In the case of activities that fall under this scope of support by the integrated social-health network, it is important for feedback to be given to the Health Service and Social Service in a formal way with respect to psychosocial intake. Scheduling resources and services with preventive psychosocial support purposes make it possible to reduce and mitigate risks, easing the burden on the National Health Service.

2. Detection of vulnerabilities that REQUIRE integrated NHS care
The territorially competent service (family counselling/clinincal psychology services/ NPIA SerT/Adult psychiatry for adults) in collaboration and liaison with other services and agencies involved, is responsible for taking charge and defining the treatment

pathway (Integrated Care Plan) or therapeutic/rehabilitation project defined for the person most appropriate to the needs, in collaboration with the figures with guardianship and responsibility for the person (e.g., legal guardian).

Coming of age

In the planning of interventions and actions, pay attention to the criticality of children's transition to legal age, which in our service system results in a "gap" in caretaking, differentiated between services for minors and services aimed at adults. This discontinuity has an impact on access to care and support, particularly in territories where the services are not used to communicating and cooperating in terms of continuity, which has major repercussions on people's right to health and well-being.

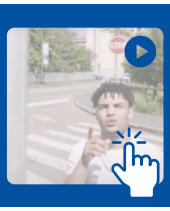
Activities aimed at preventing and mitigating states of psychosocial stress and emotional distress

Attention to the psychosocial well-being of migrant and refugee minors and youths is a key pillar in their process of integration and adaptation in a new social and cultural context. During the migration period, minors may face a range of emotional and psychological challenges related to separation from family, adaptation to a new language and culture, as well as to the building of new relationships and identities. In this context, the proposed activities aim first and foremost to prevent and mitigate stress arising from these experiences, providing individuals with practical tools and emotional support to cope with daily challenges.

Promotion of a sense of security, of connections and design

- Implement initiatives that foster a sense of safety among migrant minors, creating welcoming and reassuring environments.
- Actively promote the formation of positive connections among children by encouraging social interaction, peer support and the building of trusting relationships.
- Support individual and group planning, providing opportunities for learning and personal development.

Sense of protection, safety and peer support



Orientation activities

Awareness related to the migration project

- Provide informational and educational support regarding the migration project, addressing awareness gaps about the processes of integration, job search and support for families of origin.
- Organise orientation activities that help minors understand and plan their migration path more consciously.

De-escalation strategies for critical situations

- Train operators and other caregivers to effectively recognise and manage crisis situations, while always keeping the safety and well-being of the children as a priority.
- Identifying triggers and acting on activating factors reduces the risk of activating crises
- Communication methods and verbal and nonverbal interventions in de-escalation cannot rely solely on common sense, but require specific knowledge, sharing, and experience
- Activating de-escalation interventions with the goal of reducing the level of activation, anger, restlessness, and arousal requires specific training (verbal and nonverbal communication techniques, validation, interventions on external and precipitating factors)
- Develop de-escalation strategies to handle critical situations, such as planning engaging activities that have clear and measurable goals.

Workshops on relational dynamics and gender norms

When working with groups of adolescents who come from different cultural backgrounds, countries and places, you will certainly encounter multiple situations related to gender, expectations, norms, stereotypes and discrimination related to it, sometimes at odds with each other. Working with girls and boys from the perspective of facilitating exchange and constructive confrontation between cultures, certain principles and concepts must be kept in mind:

- Listen to how adolescents understand and talk about discrimination and social equality: is it a taboo subject or something that is easily discussed? What is the role of gender norms within this discussion?
- Understand ideas and visions, both conscious and unconscious, that underlie harmful practices rooted in cultural and/or social tradition in order to support a vision of alternative practices.
- Taking a gender perspective often requires targeted intervention to promote the empowerment of women and to protect girls' and women's rights, for equity and countering discrimination, violence or abuse. However, equality is impossible to achieve if boys and men are left out of the process of change: they must be involved as active allies and advocates.
- There are situations where, due to gender norms, the psychosocial well-being and freedom of boys and men may similarly be at risk or harmed. For example, boys may be subjected to harsher physical punishment or exposed to dangerous living or working conditions. Sexual violence greatly affects migrant and refugee men and boys, especially, but not only, in detention centres and clandestine prisons in countries of origin and transit. Because of stigma and a sense of shame, the emergence of violence is often complex and access to specialised services, which is even more limited for this category of survivors, is reduced.
- In general, due to stereotypical gender roles and expectations, boys and men may have greater difficulty in recognising and expressing emotions, and in being met with empathy and support when such emotions are externalised. To prevent incidents of discrimination and violence (including sexual and gender-based violence) and to promote psychosocial well-being more broadly, it is essential to implement

permanent workshops that explore relational dynamics in participatory and nonjudgmental ways, helping the minors to strengthen their life skills, including emotional, social and communication skills, for dealing with problems and conflicts. An important aspect is the work on affective and sexual experiences in adolescence and the realisation of relationships based on consent, respect and equality, in order to support adolescents and teenagers in safely confronting sexist, discriminatory, and violent attitudes.

