New Paths

Good practices in mental health and psychosocial support services for adolescents and young refugees and migrants in Italy
Contents

Executive summary 4

Glossary 11

Chapter 1 - Introduction 15
  1.1 The theoretical and methodological framework of UNICEF’s MHPSS interventions 16
  1.2 The reasons for mapping MHPSS practices for UASC and migrant and refugee children 21
  1.3 Phenomenology 22

Chapter 2 - Methodology 27
  2.1 Disciplinary approach and methodology 28
  2.2 Scientific committee and ethical issues 30
  2.3 Limitations 31
  2.4 Definition of good practice and phases of research 31

Chapter 3 - Analysis of the legal and policy frameworks 37
  3.1 The governance system of MHPSS services 38
  3.2 Operational implementation of MHPSS services 47

Chapter 4 - Identification of practices 51

Chapter 5 - Success factors of the practices and challenges for the MHPSS system 93
  5.1 The distinctive features of the practices analysed: what works, how and why? 95
  5.2 Challenges for the MHPSS system 132

Chapter 6 - Conclusions 147

Appendices 150
  Appendix 1: The Role of UNICEF in the field of MHPSS in Italy and the operating principles 150
  Appendix 2: Operating principles guiding UNICEF interventions 153
  Appendix 3: Guidelines for MHPSS services delivered to migrant users 154

References 158
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Executive summary

With this mapping of mental health and psychosocial support (MHPSS) interventions, UNICEF aims to contribute to the collective reflection within the protection and reception system for unaccompanied and separated children (UASC) and young refugees and migrants. The report emphasizes the good, promising and emerging practices identified in this crucial area of intervention, which acts as a central gateway between the reception system, social and health services.

The mapping exercise provides an overview of the most significant practices currently in place. The aim is to develop an up-to-date body of knowledge and lessons learned, and to identify effective models of action and minimum standards that can be replicated in or disseminated to other locations.

Based on specific analysis criteria, and following an extensive consultation process, the research identified, through relevant literature, 13 good, promising and emerging practices. These practices offer innovative MHPSS services through the development and provision of services tailored to the specific needs of UASC and young refugees and migrants hosted in reception facilities. They are based, in six regions (Piedmont, Lombardy, Emilia-Romagna, Latium, Sicily and Puglia).

In addition to identifying the practices, the research gathered evidence from interviews and focus group discussions with MHPSS professionals, at both regional and national levels, and with migrant and refugee children and young people hosted in the second-line reception system. These consultations with service providers and users allowed for an in-depth analysis of the interventions (including the rationale behind their planning and delivery), individuals’ personal opinions on the challenges faced in accessing services, and the recommendations to be taken into consideration to improve the response. An outline of each identified practice was summarized in a ready-to-use fact sheet, designed to offer professionals working in the reception system a quick snapshot of the interventions, including methodological approaches; multidisciplinary teams involved; types of services provided; and networks promoted. The preliminary results of the research were discussed and integrated in a consultation workshop in October 2021 when representatives from all the mapped practices attended the workshop and validated the fact sheets for their own practices.

Through the voices and experiences of MHPSS professionals and boys and girls using MHPSS services, we analysed intervention models, delivery procedures and factors that enabled or limited access to services. This analysis was combined with a study of the success factors for the practices identified, and the challenges affecting both MHPSS services and the mechanisms of coordination with the reception system.

The mapped practices differ significantly in terms of services they provide, the paradigms that inspire them, and the network models they use. However, they all share common success factors that determine their quality and replicability, as follows:
<table>
<thead>
<tr>
<th>SUCCESS FACTOR</th>
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<tr>
<td><strong>1: Ability to tailor services to effectively respond to the mental health and psychosocial needs of migrant and refugee adolescents and youth</strong></td>
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<tr>
<td><strong>MAIN FEATURES IDENTIFIED</strong></td>
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</table>
| • Attention to the uniqueness of each boy and girl and to their multidimensional needs, through appropriate psychosocial support and mental health interventions.  
• Use of multidisciplinary technical expertise (including psychology, pedagogy, transcultural and gender-oriented approaches, and cultural-linguistic mediation) that enhances active and empathic listening, allows for the early identification and holistic assessment of needs, and for the planning of interventions based on the continuum of care.  
• Solid experience in designing actions combining different skills, scope and settings (e.g. group, individual or specialized psychosocial support) in order to enhance and capitalize on the user’s resources and to support all dimensions of psychosocial well-being, through a multidisciplinary and integrated approach.  
• A leading role in the municipal and/or regional welfare system in providing psycho-socio-health services. These entail psychosocial support designed to create customized paths of social inclusion and socioeconomic integration.  
• Constant attention to the creation of individualized interventions for the prevention of psychological distress, focused on the child as an individual with social, relational and psychological needs, and as a subject with rights rather than a passive beneficiary. These interventions are developed through community and local networks. |
| **2: Multidisciplinary teams working in the reception system and in local social and health-care services to guarantee continuity of care and integrated case management** |
| **MAIN FEATURES IDENTIFIED** |
| • Working in multidisciplinary teams, consisting of professionals with different educational and disciplinary backgrounds; avoiding standardized and routine responses to the users’ unique needs.  
• Adoption of an integrated MHPSS approach, oriented towards the provision of interdisciplinary, multidimensional and intercultural care and customized support pathways that pay attention to |
Despite the significant commitment of the many institutional and civil society actors working in the field of MHPSS services, the mapping exercise was also an opportunity to identify some areas for improvement, both in the reception system for UASC and young migrants and refugees and in MHPSS services.

These areas for improvement are described below.
<table>
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<tr>
<th>AREA</th>
<th>MAIN ASPECTS</th>
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| **1 Coordination between the reception system and MHPSS services** | • Unclearly and inconsistently organized provision of MHPSS interventions within the reception system, especially in first-line reception.  
• Management of mental health and psychosocial support interventions carried out by reception centre workers, who do not always have the opportunity to work in synergy with social and health services and are often not able to identify psychological distress at an early stage.  
• Limited attention to the provision of non-specialized psychosocial support right from the first-line reception. Such support can prevent the deterioration of psychosocial well-being and more severe forms of psychological distress.  
• Limited investment in the role of educators in the reception system during the design and provision of mental health and psychosocial interventions. Often, prevention and support activities for people in psychosocial distress are identified late and are limited to a referral to specialized external services.  
• Significant increase in job insecurity within the reception system. This has an impact on educators’ careers, and on the quality and continuity of relationships with users.  
• Involvement of external mental health services, including specialized services, as an emergency response following the exacerbation of mental health conditions that can no longer be effectively managed and mitigated by the personnel at the reception facility.  
• Occasional, unstructured and inadequately funded outreach initiatives by mental health public services within the reception system. |
| **2 Suitability of public mental health services for supporting young refugees and migrants** | • Public mental health services are not always suitable for supporting young refugees and migrants. This adds to the problem of a lack of competences in the field of adolescence and transition to adulthood. |
| Scarcity of child and adolescent neuropsychiatric services and other specialized public mental health interventions to address the specific needs of young refugees and migrants. |
| A scarcity of linguistic and cultural mediators and a lack of established intervention models based on culture-sensitive case management. |
| Long waiting lists for case management in child and adolescent neuropsychiatric services and public MHPSS services. |
| Limited coordination between child and adolescent neuropsychiatric services and the public services that provide MHPSS for adults. Often the transfer of care to adult services takes place without adequate information-sharing, and this hampers continuity of care and quality of provision. |
| Major delays in establishing a shared intervention model based on continuity of care. MHPSS services are still poorly connected and there are often barriers in accessing specialized mental health services, which struggle to ensure timely and targeted responses to migrant minors with psychological conditions and psychiatric disorders. |
| Insufficient human and financial resources and a significant increase in demand for specialized support from host communities put pressure on public mental health services, which struggle to meet the specific challenges faced by migrant and refugee children. |
| The public mental health system is significantly burdened by job insecurity and high staff turnover. This significantly obstructs the consolidation of teams and leads to a lack of standardized working tools. |
| Many public mental health services designed for migrant and refugee users struggle to ensure long-term sustainability and are constantly burdened by funding shortages, which undermine their continuity and limit chances for updating, adapting and transferring interventions that have proved to be effective. |
3 Mechanisms for identification, referrals and intake

- Mechanisms for the identification, referral and intake of minors are often fragmented and poorly established.
- There are no defined procedures for coordination between the reception system and external MHPSS.
- Coordination between the reception system and external public or private MHPSS relies mainly on personal contacts, relationships and individual resources.
- Where they do exist, standard operating procedures, protocols and guidelines to promote coordination between the reception system and external social and health services are not well promoted, so most of the professionals are unaware of them.

4 Participation of UASC in the care processes that concern them

- Lack of involvement and participation of migrant users in the development of MHPSS activities, and limited information on available services and how to access them.
- Poorly managed involvement of migrant and refugee boys and girls in the decisions and problems affecting them, in particular the methods and timing of planning, promoting and communicating psychosocial and mental health activities.
- Inexperienced reception staff, inconsistent use of cultural mediators, delays to social inclusion programmes and excessive bureaucracy can all negatively affect individual paths and projects.
- Support provided by educators at the reception centres is sometimes characterized by a fragile listening capacity and limited time to build a trustworthy and supportive relationship. The support can be undermined by staff inexperience and excessive bureaucracy.
- The right to be heard and to participate are not always guaranteed at the different stages of integrated case management.
<table>
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<th>A lack of transcultural training programmes for MHPSS professionals working with migrant users to ensure empathic, respectful and non-judgmental listening skills.</th>
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<tr>
<td>Users tending to delegitimize or abandon interventions that they perceive as inappropriate, imposed on them, or lacking an empathic, respectful and non-judgmental approach.</td>
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With adequate investments and improved coordination among stakeholders responsible for planning, implementing and monitoring MHPSS services, inside and outside the reception system, the **mapped practices can serve as a basis for minimum standards to guide MHPSS interventions** designed for migrant and refugee children and youth.

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1 Among the intervention models identified at regional level, good, promising and emerging practices were identified in terms of impact, relevance, coherence, effectiveness, efficiency, sustainability, transferability, partnership involvement, participation, respect and protection of rights, non-discrimination and equality.
Glossary

**Adolescent:** Defined by the United Nations as any person between the ages of 10 and 19.

**Asylum, Migration and Integration Fund (AMIF):** A European Union financial instrument aimed at supporting Member States to improve the integrated management of migration. The AMIF national programme is a policy document drawn up by the Italian Government. It sets strategic and operational objectives and defines a range of initiatives to be supported through calls for proposals issued within this funding and promoted by the Ministry of the Interior.

**Best Interests of the Child:** This is one of the core principles laid down by the Convention on the Rights of the Child, set out in Article 3 (1). The principle is that, in all actions and decisions concerning children, whether undertaken by public or private institutions, the best interests of the child shall be a primary consideration.

**Coping strategies:** Coping mechanisms or strategies are adaptive processes, linked to cognitive-behavioural skills and efforts, that an individual uses to manage adverse circumstances. These adaptive processes are dynamic and constantly evolving. They can be positive, constructive and functional for an individual’s adaptation and evolution, or dysfunctional, negative and even detrimental to their well-being.

**Distress:** see ‘stress’.

**Emotional/psychological distress or suffering:** A state of unease or unpleasant or painful emotions that the person’s psychosocial well-being. This state can be temporary and transitory, and does not imply an underlying psychopathology or psychological disorder.

**Focus group discussions (FGDs):** An interactive face-to-face data-collection method used in qualitative research to gather the views of a small group of subjects on specific topics and issues. It consists of a group-interview, in which participants can discuss and express their ideas, answer questions and carry out small, proposed activities.

**Individual Educational Programme (IEP):** A document prepared for each UASC in the reception system. It considers the child’s skills, capacities and ambitions, and contains personal, educational, training, work and social inclusion goals.

**Mental health and psychosocial support (MHPSS):** This composite term is used to describe "any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder" (IASC, 2007).

**Mental health and psychosocial well-being:** According to the World Health Organization (WHO), psychosocial well-being is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". Moreover, it is “a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community. In this sense, mental health is fundamental to our collective and individual ability to function properly” (WHO, 2005).
Agency Standing Committee (IASC) guidelines on MHPSS in emergency settings consider individual and community psychosocial well-being as determined by three interconnected and interacting factors:

- **individual functioning**, defined as physical, psycho-emotional and cognitive health (including positive thoughts and emotions, a good level of self-esteem, good adaptability, and skills and competences learned)
- **social ecology**, meaning social balance, determined by an individual’s social network within their community (for example, being able to establish trustworthy and supportive relationships.)
- **cultural and value system**, defined as those values that belong to an individual’s cultural background and are shared with society. These could include the sense of belonging to one or more groups/communities, and the ability to share meanings and engage in behaviours consistent with the own cultural/community value system

Therefore, psychosocial well-being and positive mental health refer to a positive state of well-being, resilience and personal fulfilment.

**Psychosocial**: The interconnection between psychological and social processes which continually interact with and influence each other (IASC, 2007). The psychological dimension includes the inner, emotional and introspective processes, feelings and reactions of an individual. The social dimension concerns relationships, family and community networks, social values and cultural practices.

**Resilience**: The ability to respond and recover positively when faced with challenging and difficult experiences. During childhood and adolescence, resilience does not depend only on inborn resources and individual adaptation strategies, but also on the combination of risk elements and protective factors of the sociocultural environment (UNICEF, 2018)

**Social file**: Law 47/2017, adopted in May 2017, established a new tool called the social file. The purpose of the file is to collect all relevant information in relation to a child’s reception path from a health, legal, educational and social point of view. This information was previously collected within the Individual Educational Plan (IEP, Piano Educativo Individuale). The social file is sent to the social services in the municipality of destination and to the Public Prosecutor’s Office at the juvenile court. Currently, the implementation of this provision is proceeding at a slow pace, and many centres still use only the IEP.

**Stress/stress factors**: The term ‘stress’ is used to describe a psychological and physical response activated by the body in the face of tasks, challenges or life events perceived as excessive or dangerous. Stress usually entails a feeling of mental and emotional pressure. The psychophysiological response of stress varies from person to person and with age. In adolescence, stress can be displayed through insomnia, lack of appetite, mood swings, emotional fragility, nervous tension, anxiety, withdrawing behaviours, inability to focus, etc. When a state of stress persists or becomes overwhelming, it poses a threat to the person’s psychosocial well-being. In relevant literature and also in this report, the term ‘distress’ is used with the equivalent meaning. Being stressed/distressed is not related to a clinical diagnosis or syndrome and should not be referred to using specialized terminology or labels, such as ‘trauma’ and ‘post-traumatic stress disorder’, which are often used inappropriately.
System of reception and integration (SAI): Law 173 of 18 December 2020, renamed the second-line reception system SIPROIMI – Protection system for holders of international protection and unaccompanied foreign minors, into the SAI. The new system includes UASC, as well as refugees who have reached the age of majority, who are granted continued protection and assistance until the age of 21. The SAI also hosts holders of special protection permits or residence permits for special cases (beneficiaries of social protection; victims of domestic violence; victims of labour exploitation; victims of disasters; migrants who are recognized as having civil value; and holders of a residence permit for medical treatment).

Trauma/traumatized person: Psychological trauma is a response to a profoundly destabilizing experience which violates one’s feeling of safety and psychophysical integrity. It is usually an unexpected and highly threatening event, in the face of which the individual feels powerless. It must be recognized that a potentially traumatic event does not trigger the same reaction in all individuals exposed to it, no matter how dramatic and threatening the event can seem. In fact, the condition of trauma is caused by the combination of multiple contributing factors. Most people experiencing catastrophic events (such as natural disasters or wars) manage to overcome the high level of distress and acute psychological suffering, thanks to individual coping strategies and external resources. Therefore, it is necessary to use accurate language, replacing any terminology that implies inappropriate generalizations or false diagnoses with more respectful expressions that recognize and value individual experience and resources. For example:

- instead of ‘trauma’ or traumatic event/situation/episode’ it is preferable to use adjectives such as dramatic, serious, disturbing, threatening, painful, of strong emotional impact, or destabilizing
- instead of ‘traumatized boy/girl,’ it would be preferable to use expressions such as ‘boy/girl who has experienced a/a number of potentially traumatic event/s’ (or, instead of ‘potentially traumatic’ it is even better to use the above adjectives to describe the destabilizing extent of the event) or to highlight the affected person’s emotional reaction, such as ‘a girl with deep/acute emotional distress’

Unaccompanied and separated child/children (UASC): Article 2 of Law 47/2017 defines a UASC as a minor under 18 years of age, who is either a national of a non-European Union country or a stateless person, and who is, for whatever reason, in the national territory without the legal assistance and representation of his parents or other adults legally responsible for him/her.

Vulnerability: Implies an increased risk, for an individual or a group of individuals, of being negatively affected by an event, with a harmful or destabilizing impact on one’s safety and/or psychophysical well-being. Understanding the concept of vulnerability makes it easier to recognize and act on those factors – individual, familiar, social, environmental, cultural, etc.-that trigger a state of greater fragility or increased exposure to a threat or compromise an individual’s ability to face adverse experiences. For example, in the context of child protection, a child without adequate parental protection is exposed to heightened protection risks compared to a peer who can rely on parental supervision and support. Lack of support from key caregivers can also lead to increased difficulty in dealing with adverse situations, with consequent impairment of the child’s psychosocial well-being and psychophysical development. For the focus of this report, groups recognized as particularly vulnerable are: unaccompanied and separated migrant and refugee children; young migrants and refugees moving alone; boys and girls with disabilities, with psychological distress, chronic or acute illnesses, etc.
Well-being: A term describing a positive state that allows an individual to develop and thrive. In the field of MHPSS, three dimensions of well-being are considered: individual (e.g. positive thoughts and emotions); interpersonal (e.g. sense of belonging to one or more groups/communities, experiencing positive relationships); and skills and knowledge (e.g. ability to learn, make functional decisions, and respond efficiently to challenges).

Youth: The United Nations defines ‘young people’ as individuals aged between 10 and 24 years, and ‘youth’ as people aged between 15 and 24. Depending on the context, broader age groups up to 30 years are taken into account, e.g. for comparative statistical purposes, the European Commission defines ‘youth’ as being between 15 and 29 years old.\(^4\)

\(^2\) See www.unicef.it/convenzione-diritti-infanzia/articoli/
\(^3\) See www.issalute.it/index.php/a-salute-dalla-a-alla-z-menu/s/stress
\(^4\) See https://ec.europa.eu/eurostat/web/youth
Chapter 1
Introduction
UNICEF’s global priority is to provide mental health and psychosocial support (MHPSS) to children, particularly those who are vulnerable or in danger, such as unaccompanied and separated children (UASC.)

In all regions where UNICEF works, psychosocial support and mental health interventions are integrated into all prevention and support programmes that cover child protection, health, gender-based violence, education. UNICEF also aims to promote the active participation of children, adolescents and young people by tailoring these programmes to specific contexts and identified needs.

In the past, the public debate about the psychosocial well-being and mental health of children and adolescents, including migrant and refugee children, was divisive, influenced by prejudice and stigma. However, over the last two years, especially since the Covid-19 pandemic (UNICEF 2021), psychosocial well-being and mental health have increasingly become a collective and institutional concern. This has stimulated political decisions and programmatic actions, both at the governmental and civil society level, nationally and globally. This shift has also highlighted the importance of MHPSS in UNICEF’s programme in Italy, which was developed in accordance with recommendations from the UN Committee on the Rights of the Child (point 29), and with UNICEF’s global strategic plan for 2018-2021 and UNICEF’S Strategic Plan 2022-2025.

This report presents a review of MHPSS services for children and young migrants and refugees, highlighting good, promising and emerging practices. Through the identification of well-functioning systems, we hope to add to the evidence about MHPSS services for migrant children and to encourage the sharing, replication and scale-up of effective and promising practices.

This report is divided into five chapters, as follows:

**Chapter 1** explains the background to the mapping exercise, and the programme and advocacy goals.

**Chapter 2** provides an overview of the theoretical and methodological approaches that guided the research.

**Chapter 3** analyses the legal, policy and programme aspects of MHPSS services in Italy, highlighting the main policy developments and challenges faced in delivering MHPSS services to migrants and refugees.

**Chapter 4** provides a detailed overview of the 13 mapped practices, together with ready-to-use fact sheets, which summarize the interventions, the methodological approaches used, the types of staff employed and services provided, and the networks that are promoted to professionals working in the reception system for UASC.

**Chapter 5** analyses the success factors of the identified practices and outlines the main challenges for both MHPSS services and the related coordination mechanisms within reception systems.

### 1.1 The theoretical and methodological framework of UNICEF’s MHPSS interventions

MHPSS programmes are at the core of UNICEF’s protection interventions for children, adolescents, young people and families, both in emergency and low-income settings and in high-income countries. These interventions are included in programmes that address different needs, including education, nutrition, livelihoods, health, and adolescent participation.
The Social Ecological model (see diagram below), which lies behind UNICEF’s MHPSS interventions, places the child at the centre of at least three types of environments – family, community, culture and society – in which a child’s development and well-being (central circle) take shape and are consolidated over time.

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Protective Factors</th>
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<tr>
<td><strong>CULTURE &amp; SOCIETY</strong></td>
<td><strong>COMMUNITY</strong></td>
</tr>
<tr>
<td><strong>FAMILY/CAREGIVER</strong></td>
<td><strong>DEVELOPMENT</strong></td>
</tr>
<tr>
<td><strong>COGNITIVE</strong></td>
<td><strong>SOCIAL SPIRITUAL</strong></td>
</tr>
<tr>
<td><strong>EMOTIONAL</strong></td>
<td><strong>PHYSICAL</strong></td>
</tr>
<tr>
<td><strong>CHILD</strong></td>
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</tbody>
</table>

This model has been adopted by international protection programmes and shared worldwide by all UN agencies and main bodies involved in protection and well-being work. It upholds two main principles:

1. Children are at the centre of all interventions and should be considered as active players and carriers of resources, needs and desires.

2. Interventions that aim to protect and

These programmes involve multi-sectoral integration, reflecting the broad definition of mental health provided by the WHO: “Mental health constitutes a crucial component of the broader person’s health. This definition considers health as a state of complete physical, mental and social well-being and not merely as the absence of disease or infirmity. Therefore, psychosocial well-being means a state in which a person acknowledges his or her own abilities; deals with ordinary life strains and is able to work productively and contribute effectively to his or her community. Mental health and psychosocial well-being are not solely individual dimensions, but the foundation of a community’s ability to function properly.”

Therefore, mental health depends on multiple factors that must all be provided at a minimum level to ensure the achievement and maintenance of psychosocial well-being, which includes emotional, biological/physiological, cognitive/mental, cultural, social and material aspects.

Supporting children’s psychosocial well-being requires the use of the principles established in the Convention of the Rights of the Child, which recognizes the right of children and adolescents to be heard and to actively participate in all protection and care processes affecting them. According to the Convention framework, mental health and psychosocial well-being are not confined to the individual sphere, but depend on a continuous and dynamic exchange between a person and his/her environment. Mental health and psychosocial well-being interventions promoted by UNICEF recognize and give value to this complexity, considering not just multidimensionality, but also the external factors influencing and interacting with the individual well-being.
support children’s and adolescents’ well-being and development must consider the environment in which they grow, including key caregivers, supportive relationships, available services, and the legal framework protecting children.

In line with these principles, MHPSS interventions work in an integrated manner to:

a) reinforce all the above-mentioned levels (including services for children, families and communities; and policies, laws and services that provide support for children and adolescents

b) strengthen protective factors (such as internal and external resources)

c) minimize the factors that undermine well-being (for example, by identifying maladaptive strategies and reducing vulnerabilities and risks)

In recent decades, MHPSS interventions have been wide-ranging, both at a national and the global level. This wide variety of models, supported by unclear theoretical and practical concepts, has led to a range of contrasting approaches and a fragmentation of practices. These inconsistencies have jeopardized the effectiveness of services.

In 2007, the IASC developed the first inter-agency worldwide guidelines on MHPSS interventions in emergency settings – the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. These guidelines were designed to establish consistent approaches and ensure more integration within interventions. The IASC MHPSS Reference Group for Mental Health and Psychosocial Support was also established, with the aim of raising awareness and promoting a body of key guidance. The IASC guidelines are a milestone for MHPSS interventions globally, representing a remarkable outcome from a highly participatory process. Their wide dissemination and use over the last 15 years have led to a common language, applied universal guidelines and a shared reference paradigm. Overall, there is now increased consistency based on minimum quality.

Following these guidelines, the Reference Group for Mental Health and Psychosocial Support has developed many other technical tools and guidance on specific matters, including need assessment, service mapping, monitoring, ethics, advocacy, and integration of MHPSS interventions across sectors. The IASC guidelines have so far exceeded the initial ambitions of the project. Not only have they been the most widely accepted technical reference tool for MHPSS interventions, but their application has extended well beyond the emergency settings for which they were originally conceived. The guidelines are now available in 13 languages and have been widely adopted and adapted for mixed and high-income settings where UNICEF implements system strengthening programmes (See appendix 2 for a more detailed explanation).
The IASC Guidelines created a four-layer pyramid representing MHPSS interventions (see figure below): Each of the four layers of the pyramid outlines a response to specific needs. Moving from the base of the pyramid to its top, psychosocial and mental health needs become progressively more intense and require greater attention and increasingly specialized skills:

**Layer 1: interventions to ensure basic needs, safety (both actual and perceived) and protection**

All necessary considerations and arrangements are to be implemented to ensure the dignity and effective participation of children, and to promote their best interests. This approach is followed in each layer and should be applied across all sectors and services in response to basic needs. These include food; water, sanitation and hygiene (WaSH); health; non-food items (such as the provision of clothes or blankets), shelter; and case management for unaccompanied or other vulnerable children. In addition, **individual safety is a non-negotiable principle** that requires a physically and emotionally safe environment where children feel supported. For example, this first layer of interventions includes awareness-raising and sensitization about available services, human rights (such as the UN Convention on the Rights of the Child), and psychosocial well-being, among other critical topics.
Layer 2: support for families, groups and communities with the aim of re-establishing and/or strengthening individual and group resilience, protective factors (both individual and community), and functional coping strategies

This layer includes most of the interventions that support psychosocial well-being. Services in this layer are generally referred to as psychosocial support and involve structured activities targeting specific groups, for example, based on gender, age or cultural background. Such interventions have predefined objectives, focus on identified needs, and reinforce interpersonal relationships and social support networks.

Examples of this type of services for adolescents include group activities and workshops designed to build participants’ self-esteem and emotional regulation and to help them handle conflict situations and overcome challenges. Other services in this layer include: peer-to-peer support; awareness-raising activities (about stigma, discrimination, etc.); support services; sport and training activities; psycho-socio-educational interventions and formal and informal education.

Layer 3: focused support interventions to address the specific needs of an individual or a small group of people with similar experiences, needs or issues

This layer includes a range of individual or group activities with different goals. They tend to be managed by staff with specific skills and defined competences, but not necessarily with clinical training. These services can be provided by professional educators and staff with educational, pedagogical and psychological skills, such as active and empathic listening; emotional support; age-appropriate supportive communication techniques. This layer also includes psychological first aid and tailored psycho-socio-educational programmes.

Layer 4: clinical interventions and specialized care

At the top of the pyramid are clinical and medical services that focus on the individual’s experiences and inner psychological dimensions. Provision of these services requires specialist skills, including psychological, psychotherapeutic, neuropsychiatric, psychiatric, and neurological support.

Overall, the four support layers highlight the connection between basic services and services that strengthen individual resilience and social support in both the reception community and local environment (I and II level); services that support the coping skills of specific vulnerable groups within a wider population (II level); and focused services addressing specific individual needs (III and IV level) that may also include specialized interventions (IV level). The IASC operational framework emphasizes the importance of interconnection and integration among the great variety of interventions and professionals implementing them, and highlights the critical need for complementary and integrated approaches within a holistic and multidimensional response.

MHPSS services therefore take shape across several types of intervention. Some MHPSS services are implemented outside the health sector by organizations who deliver services ascribed to psychosocial well-being, while others are provided from within the health sector by actors who oversee clinical mental health interventions. According to practitioners, the goal of MHPSS
is to ‘include in an interdisciplinary way the three key figures of psychosociology: psychiatrists, psychologists and social workers; each interacting with the others, but with different tasks according to the given intervention, excluding multidisciplinary and isolated approaches that were shown to be reductive and inappropriate in the past.’ (Castelletti, 2008:7)

This model implies that three key conditions are needed to pursue effective interventions: inter-agency coordination, a multidisciplinary approach and integrated case management. Moreover, for an intervention to attain a positive and sustainable impact on psychosocial well-being and mental health, needs at the lower layers should already be met, or at least concurrently addressed. The arrow in the diagram, moving from bottom to top, shows the priority of interventions. This is not intended as a hierarchy of interventions, in which some services are more important than others. Rather, it suggests using interventions in the upper layers of the pyramid only after proper activation of the lower layer, which may already address a large part – if not all – of the individual’s MHPSS needs. When all levels of services are properly activated, interventions are likely to be more effective and durable over time. In addition, the number of individuals requiring focused care, specialized skills, dedicated resources and long-term support will decrease as we step up through each layer of the pyramid.

A key reference for UNICEF in its MHPSS intervention models is the ‘Operational guidelines: Community-based Mental Health and Psychosocial Support in Humanitarian Settings: Three-tiered support for children and families’ (UNICEF, 2018) which integrates the IASC guidelines with the Social Ecological model and adopts a child-protection perspective.

1.2 Reasons for mapping MHPSS practices for UASC and migrant and refugee children

In 2008, the Global Protection Cluster recognized that developing good practices in child protection was a global priority. According to the IASC Guidance Note on Using the Cluster Approach to Strengthen the Humanitarian Response, identifying and exchanging good practices in this field can significantly enhance planning and programming, as well as ensuring better protection. The European Union Strategy on the Rights of the Child also highlights the importance of sharing good practice to address children’s mental health, since migrant children “suffer from mental health issues due to dramatic situations experienced in the country of origin, on the migratory route, uncertainty or degrading treatment in the country of transit and arrival”.

Moreover, since 2011 and as recently as 2021, the inter-agency Working Group for the Convention of the Rights of the Child, which includes the UNICEF Italian National Committee, has expressed concern about the lack of a national strategy or system to assess and monitor children’s mental health (in particular, adolescents with a migratory background), as per the concluding observations of the UN Committee on the Rights of the Child’s address to Italy. While there are a great many projects and programmes providing psychosocial support and mental health to UASC and migrant and refugee children in Italy, there is a lack...
Indeed, there is no shared definition of good practice in the field of MHPSS. Only a few studies to date have investigated good practice in Italy (Zani, 2008; Mela, 2013; Rostirolla, 2016; Gatta, Segneri 2017, Barbaro et al. 2021). Little is known about the quality standards or operational frameworks of MHPSS services for migrant and refugee children, and consistent knowledge on coordination mechanisms and case management and referral procedures is not available. Therefore, even public debate suffers from a lack of evidence and collectively agreed definitions, and even the term ‘good practice’ is used improperly.

Through this mapping, UNICEF aims to contribute to the collective reflection on the protection and reception system for UASC and young migrants and refugees, and on the MHPSS services they are offered. It provides an overall picture of current services and structures, analysing and emphasizing good, promising and emerging practices in this crucial area of intervention. Ultimately, the aim is to develop an up-to-date body of knowledge and lessons learned, and to identify positive models of action and minimum standards that can be replicated in and disseminated to other territories.

1.3 Phenomenology

Migration of UASC has become significant over the last decades at both global and European levels (Menjivar, C. e K.M. Perreira, 2019; Valtolina 2014). In 2019, 12 per cent of global international migrants (33 million of people) were children, with many travelling to or through Europe.

Since 2014, 86,967 UASC have reached Italy after crossing the Mediterranean Sea with significant risks. This figure does not include UASC arriving in Italy through northern border crossings. On 31 December 2021, there were 12,284 UASC in the reception system, representing an increase of 73.5 per cent compared with the previous year. The children are mainly male (girls account for only 2.7 per cent of the registered population), aged 16-17, and most come from Bangladesh (2,843), Egypt (2,221), Tunisia (1,560), Albania (1,186), Pakistan (784) and Somalia (463). Other countries of origin include Côte d’Ivoire (460), Afghanistan (446), and Guinea (359). The Italian regions that host the largest number of UASCs are Sicily (28.2 per cent), Calabria (12.3 per cent), Lombardy (9.8 per cent), Friuli-Venezia Giulia (8 per cent), Puglia (7.8 per cent) and Emilia-Romagna (7.5 per cent).

Most of these boys and girls come from countries with poor socioeconomic and education systems and collapsing or heavily damaged health services due to the long-term humanitarian crisis. Many were exposed to armed conflicts in their countries of origin or transit, and all have faced unfamiliar and often hostile environments. Factors such as young age, separation from family members or key carers, and painful experiences – including torture, sexual abuse, or gender-based violence – in their countries of origin or during the journey all contribute to the high exposure of migrant children to extreme stressors (Sanfelici, Wellman, Mordeglia, 2021). Literature and practice have shown that many UASC
experienced traumas related to experiences of submission and abuse, such as forced labour and sexual exploitation (Van Reisen, 2016; Smith 2018; UNICEF 2021; UNICEF 2017; Pagano 2016). The hardships linked to forced displacement (Zanfrini, 2021) may also negatively affect the psychosocial well-being of UASC during their migration journey (Huemer et al., 2009; Vervliet et al., 2014). The combination of “distressing pre-migratory, peri-migratory and post-migratory experiences” (Foschino Barbaro 2021: 19) may produce psychopathological effects that are exacerbated by the intrinsic vulnerability of having “survived pre-migratory and peri-migratory traumas and [having] to make an ongoing adaptive effort that will last throughout the integration process in their host country” (CISMAI 2020: 19). In the country of arrival, foreign children and youth are often faced with integration processes that are not always linear. Also, these processes mostly share a “migrant condition: a context of subordinated social positions characterized by discrimination, job insecurity and a stigma built on an ethnic, racial and cultural basis”. (Gilberti and Queirol Palmas, 2014: 26).

