

A close-up portrait of a young woman with voluminous, curly brown hair. She is looking directly at the camera with a neutral expression. She is wearing a dark blue, textured jacket over a white t-shirt. The background is a soft, out-of-focus grey.

Mental health and well-being of unaccompanied minors

A Nordic overview



Nordic Welfare
Centre

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Foreword

What do we know about the mental health and well-being of unaccompanied minors in the Nordic countries? This report tries to answer a very complex question. The overall purpose is to collate and disseminate Nordic knowledge and existing research about the mental health of unaccompanied minors. And in doing that, hopefully also promote mental well-being and improve interventions for unaccompanied minors. The report is aimed primarily at professionals that encounter unaccompanied minors, such as teachers and social workers, but also NGO's, researchers and public officials.

Main chapters of this report include:

- Mental health situation of unaccompanied minors
- Risk and protective factors for migrant health
- Female unaccompanied minors
- Mental health interventions targeting unaccompanied minors

For all of us, our mental health and well-being consists of countless aspects and factors, and some that cannot possibly be explained or measured. In order to keep the report within limits we have been forced to define mental health and well-being narrower than we would have wished. Therefore, it is important for the reader to keep in mind that there are important factors, not included in this report, that have great bearing on the mental well-being of unaccompanied minors.

This report is the product of an assignment given to the Nordic Welfare Centre by the Nordic Council and the Nordic Council of Ministers. Integration is a Nordic priority area, playing an important part in the Nordic Council of Ministers' vision of a socially sustainable region. Learning from each other and sharing experiences are the cornerstones of Nordic collabora-

tion. This report is a part of the Nordic co-operation programme on the integration of refugees and immigrants.

The Nordic Welfare Centre would like to thank the members of the Network on early interventions for newly arrived children and families (coordinated by the Nordic Welfare Centre) for their input in the early stages of this work. In addition, we are indebted to several experts for their input, namely Petra Rinman, Ove Ledin, Anders Hjern and Ketil Eide. Thanks to Gustaf Norlén at Nordregio we present some statistical data. Our colleagues have provided useful input and advice during the writing process, especially Aila Määttä who provided excellent research support.

It is our hope that this report will contribute to unaccompanied minors receiving best possible reception and the support they need for successful integration. We want unaccompanied minors to have the opportunity to develop to their best potential. We also hope to spur further research, especially in areas where knowledge is scarce.

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NORDIC COLLABORATION

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www.integrationnorden.org

Background, aim, and purpose

This report surveys different aspects of health of unaccompanied minors who have arrived in the Nordic region. The focus is on mental health issues rather than physical health, as the former are usually seen as posing more of a challenge to successful integration and to the social and health services in the Nordic countries. The report builds on recent research and studies, mainly from 2012 onwards. Older studies have been included if they offer additional insights. As the emphasis is on Nordic research, international research on migrant mental health is less referred to. This report is not a systematic review of all Nordic research, but rather a snapshot of main studies and reports. It highlights and summarises some of the knowledge from both general overviews and specialised scientific literature. Much of the research and data come from national bodies of social, health, and integration issues, research institutions, and universities. Some reports, overviews, and evaluations are outcomes of projects granted by ministries and directorates to different research institutions.

The search for information and data has to a large extent focused on unaccompanied minors. Studies and reports which do not differentiate between accompanied and unaccompanied minors have in most cases been excluded. Our priority has been to include quantitative studies that measure mental health and well-being, but some qualitative studies have also been discussed to illustrate different aspects of the bigger picture. There are plenty of qualitative studies, such as interview studies, available on the experiences of unaccompanied minors that are not mentioned in this report. There is also a lot of information available on the different aspects of the asylum-seeking process for unaccompanied minors, their rights, living conditions, education, etc. in the Nordic countries that

this report does not cover. Here the focus is on health.

We have made a concerted effort to find quantitative research on unaccompanied girls, but this appears to be an area of little Nordic research so far. This may be partly explained by their significantly lower numbers, but it is nevertheless an issue that needs attention.

The report also highlights risk and protective factors for refugee mental health, interventions for promoting mental health among unaccompanied minors, and the importance of giving a voice to the unaccompanied minors themselves.

Iceland, Greenland, Faroe Islands, and the Åland Islands could not be included in the report due to both small numbers of unaccompanied minors and a lack of studies.

The report only includes information and research on unaccompanied minors registered as asylum seekers. We have not discussed paperless' migrant children or those who disappear during or after their asylum process.

Another limitation is that we have not been able to evaluate and compare the quality or strengths of the research and studies that we have identified.

It is not possible to separate health issues from well-being in general. Several other factors are prerequisites of well-being among unaccompanied minors, such as learning a new language, having close social contacts, doing well in studies, and entering the labour force. These factors are not the focus here and are therefore only briefly mentioned when they are deemed necessary to the understanding of mental health aspects. Often, reviews on mental health do not address mental well-being or psychosocial problems but focus on mental disorders as outcome. Therefore, we cannot claim that this report paints a complete picture of the mental health status of unaccompanied minors in the Nordic region.



Definition of unaccompanied minors

A refugee is someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion (according to the 1951 UN Refugee Convention¹). Refugees are distinguished from asylum seekers (individuals seeking international protection whose claim for refugee status has not yet been decided) and from other immigrants who leave their homes voluntarily for reasons such as seeking better life opportunities.

In the European Union, unaccompanied refugee minors (URM) or unaccompanied minors

(UMI) are defined as third-country nationals or stateless persons below the age of 18 who arrive on the territory of the member states unaccompanied by an adult responsible for them whether by law or custom and for as long as they are not effectively taken into care of such a person, or minors who are left unaccompanied after they have entered the territory of the member states (article 2(f) of the EU Council Directive 2001/55/EC).² The figure below shows that 'unaccompanied minors' also refers to children who do not actually arrive alone.

This report will use the term 'unaccompanied minors' and 'UMI' throughout the text.

Figure 1. Unaccompanied children (scope)



Source: European Asylum Support Office EASO (2018): Guidance on reception conditions for unaccompanied children: Operational standards and indicators (p. 12).³

Unaccompanied minors in an international rights perspective

Whether unaccompanied minors are foremost children or asylum seekers are two widely separate policy frameworks and will largely define how they should be received and what rights they are offered. Under international conventions, all unaccompanied minors are entitled to special protection, also those who may not seek asylum. The EU framework finds them to be children first and foremost, and all considerations relating to their immigration status must be secondary. However, there is a challenging dilemma between treating the children and young people humanely, with the best interests of the child at heart, while complying with current immigration and asylum policies (Eide & Hjern, 2013).

One of the primary conventions governing the treatment of unaccompanied minors is the United Nations Convention of the Rights of the Child, adopted in 1989. The most relevant articles lay down the following:

Art. 1 Definition: those below the age of 18 years are children

Art. 2 States have to guarantee all the rights to all children without discrimination, whatever their ethnicity, sex, religion, language, abilities, or any other status, whatever they think or say, whatever their family background.

Art. 3 The best interests of the child must be a top priority in all decisions and actions that affect children. See the description of key elements in the concept 'best interests of the child' in figure 2.

Art. 22 If a child is seeking or has refugee status, governments must provide them with appropriate protection and assistance to help them enjoy all the rights set forth in the Convention. Governments must help refugee children who are separated from their parents to be reunited with them.

Art. 24 Each child has the right to the best possible health. Governments must provide good-quality health care, clean water, nutritious food, a clean environment, and education on health and well-being so that children can stay healthy.

Art. 39 Children who have experienced neglect, abuse, exploitation, torture, or who are victims of war must receive special support to help them recover their health, dignity, self-respect, and social life.

Other important conventions regulating the rights of unaccompanied minors are the UN Refugee Convention of 1951, the 2006 UN Convention on the Rights of Persons with Disabilities⁴, and 1966 UN International Covenant on Economic, Social and Cultural Rights⁵. The UN Refugee Convention (recommendation B) recognises the crucial principle of family unity: the unity of the family, which is the natural and fundamental group unit of society, is an essential right of the refugee. When this unity is constantly threatened, the rights granted to a refugee are therefore to be extended to members of his/her family. Governments are required to protect the refugee's family, especially with a view to protection of refugees who are minors and in particular unaccompanied children and girls.



Figure 2. Key elements (non-exhaustive) of the best interests of the child, indicating the legal instruments as reference

Source: European Asylum Support Office EASO: Practical guide on the best interests of the child in asylum procedures (p. 20⁶).

European Union⁷ and guidance on unaccompanied minors

Unaccompanied children in migration require specific and appropriate protection. They are in a state of particular vulnerability due to their age, distance from home, and separation from parents or carers. They are exposed to risks and have possibly witnessed extreme forms of violence, exploitation, human trafficking, physical, psychological, and sexual abuse before and/or after their arrival on EU territory.

- They may risk being marginalised and drawn into criminal activity or radicalisation. Unaccompanied children as a particularly vulnerable group are more easily influenced by their environment.
- Unaccompanied girls are at special risk of forced and early marriages, as families

struggle in straitened circumstances or if their families wish to see their daughters married in order to protect them from further sexual violence. Unaccompanied girls could furthermore already have the responsibility of caring for children of their own.

