

# Visibility, resilience, vulnerability in young migrants

Health

1–18

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**Abstract**

Young unaccompanied asylum seekers have been portrayed as vulnerable, resilient or both. Those granted residency in Europe are offered support by health and social care systems, but once they leave the care system to make independent lives, what part can these services play? Our review of research with migrants who have been in care in Sweden and the United Kingdom found evidence of unmet need, but little research describing their own views of services. The limited published evidence, supplemented by interviews with care leavers in a UK inner city, suggests that in defining health needs, young people emphasise housing, education, employment and friendship over clinical or preventative services. Some felt well supported while others described feeling vulnerable, anxious, angry or sad. These experiences, if linked with the insensitivity of even one professional, could lower young people's expectations of healthcare to the extent that they avoided contact with service providers. In supporting young migrants' resilience to meet everyday challenges, friendly support from peers, carers and professionals was important. They needed determined advocacy at key moments. The different challenges for the Swedish and UK health and welfare systems along with the resilience/vulnerability trajectory are described.

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## Keywords

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## Introduction

Responses in Europe to the 2015 refugee crisis and its aftermath have been polarised. During 2015, over a million people reached Southern Europe over land and sea, with 84 per cent coming from the world's top 10 refugee-producing countries, especially Syria, Afghanistan and Iraq.<sup>1</sup> This mass movement of people was used by populist protest parties and sections of the media to fuel anti-migrant, anti-Muslim sentiment. After images of a policeman carrying Alan Kurdi's tiny corpse from a Turkish beach circulated in September 2015, the 'migrant crisis' was more likely to be termed a 'humanitarian crisis'.<sup>2</sup> Citizen movements rallied to welcome and support new arrivals, terming the 'crisis' one of 'solidarity and of racism'. Young people and children, especially those arriving on their own, became symbols of this crisis serving both sides of the polarised response. Children vulnerable to drowning and exposure illustrated the desperation of migrants for refuge<sup>3</sup> while images of unaccompanied teenage boys illustrated a threat, querying the legitimacy of their asylum claims.<sup>4</sup>

Unaccompanied underage migrants seeking asylum are vulnerable and their treatment is symbolically important, speaking to the values of the receiving society (Apap, 2016). An emphasis on individual vulnerability has been criticised as ignoring the political causes of that vulnerability (Chase, 2016). Arduous journeys undertaken by lone young migrants, without familial or statutory support speaks also to resilience. This combination of resilience and vulnerability has allowed young migrants to represent the energetic hopes of building a better life against the odds, while also being vulnerable to death, despair and exploitation. Having survived the perils of travel from Syria, Afghanistan or Iraq, teenage boys may be viewed as 'too resilient' with their claims for asylum, shelter and care threatening resident society by exacting too great a cost.

Cultural practices, social processes, social change and the nature of individual-social relations have all been implicated in building resilience to withstand adversity (Bottrell, 2009). Resilience theory has developed models of ecological and contextual factors to support young people (Ungar, 2012), with global, as well as culturally and contextually specific aspects, in terms of outcome and process (Ungar, 2006). For each setting, the relationship between risk and protective factors of resilience differ (Marie et al., 2016), such that policies to support a young person's resilience need to be locally specified and studied, with both individual and collective aspects of resilience implicated in off-setting marginalisation and social exclusion. Resilience is understood to be coping and competence demonstrated in the face of adversity, involving identity work and cultural management drawing on individual strengths and capabilities which are themselves constituted by social positioning and a network of social relations (Bottrell, 2009).

The appropriate response to young non-European migrants, the majority of whom are male and Muslim, arriving without parents continues to be contested in Europe, despite a recognition that with support to fortify their evident resilience they can offer social and

economic potential. Given the trauma that many have experienced and ongoing uncertainty regarding their migration status, providing care is a significant challenge. How can services support young people's resilience in establishing themselves as adult members contributing to a new society while acknowledging past trauma and future uncertainty? What role can and should individual and collective support for resilience play?

Policy supporting young asylum seekers is part of a wider politics of migration. The International Convention on the Rights of the Child covers child refugees claiming asylum. Who qualifies as a refugee and can claim asylum is informed by the interests of the nation state in controlling immigration (Zetter, 2007), often outweighing solidarity and access to appropriate and equitable health and welfare services (( Humphris & Bradby, 2017). Despite their vulnerability to the risks involved in international exile, and despite the formal protection of the Convention, young people's efforts to claim asylum in Europe have been thwarted.<sup>5</sup> For those granted residency, integration of unaccompanied minors into adult life represents a challenge and one that is likely to persist, given that the number of child refugees has doubled from 2005 to 2015 (United Nations Children's Fund, 2016). Young migrants arrive in search of safety from prosecution, war and poverty to realise their potential as they grow into adulthood. Policies in the United Kingdom and Sweden to support young people have to socialise them to navigate the cultural expectations of a new setting, making it possible for them to fulfil their own aspirations. A central question is how to meet young migrants' needs and introduce them to the support available through the health and social care service systems.