Box 2 - Adolescence and migration

Adolescence marks the transition from childhood (pre-adolescence) to young adulthood. The UN Convention on the Rights of the Child defines adolescents as individuals aged between 10 and 19 years, while young people as those aged between 15 and 24 years. Adolescence is a developmental stage characterized by critical physical, cognitive and social changes. These changes can be so rapid that some boys and girls may struggle to maintain a strong psychosocial balance and sense of well-being, and may have difficulties in understanding these changes. Adolescence can thus be considered almost as a second birth, in which an individual faces many challenges, including those related to the definition and consolidation of his or her own identity.

The rapid physical and cognitive development may cause boys and girls to be susceptible to influences. When adolescents try new experiences, this may lead to innovation and success, but it may also make them vulnerable. During this transition, gender roles are often consolidated, and girls may bear the heavy burden of gender inequality. Adolescents’ well-being may depend on the quality of their environment, relationships and experiences. Some crucial elements that can influence their growth include: care and support, services, social norms and the ability to influence the decisions affecting them. Investing in adolescents can strengthen their skills, promote human rights and build a better future for them, their families and communities.

It is likewise important to note that the experience of adolescence is intrinsically related to the individual’s culture and society. Indeed, in some societies, transitioning from childhood to adolescence is less gradual and occurs in a predefined and circumscribed way, through rites of passage (Mead, 1954). Even the definitions of childhood, pre-adolescence, adolescence, youth, and adulthood can vary according to the context. These differences are compounded by socioeconomic factors or differences in gender, social class and social status (Demaria, 2016). Unaccompanied migrant boys and girls have the typical characteristics of adolescence but also experience an early transition to adulthood, although with a mismatch between basic needs.
and responsibilities due to their migrant condition. Indeed, these young people experience migration as an entrance to adulthood and their journey represents a rite of passage to adulthood (Taliani, Vacchiano 2006).

In this process, the overlap between adolescence and young adulthood may cause confusion and uncertainty. Some ‘adult-like’ behaviours may hide the true needs of adolescents, particularly in individuals who have suffered deprivation, mistreatment and violence. Therefore, providing MHPSS support to these boys and girls often requires a delicate balance between the risk of infantilization and failure to take their needs into account, and the risk of abandoning them by not providing them with the necessary skills to acquire integration and independence within the reception society. Two important phenomena help us understand these complex psychosocial dynamics.

**Triple transition** (UNICEF, UNHCR, IOM, ISMU Foundation, 2019): a) transition from adolescence to adulthood, typical of the human developmental process; b) transition related to migration that leads to detachment from one’s context of origin and the need to build a new life in a new cultural and social environment; and c) the transition related to overcoming suffering and possible traumatic events during or after the migration journey, fostering a new sensation of psychosocial well-being.

**Double absence**: Individuals who have left their country often experience a ‘double absence’ (Sayad, 2002, 2018), namely the feeling of not belonging to either their own country, nor the country of arrival. This situation is likely to be devastating for children, who, in the transition to adulthood, are in the process of defining their identity.

Therefore, it is extremely important to acknowledge that migrant boys and girls do not only bear painful memories and emotions, but also possess skills and resources that should be identified, valued and strengthened.

In this regard, several studies (Papadopoulos, 2007; Leal, Ramos 2013, Tedeschi et al., 2004) highlighted the phenomenon of ‘adversity-activated development and post-traumatic growth.’ This phenomenon states that exposure to adverse or dramatic events (potentially traumatic, but not necessarily leading to trauma) can push an individual to strengthen his or her internal resources and develop
new coping strategies, appreciate life and relationships with others, identify new opportunities and develop personal strength. For instance, Tedeschi and Calhoun (2006) observed the ability of some people who had lived through traumatic experiences to withstand difficult circumstances by generating positive changes. Studying the nature of this process, these two authors coined the expression ‘post-traumatic growth,’ which they define as “positive psychological changes experienced as a result of the struggle with highly challenging life circumstances.” Children, especially those transitioning to adulthood, are able to make decisions, since they are active people in their environments and willing to establish social and cultural relationships. (AGIA, UNHCR, 2019). Recognizing and giving value to their points of view and their coping and resilience strategies are essential to ensure their full participation in protection actions that concern them (Luster et al., 2010; Ni Raghallaigh & Gilligan, 2010, Monacelli Fruggeri, 2012).
19 Educators, pedagogues, trainers, social workers, volunteer guardians, cultural mediators, animators and other workers who are in charge of ensuring boys’ and girls’ well-being and provide them with social, educational and emotional support.
21 The Global Protection Cluster (GPC) is a network of nongovernmental organizations (NGOs), international organizations and United Nations agencies engaged in protection work in humanitarian crises, including armed conflict, climate change related crises and natural disasters. The GPC is mandated by the IASC, led by the United Nations High Commissioner for Refugees (UNHCR), governed by a Strategic Advisory Group, co-chaired by the GPC Coordinator and an operational NGO, and serviced by a multi-partner operations cell. See www.globalprotectioncluster.org
24 Ibid.
28 An analysis of the data made public by the Ministry of the Interior lists 83,326 unaccompanied minors who arrived in Italy by sea between 1st January 2014 and 31 December 2021. This is a partial figure that does not include unaccompanied minors arriving via land crossings or tracked down in the territory following irregular entry, which nevertheless allows some considerations to be made. See www.liberarivoluzionigranazioni.dici.interno.gov.it/it/documentazione/statistica/cruscotto-statistico-giornaliero
29 Reference is made, specifically, to the governmental first-line reception facilities established pursuant to Legislative Decree 142/2015, Article 19 paragraph 1, financed with resources from the Asylum Migration and Integration Fund (AMIF); the temporary reception facilities activated by prefects pursuant to Article 19, paragraph 3-bis of Legislative Decree 142/2015; the first-line reception facilities accredited/authorised by municipalities or regions and emergency and temporary reception facilities; and finally to the facilities pertaining to the System of Reception and Integration (SAlI) financed by the National Fund for Asylum Policies and Services (FNPSA), with the Asylum Migration and Integration Fund (AMIF) and all the second-line reception facilities accredited/authorised at regional or municipal level.
31 For more information, see: https://www.unicef.org/adolescence
Chapter 2
Methodology
2.1 Disciplinary approach and methodology

Mapping MHPSS services for UASC and young migrants and refugees represents the interdisciplinary field of research par excellence. This mapping is based on the methodological assumption that the full understanding of the highly varied world of MHPSS services provided to migrant users, and the analysis of the multiple factors regulating, facilitating or restricting their access, requires an approach that holds together different conceptual categories and methodological approaches (Borkert, 2018).

In the last 20 years, the issue of interdisciplinarity has been widely debated by the scientific community and the community of practice. The interaction between different types of knowledge has been identified as the most appropriate way to overcome disciplinary boundaries and understand complex social problems (Morin, 1994; Chettiparamb, 2007; Moran, 2002; Belloni et al., 2018). This reflection gave rise to the vast field of migration studies, whose branches have also analysed the link between migration and health and, more recently, psychosocial support for migrants (Ambrosini, 2015; Bodini Geraci, 2011; Geraci, 2004 and 2011; Taliani Vacchiano, 2006; Tognetti Bordogna, 2013). The large amount of interdisciplinary evidence on psychosocial support for migrants is feeding into reflections on MHPSS reform, such as by providing a better understanding of the multiple dimensions of the problems to be tackled, or by prompting a rethink of appropriate forms of support.

Therefore, mapping this heterogeneous and complex universe involved a theoretical framework that was developed through dialogue with the different disciplinary areas of social and political sciences that study forced migration; vulnerabilities; specific needs arising from the migration experience; and social and health policies for boys and girls (Zannoni 2020).

The examination of the operations and strategies of the selected intervention models investigated in this mapping is mainly based on political, sociological and legal literature. To analyse the specific dimension of mental health and psychosocial well-being of minors and young adults living in the reception system, reference was made to social psychology, ethnopsychiatry and anthropology studies. These perspectives emphasized the importance of viewing individual and collective health and well-being issues in the light of different cultural backgrounds (Beneduce, 2007; Vacchiano, 2005, 2015 and 2012; Zorzetto, 2017). Finally, scientific literature was also consulted, through the analysis of relevant reports from national authorities, International organizations, NGOs and civil society organizations.

The analysis was based on a mixed methodology, mainly qualitative with a quantitative component. This approach was chosen to investigate MHPSS from a dual and complementary perspective: the perspective of the boys and girls who have access to these services and that of the urban/metropolitan providers in the six
investigated regions (Piedmont, Lombardy, Emilia-Romagna, Latium, Apulia and Sicily). These regions were selected for the following reasons:

• They are representative when compared to UASC and young adults’ presence in the reception system.

• They are representative of the various MHPSS models deriving from different regional regulatory frameworks and from the heterogeneous public and non-public actors involved in the service provision: Central Italy (Latium), Southern Italy (Sicily, Apulia), Northern Italy (Lombardy, Piedmont, Emilia-Romagna).

• They provide significantly different intervention models in terms of the type of actors involved and the intervention methodologies adopted. Some of these models are complemented by health aspects and have a clear inter-institutional structure, while others are chiefly supported by civil society organizations in coordination with the reception system.

• They use a variety of referral mechanisms to facilitate the integrated case management of users’ MHPSS needs.

The MHPSS professionals’ and users’ experiences and points of view are supplemented by interviews carried out with professionals working at national level both in institutional and civil society organizations.

The qualitative research involved a sample of 70 respondents and took the form of:

• Semi-structured interviews with 31 professionals (psychologists, psychotherapists, educators, psychiatrists, child neuropsychiatrists, psychiatric rehabilitation technicians, speech therapists, and social workers) operating at a local level and working with UASC and young migrants and refugees aged 16-21

• Semi-structured interviews with 13 stakeholders who have a nationally recognized institutional role in the MHPSS community of practices

• Focus group discussions (FGDs) and semi-structured interviews with 26 UASC and young migrants and refugees aged 16-21, hosted in second-line reception facilities.

The qualitative research was complemented by quantitative data collection, using:

• an online questionnaire to collect information on existing models of action at local level and on the regulatory and programme frameworks for MHPSS interventions at regional level. This was answered by 62 professionals working in the MHPSS sector, mostly educators, psychologists and psychotherapists working in one of the six regions.

• an opinion poll (carried out on the U-Report platform) of 101 adolescents and young refugees and migrants aged 16-21, living in Italy (85 per cent boys and 15 per cent girls).

This sampling of these respondents was carried out according to a non-probability method. For UASC and young migrants and refugees, selection was carried out with the support of the managers of the second-line reception facilities in the investigated regions. They were asked, together with their teams, to identify boys and girls whose sociodemographic background was consistent with the research variables. As far as possible, priority was given to migrants who had been living for at least one year in SAI facilities or in second-line facilities authorized at regional or municipal level, and who were familiar with MHPSS services inside and outside of the reception system. Participants were required to read and sign an informed consent form.
Interviews and FGDs were audio-recorded, except in five cases where respondents did not permit recording. The recordings were listened to and selectively transcribed. Respondents’ names have been changed in the report to ensure anonymity. Similarly, reference to the country of origin and the region where respondents live has been omitted or replaced where necessary.

Data collection was carried out by a researcher, who was assisted during the FGDs by a second researcher, who acted as observer and notetaker, and by a clinical psychologist expert in child protection and MHPSS.

Cultural mediators were involved in the interviews and FGDs with boys and girls whose knowledge of Italian language could not ensure their full participation in the discussions. Cultural mediators were appropriately trained and equipped with a glossary, to help them communicate clearly and empathetically while also remaining neutral. To enable the respondents to freely express themselves and to ensure confidentiality, independent mediators (not employed at the facility where the meeting took place) were preferred.

### 2.2 Scientific committee and ethical issues

The research protocol and all data-collection tools were validated by a scientific committee and underwent an external and independent ethical review process carried out by HLM IRB Research & Ethics. Particular attention was paid to preventing risks to minors arising from participation in research. Ethical standards, consistent with UNICEF guidelines (Berman, 2016; UNICEF Office of Research, 2013,) were the guiding principles when planning research phases; designing the research tools and consent forms; encouraging the expression and involvement of UASC; conducting the research; and arranging data storage and dissemination of the findings.

In line with the IASC Recommendations for Conducting Ethical Research on Mental Health and Psychosocial Health in Emergency Settings, the following ethical issues were specifically considered:

- The research methods and tools used in this research were developed in line with the ‘do no harm’ principle and their design followed internationally recognized standards for MHPSS data collection.
- Interviews and discussions were carried out in a way that protected the safety, privacy and confidentiality of all participants, avoiding any possible inconvenience to respondents.
- The principle of ‘no survey without service and no service without survey’ was ensured. In line with this standard, the research group always sought, when appropriate, to ensure direct advantages to the investigated population, by sharing relevant information about their rights and available services, and by supporting referral to existing psychosocial support services where necessary.
- Existing research on MHPSS in Italy was reviewed to avoid any duplication.
- To ensure fair and direct benefits, and minimize research risks, including personal safety, the potential risks and benefits were identified and discussed with participants.
- Standardized procedures were used to respond to any discussions of intense or disturbing emotional experiences – for example, by offering emotional support or assisting participants in distress. This involved referral to psychosocial support in two cases.
- All participants read and signed consent forms before starting the interview or FGD. Each
informed consent form provided clear details of respondents’ rights, including the right to choose whether to answer certain questions, to participate in specific phases of data collection, and to withdraw at any time. Clear information was provided in writing or verbally about the potential risks and benefits linked to participation; the degree of confidentiality, including procedures to ensure anonymity; the use of particular means of data collection such as a recording device; and data ownership, including collection, storage and security procedures.

• Respondents’ participation in the research was entirely free and voluntary.

The signed consent forms were returned to the researchers before the beginning of the interview. In the case of online interviews or FGDs, a digital version of the informed consent was sent to participants before the interview and signed before it began.

Three different types of consent form were used, depending on the sample population interviewed:

• Individual Consent Form for young adult migrants and refugees (18-21). There was also a version of this form for minors’ guardians and one written in a language appropriate to the adolescent group (aged 16-18). In the case of minors, additional signatures of legal guardians were required. This included requesting the consent of legal guardians, in full compliance with national laws on delegation.

• Individual consent form for professionals working regionally.

• Individual consent form for stakeholders working nationally.

Finally, the research group received appropriate training on the research ethical aspects, especially about working with minors and vulnerable groups.

2.3 Limitations

Minors and young adults living outside the second-line reception system were not included in the sample; therefore, their needs and access to services were not investigated in this research. Moreover, the interviews did not include any minors or young adults residing in governmental first-line reception facilities financed by AMIF, in temporary reception facilities opened by the Prefects (the so-called Emergency Reception Centres, CAS), in first-line reception facilities accredited/authorized by municipalities or regions, or in emergency and temporary facilities. On 30 June 2021, these types of facilities housed 10.6 per cent of UASC in the national territory (data from the Italian Minister of Labour and Social policies MLPS, 2021). Finally, the research involved fewer girls than boys. This is consistent with the reduced presence of this target population within the Italian reception system. Girls accounted for 2.7 per cent of the unaccompanied children population in Italy as of 31 December 2021 (data from MLPS, 2021).

2.4 Definition of good practice and phases of research

This research mapped and analysed good, promising and emerging practices (see box below) implemented within MHPSS services for UASC and young migrants and refugees aged 16-21 hosted in the second-line reception system in Piedmont, Lombardy, Emilia-Romagna, Latium, Sicily, Apulia.

The following chapters map the most successful intervention models identified, together with an analysis of the factors that lead to success, and the identification of challenges that hinder full access to MHPSS services, both within the reception system and external services.
Box 3 - Good, promising and emerging practices: definitions

Good practice: There is currently no agreed definition of good practice among scholars or professionals in the field of MHPSS. Various definitions and assessment criteria have been used at different times by different actors. The analysis of the most widely known intervention models in the literature and in the community of practices allowed us to observe some recurrent success factors, which were useful in developing an operating definition.

This mapping defines as a good practice: **an action, or a set of actions, which have been shown, through quantitative and/or qualitative evidence, a positive and tangible impact on a specific challenge, leading to greater protection and respect for the rights of the people concerned.**

The adjective ‘good’ refers to the capacity of the practice to become a model that can be transferred to other contexts to solve the same or similar problems. The good practices identified in this research are not necessarily without room for improvement but are the best available solution to address users’ needs in the operating contexts investigated.

Promising practice: “A promising practice is one that is relevant, effective, changes the social protection system, or has an impact on children and their families, as demonstrated by quality and reliable evidence” (UNICEF 2016). In particular, the term ‘promising’ is used in this mapping to refer to practices that have significant potential but are still too recent, or not sufficiently tested, to be defined as good practices.

Emerging practice:
Emerging practices refer to innovative interventions that have been adopted as pilot interventions, whose findings are still being monitored, and whose models have not been formally assessed, reviewed or transferred at national level.
The practices identified through the literature review were subsequently integrated with evidence from the interviews and focus groups with professionals working in the MHPSS field, at both regional and national levels, and with migrant and refugee children and young people hosted in the second-line reception system. The discussions with service providers and users enabled us to delve into the interventions and the logic governing their planning, organization and provision. Moreover, they enabled us to understand different perspectives on the challenges faced in accessing the services and how they could be improved.

Evidence collection and analysis included four phases, as outlined below.

Phase 1: Identifying intervention models

For each of the regions analysed, we identified models of MHPSS intervention, already known from the literature and/or recognized by the community of practice, for users with a migrant background. The models were chosen according to:

- relevance to UNICEF’s programme target group (UASC and young migrants and refugees aged 16-21)
- provision of qualified mental health and psychosocial support services, consistent with the MHPSS approach (see chapter 1)
Phase 3: Field analysis of good, promising and emerging practices

Among the selected good, promising and emerging practices, 13 intervention models were investigated in the field to delve into operating procedures and increase awareness of the specific needs of the users.

Phase 2: Selecting good, promising and emerging practices through identification criteria

From the intervention models identified at regional level, we selected good, promising and emerging practices (see box above) based on their **impact, relevance, coherence, effectiveness, efficiency, sustainability, transferability, partnership involvement, participation, respect for and protection of rights, and non-discrimination and equality** (see Box 4 below).49

**Box 4 - Criteria used to select good, promising and emerging practices**

- **Impact** - The practice has a positive impact and results in improved mental health and psychosocial well-being of individuals
- **Relevance** - The practice responds to the needs and priorities of the people concerned
- **Consistency** - The practice is consistent with the regulatory framework and professional codes of conduct, including relevant legal and quality standards such as the IASC guidelines on MHPSS
- **Effectiveness** - The practice achieves its objectives
- **Efficiency** - An efficient use of available financial, human and other resources is made
- **Sustainability** - The practice is sustainable and/or has a long-lasting impact
- **Transferability** - The practice can be replicated in different contexts
- **Partnership involvement** - The practice involves a multilevel, multi-stakeholder consortium including a public-private partnership. The practice complies with a coordinated inter-agency intervention framework and a continuum of care across the four levels of the MHPSS pyramid
- **Respect and protection of rights** - The practice is based on and aims to ensure respect and protection of the rights and dignity of the people concerned
- **Participation** - All age and gender interest groups are consulted and participate in the planning, implementation, monitoring and assessment of the practice
- **Non-discrimination and equality** - Women, men and children of different ages, abilities and backgrounds have equal and real access to the practice and these services take into account gender differences and the specific needs of each age group

**Phase 3: Field analysis of good, promising and emerging practices**

- participation in **reception mechanisms** that include complementary services of different types (in particular, services offering non-specialized support to UASC and young people - usually provided by reception facilities and civil society organizations - and specialized support and care services - provided by public and private health services).
Phase 4: Identifying critical areas of the Italian MHPSS system for UASC and young migrants and refugees

In this phase, the preliminary research findings were discussed and integrated in a consultation workshop (carried out in October 2021) that involved the representatives of all the mapped practices. The representatives validated the contents of the fact sheets for each practice. Finally, gaps and challenges were identified and analysed.

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33 Establishment in line with Article 19, paragraph 3-bis of Legislative Decree No. 142/2015, Article 19, Paragraph 1.
34 A community of practice is defined as a group of public and civil organization actors representing different services and methodological perspectives working in the field of MHPSS, interacting with each other informally and exchanging and developing knowledge through discussion.
36 Bell, L., L. Miller, ‘Documenting, Validating and Sharing Good Practice in Europe and Central Asia’, UNICEF template, March 2017. According to this document we can define promising practices as: “Programming practices, which often demonstrate new approaches (or
adaptation of existing approaches) where some evidence of success/impact has been documented. Ideally, these should be implemented on a national scale but may not have been formally assessed or replicated internationally; however, there should be some evidence of the results achieved and lessons learned from the initiative.  

48 A community of practice is defined as a group of public and civil organization actors representing different services and methodological perspectives, working in the field of MHPSS, interacting with each other informally and exchanging and developing knowledge through discussion.


50 Evaluation criteria are based on, and integrate, the criteria proposed by OCSE in 'Applying Evaluation Criteria Thoughtfully', OECD Publishing, Paris, 2021, https://doi.org/10.1787/543e84ed-en. These criteria were discussed with the Scientific Committee and also reflect the guidance provided by the best-known tools on MHPSS promoted by WHO, UNICEF and other organizations.
Chapter 3
Analysis of the legal and policy frameworks
3.1 The governance system of MHPSS services

In Italy, MHPSS for UASC and young migrants and refugees has been developed in accordance with universal regulations\(^5\) that govern the integrated system of health and social interventions and services, and with laws on the protection of UASC.\(^6\) MHPSS services for UASC and young migrants and refugees involve two types of interventions:

1. **Psychosocial support**: delivered both within and outside the reception system, jointly with public services and national civil society services.

2. **Mental health**: delivered through specialized services provided by national health authorities or by civil society organizations, upon request and referral from reception facilities, in coordination with qualified social services and guardians.

Although intrinsically linked, these two dimensions are governed by different regulatory frameworks and operational models. Moreover, they are entrusted to different public and civil society actors, which often have different approaches, intervention models and technical skills. This issue is well explained by Terre des Hommes:

“Aid intervention agencies operating outside the health-care sector tend to talk about psychosocial well-being support. Health agencies tend to talk about mental health, although they always used terms like psychosocial rehabilitation and care to define non-biological interventions for mental disorders.” (Terres des Hommes, 2017: 11)

MHPSS services are addressed by two policy frameworks: social care policies and health-care policies. Although interconnected, these two dimensions have long seemed disconnected in terms of both institutional power and types of services delivered. However, starting from the 2000s, the Italian MHPSS system has progressively been moving to an integrated health and social approach.
The Ministry of Health has recognized that health-care processes have to be carried out through both specialized mental health services (mental health departments (MHD) and/or child and adolescent neuropsychiatric services) and by integrating health-care, social care and educational services, whether formal or informal, institutional or not.

Box 5 - Health and social integration services

The Italian policy framework recognizes the importance of integrating health and social services in mental health and psychosocial interventions. This is in line with the WHO definition of health: "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Moreover, the framework addresses social protection, in line with the definition of health and social services provided by Legislative Decree no. 229/99. “Health and social services aim to meet individual health-care needs through integrated care processes. These needs require health-care services and social protection work able to ensure long-term continuity of care and rehabilitation.” Health and social services include:

a) Health-care services ensured by local health authorities. These services form part of the Essential Levels of Health Care or (Livelli Essenziali di Assistenza) (LEAs) which aims promote health, as well as prevent, identify, eliminate, and contain degenerative and disabling outcomes of congenital and acquired pathologies.

b) Social services related to health care provided by municipalities. These services aim to support people in need who have disabilities or face marginalization issues affecting their health.

c) Integrated health and social services provided by the local health authority are included in the LEAs. These services are therapeutically relevant and focus on the health component in the scopes of parent-child relationships, psychiatric pathologies and addictions.

Box 6 - The network of public local services for mental health

Mental Health Department (MHD)

A network of facilities and services established to meet mental health care and protection needs within the territory under the local health authority’s responsibility. The MHD provides:

Day care services: centres for mental health

Semi-residential services: day care centres

Residential services: residential treatment centres and social-rehabilitation centres
Hospital services: psychiatric diagnosis and treatment services and day hospitals

**Centres for Mental Health**

Centres for Mental Health act as the first reference for citizens suffering from mental disorders. They provide outpatient and/or in-home operations and are available six days a week, at least 12 hours a day. They are in charge of all prevention, care and rehabilitation interventions for citizens with mental disorders.

The centres are headed by professional teams composed of at least a psychiatrist, a psychologist, a social worker and a professional nurse.

The centres are responsible for:

- Psychiatric and psychotherapeutic treatments; social interventions; admitting patients to day hospital centres, residential facilities and hospitals
- Diagnosis with psychiatric examinations and psychological examinations with the aim of defining appropriate therapeutic, rehabilitation and socio-rehabilitation programmes from an integrated approach – which could involve outpatient, in-home or residential interventions complying with the therapeutic continuity strategy
- Liaison with general practitioners to provide psychiatric counselling and to cooperate in therapeutic and training projects
- Specialized counselling for severe disorders (alcoholism, drug addictions, etc.) and for residential facilities for older people and people with disabilities
- Examining hospitalizations and controlling hospital stays in accredited private neuropsychiatric facilities with the aim of ensuring the continuity of treatment
- Assessment with the aim of continuously enhancing the quality of adopted practices and procedures
- Programme agreements with municipalities to find a job for psychiatric patients and to administer non-kinship foster care and in-home care
- Cooperation with volunteer organizations, schools, social cooperatives and territorial agencies

**Child and Adolescent Neuropsychiatric Service - NPIA** provide diagnosis, care and rehabilitation for neurodevelopmental disorders and developmental mental disorders for people aged under 18. This can include prevention, diagnosis, care and intervention for those in distressing situations. Interventions are provided through direct services delivered to minors and their families, as well as through consultations with units or cooperation with general practitioners, schools or social workers.
**Day care centre**

Day care centres are semi-residential facilities with therapeutic and rehabilitation functions, located in the territory and open six days a week, eight hours a day. The centres have their own teams, possibly supplemented by workers from social cooperatives and volunteer organizations. As part of the framework of personalized therapeutic and rehabilitation projects, day care centres implement therapeutic procedures and teach skills regarding self-care, daily activities, and individual and group interpersonal relationships in order to help users find a job.

Day care centres may be managed by the MHD or by civil society and business organizations. In compliance with national accreditation standards, relationships with the MHD are regulated by special agreements that guarantee continuity of care.

**Residential facilities**

Residential facilities are non-hospital facilities that provide care during specific hours (this could be 12 hours, or 24, for example). They have a maximum of 20 rooms, in which therapeutic, rehabilitation and socio-rehabilitation is provided for citizens with mental disorders, who have been referred by the centres for mental health with a personalized and regularly monitored programme.

These facilities aim to offer a network of relationships and emancipatory opportunities within the scope of specific rehabilitation activities. They are located in urban and easily accessible locations to avoid users from isolation and to foster social relationships. Residential facilities may be founded and managed by the MHD or by civil society and business organizations. In this case, relationships with the MHD are governed by special agreements that set out the procedures for hospitalizations and discharges.

**Psychiatric diagnosis and treatment services**

Psychiatric diagnosis and treatment services are provided by hospitals (including hospital corporates, hospital centres of health authorities, university hospitals). They consist of voluntary and mandatory psychiatric treatments and may involve hospitalizations or consultations with other hospitals. These services form an integral part of the MHD, even when not administrated by the same health authority. In such cases, the relationship between the two health authorities is governed by compulsory regional agreements. Each psychiatric diagnosis and treatment service contains no more than 16 beds and is equipped with enough space.

**Psychiatric day hospitals**

Psychiatric day hospitals are semi-residential units providing short and long-term diagnostic, therapeutic and rehabilitation services. These units are sometimes located within hospitals, where they work closely with psychiatric diagnosis and treatment services. They may also be located in facilities outside hospitals, such as centres for mental health, where there is adequate space, equipment and necessary staff.
A wide range of international, European, national and regional regulations establish the right for individuals to access health-care services, including mental health services, nationally, regardless of their legal status or origins. This approach is outlined in the Constitution (Article no. 32), the Charter of Fundamental Rights of the European Union, and the Ordinary Law.\[^{58}\]

The UN Convention on the Rights of the Child\[^{59}\] requires that Member States provide children within their territory with essential civil, political, economic, social and cultural rights including health care.\[^{60}\] In accordance with the UN Convention, the Italian legislation recognizes compulsory and free registration with the National Health Service\[^{61}\] for all foreign children who are in Italy, regardless of the legality of their stay. This entitlement is the same as that of Italian citizens,\[^{62}\] complying with Law 47/2017 on the protection of UASC.

The National Health Service\[^{63}\] is based on the principles of universality, equality and equity. Its health programmes are based on cooperation between the different levels of national and regional governing bodies. Within this governance framework, the Government determines the LEAs,\[^{64}\] which are services that the National Health Service is required to provide to all citizens and provides regions with the necessary resources.\[^{65}\] The regional governments plan and manage health care within their territory, and cooperate with the Government, local health authorities and municipalities to ensure uniform and equal health services for all citizens.

The new LEAs,\[^{66}\] issued in 2017, address the criteria for the provision of integrated mental health care services. Within the scope of district, home and territorial care, the standards require that the National Health Service guarantees specialized, diagnostic and therapeutic services for children, and therefore UASC, since they are equal to Italian children by law.\[^{67}\]

These services should include prevention, assessment, care, and psychosocial support for children suffering from mental health disorders, and for victims of neglect and abuse. For children with neuropsychiatric and neurodevelopmental disorders, the LEAs establish a multidisciplinary care programme, and require individual therapeutic programmes that vary according to intensity, complexity and duration. These programmes should include specialized diagnostic, therapeutic, psychological and psychotherapeutic, and rehabilitation services, integrated with social interventions according to need.

**Psychosocial and mental health support services are included in health and social services** (see Box 6). This sector is characterized by a “multilevel vertical subsidiary system” (Anconelli, Michiara, Saruis 2018; Carletti 2015). This system was founded in 1978, when Law 833/1978 and Law 180/1978 (Basaglia Law) radically changed the health-care system and the treatment of people with mental disorders.

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Psychiatric day hospitals are open at least six days a week, eight hours a day. They provide complex diagnostic tests and pharmacological treatments, and can reduce the need for hospitalization or limit its duration. Users are referred by MHD workers.

The law reformed intervention models at all levels, establishing a health and social intervention model for psychosocial support and mental health services based on territories and communities. However, inconsistent regional regulations and disorganized distribution of legislative powers within the institutions involved mean there is no standardized national health and social integration model aimed at ensuring continuity of care. In addition, complexities of coordination between the bodies responsible for establishing programmes (Ministry of Health, Ministry of Labour and Social Policies, regions and local authorities) and those providing psychosocial support services (private and public health and social services) have caused even more confusion (Maretti 2008).

“These inconsistencies have caused a lack of integration between the health and social sectors leading the social sector to play a minor role” (Anconelli, Michiara, Saruis, 2018: 12).

This lack of integration between the sectors has influenced psychosocial support services. Framework Law 328/2000, known as the “manifesto of an integrated system” (Martelli, 2007: 100), guides local authorities in implementing integrated intervention systems and encourages coordination between social services and health-care workers. This law represented the first attempt to counter territorial inequalities, defining for the very first time a ‘universal’ national intervention system and endorsing key tools: the Essential Levels of Social Services or Livelli Essenziali delle Prestazioni Sociali (LEPS) and a National Social Policy Fund (Arlotti, Sabatinelli, 2020). However, 20 years since it was passed, the law’s ambitious programmes present some implementing limitations.

The first critical aspect concerns regional inconsistencies in social services designed to provide psychosocial support. This situation stems from the lack of a clear definition in the LEPS about which social and civil rights should be ensured nationally (Kazepov 2009; Benassi, 2012). Local social services continue to suffer from pre-existent welfare local systems managed only at a regional level and not so much coordinated with the national level. Since the Government does not define essential national social and civil rights services, the implementation of the Framework Law 328/2000 was subordinated to local welfare resources available in the territories (Kazepov 2009). This exacerbated the unequal quality of services provision between the North and the South of Italy.

“Attributing to regions ‘exclusive’ legislative powers over social services has failed to put into practice Law 328/2000, since it establishes that there should be a standardized regulation governing the national multi-layered measures and procedures for the provision of social services. 21 regional welfare systems, including Trento and Bolzano, were established, which caused unequal access to social services in Italy” (Martinelli, 2019: 51).

The second critical aspect concerns the lack of coordination between the psychosocial support services that derive from the LEPS, and the mental health services covered by the LEAs. As a result, another critical element emerged: ‘a division of competences that have hindered investments in the social field’ (Ministry of Labour and Social Policies, 2021:19).

The lack of coordination between the LEAs and the LEPS has meant that the interconnections between ‘psychosocial support’ and ‘mental health’ interventions has been recognized only recently. Indeed, only in 2021 did the National Action Plan for Social Services 2021-2023 consider the LEPS as complementary tools to the LEAs, stating that: “It is important to implement a coordinated organized model to functionally use professional and psychological resources. The latter can connect services that can greatly influence personal and social distresses and are provided in all LEAs with the aim of ‘ensuring individual and collective psychological well-being’”.

Also thanks to the National Association of
Social Workers, the issue of strengthening the integrated network of social services returned to the forefront of the political agenda in 2020 (Turco, 2020). In this year, Law 77/2020 described some of the services provided in Article 4 of Law 328/2000 as essential services: social, social care and health and social services. Law 77/2020 also proposes the piloting of "facilities for local home-care services to promote health and to provide MHPSS services and rehabilitation for the most vulnerable groups". This programme is based on the principle of integrating the health and social sectors by involving all relevant actors at a national level. It also recognizes the ongoing experiments in some regions, such as the Case della Salute (facilities providing a wide range of health and social services to ensure continuity of care) in Emilia-Romagna. The National Recovery and Resilience Plan (NRRP) provides for local home-care services to be strengthened. To this end, the NRRP has allocated EUR 2 billion to establish 1.288 Case della Comunità under the leadership of the Ministry of Health by mid-2026. The Ministry of Health is expected to establish a programme to involve regional institutions and other interested bodies by the first quarter of 2022.

According to the NRRP, “the Case della Comunità will be the only access to health-care services.

The Case della Comunità are facilities where a multidisciplinary team of general practitioners, paediatricians, specialized doctors, community nurses, other health professionals and social workers cooperate”. These professionals provide health and social services by implementing a general-medicine-oriented approach. Social workers operating in these facilities are important since they are able to strengthen territorial social services and promote the integration between these and health-care services.