- In addition, unaccompanied children with disabilities are particularly vulnerable; they are at a high risk of being victims of violence.
- Unaccompanied children may also be particularly vulnerable due to their sexual identity, sexual orientation, or gender expression.

It is therefore a priority for the EU to protect children in migration – unaccompanied children



in particular – and to ensure that their best interests are respected regardless of status and at all stages of migration. Assessing the vulnerabilities and addressing the needs of unaccompanied children does not mean that their strengths should be overlooked.

The European Commission's Action Plan on Unaccompanied Minors 2010–2014⁸ proposed an EU approach based on three main strands for action: prevention of unsafe migration and trafficking; reception and procedural guarantees in the EU; and identification of durable solutions. It set out the goal that a decision for each unaccompanied minor should be taken by competent authorities – preferably within six months – from the moment the child is detected on EU territory or at EU borders.

In addition to different funding mechanisms,

such as the Asylum, Migration and Integration Fund, the European Union has several other tools on migration and asylum affairs. The European Migration Network (EMN)⁹ provides up-to-date and comparable information on migration and asylum, including country factsheets, to support policymaking in the European Union. The European Asylum Support Office¹⁰ (EASO) is a European Union agency set up to provide technical and operational support to Member States on the many aspects of asylum. For this report, the two EASO guidance reports are the most relevant:

- Practical guide on the best interests of the child in asylum procedure¹¹
- Guidance on reception conditions for unaccompanied children: Operational standards and indicators.¹²

Number, gender, and age of unaccompanied minors in the Nordic countries

This chapter gives a short overview of the number, gender, and age of unaccompanied minors who have arrived in the Nordic countries in 2011–2018. The highest number of arrivals, in 2015, is visible in all countries except Iceland. Also, Sweden has consistently been a bigger recipient of unaccompanied minors than the other countries. Both graph 1 and table 1 also show the low number of UMIs arriving in 2017

and 2018. The proportion of boys has historically somewhat varied but has decreased in Sweden, Finland, and Norway during the last three years. In terms of age, the unaccompanied minors of the special year of 2015 were older, while the general trend during the last three years is towards a larger share of unaccompanied minors being under 14.

Graph 1. Number of unaccompanied minors registered per country 2011 to 2018

Source of data:¹⁹ Denmark: Udlændingestyrelsen; Finland: Migrationsverket; Iceland: Útlendingastofnun; Norway: Utlendingsdirektoratet; Sweden: Migrationsverket.

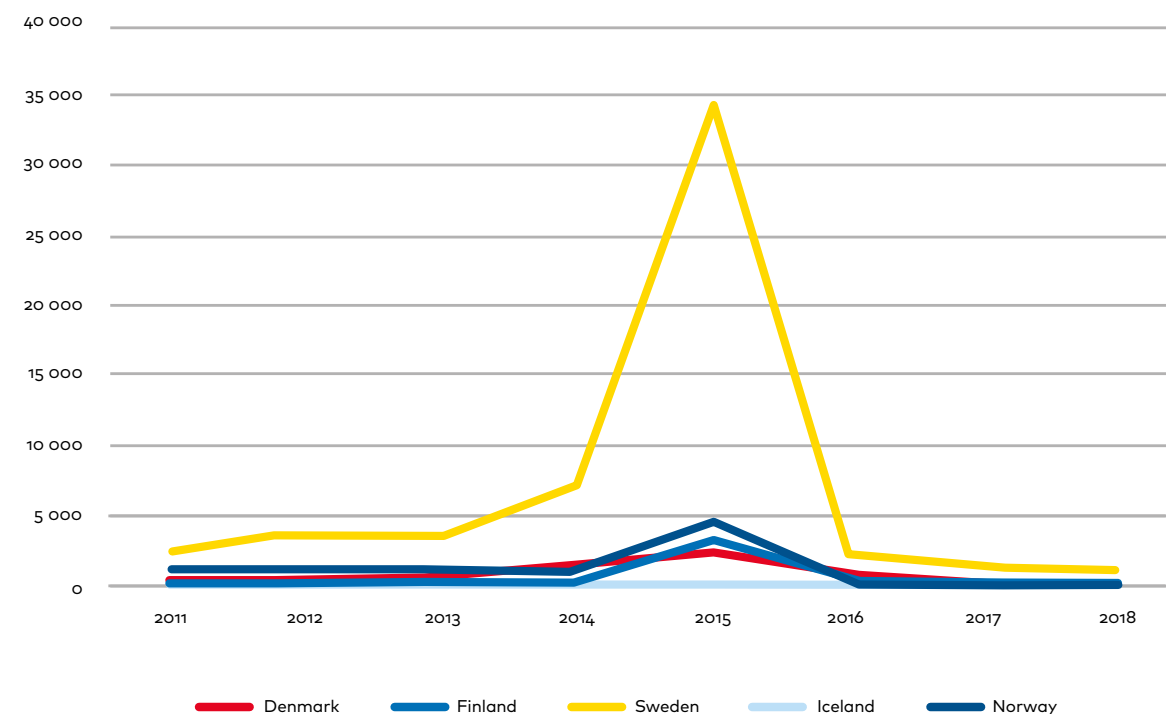


Table 1. Number of unaccompanied minors per country 2011–2018

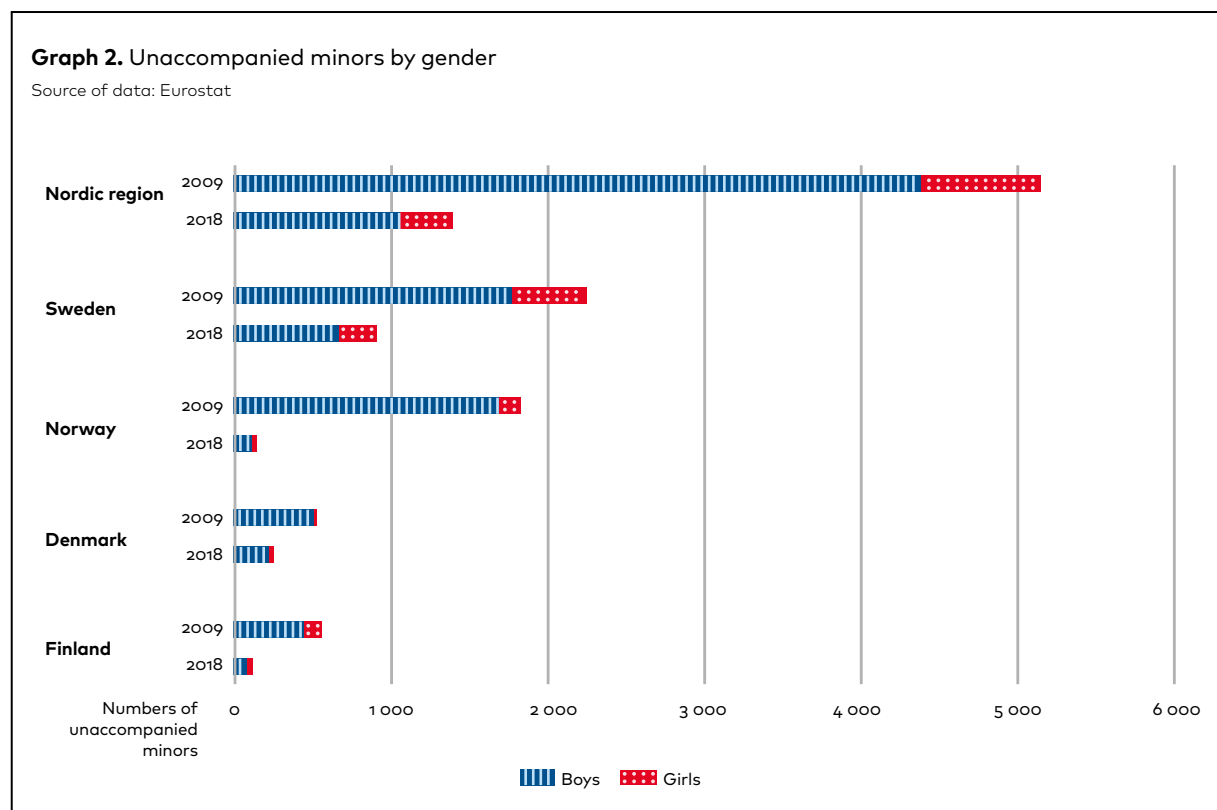
	2011	2012	2013	2014	2015	2016	2017	2018
Denmark	270	355	355	820	2130	1180	462	243
Finland	115	115	95	190	2530	370	142	109
Sweden	2655	3575	3850	7045	34300	2200	1336	944
Iceland	0	5	0	0	10	15	27	18
Norway	635	705	670	940	4790	270	191	159
Total	3675	4755	4970	8995	43760	4035	2158	1473

Source of data: Denmark: Udlændingestyrelsen; Finland: Migrationsverket; Iceland: Útlendingastofnun; Norway: Utlendingsdirektoratet; Sweden: Migrationsverket.

Graph 2 illustrates the gender of the unaccompanied minors in 2009 and 2018. There has been an increase in the number of females: they represented 40% of all UMIs arriving in Finland in 2018 (vs. 26% in 2009), 37% in Sweden (27%), 33% in Norway (8%), but only 13% (4%) in Denmark.