- When addressing sensitive issues, it is desirable to provide mixed activities but also activities separated by gender and/or other identified vulnerabilities and needs, so as to promote effective participation and safety of the participants. This is one of the considerations to keep in mind to ensure that the workshop represents and is perceived as a safe space. Pay special attention to the accessibility of the space, in particular in the case of disabilities, and to the confidentiality of the space so that activities can be carried out calmly.
- In the event of the emergence of questions or difficulties associated with a person's sexual and affective orientation or gender identity, it is essential to present a welcoming and nonjudgmental attitude. It must also be ensured that information about gender identity, sexual characteristics, and romantic and sexual orientation is discussed in a safe and confidential setting and that the confidentiality of what is shared is maintained.
- In addition to workshops with a dedicated focus, it is important to remember that gender roles and equality are issues cross-cutting and, as such, can provide important insights into all kinds of activities, reinforcing awareness of the impact of gendered social norms in the daily lives of every individual and group.

Although staff remain to lead the interventions in general, the **progressive empowerment** of those who participate in them offers numerous benefits, including increasing the sense of belonging and involvement in activities and strengthening the network and solidarity among group members, thereby promoting their psychosocial well-being. Below are some tools that can be used by properly trained personnel to carry out the activities in this chapter.

Expression and Innovation Kit for Adolescents, originally Adolescent Toolkit for Expression and Innovation
https://www.unicef.it/media/kit-di-espressione-e-innovazione-per-adolescenti-un-prezioso-strumento-supporto-psicosociale/

I support my friends
https://www.unicef.org/documents/i-support-my-friends

TeamUp
https://resourcecentre.savethechildren.net/document/teamup-support-refugee-children-worldwide/

HERE4U
https://www.unicef.it/media/alle-radici-della-resilienza-here4u-e-il-supporto-psicosociale-giovani-rifugiati/

Promoting a cross-cultural, intersectional and transitional approach to coming of age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To promote continuity of care for foreign children, it is essential to take a **multidisciplinary, intersectional, and cross-cultural approach**. This involves carefully considering the cultural, social and personal specificities of the children involved, recognising the importance of a context that respects cultural diversity and fosters a thorough understanding of their needs.

The cross-cultural approach aims to overcome cultural barriers by ensuring that care practices are sensitive to the ethnic and cultural diversity of minors. At the same time, intersectionality is integrated to give in-depth consideration to the complex aspects of their identities, such as the relationship between culture, gender, and other factors that may affect their experience of care.

To this aim, it is crucial to ensure effective coordination and smooth exchange of information between services aimed at minors (NPIA) and Mental Health Centres (MHCs)/DSMs for adults. This synchronisation aims to prevent the transition to adulthood from resulting in an abandonment of the therapeutic pathway begun as a minor.

Glossary and acronyms/abbreviations

Teenager
According to the United Nations, an adolescent is defined as any individual between the ages of 10 and 19.

Wellness
Term describing the positive condition in which a person develops. In the lexicon of mental health and psychosocial support, three dimensions of well-being are considered: *individual* (thoughts and emotions); *interpersonal* (sense of belonging to one or more groups/communities, maintaining satisfactory relationships); *skills and knowledge* (ability to learn, make functional decisions, respond effectively to difficulties).

Best Interest of the Child
The best interest of the child represents one of the fundamental values affirmed by the Convention on the Rights of the Child, which in Article 3(1) recognises the right of the child to have the best interests of the child valued as paramount and superior in all actions or decisions that affect him/her, whether in the public or private sphere2.

Burn-out
In the World Health Organisation's conceptualisation,[31] burn-out is a syndrome resulting from a condition of chronic distress in the workplace that has not been adequately managed. Burn-out is characterised by three dimensions: *feeling of exhaustion of one's energy; increased mental distance from one's work, or feelings of negativity or cynicism related to one's work; and reduced professional effectiveness*. Burn-out specifically refers to phenomena in the work context, however, it is commonly used to describe conditions of severe fatigue and overload in other areas of life as well.