Although the NRRP marks significant process in recognizing the universal value of health and its status as a fundamental public asset that should be provided together with social services, it lacks any provision for interventions to address the specific needs of migrants and refugees. This is likely to make it harder to reach the goal of an integrated system of personal services that address health and social needs at a national level.

Migrants’ access to psychosocial support and mental health services within reception systems is affected by many complex factors, including the peculiar governance system that relates to the right to health of migrants and refugees. "While Italians are provided with health-care services by the Ministry of Health and Regions,
the services offered to migrants are governed by regulations that determine their access and stay in the reception system” (Carletti, 2015: 7). In this regard, the Italian Authority for Children and Adolescents stated: “The existing inequalities in Italy in terms of right to health partially derive from attributing regions’ legislative powers, including drafting programmes and defining local health priorities by implementing regional health-care plans. The measures adopted and their repercussions exacerbated inter- and intraregional inequalities, thus infringing the principles of equity and equality” (Italian Authority for Children and Adolescents, 2015: 10).

Box 7 - Psychosocial support services for UASC and young migrants provided by first-line and second-line reception centres

Article 7 of Law 47/2017 promotes foster care, rather than reception facilities, for UASC. However, the vast majority of the 12,284 UASCs in Italy as of 31 December 2021 are hosted in reception facilities, and only 4% are in private care (MOLSP 2021: 36). The governance system for UASC’s reception is outlined in Article 19 of Legislative Decree no. 142/2015. Unlike the governance system for adult migrants, it is not exclusively managed by the Ministry of Interior. Instead, local authorities are required by law to cooperate with the Ministry of Interior in this regard.

The system for UASC involves a first-line reception in highly specialized government facilities, and a second-line reception within the SAI. Government first-line facilities include facilities funded by AMIF, temporary reception facilities established by Prefects, authorized/accredited first-line reception facilities established by municipalities or regions and, finally, temporary or emergency facilities.

First-line reception facilities are regulated by paragraph 1, Article 19 of the Legislative Decree 142/2015. UASCs stay in these facilities for the length of time needed to verify the children’s identity and, where there is doubt, their age. This time must not exceed 30 days, and identification processes must not exceed 10 days. First-line reception facilities provide specialized services aimed at the subsequent transfer to SAI second-line reception facilities.

Since 2020, due to the implementation of anti-COVID-19 regulations, any UASC who disembarked or were tracked down for the first time nationally have been hosted in ad hoc facilities (so-called quarantine facilities) where they stay during quarantine before being transferred to dedicated reception facilities. These facilities were established at a regional level, meaning that the management of MHPSS services delivered to minors during quarantine was inconsistent.

Second-line facilities include facilities belonging to the SAI network, facilities funded by AMIF and all accredited/authorized second-line reception facilities at a regional or municipal level. The latter are governed by Ministerial Decree 308/2001, which provides that regions must implement and integrate the minimum standards included therein according to local needs, in accordance with paragraph 2, Article 11 of Law 328/2000. Differing regional implementation led to three different types of family-based communities: family-type communities, clusters of flats, and community-based facilities; while preserving the minimum organizational and infrastructural requirements provided by

The legal framework establishes that staff working in first-line and second-line reception facilities must coordinate psycho-educational and psychosocial services to UASC, in cooperation with local social services.

**MHPSS services provided by government first-line reception facilities:**

Paragraph 2 bis, Article 18 of Legislative Decree 14/2015 states that “emotional and psychological support provided to UASC is ensured at any stage of their care process by qualified staff chosen by UASC themselves, as well as groups, foundations, associations and non-governmental organizations with demonstrated experience within the field of care”.

During their stay in first-line reception facilities, UASC are ensured an interview with a child and adolescent psychologist, with the support of a cultural mediator, if necessary, to determine personal situations, the reasons and circumstances of departure and migratory journey, as well as future expectations.

**MHPSS services provided by SAI second-line reception facilities:**

Articles 34, 35 and 36 of Ministerial Decree 18/11/2019 govern the basic and specific services that multidisciplinary teams working in communities must provide for UASC staying in SAI second-line reception facilities, in cooperation with other territorial facilities if necessary. Within general reception services, local bodies that coordinate SAI projects must ensure adequate psychological, health and social protection through psychological and social services, based on individual needs. They should also provide psychosocial and educational services, and information about social protection and welfare, as well as registering UASC with the National Health Service.

Where users have specific needs for MHPSS services, SAI reception centres should:

- ensure access to psychosocial and health-care services, integrating individual rehabilitation therapies with social care services
- ensure that interventions can be shaped according to individuals’ needs and vulnerabilities
- establish and strengthen cooperation with organizations that provide support, rehabilitation and care for users with specific psychosocial and health-care needs
- establish and strengthen cooperation with public and private bodies that may participate in the overall provision of care
- acknowledge that individuals’ needs will vary according to their migratory and personal journeys, their experience of specific conditions such as exploitation or violence and/or torture

For users with mental disorders who need specialized MHPSS services, reception projects should assess needs and provide individual therapeutic and rehabilitation programmes to be activated by territorial mental health services. Therefore, local authorities must:

- activate support and rehabilitation programmes in coordination with local health authorities
- provide MHPSS services directly at residential facilities if required
- ensure standardization within territorial mental health facilities by means of agreements that define the cooperation levels needed to support specific interventions
- establish a territorial network with the aim of making MHPSS services sustainable and accessible.
3.2 Operational implementation of MHPSS services

Coordination between regions and autonomous provinces, and between these two structures and the Government (in particular, the Ministry of Health, Ministry of Labour and Social Policies and Ministry of Interior), as concerns MHPSS services is based on a specific governance system, which involves a system of conferences. The most important conference for MHPSS services is the State-Regions Conference, where important decisions on health and social policies are adopted by means of Agreements (Neri, 2020).

Since 2012, many programmes promoted by the Government and endorsed by the State-Regions Conference have highlighted the importance of child and adolescent psychosocial and mental health and well-being, and have proposed operational approaches to standardize national interventions, especially for migrants.

In 2012, with the aim of standardizing local approaches, the Immigrazione e Servizi Sanitari (Migration and Health-care Services) Technical Working Group of the Health Committee of the Regions-Autonomous Provinces Conference established the Guidelines for the Correct Implementation of Regulations on Health-care Services Provided by Regions And Autonomous Provinces to Migrants, referred to in State-Regions Agreement no. 255 of 10 December 2012. This document provides operational guidelines to promote a standardized implementation of regulations at a national level in order to improve access to services and eliminate divergent interpretations of regulations governing LEAs. The agreement states that UASC must be registered with the National Health Service, even when they do not hold a residence permit, as highlighted by Law no. 47/2017.

In 2013, the Joint Conference endorsed the National Action Plan for Mental Health, which represents the main reference framework for mental health programmes and strategies at national, regional and local levels. Complying with the recommendations of the WHO, the plan describes child and adolescent mental health as a ‘priority need’. It provides for an immediate and integrated intervention on severe mental health disorders at the onset of psychiatric acute cases to be monitored by two indicators:

- regional recommendations, including guidelines for facilities to manage child and adolescent psychiatric hospitalization
- local protocols shared with other facilities and departments (including child and adolescent neuropsychiatry, MHDs, pediatrics, emergency rooms, addiction services, and social services) that may be involved in managing acute disorders

In 2014, to implement the guidelines included in the National Action Plan, the Joint Conference established an agreement on "residential and semi-residential therapeutic and rehabilitation interventions for child and adolescent neuropsychiatric disorders". The aim was to establish a regional network of dedicated residential and semi-residential therapeutic facilities providing non-hospital treatments to children and adolescents with neuropsychiatric disorders, in close cooperation with territorial facilities. The agreement highlights the importance of integrating health and social sectors for the benefit of minors with neuropsychiatric disorders. These minors must also be provided with health-care interventions (including therapeutic and rehabilitation services) and social interventions (such as education). The agreement also establishes potential socio-educational health-care interventions that can be provided by social workers through protocols.

In 2021, the National Monitoring Centre on Childhood and Adolescence endorsed the Fifth National Action Plan for the Protection of Child Rights and Development. This plan is the result
of a cooperation between public and civil society organizations. It highlights the importance of considering mental health in the context of a broad definition of psychological well-being. Of particular relevance to UASC, Action 22 relates to social care, health-care and educational services. These services have to ensure the rights included in the United Nations Convention on the Rights of the Child – in particular, non-discrimination and participation – and provide, if necessary, parenting support even in non-family reception settings. The aim is to provide uniform protection for all migrant and refugee children, boys, and girls. The plan is to be implemented jointly with other existing strategies, creating a public, integrated system of health-care and protection services; as well as implement integrated policies to strengthen and establish local networks between schools, health services and the third sector (with family counselling as the focal point of the network), as indicated in the National Guidelines for the Protection of Children and Families endorsed by the Ministry of Labour and Social Policies (2017).

In 2020, the State-Regions Conference adopted the National Prevention Plan 2020-2025. This plan states that mental health forms an integral part of health and well-being and thus can be influenced by socioeconomic factors, which should be countered with promotion, prevention, treatment, and recovery strategies. It underlines the importance of promoting the mental well-being of children and adolescents in community settings, describing this as an important dimension where “information and awareness initiatives addressed to citizens have to take place with the aim of promoting a standardized approach with regards to mental disorders in order to eliminate stigmas and prejudice as well as promote integration”. The plan also highlights the need to intervene at an early stage, as part of a holistic approach to promote health, develop life skills, and counter the dysfunctional phenomena that can negatively affect mental well-being and can precede the onset of mental disorders. Such an approach involves identifying at an early-stage mental suffering and dysfunctional behaviours in children and adolescents, including self-harming behaviours. By so doing, prompt interventions can be implemented.

In July 2021, the Social Protection and Inclusion Network, governed by the Ministry of Labour and Social Policies, endorsed the new National Action Plan for Social Services. This plan bridges a gap that lasted for years and identifies the priorities related to the National Social Policy Fund and its establishment, highlighting the differences between general actions and actions addressed to minors. The plan also recalls that the health sector has to cooperate with the social sector. (Ministry of Labour and Social Policies, 2021: 24)
Italy, together with other six European Countries, has been testing the Child Guarantee, an initiative promoted by the European Commission that aims to counter and prevent child poverty while promoting social inclusion and enhancing access to fundamental services, including mental health services. In cooperation with the European Union, UNICEF is supporting Italy during the pilot stage of the Child Guarantee, which also provides minors with a migratory background with health-care and easily accessible health promotion programmes, drawing in part on existing local opportunities.

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51 The Italian MHPSS system supports everyone, regardless of their cultural background. Universality implies the extension of health services to the whole population. The National Health Service is a network of facilities and services designed to provide citizens with universal access to health services, in accordance with Article 32 of the Constitution, which states: “The Republic safeguards health as a fundamental right of the individual and as a collective interest and guarantees free medical care to the indigent. No one may be obliged to undergo any given health treatment except under the provisions of the law. And law cannot under any circumstances violate the limits imposed by respect for the human person.”

52 For a complete overview of the legislation regulating the protection of UASC, see: www.interno.gov.it/sites/default/files/2021-03/vademecum_operativo_per_la_presa_in_carico_e_l’accoglienza_dei_minori_def.pdf


54 Article 3 septies of Legislative Decree 502/92, as amended by Legislative Decree 229/99 and subsequent Decreces.

55 In some regions, local health authorities have different names. For example, in Lombardy, local health units are called ASST (Azienda Socio Sanitaria Territorial – Health-and-social Territorial Units), while local health authorities are called ATS (Agenzie di Tutela della Salute – Health protecion units).

56 Essential levels of care (LEAs) are services that the National Health Service is obliged to provide to all citizens, free of charge or against payment of a participation fee (ticket), with public resources collected through general taxation.


58 Paragraph 3, Article 35 of Legislative Decree no. 286/26, July 1998

59 Article 24 of the UN Convention on the Rights of the Child, 1989. “1: States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.”


61 Provided in paragraph 1, Article 34 of the Unified Text on Immigration (Legislative Decree 286/1998), as amended by Law no. 47 of 7 April 2017. Provisions on measures for the protection of UASC. These provisions came into force on 6 May 2017 and are extended to UASC, i.e. those who are without care or representation by parents or other adults legally responsible for them. They highlight that the person in charge of the reception facility has to request a health card for UASC.

62 For more information, see www.salute.gov.it/imgs/C_17_opuscoliPoster_297_allegato.pdf

63 The National Health Service was established in 1978 by Law no. 833. It includes the network of facilities and services aimed to ensure citizens universal and equal access to health services, complying with Article 32 of the Constitution, which appoints the State and regions to exercise legislative powers.

64 Recognizing the complexity of treatments for mental health, along with bio-psychosocial risk factors and rehabilitation and social inclusion work, the Ministry of Health defined LEAs as “care and treatment processes and not as single services.” This approach corresponds to a precise model of integrated intervention that should ensure:

- accessibility, care, continuity of care, personalization of projects
- processes with different care intensity, according to the needs for care
- flexible services aimed to meet needs
- that LEAs are ensured by the local health authority as a fundamental part of its services, and not only by the mental health department or the Child and Adolescent Neuropsychiatric Disorders Services
- processes that can be taken individually, even when included in group or community activities

The power appointed to regions is much stronger, thanks to the principle of subsidiarity. Regulatory power is in generally regional, except for specific powers reserved for the State.

65 Official Gazette General Series no. 15 of 18 March 2017 Ordinary Supplement no. 15. Decree of the President of the Council of Ministers, endorsed on 12 January 2017 on ‘New definition of essential levels of health care’.

66 Law 47/2017

67 Each type of healthcare service is attributed to a specific institutional level: the first and the third are entrusted to the health authorities and included in the LEAs according to the legislation, national and regional plans and national and regional projects. On the other hand, the services in the second degree are entrusted to municipalities, which provide for their funding complying with Regional Laws.

68 See paragraph 1, Article 2 of Law 328/00


74 With reference to paragraph 2, according to the organizational models in force, regional laws provide for given services within the territories included in letter a), paragraph 3, Article 8 also taking into consideration urban and rural needs. These services include: a) professional social care services and social secretariat for information and counselling to individuals and family units; b) social emergency services for personal and family emergency situations; c) home care, d) residential and semi-residential facilities for people with social care needs and day reception centres.”

14 “With the aim to comply with paragraphs 3 and 4 and on the basis of a Memorandum of Understanding endorsed by a State-Regions
Autonomous Provinces Conference, the Ministry of Health coordinates the testing of facilities for local home care services to promote health and to provide MHPSIS services and rehabilitation for the most vulnerable groups. This testing derives from the principle of integrating fully both the health and social sectors by involving territorial institutions jointly with local volunteer organizations and non-profit organizations. The projects must provide for interventions that aim to reduce institutionalization, promote home care and enable the assessment for individual needs and community health budgets. Ex paragraph 4-bis, Article 1 of Law 77/2020. The testing provided by the latter is based on the National Health Plan - Guidelines for access to co-funding for the Regions and Autonomous Provinces of Trento and Bolzano (Official Gazette no. 236 of 30 October 2022). A total of 26.8 million euros shall be allocated out of the total amount referred to in the first sentence of paragraph 11. According to the organizational modalities of the Regions, the services and performances offered by healthcare residences for the elderly, by the foundations (formerly IPAB) or by the Aziende Pubbliche di Servizi alle Persone (ASP) or by other entities of the third sector with the objective of maintaining the person in his or her living contexts shall also contribute to the strengthening of home care as per paragraphs 3, 4, 4-bis."

"The Casella della Salute is easily accessible hubs where professionals and services operate. In these facilities, care services are delivered by means of a joint cooperation between practitioners, paediatricians, specialist doctors, nurses, social workers, midwives, social workers, counter staff, patient associations and volunteer organizations. There are 125 Casella della Salute in the region."


"First-line reception facilities include facilities provided by AMIF; temporary reception facilities established by prefects, accredited/authorised first-line facilities established by municipalities or regions and emergency facilities. These facilities are referred to in paragraph 1, Article 19 of Legislative Decree 142/2015. UASCs are authorized to stay in these facilities for the time needed for identification and, in case of doubt, age verification procedures. This time must not exceed 30 days, and identification processes must not exceed 10 days. First-line reception facilities ensure specialized services aimed at the subsequent transfer to SAI second-line reception facilities, together with projects specifically addressed to users."

"A body for political coordination and discussion between the presidents of the regional councils and the autonomous provinces and for inter-regional institutional interlocution, where documents are drafted and presented to the State-Regions Conference and the Joint Conference. See www.statoregioni.it/it/presenza/attivita/conferenza-stato-regioni/"

"The document was endorsed by the State-Regions and Autonomous Provinces Conference. (Act no. 255/2012) and subsequently published in the Official Gazette (Ordinary Supplement n. 32 of 7 February 2013).

"The Joint Conference was established by Legislative Decree No. 281/97 and consists of the State-Regions and Autonomous Provinces Conference and the State-Cities and Local Authorities Conference, which meet at least twice a year. It forms part of the decision-making processes involving major content is that vested in the State and the regions, in order to foster cooperation between the State and the system of autonomous, examining matters and tasks of common interest and also performing consultative functions. It is chaired by the President of the Council of Ministers and the State-Cities and Local Authorities Conference, which meet at least twice a month. It forms part of the decision-making processes involving the regions and autonomous provinces, also by means of protocols and agreements."


"See www.salute.gov.it/sites/default/files/2021-03/vademecum_operativo_per_la_presa_in_carico_e_l'accoglienza_dei_msna_def.pdf


"Article 36 of Ministerial Decree 18/11/2019 states that the local authorities holding funding are required to:

- a) ensure a multi-disciplinary team with adequate skills related to services provided by reception projects. The team should work in cooperation with public and local public facilities and also by means of protocols and agreements.
- b) ensure specialized staff with long-term experience, adequate to the role they play and able to ensure effective care for people in reception facilities
- c) ensure adequate work organization and team management through planning and coordination activities
- d) in case of the reception of people with specific needs or vulnerabilities or the reception of minors, teams with adequate experience and professionalism should provide for their inclusion
- e) monitor the proper performance of the staff employed within the scope of SIPROIMI (now SAI) interventions

- The State-Regions and the Autonomous Provinces of Trento and Bolzano Conference was established by the Ministerial Decree of 12 October 1983 as a forum for cooperation between the State and the regions and autonomous provinces, and normally meets fortnightly. It is a forum for political coordination between the central and regional administrations, where the Government acquires the opinion of the regions in relation to the Government’s general policy guidelines on matters falling under regional competence. www.statoregioni.it/media/2883/p-5-csr-atto-rep-n-127-6ago2020.pdf


Chapter 4
Identification of practices
The analysis selected and explored 13 intervention models that can be considered as good, promising or emerging practices relevant to the provision of health and psychosocial support developed in six Italian regions: Piedmont, Lombardy, Emilia-Romagna, Latium, Sicily, Apulia, or at national level.

<table>
<thead>
<tr>
<th>PRACTICE</th>
<th>REGION</th>
<th>INTERVENTION TERRITORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Frantz Fanon Centre</td>
<td>Piedmont</td>
</tr>
<tr>
<td>2</td>
<td>SAMMI- Migrants’ Mental Health</td>
<td>Piedmont</td>
</tr>
<tr>
<td>3</td>
<td>UONPIA (child and adolescent neuropsychiatry unit)- Fondazione IRCCS Cà Granda Ospedale Maggiore Policlinico</td>
<td>Lombardy</td>
</tr>
<tr>
<td>4</td>
<td>Start.ER (health, protection and reception of asylum seekers and holders of international protection in Emilia-Romagna)</td>
<td>Emilia-Romagna</td>
</tr>
<tr>
<td>5</td>
<td>SAMIFO</td>
<td>Latium</td>
</tr>
<tr>
<td>6</td>
<td>Centro PENC- Anthropology and geoclinical psychology centre</td>
<td>Sicily</td>
</tr>
<tr>
<td>7</td>
<td>Silver</td>
<td>Sicily</td>
</tr>
<tr>
<td>8</td>
<td>ASP (provincial health authority) Catania- Transcultural psychiatry unit</td>
<td>Sicily</td>
</tr>
<tr>
<td>9</td>
<td>FARO</td>
<td>Sicily</td>
</tr>
<tr>
<td>10</td>
<td>AL HIMAYA- Free from violence (multi-action programme to strengthen and improve the response to violence against foreign minors)</td>
<td>Sicily</td>
</tr>
<tr>
<td>11</td>
<td>GIADA Team- Paediatric Hospital Giovanni XXIII, Polyclinic of Bari</td>
<td>Apulia</td>
</tr>
<tr>
<td>12</td>
<td>ICARE Project</td>
<td>Emilia-Romagna, Latium, Tuscany, Sicily</td>
</tr>
<tr>
<td>13</td>
<td>Here4U</td>
<td>National level</td>
</tr>
</tbody>
</table>
# Mapped practices in Northern Italy

![Image of a map](https://example.com/image.png)

**PIEDMONT**
Frantz Fanon Centre  
[https://associazionefanon.it](https://associazionefanon.it)
Territory of intervention: Metropolitan City of Turin

<table>
<thead>
<tr>
<th><strong>Organizations involved</strong></th>
<th>Autonomous intervention (cooperation with local health authority of Turin 1 until 2013).</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Key features of the practice</strong></td>
<td>Counselling, psychotherapy and psychosocial support service for migrants, refugees and victims of torture. Founded in 1997, the centre brings together professionals with different backgrounds engaged in the development of clinical interventions for migrants' mental health. It cooperates with the Municipality of Turin Ufficio Minori Stranieri (Office for Foreign Minors) to provide MHPSS interventions for foreign minors, including unaccompanied children. Care and rehabilitation are inspired by medical anthropology and ethnopsychiatry. It promotes the integrated care of minors in cooperation with local services and associations dealing with asylum seekers and refugees. It offers supervision to practitioners and front-line workers (both in public services and private associations) on cases and in combination with continued training.</td>
</tr>
</tbody>
</table>
| **Level of intervention and services provided, in accordance with the IASC pyramid** | **Level 2: services promoting individual resilience, family ties and supportive relationships including peer-to-peer and community networks**  
- Psycho-educational interventions  
- Territorial informative and orientation services  
**Level 3: non-specialized services focused on the needs of an individual or a small group**  
- Psycho-educational and psychosocial support  
- Lay counselling, provided by trained non-clinical professionals (educators and cultural anthropologists)  
**Level 4: clinical services and specialized care**  
- Clinical support (e.g. psychological, neuropsychiatric, psychiatric care) provided by trained professionals (such as psychologists or neuropsychiatrists) |
| **Users reached** | Foreign minors, families, refugees and victims of torture, women victims of violence. |
| **Professionals employed** | Multidisciplinary team: psychologists, psychiatrists, cultural |

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**Note:** The information provided is based on the available data and may be subject to updates. For the most current and accurate information, please visit the official website or contact the Frantz Fanon Centre directly.
**Inter-agency coordination and partnerships**

A well-established centre connected to the public and private services providers working in the protection and care of users with migration backgrounds.

**User participation and involvement**

Creation of individual pathways based on listening to, and active involvement of, users.

**Success factors**

- Individual pathways tailored to the user’s specific needs
- Approach based on community resources: activation of formal and informal networks, also in cooperation with other projects active in the area
- Regular monitoring of clients’ resource activation
- Use of informal, welcoming and non-institutionalizing settings
- Linguistic and cultural mediators with specific basic competences in psychological and psychiatric care, and trained in the use of communication techniques sensitive to child and young migrant users’ specific needs
- Cultural mediators involved in all internal and external training activities, supervision, clinical discussions
- Language resources are provided according to individual needs: English, French, Spanish, Arabic, Pidgin, Urdu, Farsi, Bambara, Wolof, Pular and Mandinga.
### Organizations involved

Prefecture of Turin (Lead Partner), local health authority of Turin, municipality of Turin, University of Turin, IRES Piemonte (Economic and Social Research Institute).

### Key features of the practice

Project funded by the Ministry of Interior through the 2014-2020 Asylum, Migration and Integration Fund (AMIF). Started in October 2020, expected to end in 2022.

**Goals:**
- Promoting the coordination mechanisms between the reception system and health and social and mental health services.
- Supporting migrant users’ access to the territorial network of services through outreach activities in reception centres and dissemination of information in order to prevent chronic mental health disorders.
- Increasing and strengthening the knowledge and skills of workers operating in reception facilities and in various territorial services for the care of single adults and UASC suffering from drug-related problems and mental health disorders. This is achieved through refresher and training courses on social, anthropological, ethnopsychiatric skills open to health workers; doctors; nurses; health-care assistants; psychologists; professional educators; physiotherapists; speech therapists; extraordinary reception centre (CAS) workers; care assistants; cultural mediators; reception workers for victims of violence; municipal workers; and social workers.
- Modelling of care processes related to psychological, health and social vulnerabilities.

### Level of intervention and services provided, in accordance with the IASC pyramid

**Level 1: Fulfilment of basic needs, including access to essential services, protection and security:**
- Shared assessment between services and reception centres of individual priority cases, and for migrants being discharged or already hosted by CAS or SAI facilities
- Support for local workers during migrants’ reception and assessment activities
- Referral to existing health and social services
<table>
<thead>
<tr>
<th><strong>Users reached</strong></th>
<th>Asylum seekers and holders of international protection, UASC, migrant residents.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Professionals employed</strong></td>
<td>Territorial multidisciplinary team made up of: doctors, psychiatrists, neuropsychiatrists, psychologists, nurses, educators, cultural mediators and social workers.</td>
</tr>
<tr>
<td><strong>Inter-agency coordination and partnerships</strong></td>
<td>Partnership between relevant actors in the area of intervention at metropolitan level.</td>
</tr>
<tr>
<td><strong>User participation and involvement</strong></td>
<td>Individualized health-care pathway oriented towards recovery, strengthening of individual resources, self-determination and definition of pathways towards autonomy, aiming for autonomous job placement and residential access.</td>
</tr>
</tbody>
</table>
| **Success factors** | • Strengthening workers’ capacity to manage psychological, health and social vulnerabilities and to define care processes through the analysis of specific cases.  
• Testing of new pathways to access territorial care, rehabilitation, reintegration and social inclusion services.  
• Testing with supported non-kinship foster care of migrants, consisting of integration of migrants in families of volunteers supported by health and social professionals. |
The programme consists of: a) formalizing an inter-institutional modus operandi among all the territorial actors in charge of health and social care of people with vulnerabilities; b) systematizing the activities implemented in the framework of Asylum, Migration and Integration Fund 2014-2020 (AMIF); and c) discussing complex cases through a digital platform dedicated to social workers and health-care professionals.
**LOMBARDY**

**UONPIA (Child and Adolescent Neuropsychiatric Service, NPIA), Fondazione IRCCS Cà Granda Ospedale Maggiore Policlinico**

[https://www.policlinico.mi.it/reparti/45/neuropsichiatria-dellinfanzia-e-delladolescenza](https://www.policlinico.mi.it/reparti/45/neuropsichiatria-dellinfanzia-e-delladolescenza)

Territory of intervention: Metropolitan city of Milan

<table>
<thead>
<tr>
<th>Organizations involved</th>
<th>Health Protection Agency of the Metropolitan City of Milan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>UONPIA (child and adolescent neuropsychiatry unit) Lead partner Migration and Child and Adolescent Neuropsychiatry Disorders. Project financed by the region since 2009</td>
</tr>
<tr>
<td></td>
<td>UONPIA Fondazione IRCCS Cà Granda Ospedale Maggiore Policlinico</td>
</tr>
</tbody>
</table>

**UONPIA (child and adolescent neuropsychiatry unit) participants:**

- UONPIA Fondazione IRCCS ‘Cà Granda’ Ospedale Maggiore Policlinico
- UONPIA ASST Fatebenefratelli-Sacco
- UONPIA ASST Santi Paolo e Carlo
- UONPIA ASST Nord Milano
- UONPIA ASST Melegnano e della Martesana
- UONPIA ASST Grande Ospedale Metropolitano Niguarda
- UONPIA ASST Rhodense
- UONPIA ASST Ovest Milano
- UONPIA ASST Lodi

**Other bodies/institutions/units involved:**

- ATI (Cooperativa Terrenuove, Fondazione L’Aliante, Fondazione Cecchini-Pace, Cooperativa Crinali, Cooperativa Kantara, Agenzia di Ricerca Sociale Codici)
- Municipality of Milan (Municipal social services, Office for Migration Policies, Inclusion and Immigration Policies Unit-Social Emergencies Area, Rights and Inclusion, Office for Foreigners, disability and mental health sector, education sector, Poli Start)
- Other civil society organization agencies (Centro Come, Filo D’Arianna Cooperative, L’abilità cooperative, educational communities in Milan, associations)
- Health intervention units for minors undergoing criminal proceedings
- ASST Santi Paolo e Carlo - Youth Detention Centre and Penal
<table>
<thead>
<tr>
<th>Institution for minors, Cesare Beccaria</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Paediatric unit</td>
</tr>
<tr>
<td>• Addiction treatment services in the HPA territory</td>
</tr>
<tr>
<td>• Provincial school office</td>
</tr>
<tr>
<td>• Emergency rooms and hospital departments of hospitals involved (psychiatric intensive-care units, paediatrics unit, etc.)</td>
</tr>
<tr>
<td>• Paediatricians and general practitioners</td>
</tr>
<tr>
<td>• Rehabilitation centres for children and adolescents</td>
</tr>
<tr>
<td>• Sigmund Freud University</td>
</tr>
<tr>
<td>• Grande Ospedale Metropolitano (ethnopsychotherapy outpatient clinic)</td>
</tr>
<tr>
<td>• LABANOF</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key features of the practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>From 2009 to 2017, many regional child and adolescent neuropsychiatric projects concerning migration and child and adolescent neuropsychiatric disorders were set up in five of the 15 Lombardy local health authorities. Following the evolution of the regional health system, a single project called Migrazione e disturbi NPIA (Child and Adolescent Neuropsychiatric Services - NPIA, 2017-ongoing) was established with the aim of encouraging dialogue and sharing good practices between child and adolescent neuropsychiatric services and ensuring timely and innovative responses to the mental health needs of foreign minors and their families.</td>
</tr>
</tbody>
</table>

Since 2009, a multi-professional and inter-institutional team has been working at the Policlinico in the child and adolescent neuropsychiatric unit. The team follows a trauma-oriented model and takes care of asylum seekers and holders of international protection with psychological vulnerability. Particular attention is paid to UASC and their traumatic experiences and to supporting their recovery.

The trauma-informed care approach recognizes that the effects of trauma affect the health of individuals, organizations and society. It promotes practices and policies for early identification and care of post-traumatic disorders on the basis of a cost-benefit analysis. Such analysis considers prevention as a fundamental tool for reducing the health and social effects of post-traumatic disorders.

In order to promote mental health and provide timely responses to critical situations, the migrant team makes use of two early psychopathological risk detection tools in close
cooperation with the UASC reception system: the Refugee Health Screener (RHS) and Risk Sign Observation Grid (GOSR), used respectively in the first-line reception centres, especially in Centro Servizi per MSNA (service centre for UASC) in Via Zendrini in Milan, and in second-line reception communities.

The connection with the ethnopsychiatry outpatient clinic (GOM Niguarda) ensures care pathways for UASC in the transition to adulthood, a period which often entails the interruption of therapeutic and reception interventions, thus representing a serious risk factor for mental health, especially for young people with previous mental health fragility.

European projects financed by the AMIF in addition to regional funding, (Salut@Mi: Connection and good practices for UASC mental health in Milan’ 2016-2018 and 2019-2021 PASSI (Progress of Health Authorities for Mental Health in Italy) have been established over the years.

The synergistic action of the different migration projects has enabled comparison between practices and the dissemination of good intervention models at regional and national level. The aim is to optimize health and social integration to ensure appropriate and effective responses to UASC’s mental health needs and reduce chronic mental illnesses and deviance, even at times of greater influx of migrants.

In cooperation with the Labanof Centre (anthropology and odontology lab) of the State University of Milan, the team is experimenting an integrated protocol for the age assessment of undocumented UASC.