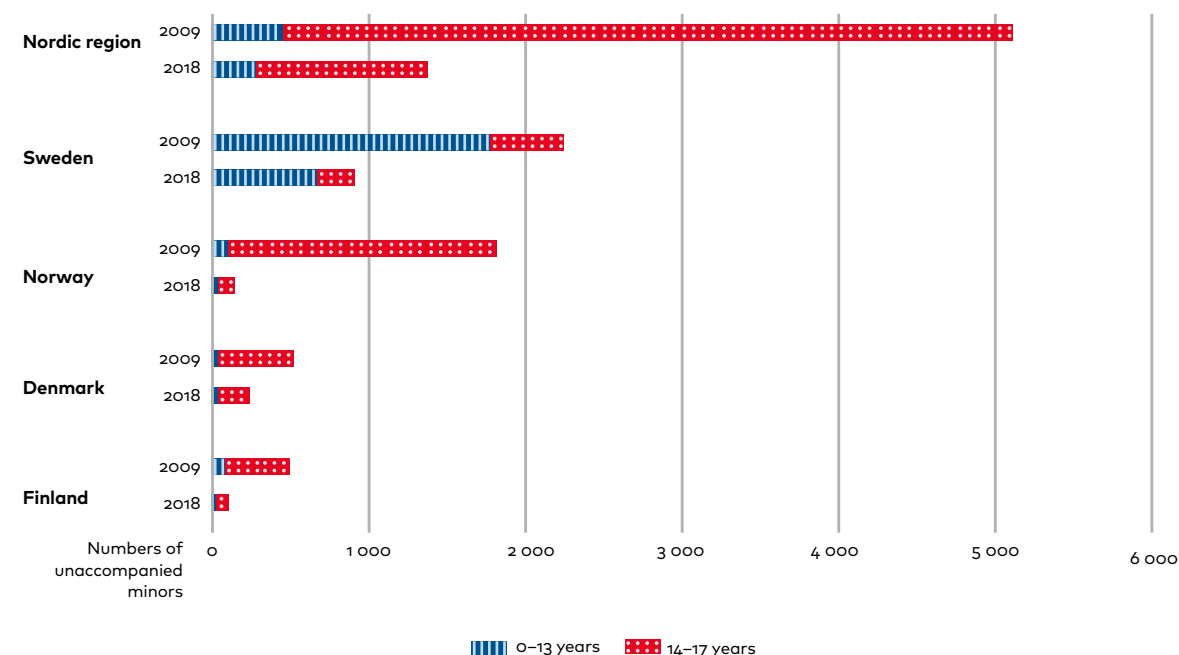
Graph 3 illustrates the number of unaccompanied refugee minors by age group in

2009 and 2018. The proportion of the younger age group, those below 14 years of age, has increased in all the Nordic countries. In 2018, those below 14 made up 28% of the UMIs arriving in Sweden (vs. 13% in 2009), 26% in Norway (6%), 23% in Finland (14%), and 14% (5%) in Denmark.



Graph 3. Number of unaccompanied minors by age group

Source of data: Eurostat



Nordic research collaboration on unaccompanied minors

Unaccompanied minors are a rather new field of research in the Nordic countries. Previously, most of the research was done in small projects by individual researchers or PhD students. However, unaccompanied minors are a heterogeneous group in terms of age, gender, ethnicity, past experiences, and current life situations. Research on unaccompanied minors therefore requires a multidisciplinary approach. There is a need for coordination and cooperation on both research and research training, and development of comparative research projects between different Nordic countries.

Consolidated Nordic research on unaccompanied minors will increase the understanding of UMLs' diverse and complex needs. The Nordic research tradition values the notion of the competent child and a child-centred, participatory research approach.

The Norwegian Centre for Violence and Traumatic Stress Studies initiated the Nordic Network for Research Cooperation on Unaccom-

panied Refugee Minors (Nord-URM) that was funded by the Nordic Research Council (NordForsk) in 2011–2014. The aim was to enhance research and research training on a Nordic level, and to develop comparative research projects. The cooperation continued into the CAGE research programme (Coming of Age in Exile), funded by NordForsk in 2015–2019. The project has studied health and socioeconomic inequities in young refugees in the Nordic welfare societies,¹⁴ and has published valuable research, which is included in this report.

"There is a need for coordination and cooperation on both research and research training, and development of comparative research projects between different Nordic countries."



The context of unaccompanied minors and well-being

A substantial proportion of asylum seekers arriving in Europe find their way to the Nordic region, and a sizeable proportion of them are unaccompanied minors. Their specific situation makes them in many cases vulnerable, as they often lack the support that families can provide. They may have faced great hardships along the journey that they have had to deal with on their own. Upon arrival they are met with new stressors such as the asylum-seeking process with several interviews and a long waiting time, uncertainty of whether asylum will be granted or not, age assessment procedures, settling into new living conditions, and learning a new language and culture. What we need to bear in mind, however, is that unaccompanied minors are not a homogenous group. Their reasons for leaving home vary just like for other refugees – from war and conflict, poverty, deprivation, and human rights violations to seeking a better future for themselves or their loved ones.

Unaccompanied minors have commonly experienced traumatic events. According to Sandahl, Norredam, Hjern, Asher, and Smith Nielsen (2013), there are three phases of possible traumatic events that may act as predictors of mental health problems: exposure to events in the country of origin; experiences of neglect and assault during the flight; and prolonged post-migration stay in reception centres, multiple relocations, lack of social contacts and cultural isolation. Already existing pre-migration traumatic experiences may be exacerbated by post-migration stress. Consequently, many unaccompanied minors may need diagnosis, treatment, and preventive care. Access to these services vary greatly between the Nordic countries.

Social workers have traditionally tended to emphasise the vulnerability of unaccompanied minors, all of whom have mostly been assumed

traumatised. This is reflected on the research on unaccompanied minors: older studies have largely focused on vulnerability, trauma, and mental health problems such as anxiety, depression, and post-traumatic stress disorder (PTSD). More recent research has shifted the focus to discussing and measuring the strength and resilience obviously possessed by the unaccompanied minors who make it all the way this far north. A further step in this direction is to examine the protective factors and coping strategies that can make a real difference in the unaccompanied minors' lives.

Vulnerability and resilience are not mutually exclusive or opposing categories. They go hand in hand. Unaccompanied minors are thus both dependent and independent at the same time. They should not be regarded as adults that are strong and independent but also not as weak, incapable, and in need of help. Vulnerability may show in mental health problems at the same time as the unaccompanied minors have capabilities to help them settle in the new country. Research shows that unaccompanied minors are able to cope if they retain affiliations from the past and have people to rely on in the present (Kohli, 2011).

Contacts to the ethnic community are important; those who adapt to the new majority culture while maintaining their culture of origin tend to integrate the best. Engaging in different activities, such as clubs or sports give opportunities to finding friends, socialising, and forgetting about past problems. Social support, together with religious beliefs, play an important role in positive change. Most unaccompanied minors have strong aspirations to succeed and focus hard on their studies. The attitude of working hard is both a protective factor and a coping strategy. However, if the pressure to succeed comes from obligations to family in



the country of origin, the stress may become difficult to handle.

Although child and youth participation ('talk to us, not about us' or 'nothing about us without us') in decisions regarding themselves is a well-known paradigm, many practitioners working with unaccompanied minors may be unaware of how to promote it. The asylum process is long and hard, and without enough meaningful activities during that process it can harm the social and mental development of the child. Overprotection, doing everything on behalf of the child, and labelling the child as permanently traumatised is also unhelpful.

A prerequisite for a successful process of integration is building a bridge between what was, what is, and what is to come. This kind of holistic view is especially important for unaccompanied minors. Research literature often refers to a sense of coherence in explaining what promotes resilience and coping in the face of adverse or traumatic events. Antonovsky (1987) observed that while stress is ubiquitous, not all individuals have negative health outcomes in response to stress. Instead, some people achieve health despite their exposure to potentially disabling stress factors. In Antonovsky's words, the sense of coherence has three components:

1. **Comprehensibility:** a belief that things happen in an orderly and predictable fashion, and a sense that you can understand events in your life and reasonably predict what will happen in the future
2. **Manageability:** a belief that you have the skills or ability, the support, the help, or the resources necessary to take care of things, and that things are manageable and within your control.
3. **Meaningfulness:** a belief that things in life are interesting and a source of satisfaction, that things are worthwhile, and that there is good reason or purpose to care about what happens.

In addition to a sense of coherence as a fundament for mental well-being, a sense of belonging is similarly important. After examining perceived discrimination in the general immigrant population rather than specifically among unaccompanied minors, Straiton, Aambø, and Johansen (2019) concluded that mental well-being benefits from a sense of belonging. What matters to immigrants is a sense of belonging to both the receiving country and the country of origin. Adopting the language and behaviours of the new country while maintaining one's own ethnic identity seem the key. The other moderating factor stemming from Straiton et al. is trust in other people: higher levels of trust protect from negative effects of perceived discrimination.

Physical health issues among unaccompanied minors

This report focuses to a large extent on mental health, but it is important to acknowledge that physical and mental health are interconnected, and physical health plays a vital role also in mental well-being. Some countries in the European region have mandatory health examinations for asylum seekers but in the Nordic countries they are voluntary and aim both to screen for infectious diseases and to identify individual health care needs on a broader basis.