'Social anchoring' whereby newcomers find appropriate support to restore a sense of security and meaning is a means of re-making resilience in a new setting (Grzymala-Kazlowska, 2015). An anchoring metaphor suggests a single point of contact, for instance with a carer or social worker, whereas solidarity implies a wider process of cooperative cohesion, perhaps resulting from multiple anchors. Good access to health and social care services is an expression of solidarity, where those in need receive appropriate support, permitting resilience to develop in a new context. What happens when access to services for young migrants is contested by querying their stated age and entitlement to support? How does a sense of solidarity being withdrawn influence young migrants' ability to access services?

## Background

Sweden and the United Kingdom offer different approaches to the refugee crisis. As a destination for refugees and migrant labour in the twentieth century, the United Kingdom remains attractive for those who speak English and/or have family connections. The 3043 applications for asylum in the United Kingdom from unaccompanied children in 2015 represented a 56 per cent increase on 2014's 1945 claims. The Home Office guidelines state that 'Every child matters, even if they are subject to immigration control' and that children 'should have their applications dealt with in a way that minimizes the uncertainty that they may experience'.<sup>6</sup> Delays in accepting unaccompanied child migrants seeking asylum and family reunion have been contested in parliament. Joint working guidance on age assessment from the Home Office and Social Services (2015)<sup>7</sup> refers to Department for Education guidance (2014)<sup>8</sup> stating that

Age assessments should only be carried out where there is significant reason to doubt that the claimant is a child. Age assessments should not be a routine part of a local authority's assessment of unaccompanied or trafficked children.

In the United Kingdom, unaccompanied children who seek asylum or refugee status enter the social care system as looked after children. As they age out of the care system, they become care leavers eligible for tailored health and social care provision to support their transition to further study and employment.<sup>9</sup> Policy-makers have focused on the relative importance of children's educational qualifications, emotional and physical health for long-term adult life satisfaction. The most powerful childhood predictor of adult life satisfaction is a child's emotional and physical health (Layard et al., 2014), so how services can support the development of young people's emotional resilience has important implications for future public health.

Sweden has offered asylum to significant numbers of refugees since the 1970s and remains a preferred destination for many.<sup>10</sup> In 2015, Sweden accepted 35,369<sup>11</sup> applications for asylum from unaccompanied children, the majority (66%) being Afghani. Sweden's role as a 'leading actor' in international refugee work (Borevi, 2012: 65) informed the opening of borders to Syrian refugees during the summer of 2015. Since November 2015, migration policy has become less open to refugees and borders harder to cross. The centrality of the child's best interests ('barnens bästa') notwithstanding, deficiencies in reception facilities and services available to child refugees have been noted, with basic rights disregarded (Barnombudsmannen, 2016). In 2016, an announcement was made that a significant number of asylum seekers' applications would be rejected.<sup>12</sup> Migration officers have the right to determine the age of an asylum seeker who claims to be a child, and that determination cannot be appealed. If an asylum seeker is determined to be over 18 years of age, the case is treated through the adult asylum system.<sup>13</sup> The discretionary nature of age determination, the uncertainties of medical age determination (Hjern et al., 2012) and its serious consequences for those deemed over 18 years have provoked demand for reform (Aftonbladet, 2016; Malmberg, 2016).

## Methods

Our qualitative data on young migrants' experiences and views draw on a study in two parts. In 2015, we undertook a participatory study of care leavers' health and social care needs in England with 24 ethnically diverse care leavers some of whom had arrived as unaccompanied minors (Liabo et al., 2017). The following year, we carried out individual interviews with unaccompanied young migrants and learning disabled care leavers (see Roberts et al., 2017). As part of these follow-ups, a scoping review of UK and Swedish grey and scholarly literature (in English and Swedish) was undertaken, focusing on care leavers' accounts of their health needs and priorities. The term 'unaccompanied child migrant' is broadly equivalent to '*ensamkommande barn*', and in England, 'children looked after' (co-terminous with children in care).

The initial study and the follow-up were both approved by the HRA Social Care Research Ethics Committee (15IEC08/0009) and young people gave informed written and verbal permission for their words to be used. Written information sheets were provided and young

people were aware that if they raised issues giving us cause for concern, we would discuss these with them, and with trusted colleagues in line with safeguarding procedures. We recruited to the study through the Children's Services department of an inner city local authority, where initial interest was first canvassed without the researchers present. We had no concerns that the risks of participating in the study would be greater than those experienced in everyday life by these young people. However, all research carries risks (including the risk of not being 'heard'), and we have written elsewhere about the need to operate an 'ethical radar' in research with vulnerable populations (Liabo et al., submitted). The interviews took place in a familiar environment, and by the time of the second interview, the young people knew their interviewer and could assess her trustworthiness. No individual declined an invitation to be interviewed, and none made contact with the independent clinician researcher who was named on the information sheets as the person to contact with any complaints.