<table>
<thead>
<tr>
<th>Level of intervention and services provided, in accordance with the IASC pyramid</th>
<th>Level 1: Fulfilment of basic needs, including access to essential services, protection and security</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level 1:</strong> Fulfilment of basic needs, including access to essential services, protection and security</td>
<td></td>
</tr>
<tr>
<td>Over the years the multidisciplinary migrant team:</td>
<td></td>
</tr>
<tr>
<td>• has promoted awareness-raising and literacy days on issues related to childhood migration for health-care professionals, trainers and educators</td>
<td></td>
</tr>
<tr>
<td>• participates in local and regional working groups for the development of policies to protect the mental health of migrant minors</td>
<td></td>
</tr>
<tr>
<td>• has taken part in research and scientific dissemination projects to systematize an integrated social, psychological, health and trauma-informed approach to UASC reception</td>
<td></td>
</tr>
<tr>
<td><strong>Level 2: services promoting family ties and supportive relationships including peer-to-peer and community networks</strong></td>
<td></td>
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<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>The project cooperates with host communities and network services to promote supportive relationships through working groups, specific training and an integrated implementation of ad hoc prevention interventions</td>
<td></td>
</tr>
</tbody>
</table>

**Level 3: non-specialized services focused on the needs of an individual or a small group**

- Training and support in the use of specific tools for early detection of mental health risk
- Individual orientation and screening interviews carried out by developmental psychologists to all UASC in first-line reception, in order to assess referral to specialized services

**Level 4: Clinical services and specialized care**

- Neuropsychiatric counselling. Early interventions for UASC mental health aim to prevent or limit emergency room admissions, sudden discharges from communities, interruptions of ongoing projects and other potentially re-traumatizing events for UAS boys and girls (care in the child and adolescent neuropsychiatry unit begins after identifying the community/legal guardian/foster parent needs).
- Standard activation of care pathways in 30 days, urgent activation in 72 hours. Following the report, a micro team is set up to assess and manage the case (i.e. psychological, neuropsychiatric and psychiatric health care).

| **Users reached** | Foreign minors, migrant families, unaccompanied foreign minors. |
| **Professionals employed** | Psychologist, child neuropsychiatrist, cultural mediator, professional educators, social worker. |
| **Inter-agency coordination and partnerships** | Constant dialogue with the service network. Working group with socio-educational communities, social services and third sector. Regional coordination round table (directors and project representatives of the territorial health and social agencies – Child and adolescent neuropsychiatry unit of the Health Protection Agency in Milan). |
| **User participation and involvement** | // |
**EMILIA-ROMAGNA**

**Start-ER 2 (Health, protection and reception of asylum seekers and holders of international protection in Emilia-Romagna)**

[https://ambo.ausl.bologna.it/pro/starter](https://ambo.ausl.bologna.it/pro/starter)

Territory of intervention: Emilia-Romagna region

<table>
<thead>
<tr>
<th>Organizations involved</th>
<th>Lead partner: local health unit in Bologna. Project partners: local health units of Imola, Ferrara, Romagna, Modena, Reggio Emilia, Parma, Piacenza, Arca di Noè Social Cooperative, Caleidos non-profit social cooperative, Cidas social cooperative, DiaLogos social cooperative, Dimora d’Abramo social cooperative, Società Dolce Società Cooperativa social cooperative, Lai Momo social cooperative, Mondo Donna non-profit association. Cooperation with metropolitan first-line reception centre and second-line reception centres for UASC.</th>
</tr>
</thead>
</table>
| Key features of the practice | Financed by ongoing 2014-2020 AMIF, START-ER 2 has the same targets as Start-ER, implemented in 2016-2018. The project aims to reinforce the care of psychological and mental health needs of applicants and holders of international protection, including UASC, by strengthening the synergies between public and civil society organization services. This has been done by introducing a model to increase basic health competences, as well as a network system to ensure early and adequate care for people with vulnerabilities, and proper follow-up of implemented pathways. A further objective is to consolidate, integrate and structure the tested actions, in order to strengthen and update the competences and the technical and institutional operating tools in the field of MHPSS, and to facilitate cooperation between public service and civil society by implementing intervention methodologies that form a reference point for identifying an exhaustive regional model. The service operates with integrated multidisciplinary teams, which carry out:  
• Ethnoclinical and culturally-oriented care of mental distress  
• Implementation of training activities aimed at capacity-building of operators  

The main result expected from the current implementation is a regional homogeneous integrated model of early care for vulnerable people, which ensures a better access to services. Developing the competences of the workers involved means the model can continue once the funding has ended. |
<table>
<thead>
<tr>
<th>Level of intervention and services provided in accordance with the IASC pyramid</th>
<th>Level 1 and 2: Fulfilment of basic needs, protection and security; services promoting family ties and supportive relationships in the community</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Thanks to civil society partners, the project ensures integrated care for mental health and psychosocial needs, from the first-line to second-line reception, and enables a rapid activation of network services, investing in community-led supportive networks. Given the regional scope of the project, each territory promoted different intervention models, based on gaps identified during previous experiences and the findings from specific action-research.</td>
<td></td>
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<tr>
<td>Level 3: Non-specialized services focused on the needs of an individual or a small group</td>
<td></td>
</tr>
<tr>
<td>• Provision of early interventions for UASC mental health through integrated multidisciplinary teams (public-private) composed of psychiatrists, psychologists, anthropologists, social workers, and nurses.</td>
<td></td>
</tr>
<tr>
<td>Level 4: Clinical services and specialized care</td>
<td></td>
</tr>
<tr>
<td>• Clinical services (such as psychological, neuropsychiatric and psychiatric care) provided by specialized professionals (including psychologists and child neuropsychiatrists.) from local health units and civil society organizations, allowing the provision of support services both to asylum seekers and holders of international protection who suffer from mental health conditions.</td>
<td></td>
</tr>
</tbody>
</table>

| Users reached | Adult asylum seekers and holders of international protection and unaccompanied foreign minors. |
| Professionals employed | Psychiatrists, psychologists, anthropologists, physicians, child neuropsychiatrists, social workers, linguistic and cultural mediators, nurses, psychiatric rehabilitation technicians, specialist physicians in various medical disciplines. |
| Inter-agency coordination and partnerships | Constant dialogue with the services network through a local health unit and authority coordination table with the socio-educational communities, social service and third sector. |
| User participation and involvement | The rationale of the project is to support individual care processes from a systemic view. The approach is focused on people, their relationships and communities by means of support actions involving people or groups facing challenges, local administrations, the (educational, health and social, legal, administrative) service system, associations. |
Success factors

• Ability to adapt to the pandemic by reviewing implementation methods; identifying new needs; disseminating information; awareness-raising, counselling, and distribution of medical devices to target users.
• Establishing the Journal Club, an interdisciplinary course launched in 2020, which is coordinated by the Bologna Local Health Unit and Authority. Scientific articles about international protection are presented and discussed, structured in three modules concerning the right to asylum and related policies; medical anthropology/transcultural psychopathology; and reception practices and systems.
• From January to July 2020, the Centre for International and Intercultural Health (Social Promotion Association) carried out and implemented an action-research project at regional level to identify the training needs of health and social workers working with applicants and holders of international protection who suffer from psychological and health vulnerability. In the light of its findings, the project’s scientific committee drew up a regional training plan.
• Multidisciplinary and integrated public/private work – a key characteristic of Start-ER 2 throughout the region.
• Gender sensitivity.

Mapped practices in Central Italy

LATIUM
SAMIFO - Health Centre for Asylum Seekers and refugees (local health authority Roma 1)
https://www.aslroma1.it/migranti
Territory of intervention: Latium

Organizations involved

Local Health Authority Roma 1, in cooperation with Centro Astalli Association and Roma Capitale. Synergistic actions with regional local health authorities, numerous civil society organizations and some regions.
**Key features of the practice**

Local Health Authority Roma 1’s commitment to the protection of migrants’ health began in 2007, with the creation of a district partnership unit called Migrant Care. This was the culmination of a process that began in 1993 with the Migration Agency, followed by the Migration and Health Working Group (1996), Migrant Reception Space (1999), Migrant Health Coordination (2006), and more recently the Intercompany Migrant Health Plan (2015). SAMIFO is a regional health facility, part of the local health authority Roma 1, for the health care of forced migrants. It has acted as a point of contact for bodies working for migrants’ protection since 2006. It is a first-line reception centre, providing psychological, health and social care, assessment, care and guidance for migrants and refugees.

In addition to several specialized outpatient clinics, multi-professional mobile units operate in the second-line reception system to promote early detection of health and psychological vulnerabilities and facilitate access to services for applicants and holders of international and subsidiary protection. Different teams within the service complete their assessment process by providing in-house services for a longer period of time or by referring users to the relevant health facilities. Its organization model is based on integrated health-care processes, including health services and social protection for victims of war, inhumane and degrading treatment such as torture, sexual harassment, forced marriage, female genital mutilation (FGM) and other forms of intentional violence. The service is provided by professionals from local health authority Roma 1, social workers and volunteers from the Astalli Centre, general practitioners and linguistic and cultural mediators. Trainees from different training bodies, both public and private, and civil service workers are welcomed.

Linguistic and cultural mediation in the SAMIFO centre is provided by the Astalli Centre, Roma Capitale and by projects supported by AMIF (ICARE, FARO, PSIC) and regional funds. The health-care strategy of SAMIFO is based on the implementation of interdisciplinary, multidimensional and intercultural individual care and support pathways that are appropriate to the physical, psychological and social suffering of forced migrants, and on the integration between basic and more specialized health care.

SAMIFO organizes, implements and supervises continuous cycles of basic and second-level training in partnership with
other bodies for health and social workers (doctors, nurses, psychologists, social workers, administrative staff of the NHS and health communication monitoring centre). Training covers the following issues: post-traumatic vulnerability and severe psychological and health distress; work-related stress management and prevention of vicarious traumatization; applicants and holders of international protection health care; asylum seekers and holders of international protection suffering from diseases; and dissemination of guidelines on victims of torture.

The team assisting foreign minors, which is funded by AMIF within the FARI 2 project, began its activities in July 2017. It is made up of a child neuropsychiatrist, an evolutionary psychologist, a social worker, a speech therapist, a neuropsychomotor technician and an educator. It employs linguistic and cultural mediators when necessary. It has a scientific committee which comprises experts in the field, university, scientific society and civil society organization representatives.

<table>
<thead>
<tr>
<th>Level of intervention and services provided in accordance with the IASC pyramid</th>
<th>Level 1: Fulfilment of basic needs, including access to essential services, protection and security</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level 1: Fulfilment of basic needs, including access to essential services, protection and security</strong></td>
<td></td>
</tr>
<tr>
<td>• Health and social reception help desk, offering orientation, support and cultural mediation functions to facilitate access to other services (medical, psychological, social and nursing).</td>
<td></td>
</tr>
<tr>
<td>• Open-access health care through general practitioners and mobile units active in the reception system and on the street for the early identification of needs.</td>
<td></td>
</tr>
<tr>
<td><strong>Level 2: Services promoting individual resilience, family ties and supportive relationships including peer-to-peer and community networks</strong></td>
<td></td>
</tr>
<tr>
<td>• Participation in the integrated care for applicants and holders of international protection with health and social and mental health needs. This care begins in the reception communities, thanks to the mobile units staffed by multidisciplinary teams of health-care workers. The aim of the units is the early identification of people with health and psychological vulnerabilities, who can be directed towards the most appropriate territorial services for assessment and care.</td>
<td></td>
</tr>
<tr>
<td><strong>Level 3: Non-specialized focused services addressing the needs of an individual or a small group</strong></td>
<td></td>
</tr>
<tr>
<td>• SAMIFO professionals support the public services in host communities, informal settlements, and community and hospital centres. This activity is provided by SAMIFO</td>
<td></td>
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</tbody>
</table>
Users reached

<table>
<thead>
<tr>
<th>Professionals employed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forced migrants, victims of torture, sexual violence, or other severe forms of psychological, physical or sexual abuse; people suffering from severe diseases or mental disorders; foreign minors, including unaccompanied minors.</td>
</tr>
</tbody>
</table>

The permanent staff comprises doctors, psychiatrists, gynaecologists, orthopaedists, forensic physicians, psychologists, psychiatric rehabilitation technicians, nurses, social workers, obstetricians, working in the National Health Service, and in the primary health-care system; social workers or volunteers from the Astalli Centre; and linguistic and cultural mediators.

Within the framework of the FARI project, six multidisciplinary teams were set up, made up of: general practitioners and psychiatry; child neuropsychiatry, gynaecology, orthopaedics, forensic medicine specialists, linguistic and cultural mediators, psychologists for adults and for developmental age, social workers for adults and minors, psychiatric rehabilitation technicians, obstetricians, nurses, speech therapists, neuropsychomotor technicians, educators, linguistic and cultural mediators.

At SAMIFO it is also possible to undertake postgraduate internships in various disciplines that support the multidisciplinary teams.

Level 4: Clinical services and specialized care

- Standardization of intake and the provision of care processes.
- In the case of adult applicants for international protection who are suffering from severe psychopathologies and require long-term treatment and a care in the territory, SAMIFO workers refer them to the appropriate mental health centre, sending written reports and, if necessary, accompanying the patients. In these cases, the MHD uses combined methods of reception, assessment and implementation of the Individualized Therapeutic Rehabilitation Project (PTRI), possibly followed by reception in residential or semi-residential rehabilitation centres.
- For minors from third countries, including unaccompanied minors, the assessment and care is carried out by the FARI 2 project team of the local health authority Roma 1. In some cases, staff may refer them to appropriate facilities in the local area, first and foremost the Unit for the Protection of Mental Health and Rehabilitation in developmental age (TSMREE).
| **Inter-agency coordination and partnerships** | • Within the framework of the various projects, the partnership with the Astalli Centre Association, the Centre for Politics and International Studies (CeSPI), CRS Cooperativa Roma Solidarietà (Rome Cooperative for Solidarity), Integra Programme, Caritas Roma, Active Citizenship, regional local and health authorities of Emilia-Romagna, Tuscany and Sicily ensures the implementation of the activities planned.  
• Participation in the working groups ‘Promotion of a solidarity community’, ‘Marginalization and Social Inclusion’, etc.  
• Networking and dialogue with numerous civil society organization actors: Consorzio Roma Solidarietà (Rome Diocesan Caritas); Community of Sant’Egidio, Welcome Centre, CIES Centro Informazione e Educazione allo Sviluppo (Information and Education Centre for Development); Associazione Focus Casa dei Diritti; Doctors Against Torture Association; Erythros Association for the protection and promotion of human rights; ACSE Comboni Association - Migrant and Refugee Service; Associazione Solidarietà Vincenziana (St. Vincent Solidarity Association); SRM Servizio Rifugiati e Migranti (Migrant and Refugee service); FCEI Federation of Evangelic Churches in Italy; Save the Children Italy; AMREF, Sanità di Frontiera (Health beyond Borders); Sport without Borders.  
• In order to facilitate integration processes, SAMIFO works with for-profit organizations in some sectors (such as catering, green maintenance, haute couture and agriculture) in which trained asylum seekers and holders of International protection carry out internships of varying lengths.  
• It takes part in the Coordination of Regional and National Group on Migration and Health. Local Immigration and Health groups.  
• It takes part in the national technical table for 2021/2027 AMIF programming. |
| **User participation and involvement** | Gender- and culture-oriented approach, focused on the individual, his/her relationships, and the community. |
| **Success factors** | • It uses scientific evidence and clinical experience as the basis for an innovative and sustainable public health model, based on the participatory analysis of health needs.  
• The mobile units have reduced the responsibilities of reception centre workers for health tasks that are not specifically their own.  
• The practice is sustainable. SAMIFO forms part of the local health authority Roma 1 organization, ensuring it has the necessary resources to continue its provision. It is an inter- |
• District operating unit with its own budget.
  • Free services and free access to the front office and general practice. Specialist medical examinations are carried out by appointment, but there is always priority for listening and responding to any emergencies.
  • Assessment, support and psychotherapy interviews are carried out, when necessary, with linguistic- and cultural mediators. This service is available (not on-call) in the following languages: Amharic, Arabic, Bambara, Bengali, Chinese, Kurdish, Dhari, Djoula, Farsi, French, Hindi, English, Mandinga, Pashtu, Pidgin, Poular, Somali, Soninké, Sorani, Spanish, Tigrinya, Turkish, Urdu and Wolof. On-call mediation is also available for other languages.
  • Part of a formal and informal territorial network with numerous public and private, for-profit and non-profit organizations. Network consolidated by the memorandum of understanding signed in 2018 by local health authority Roma 1, Roma Capitale (Social Policies, Subsidiarity and Health Department and Educational and School Services Department, Family and Childhood Policies), municipalities of Rome I, II, III, XIII, XIV and XV, and school districts/School Pole for Inclusion. The memorandum establishes the institutions' willingness to jointly commit to “ensure the development of educational, health, and health-and-social integration services and interventions aimed at increasing school inclusiveness, and decreasing school leaving and disaffection, as well as the health promotion”.

[Image of two individuals]
## Mapped practices in Southern Italy

<table>
<thead>
<tr>
<th>Organizations involved</th>
<th>UNICEF, Regional Ombudsman for Children and Adolescents.</th>
</tr>
</thead>
</table>
| **Key features of the practice** | Centro PENC Anthropology and Geoclinical Psychology is a non-profit association founded in 2015 and recognized as a non-profit organization in 2017. It offers psychological care pathways following the geoclinical ethnopsychiatry approach. This approach considers the patients’ places, languages and histories of origin, and considers geopolitical events as a fundamental part of everyone’s experience.  

The centre of ethnopsychology, funded within the University Hospital of Palermo ‘P. Giaccone’, has been active in the regional Ombudsperson for Children and Adolescents locations of the Municipality of Palermo since 2017. It represents the core activity of Centro PENC and offers psychotherapy and psychological support for individuals and groups; remote psychological support, when physical access by the patient is not possible; training and supervision activities in clinical ethnopsychology; and linguistic and cultural mediation in 15 languages: Somali, Tunisian Arabic, Mandinka, Wolof, Bambara, Dyula, Malinké, Pidgin English, Benin-Edo, Bangla, Fula-Pular-Fulbe, English, French, Portuguese.  

The centre carries out widespread training activities for educators, psychologists, social workers and mediators working in reception centres and mental health services. It also provides ethnopsychology counselling for patients and advocacy, and is also specialized in clinical supervision for unaccompanied foreign minors and refugees and asylum seekers in reception centres.  

The centre also manages the *Women and Girls Safe Space*, a space that welcomes women, girls and their children daily, thanks to UNICEF support. It offers opportunities for socialization and meeting, empowerment pathways to access information and services, as well as individual and group |
psychological support provided by specialized workers, who also facilitate peer-to-peer group support. Services are free of charge for users.

<table>
<thead>
<tr>
<th>Level of intervention and services provided in accordance with IASC pyramid</th>
<th>Level 2: Services promoting individual resilience, family ties and supportive relationships including peer-to-peer and community networks</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The PENC team is in contact with the local communities of foreign citizens thanks to cultural mediators, who act as a ‘radar’ for the territory. Indeed, they provide an interface between local communities and services provided by PENC. They also support more isolated users whose cases are managed by PENC in the integration process within local communities. Moreover, PENC offers psychosocial and recreational activities through the Women and Girls Safe Space.</td>
<td></td>
</tr>
</tbody>
</table>

**Level 3: Non-specialized focused services addressing the needs of an individual or a small group**

- PENC offers a case management service, referrals to other socio-health services, such as linguistic and cultural mediators, as well as facilitating access to other services such as sexual and reproductive health, or safe houses in the case of gender-based violence or domestic violence.
- The Women and Girls Safe Space gives specific attention to individuals’ unique needs and may refer to specialized services.

**Level 4: Clinical services and specialized care**

- PENC provides psychological and psychotherapy support, as it is a centre that specializes in ethnopsychology and extreme trauma treatment.

| Users reached | The services are tailored to the needs of refugees, asylum seekers, regular and non-regular migrants, unaccompanied minors, single women or women with children, survivors of gender-based violence or other forms of violence, victims of trafficking; foreign women, men, and UASC boys and girls, including those in foster care or adoption. Counselling services are also provided to voluntary legal guardians, community workers and professionals working in migration. |

| Professionals employed | Ethnopsychologists, social workers, linguistic and cultural mediators, and trainees from the University of Palermo, the University of Milan-Bicocca, and the University of Bologna Alma Mater Studiorum - Department of Legal Sciences. |
| **Inter-agency coordination and partnerships** | Networking with public institutions (including the Guarantor for children and adolescents of the municipality of Palermo; hospitals; social services offices of the municipality of Palermo; Casa dei Diritti operating unit of the municipality of Palermo; Territorial Commissions for the recognition of international protection; and the juvenile court) and civil society organizations (managers of reception centres, IOM, UNICEF, and Save the Children), and with foreign communities historically settled in Palermo. |
| **User participation and involvement** | Culture- and gender-sensitive approach focused on the individual, his/her relationships and community. |
| **Success factors** | • Methodology based on the ethnopsychiatric approach, which integrates clinical questions with an analysis of geo-cultural and geopolitical elements according to a patient’s mindset and place of origin.  
• Practice recognized by, and integrated into, a wide network of territorial health and social, care and legal services.  
• The Women and Girls Safe Space, supported by UNICEF, is an innovative intervention model capable of effectively integrating psychosocial services with specialized support. |
### SICILY
**Silver project (Innovative Solutions for Migrant Vulnerability and social reintegration), approved under 2014-2020 AMIF**
Territory of intervention: Sicily region

<table>
<thead>
<tr>
<th>Organizations involved</th>
<th>The lead partner is Trapani Provincial Health Authority, working in partnership with seven Sicilian health authorities and a network of 11 civil society organization actors, with the support of the WHO, the Regional Councillor for Health, and the Prefectures of Sicily.</th>
</tr>
</thead>
</table>
| Key features of the practice | Financed by the 2014-2020 Asylum Migration and Integration Fund (AMIF), the project was active from 2016 to 2018. It aimed to strengthen the first-line and second-line reception system and the health protection of applicants for, and holders of, international protection who are experiencing psychological or health vulnerability. It did so in part by reinforcing institutional competences.  

The specific objective of the project was to provide health care to migrants in Sicily’s institutional reception system who were specifically in need of MHPSS. During the implementation of the project, outpatient clinics for adults and minors, run by dedicated multidisciplinary teams, were set up in each provincial health authority. At the same time, mobile units were established to reach the reception centres. Anthropologically and cross-culturally based capacity-building sessions were also held for all staff in the MHPSS services (reception and health). The project also promoted networking and collaboration between health authorities and civil society organizations through training, monitoring and supervision at reception centres, SAI facilities.  

The innovative actions of the project included:  
- the definition of a regional long list of cultural mediators and a web-based emergency call system, available by phone or webcam  
- software for the management of foreign patients that could be used and implemented by health authorities in the future  
- definition of common and shared standard operating procedures (SOPs)  
- tailored training activities for reception centre workers,
paediatricians, general practitioners, and health-care staff
• research activities on multidisciplinary work in the ethno-psychological field
• social and economic support for migrants through job and training grants at participating bodies

<table>
<thead>
<tr>
<th>Level of intervention and services provided in accordance with the IASC pyramid</th>
<th>Level 2: Services promoting individual resilience, family ties and supportive relationships including peer-to-peer and community networks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Mobile units equipped with multidisciplinary teams designed to ensure timely needs identification within the migrant and refugee population</td>
</tr>
<tr>
<td></td>
<td>Level 3: Non-specialized focused services addressing the needs of an individual or a small group</td>
</tr>
<tr>
<td></td>
<td>• Integrated care of mental health and psychosocial needs at the reception centre through the activation of job grants to support migrants’ and refugees’ social and economic integration, and the establishment of a network of territorial services</td>
</tr>
<tr>
<td></td>
<td>Level 4: Clinical services and specialized care</td>
</tr>
<tr>
<td></td>
<td>• Focused services provided by specialized staff in multidisciplinary teams, including a cultural mediator, at the regional local health units</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>User reached</th>
<th>Adult asylum seekers and unaccompanied foreign minors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professionals Employed</td>
<td>Social workers, linguistic and cultural mediators, psychologists, psychiatrists, neuropsychiatrists, educators</td>
</tr>
<tr>
<td>Inter-agency coordination and partnerships</td>
<td>Networking with public institutions (hospitals, municipalities, territorial commissions for the recognition of international protection, juvenile court) and civil society institutions</td>
</tr>
<tr>
<td>User participation and involvement</td>
<td>N/A</td>
</tr>
<tr>
<td>Success factors</td>
<td>• First attempt to systematize an intervention model for the care of MHPSS needs at regional level in an inter-agency and multilevel structure</td>
</tr>
<tr>
<td></td>
<td>• First attempt to standardize procedures through SOPs dedicated to specific users</td>
</tr>
<tr>
<td>Organizations involved</td>
<td>Provincial health authority of Catania</td>
</tr>
<tr>
<td>------------------------</td>
<td>--------------------------------------</td>
</tr>
</tbody>
</table>
| **Key features of the practice** | Active unit since 2005 and part of the mental health department of the Catania 3 provincial health authority located within the provincial health authority’s Agorà centre. The centre houses a social area, general practice outpatient clinics, a nurse reception service and the Urban Suffering Studies Centre. The proximity of the outpatient clinics and offices ensures cooperation between services and easier access for foreign users, who may have difficulty in reaching different areas of the city. It offers the following services. **Clinical activity**  
- Outpatient services  
- Hospital ethnopsychiatric counselling activities  
- Clinical psychology and psychological support interventions  
- Ethnopsychiatric counselling to public institutions and voluntary associations  
**Training activities**  
- Organization of training courses for institutional (health, education, social, etc.) workers dealing with migration  
**Information activities**  
- Dissemination of information about territorial outpatient clinics providing a response to migration problems  
**Prevention activities**  
- Primary prevention interventions for migrants and citizens |
| **Level of intervention and services provided in accordance with the IASC pyramid** | **Level 2**: Services promoting individual resilience, family ties and supportive relationships including peer-to-peer and community networks  
- Outpatient support services  
**Level 3**: non-specialized focused services addressing the needs of an individual or a small group  
- Hospital and community ethnopsychiatry counselling activities  
**Level 4**: Clinical services and specialized care  
- Clinical psychology and psychological support interventions |
<p>| <strong>Users reached</strong> | Migrants, asylum seekers and refugees, including children, UASC, single women who have survived gender-based violence, and victims of trafficking. |</p>
<table>
<thead>
<tr>
<th>Professionals employed</th>
<th>Clinical psychologists and psychiatrists following an ethnopsychiatric approach, neuropsychiatrists, cultural mediators and trainees.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inter-agency coordination and partnerships</td>
<td>Networking with public institutions (hospitals, municipalities, territorial commissions for the recognition of international protection, and the juvenile court) and civil society organizations. Part of the Italian Society of Migration Medicine (SIMM).</td>
</tr>
<tr>
<td>User participation and involvement</td>
<td>Culture- and gender-oriented approach focused on the individual, his/her relationships, and community</td>
</tr>
</tbody>
</table>
| Success factors | • Methodology based on the ethnopsychiatric approach: a psychotherapeutic project which considers the biographical, religious and symbolic aspects that are relevant for the patient, according to their experiences and needs for treatment.  
• Recognition of the psychiatric pathologies linked to the journey, including humiliations suffered, threatening archaic rituals, and adaptation of the therapeutic pathway. |

**SICILY REGION**  
FARO: Early identification of foreign minors’ psychosocial vulnerabilities from arrival to first-line reception, and strengthening of the reception system in the provinces of Catania, Messina, Palermo, Ragusa, Siracusa (AMIF project 1635)  
Territory of intervention: Provinces of Catania, Messina, Palermo, Ragusa, 

**Organizations involved**  
University of Messina - CEMI; University of Palermo, Institute of Political Education ‘Pedro Arrupe’ - Centre for Social Studies. 

**Key features of the practice**  
The project was funded by the **2014-2020 AMIF, under its Specific Objective 1. Asylum - National Objective NO1 - letter b) - Interventions for Foreign Minors in conditions of psychosocial vulnerability**.  
It comprised two parallel lines of intervention, to respond to different needs:  
• psychosocial support to UASC and families with children from arrival to first-line reception centres
• strengthening the skills of the workers involved in the care of the target subjects

The project enhanced networking by referring to internationally accredited care models for UASC and the migrant population, with a focus on integrated interventions. The latter focus on harm and risk reduction and the promotion of individual, family, group and community resources from a transcultural point of view.

It is a practice that collects and develops the experiences gained over the years in the FARO project, which has become an intervention model for the psychological and psychosocial support for foreign minors. These experiences were collected by the Terre des Hommes foundation in the FARO Model Guide, sponsored by the Sicily region health department (date of the agreement: 26.03.2018).

<table>
<thead>
<tr>
<th>Level of intervention and services provided in accordance with the IASC pyramid</th>
<th>Level 1 and 2: Fulfilment of basic needs, protection and security; services promoting family ties and supportive community relationships:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Technical support to front-line workers at the disembarkation points</td>
</tr>
<tr>
<td></td>
<td>• Accompanying clients to access necessary services</td>
</tr>
<tr>
<td></td>
<td>• Dissemination of information materials on the context and available services</td>
</tr>
<tr>
<td></td>
<td>• Support for mothers to access necessary services and items for their children</td>
</tr>
<tr>
<td></td>
<td>• Case referral to health or prefectural services as needed</td>
</tr>
<tr>
<td></td>
<td>Level 2: Services promoting individual resilience, family ties and supportive relationships including peer-to-peer and community networks:</td>
</tr>
<tr>
<td></td>
<td>• Facilitating clients’ access to relevant services</td>
</tr>
<tr>
<td></td>
<td>• Information and awareness-raising on reception procedures to provide emotional support and foster a sense of protection</td>
</tr>
<tr>
<td></td>
<td>• Support for family reunification following the hospitalization of a member after arrival, and maintenance of family relationships</td>
</tr>
<tr>
<td></td>
<td>Level 4: Clinical services and specialized care:</td>
</tr>
<tr>
<td></td>
<td>• Detection of psychological vulnerabilities immediately and upon disembarkation of migrants</td>
</tr>
<tr>
<td></td>
<td>• Vulnerability monitoring and provision of care throughout migrants’ stay at the hotspot</td>
</tr>
<tr>
<td></td>
<td>• Referral of particularly severe cases to local specialized services</td>
</tr>
<tr>
<td><strong>Users reached</strong></td>
<td>UASC and health and social workers involved in their care, treatment and protection.</td>
</tr>
<tr>
<td>--------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Professionals employed</strong></td>
<td>Multidisciplinary teams made up of a psychologist, anthropologist and cultural mediator; and expert trainers in the legal, social and health fields.</td>
</tr>
<tr>
<td><strong>Inter-agency coordination and partnerships</strong></td>
<td>In addition to the project partnership, a strong cooperation has been developed with the social services of the involved territories and their prefectures.</td>
</tr>
<tr>
<td><strong>User participation and involvement</strong></td>
<td>Unaccompanied foreign minors, reception facilities workers and third parties involved in the care and protection of minors.</td>
</tr>
</tbody>
</table>
| **Success factors** | • The project represents a milestone as it confirms how the quality and usefulness of the FARO intervention model is appreciated and recognized by the Ministry of the Interior, following its promotion in previous years by Terre des Hommes.  
• One of the strengths of the project is its great capacity for adaptation, flexibility and responsiveness to unanticipated events, which have entailed changes and adjustments to the country’s changing migration management policies. |
**SICILY**

**AL HIMAYA - Free from violence. Multi-action programme to strengthen and improve the response to violence against foreign minors in Catania, Messina, Palermo, Ragusa, Trapani**

Territories of intervention: Catania, Messina, Palermo, Ragusa, Trapani

<table>
<thead>
<tr>
<th>Organizations involved</th>
<th>Municipality social services.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Key features of the practice</strong></td>
<td>The AL HIMAYA - Free from violence project aims to strengthen the role of territorial services in preventing and mitigating violence against migrant and refugee children. The direct users of the intervention are staff in public and civil society organizations. They receive support on cases of violence, or alleged violence, against foreign minors through multidisciplinary training, capacity-building and counselling activities. The project also provides peer-to-peer training for community leaders and awareness-raising activities for migrant families.</td>
</tr>
</tbody>
</table>
| **Project start date:** 01/04/2021  
**Project end date:** 30/09/2022 | |
| **Funder:** Ministry of Interior - 2014-2020 Asylum, Migration and Integration Fund (AMIF). | |
| **Level of intervention and services provided in accordance with IASC Pyramid** | **Level 2: Services promoting individual resilience, family ties and supportive relationships including peer-to-peer and community networks**  
- Enhancing local services to prevent violence against boys and girls and minimize protection risks affecting migrant and refugee children  
- Training on peer-to-peer support for community leaders, to promote a protective and conducive environment and prevent violence  
- Sensitization for migrant families  
**Level 3: Non-specialized focused services addressing the needs of an individual or a small group**  
- Provision of training and technical guidance for practitioners working in public and private services on the early identification of vulnerabilities and signs of violence, and case monitoring |
<p>| <strong>Users reached</strong> | Staff in public and private territorial services; community leaders; migrant families with children and UASC. |</p>
<table>
<thead>
<tr>
<th>Professionals employed</th>
<th>Psychologists, anthropologists/sociologists, social workers, cultural-linguistic mediators, doctors, trainers.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inter-agency coordination and partnerships</td>
<td>The project partners are: Astalli Centre for Migrant Care, Catania; Centro PENC Anthropology and Geoclinical Psychology, Municipality of Palermo; Consorzio Solidalia non-profit social cooperative; Formazione e Comunione non-profit social cooperation; Italian Society of Migration Medicine (SIMM); University of Messina - CEMI; University of Milan; and University of Milan-Bicocca.</td>
</tr>
<tr>
<td>User participation and involvement</td>
<td>User participation and involvement is facilitated through awareness-raising events on issues related to violence against children and targeting foreign communities.</td>
</tr>
<tr>
<td>Success factors</td>
<td>Success factors will be identified at the end of the project.</td>
</tr>
</tbody>
</table>
APULIA REGION
Polyclinic of Bari Paediatric Hospital Giovanni XXIII GIADA team
http://www.giadainfanzia.it/
Territory of intervention: Bari and Province

Organizations involved
Polyclinic of Bari Paediatric Hospital Giovanni XXIII GIADA team, in collaboration with local social services, UASC host communities, section for minors and families of the Apulia region, Department of Education Sciences, Psychology, Communication of the University of Bari, ‘Aldo Moro’, Specialization School of Cognitive Psychotherapy of Bari (AIPC) and Lecce (APC).

Key features of the practice
In 2000, the Paediatric Hospital Giovanni XXIII in Bari established the GIADA (Interdisciplinary Group for Abused Children and Women Care) team. This includes an interdisciplinary team with coordination functions, a network of hospital representatives, a clinical psychology service, an observatory, and training and awareness-raising activities.

In 2017 GIADA took part in an action-research project dedicated to UASC, in cooperation with the Apulia region and ARESS (the strategic regional agency for health and social affairs in Apulia). The aim of the project is to systematize a protection process that leads to the definition of an organic and integrated system of UASC psychological, health and social care through the early detection of signs of distress.

The phases of the intervention for UASC were inspired by the regional guidelines on abuse and violence against minors. This early care of UASC vulnerabilities represents a coordinated and integrated set of health and social interventions aimed both at preventing or removing the situation of psychological/psychopathological vulnerability, and at promoting psychosocial well-being. The operational pathway includes the specific involvement of not only of the health and social actors identified by the regional guidelines, but also of reception workers, who play a crucial role in UASC well-being.