For example, in **Norway** the Directorate of Health recommends that local governments at three months after arrival offer a health check-up to all asylum seekers and refugees to map their health situation and potential need for follow-up of physical or mental health. The format established by the Directorate of Health is recommended.¹⁵ The questions about mental health come from the Harvard Trauma Questionnaire and Posttraumatic Symptom Scale (PTSS-10).

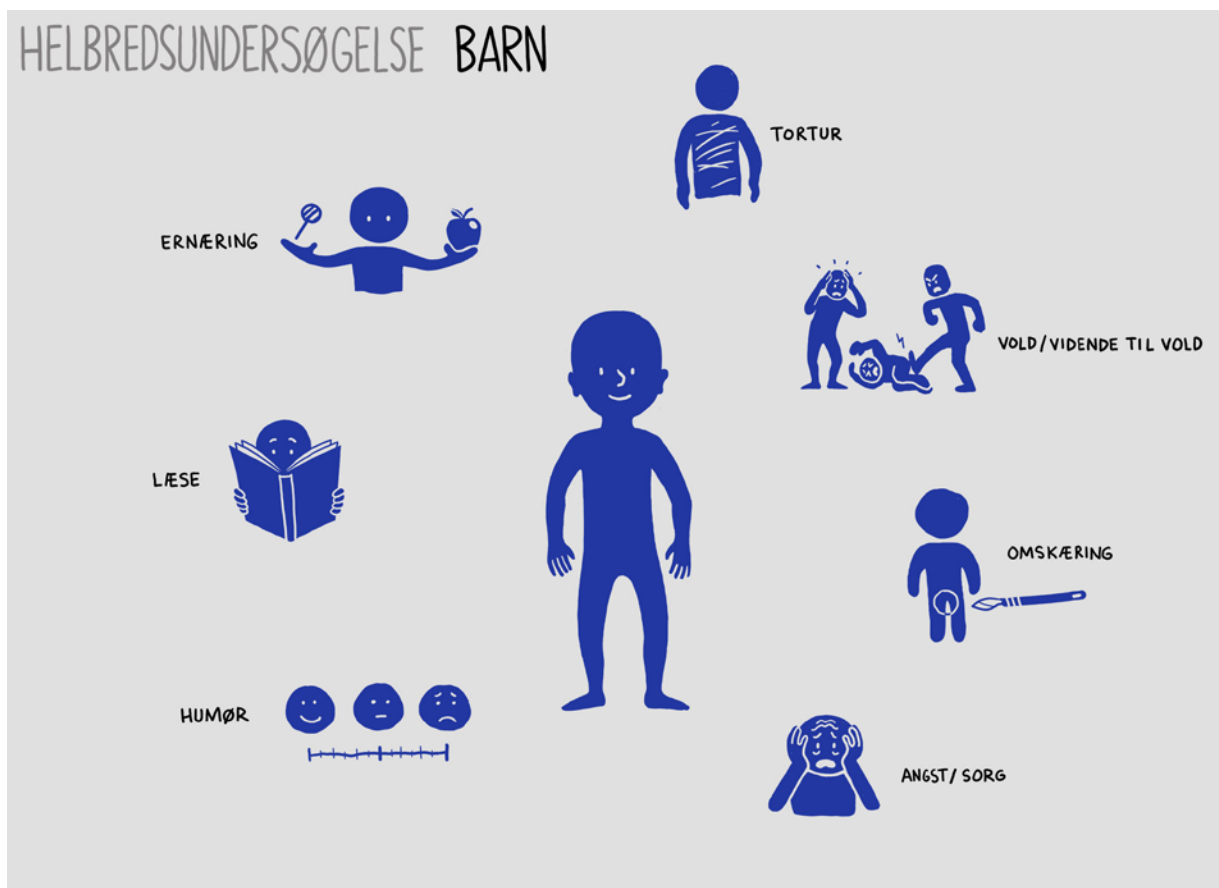
In **Finland**, the Finnish Institute for Health and Welfare recently concluded a comprehensive study 'Developing the health examination protocol for asylum seekers in Finland: A national development project (TERTTU)'.¹⁶ One of the aims was to produce an evidence base to devel-

oping systematic screening of asylum seekers' health, well-being, and health service needs.

In **Sweden**, unaccompanied minors should in principle be offered two health check-ups, as there are two separate legislations governing them, the Law on health care to asylum seekers and the Law on health check-ups to children who are placed into care. The National Board of Health and Welfare does not recommend any specific screening method for mental health but has guidelines for what a health check-up should include.

In **Denmark**, the Integration Law stipulates that all local governments are obliged to offer health check-ups to all immigrants and asylum seekers. For unaccompanied minors it is the temporary legal representative that will take the decision about the services offered. The National Board of Social Services has issued a guidance document to physicians that includes a visual tool to use in dialogue with patients, in addition to having an interpreter present. There is a general tool for all patients and additional ones for men, women, and children. The aim is to prepare the patients for the check-up and reduce fears or misunderstandings. The children's tool is shown on the next page.¹⁷

"Some countries in the European region have mandatory health examinations for asylum seekers but in the Nordic countries they are voluntary and aim both to screen for infectious diseases and to identify individual health care needs on a broader basis."



Graph 4. Visual tool for general health examination of refugee children

In the European region, the European Centre for Disease Prevention and Control¹⁸ (ECDC) is tasked with work against infectious diseases. The ECDC guide on Public health guidance on screening and vaccination for infectious diseases in newly arrived migrants within the EU/EEA¹⁹ provides scientific advice to help effective screening and vaccination for priority infectious diseases among newly arrived migrant populations. It supports EU/EEA Member States to develop national strategies to strengthen infectious disease prevention and control among migrants, and to meet the health needs of these populations. The following infectious diseases are covered: tuberculosis infection, HIV, hepatitis B, hepatitis C, vaccine-preventable diseases (measles, mumps, rubella, diphtheria, tetanus, pertussis, polio, Haemophilus influenzae type B), and two parasitic infections (strongyloidiasis and schistosomiasis).

An area of physical health among migrants that receives attention is vaccinations or lack thereof. Vaccinations among the whole migrant population, not only UMIs, have important implications for effective national immunisation programmes and in reducing the risk of preventable infectious diseases in communities. In a recent Danish study, 33% of all migrant children and adolescents were not immunised in accordance with national Danish guidelines, while 7% were partly immunised and 60% adequately immunised (Nakken et al., 2018).

To describe the broader health care needs in newly settled refugee children, a recent study in Sweden (Hjern & Kling, 2019) illustrates findings among UMIs in a school setting as follows: about 20% had impaired vision, 12% impaired hearing, 5% needed daily medication, and almost 50% had untreated caries. All these rates were comparable with those of accompanied refugee children. Only

the screening for mental health issues showed a difference between unaccompanied and accompanied refugee children. UMI had considerably higher rates of sleeping problems (33% vs. 23%) and post-traumatic stress symptoms (22% vs. 13%) than accompanied children.

For different reasons, such as fear of a negative impact on the asylum application, UMI probably underreport their health problems. Comprehensive health check-ups that also include dental care, chronic diseases, disabilities, and vaccinations are therefore important. As young people, UMI also need information about sexual and reproductive health, and access to contraceptives.

A study among asylum-seeking children (Berg & Tronstad, 2015) highlights the following health-related recommendations: thorough health check-ups at arrival in ordinary health

"UMI had considerably higher rates of sleeping problems (33% vs. 23%) and post-traumatic stress symptoms (22% vs. 13%) than accompanied children."

centres; more use of interpreters and written health information in different languages; detailed information on how the health system works; free health care to all children regardless of asylum status; government support for health workers in the asylum stations; and increased competence for diagnosis of physical and mental health issues and trauma.





Introduction to mental health and mental well-being

The World Health Organization (WHO) defines health as a 'state of complete physical, mental and social well-being and not merely the absence of disease or infirmity', and mental health as a 'state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to her or his community'. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic, or social condition.

WHO actively promotes the health of refugees and migrants through reviews, strategies, and action plans, such as Promoting the health of refugees and migrants: Draft global action plan, 2019–2023²⁰ and Public health aspects of migrant health: A review of the evidence on health status for refugees and asylum seekers in the European region.²¹

As is evident from the WHO definition, mental health is more than the absence of disease. Therefore, the mental health of refugees, unaccompanied minors or not, cannot be measured by the mere presence or absence of mental disorders (often post-traumatic stress disorder and depression), but reflects a much more general mental well-being with or without psychosocial problems. Such problems arise as a response to abnormal conditions that refugees and asylum-seekers are often exposed to and include grief, distress, and emotional problems. Psychosocial problems can dissolve over time or develop into mental disorders. Mental health can be viewed as a continuum from mental well-being to psychosocial problems to mental disorders (Ikram & Stronks, 2016).

There is a great deal of international research on psychological trauma among refugee children. However, there is also criticism that the

western world is preoccupied with primarily identifying and treating mental illness in individuals and with a strong focus on diagnosis. Our diagnostic system does not take into account traditional ways of healing and lacks receptivity to refugees themselves in terms of their own expressed needs, problems, and priorities. Predefined categories of mental illness are applied to refugee populations rather than created in consultation with refugees on their own concepts of illness and well-being. A psychosocial approach to well-being requires paying attention to subjective well-being, material conditions (objective well-being), and social well-being. It is a holistic and engaged approach (Bhabha, Kanics, & Senovilla Hernández, 2018).