Social folder
Since May 2017, the implementation of L.47/2017 has provided for a tool called the Social Folder, with the purpose of collecting all the significant information regarding the child's care path from the health, legal, educational and social points of view, which were previously collated in the IEP. The Social Folder should then be forwarded to the social services of the destination municipality and the Public Prosecutor's Office at the Juvenile Court. Currently, the implementation of this regulatory provision is proceeding quite slowly and many centres continue to fill out just the IEP.

Child safeguarding
Child safeguarding refers to the measures taken in policies, procedures and programmes, to ensure physical and emotional safety and evaluate and reduce the risks of causing harm to children and adolescents with whom organisations come into contact, directly or indirectly, through their own work or that of staff and partners.

Compassion fatigue
Professionals who work with highly distressed clients, such as those who have experienced trauma, are at risk of developing "compassion fatigue" as a result of their work. Compassion fatigue has been described as the empathic tension and general exhaustion involved in treating people in distress. It is characterised as a state of deep physical consumption accompanied by significant emotional pain and a marked reduction in the ability to feel empathy and compassion for others.

Emotional/psychological distress or emotional/psychological suffering
The term emotional or psychological discomfort or suffering refers to a state

31 https://www.who.int/news/item/28-05-2019-burn-out-an-occupational-phenomenon-international-classification-of-diseases

characterised by unpleasant or painful emotions that limit the person's psychosocial well-being. This state may also be temporary, transient, and does not imply that there is a psychopathology or psychological disorder.

Disability
In the definition of the UN International Convention on the Rights of Persons with Disabilities, "persons with disabilities, at any age, include those who have long-term physical, mental, intellectual or sensory conditions that in interaction with various barriers may prevent their full and effective participation in society on an equal basis with others." Along with permanent and long-term conditions, the World Health Organisation also considers temporary disability conditions. To ensure nondiscrimination and inclusive language, it is important to consider that people with disabilities may choose to define themselves by placing greater emphasis on the disability, as foundational to one's identity, with an *identity-first* approach (disabled person), or define oneself with a *person-first* approach (person with a disability).

Gender expression
External manifestation of each person's gender, which may or may not match culturally normed expectations.

Genus
This refers to the set of socially ascribed norms at a person's birth based on biological characteristics, prescribing or condemning behaviours considered more or less acceptable or desirable according to these characteristicsacross the life span. Gender roles are mobile, i.e., they vary across cultures and over time.

Youth
According to the United Nations, 'youth' are individuals between the ages of 10 and 24 while 'youths' are between the ages of 15 and 24. Depending on the reference context, broader age ranges up to age 30 are considered, for example, to produce comparative statistics for all member states, the European Commission uses an age range of 15 to 29 years.

Gender identity
Deeply individual experience that each person makes of his or her gender, which may or may not correspond to the sex assigned at birth and which includes the personal sense of one's body.

Intersectionality
Intersectionality is the study of social identities, which overlap or intersect (gender, age, disability, physical and mental health status, sexual and relational orientation, nationality, ethnicity, culture and language, familial and social status, religion, and others) and related systems of oppression, domination or discrimination towards such identity characteristics, which may be present, even in a systemic form, within social groups, collective and community contexts.

MHPSS - Mental Health and Psychosocial Support
Expression used to describe "any type of local or external support aimed at protecting or promoting psychosocial well-being and/or to prevent or treat mental distress" (IASC, 2007).

Unaccompanied and Separated Child (UASC)
Article 2 of Law 47/2017 defines UASC as a minor who is not a citizen of Italy, or of the European Union, who is for any reason in the territory of the State or who is otherwise subject to Italian jurisdiction, lacking the assistance and representation by parents or other adults legally responsible for him/her under the laws in force in the Italian legal system.

Neurodiversity
Neurodiversity is an alternative paradigm to a medicalised view of neurodevelopment, which analyses and questions a pattern of individual functioning defined as "normal" or "healthy" as opposed to functioning

defined as "pathological." This approach has been consolidated, above all, in relation to the experience of people with modes of functioning that are clinically attributable to neurodevelopment-related conditions and neurodivergences, such as autism spectrum, attention deficit and hyperactivity, etc. This approach emphasises that "atypical" modes of functioning are not to be considered pathological a priori, but rather are an expression of natural human variability and should be considered in their inherent dignity, on par with others, receiving necessary accommodation and adequate support. Moreover, the neurodiversity paradigm highlights the extent to which a stigmatising social environment, prejudice and discriminatory norms have a strong responsibility in creating disparities and disadvantages for individuals who do not align with "typical" development or standards of functioning considered "compliant."