The currently developing organization model in the Apulia region provides for a centralized structure, guaranteed by the Paediatric Hospital Giovanni XXIII, and a decentralized territorial structure, implemented by the local health authorities, the
Levels of interventions and services provided in accordance with IASC pyramid

<table>
<thead>
<tr>
<th>Users reached</th>
<th>Accompanied and unaccompanied foreign children.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professionals employed</td>
<td>Four psychologists with a background in paediatric contexts and in the use of assessment procedures for attachment bonding, one social worker with a background in child abuse, a functional team of paediatric specialists in medical disciplines contributing to improve the process of diagnosis related to different forms of violence, including genital mutilation.</td>
</tr>
<tr>
<td>Inter-agency coordination and partnership</td>
<td>Hospital facilities where the paediatrics unit is present. This unit is part of the local health authorities of Bari, Barletta, Brindisi, Foggia, Lecce and Taranto; the Riuniti Hospital in Foggia, the ecclesiastical institutions Miulli in Acquaviva delle Fonti and Panico in Tricase, and the IRCCS Casa Sollievo della Sofferenza (home for relief of suffering) in San Giovanni Rotondo, and Medea in Ostuni. Abuse and ill-treatment teams are made up of social workers from the municipalities, psychologists from the family counselling centres working within the local health authorities, and centres against violence accredited by the Apulia region.</td>
</tr>
<tr>
<td>User participation and involvement</td>
<td>The GIADA team has experimented with and adapted a specific process for the early identification of UASC vulnerabilities and fragilities. In this way, the team has created a comprehensive and timely system of care for minors, helping to ensure their effective and full integration in their new country. A health and social services of the municipalities and the centres against violence. Since 2009, the regional council has supported GIADA, including it in the strategic objectives of the region and providing funding, in order to strengthen the care for at-risk and/or abused children/adolescents and families, as well as to implement a regional pilot of an interdisciplinary and inter-institutional health and social network. GIADA is currently a permanent service in the psychology service of the Paediatric Hospital of Bari.</td>
</tr>
</tbody>
</table>

**Level 4: Clinical services and specialized care**

- GIADA provides first-level care in the assessment and treatment of vulnerabilities and represents a competent centre in diagnostic and therapeutic interventions for minors, including recognition, diagnosis, health assessment and treatment.
- It provides clinical support and care services at centres for psychological distress and child interpersonal trauma through specialized staff working in teams.
A social commission for UASC age assessment was set up within GIADA pursuant to Law 47/2017.

| Success factors | • Recognition of the crucial role played by reception system workers, who provide essential services and community support. The team has provided specialized training and early vulnerability detection tools to be used by the reception communities. During the health emergency, they also provided remote monitoring and counselling.  
• Involvement of health and social care actors with specific tasks and roles, who collaboratively contribute to the construction of an integrated and multidisciplinary system for the identification, assessment, treatment and care of UASC’s specific vulnerabilities.  
• The project is based on ‘action-research’, a methodological approach whose objective is to overcome a problem by a participatory design of interventions, to be launched as pilot projects and subsequently extended to the entire regional territory. |

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EMILIA-ROMAGNA, TOSCANA LATIUM, SICILY
ICARE project integration and community care for asylum and refugees in emergency
http://www.progettoicare.it/home
Territories of intervention: Emilia-Romagna, Toscana, Latium, Sicily

<table>
<thead>
<tr>
<th>Organizations involved</th>
<th>Project lead partner: Emilia-Romagna region. Other partners: Tuscany; Latium; Sicily.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key features of the practice</td>
<td>European project promoted by the Emilia-Romagna region, which ran from January 2019 until February 2022, in cooperation with Tuscany, Latium and Sicily. It was co-financed by the Directorate General Integration and Community Care for Asylum and Refugees in Emergency. Its objective is to improve the procedure for accessing territorial health services for holders of, or applicants for, international protection, humanitarian permits and special cases, ensuring a homogeneous and systemic response to health needs. From March 2020, during the Covid-19 pandemic, ICARE extended the target group to all third-country citizens for prevention and Covid-related activities. Unlike the previous projects, which focused on the emergency health and health and social phase immediately after arrival, ICARE gives priority to the subsequent phases of the migration process, acting on the emergency experienced in the second-line reception and working on the integration of the target group in the health services. The project adopted a system approach and an intervention procedure shared by all the participating regions. The strategic deliverable is the creation of a model of integrated, multidisciplinary territorial care process for holders of and/or applicants for international protection, special and humanitarian cases, and unaccompanied foreign minors. This model is unique, can be replicated on a national scale, and reflects specific local contexts, in compliance with national guidelines. The group of experts involved in the project identified several priority areas for intervention among the various clinical health care pathways throughout the national territory, with the aim of ensuring fair health care. The 10 areas identified are:</td>
</tr>
</tbody>
</table>
Intervention level and services provided in accordance with IASC pyramid

<table>
<thead>
<tr>
<th>Intervention level and services provided in accordance with IASC pyramid</th>
<th>Level 1: Fulfilment of basic needs, including access to essential services, protection and security</th>
</tr>
</thead>
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<tr>
<td>• a clinical pathway for health care based on patient-centred learning organization (PCLO)¹⁰⁷ territorial outpatient clinics&lt;br&gt;• integrated health care at birth&lt;br&gt;• transcultural health care for voluntary termination of pregnancy&lt;br&gt;• transcultural health care for FGM and sexually transmitted diseases&lt;br&gt;• integrated health and social care for women victims of trafficking and exploitation&lt;br&gt;• health care for women victims of sexual abuse and violence&lt;br&gt;• mental health pathways for refugees who are victims of traumatic violence&lt;br&gt;• medical and legal certification for the right to asylum&lt;br&gt;• follow-up of non-European Union minors born in risky conditions&lt;br&gt;• Covid-19 vaccination pathway</td>
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<td>The Covid-19 pandemic, whose outbreak occurred exactly one year after the start of the project, in the central phase of the project, represented a major challenge for health organizations and, therefore, for the project itself. Through a pro-active approach, measures were implemented to overcome the obstacles, turning a difficult situation into an opportunity for the services involved in the project. This took place through support for public health departments who were fighting the pandemic; the reprogramming and online conversion of workshops intended for the target population, with a special focus on practice dissemination to prevent infections (also through the support of intercultural mediation); the constant multilingual information disseminated to fight the pandemic; the intensification and development of synergies, where still not present, with the third sector; and the development of new working methods that allowed constant remote updating of all organizations involved in the project.</td>
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Level 3: Non-specialized focused services addressing the needs of an individual or a small group

| • Networks within and outside the company were developed and strengthened to establish workshops and psycho- |

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¹⁰⁷: Reference or note number

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unicef
| **Users reached** | Holders of or applicants for international protection and special cases; foreign minors including unaccompanied minors and third-country citizens. |
| **Professionals employed** | Health professionals, health and social professionals, linguistic and cultural mediators, social and third sector workers, psychologists, psychiatrists, neuropsychiatrists, GPs, gynaecologists, obstetricians, nurses, dieticians, hygienists, infectious disease specialists, social workers, sociologists, intercultural mediators. |
| **Inter-agency coordination and partnerships** | Regions and local health authorities and units; local health authorities; provincial health authorities; INMP (National institute for health, migration and poverty); and medical volunteer associations. |
| **User participation and involvement** | A culture-sensitive approach that systematizes the intervention models applied by specialized services in the areas of intervention. Multidisciplinary and multi-professional teams, including the support of linguistic and cultural mediation, have been set up in each health authority to provide services based on the real needs of the individual approaching the services. To contribute to the achievement of equal access (health for all), an outreach approach was developed, capable of reaching the target population in various locations (home or reception centres, makeshift accommodation). This was also achieved through mobile units and portable equipment purchased with project funds. |
| **Success factors** | • The project aimed to develop a reception and orientation model in health services and integrated multidisciplinary |
territorial care for holders of and/or applicants for international protection; special and humanitarian cases; and unaccompanied foreign minors. The model can be used at a national level, reflecting local specificities.

- Outreach actions in closed and informal communities.
- Acquisition of mobile project units.
- Definition of objectives for general managers in Emilia-Romagna.
- Establishment of a global migrant health centre in Trapani provincial health authority.
- Collaborations between departments and services (for example, community paediatricians and counselling centres) which enabled a holistic care of individuals.
**REGION: EMILIA-ROMAGNA, LATEX**

Name of practice: Here4U project - listening and support


Territories of intervention: Emilia-Romagna (on-the-spot interventions); remote intervention at national level

<table>
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<tr>
<th>Organizations involved</th>
<th>ARCI-UNICEF Regional Office for Europe and Central Asia, Approdi.</th>
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| **Key features of the practice** | Project for migrant and refugee children and youth in Italy, through the UNICEF platform [U-Report On The Move](https://www.facebook.com/UreportOnTheMove). The project, Here4U, mainly consists of remote interventions, and includes:

- Information on legal and administrative aspects of psychosocial well-being disseminated via the U-Report On The Move platform
- Orientation to available territorial services, including those for the achievement of social inclusion and individual autonomy
- Psychosocial support interventions, through the provision of clinical sessions by psychologists and psychotherapists

Young migrants are supported to produce video, audio and narrative materials for their peers to discuss issues related to mental well-being, self-care, seeking help and available services. They use accessible language that is sensitive to age, gender and cultural variations. The aim is to raise awareness among young people and foster a positive approach to issues that are often stigmatized.

The service is provided in the dedicated chat on the Facebook and Telegram pages of U-Report On The Move. By sending a message on Facebook Messenger, U-Reporters will be connected with psychosocial well-being professionals and will have a dedicated tele-session when necessary.

The psychosocial and mental health component of the service is run by the Approdi association, and is provided by a multidisciplinary team composed of psychologists, psychotherapists, psychiatrists, doctors, anthropologists and educators, affiliated to the Arci Committee of Bologna.

After an initial informative session, a support process can
be started with a psychotherapist, who will meet the client in person, if he/she is in the same territory, or remotely by phone/video call. The intervention consists of three modules, that can be repeated. Psychological support is accompanied by a legal support service; orientation and support for the bureaucratic procedures related to legal issues; facilitation of access to different types of services (psychosocial, housing, etc.) and supporting unaccompanied foreign adolescents and minors towards autonomy.

MHPSS services promoted by Here4U do not aim to replace public services specialized in the treatment of mental distress. Here4U manages to identify needs thanks to the easy access to the platform and the possibility of remaining anonymous when requesting help. The intake occurs when a migrant or refugee boy or girl cannot access the necessary service in their territory because it is not available or is considered ineffective. All interventions will be supported by a network of linguistic and cultural mediators to enable migrants to receive information and speak in their mother tongue.

| Users reached | Unaccompanied minors and young migrants and refugees up to the age of 24. |
| Professionals employed | Psychotherapists, psychologists, psychiatrists, doctors, specialized workers, cultural and linguistic mediators, lawyers. |
| Services provided | **Level 1: Fulfilment of basic needs, including access to essential services, protection and security**
  - Remote coordination between the individual and the service for the joint construction of the next steps.
  - Production of sensitization digital products on MHPSS, with the constant engagement of young migrant and refugees.
  - Joint assessment of the client’s needs, resources and expectations.
  - Mapping and research of local services that can help and guide the client in his/her plans (e.g. Arci local groups, minority communities, volunteer networks).
  - Referral and case monitoring.
**Level 3: Non-specialized focused services addressing the needs of an individual or a small group**
  - Remote research and coordination with the services that best fulfil the individual’s specific needs. |
**Inter-agency coordination and partnerships**

- Joint assessment of the individual’s needs, resources and expectations.
- Research about local reference professionals (such as social workers and social services) or services that can be accessed remotely (for example, the network of Approdi association volunteers with specific skills).
- Remote coordination between the user and the service for the joint construction of the next steps.

**Level 4: Clinical services and specialized care**

Integrated psychosocial support based on a complex intervention methodology structured in three phases (after the diagnostic phase):

- **Phase 1**: stabilization, reducing the state of alert and increasing the sense of security concerning emotions and thoughts, relationships and places
- **Phase 2**: narration
- **Phase 3**: rehabilitation with the aim of giving continuity to one’s story

The service provider can connect with other relevant actors as needed.

**User participation and involvement**

Efforts to listen, counsel and actively involve people are significant and regular. The process is always jointly constructed with the users and is based on the principles of cultural and gender sensitivity.

The U-Report platform fosters new U-Reporters, followed by the Here4U project which gives voice to issues concerning users and their communities.

**Success factors**

- Here4U ensures a specific psychosocial support service for all those conditions known as acute suffering: i.e. traumatic experience, repeated or prolonged, suffered in a coercion regime or inability to flee.
- Here4U allows for the activation and construction of community care through a network of territorial services and in partnership with the toll-free number for asylum seekers and refugees.
- Here4U promotes the construction of a social support network in the territory as well as cooperation with the existing network of services.
• Here4U gives voice to refugees and migrants through the U-Report On The Move platform, allowing them to contribute, to empower, inform and connect young people from all over the world by engaging them in talking about issues that directly affect boys and girls (i.e. Infopills, Activate Talk, etc.).
As concerns the territorial coverage, most mapped interventions provide services at an urban/metropolitan level, with the sole exception of two interventions: START.ER in Emilia-Romagna and Silver in Sicily cover, or have covered, the entire regional territory. One intervention (ICARE) covers the territories of four regions, and another (HERE4U), provided remotely, operated at national level.

Four of the identified practices (FARO, AL HIMAYA, Centro PENC, Centro Frantz Fanon) are conceived, promoted and coordinated by civil society organizations in coordination with social services and local health services. One practice (HERE4U) is conceived, promoted and coordinated by UNICEF and implemented by civil society organizations. Another practice is coordinated by a prefecture (SAMMI), and seven practices are coordinated by local health services working in collaboration or in formal partnership with the reception system and territorial social services. Eight practices out of 13 are structurally supported by the 2014-2020 AMIF programme.

The mapped practices have been examined carefully, analysing in particular the logic of intervention and the factors that facilitate or limit access to services. Our study of the practices involved the voices and experiences of professionals working in MHPSS services, and the boys and girls who use them. This analysis was combined with a study of the success factors of the practices and an examination of challenges affecting MHPSS services and the coordination mechanisms between these and the reception system.

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103 Among the aims of the SAMMI project is “the strengthening of existing territorial networks and their workers, within a general strengthening of governance and, through the experimentation of new methods and pathways, the improvement of the operational management of complex cases and of the synergy between health and health-and-social services”. More specifically, the precise objective of the project is the creation of skills updating and training processes, operations and models, aimed at the development of psycho-health and social pathways and the identification of local synergies among territorial actors involved in the reception of migrants. The operation aims to strengthen competences in the management of vulnerabilities and in the definition of the related care pathways through case analysis. Another objective is to systematize the results of the experimentation and to structure care pathways for psycho-sanitary and social vulnerabilities. Specifically, the training course, characterized by a ‘field-based’ methodology, involves theoretical and applied learning and related experimentation, in a ‘learning-by-doing’ approach, using tools such as the Assessment of Abilities, Definition of Objectives (VADO) and the Health of the Nation Outcome Scales (HoNOS) – both of which are informant reports and are filled out through a discussion/interview between the researcher and the workers in charge of the case.

104 To provide an example of the type of interventions for the early detection of vulnerability, a shared experience at the regional level of all the working groups may be reported, which pays particular attention to the analysis of the needs represented by the reception teams, providing tools for a transversal reading of the needs represented, in order to provide guidance on possible interventions and to refer the users to the competent territorial services. The work is therefore carried out both in the cultural dimension, through the use of a multidisciplinary team capable of offering culturally-oriented support for the users and for the complementary healthcare system as well as the structural competence of the services.

105 The long list is not currently active, it will be launched as part of the AMIF project ‘Building capacities for Sicily.’


107 A patient-centred learning organization (PCLO) involves working in a multidisciplinary team to understand and treat the patient from a global perspective, developing individual and comprehensive care plans in which physical health, mental health and social needs receive as much attention as traditional medical care. Working in a PCLO, professionals implement their skills and knowledge on a daily basis by caring for users who often suffer from distress and pathologies not widely known in the western world. In carrying out their specific and complementary functions, the professionals in the multidisciplinary team constantly support users, preventing them from moving from one service to another, and ensuring that their physical and psychosocial health are fully taken care of.

108 The 2014-2020 Fund for Asylum, Migration and Integration (AMIF) was established by EU Regulation No. 516/2014 with the aim of promoting an integrated management of migration flows. The AMIF National Programme (NP) is the programme document drawn up by Italy to define the strategic and operating objectives, as well as the interventions to be implemented with the available budget. The Responsible Authority of the Fund is the public body of the involved Member State, responsible for the correct implementation of the NP. In Italy, the Responsible Authority is the Department for Civil Liberties and Immigration of the Ministry of the Interior. See www.interno.gov.it/sites/default/files/2021-10/fami_db_progetti_rev_01.10.2021.pdf
Chapter 5
Success factors of the practices and challenges for the MHPSS system
The mapped practices were analysed according to the criteria outlined in chapter 2. Research and discussions with representatives revealed that the practices differ significantly in terms of the services they provide, the disciplinary approach they are inspired by, and the network models they adopt. However, five main shared success factors contribute to make the practices successful and replicable:

**SUCCESS FACTOR 1:** Ability to tailor services to effectively respond to the mental health and psychosocial needs of migrant and refugee adolescents and youth

**SUCCESS FACTOR 2:** Multidisciplinary teams working in the reception system and in local social and health-care services to guarantee continuity of care and integrated case management

**SUCCESS FACTOR 3:** Provision of culture-sensitive case management, based on the integration of transcultural/ethnoclinical/ethnopsychiatric paradigms, and cultural and linguistic mediation services

**SUCCESS FACTOR 4:** Permanent efforts to improve the capacity of the reception system, and local social and health services through capacity-building programmes and awareness-raising campaigns

**SUCCESS FACTOR 5:** Establishment of networks and multi-stakeholder coordination mechanisms involving the reception system, and local social and health services
5.1 The distinctive features of the practices analysed: what works, how and why?

SUCCESS FACTOR 1: Ability to tailor services to effectively respond to the mental health and psychosocial needs of migrant and refugee adolescents and youth

Supporting individual well-being is far from a linear process and requires an overall assessment of specific needs. ‘Need’ implies the lack or imbalance of one of the many aspects of well-being\(^\text{109}\), which is, as explained in chapter 1, multidimensional. The complexity of needs lies both in their multidimensionality and intensity: the deeper the lack or frustration, the more compromised the overall state of well-being will be. Along with other elements, the intensity of an unmet need may be a determining factor in the activation of specialized services.

The multidimensional needs of UASC and young migrants and refugees are linked to the ‘triple transition’ they experience:

“The transition from adolescence into adulthood, typical of the human developmental process; the transition associated with migration, that entails the separation from their context of origin and the need to build a new life in a different cultural and social context; finally, the transition related to overcoming traumas experienced before, during or after the migration journey, that triggers resilience factors and fosters a new sensation of well-being.”\(^\text{110}\)

Interviewed professionals frequently referred to intense vulnerabilities in the migrant and refugee children who have arrived in Italy over the last two years. The worsening situation is due both to the deteriorating living and safety conditions in many countries of origin, and to physical and psychosocial suffering along the migration route, particularly in Libya – the main country of transit for young migrants arriving in Europe\(^\text{111}\), and along the Balkan route (Save the Children, 2020; AGIA, 2020), where unaccompanied migrant and refugee children are increasingly travelling.

Some of the migrant and refugee children we met struggled to talk about the hardships, suffering, violence and abuse they experienced or witnessed in Libya

“We all went through Libya. All of us. When we go away from Libya, you know what we have suffered! You know that Libya is a hard place for migrants! When they (Libyans) see Africans with black skin, they think that we are slaves.”

(A., 16, Côte d’Ivoire, Emilia-Romagna)

When some migrant and refugee children talked about Libya, they stared into the void, with broken sentences and long silences. This inability to talk about their past is attributable to the unspeakable experiences and the intense, overwhelming, and disturbing emotions they lived. Often the emotional experiences not worked through remain frozen in our psyche, proving an underlying trauma (Biggeri, Ciani, 2021). This process has been extensively investigated in the literature and well summarized by Pasquarelli (2018:126):

“Trauma blocks, blinds, locks, for defensive purposes, in an attempt to avoid reality, dissociating the psyche to preserve it from the traumatic experience.”

Only in three cases were migrant and refugee children able to talk about their experience of migration and detention in Libya, expressing their urgent need for emotional support:
B., 17, Gambia, Emilia-Romagna: “When we arrive here, we need someone to talk to, to pour out our problems. They don’t say how. But it’s obvious that we need a psychologist. We come here with our head exploding, and there is nobody to help you. I’ll give an example: he has been here for one year (he points to a friend). He has never seen the psychologist and he has many things in his head. You know, after Libya... What happens in Libya cannot be told... I saw shootings, I was in jail, I was stabbed. When we arrive here, we don’t have any chances to explain, to feel better because the psychologist is not there.”

Interviewer: And do you need psychological support?
B.: “I certainly need it, so I can relax a little, I can talk, tell someone the things I have in my head.”

Addressing past painful experience and the psychological stress that migrant and refugee youth face to adapt to the new context and to decode new cultural models is one of the main challenges for the practices analysed. The migrant and refugee boys and girls met during the research experienced different migration stories and journeys. Viewing all UASC as a homogeneous group risk not only underestimating relevant individual circumstances, but also designing standardized psychosocial support that may not be useful for all UASC.

How can we ensure, therefore, the ability to respond to the needs of migrant and refugee boys and girls? What are the principles that can be used as a basis for interventions? Understanding the needs and adapting the response to such heterogeneous experiences requires specific skills.

The mapped practices encompass considerable skills, professionals and methodological approaches for interpreting and addressing young refugees and migrants’ complex needs and intense emotional suffering, as witnessed by the quotes at the beginning of this chapter.

These practices emphasize active and empathic listening and use multidisciplinary technical expertise (including psychology, pedagogy, cross-cultural and gender-oriented approaches, and linguistic and cultural mediation) that enable the early identification and holistic assessment of needs, as well as the planning of interventions based on the continuum of care. They have also adapted specific skills in the design of interventions that combine different settings (e.g. group/individual support, specialized/non-specialized support), in order to enhance and capitalize on clients’ resources and support all dimensions of well-being, through multidisciplinary and integrated interventions.

Box 8 - Understanding the needs and supporting the psychosocial well-being of UASC: prevention, support and care activities

The needs of migrant and refugee boys and girls are not always expressed in ways that can be easily decoded by reception centres workers or by other carers. It is often necessary to help them giving a meaning to their experiences. Supporting needs and psychosocial well-being is based on two types of intervention:

1 Prevention interventions, aimed at strengthening psychosocial well-being and enhancing
individual and environmental resources that support and facilitate the ability to effectively manage developmental challenges and adaptive processes. This category includes all those services aimed at improving individual competences and strengths (at the level of cognitive-intellectual, emotional-relational skills, etc.), and promoting social connections of trust and support (among peers, family members, with adult key carers, etc.). The methodological approach that places migrant and refugee adolescents and youth at the centre of the intervention and encourages their active participation in a systematic way is a good practice, as it creates the necessary conditions for individuals to feel like co-creators of change, increasing their self-awareness, self-efficacy and autonomy. Activities designed to support and enhance psychosocial well-being also contribute to improving the child’s ability to cope with difficult situations, emotional distress and suffering. In that sense, they strengthen resilience and are considered as protective factors in maintaining well-being and mental health. UASC should always be able to access this service throughout their integration and inclusion pathway, according to their individual needs.

2 Support and care interventions. These interventions are provided in response to emotional distress, psychological suffering, or - in more serious cases - psychological disorder or psychopathology. Emotional distress can take a variety of forms, not always easily recognizable, and can sometimes hide behind behaviour that seem to communicate conflicting messages. Professionals such as educators, community coordinators, social workers, psychologists, etc. and other possible key carers of UASC (such as voluntary guardians, foster families, teachers or tutors of apprenticeships, sports coaches or animators in social-recreational centres, etc.) should master the tools necessary to interpret the child’s behaviour and promptly identify signs of suffering and possible emotional distress. These signs of distress, when promptly identified and addressed with the appropriate support, can be managed and overcome through interventions at levels 2 and 3 of the MHPSS pyramid (and therefore without the need of clinical professionals and specialized interventions). Sometimes, using active and empathic listening at the first signs of discomfort, and helping migrant and refugee children to strengthen their own network of trust and go ahead with their projects, is a precondition to enable UASC to overcome difficulties independently. Moreover, the inability or ineffectiveness of the reception system to respond to signs of distress and suffering can negatively affect well-being and exacerbate vulnerability.

An extensive literature review of socio-psycho-educational interventions in complex contexts with vulnerable individuals highlights the need to focus on individual peculiarities, needs and expectations (Accorinti 2013, Scivoletto 2012, Saglietti 2012, De Michiel 2020, Long 2018). These considerations are echoed in the observations on response strategies made by an educator:

“We address a wide range of needs, depending on the individual. In general, the main need is for acceptance and security. In most cases, young migrants and refugees who arrive here after troubled experiences need to find a place to live and a network that makes them feel welcomed and protected. I would say that the underlying need is that of acquiring tools allowing UASC to
understand the new social context and create a network of peers and other people - friends or institutional actors - with whom they can then interact throughout their life and particularly after the conclusion of a project."

(C., educator, Piedmont)

Overall, the identified practices showed competence in ensuring an adequate response to the specific background of UASC, recognizing their individual differences and uniqueness.

This approach was reflected in the constant attention given to the psycho-socio-educational dimension throughout the whole process of case management. Reception centre workers and external service providers analysed experiences and observed behaviours according to a social ecological approach (see chapter 1) This approach provides for the collection, analysis and sharing of information with all the actors involved in the integrated care of young refugees and migrants. This allows a targeted observation, aimed at defining and determining whether referral to specialized public or private services might be needed.

The emphasis on the multidimensionality of needs and the uniqueness of each UASC is a cross-cutting feature of all the practices identified and was highlighted by the professionals interviewed:

“Needs are never only health, mental or psychological, but they are a complex system.”

(C., psychiatrist, Sicily)

The complexity and multidimensionality of the needs requires a response model that involves collaboration and cooperation between the different actors/professionals operating within the territory. All the practices analysed have a leading role in the municipal and/or regional welfare system aimed at providing ‘psycho-socio-health protection’ interventions, including guidance and psychosocial support to foster the social inclusion and socioeconomic integration of children.

This method, which is also provided for by the Ministerial Decree regulating the reception facilities within the SAI\(^2\), is based on the assumption that ‘the provision of MHPSS services to people with special vulnerabilities or needs adds complexity to the analysis of needs, emerging distress, building of a relationship of trust, and requires a strengthening of networking with public and private local services and with external professionals and experts supporting the provision of care and promoting rehabilitation and reintegration processes’ (SIPROIMI, 2020:52). In all the regions studied, the main factor explaining the success of the response capacity of the selected practices lies in cooperation between the reception and social and health services.

As regards methodology, all practices, even those provided by specialized mental health services, show a constant attention to individualized interventions for preventing psychological suffering. They are built by enhancing community and local networks, focused on the migrant and refugee child as an individual with social, relational and psychological needs and as a right holder, not as a passive user to be institutionalized.

This attention to the expectations of migrant and refugee boys and girls pervades all the practices studied. Strengthening positive ways of coping and resilience are shared goals in the interviews with professionals. This attention is particularly evident also in specialized mental health services. The practices led by the local health agencies use a multi-layered community-based model of psychological health, which supports individuals, their communities and the territories where they live.
The research carried out in six regions showed how the **integrated and community-based approach** - the type of intervention “centred on the active involvement of local community actors to allow the mobilization of their resources and competences to implement services and activities designed to respond more efficiently and effectively to the specific needs of the context” (Bova et al., 2014: 107) - also applies in the specialized services established to support host communities, in low thresholds, youth centres and in training contexts.

Where young people are guided, through group activities, exercises and games, to develop their emotional, cognitive, psychomotor and social skills, they can get to know themselves and their emotions better, collaborate with others, identify the best strategies for dealing with challenges, identify challenges in advance and develop solidarity and social responsibility behaviours.

In Milan, interviewees explained the integrated, community-based approach:

“I have to say that both the neuropsychiatrist and the psychologists of UONPIA are key actors.”
(C., educator, Lombardy)

“NPIA (Child and Adolescent Neuropsychiatric Services) play a liaison role that should be the responsibility of the local authority, the municipality (...), which deserves a lot of credit for many aspects concerning unaccompanied foreign minors, but has always struggled to think in terms of management, of intentional building of a network of all the partners involved in the reception system. This was a neglected issue that NPIA (Child and Adolescent Neuropsychiatric Services) took on, also because of the strong need that led to the development of the programme about UASC.”
(D., psychologist, Lombardy)
Focus: MHPSS services for unaccompanied and separated girls and migrant and refugee young girls

The focus groups and interviews mainly concentrated on the psychosocial support provided to UASC and young refugees and migrants in second-line reception services.

However, some of the issues that emerged from the interviews with migrant girls and the professionals working with them require further consideration, as they help to illustrate the specific needs of this group of users, and the gender-differentiated response strategies implemented by some of the selected practices.

In Italy, girls represent a tiny proportion of the UASC hosted in the reception system. As of 31 December 2021, according to data provided by the Ministry of Labour and Social Policies, girls accounted for only 2.7 per cent of the total population of UASC living in Italy. Unlike the boys, who tend to be close to the age of majority, the girls fall into different age groups: 38.2 per cent of the girls are 17 years old, 23.1 per cent are 16 years old, 24 per cent are under 14 years old and 11.7 per cent are 15 years old. In the first six months of 2021, there was a significant increase in the number of unaccompanied girls from Côte d’Ivoire and Guinea.

Behind the numbers, the stories of the girls interviewed within UNICEF research and programmes tell of the constant exposure to specific risk factors during the migration journey (Pasian and Toffanin, 2018; Hadjicharalambous, Parlalis 2021, Ortensi 2019). Gender-based violence against girls and women on migration routes, for example, is a chronic and pervasive phenomenon that is widely documented (IFRC 2018). Although all migration routes are dangerous, the central Mediterranean route presents particular critical issues (UNICEF, IOM 2018).

An approach based on intersectionality (Crenshaw 1990; Bello 2020) helps to consider gender-based violence not as a category in itself, but as a component that interacts with other forms of violence and multiple discrimination. Women who are victims of violence, trafficking for sexual exploitation or degrading sexual abuse and treatment often experience severe difficulties from an economic, social and cultural perspective (Rigo, 2016). The girls and women often face different forms of subordination, discrimination and violence based on multiple components of their identity, including gender, ethnicity, religion, legal status and age (UNICEF, Washington University in St. Louis 2022).

Uncertainty about their future, loneliness and frustration are some of the feelings recurring in the interviews with young women, who were all between 17 and 21 years old, had arrived in Italy through the central Mediterranean route or humanitarian corridors, and had received support through the programme for social assistance and integration of victims of trafficking, or the SAI. Beyond the specific migration paths and projects, the stories of these girls offer an insight into the psychosocial support services provided inside and outside the reception system, which seem to be less tailored to the needs.
of female users. In particular, the shortage of professionals who can support the processing of experiences of gender-based violence, and to plan individualized care paths within the reception system, means that, in some cases, the reception system simply provides standardized services and is unable to respond to individual experiences from a gender perspective.

This situation can cause further violence against female users, who are expected to uncritically adhere to rules and structures of reception that are not in line with their ambitions and expectations.

Yet, in general, the migrant and refugee girls interviewed did not show uncertainty about their life plans, which have been blocked or hindered by some criticalities of the reception system and the difficulty in providing gender-sensitive interventions.

“I want to go to school! In addition to the internship, I would like to go to school, to learn a trade.”
(F., 20, Somalia, Latium)

A common feature of young migrants and refugees’ stories is the desire to overcome the violence and the traumatic experiences they suffered, and to look to the future (UNICEF, IOM, 2015).

“What’s past is past. Let’s talk about now. I have no answers. What’s past is past. There’s no need to tell of my past. I don’t look back, I’ll look forward.”
(F. 20, Somalia, Latium)

Outside the reception system, several psychosocial support services have been provided to meet the specific needs of these users.

The mapping of practices, for example, showed that in all the regions studied there are local services that pay special attention to gender and to survivors of gender-based violence.

Among these, Centro PENC in Palermo deserves a closer look. It is the first service in Italy to establish a Women and Girls Safe Space (WGSS), a pilot initiative supported by UNICEF and the Ombudsman for Children and Adolescents of the Municipality of Palermo. The WGSS, based on a model of intervention already tested by UNICEF in other humanitarian contexts (UNFPA 2015), provides migrant and refugee girls, women and their children a safe space where they can freely talk about psychological distress, domestic violence, improve their psychosocial well-being, and strengthen their skills and resources. During the time in the space, women and girls can engage in recreational activities that encourage sharing, self-confidence, trust and have a positive impact on their psychosocial well-being. The activities offered include: a tailoring course, hairdressing, yoga, cooking, Italian and dance classes. The WGSS also offers training and information about the right to housing (finding a first home or renting), mother-and-child health, legal advice, and psychosocial counselling. Every
week, using a participatory methodology and in cooperation with the centre staff, women and girls invite external experts, or representatives of services, associations or organizations to address the group. Within the WGSS, there is also an area for children’s activities, run by professional educators, to enable women to access services for/with their children. Access to the WGSS is free, and migrant women and girls can invite their family members and friends. It is also open to Italian women and girls.

In Rome, Centro SAMIFO, a regional health facility that provides care to asylum seekers and beneficiaries of international protection, is promoted by the local health authority Roma 1. This facility has carried out regular interventions aimed at increasing women’s awareness on FGM, through discussions and by involving the community in which women live. The training sessions were attended by an anthropologist, a linguistic and cultural mediator, a facilitator, a social worker, a doctor, and about 20 women for each group of origin.117

A protocol has been developed for managing deinfibulation surgery for grade III victims of FGM. The aim is to recover the physiological functioning of the external genitalia, reduce the consequences on women’s psycho-physical and reproductive health, and restore the function of the vaginal canal for childbirth. The project represents a natural evolution of previous activity in this area, foreseeing to offer patients also surgical-reparative assistance thanks to collaboration with the hospital in a perspective of territorial proximity between the obstetrician-gynaecological clinic of SAMIFO and the obstetrics and gynaecology department of the San Filippo Neri hospital.

Regardless of the method of referral, the evaluation of FGM is carried out by the SAMIFO obstetrician-gynaecological clinic, which verifies the typology of FGM and the necessary treatment path.

Three different pathways have been designed for women with severe FGM, as follows:
1. FGM in pregnant patients
2. FGM in non-pregnant patients with mainly physical symptoms
3. FGM in non-pregnant patients without major physical symptoms but who experience psycho-sexual discomfort

Another example of gender-sensitive interventions is the practice promoted by the GIADA project at the Giovanni XXIII Children’s Hospital in Bari. The GIADA project has structured a specific care pathway for girls who are victims of FGM, inspired by the Guidelines for Early Recognition of FGM or other harmful practices, issued by the presidency of the Council of Ministers - Department for Equal Opportunities (2017).