Mental or psychological distress refers to mental health problems that can be an indication or a part of mental disorders, but not always. A differentiation requires a clinician's evaluation through clinical interviews (Kale & Hjelde, 2017). Mental illness or disorders usually refer to conditions based on an evaluation of the symptoms' intensity and duration, and the extent to which they influence a person's daily functioning. Clinically, in order to call a condition a mental illness or disorder, the symptoms should meet the diagnostic criteria laid out in psychiatric diagnostic systems such as the Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD).

Consequently, in this report we refer to mental health and mental well-being to describe mental health problems detected by self-report tools, and talk about mental disorders when the assessments were made by clinicians using diagnostic tools and interviews. However, sometimes the underlying reports and studies combine these two categories or have unclear definitions, which makes the distinction difficult.

Risk and protective factors for refugee mental health

A few main factors emerge from the varied body of research on protective factors for general refugee mental health. Firstly, there is the sense of belonging and trust in others. Immigrants with a sense of belonging both to their new country and the country of origin report better mental health overall. Meta-analysis shows that those who adopt the language and behaviour of the new country while maintaining their ethnic identity have advantages in terms of psychological well-being. Also, higher levels of trust in others may be protective. Strategies that aim to increase social capital among immigrants could potentially protect against mental health prob-

lems. Secondly, other factors associated with better mental health are social support and a comfortable financial position. Usually, language proficiency is positively related to education, labour market participation, and socioeconomic status, all factors that are associated with a lower risk of mental health problems (Straiton et al., 2019).

In a literature review, Ikram and Stronks (2016) survey the risk and protective factors post-migration (see table 2 below). These factors are not specific to unaccompanied minors but rather apply to all asylum seekers, and in some cases to refugees in general.

Table 2. Risk and protective factors for general refugee mental health

Risk factors	Protective factors
Personal characteristics Older age, female, unaccompanied minors Pre-migration traumatic events, torture and sexual violence	Personal characteristics Psychological coping, focusing on present and future (not the past), normalisation/acceptance of difficulties
Family and community networks Low social support and small networks, isolation and forced separation, conflicts in informal networks	Family and community networks Social support from informal network, family reunion, parental disclosure of past traumatic experiences, practising religion (praying and religious beliefs)
Social conditions in host country Poor host language skills, discrimination, difficulty adjusting to cultural differences, loss of social status, low current socioeconomic status, Conditions during asylum procedure, uncertainty regarding legal status and procedure, changes in residence, detention Mental health services underutilisation, barriers to access	Social conditions in host country Host language proficiency, economic opportunities, private and permanent accommodation Culturally sensitive mental health services with interpretation Longer time since displacement

Source: Ikram & Stronks, 2016

With regard to unaccompanied minors, Oppedal et al. (2009) report that UMLs have higher rates of PTSD and depression than other migrant youth and that they are also more prone to loneliness, school-related problems, and acculturation stress. They also worry much more about family in their country of origin, and struggle with monetary problems, which causes both social and practical problems in their everyday lives. In fact, those UMLs that worried extensively about their family back home had higher levels of mental disorders than did those who worried less (Dittmann & Jensen, 2010).

In a Nordic overview, Borsch et al. (2019) showed that protective factors against depressive symptoms were social support from community, family, and friends; greater Nordic language proficiency and higher educational attainment; and competence within both ethnic minority and majority cultures. A Norwegian study (Oppedal & Idsoe, 2015) which looked at factors leading to lower frequency of depression confirmed that ethnic and cultural competence (country of origin and Norway) led to lower frequency of depression, while discrimination and PTSD co-varied with higher frequency of depression. These results underline the crucial importance of social context, both with the same ethnic group and with the majority population, as well as the role of combating discrimination in all forms.

The key to kindling the competence of the unaccompanied minors is largely about identifying and creating protective factors in the child and the environment. Practitioners who work with UMLs should familiarise themselves with protective factors that promote resilience. These include effective coping strategies and building protective and stabilising psychosocial caring structures and school environments. Adequate schooling can increase confidence by providing daily activities that are structured, transparent, and predictable (Eide & Hjern, 2013). Substitute caregivers who can form lasting and close relationships to the children are essential if the

children are to reach their full potential. This explains why UMLs who are cared for in foster care or in kinship placements have lower rates of depression than those living in supported (or unsupported) housing. It is therefore important to avoid changing the substitute caregivers (Eide & Hjern, 2013). However, there may be other issues with kinship placements that warrant attention such as potential isolation or exploitation for work.

According to Carlson, Cacciatore, and Klimek (2012), it is possible to distinguish between different sources of resilience which allow UMLs to adapt to a new cultural environment. These sources can be categorised into individual, family, and community protective factors. Individual protective factors include easy temperament, good coping skills, and faith or religious orientation. Familywise, UMLs with ties to extended family and an attachment to at least one parent are less likely to experience long-term emotional problems. Connectedness to pro-social organisations in the community can also act as a buffer against at-risk individuals' developing adverse outcomes.

In explaining differences between UMLs who maintain or develop good mental health versus those who maintain or develop poor mental health, the acculturation process is a key factor. This is the psychological adjustment within the heritage cultural domain (culture of origin) and that of the majority society. Although longitudinal research has shown stable levels of mental health problems among UMLs, substantial variation over time has been demonstrated at an individual level. About 60% of UMLs could

"The key to kindling the competence of the unaccompanied minors is largely about identifying and creating protective factors in the child and the environment."



be defined as healthy or resilient, and about 40% retained or developed mental health problems during the first few years after resettlement (Keles et al., 2018). Protective factors were longer stay (four or more years seems the watershed), heritage culture competence, and fewer acculturation hassles. The study underscores the importance of facilitating opportunities for refugees to preserve their competence with the heritage culture's verbal and non-verbal communication and values. In addition, interventions are needed to reduce or help to cope with daily hassles (economic strains, school pressure, social relations) and acculturation hassles (including discrimination) (Keles et al., 2018).

Organisational factors during the asylum process such as the length of stay and the number of relocations can also be risk factors.

Studies in Denmark show that children who have been in the asylum-seeking process for more than a year and/or have had four or more relocations have an increased risk of mental difficulties that will require psychiatric treatment (Nielsen et al., 2008; Montgomery & Foldspang, 2005). Another study on the impact of the asylum process itself on mental health concluded that a group of male UMIs reported high levels of psychological distress on arrival and that the levels stayed relatively unchanged over time. However, 56% of the UMIs were not recognised as underage (after age assessment procedures) and were therefore relocated to reception centres for adults – which greatly increased their distress, compared to those that remained in youth centres. Not surprisingly, those that were refused asylum also experienced high levels of distress (Jakobsen, Demott, & Heir, 2014).

Mental health situation of unaccompanied minors in the Nordic region

There is great variety in the results of quantifying mental health difficulties among UMI. This is down to many factors such as differences in study methodology, assessment tools, populations (age, origin), time of study in the asylum process, etc. The UMI population is also different in the different Nordic countries. Still, literature indicates consistently that UMIs have a markedly higher prevalence of poor mental health compared with background populations (both accompanied refugee children and those native). UMIs experience a range of trials in their everyday lives, some that are common to all youth, such as conflicts with friends, and some that are specific to the immigrant or acculturation context such as discrimination. Both types of hassles have a unique and an equally strong effect on depressive symptoms. Interventions should be developed that aim at reducing the number of daily hassles and teaching more effective coping strategies in response (Keles, Idsoe, Friborg, Sirin, & Oppedal, 2017).

A Nordic overview (Hedström, 2017) shows that UMIs have an estimated two times higher prevalence of mental disorders compared to background population and a high frequency of depression (20–44%), anxiety (30–38%), and PTSD (52–54%). Neurotic disorders, exhibited self-harm, and suicidal behaviour are more common among UMIs admitted to clinical inpatient care than among other patients. This chapter provides insights into some of the studies in the Nordic region that estimate

different aspects of UMIs mental health status.

While UMIs have high rates of mental health problems shortly after resettlement and some years later, we should keep in mind that their long-term adjustment in high-income countries is quite successful. This is significant, given that depressive symptoms are often of a rather chronic nature (Eide & Hjern, 2013).

Studies that estimate mental disorders, symptoms, or diagnoses

After arrival in the host country, a group of male UMIs in clinical interviews showed that altogether 41.9% fulfilled diagnostic criteria for current psychiatric disorder. The most prevalent were PTSD (30.6%) and major depressive disorder (MDD). Most of these UMIs had experienced life-threatening events (82%), physical abuse (78%), or loss of a close relative (78%) in their former life (Jakobsen et al., 2014). Another study on male UMIs on arrival showed a high level of anxiety (44.6%), depression (49.7%), and PTSD (52%). Traumatic experiences strongly influenced the mental health: the higher the number of reported traumatic experiences, the higher the incidence of symptoms of anxiety, depression, and PTSD (Vervliet et al., 2014).