Sexual orientation
Attraction, enduring, innate or unchanging, emotionally, romantically or sexually, to persons of one or more genders.

PSEA
Protection from Sexual Exploitation and Abuse (PSEA) is the term used to refer to systems aimed at protecting people in vulnerable situations from sexual exploitation and abuse by humanitarian actors and associated personnel, including humanitarian staff, volunteer(s), contractor(s), and supplier(s) of goods and services for humanitarian aid.

Psychosocial
This refers to the dynamic interconnection that exists between psychological and social processes, and the continuous interaction and mutual influence of these two dimensions (IASC, 2007). The psychological dimension includes a person's internal, emotional and introspective processes. The social dimension includes relationships, family and community networks, social values and cultural practices.

Mental health and psychosocial well-being
According to the World Health Organisation, WHO, psychosocial well-being means *"a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."* And again "a state of well-being in which the individual realises his or her abilities, is able to cope with the normal stresses of life, is able to work productively and fruitfully, and is able to make a contribution to the community in which he or she lives. In this sense, mental health is the foundation of a person's well-being and the community's ability to function properly" (World Health Organisation, 2005). The 2007 Inter-Agency Standing Committee (IASC) Guidelines on Psychosocial and Mental Health Support in emergency situations consider the psychosocial well-being of individuals and communities as determined by three interconnected and interacting factors:

- *individual functionality*, understood as physical, psychoemotional and cognitive health (this includes positive thoughts and emotions, a good level of self-esteem, good adaptability, learned skills and abilities, etc.);
- *social ecology*, understood as the social balance given by the network of social connections an individual has within the community in which he or she lives (e.g. being able to establish trusting and supportive relationships, etc.);
- *The cultural and value system*, understood as the set of values shared with the society and culture to which one belongs (including the sense of belonging to one or more groups/communities and the ability to attribute meanings and implement congruent behaviours to the cultural/community system to which they belong).

Psychosocial well-being and mental health thus refer to a positive state of well-being, resilience and self-actualisation.

Self-care
According to the World Health Organisation's definition,[32] self-care refers to the ability of individuals, families, and communities to promote health, prevent illness, maintain health, and address conditions of disease or disability, with or without the support of health professionals or specialists. This approach recognises individuals as active agents in managing practices related to health care and treatment, in areas such as: health promotion; disease prevention and control; self-medication; care provision for dependent persons; rehabilitation, including palliative care. Self-care practices do not replace the health care system but rather, they provide additional choices and options for health care.

Coping/adaptation strategies and mechanisms
Coping means *'to cope, to react, to resist, to manage.'* Coping mechanisms or strategies are, therefore, adaptive processes related to cognitive-behavioural skills and efforts made by the individual to cope with adverse circumstances. These adaptive processes are dynamic and constantly evolving. They can be positive, constructive and functional for the individual's adaptation and evolution, or dysfunctional, negative and even detrimental to the person's well-being.

Stress/stressors
The term 'stress' is used to describe the body's psychological and physiological response to tasks, difficulties or life events that are deemed excessive or dangerous. The feeling one experiences in a stressful situation can lead to being faced with severe mental and emotional pressure. The psychophysiological stress response varies from person to person and with age. In adolescents and teenagers, it may manifest as insomnia, altered appetite, variable mood, emotional fragility, increased nervous tension, anxious states, tendency to isolate oneself, difficulty concentrating, etc. Being in a state of stress is not related to a diagnosis or syndrome and should not be confused with diagnostic terminologies, such as 'trauma' and 'post-traumatic stress disorder,' which are often used as synonyms for 'stress' and therefore improperly.