The care pathway is managed by a multidisciplinary team consisting of a paediatrician, gynaecologist/surgeon, nurse, psychologist, medical examiner and social worker. It recommends the involvement of a case manager, entrusted by a psychologist and/or a social worker, who can provide reception, counselling, guidance and support.
During the reception phase, the team ensures confidentiality, and offers a safe and private space, listening in a non-judgmental manner, with female staff and a linguistic and cultural mediator. With the help of a linguistic and cultural mediator, information is provided on all the steps of the procedure, in order to obtain informed consent and to provide appropriate knowledge about the medical examinations. Girls are asked if they want their parents/educators to stay with them or if they prefer to undergo the procedure alone.

The diagnostic and therapeutic process continues with a specialist consultation. Where possible, this takes place around the same time as the initial reception, to avoid subjecting these vulnerable girls and women to secondary trauma.
SUCCESS FACTOR 2: Multidisciplinary teams working in the reception system and in local social and health-care services guarantee the continuum of care and integrated case management

The second success factor focuses on the operational arrangements of the multidisciplinary teams in the mapped practices.

The methodological framework of the interventions delivered within the practices analysed is based on multidisciplinary teams. Many of the professionals interviewed explained how the creation of multidisciplinary teams arose from the need to avoid standardized and routine responses to the complex and multidimensional needs they have had to face over the years, when the number of UASC increased significantly.

According to some interviewees, the use of multidisciplinary teams partly stems from the identification and analysis of the critical issues and failures that characterized the first interventions with migrant children. Self-analysis and the ability to question previous work and structural weaknesses led to the design of an integrated response, based on experience and expertise developed on the ground.

For this report, the analysis focuses mainly on the professional and organizational dimension. Who are the professionals working in multidisciplinary teams? How do they work in collaboration? Which external actors deal with the teams, and how?

The multidisciplinary teams of the 13 practices

<table>
<thead>
<tr>
<th>PRACTICE</th>
<th>PROFESSIONALS WORKING IN THE MULTIDISCIPLINARY TEAMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Centre Frantz Fanon (Piedmont)</td>
<td>Psychologists, psychiatrists, linguistic and cultural mediators, educators, cultural anthropologists, child neuropsychiatrists</td>
</tr>
<tr>
<td>2 SAMMI – Migrants’ Mental Health (Piedmont)</td>
<td>Physicians, psychiatrists, neuropsychiatrists, psychologists, nurses, educators, linguistic and cultural mediators and social workers</td>
</tr>
<tr>
<td>3 UONPIA - Fondazione IRCCS Cà Granda Ospedale Maggiore Policlinico (Lombardy)</td>
<td>Psychologist, child neuropsychiatrist, linguistic and cultural mediator, professional educators, social worker</td>
</tr>
<tr>
<td>4 Start.ER (health protection and reception of applicants and beneficiaries of international protection in Emilia-Romagna)</td>
<td>Psychiatrists, psychologists, cultural anthropologists, physicians, child neuropsychiatrists, social workers, linguistic and cultural mediators, nurses, psychiatric rehabilitation technicians, specialists in various fields</td>
</tr>
<tr>
<td></td>
<td>Organization/Program</td>
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<td>---------------------------------------------------------</td>
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<tr>
<td>5</td>
<td>SAMIFO (Latium)</td>
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<tr>
<td>6</td>
<td>Centro PENC- Anthropology and Geoclinical Psychology (Sicily)</td>
</tr>
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<td>7</td>
<td>Silver (Sicily)</td>
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<tr>
<td>8</td>
<td>ASP Catania, Cross-cultural Psychiatry Clinic (Sicily)</td>
</tr>
<tr>
<td>9</td>
<td>FARO (Sicily)</td>
</tr>
<tr>
<td>10</td>
<td>AL HIMAYA – Free from violence. Multi-action programme for strengthening and qualifying the response to violence against foreign minors in Catania, Messina, Palermo, Ragusa (Sicily)</td>
</tr>
<tr>
<td>11</td>
<td>Team GIADA - Giovanni XXIII Children’s Hospital - Bari (Puglia)</td>
</tr>
<tr>
<td>12</td>
<td>Project ICARE Emilia-Romagna, Latium, Tuscany, (Sicily)</td>
</tr>
<tr>
<td>13</td>
<td>Here4U (National)</td>
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</tbody>
</table>
As shown in the table above, the teams consist of different professionals, and therefore, multiple operating methods regulate their activities.

Certain groups of professionals operate in all the practices mapped, while others appear only in some areas.

Psychologists, child neuropsychiatrists and linguistic and cultural mediators can be found in most of the intervention models, even though linguistic and cultural mediators are used mainly on an ad hoc basis, as required.

On the other hand, more specialized clinical/health professionals, such as psychiatrists, psychiatric rehabilitation technicians and neuropsychomotor technicians, tend to be employed mainly in services provided by or coordinated by public health services.

We found more limited, patchy involvement of other professionals, including social workers, educators, anthropologists, and trainers. Seven of the 13 practices employ professionals working in an ethno-psychological/psychiatric paradigm, while four employ anthropologists. In some cases, practices make occasional use of professionals with legal expertise, who are employed both to support services and to provide training within projects.

Overall, the multidisciplinary teams use an integrated MHPSS approach, oriented towards the provision of interdisciplinary, multidimensional and intercultural care and individual support pathways. They are attentive to the complexity of migrant users’ physical, psychic and social suffering.

All the professionals interviewed described teamwork and multidisciplinary collaboration as the two essential conditions for building a meaningful relationship, to be started in the
early stages. However, **the multidisciplinary teams in the various practices do not all employ the same organizational approach or operating methods**. Instead, they share the fundamental need, as expressed by one interviewee, to "put together more views and more knowledge" (A., educator, Sicily), bringing together different disciplinary approaches to support decisions on the integrated care of UASC.

Interviewees reported that sharing knowledge was a necessary way to understand the specific multidimensional needs of UASC, and to develop projects and care plans (when necessary) that are appropriate for the experiences, needs and expectations of UASC. However, several respondents reported some difficulties due to the daily alignment to the lack of a common language among professionals with different backgrounds.

Coordination between social workers and health workers within the same team can be challenging on a practical level, due to their unequal roles or the rigid organization and bureaucracy in different working contexts. The professionals interviewed described guidance and team meetings as two key tools for developing a shared approach and for addressing any problems arising from the interaction between different disciplinary perspectives. Most of the practices require team members to be under the guidance of a psychologist, who can support the professionals’ own emotions and their ability to investigate the users’ psychosocial needs. In some cases, the guidance provided was designed both to promote discussion of the cases managed by the team, for a shared and effective needs assessment, and as an opportunity to explore the challenges that professionals themselves face. Regular meetings are held to discuss and compare operating decisions concerning UASC, and also to collectively discuss organizational issues and challenges.

The teams’ internal organization may also vary. In the practices coordinated by civil society actors, internal interactions seem to be organized mainly according to ad hoc daily needs.

"*We do not have defined roles. We all do everything. From the clinical point of view, professionals do not support exclusively families, children or so on.*"  
(R., psychologist, Piedmont)

Generally, it is the professionals providing psychosocial support services inside the reception centre who involve external professionals, based on observations of users.

"*One of our strengths is the ability to know how to engage with UASC. There is constant dialogue within the team to gather information about the youth, to explore their problems or any concerns we may have.*"  
(G., educator, Sicily)

This feeds the perception that those who work in the psychosocial field play a facilitating role, acting as an intermediary between the needs of users and the professionals providing specialized care.

The research found that, in some areas (Turin, Milan, Bologna, Rome, Bari, in particular), an effective dialogue has been achieved between the practices and local health and social services. All the multidisciplinary teams within the practices play a key role at a territorial level in identifying and addressing the needs and vulnerabilities of migrants and refugees, in collaboration with local social services. In some cases, they play a crucial role in providing and facilitating access to specialized services. In this regard, **memorandums of understanding**
between the local social services and the health districts, proved useful in defining the role of each authority, making connections between the professionals involved, and organizing working groups involving all the relevant actors.

Some of the practices mapped also collaborate with the local services designed to prevent and support psychological suffering, for example, through providing information and access to local services, teaching Italian language and educational activities, vocational training and job placement, legal advice, and psychosocial and health protection.

In these areas of intervention, the practices follow the model of ‘integrated reception’, as described in the regulatory framework that governs reception standards for UASC. They also use an innovative way of adapting prevention psychosocial interventions within the territorial network.

“As far as our intervention is concerned, we also have a great connection with the team dealing with guidance, training and work, so that we basically worked in collaboration with the colleagues responsible for the implementation of workshops and internship for training purposes. Therefore, all these projects are job-oriented, and offer remuneration – a fundamental aspect especially for those who come here with the mandate to contribute to a complex situation in the country of origin."

(I., psychologist, Emilia-Romagna)
The vulnerability of UASC and their need for protection means it is necessary to plan services that are provided by a broad network of public and civil society actors at territorial level. The practices we studied are an integral part of this network, right from the drafting of the IEP. They define each child’s individualized programme and the goals for inclusion and psychosocial well-being. In addition our research also showed that selected practices also supported host communities (for example, through the provision of multidisciplinary support services), investigated cases, and sought the child’s opinion in the drafting of the IEP through listening and participation.

In other words, the practices observed integrate and strengthen the initial assessment by reception facilities and provide technical
tools to interpret the expectations of migrant and refugee children, include them in the goals of the IEP, and actively involve them in defining their life plans.

The representatives of the selected practices reported quite structured forms of cooperation and dialogue with several key actors involved in the provision of care for UASC. These include actors both within the reception system and outside it. Their various roles in the provision of MHPSS services are analysed below.

Educators

Educators organize and manage educational and rehabilitation projects and services within health or socio-educational services, aimed at different types of users, including UASC. Educators "work in multidisciplinary teams, encouraging groups and individuals to pursue social reintegration by defining educational, care and health interventions that meet individual needs through the development of autonomy, individual skills and social relations with the external environment". In 2021, the Minister of Health, in agreement with the Minister of University and Research, issued a Ministerial Decree defining the profile and functions of socio-pedagogical professional educators as professionals who work "with regard to socio-educational matters, in social care, health-and-social and health services and facilities" in areas concerning "the pedagogical dimension of marginality, disability and deviance, [...] designing actions aimed at avoiding and, in any case, mitigating educational-relational problems and educational poverty. They also offer training paths and projects to promote individual and social well-being".

The educators interviewed, and those mentioned by other professionals and young refugees and migrants, work mainly in the socio-pedagogical services provided in reception facilities for UASC. Professionals and users of health-and-social and mental health services recognize the central role of educators, who work closely with migrant and refugee boys and girls. This means educators are in a good position to be able to share information about the evolution of individual cases with other professionals. Such information can be used to fine-tune the objectives initially planned within the care programme.

Educators have a unique insight into UASC experiences and needs and therefore several informants referred to their central role in developing the IEP and their ability and competence in understanding and conveying the needs, expectations, problems and resources of the migrant users.

In all regions, educators appear to have a highly versatile role. This multi-functionality is in some respects typical of front-line workers, whose responsibilities and functions are often determined by urgent and unpredictable situations.

Most of the young migrants and refugees interviewed considered educators as a key figure in the inclusion process, because they are able to understand the young people’s needs and requirements, and to guide them in learning personal skills independently.

The box below tells the story of L., a young adult in Lombardy, who feels that an educator was fundamental in helping him overcome the obstacles of entering the labour market.:
L.’s story: “I used to talk to the educators all the time”. When the support of educators helps to overcome worries.

L. is a boy from Kosovo, who arrived in Lombardy just before turning 18, in the middle of the COVID-19 pandemic. His plan is to work and help his family overcome financial difficulties. On his arrival in Italy, he was isolated in a quarantine facility for five long months.

“You know... I didn't like anything about — (the quarantine centre). Because I spent five months there, a very bad time for me, because I was in quarantine, I couldn’t go out, I always had to stay inside.”

Staying in the quarantine centre has been exhausting. L. was not kept informed about the reasons behind his quarantine and how long he had to stay at the centre. After five months, L. was finally transferred to a SAI second-line reception centre. This was the opportunity he had been waiting for many months. In the reception centre, L. saw the possibility of overcoming the frustration and suffering of the days spent in the quarantine facility. From the very beginning, he put himself in the game, asking to actively participate in the training activities organized by the reception centre, in collaboration with the municipality’s services.

“Here time goes by very well, I work, we play games, we watch television, we can go out...”.

L. is motivated, he wants to “build his future”, he wants to learn a job and work as soon as possible. He proudly recounts the challenges he faced when attending the vocational training course as an electrician, which was arranged through an agreement between the reception centre and the local job centre.

“The first month was a bit difficult, but after I’ve understood how it works, it became easier. At the beginning it was hard. When I came back to the reception centre, I used to say: 'I want to leave this job because it is too difficult!' But after a month, I felt a bit better, relaxed.”

L. discussed his uncertainties with the educators, who supported him and helped him to deal with the initial challenges.

“I used to talk to the educators all the time...Because they treat you like a son. Yes! Their advice helped me a lot. Now I don’t think about leaving my job. Now, when I am at work, I always look at the days going by, I want to go to work, I want to work, I want to work!”

Other professionals in the service network helped L. Among them, an Italian teacher played a crucial role.
“I didn’t have a professor; I had a teacher. I studied with her for three months, she helped me a lot! Thanks to her, I could get the A1 certificate in Italian!”

The support of his peers is important for L. and he asked them for advice about the project that he and the educators of the centre designed together:

“I listened to my friends’ opinions and then I put all their words together. The result is that I want to stay here!”

L. said that, after one month, he felt he was doing the right thing and he proudly shared some aspects of his work:

“It’s a job that requires a big mental effort, because you always have to remember the numbers, the colour of the cables, select the right cables, which tools you have to use, which ones you don’t have to use…you have to stay focused!”

He is proud of his work and when he goes back to the centre, he is very tired. Sometimes he doesn’t even have time to chat with his friends at the centre, but in the evening, he always remembers to make a phone call to his family to tell them how much he is learning. L. is aware that he can also be helpful to the other children at the reception centre, and when new refugees and migrants arrive, he supports them, offers advice and helps them to understand Italian.

“I like the youth who come here for the first time. They don’t know Italian, but if you speak Italian with them it’s a good thing. They don’t know what you are saying, but you try to help them!”

Whether or not young migrants and refugees build a relationship with educators seems to depend on the way they work and on their personality. The ability to listen, and show empathy, respect and patience are some of the features that young migrants and refugees consider essential to build a relationship of trust. However, these characteristics cannot be found everywhere. A., for example, described a range of approaches among the educators he met:

“The first thing the educator has to do... he has to be patient. And then, he has to be kind and willing to listen to the young refugees and migrants. Some of them, when you go to talk to them, are really in a hurry to chase you away, they get tired of listening to us! Do you get what I mean? And you feel that they don’t want to listen to you. But some educators, when they are in front of you, they look at you like a monument, they listen to you, it’s beautiful! And then they tell you everything to make you understand, to explain where you went wrong.”
(M., 18, Côte d’Ivoire, Piedmont)

Interviewer: “Did the educators help you when you felt discouraged or sad?”
N. (20, Nigeria, Latium): “Yes, but that’s not all. Every person is different, let’s say.
You are fine in this part, and in this part, you are not fine.”

The effort to qualify the care relationship with migrant and refugee adolescents with complex backgrounds is described by an educator of a reception centre for girls as ‘warm care’:

“Almost all girls, on their arrival at our reception centre, undergo a period of regression, during which they express all those aspects of their personality, even childish ones, that they were not able express in Africa. They become moody, difficult, angry adolescents. And so, there is an initial part, not of maternage, since it is not our approach, but of warm care. A very strong closeness, because that is what they need, carried out also by the operators who work during the nights - who are almost all linguistic and cultural mediators and who are therefore able to see things that we are not able to see or understand.”
(O., educator, Piedmont)

The operational setting places educators and users very close, and facilitates interlinguistic and cultural mediation within the social context in which the children are placed.

Social workers

According to Law 84/1993, social workers
operate with technical-professional autonomy and judgment in all phases of intervention for the prevention, support and recovery of individuals, families, groups and communities in situations of need and distress, and may carry out educational-training activities. In the last 20 years, this profession has achieved a defined professional status (Ciaschini et al., 2012), formalized by the creation of a professional association and the drafting of a code of ethics, indicating the methods of intervention that each member of the professional board must know, observe, and help to disseminate (Castro 2012). In the process of providing integrated care for UASC, the social worker is a crucial figure, whose task – in health and social services and in the third sector - is to monitor UASC’s living conditions and protection needs. In the reception context, so strongly characterized by the principle of integration, social workers can play a strategic role as an interface between three distinct but integrated dimensions: the reception system, social services, and health services.

Social workers may contribute to overcoming the fragmentation and discontinuity of the integrated care processes, helping to coordinate access to reception and health and social services.

The social worker, as an integral part of the integrated care network, “must not replace other professionals, but should know how to perform his or her profession properly, be able to activate resources, build a relationship in every context, with an adequate language and role. When faced with a problem, he/she can require referral for a clearer understanding or implement his/her own intervention” (Fiorini, Grossi 2003:148). Concerning this professional role, however, both the literature (Rosignoli 2018, Fazzi 2018, Della Valle Allegri 2021) and the evidence collected show some challenges relating to the interaction between social workers in public social services and other professionals working in integrated care. Discussions revealed the challenge of establishing a network approach with social workers operating at a municipal level, mainly due to the excessive bureaucracy linked to their functions and to the excessive number of cases they manage.

As observed in the literature, the social worker’s functions seem to be affected by “the emergency conditions that services are facing, as well as by the high workload and the lack of personnel. Therefore, the interventions managed by social workers seem to be more and more restricted to the management of the ‘single case’, rather than open to consider long-term preventive and promotional aspects” (Ciaschini et al:2012:69). This analysis is echoed in the words of a professional from Lombardy:

“For many social workers, there is a certain split. During their working time, they do not include the world of the relationship with the neighbourhood, the real contexts of integration!”
(P., psychologist, Lombardy)

Also, some young refugees and migrants reported a certain distance surrounding social workers, combined with a basic misunderstanding of their professional mandate

“I met a social worker. We talked. I asked about the rules, what I have to do... I met this person twice. Only once in person, but I’m not on friendly terms with her.”
(Q., 18, Cameroon, Emilia-Romagna)

“I talked to the social worker through a video call, but I have never met her since I arrived here 6 months ago.”
(R., 16, Guinea, Emilia-Romagna)

The issue of “dualism between help and control” (Kobelinsky, 2011, Accorinti 2020) is clear in the words of some young refugees
and migrants and reception centre workers, according to whom social workers mostly manage urgent bureaucratic procedures or intervene on the request of the reception centre in case of disruptive behaviour. Such tasks are at the expense of a care process that is more attentive to needs and more focused on the care relationship.

Interviewer: “Are you saying that the social worker is called if a boy causes troubles?”
S., 18, Côte d’Ivoire, Piedmont: “Yes, and you are afraid, she’d tell you that you have to follow the rules!”

“For me, whoever goes to the social worker has some problems. When you are good, the social worker does not come. And then social workers always change! When you go to another centre, you find a new social worker! With the first one I was fine, I liked to joke around. But when you find a new social worker, everything changes! In one year, I met two social workers!”
(T., 16, Côte d’Ivoire, Emilia-Romagna)

The critical aspects highlighted by young refugees and migrants seem to be partly mitigated in those territorial contexts (Milan, Bologna, Turin) where social and health services have signed a memorandum of understanding which defines the role of each service and outlines the conditions for cooperation. Such a system leads to greater continuity and allows for frequent exchanges between professionals in the development of the response.

In Turin, for example, a girl interviewed during a focus group, in which most participants reported that the role of social workers was almost irrelevant in the care pathways, shared her opposite experience:

“But my social worker is not like that! When he enters the room, he’d ask, “How are you”? He’d ask about my health; we have a good relationship. Every now and then, he’d text me and ask me how I am, how the project is going. If I have behaved badly, he’d come to me and ask what’s happened…He doesn’t behave as he says, he doesn’t call me only when I have done something wrong!”
(U., 18, Côte d’Ivoire, Piedmont)

Social workers mainly work for public institutions (municipal social services and, rarely, health services, as in some of the practices mapped), so it is not surprising that the quality of their work may be affected not only by the high workload and staff shortages, but also by the budget cuts that social services have been facing for more than a decade (Rosignoli 2018).

Starting from this assumption, one professional called for capacity-building action aimed at better qualifying the crucial work of social workers:

“We have to keep on working to improve social workers’ ability to provide a less rigid and more dynamic care. I get the feeling that sometimes certain behaviours are too stereotyped: ‘They are Albanians, they do this way’, or ‘They are Moroccans, they do this way’. This is a way of thinking often reinforced by some linguistic and cultural mediators who tend to ethnicize differences and paths. On the one hand, I think that the real issue is interpreting certain behaviours; on the other, the problem is to understand how much some behaviours must necessarily be considered as symptoms and not as attitudes. Just think about the debate on substance use, crimes, non-compliance with community rules. It is clear that if I read this [behaviour] as elements of deviance or anti-sociality that I have to correct, I will have a certain attitude.
If I consider them as signs of lack of integration, difficulty in interpreting a new identity in a radically different context, but also as a reaction, I behave in a radically different way. The issue of interpretation is crucial, particularly with reference to social workers because they have a much stronger power to determine outcomes and paths than educational teams. So we should pay attention to interpretation in a stronger and more precise way.”
(D., psychologist, Lombardy)

Volunteer guardians

Voluntary guardians are independent citizens who provide legal representation of unaccompanied children who arrived in Italy without their parents or other caregivers. Voluntary guardians act to safeguard the child’s best interests in cooperation with the institutional and non-institutional actors providing integrated care. The voluntary guardianship system is an essential part of the reception system: not only are voluntary guardians the adult of reference for unaccompanied foreign minors, but they are also the link between social services, reception centres, regional educational services and schools, juvenile courts and prosecutors’ offices.

Volunteer guardians legally represent unaccompanied minors, safeguard their rights, promote their psycho-physical well-being, supervise their education, inclusion, and reception conditions, ensure their safety and protection, always guaranteeing that their opinions are heard and considered. Volunteer guardians should be able to establish a sensitive relationship, paying attention to the child’s needs and informing and asking for the child’s opinion on all issues that affect him/her, considering the child’s age, maturity and skills. Every UASC has the right to have
a volunteer guardian. However, in some regions of Italy, the number of volunteer guardians is still inadequate compared to the number of UASC in need.

Both professionals and young migrants and refugees expressed a variety of views about the role and functions of voluntary guardians. For some professionals it is a key figure, but not easy to access or to ‘activate’ due to the lack of volunteer guardians available, or to the difficulties faced in trying to involve guardians in integrated care, including social-health services.

“It depends on the individual case, not everyone has a guardian. Maybe because, when they arrived, they had already come of age. Many guardians are kept informed by us, they are constantly updated, but they do not have an important role for the youth.

Migrant and refugee boys and girls do not recognize the role of the volunteer guardian, and it is regarded as someone responsible just for recreational activities. Arranging a picnic or a family lunch in the weekend, for example. Things like that, but not the daily routine. It is also difficult to involve them in medical examinations, maybe because they do not feel they have a central role, or are competent. But we have always seen reticence in getting involved in the organizational process. With the police, they are more present* (C., educator, Lombardy)

Some professionals in the multidisciplinary teams at the selected practices also referred to a sporadic dialogue with volunteer guardians, who were not fully integrated in the psychosocial support strategies or the development of the help pathway.

“The figure of the volunteer guardian is a sore point. When there were many arrivals, the court appointed the mayor who, in turn, delegated the social workers of the municipality. So, there was a social worker who was the guardian of 300 UASC. How can you follow 300 people? Now the juvenile court is delegating [the role to] the educators (of the reception centres). For example, I am the volunteer guardian of a boy who is a guest here, and my colleague is the guardian of another one. From a certain point of view this is easy for the documents. Because the social worker of the municipality sometimes is there and sometimes is not. There are very few volunteer guardians. My cooperative is providing courses for volunteer guardians and is doing a recruitment campaign for guardians, but this is still a difficult sector.” (G., educator, Sicily)

When the volunteer guardian is appointed (the research found several cases of failure to appoint the guardian due to delays by the juvenile court or lack of available guardians), young migrants and refugees generally recognize their importance and their parental role.

On the whole, young migrants and refugees portrayed a multifaceted image of volunteer guardians, who seem to have a ‘multifunctional’ nature. This could make this figure crucial both for the performance of practical support functions (dealing with bureaucracy, for example), and as a point of reference in the process of social inclusion and integration.

“I think that we should all have a volunteer guardian. We need honest people who speak Italian well, who can help us solve issues, complete the documents.” (T., 17, Côte d’Ivoire, Emilia-Romagna)

“The guardian is an important figure. For me it’s a woman. Someone a bit old. A responsible person. When I’m with her, she teaches me to read well. She helps me speak the language. Sometimes we
I also go for walks in the woods with her. With her I met new people and felt good. It is important to have people as a tutor to learn things. You need someone next to you. We talk all the time. In the morning, I text her: ‘How was your night?’ to know if she slept well. **She answers like a mother.** For this I thank Italy. Thanks to Italy, today I can overcome many challenges. Also, thanks to her.”

(O., 18, Cameroon, Emilia-Romagna)

“I met my guardian after three months. She helped me with my studies at the beginning, and then she took me to sports, she was always by my side in everything. We’re still in touch, all the time, she still takes care of me, I’m like a nephew for her! I’m like a family member now, she also supported other youth, but she says there is no one like me.”

(U., 19, Albania, Lombardy)

“I have a male guardian, but I preferred a female guardian, who **is a bit like a mother.** Then I met Giuseppe, who helped me a lot, he comforts me a lot.”

(O., 18, Cameroon, Emilia-Romagna)

I: “How is your relationship with the guardian, are you still in touch?”

N., 18 Nigeria, Latium: “She is very nice, she is **like my mother.** ‘Where are you?’ ‘What have you done?’ ‘Life is not like that... you have to be calm...’ So she calms me down a little bit. But now I don’t have a guardian anymore because I am an adult.”

Interviewer: “Are you still in touch?”

A: “Yes, but not every day. We text each other on WhatsApp.”

According to one of the professionals interviewed, supporting young people in socializing with the real world from a family perspective is one of the areas of intervention of volunteer guardians that is still undervalued.

Focus - Migrant and refugee boys' and girls' views on MHPSS services

What do migrant and refugee boys and girls think about the MHPSS services designed for them? How do they decode the interaction with professionals of MHPSS services inside or outside the reception system?

The migrant and refugee boys and girls interviewed gave a critical reading of the MHPSS services designed for them. The main issue concerns the intelligibility of the heterogeneous MHPSS system.

The variety of professionals working within the multidisciplinary teams and the role that each of them plays within the psycho-socio-educational process are not always easy to understand.

In moments of confusion, sadness or suffering, the main **reference professionals** for the migrant and refugee youth involved in the research are **educators**, whose role is clear also by virtue of the closeness and daily exchange with UASC, and **guardians who, when appointed**,
provide support. On the other hand, the figures of the social worker and the psychologist seem to remain in the shadows and are described more on the basis of ‘hearsay’ than of direct experience.

If, for young migrants and refugee the social worker seems to have a purely bureaucratic function, they have a more heterogeneous view of the psychologist, even though just few UASC received psychological support. Some of them, mostly coming from sub-Saharan countries, reported having met a psychologist in the context of interventions provided by humanitarian organizations in transit countries, at arrival or during first reception. Others, including C., told of having started a therapy path.

“*I don’t go there because I’m... it’s just that sometimes I think too much, and she helps me to calm down and find the right way. When I’m with her I forget all my problems. This psychologist works in a counselling centre and I’ve been seeing her for six months (once a week).*“
(O., 20, Cameroon, Emilia-Romagna)

For the majority of migrant and refugee boys and girls, the psychologist remains an undefined professional, often associated with stigma. For most of those we interviewed, direct experience with these professionals was not reported as helpful. Others described negative connotations of psychologists.

“*In Albania if you go to the psychologist, it means that…. [everyone laughs claiming that whoever goes to the psychologist is ‘mad’].“*
(U., 18, Albania, Lombardy)

“*The psychologist can be a helpful professional, but it’s not important for my life.*“
(V. , 18, Albania, Lombardy)

A possible explanation for this interpretation could be found in the composition of the teams working in the reception facilities for UASC, which are mostly made up of educators (sometimes with a degree in psychology but contracted as educators), working with linguistic and cultural mediators and legal advisers. Usually, the psychologists who provide support to reception facilities are external consultants who are employed, when necessary, both to support young refugees and migrants who experienced a wide range of problems and to monitor the team.

In addition, in some countries of origin, there is no role that corresponds to psychologist, and this complicates the understanding of his/her professional mandate. This lack of understanding is also due to a lack of internal mechanisms to raise awareness about psychological support among boys and girls living in reception facilities.

Some refugee and migrant youth associated the referral to an external psychologist with inappropriate behaviour within the reception centre.
"I know why they sent me to her [the psychologist working with the centre] because I was messing up! They told me: ‘Go to the psychologist so you can calm down’.”
(V., 18, Albania, Lombardy)

For many young refugees and migrants, strategies to cope with adverse or emotionally challenging situations include first of all support from peers, often compatriots, then support from trusted educators, and in some cases, support from the tutor/guardian.

The in-depth study during the focus groups also made it possible to identify the factors that seem to ‘make the difference’ in helping young people to cope with difficult phases of confusion, sadness or suffering. These are mostly individual adaptation strategies that young refugees and migrants use particularly when they are uncertain about who to seek for help.

Setting goals and remembering the reasons for migration is one of these strategies.

“You always have to focus on a goal. Always a different goal, if you don’t have a goal, you can never go on. And my goal was my family, to help my family. Also, for other youth who come... I think everyone comes to help their family.”
(L., 18, Albania, Lombardy)

Other UASC also expressed the idea that the ability to adapt, to be able to look beyond the difficulties of the here and now, helps to manage difficult situations. This idea is effectively summarized by B.:

“They’d tell me ‘B., you’ve been lucky!’ Even the other boy in the house, he was from Africa, he was Egyptian, he told me that I have always been lucky! No, it’s not luck! I just know how to adapt wherever I am, do you understand? People who try to adapt will always have good luck. Wherever I go, I’ll adapt immediately. That’s why I always deal with a lot of people.”
(B., 18, Côte d’Ivoire, Piedmont)

On several occasions, religion has emerged as a refuge and as an opportunity for meditation and relief.

“For me, religion comes first. When I feel bad like this, I start praying, even if I don’t talk about it with anyone. I start praying, so I relax, I forget the problems. Praying makes me feel good.”
(V., 17, Albania, Lombardy)

“Because I believe in God. It’s important to believe. Because when there’s something that’s not right for you, you have to explain to God how to do it. I don’t know God, but I feel I have to pray. God helps me to do everything. God is like that!”
(N., 20, Nigeria, Latium)
SUCCESS FACTOR 3: Provision of culture-sensitive case management, based on the integration of transcultural/ethnoclinical/ethnopsychiatric paradigms, and cultural and linguistic mediation services

According to the professionals working for the selected practices, the psychological well-being and mental health care of UASC and young migrants and refugees should take into consideration the users’ cultural values and cultural backgrounds, adapting the treatment methods and the therapeutic tools accordingly.

Although not all the analysed practices are openly inspired by cross-cultural disciplinary paradigms (Beneduce, 2004, Inglese, Gualtieri 2015; Altin, Sanò, 2017), they all give significant attention to the provision of a culturally competent intake (presa in carico culturalmente competente) (Dell’Aversana, Bruno, 2018; Cross et al., 1989). This approach aims to address patients’ psychic distress by trying to ‘read’ the disorder in the context of the culture of origin, also through the help of linguistic and cultural mediators.

“For us, ethnopsychiatry means essentially an attention to the patho-plastic dimension of cultures, but above all to the political dimension of suffering, which also means rehabilitating the person as a witness, for example, not only as a victim of violence.” (A., psychologist, Piedmont)

Box 10 - Supporting professionals: results of the survey of UASC

The aspects explored in the focus above are confirmed by the results of the survey of UASC, administered through the U-Report platform. The survey found that 49 per cent of UASC consider friends, family of origin and the staff of the reception facility as supporting figures. Only 10 per cent indicated the psychologist as a relevant figure. The marginal role of psychologists is reflected by the fact that 60 per cent of UASC have never met a psychologist in the places they usually frequent. A lack of familiarity with this profession seems to be related to the lack of information about how to access psychology services (25 per cent had received this information), as well as to the missing knowledge of the services provided (19 per cent).

This approach is more evident in some of the interventions observed and more nuanced in other practices.

“The Western approach is a failure. I am not saying it can be harmful, but it does not achieve results. I can say this because often people come here after an ordinary intervention that didn’t yield any results, precisely because the individual background has not been accepted. The fundamental aspect is to accept the other person’s world. Yes, a pharmacological intervention is made, but the psychiatrist must learn to read the different ways of communication to try to understand. The professional skills of each of us is to understand and to use those tools that are necessary to understand.” (G., psychiatrist, Sicily)

The majority of the practices studied refer
to the cross-cultural approach, ensured by the constant use of linguistic and cultural mediation. For example, SAMIFO (Rome) uses linguistic and cultural mediation with a cross-cultural approach to facilitate and foster social integration, with a view to protecting the right to psychophysical well-being of each individual and their fundamental rights, including the right to health.

In urban practices mapped, the services provided are based on ethno-psychological intervention models. However, practices covering regional or multi-regional areas of intervention present within the same project different approaches to culturally sensitive intake referring to a broader meaning of ethnopsychology or cross-cultural approach.

In Emilia-Romagna, for example, within the Start.Er project, different approaches to culturally sensitive clinical care were reported. In some areas, interventions were inspired by the theoretical models of Tobie Nathan’s ethnopsychiatric group approach while others use “more traditional clinical settings in which a psychologist or psychiatrist conducts the interview, possibly assisted by a linguistic and cultural mediator”. In Bologna, the Public Personal Assistance Authority (ASP) has set up an ethnopsychiatry service that includes a cross-cultural psychiatry outpatient clinic, which provides psychological and psychiatric interviews to immigrants, asylum seekers and refugees hosted within the metropolitan SAI network. This service is part of the International Protection Service and is available for clinical assessment of patients who don’t receive care by the National Health Service and patients under the care of the Bologna Department of Mental Health or General Practitioners. All the selected practices include linguistic and cultural mediators. However, the professional profiles of mediators, the disciplinary paradigms guiding their actions, and the methods of recruitment seem to vary from territory to territory.
In general, the interviews with professionals identified mediation as a fundamental tool for building effective and constructive intercultural relationships. However, the role of mediation in the mapped practices is not present anytime and anywhere. Literature and evidence from practice highlight, in fact, how mediation in many areas of the country is limited to an interlinguistic dimension, determined by the fact that “the participants – health and social service workers and migrant minors – speak different languages” (Baraldi 2013: 67).