A rare longitudinal study of UMIs (Jensen, Bjørge Skårdalsmo, & Fjermestad, 2014; Jensen, Fjermestad, Granly, & Wilhelmsen, 2015; and Jensen, Solheim Skar, Andersson, & Skogbrott Birkeland, 2019) has shown the persistent characteristics of mental health issues. Among 10–16-year-old UMIs, 54% suffered from PTSD after six months of arriving in Norway, 30% suffered from anxiety, and 20% from depression. After two years' stay, there was no significant change (60% had PTSD and 50% had anxiety or depression). After five years, the levels of PTSD and anxiety remained almost the same,

"Neurotic disorders, exhibited self-harm, and suicidal behaviour are more common among UMIs admitted to clinical inpatient care than among other patients."

while the level of depression seemed to diminish (42% had PTSD, 25% anxiety, and 15% severe depression). Those who arrived younger had less mental health issues. About 60% said they had received less social support than they would have needed and 30% had nobody to care about them. Daily challenges had a great impact on well-being, the most important being lack of money, feeling unsafe, and feeling unsure about the future. The persistent character of mental health problems has been confirmed by Barghadouch, Carlsson, and Norredam (2018); and Norredam, Nellums, Nielsen, Byberg, and Petersen (2018) in that UMIs have higher rates of both nervous and psychotic disorders even in a longer-term follow-up (six years on average), while Keles et al. (2017) finds that the average level of depressive symptoms shows no significant decrease over time.

However, sometimes PTSD may be over diagnosed, when the underlying problems may simply be due to anxieties about, for example, families left behind. There is a risk of pathologising and medicalising a normal human response to extreme adversity and loss.

A study which measured the well-being and integration among UMIs after their asylum process is finished showed that 52% of boys and 60% of girls had depression severe enough to warrant help. Those arriving from Afghanistan and Iraq had significantly higher depression rates than those from other countries. In addition, 61% of UMIs suffered from flashbacks of events and 47% had nightmares related to traumatic events. Both flashbacks and nightmares are closely linked to depression. Among those that showed signs of PTSD (flashbacks and nightmares), 62% also had signs of depression. According to the theory of attachment, it is essential for the normal social and emotional development of a child to have a close and trustful relationship to at least one adult person. In this study the group that did not have any such close contact showed 75% depression rates, although causality cannot be established.

We cannot know whether they are depressive and therefore have no social contacts or the other way around (Oppedal et al. 2009).

In general, in asylum-seeking populations (not UMI-specific), PTSD rates vary from 3–86%, and common mental disorders in this population are twice as high as among economic migrants (40% vs. 21%). Refugees are 10 times more likely to have PTSD than are age-matched native populations, and substance abuse and self-harm are also commonly reported (Bhugra et al., 2014). Research also shows that different categories of refugees, such as quota refugees or asylum seekers have different risks of psychiatric disorders, possibly due to different experiences of the migration process (Duggal, Kirkbride, Dalman, & Hollander, 2019).

Although not UMI-specific, much of the established research on refugee mental health is focused on neurotic disorders such as PTSD and depression. More recent studies worryingly demonstrate vulnerability also to psychotic disorders, which are among the most severe psychiatric diagnoses (Barghadouch et al., 2018). Refugees were on average 66% more likely to develop schizophrenia (or other non-affective psychotic disorder) than non-refugee migrants from the same region of origin, and up to 3.6 times more likely to do so than the Swedish-born population. The effect is more pronounced among men than women (Hollander et al., 2016).

Studies on suicide and self-harm

Mittendorfer-Rutz et al. (2019) found that the level of suicides among 10–21-year-old UMIs was

"A study which measured the well-being and integration among UMIs after their asylum process is finished showed that 52% of boys and 60% of girls had depression severe enough to warrant help."

51.2 per 100,000 in Sweden in 2017, compared to 6.1 per 100,000 among the host population (the number of suicides was 12 among UMIs). All those who committed suicide were boys/young men, and Afghanistan as the country of origin was overrepresented. The most common method of suicide was by hanging. Suicide was the most common cause of death in the UMI group.

A review of self-harm, suicide, and mortality among UMIs (Hagström et al., 2018) also identifies specific risk and protective factors for suicide and self-harm. These are listed below.

Risk factors include:

- Traumatic events (war, violence, separation from parents, torture, etc.) also produce PTSD, which is a risk factor for suicide
- Long wait for asylum decision
- Social marginalisation
- Discrimination
- Use of alcohol and drugs

Protective factors include:

- Safe environments and living conditions
- Stable school situation
- Social safety net
- Support discussions
- Minimising availability of potentially dangerous objects
- Identifying and supporting the youth at risk
- Screening for suicide in clinical settings
- Providing suicide-specific treatment methods

Studies on utilisation of mental health services among unaccompanied minors

Overall, studies indicate that UMIs are overrepresented in inpatient psychiatric care. For example, findings by Ramel, Täljemark, Lindgren, and Johansson (2015) show that more UMIs exhibit self-harm or suicidal behaviour and that a large

group of UMIs (86%) are admitted with symptoms relating to stress in the asylum process. In both inpatient care and involuntary care, the UMIs are overrepresented. This picture is confirmed by Manhica, Almquist, Rostila, and Hjern (2016), who find that unaccompanied minors are more likely to experience compulsory admission to a psychiatric hospital and psychiatric inpatient care compared with the native population.

Also when compared to accompanied minors, UMIs have a higher risk of utilisation of in- and outpatient care and being prescribed psychotropic drugs (except for ADHD medication), and the time from immigration to admission to inpatient psychiatric care was significantly shorter among UMIs than accompanied minors (1.58 years vs. 3.86 years). The hypothesis is that having a legal custodian and living conditions often with professional staff or foster parents who are familiar with the local social and health care system, and who therefore have health literacy, eases the treatment seeking for UMIs as compared to the accompanied minors (Axelsson et al., 2019).

However, in terms of outpatient care visits UMIs appear similar to the native population. The longer the UMIs have had residency, the more they use outpatient psychiatric care. The findings also indicate that the use of psychiatric care services increases with the level of education in the refugee population, while the opposite is true for the native population (Manhica et al., 2016).

Even with the overrepresentation of UMIs in inpatient care there is an underuse of psychological help in the UMI population. For example, Oppedal et al. (2009) found that only 30% of UMIs with severe PTSD had visited a doctor or a psychologist.

There seems to be both formal and informal barriers to health care and psychiatric care in the UMI population. Lengthy waiting times may hinder adequate treatment, which may lead to more severe psychiatric symptoms and possibly partly explain higher use of coercive measures (Barghadouch et al., 2018).



Mental health and well-being of unaccompanied girls

Abebe, Lien, and Hjelde (2014) conclude that gender is a well-established predictor of mental health problems also in migrant populations. Premigration experiences of war or conflict, and a shift in the status and roles of men and women in societies may explain the different levels of distress. Also, differences in the experience of social integration have been advocated as a possible explanation. In men, good social integration can create opportunities for paid employment and better income with subsequent positive impact on health. In contrast, social integration in immigrant women has been found to increase psychological stress, because the traditional role of women within their family can be challenged by cultural values that differ from their own. This may provoke negative reactions and conflict about socially acceptable norms and identity.

An example from Sweden shows a large difference in the UMIs' long-term integration. At the age of 27 years, 65% of male UMIs were working, while the corresponding figure for females was 45%; among the Swedish-born, the corresponding percentages were 82 and 79. A partial explanation is that female UMIs study longer than the male (Celikaksoy & Wadensjö, 2015).

Quantitative studies on female unaccompanied minors

Very few Nordic quantitative studies specifically examine the mental health situation of female UMIs. This is understandable in the light of their smaller numbers, but the scarcity of studies is still unfortunate. With an increasing share of the UMIs being girls, more research is hopefully forthcoming.

Some international studies, mostly those from the Netherlands show that girl UMIs score much higher on anxiety, depression, PTSD, and hyperarousal than boys. Also, 39% of the girls have

been sexually abused, compared to 12% of boys. Boys only score higher on externalising problems, acting out in different ways (Bean, Derluyn, Eurelings-Bontekoe, & Spinhoven, 2007).

The few Nordic studies paint a similar picture: girl UMIs have higher rates of mental health problems, identical to those among the majority population (Keles, Friborg, Idsøe, Sirin, & Oppedal, 2016). Oppedal et al. (2009) shows the extent to which girls seem to have higher degrees of such mental health issues as depression. Among UMIs, 52% of boys and 60% of girls suffer from depressive symptoms at a level that require interventions. In a Nordic overview, Borsch et al. (2019) showed that UMIs have much higher rates of depressive symptoms than the native-born but that the gender gap is very much smaller. Among the native-born, the difference in depression between boys and girls is very large (17% vs. 45%) but is much less pronounced among UMI boys (52%) and girls (60%). This is partly perhaps because female UMIs now have greater access to educational and career opportunities that may shift their traditional understanding of the gender roles. This may contribute to their positive development over time (Keles et al., 2018).

Qualitative studies with female unaccompanied minors

Some qualitative interview studies have been conducted with girl UMIs in the Nordic countries. As Ekström (2019) shows, these studies mostly cover questions around the girls' experiences of being rather invisible as a group – until recently – in both academic research and media. The girls risk being constructed as 'others' due to their status as unaccompanied minors, because they are female, and in relation to general perceptions of what it means to be Swedish.