Trauma/traumatised person
Psychological trauma normally arises from a deeply destabilising experience that violates a person's sense of security and psychophysical integrity. It is usually an unexpected and highly threatening event, in the face of which the person feels helpless. It should be kept in mind that a potentially traumatic event, no matter how dramatic it may appear, does not generate the same reaction in all people exposed to it, since there are multiple factors at play. Most people exposed to catastrophic events (natural disasters, wars, etc.) manage to cope with and overcome the high level of stress and profound psychological distress that result, thanks to personal coping strategies and the external resources available to them. It is therefore necessary to make a careful choice of terminology adopted, favouring expressions that respect individual specificities and resources over generalisations and misused diagnostic labels. Below are some examples:

- instead of *'trauma'* or *'traumatic event/ situation/episode/fact'* it is preferable to use the adjectives dramatic, severe, disturbing, threatening, painful, of strong emotional impact, destabilising, etc.
- instead of *'traumatised child!'* it is preferable to use expressions such as *'child who has experienced a potentially traumatic event/ series of events (or, instead of 'potentially traumatic' even better to use the adjectives above to describe the destabilising magnitude of the event)'*, or again focus on the emotional impact observed in the person: 'a girl with deep/acute emotional distress', etc.

32 https://www.who.int/news-room/fact-sheets/detail/self-care-health-interventions

Vicarious trauma
Vicarious trauma indicates the potentially disruptive impact resulting from the engagement of those involved in supporting people who have survived traumatic events, from contact with situations of severe suffering, loss, human cruelty, crisis and disaster. Anyone working to support survivors can potentially be affected: rescuers, service professionals, volunteers, people in the outreach solidarity network. The situations that can generate a condition of vicarious trauma are different, and more or less direct and persistent over time: witnessing one or more traumatic event (e.g., witnessing a serious accident, accompanying people to identify deceased family members); listening to explicit accounts of traumatic events (e.g., gathering testimony from survivors of violence and abuse); becoming aware of traumatic events through the media (conflicts, genocides, environmental and humanitarian disasters). From vicarious trauma comes excessive involvement empathy and identification towards the assisted persons, resulting in a process of change in support providers, from an emotional, cognitive, psychophysical, social, spiritual, identity and values perspective. Vicarious trauma, when not adequately intercepted and managed, can lead to burn-out and issues related to physical and mental health.

Gender-based violence
Gender-based violence is a broad and inclusive term used to describe any harmful act perpetrated against a person's will and based on socially attributed (i.e., gender) differences between males and females. The term encompasses all acts that inflict physical, sexual, or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty. These acts can occur in public or in private.

Vulnerability
This refers to a condition, for an individual or group of individuals, of increased risk to be adversely affected (thus with harmful or destabilising impact on one's state of safety and/or mental and physical well-being) by an event. Understanding the concept of vulnerability makes it possible to recognise and be able to act on the factors - individual, family, social, environmental, cultural, etc. - that induce a state of increased fragility, or increased exposure to a threat, or again, an impaired ability to withstand adverse impact. For example, in the context of Child Protection, a minor without adequate parental protection is at heightened protection risk compared to a peer who can rely on supervised and parental support. The lack of support from reference figures can also generate increased difficulty in dealing with hostile situations, resulting in impairment of the minor's psychosocial well-being and psychophysical development. For the focus of this report, the groups commonly recognised as most vulnerable are: unaccompanied foreign minors, lone migrant and refugee youths, and children with disabilities, psychological distress, chronic or acute illness, etc.

Psychosocial vulnerabilities
For the purpose of this paper, 'psychosocial vulnerabilities' are considered to be all the conditions of an individual and/or environmental nature, which pose potential or actual risks to a person's safety, physical health, mental health and psychosocial well-being. As outlined in the Vulnerabilities Vademecum, "An individual may have several concomitant vulnerability conditions (multiple vulnerabilities) that, as above, may emerge during the different stages of reception." (p. 8). "... Among the vulnerabilities indicated by the reference regulation, some relate to explicit and objective conditions inherent in the subject's health condition or socio-legal status, such as being an unaccompanied and separated child (UASC). Others are less identifiable, such as psychological distress, and therefore require non-urgent but as early as possible detection in order to ensure specialised and qualified referral." (p. 12). So, in view of the specific focus of this guide and the priority vulnerabilities identified by the

aforementioned inter-agency reference text, the following categories can be recognised in an illustrative and non-exhaustive perspective: unaccompanied foreign minors, trafficked minors, minors whose physical, mental health and psychosocial well-being are impaired or at risk of deterioration, minors who are survivors of or at risk of violence, abuse, mistreatment, exploitation and gender-based violence, minors with disabilities, minors at risk of discrimination because of their sexual orientation, or other characteristic related to their person or their linguistic and cultural background or belonging.


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