Several professionals acknowledged that the mediation activity provided in the practices goes beyond interpreting and explained how a mediator can act as a “bridge between different cultures and societies, as a technician and professional of intercultural communication” (Esposito, 2011:26). From the discussions, it emerged that cultural mediators, even when recruited on an ‘on-call’ basis, are perceived as integral professionals within the team of selected practices. The significance of the role was also reported by professionals working in clinical settings, where the mediator, rather than being a third party and a facilitator, becomes an active subject in a three-way relationship (e.g. therapist/counsellor and minor). The professional role of the mediator in these cases, according to the professionals interviewed, goes beyond the mere function of an interpreter and includes communication skills that also help mutual understanding between cultures.

From the UASC’s point of view, mediation (if available), can improve relations between the parties, promoting mutual recognition and empowerment and the ability to express and assert one’s own point of view.

Our study found several examples where linguistic and cultural mediation was crucial to ensure mutual understanding between the parties involved, by facilitating the recognition and understanding of individual perspectives.

“Before living in Bologna, I lived in Sicily and Naples. In Naples I did not speak Italian, I spoke French and I became friends with a linguistic and cultural mediator from Naples. We are still friends; she helps me a lot. When I arrived in Bologna, we kept in touch, she introduced me to some of her friends here. For me she is like an older sister.”

(O., 18, Cameroon, Emilia-Romagna)

Literature and practice also remind us, however, that forms of ethnocentrism can be reproduced through linguistic and cultural mediation (Baraldi, 2013; Castiglioni, 1997; Esposito, 2011). Independent initiatives carried out by linguistic and cultural mediators, who act as privileged interlocutors of a participant, as gatekeepers, isolating other people with mediation actions, heighten the us/you dichotomy.

The inadequate training of linguistic and cultural mediators also emerged from the words of another boy:

“It also happened to a friend, he spoke French, and the mediator translated different things from what he was saying. They told him to go away.”

(M., 18, Côte d’Ivoire, Piedmont)

Often, difficulties in finding a mediator means that services, especially those provided within the reception system, have to resort to untrained compatriots as mediators:

“A girl from my country helped me, when I went to the office, she always came with me and explained; she was good, she helped me.”

(V., 18, Albania, Lombardy)

However, the linguistic and cultural mediation offered by untrained compatriots is not enough. Linguistic, relational and communication skills deriving from the migratory experience
and, in some cases, from sharing similar experiences, are not sufficient to provide a quality and culturally competent service.

A mediator should also know how to work in the context in which he/she is employed, including clinical-therapeutic settings, providing health and social services staff and users with a particular set of psychosocial skills, active and empathic listening, ability to communicate and interact with specific age groups, and to manage and facilitate communications that can involve intense and disturbing emotional content, language and cultural skills (Esposito and Vezzadini, 2011). When engaging with UASC, the mediator should also be adequately trained to work with vulnerable foreign youth and adolescents.

Since cultural mediation is not organized in a uniform way at the national level, different ways of recruiting mediators were observed in the various regions. In most of the regions analysed, mediators provide time-limited services for several different organizations. Although this mapping found cases where public services have permanently integrated mediators into their teams, the majority of the mediators working in civil society organizations are employed only occasionally. Job insecurity can translate into a delegitimization of the mediators’ work, which often fuels frustration. Mediators are often a reference professional for the migrant community even outside of working hours.

This aspect, in the case of the PENC practice, led to the creation of a dedicated space for sharing and reducing work pressure.

“We have created a space to reduce work pressure, and we let the mediators talk about the stress they were experiencing. They have a life outside, but inside the reception centre, many people always turn to them because they know them, and this puts them under pressure.”

(B., psychologist, Sicily)

SUCCESS FACTOR 4: Permanent efforts to improve the capacity of the reception system, and local social and health services through capacity-building programmes and awareness-raising campaigns

All the practices mapped contribute to strengthening the capacity of the reception system and health and social services, through training and awareness-raising activities on mental health and migration.

These training courses are often addressed to a broader audience than professionals and are often available online, accessible to different actors. Some training courses are the result of agreements with the SAI network or with professional boards or associations (e.g. CNOP, CNOAS, Fondazione Nazionale Assistenti Sociali), which may grant credits for participation.

The importance of training about MHPSS services for migrant and refugee children is recognized by many of the professionals interviewed, who described it as an opportunity to reflect on the therapeutic approaches adopted and to talk with other actors in the reception system about the operational implications and methodology challenges related to service provision.

In terms of content, professionals pointed out the importance of giving continuity to training concerning psychosocial well-being and mental health (psychosocial, psycho-educational, clinical intervention, etc.); transition to adulthood; gender issues; and the social, political and economic context of migrants’ countries of origin. In most regions examined, the training provided to professionals included modules on critical medical anthropology and ethnopsychiatry.

In Milan, for example, UONPIA - Fondazione IRCCS Cà Granda Ospedale Maggiore Policlinico and its partners have been providing training in
transcultural, psychodiagnostics and psychotraumatology for more than a decade. Their aim is to contribute to the development of an integrated and flexible model of care, based on patients’ needs and evidence-based treatments. Since 2021, this practice has combined training with activities to develop and strengthen the network. Several working groups have been set up to identify good practices (with a focus on tools and procedures) and to reflect on the emerging needs of young refugees and migrants and plan useful actions to address such needs. The practice has also contributed to find a common approach within the services, which enabled it to develop useful tools for the early identification of vulnerabilities related to mental health (see practice cards).

Similarly, for SAMIFO in Rome, training is aimed at increasing the response capacities of professionals and building an effective system in the field of mental health and migration. For more than a decade, this practice has been providing training activities for social and health workers and civil society organizations, focusing on vulnerability, early diagnosis methods, culturally-oriented care, and referral to local health facilities. Of relevance to this report is the training on post-traumatic vulnerability and severe psycho-health distress, now in its tenth edition, provided to staff in local health authorities, reception centres and protection agencies.

In Emilia-Romagna, the Start.Er. 2 project ran a “survey of the training needs of health-care assistants in the framework of the FAMI Start. Er. 2 project”, carried out by a multidisciplinary team of three anthropologists and four physicians. The survey was designed to identify training needs, including knowledge, skills, content and methodologies, in order to design effective training pathways.

The ICARE project, one of the few interventions that offers a common MHPSS intervention model in four different regions, has been implementing training designed to strengthen the skills of professionals working in public services and civil society organizations. The ‘integrated’ training includes techniques for managing relationships with ‘diversity’, the development of communication strategies for health services, and in-depth studies on procedures concerning access to care and local health care, with particular attention to women, children, and vulnerable individuals.

In Apulia, the GIADA psychology service of the Paediatric Hospital Giovanni XXIII - Polyclinic of Bari has been appointed by the region to provide specialized training in partnership with the Italian Coordination of Services against Child Abuse (CISMAI), including regional specialized training on mental health. This course was designed for professionals working in integrated multidisciplinary teams, those working in the GIADA hospital network, and those in psychology/counselling services of the specialized centres for the treatment of childhood trauma, including NPI, DSM, SERD, paediatricians, the specialized anti-violence services of the third sector.

Several respondents pointed out the urgency of improving culturally oriented training for professionals working in public mental health services. A psychologist described the issue as follows:

“What we need is an ethnopsychiatric approach to child and adolescent neuropsychiatry, since one of the main challenges for psychiatrists and neuropsychiatrists is to adapt their expertise. So, more training of health professionals on ethnopsychiatry is needed.”

(B., psychologist, Sicily)

In Sicily, the training course designed within the Silver project, in which other practices (PENC, ASP CT, FARO) also took part, not only strengthened the skills of specialized services, but
also activated and strengthened the territorial network and proved useful in consolidating the integrated intervention model.

“We talk about a strong, cohesive and active network, mainly based on the training of these people. The agencies have completed a long training – a classroom-based and on-the-job training programme. The aim was to create this kind of activity starting with people. The training was based on mental health, ethnopsychiatry and anthropology. It was carried out by people who are experts in the various immigration programmes and it was interesting to find that these people helped us throughout the project. And this training programme has become a SOP, a standard operating procedure. So we ask: ‘Do you want to provide health care to migrants? First follow an on-the-job training, and then you can start working with migrants and refugees.’”

(C., ASP manager, Sicily)
SUCCESS FACTOR 5: Permanent efforts to improve the capacity of the reception system, and local social and health services through capacity-building programmes and awareness-raising campaigns

All the mapped practices have helped to expand local multi-stakeholder networks that have explored integrated intervention models designed for migrant users. The networks operating in the provision of psychosocial support and mental health services to migrants have been extensively studied (Geraci Bordini, 2011, Tognetti Bordogna, 2013). The reception of UASC can be considered as a test-bed for programming innovation in many Italian regions (Campomori, Feraco 2018; Zanfrini 2018), where the need to facilitate access to social and health services for migrant and refugee children has led to the testing of services for migrant users based on the principle of equitable access and non-discrimination (Campomori, 2007; Ambrosini, 2015; Geraci and Bodini, 2011). The evidence from the mapping shows how some of these innovative services build on the ability to ‘co-create’ models of integrated interventions, rather than overcoming the complex dialogue between the reception system, social services and health services.

Participatory planning (Maino, Ferrera, 2015), co-provision of services (Osborne et al., 2008; Pestoff and Brandsen 2012) and hybrid welfare (Bertin, Pantalone, 2018) are some of the definitions used in the literature to identify this way of networking, in which public and civil society actors have built and expanded networks that increasingly include actors operating in the government reception system. ‘Essential’, ‘necessary’ and ‘inevitable’ are some of the terms professionals used when discussing these networks. In all the practices mapped, the network emerged as the obvious operational method to tackle the limits and challenges of the system and to offer coordinated and timely interventions.

“Our model is a virtuous example of networking. The fact that we have been active in the territory all these years gave us the possibility of building relationships with all the associations or bodies that deal with migration, so we have the possibility to promptly intervene when necessary. Let’s say that the waiting time for a visit is around one day, or a week if the user decides to postpone it.”
(M., Staff physician, Sicily)

Similar considerations were made by a professional from Turin and a psychologist from Milan:

“The network we interface with is huge. It really includes a lot of different contexts, ranging from schools, to training agencies, to associations operating in the territory and offering both training and recreational spaces. And then the sports clubs, all those agencies that have to do with the provision of something necessary, the projects of employment centres for young refugees and migrants.”
(C., educator, Piedmont)

“So, what works? I’d say the network, meaning that, especially in a city like Milan - with many stimuli, many people, many situations - if there is not a network that works as a team, I think we can’t get anywhere. It has often happened that projects have a positive outcome because everyone does their work, professionally. It means that social workers do their job, the community does its part.”
(D., psychologist, Lombardy)

This approach can also be found in SAMIFO in Rome, which describes the network as “a set of relationships between different actors,
who converge on objectives, strategies and working methods, creating shared cultures to achieve certain results’ (Vercillo, Santone 2018:71).

**But how are networks created? How do they work? What are the challenges they address?** The networks created by the practices observed in the mapping offer a chance to explore some ideas. The first is that, on the whole, networks have been defined and developed as part of the evolution of national and local social policies. For this reason, many are complementary to existing social and health systems and are bound by social and health policies at the regional and local levels.

The second idea is that, in some of the regions examined, the development of structured cooperation between public and civil society institutions is a result of the initiative, involvement and in some cases hyper-responsibility and dedication of the civil society sector. According to some of the professionals interviewed, civil society organizations have worked to integrate the services of public institutions, initially providing resources and professionals for psychosocial support to migrants, and then taking on the function of a ‘pressure group’, playing a decisive role in claiming and sometimes acquiring rights in the social-health area (Ambrosini, 2014). This approach is particularly evident in the case of Fanon in Turin and PENC in Palermo, which, especially when they began, complemented a public service that was not sufficiently ready or equipped to deal with the specific needs of migrant users. In fact, if we consider the role played by these two associations in providing care to vulnerable foreign children outside the government reception system, we can see how civil society actors have become ‘necessary’ partners of public bodies that, due to their institutional mandates and resources (human and financial), could not or did not intervene.

The third consideration is that the combination of highly integrated public social and health policies (as in the case of the Emilia-Romagna and Apulia regions) and the increasing availability of funding from European Union programmes has strengthened the use of the networking approach within intervention models. For example, in the specific case of MHPSS interventions, the 2014-2020 AMIF programme financed interventions (new and pre-existing) based on homogeneous criteria in all the regions examined. Funding criteria have focused on an approach designed to establish or consolidate network interventions that improve integrated care processes and multi-stakeholder collaboration. In some regions (Latium, Emilia-Romagna, Piedmont), the network was has also proved useful in activating connections and cooperation oriented towards raising awareness about the issue of mental health linked to migration.

In Latium, for example, SAMIFO, together with the Italian Society of Migration Medicine (SIMM) and the Regional Group for Migration and Health (GRIS), played a leading role in the mobilizations to guarantee migrants ‘access to MHPSS services, structuring what has been defined as a ‘necessary network’ (Geraci and Bodini, 2011:148).

However, cooperation procedures related to integrated care are not always based on SOPs and cooperation protocols. The institutionalization of network relationships, through specific protocols and structured coordination rules, was observed in only a few cases in urban areas (Milan, Bologna). In other cases, such as Sicily, no evidence of their implementation was found, even when SOPs and memorandums of understanding existed in regional projects.
“Our network is informal. When we talk about a network in the territory, very often the concept of a network is linked to the concept of tendering, ok? So the network is necessary to gather professionals to take part in tendering procedures, to provide services, etc. etc.”

(D., facility coordinator, Emilia-Romagna)

The words of this professional shed light on a not insignificant fact: many public-private networks work together to apply for European funds (such as AMIF funds) or to participate in calls for proposals organized by private donors. While this approach confirms the prominence of bottom-up initiatives, which at local level seek to ensure the continuity of existing services with limited available resources, it also raises questions about the long-term sustainability of these initiatives.

According to one of the experts interviewed, a network’s success should not detract from the responsibility of the institutional actors in the reception system, including the prefecture, who are still required to play a directing and strategic planning role:

“There are some extremely positive experiences in Italy and the cornerstones of these positive experiences are basically two; the first one is the projects for integrated reception – let’s say, the system of reception and integration –. The other foundation is the prefectures. The prefectures are mandated to manage and promote interactions and urge for protocols. Some prefectures do it through the various governance tools they have at their disposal, including the Territorial Council for Immigration.”

(F., researcher, Latium)
One operational goal of the networks established within the practices is the coordination of referral mechanisms.

In all the practices mapped, the host communities, social services and health services provide services that form part of the integrated care procedure, as envisaged by the regulatory framework (see chap. 3). In this framework, each actor plays a key role, according to their specific mandate, in ensuring identification, referral and provision of care in cases of mental suffering and disorder.

In all the regions studied, in accordance with the regulatory framework, early identification and reporting of visible or presumed signs of mental distress or disorder is a primary responsibility of reception centre workers. They must inform local social services about any cases of vulnerability in order to identify, together with the child and the voluntary guardian, the most appropriate care intervention.

Therefore, reception centre workers and local social services have a crucial role in ensuring integrated care for UASC. It is the responsibility of the reception facility and the local social services to identify risk indicators at an early stage and make a timely referral to the relevant psychosocial support and mental health services.

In cases of mild mental suffering, intervention is limited mainly to psychosocial and psycho-educational support activities provided by reception centre workers (who may require external services, such as those provided by the practices) inside the reception facility or through projects implemented at a local level. Many practices, for example, are regularly involved from the beginning in mitigation and strengthening interventions, which are based on the interpretation of past and traumatic experiences and aimed at promoting the early detection of psychological distress.

In case of severe mental suffering and distress, it is the responsibility of local social services, following a report from the reception facility, to request specialized mental health support in collaboration with the NHS.

The coordination mechanisms that regulate the provision of care for cases of mental vulnerability and distress between reception centres, social services and external services appear, however, to be highly heterogeneous. In most cases, as shown in the diagram, social services are in charge of coordinating the provision of care. In coordination with reception facility teams, they analyse and assess the intervention to be provided for each case and the referral mechanism to be used. In other cases, as in Milan and Bologna, the coordination mechanism is regulated by specific procedures and collaborations. Here, coordination is managed by working groups promoted by local authorities, which involve mental health services and other actors in the network, with the aim of discussing individual cases. However, neither child and adolescent
neuropsychiatry units, nor therapeutic communities are an integral part of the coordination mechanisms of the various regions. This is an issue highlighted by Codici, which points out: “These structures are not considered as a possibility and access is unlikely due to the difficulty of diagnosis by the National Health Service. Even when this happens, it is not taken for granted that there is availability of seats in the structures” (Codici 2020: 10).

Among the practices studied, it is worth noting the mechanism of multi-professional and inter-institutional coordination for the promotion of mental health and the prevention of psychiatric disorders. This was established in Milan in 2009 by the migrant team in the UONPIA of the Policlinico di Milano, together with the municipality of Milan and the socio-educational communities that have an agreement with it: ATS Metropolitan City; and third sector and other services involved in the reception and integration of UASC.

This model has multiple levels of organization, management, and responsibility among the various actors responsible for UASC. The system enhances the value of all the local actors and promotes the participation of the National Health Service from the beginning of the care process.

MODEL FOR CASE INTAKE

<table>
<thead>
<tr>
<th>First-line reception</th>
<th>Second-line reception</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risks identified in the initial screening</td>
<td>Other signs of risks</td>
</tr>
<tr>
<td>Suicidal ideation, self-harm, emotional and behavioural outbursts, psychomotor agitation, psychic disorganization, substance use, antisocial behaviour, cognitive impairment, anxiety-depression, somatic-vegetative symptoms</td>
<td></td>
</tr>
<tr>
<td>Referral to relevant specialized service/s</td>
<td></td>
</tr>
<tr>
<td>Case intake by UONPIA (Operational Unit of Child and Adolescent Neuropsychiatry) - Team specialized for migrants and refugees: Establishment of a micro team, creating and/or strengthening inter-agency MHPSS network, individual session with a psychologist/educator/neuropsychiatrist</td>
<td></td>
</tr>
<tr>
<td>Multidisciplinary team:</td>
<td></td>
</tr>
<tr>
<td>Child Neuropsychiatrist, professional educator, social worker, psychologist and cultural linguistic mediator</td>
<td></td>
</tr>
<tr>
<td>Ordinary service-activation: 30-40 days</td>
<td></td>
</tr>
<tr>
<td>Urgent activation: 72 hours</td>
<td></td>
</tr>
<tr>
<td>Continued inter-agency work, flexibility, intervention according to client’s needs and life-project</td>
<td></td>
</tr>
</tbody>
</table>

5.2 Challenges for the MHPSS system

The research and discussions held during the consultation workshop with practice representatives identified the persistence of some structural shortcomings and vulnerabilities in the provision of and access to MHPSS services by UASC and young refugees and migrants.

These issues fall into four main areas:

1. Coordination between the reception system and MHPSS services
2. Suitability of public mental health services for supporting young refugees and migrants
3. Mechanisms for identification, referral and intake
4. Participation of UASC in the care processes that concern them

AREA 1: COORDINATION BETWEEN THE RECEPTION SYSTEM AND MHPSS SERVICES

Although the legal system recognizes the importance of promoting and protecting the psychosocial well-being of UASC within the reception system, the provision of MHPSS interventions does not have a clearly defined role within the reception system, in particular in first-line reception centres. When psychosocial support services are provided, they are poorly integrated with other reception centre activities.147

The limited involvement of educators in the design and provision of psychosocial interventions means that the prevention and support needs of people in psychological distress are sometimes detected late, and these individuals are referred to specialists in external services, such as those operating in the practices examined. In short, the reception system tends to outsource psychosocial support services, focusing internal interventions on education and vocational training.

The limited role of psychosocial support in the reception system emerges clearly from M.’s words:

“We tend to repress our psychological side. I mean that our psychologists are educators. The first thing they are told is to forget they are psychologists. Then not everyone does it very well, but the goal is that if you are an educator, you work as an educator. The psychologist is there if the child has problems. We have an internal psychologist that we can call and ask for a psychological interview. And then there is a whole network, let’s say, of care.”

(M., Facility coordinator, Lombardy)

Access to external MHPSS services by migrant users is mediated by the reception centre workers, who often act as a real gatekeeper between the reception system and external MHPSS services provided at a local level. The function of this role is twofold. On the one hand, it makes it possible to preliminarily identify situations of vulnerability in a timely manner, and to provide support services directly in the place where the child lives and relates to peers. On the other hand, it implies a centralization of psychosocial support interventions in the hands of the reception centres, which do not always have the capacity to work in collaboration with external services. This is due to inadequate staffing and a lack of standardized mechanisms governing interaction with external services.
In general, the Italian system of psychosocial support services for UASC and young migrants and refugees pays little attention to psychosocial interventions in first-line reception facilities, even though such interventions can strengthen well-being and prevent more severe forms of psychological distress.

The refugee and migrant boys and girls interviewed during the research clearly referred to the failure to attend to their psychological suffering during their stay in first-line reception and quarantine facilities. Some of them, already exhausted by the migration journey, by detention in Libya or by the hardships experienced along the Balkan route, spent a long time in first-line reception centres without receiving psychological or emotional support or any clear information about their rights, the services available to them, or the protection set out in Italian law.

F., 16, Guinea: “I arrived during the pandemic. And I arrived in Sicily, where I was put in a quarantine facility. I spent two months there. There were no good places in Sicily. The reception centre workers were not good. They didn’t give me information. I didn’t know how long I had to stay there.” Interviewer: “It must have been difficult for you…” F: “Yes, it has been.”

The state of discomfort, anxiety and frustration generated by this sense of ‘suspension’ (Sayad, 2002), also detected in some cases in second-line reception, could have been mitigated with specialized psychosocial support interventions, provided promptly and in collaboration with existing MHPSS services at the local level. Even though reception centres are a crucial place, where the need for specialized and non-specialized psychosocial support is detected, the involvement of external professionals generally occurs only as an emergency response to heightened mental suffering that cannot be addressed by reception facility workers. In the same way, outreach initiatives to promote MHPSS within the reception system are sporadic, unstructured, and inadequately funded.

“In the last municipal coordination meeting, the request that almost all the communities made was to further implement this collaboration (with mental health services). Why? Because, especially in the last year, cases of vulnerability are increasing. The difficulties in managing the groups are increasing, and therefore our proposal was to stay less inside the office and go outside, into the community” (P., educator, Lombardy)

It is, therefore, necessary to reflect, as highlighted in a report drafted by one of the mapped practices (FARO, Sicily), on the necessary skills for educators:

“This does not mean transforming educators into psychologists, nor does it mean psychologizing the problem; it means strengthening educators’ basic skills, acquired in training and through experience, in order to increase their empirical knowledge. These increased skills will translate into a better capacity to welcome, understand and take care, as educators, of migrant and refugee children’s mental suffering. Moreover, educators trained in such a way that they will be able to accurately identify children who are deeply troubled, or suffering, who need specialized support since the availability and care provided by educators is no longer sufficient” (Terre des Hommes, 2016:29)
AREA 2: SUITABILITY OF PUBLIC MENTAL HEALTH SERVICES FOR SUPPORTING YOUNG REFUGEES AND MIGRANTS

The high quality of specialized mental health services delivered by some of the practices surveyed do not represent the state of mental health services at the national level. Criticisms were made in all territories about access to NPIA (Child and Adolescent Neuropsychiatric Services) and CMHs (Mental Health Centres), concerning coordination between reception centres and specialized services; waiting times for receiving care; poor coordination between the NPIA (Child and Adolescent Neuropsychiatric Services) for minors and the CMH for adults; the lack/insufficiency of linguistic and cultural mediators; and the lack of consolidation of intervention models inspired by culturally sensitive approach.

Indeed, there is no real agreement, for example with NPIA (Child and Adolescent Neuropsychiatric Services), which is really difficult to access. Therefore, in cases where situations of this type arise – that the various actors operate in a somewhat individual way – we seek contact with the neuropsychiatry unit, but without there being a procedure and a practice set up yet. It is certainly one of the issues on which we have been working in recent years, also in light of the fact that children are increasingly expressing needs in this kind of direction, so it is a very, very central theme. At the moment, neuropsychiatric care depends on the ability of the individual service and on how much the local health authority (ASL in this case) is willing to accommodate.”

(M., operator, Piedmont)

“As far as children are concerned, there is almost no contact with neuropsychiatry. Neuropsychiatry works on its own and we generally do not manage to make referrals to neuropsychiatry precisely because
referrals to neuropsychiatry come through a different channel. Through the National Health Service, many referrals come from the juvenile court. But they have their own ways of functioning, so it is difficult for us to send to them.”
(B., psychologist, Sicily)

On the whole, with a few exceptions, the professionals interviewed consider public mental health services as not always adequate for migrant and refugee children and youth, in part because they lack competence in the field of adolescence and transition to adulthood.

Box 12 - Capacity of MHPSS services to identify and support the specific needs of UASC and young migrants and refugees

When asked: “Are psychosocial support and mental health services in your region able to effectively identify and support the specific needs of vulnerable groups, specifically migrant and refugee children, adolescents, and young people?”, 68 per cent of the professionals interviewed answered “rarely.”

When asked: “Are there in your region NPIA (Child and Adolescent Neuropsychiatric Services) and MHD services for psychiatric emergencies in childhood where there is clinical activity dedicated to migrant and refugee children, adolescents, and young people?”, 53 per cent of the MHPSS professionals interviewed (mostly educators, psychologists and psychotherapists) answered that they did not know while 19 per cent stated that these services are not available in their region.

Research evidence also indicates that the MHPSS system has yet to achieve a unified intervention model based on the continuum of care of the integrated MHPSS approach. Psychosocial support and mental health services are still poorly connected, and continuity of care is often hindered when accessing specialized mental health services, which struggle, all over Italy, to ensure timely and targeted responses to migrant children with psychological distress and mental disorders (Convention on the Rights of the Child, 2020). The insufficiency of professional and financial resources and the “significant increase in demand for specialized support from reception centres” (S., psychologist, Lombardy) have put even more pressure on public mental health services, which appear poorly equipped to meet the specific challenges faced by migrant and refugee children.

This situation indicates the need for a dual response, involving: a) a quantitative and qualitative improvement in specialized services to meet a need that remains largely unmet, and b) also with a view to achieving better value for money—the strengthening of psychosocial support programmes designed to strengthen individual psychosocial well-being, to prevent any deterioration in psychological state, and to avoid the exacerbation of suffering frequently observed in the reception system.

Moreover, the lack of adequate specialized mental health services and the territorial differences in provision amplify the inequalities that migrants face during the reception process. Long waiting times for mental health services and the uneven availability of cultural mediators increase the
pressure on the reception system, which has to manage cases of severe suffering and distress – sometimes expressed through real crises and psychological disorders – without being adequately equipped.

NPIA (Child and Adolescent Neuropsychiatric Services) for young refugees and migrants are sporadic and limited to just some territories. Often, the transition to adulthood and the subsequent transfer of care to the CMH takes place without an adequate transfer of information to ensure continuity of care and assistance.

The experts interviewed also criticized the job insecurity and high staff turnover, which have significant repercussions on the ability to consolidate teams and the standardization of working tools.

Finally, as illustrated by the excerpt below, the current public mental health system cannot adequately meet the needs of migrant users. Because this population mostly comprises young people close to the age of majority, the responsibility for their care lies between the services provided by the NPIA for minors and those provided by the CMH for adults. The research found that transition to adulthood often overlaps with the interruption of the therapeutic path, usually due to poor coordination between professionals in the NPIA and the MHD-Mental Health Department.

“It is very hard to do something. It is very hard, because child neuropsychiatry takes a long time to provide care and does not generally deal with children of that age. On the other hand, adult psychiatry does not take care of children. There should be more continuity between child neuropsychiatry and adult psychiatry. In other words, either we decide that child neuropsychiatry follows them until they are 19 or 20, or adult psychiatry, which seems more reasonable to me, starts caring for them when they turn 16.”

(M., psychologist, Lombardy)
AREA 3: MECHANISMS FOR IDENTIFICATION, REFERRAL AND INTAKE

The research revealed several problems in the mechanisms for identification, referral and care that govern – or should govern – the provision of MHPSS services in first- and second-line reception facilities and the network of local services. These issues were discussed with representatives of the mapped practices during the consultation workshop.

In almost all the territories examined, the coordination mechanisms governing the identification of migrant children’s needs in reception centres, and subsequent referral to external MHPSS services, often appear fragmented and poorly consolidated. Where such structures exist, they seemed to be limited to a specific urban area or a single local health authority and were not always known to all the actors in the integrated care network.

Professionals based in multidisciplinary teams in reception centres are the first to detect the needs of UASC. They are therefore responsible for activating the complex process of identifying psychosocial vulnerabilities and implementing the first protective and preventive actions, in collaboration with the network of third sector actors operating in the territory. Similarly, it is up to them, in collaboration with social services, to refer migrant children to external bodies that provide specialized services in case of need.

“With the guys [the children in the centre] we have continuous talks and monitoring. They are divided, watched, and monitored on a daily basis. We are always here. There is always a colleague. If there is a need, it is shared with the whole team.”

(G., educator, Sicily)

Operationally, these steps form of a territorial coordination system directed by the reception centre, which engages all the actors involved in the psychosocial support process, including the social services of the municipality, the bodies providing MHPSS services (such as the selected practices), and the local health authority.

The process of identification, referral and care is reported in the individual’s personal file/social file in the section comprising observations of the child (including psychosocial and legal reports) and interventions carried out by the teams following internal consultation. Although the professionals interviewed made no explicit reference to the social file (which is provided for by Law 47/2017), all reported the use of a personal folder containing all the information detected by the different professionals who interacted, informed, and discussed with the minor. Similarly, in all centres, reference was made to the final multidisciplinary report, which contains details of pathways and interventions undertaken and those to be continued or initiated during reception.

The words of a professional from Milan provide an overview of how the process can work:

“Let’s say there was a good one [coordination action] yesterday. When I think of D., a boy who arrived when we opened, but before then was in another community. He was a boy who, when he came to us, was taken into UONPIA because he was an aggressive boy, he couldn’t manage his aggressive temper, but he did all the work with UONPIA. We also worked with CELAV, which is the body of the municipality of Milan that helps us find work. Outside, he got a work scholarship at the municipality of Milan as a butcher, which went very well, and now he is employed. We also enrolled him in boxing. D. no longer smashes people’s heads when he meets them, let’s say. And even in the community – despite the fact that he’s obviously still a bit in need of a lot of attention – he’s someone who has
made his way and done well from start to finish. Now we are planning to move him to a young adults’ home. After that, I have to tell you that this is more an exception than a rule.”
(C., educator, Lombardy)

C.’s case demonstrates the many factors involved in ensuring a successful outcome. Ensuring that these factors are properly addressed – by establishing coordination mechanisms to regulate the provision of the complex set of psycho-socio-health services inside and outside the reception system — is one of the main challenges faced by the MHPSS system

Currently, coordination between the reception system and external psychosocial and mental health support services appears to rely on a coordination method that is based on emergency and urgency, rather than on sound procedures.

“We take targeted action based on emergency and urgency; we don’t have a unique model.”
(F., community educator, Sicily)

In all the regions analysed, the provision of public or private MHPSS services by the reception centre was described as a process whose success depends on the use of contacts, relationships, and individual resources:

“Every single reality brings its own possible resources. Of course, with the possible sharing with the Minors’ Office, however, the part of construction and practice and procedure, that in some way would be desirable, is completely missing. My guess is that over the years we will get there, but at the moment it is really left to the hosting party… In collaboration with the Minors’ Office, of course, but if the Minors’ Office is too busy at that moment, it remains in the hands of the hosting party.”
(C., educator, Piedmont)

“It is like this for everyone: we know doctors who work inside, so sometimes there is a relationship. Otherwise, you go to the emergency room.”
(N., psychologist, Latium)

The structural dysfunctions of the reception system on the one hand, and of the mental health service system on the other, mean it is not always possible to diagnose mental distress and psychopathological and/or mental disorders at an early stage. Delays in reporting, resulting from the lack of qualified personnel able to promptly identify the distress, may compromise the effectiveness of interventions and risk exacerbating the clinical picture. Referral to specialized public services often takes a long time, and there are long waiting lists, so this type of referral is often only achieved when psychological suffering becomes so acute as to constitute a danger to the individual or other people, or when the specific needs exceed the management skills of the community operators.

The interviews with professionals and the quantitative survey both show that, even when available, mental health services appear “unprepared to welcome first or second-generation foreigners” (anonymous, online survey).

In several territories, the services offered are part of stand-alone projects and “not included in a strategic view of services and service offerings” (anonymous, online survey). This often means they have few resources and are disconnected from wider regional networks dedicated to early identification, diagnosis, treatment, or the rehabilitation of psychological and neuropsychological disorders of migrant users.
Even in those territories with SOPs, protocols and guidelines aimed at fostering coordination between the reception system and social and health services, these tools turn out to be little known, not sufficiently promoted, or used only at the metropolitan level. This is the case for the ‘Guidelines for the programming of assistance and rehabilitation interventions as well as for the treatment of mental disorders of holders of refugee status and subsidiary protection status who have suffered torture, rape or other serious forms of psychological, physical or sexual violence, implemented by the Latium region’ and for the SOPs developed in the AMIF project Silver, which, while representing an important point of reference, have not yet been publicly deployed.

Box 13 - Mental health services and the regional network for early identification, diagnosis, treatment, and rehabilitation.

When asked: “Are the services offered part of an integrated national/regional network working on the early identification, diagnosis, treatment, and rehabilitation of psychological and neuropsychological disorders in childhood?”, 66 per cent of the professionals interviewed said they did not know.

Box 14 - Guidelines/standard operating procedures/memorandums of understanding concerning the provision of MHPSS services for minors

When asked: “Are any guidelines/standard operating procedures/memorandums of understanding signed by care providers, social and health services, intermediate facilities, and hospitals, concerning the provision of MHPSS services relevant to migrant and refugee minors, adolescents, and young adults available in your region?”, only 13 per cent of the professionals interviewed answered yes. 16 per cent said such mechanisms were not present, and 66 per cent said they did not know. Even in regions where guidelines and standard procedures do exist, such as Latium or Sicily, they are largely unknown or not publicly available.