In their participatory action research project,

Kaukko & Wernersjö (2017) found that girl UMIs viewed Finland and Sweden as gender-equal societies compared to their countries of origin and that they wanted to benefit from this. Some girls said that they felt uncomfortable and afraid because of rowdy boys. The girls seemed to become more aware of gender and gender differences than the boys, because they had been placed in boy-dominated living arrangements. In other words, the girls are to some extent forced to relate to the boys and find their positions among them, while the opposite is not always the case. Thus, the girls' movements in the living units are at times limited, both physically and mentally, which may also affect their sense of security and belonging.

A long-term follow-up study of unaccompanied Somali girls (Bjerneld, Ismail, & Puthooppambal, 2018) recognised that initial difficulties were language and cultural differences such as food habits and gender norms. In the longer perspective, two factors helped the girls to integrate, while two factors were something of a challenge. The promoting factors were stable family support in the girls' country of origin (a good childhood) and finding someone supportive to talk to when they arrived in Sweden. These supportive people could be staff at the homes, teachers, and social workers who saw the girls' potential, showed patience and empathy, and boosted their self-confidence. The two chal-

lenging factors were being female and the lack of understanding of their previous lives in Somalia – such as the healthcare professionals' lack of understanding about maternal care or circumcision in Somalia. The very circumstance of being female entailed adopting new gender roles, with not uncommon clashes between the two cultures.

Another study giving examples of some characteristics of girl UMIs is that by Darvishpour and Månsson (2019), covering such issues as:

- A feeling of longing, loneliness, and worry even if they are living with relatives
- In the absence of parents, the girls grow up faster and have greater opportunities for independence and a career
- Ethnic networks can limit the girls (with boys, networks help to find housing and employment)
- UMIs who end up waiting for two years for their asylum decision have serious mental health issues, which have in some cases led to increasing self-harm. Passivity and loneliness lead to deteriorating school results.
- Easier for girls to adjust to gender equality
- Prejudice against Muslims and girls wearing a veil

"Some girls said that they felt uncomfortable and afraid because of rowdy boys. The girls seemed to become more aware of gender and gender differences than the boys, because they had been placed in boy-dominated living arrangements."

Some perspectives of unaccompanied minors themselves on their mental health and well-being

Studies have asked UMs themselves about their experiences, what kind of help they would like to receive, and what could help them at different stages of the integration process. Many UMs appreciate similar things: to have an adult contact who I can trust and who cares about me, to get an education, to be a normal young person.

A systematic review by the Swedish Agency for Health Technology Assessment and Assessment of Social Services (SBU, 2018) highlights the experiences and perceptions of unaccompanied minors with respect to factors which facilitate or hinder their social integration, physical and mental health, and ability to function.²² The review identified seven comprehensive themes:

- **Security and control:** A basic prerequisite that has a pronounced effect on everyday life and well-being as well as the ability to cope with daily issues and difficulties.
- **New country:** Both opportunities and difficulties, strong motivation for education and new life opportunities but structural and social barriers exist.
- **Coping with difficulties:** A balance of various coping strategies such as avoidance, flight, and positive thinking, with religion perceived as meaningful.
- **Daily environment:** Supportive relationships, influence on accommodation, and access to school and activities are important.



- **Relationships:** Support and guidance from adults is meaningful, contact with those of the same age is important but also difficult.
- **Social services and health and medical care:** Varying perceptions and experiences of support and need.
- **Identity and belonging:** Accommodating the past, the present, and the future; retaining language and culture while adapting to the new.

A study by Jarlby, Goosen, Derluyn, Vitus, and Smith Jervelund (2018) highlights the perspectives of the UMI themselves on healing and the mental health care offered to them. Refugee adolescents associate traditional conversational therapy with discussing negative and stigmatising aspects of their past. This is felt

to be meaningless and inadequate in terms of improving their mental health, and it also carries the risk of re-traumatisation. The UMIs describe formal, stigmatising, and at times frightening one-to-one sessions with a psychologist in a clinical setting. What they would need instead is a community-based approach in an informal setting in their everyday lives, which has a de-stigmatising effect. Collective-oriented therapies have shown an effect on mental health. Such therapies include peer-to-peer interventions and artistic expressions of UMIs' stories, which also fosters social support. Social, physical, and artistic activities were deemed helpful, but social support and strong social bonds were the most important factor. Table 3 below summarises both the impeding and promoting factors identified by the UMIs.

Table 3. Impeding and promoting factors for adolescent UMIs' mental health

Impeding factors	Promoting factors
<ul style="list-style-type: none"> – Missing my family – Needing someone to talk to – Feeling lonely and isolated – Lacking support to engage in physical and social activities – Being unemployed and lack of money – Feeling uncertain about the future – Thinking about and/or talking about bad experiences from the past (over and over again) – Having excessive thoughts – Experiencing physical pain – Having disturbances with sleep – Others are judging me as deviant – Others misunderstand me – Experiencing racism – Lacking content and meaning in daily life – Relocation from one place to another – Experiencing too many system requirements 	<ul style="list-style-type: none"> – My family is doing well – Talking with/being surrounded by good people – Going to school – Learning Danish (with native-born peers) – Working and earning money – Dreaming about a good future – Focusing on the here-and-now – Playing and listening to good music – Walking in nature – Practising religion – Running, cycling, swimming, playing football – Eating good food (with others) – Being understood and respected as a human being – Helping others – A purpose and meaning in life

Source: Jarlby et al. (2018)

National guidance and interventions for unaccompanied minors

General mental health interventions targeting unaccompanied minors

In a systematic review of the scientific literature in 2018, the Swedish Agency for Health Technology Assessment and Assessment of Social Services (SBU) failed to identify any controlled studies investigating or comparing the effects of different supportive interventions for unaccompanied children and youth.²³ What there is are qualitative interview studies about the experiences of unaccompanied minors, and a few of these studies are mentioned in the previous chapter.

There is a great deal of guidance available on UMI and mental health in the Nordic countries: guidance documents, handbooks, web portals, and films that target different audiences, professionals and practitioners working with UMIs, including social workers and teachers, legal representatives of UMIs, volunteer workers, and UMIs themselves. Some of these resources can be found at the Nordic Welfare Centre website on integration: integrationnorden.org

In general, there is evidence that interventions targeted at culturally homogenous groups (e.g., based on country of origin) are more effective in reducing psychological symptoms. Strategies to actively minimise asylum process stressors (e.g., reducing waiting times, limiting the length of stay in reception centres, seeking to avoid multiple relocations) may help to reduce the risk of psychiatric disorders. UMIs are likely to underutilise health services, so interventions situated in the community (e.g., school-based interventions) may be particularly important. They have been shown to be effective in improving mental health, in addition to improving emotional and social functioning and integration (Norredam et al., 2018).

The rehabilitation of UMIs needs to focus on

activities that build social networks and establish friendships with others of similar age. While relationship building is key, there is little research about these activities that are often carried out by such NGOs as the Red Cross and Save the Children. These are often youth to youth-based (or peer to peer) that forge new relationships, build networks, develop social capital, and are essential from an integration point of view but also for an individual's quality of life, mental well-being, and development of language skills (Svendsen, Berg, Paulsen, Garvik, & Valenta, 2018). Crucially, optimism and social support build towards positive psychological change after traumatic experiences.

The mainly psychosocial interventions mentioned above seek to alleviate social suffering and help to identify those who may need more specific psychological/psychiatric interventions.

There is substantial evidence for the efficacy of psychological, psychosocial, or 'talking therapies', but they are primarily of western origin, ego-based, and may not be acceptable across cultures. It is therefore critical that ego-based therapies are not forced on socio-centric individuals (Bhugra et al., 2014).

International research on effective psychological interventions for refugee and asylum-seeking children points to the need of locating interventions close to the children. School- and community-based interventions aimed at reducing psychological disorders in refugee and asylum-seeking children tend to focus on the verbal processing of past experiences, on an array of creative art techniques, or a combination of these. The findings suggest that interventions delivered within the school setting can successfully help children to overcome difficulties associated with forced migration (Tyrer &

"Given the complexity of issues, more multimodal interventions that bring together measures from different theoretical backgrounds and practices would enhance the currently poor evidence base."

Fazel, 2014 and e.g. Pastoor, 2017). With this in mind, a Swedish project is currently developing a method for school health services to identify mental health issues among UMIIs.²⁴

Another method of treatment that is gaining increasing momentum and has interesting results utilises a common elements treatment approach incorporating treatments for mood disorders, post-traumatic stress, or anxiety problems. This kind of transdiagnostic approach is delivered by trained lay workers, and evidence is emerging of it being as effective as disorder-specific treatments (Fazel, 2017). In addition, given the complexity of issues, more multimodal interventions that bring together measures from different theoretical backgrounds and practices would enhance the currently poor evidence base. For child refugee populations, multimodal interventions could address components of the following: exposure to previous traumatic events; adjustment to new environments; linguistic and legal assistance; family and parenting support; and school-based interventions (Fazel, 2017).

Post-traumatic stress disorder

While the treatment of post-traumatic stress disorder (PTSD) is among the more extensively studied psychological interventions, few systematic reviews are available of treatment especially for child/youth populations. Still, we know that at least three different interventions are used in

the Nordic countries, with conflicting evidence of effectiveness.

- Narrative Exposure Therapy (NET) seems to have the strongest evidence base thus far, reducing symptoms of PTSD at least in the short term (2–8 months) (SBU, 2019²⁵). There is a need to replicate existing NET studies (and NET's adaptation for children, KIDNET), as well as to test it against other treatment modalities (Fazel, 2017).
- Trauma-focused interventions based on cognitive behavioural therapy (CBT) are recommended in international guidelines such as the English National Institute for Health and Care Excellence guidance on PTSD²⁶ (NG116, 2018).
- Norway and Sweden have both trialled using teaching recovery techniques (TRT) among UMIIs. In Norway, the method has had positive effects on PTSD symptoms and quality of life, but only on those who had a settled situation, i.e., had been granted residence.²⁷ In Sweden, at baseline 76% of UMIIs screened positive for PTSD, 83% reported moderate or severe depression, and 48% had suicidal ideation or plans. Both PTSD and depression symptoms decreased significantly after the intervention. Overall, results indicate that TRT, delivered in a community setting, is a promising preventive intervention for UMIIs with PTSD symptoms (Sarkadi et al., 2018).

Concluding remarks and observations

Research at the Migration Institute of Finland (Björklund, 2015) concludes that all Nordic countries have fairly well-functioning reception systems based on the principle of the best interest of the child. However, all the countries seem to share some common issues, namely fragmented organisational structures with insufficient cooperation between different administrative sectors and problems with placing unaccompanied children in municipalities (which may be unwilling to receive them). There are also shortcomings in providing adequate language training and education; in access to health care, especially mental health services; and in following up adolescents coming of age with supporting measures.

During the process of data and research collection for this report, certain issues emerged on research about UMIs that warrant observation:

- Although research on UMIs' health and well-being is reasonably extensive, we know little about development over time. The arrival phase and the settling in is mapped, but not how the UMIs' well-being develops into adulthood. Longitudinal studies covering the general life status such as health (mental and physical), education, work, social networks, and family status are needed.
- Another gap in research is how the UMIs' mental health is affected by national immigration policies and the asylum-seeking phase, including age-testing procedures, temporary permits, changes to financial support, and family reunion regulations.
- It seems that positive mental health – such as well-being or quality of life – has been much less researched. The focus is often on problems, negative feelings, challenges, ailments, and disorders.

- The integration and well-being of female UMIs poses both an opportunity and a challenge. Girls may have new opportunities of education, employment, and social contacts to the opposite sex, while at the same time they may struggle with the social norms and culture of their origin. More research, especially quantitative research, on their mental health and well-being is much needed.
- School health surveys that include more comprehensive questions on mental health and well-being, and which separate UMIs from other immigrant children might provide valuable health information about this group.
- Using a common, standardised, and culturally validated screening instrument (and study design) across studies in the Nordic countries would provide much needed comparative research.
- Comparative studies of the effects of different living arrangements such as group housing for UMIs only, mixed refugee housing, kinship placements, or other kinds of home placements are missing.
- Research and evaluation of specific interventions to support the UMIs' mental health is sorely needed.

Unaccompanied minors are a heterogeneous group, and an increasing proportion of those arriving in the Nordic countries are girls and younger in age. These two groups have been the focus of much less research than older teenage boy UMIs. There will not be any one-model-fits-all with regard to providing mental health support for this group. Individually tailored interventions, probably at different levels of intensity, are required. Many UMIs would benefit from general psychosocial support perhaps in a school setting (including a general safe environment with activities), while some may

need more support, perhaps community- and group-based, and a few need psychiatric care services. A major missing piece of the puzzle are studies which would identify the effect of different kinds of interventions.

In the Nordic region in general, there is an increasing number of UMIIs who for different reasons may have their asylum rejected or only granted for short periods of time. This group should be the focus of new and more research. In the words of Svendsen et al. (2018), the research shows the negative impact temporary permits have on mental health and that several of these UMIIs have hurt themselves or tried/committed suicide, and large numbers of them have disappeared. In the UMIIs' own words, waiting for one's asylum decision in a reception centre is filled with uncertainty, day and night. This makes it difficult to sleep, causes nightmares, and raises lots of anxiety.

This report has tried to shed light on a very complex phenomenon, the mental health and

well-being of unaccompanied minors. There is no definite way of measuring mental health and there are no clear-cut answers on how they as a group are doing. We need to keep several perspectives simultaneously in mind: UMIIs are both vulnerable and resilient, and while they have higher rates of mental health problems, they still integrate comparably well in the long-term perspective. UMIIs can overcome past and current traumas with an optimistic belief in positive change, through creating and increasing protective factors, and with a close and trustful relationship to at least one adult. We should not lose sight of the fact that most of them are also teenagers often undergoing turbulent changes and identity development. UMIIs live with two cultures and identities and need to have a sense of belonging and acceptance in both. We should make sure the help and support they may need is available but not focus extensively on diagnosis and problems. What is needed is more emphasis on positive well-being and less on disorders.



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Notes

1. <https://www.unhcr.org/1951-refugee-convention.html>
2. <https://eur-lex.europa.eu/legal-content/en/TXT/?uri=celex:32001L0055>
3. <https://www.easo.europa.eu/sites/default/files/Guidance-on%20reception-%20conditions-%20for-unaccompanied-children.pdf>
4. <https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html>
5. <https://www.ohchr.org/en/professionalinterest/pages/cescr.aspx>
6. <https://www.easo.europa.eu/sites/default/files/Practical-Guide-Best-Interests-Child-EN.pdf>
7. Norway and Iceland are not EU members but participate in the work of the European Asylum Support Office, and Norway is a part of the European Migration Network.
8. https://ec.europa.eu/anti-trafficking/eu-policy/action-plan-unaccompanied-minors-2010-2014_en
9. https://ec.europa.eu/home-affairs/what-we-do/networks/european_migration_network_en
10. <https://www.easo.europa.eu/about-us>
11. <https://www.easo.europa.eu/sites/default/files/Practical-Guide-Best-Interests-Child-EN.pdf>
12. <https://www.easo.europa.eu/sites/default/files/Guidance-on%20reception-%20conditions-%20for-unaccompanied-children.pdf>
13. Note that there are some discrepancies in the numbers of unaccompanied minors between national immigration authorities and Eurostat due to, for example, updates.
14. For more information on the CAGE research programme, visit the webpage at <https://cage.ku.dk/>
15. https://www.helsedirektoratet.no/veiledere/helsetjenester-til-asylsokere-flyktninger-og-familiegjenforente/helseundersokelser-av-asylsokere-flyktninger-og-familiegjenforente/helseundersokelse-ved-tre-maneder/Skjema-Helseundersokelse-flyktninger-asylsokere.pdf/_/attachment/inline/86df9fb4-1f2b-4678-b8ea-98f626eb7db2:28a5424c9d1bc726de2e25de7f05adb34c19dc45/Skjema-Helseundersokelse-flyktninger-asylsokere.pdf
16. <https://thl.fi/en/web/thlfi-en/research-and-expertwork/projects-and-programmes/developing-the-health-examination-protocol-for-asylum-seekers-in-finland-a-national-development-project-terttu->
17. <https://www.integrationsviden.dk/familie-sundhed/1.-sundhed/helbredsmaessig-vurdering-af-nyankomne-flygtninge>
18. <https://www.ecdc.europa.eu/en/home>
19. <https://www.ecdc.europa.eu/en/publications-data/public-health-guidance-screening-and-vaccination-infectious-diseases-newly>
20. https://apps.who.int/gb/ebwha/pdf_files/WHA72/A72_25-en.pdf
21. http://www.euro.who.int/__data/assets/pdf_file/0004/289246/WHO-HEN-Report-A5-2-Refugees_FINAL.pdf
22. <https://www.sbu.se/sv/publikationer/sbu-bereder/stod-till-ensamkommande-barn-och-unga--effekter-erfarenheter-och-upplevelser/>
23. <https://www.sbu.se/sv/publikationer/sbu-bereder/stod-till-ensamkommande-barn-och-unga--effekter-erfarenheter-och-upplevelser/>

24. The Centre for Unaccompanied Children and Youth at the National Board of Health and Welfare in Sweden is developing a method for school health services to identify mental health issues among UMLs in order to provide adequate on-site support or refer the students to correct care facilities. School health nurses and doctors meet all immigrant children but a method on how to identify/screen and how to systematically collaborate with psychiatric services is missing. The project has tested the Refugee Health Screener (RHS) instrument. Final results are expected by the end of 2020.
25. https://www.sbu.se/contentassets/5e-e6541940fc41c5948b6d38bb24a05e/psykologiska-behandlingar-ptsd-flyktingar-asylsokande_2019.pdf
26. <https://www.nice.org.uk/guidance/ng116/evidence/evidence-reviews-december-2018-237694356181?tab=evidence>
27. <https://fhi.no/publ/2019/mestring-i-mot-tak-og-kommuner.-implementering-og-evaluering-av-teaching-rec/>

This report surveys different aspects of health of unaccompanied minors who have arrived in the Nordic region. The focus is on mental health issues rather than physical health, as the former are usually seen as posing more of a challenge to successful integration and to the social and health services in the Nordic countries. The report builds on recent research and studies, mainly from 2012 onwards.