AREA 4: PARTICIPATION OF UASC IN THE CARE PROCESSES THAT CONCERN THEM

The right to be listened to is one of the four general principles that should guide the action of States and all actors involved in the protection of minors. Article 12 of the Convention on the Rights of the Child affirms the principle of participation and respect for the views of the child and provides that all children have the right to freely express their views and be heard in all decision-making processes affecting them, and that adults have a corresponding duty to give due consideration to their opinions.

As noted by the United Nations High Commissioner for Refugees (UNHCR), “the concept of participation is used to describe
ongoing processes involving information exchange and dialogue, between children and adults, based on mutual respect and in which children can learn how their opinions and those of adults are taken into account and can influence the outcome of decision-making processes. In this sense, participation indicates a process in which the child’s involvement is not transitory, but the starting point for an intensive exchange on the development of policies, programmes, and measures in all contexts relevant to the child’s life” (UNHCR, 2021: 52).

Currently, there are problems with MHPSS measures provided both within and outside the reception system, in terms of the planning, promotion and communication of the broad spectrum of psychosocial activities provided.

In some cases, minors were not able to participate in decisions about the most suitable psychosocial support pathway, and the right to be listened to and to participate did not always seem to be guaranteed in the various phases of integrated care. Listening and empathic dialogue, and the involvement and consultation of children in the decisions that affect them appeared, therefore, to be lacking.

Life in reception facilities, and the rules on which it is structured, may not correspond to the expectations of young people. This situation, especially during adolescence, may trigger an attitude of conflict towards a care system that is not always adequately equipped. In some reception centres, there is evidence of observed of what Vacchiano describes as the ‘border’ (Vacchiano, 2011), i.e., a set of filters that act invisibly between actors operating in the reception system (migrants, professionals, social and health services), and are transmitted to users through the exchanges and negotiations that take place. In some of the documented cases, these ‘borders’ have triggered a dynamic of confrontation/clash that has led to the breaking of balances within the reception centres.

“Apart from the dedicated specialized facilities, almost all centres have a mix of users, where migrant and refugee children with significant traumatic profiles, both in terms of deeply depressive feelings, and in terms of more disturbing behaviour, often upset the internal equilibrium of the reception centres where many different UASC with different paths cannot live together. So, I think that some instability, instability of the system, is inevitable from this point of view.” (M., psychologist, Lombardy)

The instability of the system is often intensified by certain factors, as summarized by Codici (2021):

“Apart from the dedicated specialized facilities, almost all centres have a mix of users, where migrant and refugee children with significant traumatic profiles, both in terms of deeply depressive feelings, and in terms of more disturbing behaviour, often upset the internal equilibrium of the reception centres where many different UASC with different paths cannot live together. So, I think that some instability, instability of the system, is inevitable from this point of view.” (M., psychologist, Lombardy)

Interdisciplinary literature (Vacchiano, 2011; Marchetti, 2016; Fontanari, 2016) points out how the inexperience of professionals, the discontinuous presence of cultural mediators, the late activation of inclusion paths, the bureaucratization of reception processes, and the lack of support in the development of a network of relationships functional to the prospect of autonomy can contribute to problems of the reception system (Marchetti Manocchi 2016), to the detriment of individual paths and individual projects.

Many migrant and refugee boys and girls described a poor relationship with the educators of the reception centres, in some cases characterized by fragile listening, time pressures, the inexperience of the figures employed, and the excessive bureaucratization of this role.
Case study - Life here makes me angry

“I arrived here from Libya in December 2019. I’ve been in a CAS (extraordinary reception centre) for a year, and then I have been in a Sprar [protection system for asylum seekers and refugees] for nine months. From morning till night, we do nothing here; we have no activities. At the same time, they tell us that the Sprar programme is six months and once you finish your months you have to leave. I’ve understood that I have to leave, but if in six months I haven’t learned Italian, I haven’t done any activities, I haven’t learned anything, these six months are wasted.”
(M., 20, Somalia)

M.’s experience clearly portrays the problems of the reception system, in which the lack of training, psychosocial and psycho-educational activities can generate inertia and frustration and exacerbate psychological and physical suffering.

In M.’s story, the suffering was amplified when her requests for job training were ignored without any reasonable explanation, other than the limitation of certain activities due to the pandemic.

M. felt she was “wasting time” and this threw her into deep despair. Her emotional suffering increased when her requests for support were not heeded and turned into anger and psychological suffering.

“Life here makes me angry,” she told us. “Nobody can help me here, nobody. The latest [incident] happened yesterday. They called us saying: you have finished the centre and you have to go. It’s not as if my mum’s house is out there!”

The dialogue with M. revealed the lack of empathic relationships, based on active listening to needs and emotional support, in the reception system. The perceived indifference to her needs led to great discomfort and deep psychological distress, further aggravated by the hierarchical decision-making processes which failed to promote participation and the capacity for self-determination.

M., supported by her fellow countrywomen in the centre, asked to be allowed to spend her time cooking food that she and the other girls liked. Her request was denied because the centre’s regulations require food to be provided by a catering service.

This refusal, understandable on a regulatory level but apparently poorly explained, increased the frustration of M., who, in reaction, stopped eating.

- M. : “The food here arrives sealed. I won’t eat this food. It’s cold and then my stomach aches. Sometimes I’ve shown the food and said: ‘take it back’. For a month, they would bring me food and I would leave it there; I would stock it for a month. They saw that I was under stress, that I wasn’t eating.”
- Interviewer: Did anyone do anything to help you?
- M.: “At the beginning, I said: ‘I am new, I can’t understand. Help me!’ They told me this will have to do. This is the programme. Stay if you want. You can tell them whatever you want. It goes in one ear, out the other.”
- Interviewer: How do you feel physically?
- M.: “I feel that now, even if you give me food, my stomach is shut. I have no appetite anymore. Since I’m used to hunger, now I can’t eat. Sometimes my stomach aches.”

The frustration experienced by M. and the other girls increased when their request to use a tailoring workshop in the centre was denied without a reasonable explanation.

“There is a room for tailoring here, but it is closed, and they do not give you permission to enter. We asked why; I also said that I had gone to tailoring school. They (the professionals) looked at each other: they said OK, but then no one answered.”

(N., 20, Somalia)

Another girl, N., who does not know exactly how old she is but says she left her country of origin when she was about 16, said she spent a year and a half in Libya. This is a difficult experience for her to recall. N. expressed an urgent sense of wanting to erase the memories of that long stay, which probably involved by deprivation and abuse. Having been in Italy for almost two years, she says she feels “invisible” and unheard.

“There’s no one to talk to here. Nobody listens to you here. If you need support, the answer is ‘we are not here’, ‘we are busy’.”

For this profoundly distressed young girl, her stay in the reception centre has become a limbo, in which she struggles to fill her time.

“I have no one here. I’m utterly demoralized, and I don’t go out. Most of the time, I don’t go out. Where would I go? I don’t know where to go. I haven’t left here for three weeks since the end of last month.”

Her state of mind was similar to M.’s apathy and pervasive discomfort.

“Sometimes I read. I look for something to read. Otherwise, I just sit.”

The girls described how inactivity and apathy are sometimes interspersed with arguments with the centre staff. These are triggered not only by communication difficulties, but also by the inexperience of the professionals.

N. told us: “At the beginning, there was the language barrier, which was very difficult. We didn’t understand each other; now we can understand, but we can’t reply. In the centre, many of the professionals are young. When you are young and you are the same age, you sometimes clash.”
The frustration of being unable to communicate their distress, and of not having their basic needs understood and met has turned into unexpressed, silent anger. These emotions further compromise the girls’ psychosocial well-being and increase the risk that more acute and chronic forms of psychological distress might develop.

According to M., “Sometimes you just want to lay your hands on someone. We stay silent because we know our needs, but we can’t do anything, so we go back to our room.”

“Sometimes you feel like punching a wall,” said N.

In other situations, peer-to-peer support, including sharing a common state of suffering, is helpful for the girls:

“Sometimes we cry, sometimes we deal with each other, talk to each other and tell each other what we can do,” explained N. “Sometimes you just want to drop everything and go out into the street.”

In some cases, during FGDs and interviews about activities and services provided outside the reception facility, young refugees and migrants explicitly complained about their own lack of involvement in the development of activities provided for them, and the lack of comprehensive information about available services and how to access them. In some cases, even though young refugees and migrants explicitly required access to certain services, including psychological support, the interventions were not provided. The prolonged wait for support, together with the lack of information, contributed to an increase in emotional suffering, frustration, loneliness, and perceived helplessness.

“Sometimes feelings of anger and frustration emerge. Some children display behavioural disorders, such as isolation or aggressive behaviour, disrupted sleep, or difficulties in learning the Italian language, that can hinder the achievement of their own autonomy. We know from experience that, in most cases, these are short-term situations, often connected to the inability to process the traumatic experiences and violence of the migration journey, or the separation from the family of origin.” (Bestazza, 2017:198)

Some educators have related these problems to the significant increase in job insecurity among staff in the reception system. Job insecurity, together with the high turnover of staff among educators, can affect their relationships with UASC, which can be perceived as temporary and unstable.

Boys and girls specifically complained about the inadequate provision of relevant information. M., a 16-year-old boy who arrived in Italy a little over a year ago and who is visibly suffering emotionally, describes the impact of these dysfunctions.

“Are we all entitled to have a psychologist? Because I don’t know... I definitively need one! No one told me what to do. Neither here nor in Sicily... Because you know I spent a lot of time in Libya...”

(M., 16, Guinea)
Information that is late, incomplete, excessively bureaucratized, lacking in empathy, linguistically inappropriate, or unsuited to the level of development of minors can compromise the child’s rights to be listened to and to participate, both of which are guaranteed by legislation at every stage of the reception procedure. Similarly, failure to use empathic dialogue can discourage participation.

According to many of the professionals interviewed, this issue is related to a lack of transcultural training programmes designed to equip MHPSS professionals working with migrant users. This issue also emerged from the quantitative research, as summarized in Box 15.

**Box 15 - Cross-cultural training for professionals working in MHPSS services for people with a migrant background**

When asked: “Does your region recognize and make available cross-cultural training for professionals working in psychosocial support and mental health services for people with a migrant background as a working methodology?” 47 per cent of the professionals interviewed said they had no information on this issue, while only 19 per cent indicated the existence of memorandums of understanding with bodies that provide this type of training.

Appropriate timing and clear, empathic communication emerge as the two pillars on which the quality of an MHPSS intervention for UASC depends.

The research also shows that systematically involving minors in choices that affect them improves the quality psychosocial support and mental health interventions, thus contributing substantially to stronger well-being. On the contrary, children and young people tend to delegitimize, abandon, and consider as inappropriate those interventions that they perceive as being imposed on them, or carried out in ways that are far from an empathic, respectful, and non-judgmental.

The importance of empathy is reflected in the words of S., a psychologist:

“The basic paradigm is, say, one of non-judgmental listening, of putting oneself in a position of not knowing, right? Of being a figure who has a caring role, who stays within a framework of firmness, but who gives a lot of space to what the kids then share. So, all that is active listening, empathic listening, a non-judgmental approach, they have to learn not only the language, how to say, but the possibility that the word reassures them a little bit.”

(T., psychologist, Emilia-Romagna)

The research evidence and the consultation workshop indicate that the Italian MHPSS system needs to consolidate and transfer the virtuous intervention models found in this mapping, which have made the active, informed, and empathic involvement of minors a key feature of their programmes.

Many of the mapped practices provide MHPSS services that are minor-friendly in that they are adapted to the age, maturity, gender, culture, and language of the minor. Clear, accessible,
and comprehensible information, provided in an empathic, trusting, and responsive relationship, is an essential prerequisite for minors to effectively participate in their own care processes, to strengthen their skills, and restore or reinforce their psychosocial well-being. For this reason, it is important to remedy the problems identified in the system, by working on training of personnel in charge of MHPSS interventions, in order to ensure quality standards that allow for the effective participation of minors.
Outreach activities aim to support people with vulnerabilities, who otherwise cannot or do not know how to access such services in the places where they live and work. In addition to providing services, information has an educational role, raising awareness about existing services.

The voluntary guardianship system is modelled on Article 11 of Law No. 47 of 2017, as amended by Legislative Decree No. 220 of 2017 which expressly allocates competences and defines monitoring procedures.

Not all the migrant and refugee boys and girls interviewed benefitted from the services provided by the practices mapped, although all the reception centres hosting them have structured exchanges and cooperation with the practices.

Clinical ethnopsychology is a composite discipline, including contributions from various disciplines (ethnopsychiatry, anthropology, sociology, geography), that frames mental suffering by taking into account the psychological-cultural dimension of the social and cultural contexts in which the practitioner lives. Clinical ethnopsychology deals specifically with the expression of psychological distress of migrants, with particular attention paid to local models of suffering and care and to the trend of encounter/clash with host communities. Reference academics engaged with the management of cases of psychic suffering between UASC include Abdessalem Yahyaoui and Tobie Nathan.

The group approach is a method used in therapy with migrant patients, which allows conflicts and thoughts to emerge. This would not be possible in a one-to-one relationship between the therapist and the patient. Tobie, Nathan, Principi di Etnopsicoanalisi, 1993 e L’etanger: Ou le pari de l’autre. Autrement, 1994.

Disclaimer: This document contains references to websites and services in Italian. The content of these external resources is not verified or endorsed by the UNICEF or by the authors of this document.
Chapter 6
Conclusions
This study selected and analysed 13 good, promising or emerging practices in six regions: Piedmont, Lombardy, Emilia-Romagna, Latium, Sicily and Apulia. These practices have been innovating in the field of psychosocial support and mental health services thanks to the development and implementation of interventions tailored to the specific needs of UASC and young migrants and refugees hosted in reception facilities.

The mapping provides an overview of the most significant practices available, with the aim of providing intervention models that can be implemented in other settings. The need for such an overview was asserted by the UN Committee on the Rights of the Child in its latest concluding observations addressed to Italy (point 29).

The practices identified have been described in ready-to-use fact sheets, designed to offer professionals in UASC reception systems an overview of intervention models, methodological approaches, multidisciplinary teams, types of services delivered, and active networks.

Thanks to the experiences of professionals working in the field of MHPSS services and the boys and girls benefiting from them, we have been able to examine the various intervention models. In particular, the way in which services are delivered and their accessibility were thoroughly analysed. The success factors of the services and critical aspects regarding coordination within reception facilities were also taken into consideration.

The practices were able to face the challenges of providing integrated care for UASC by developing innovative intervention models that meet users’ needs and are
complementary to the reception system and public health and social services.

Many important factors emerged from this research and were discussed in a consultation workshop, in which the representatives of the practices participated. The workshop aimed to discuss and integrate the preliminary results from the research in different territorial settings and from public decision makers working at a national level. The research and the discussions with representatives highlighted that the disciplinary paradigms that inspired the practices have common success factors that determine their quality and replicability. The common success factors are:

SUCCESS FACTOR 1: Ability to tailor services to effectively respond to the mental health and psychosocial needs of migrant and refugee adolescents and youth.

SUCCESS FACTOR 2: Multidisciplinary teams working in the reception system and in local social and health-care services to guarantee continuity of care and integrated care.

SUCCESS FACTOR 3: Provision of culturally competent systems of care, based on the integration of transcultural/ethnoclinical/ethnopsychiatric paradigms, and linguistic and cultural mediation services.

SUCCESS FACTOR 4: Permanent efforts to improve the capacity of the reception system, and local social and health services through capacity-building programmes and awareness-raising campaigns.

SUCCESS FACTOR 5: Establishment of networks and multi-stakeholder coordination mechanisms involving the reception system, and local social and health services.

The mapping also helped to identify some aspects of the provision of MHPSS services that require some improvement, despite the commitment of institutional bodies and civil society organizations. These aspects fall into four categories:

1. Coordination between the reception system and MHPSS services
2. Suitability of public mental health services for supporting young refugees and migrants
3. Mechanisms for identification, referrals and intake
4. Participation of UASC in the care processes that concern them

This mapping clearly showed that psychosocial support and mental health services delivered in Italy to meet the needs of UASC, and young migrants and refugees need reconsiderations, updates, and consolidation rather than be designed from scratch. From Northern Italy to Southern Italy, several successful intervention models were identified. Despite the scarcity of funds and the intermittent commitment of national and local institutions, these models promoted psychosocial support and mental health services based on: the right to non-discrimination, respect for the best interests of the child, and the right of boys and girls to be heard. Indeed, these models should be consolidated, enhanced, and replicated.

By valuing and building on these existing models, and improving planning, implementing and monitoring of MHPSS services, it is possible to develop common codes of conduct and minimum standards that guide MHPSS work with UASC and other young migrants and refugees.
Appendices

APPENDIX 1: The Role of UNICEF in the field of MHPSS in Italy and the operating principles

UNICEF’s MHPSS Interventions in Italy

UNICEF’s work in Italy is based on an organizational framework composed of three elements. Although the common reference framework is UNICEF’s global mandate, these elements are different, but complementary.

The UNICEF Regional Office for Europe and Central Asia, located in Geneva, coordinates UNICEF’s programmatic and technical support actions with institutions, focusing on the most vulnerable groups of children and adolescents at risk of social exclusion - with particular attention on migrant and refugee minors.

The UNICEF Office of Research – Innocenti is globally qualified to conduct scientific research on all subject fields related to childhood and adolescence.

Lastly, the Italian Committee for UNICEF oversees fundraising advocacy, education on rights, information and awareness-raising about the rights and needs of children and adolescents, with the help of a network of volunteers operating at a national level.

Programmes aimed at child protection and MHPSS for migrant and refugee children, adolescents and youth are diverse and can be summarized as follows:

Direct support and integration of MHPSS services in emergency interventions. UNICEF, in cooperation with local and international partners, directly supports Psychosocial support interventions for migrant and refugee boys and girls in Italy. In border areas such as Lampedusa and Ventimiglia, UNICEF provides psychological first aid services. Other Italian regions are provided with psychological and psycho-socio-educational support services through group activities within reception facilities, and through mentorship programmes, individual and specialized counselling, both online and offline. Due to the increased need for psychosocial support in cases of violence, abuse, and exploitation experiences, MHPSS intervention has been integrated into all programmes concerning vulnerable minors and migrant girls and young women.

Programmes to prevent and reduce discrimination; promote listening and promote the voices involvement of boys and girls through the Activate Talk programme and the U-Report survey platform. UNICEF has produced a number of audiovisual products to counter prejudice and psychological distress, with details of professionals to contact in case of difficulty, and issues related to LGBTI, self-harm, sexual violence, gender-based violence, racism and discrimination. Activate Talk brings the voices, experiences and needs of boys and girls to
the forefront, offering a unique opportunity to convey strategic messages to decision makers, raise awareness of the psychosocial needs of boys and girls and consolidate cooperation with institutions and civil society.

**Research.** In recent years, UNICEF has conducted several research projects to analyse mental health and psychosocial well-being, focusing on children and young people with migrant backgrounds, and the gender dimension. All UNICEF-supported research projects aim to produce evidence-based knowledge that can inform and guide programmatic and policy actions. In 2019, a study, conducted in cooperation with other partners, analysed the factors that support or hinder the transition process from adolescence to adulthood for UASC. In 2021, three studies were developed, concerning:

1. The impact of COVID-19 on the psychosocial well-being of unaccompanied foreign minors and young migrants in Italy
2. Mapping and analysing good practices of MHPSS services for UASC and young migrants and refugees
3. The impact of the pandemic on access to services by young migrant girls and women

Furthermore, on the occasion of the first COVID-19 lockdown pandemic, the Italian Committee for UNICEF with the Department of Education Sciences of the University of Roma Tre conducted a survey to understand how families with minors were coping with stress and emotions during the pandemic.

**System strengthening.** This is a strategically important component, which cuts across all UNICEF programmes and aims to strengthen institutional capacity and improve the quality and sustainability of MHPSS and protection services for UASC children and young people. In Italy, UNICEF carries out training and supervision activities, in partnership with other organizations, for professionals and non-professionals employed in front-line protection and support services for mental health and psychosocial well-being, in UASC first and second-line reception, and in psycho-educational and social inclusion projects for migrant and refugee adolescents and young people in vulnerable situations. As part of this programme, in 2021, UNICEF consolidated a cooperation project with the professional association of psychologists and social workers and national associations of professional educators and pedagogues. The project aimed to develop an interdisciplinary training programme for all professionals who support migrant and refugee boys and girls in their growth and transition to adulthood at different levels and in multiple contexts.

**Technical support for institutions.** UNICEF is constantly engaged in dialogue with institutions, governments and civil society in the areas of governance, policy, programming and development of interventions to protect migrant and refugee children and adolescents. In line with its mandate, UNICEF offers technical support to relevant ministries, including through participation in relevant technical working groups, to ensure that the needs and rights of migrant and refugee children and adolescents are taken into account. In addition, UNICEF promotes inter-agency coordination, sharing of innovative experiences and lifelong learning among individuals working towards a common goal of promoting a more effective, collaboration-based and integrated system. To this end, UNICEF promotes events for discussion and exchange among
those who variously contribute to the mental health and psychosocial well-being of migrant and refugee children and young people.

**Development and adaptation of technical manuals and operating guidelines to harmonize approaches and methodologies and ensure minimum quality standards.** In cooperation with partner organizations, UNICEF has identified and structured knowledge and practical guidelines for integrated psychosocial UASC care, and the training of voluntary legal guardians and foster families. A series of guidelines and technical tools for psychosocial support developed at international level, including an operating manual dedicated to support migrant and refugee adolescents in vulnerable situations, is also being translated into Italian and adapted to the domestic context.

**The Italian Committee for UNICEF is a member of the National Monitoring Centre for Childhood and over the last two years has contributed to the development of the new two-year National Action Plan for the Protection of Child Rights and Development (the so-called National Childhood Plan).** In this context, it has formulated proposals to strengthen local home-care services dedicated to the psychosocial well-being and mental health of migrant and refugee children and adolescents, also in view of the critical issues arising from the Covid-19 pandemic. In this regard, the new Budget Law has allocated EUR 20 million for 2022 for the psychological support of students and school staff.

Within the framework of the Italian G20 presidency, **UNICEF also contributed to the G20 health track side event dedicated to the theme of mental health** – COVID-19 and the Need for Action on Mental Health (Rome, 3 September 2021) – which led to the final declaration of the G20 Health Ministers on 5 and 6 September 2021. The issue of mental health was also explored in the engagement working groups under the Italian G20 presidency, such as Youth20, which was also supported by UNICEF.

In line with this approach, and in cooperation with national authorities and civil society organizations, and thanks to the support of the European Commission’s Directorate General for Health and Food Safety, UNICEF has developed the programme **Strengthening refugee and migrant children’s health status in Southern and South-Eastern Europe** in the last two years. Its actions include the strengthening of the MHPSS system for migrant and refugee children through the provision of psychosocial support services, training sessions for public and civil society organization service providers, and the identification and mapping of good practices in MHPSS for UASC in transition to adulthood.
For UNICEF, both the IASC paradigm and the operating manual ‘Operational guidelines: Community-based Mental Health and Psychosocial Support in Humanitarian Settings: Three-tiered support for children and families, UNICEF 2018’, are particularly important because of their operating principles that should guide interventions at every stage (needs assessment, design, implementation, monitoring, assessment, research, advocacy, etc.). These operating principles can be summarized as follows:

1. **Equity and fundamental human rights.** Every mental health and psychosocial well-being service should promote the fundamental human rights of targeted individuals and groups. Moreover, 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 them, without discrimination on the basis of gender, age, language, cultural background, or any other human dimension. In the specific area of interest for this research, UASC are considered a vulnerable category and, therefore, they should be ensured dedicated channels to facilitate access to and use of services.

2. **Do not cause further harm.** The utmost care and attention are required to ensure that MHPSS services do not cause and do not contribute, even unintentionally, to further distress, suffering, difficulty, disadvantage, or increased vulnerability for the target person and groups. As the field of psychosocial intervention is delicate and complex, the risk of harm is higher than in other sectors. It is therefore necessary to carefully assess possible risk factors before, during and after the provision of services and to carefully monitor the impact of the intervention on the psychosocial well-being of the user.

3. **Participation of individuals and groups targeted by mental health and psychosocial well-being interventions.** Involvement and consultation with service users is essential to ensure that interventions are consistent and effective in fulfilling identified needs. Furthermore, encouraging an active role for service users within programmes ensures faster recovery, enhanced personal resources and greater capacity for self-determination. Such participation is a fundamental aspect of the consolidation of psychosocial well-being. In the case of migrant and refugee boys and girls, their voices, thoughts and emotions should always be taken into account and used as guiding elements of interventions.

4. **Make interventions on the basis of available resources and capacities, by strengthening existing systems, and exploiting the resources of targeted individuals, groups and communities.** This principle may involve mapping and assessing existing community initiatives and MHPSS services before new ones are established. Generally speaking, any intervention should respond to identified needs and be compatible with the needs, including cultural needs, of the context and users, in order to be sustainable. The continuous strengthening and reinforcement of the capacities of workers and of other stakeholders involved should be a priority pillar of any intervention. In the last years, a so-called ‘community-based’ approach, which is well exemplified by the recently developed UNICEF operational guidelines mentioned above, has become increasingly widespread.
5. Multilevel and integrated mental health and psychosocial well-being support. As already highlighted, the continuum of essential and psychosocial needs can be supported by multiple interventions, which act in an integrated and complementary way. This is important in preventing the creation of a fragmented system, which would be unable to identify and respond adequately to the complex needs of individuals and groups.

6. Inter-agency coordination and referral mechanisms. Given the wide area of services and the great multiplicity of professionals operating in different sectors supporting mental health and psychosocial well-being (health, education, protection to mention some of the main ones), effective and shared coordination mechanisms are needed. Such mechanisms would enable regular exchanges and comparisons between all the actors involved, at local, regional and national level. A good knowledge of the services active in the territory is vital for workers and professionals to provide integrated support and to be able to respond to an individual’s needs and to carry out timely and adequate interventions. The IASC guidelines include several tools to map existing services, establish effective inter-agency coordination mechanisms, and systematize referral mechanisms.

APPENDIX 3 – Guidelines for MHPSS services delivered to migrant users

Since 2008, many guidelines have been promoted nationally and locally with the aim of ensuring standardized interventions in protection, MHPSS services, and promotion of the mental health of minors and young migrants and refugees.

1. National Guidelines for Mental Health In 2008, the Ministry of Health promoted these guidelines which require regions to ensure the promotion of mental health locally, to enable equal and unhindered access to integrated services, and to bridge the gap between the social and health sectors. The guidelines point out that Law 328/2000 represents a reference for the integration of the social and health sectors, by means of policies that require coordination and integration between planning bodies (regions, local authorities and local units) and organizations providing services (public and private services within the health and social sectors.) They also include specific indications on child and adolescent mental health: requiring mental health services to take into consideration the social, educational and health fields, while strengthening environmental factors of protection. The guidelines also specifically address migrants with migratory backgrounds, a population described as having been exposed to distressing factors that are likely to provoke mental disorders and social distress. These guidelines identify the community as an arena where health and social integration processes have to interact as to eliminate cultural and organizational barriers that are likely to limit migrants to access mental health services.
2. Guidelines for the provision of care, rehabilitation and treatment to holders of refugee status or subsidiary protection with mental disorders, who experienced torture, rape or other forms of psychological, physical or sexual violence. Issued by Ministry of Health in 2017, these guidelines are aimed at applicants for international protection and vulnerable refugees at any stage of their protection and reception application. They assume that applicants and holders of international protection are likely to develop psychopathological syndromes provoked by distressing, painful or traumatic experiences. Indeed, their aim is to ensure a prompt and continuing health care in line with the need to protect these vulnerable individuals’ rights.

Another goal is to provide guidance on the implementation of uniform interventions at a national level by means of identification processes, MHPSS services and treatment of victims of intentional violence and torture, in line with existing programmes within reception facilities and health and social care facilities. They also state that a multidisciplinary, participated, integrated and holistic approach is necessary: starting from the identification processes of migrants, to assessing their cases, then referring them to the most appropriate facility. According to Article 1 of Ministerial Decree 3 April 2017, regions and autonomous provinces should implement these guidelines, issuing their own measures. Although some ministerial projects funded by the AMIF require the implementation of these guidelines, their application is still lacking to date. In many territorial settings, many aspects are still lacking, including identification processes and health-care services for survivors of intentional violence and torture, and an adequate number of professionals with psychiatric skills in post-traumatic and transcultural fields (Santone, 2021:45).

3. Guidelines ‘Border Controls. The Border of Controls. Health Checks upon Arrival and Protection Pathways for Migrants hosted in Reception Centres’, published by the National Institute of Health, the Italian Society of Migration Medicine (SIMM) and the National Institute for Health, Migration and Poverty (NIHMP). These guidelines were issued in 2017 and their aim is to standardize the variable practices adopted by regions and local authorities in terms of health-care services to migrants and applicants for international protection, upon their arrival in Italy and during their reception stages. On 10 May 2018, the State-Regions Conference and Autonomous Provinces implemented these guidelines. The guidelines provide decision makers, managing bodies of reception centres and care assistants with recommendations designed to standardize implementation measures and modalities with regards to health-care and health protection services for migrants, while also taking into consideration their mental conditions. The guidelines highlight the importance of recognizing the linguistic and social dimensions in different settings by adapting messages to given cultural systems. Moreover, they require care assistants to be adequately trained for transcultural approaches and to receive psychological support to handle emotionally distressing situations.

4. Guidelines for the reception of minors in residential services, endorsed by the Joint Conference on 14 December 2017, provide for the full integration of social and health interventions in every regional and territorial setting as well as regional and local programmes for minors’ residential reception. These guidelines require protection for UASC by means of specific care programmes that ensure adequate reception, psychosocial, health and legal support, and provide long-term solutions even after turning 18 years old.
5. Guidelines for child and adolescent neuropsychiatric and neuropsychic disorders. The Working Group for child and adolescent neuropsychiatric and neuropsychic disorders, established by the Ministry of Health, endorsed these guidelines by means of an agreement established during a Joint Conference on 25 July 2019. These guidelines govern the services provided within child and adolescent neuropsychiatric and neuropsychic fields, including neurological disorders (resulting from acquired or genetic diseases of the nervous system), developmental disorders (intellectual disability, autism spectrum disorders, specific language and learning disorders, attention deficit hyperactivity disorder, etc.), and psychiatric disorders (psychosis, affective disorders, conduct disorders, eating disorders and many others). Most of these disorders are determined by a complex interweaving of genetic predisposition, neurobiological vulnerability and environmental variables. These guidelines consider these disorders as a whole and discuss the importance of taking into consideration the frequent coexistence of several disorders in the same person. The document provides, for the first time, data concerning access to services and the services provided at a regional level. These data highlight the areas of greatest deficiency in outpatient, semi-residential, residential and hospitalization responses.

Box 16 - Applying guidelines for child and adolescent neuropsychiatric and neuropsychic disorders according to quantitative surveys

The online survey of MHPSS workers in the analysed regions revealed a lack of knowledge of the guidelines for child and adolescent neuropsychiatric and neuropsychic disorders. Indeed, when asked ‘Did your region implement the guidelines on child and adolescent neuropsychiatric and neuropsychic disorders endorsed by the Government, regions and autonomous provinces and local authorities on 25 July 2019?’, 85.5 per cent of interviewees stated that they were unable to answer this question.

It is also important to highlight the guidelines endorsed by important organizations working for the protection of children and adolescents:

6. Guidelines for Minimum Standards for the Protection of UASC. These Guidelines were endorsed by CISMAI in 2019 and disseminated in May 2020. They include measures to identify and meet the needs of UASC, including measures to identify psychological well-being or illness, and methods to identify risk factors and psychological reactions, in particular conditions related to trauma that UASC may be suffering.

7. The Guidelines for Child and Adolescent Psychiatric Emergencies (Costa et al. 2018) were published in 2018 in cooperation with the Italian Society of Child and Adolescent Neuropsychiatry (SINPIA). They provide clinical and organizational guidelines for workers, service managers/organizers, decision makers and users, with the aim of ensuring the appropriate management of adolescent acute psychiatric disorders.
Activate Talks (www.activatetalksitalia.com) is a UNICEF project designed to give a voice to adolescents and young people and engage them in a dialogue with civil society organizations, institutions, and the private sector. It involves a series of meetings on various issues relevant to the daily lives of boys and girls, focusing on those facing situations of greater fragility. Speakers participating in these talks are young people under 25, who bring their experience, their points of view and their recommendations to the adult community working on the subjects covered by the talks.

See: https://onthehmove.ureport.in/

United Nations High Commissioner for Refugees (UNHCR), International Organization for Migration, IOM, ISMU Foundation, University of RomaTre and University of Catania.


Some of the categories concerned with the training programmes are professional educators and facilitators of psychosocial activities, voluntary legal guardians, and foster families, etc.


www.youngambassadorssociety.it/Y20_2021_Communique.pdf

Possible elements that can lead to risk or damage if not adequately addressed are: the stigma and discrimination associated with the use of a psychological service; inadequate preparation of psycho-socio-educational activities; the training and supervision of workers offering psychosocial services, and their ability to identify a deeper distress and to respond in a timely manner with an appropriate referral; measures taken to protect privacy and sensitive data; inappropriate use of psychological and neuro/psychiatric diagnoses; and ensuring services are sensitive to gender, age, culture dimensions, etc.


www.salute.gov.it/imgs/C_17_pubblicazioni_779_allegato.pdf


Latium adopted the national document, implementing its approach, recalling its principles and adapting it to the regional context with the Resolution of the Regional Council no. 590 of 16 October 2018, ‘Indications and procedures for the reception and health protection of applicants for international protection’.

See www.epicentro.iss.it/migranti/pdf/LG_Migranti-web.pdf


The Guidelines are the result of collective work carried out within a national discussion involving representatives of the Ministry of Labour and Social Policies; the Ministry of Justice - Department for Juvenile and Community Justice, the Regions-Autonomous Provinces Conference, the National Association of Italian Municipalities, the Italian Authority for Childhood and Adolescence, and experts appointed by the Ministry, www.minori.gov.it/sites/default/files/Linee_per_lemergenza-urgenza-psichiatrica-in-eta-evolutiva/
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