This article draws on the scoping review, interview data from the first part of this study, a participation project which involved 5 group and 16 one-to-one interviews, our 6 follow-up interviews and a single interview with an underage migrant in Sweden in 2012, conducted as part of an earlier study (Green et al., 2014). The focus of our 2015 interviews was transition and health and in neither 2015 nor 2016 did we set out to collect specific data on individuals' asylum status, since it is not always easy for young people to repeat their stories. It was entirely up to those we interviewed to tell us as much or as little as they chose.

In the first study, of the 24 young people coming to at least one meeting or interview, 11 were unaccompanied asylum seekers, some with leave to remain, some without. Eight were young men, and three young women and they were aged 17–24. Five of them were followed up a year later together with one additional interview. Of these six, one young woman was 20, two young men 25, two young women and one young man 18. They were in care and looked after by the local authority. One young man was disabled, but we were not aware that any of the others were, although two of the young women mentioned use of mental health services. The interviews were all individual meetings and took around an hour.

The search for relevant literature was undertaken with mesh terms for the United Kingdom and for Scandinavia. The lack of refugee and asylum seekers' own voices in the literature and the even more limited evidence from young people (Humphris & Bradby, 2017) meant that the majority of sources cited here were identified through hand searching, that is, following up references cited in articles and books and contacting experts in the field.

Young men were well represented in the group interviews but were less inclined to sign up for an individual interview. Some of this reluctance chimes with the Swedish literature which suggests that for some, every encounter may be experienced as a test for citizenship (Jonzon et al., 2015).

The individual and group interviews were conducted by Anne Ingold, anonymised and professionally transcribed, and read through, analysed and discussed by all of the authors. In agreement with the gatekeepers, we provide the minimum of identifying detail. Because we did not enquire about young people's migration status or citizenship, we use the term 'young migrants'. In what follows, we listen to young people's own voices to highlight their expressed need for a sense of solidarity from carers, service providers and the wider public, in order to feel safe.

## Scoping review – health of young migrants in the United Kingdom and Sweden in their own words

We found little relevant UK literature, with refugee and asylum-seeking care leavers rarely disaggregated from the wider group of care leavers. There were even fewer Swedish sources, with almost no literature specifically focussed on young asylum seekers' *own* accounts of their health priorities, with professionals' views better represented (Backlund, 2013; Backlund et al., 2012). Where good practice around the social care of unaccompanied asylum seekers was identified, it had not been evaluated (Socialstyrelsen, 2013).

Research in the United Kingdom suggests that young migrants without adult support and especially those facing the possibility of deportation experience significant difficulties in the transition to adulthood (Wade et al., 2012). High levels of unmet need for mental health services and the disruptive effect of the asylum system can be offset, at least in part, by good quality family based care (Munro et al., 2012; Stein, 2012). However, only a minority of unaccompanied young migrants in the United Kingdom experience foster care or only do so for a short period, with most lodged in private shared housing, which can be very lonely (Chase et al., 2008; Wade et al., 2012).

Minors seeking asylum in Sweden and the United Kingdom alike face being ignored (Keselman, 2013) and treated with suspicion (Children's Society, 2014; Jonzon et al., 2015) by immigration officials, such that serious health problems may remain undisclosed (NCB, 2006). Current and former child migrants' accounts of their own health and experience of services, in common with other young people's views, are hard to find (LaValle et al., 2012).

When young people age out of the care system in England, they can continue to receive support until the age of 25, providing they are in full-time education, in work or disabled. Equivalent specialist access to support does not exist in Sweden where the universal model of healthcare provision is assumed to be open and available to all (Vinnerljung et al., 2006). Unaccompanied young migrants, in common with everyone seeking asylum in Sweden, are offered a standard health check<sup>14</sup> on arrival but no routine statistics are published. There is evidence of significant health problems among adults who have experienced out of home care (Bjorkenstam et al., 2013; Vinnerljung et al., 2015; Vinnerljung and Hjern, 2014) as well as lower educational attainment (Vinnerljung et al., 2010). There are knowledge gaps regarding the health of looked after children in Sweden (FORTE, 2015), with a lack of systematic procedures for assessing and monitoring their health (Kling et al., 2016).

The 2015 arrival of 35,369 young unaccompanied minors underlined the lack of statistical follow-up. Interviews with 450 unaccompanied minors in Swedish children's reception centres suggested unmet need for acute, chronic and psychological care as well as rehabilitation services (Barnombudsmannen, 2016). Young migrants reported being told to wait until they arrived at permanent accommodation before seeing a health professional, even when they reported pain. Despite asking several times one young person was only taken to see a doctor after having fainted and another reported having lost spectacles while in transit and not having them replaced. One child remembered being told by staff 'you have equality with Swedish children' in terms of rights to healthcare but receiving no further help to his or her symptoms (Barnombudsmannen, 2016: 14).

## Scoping review – young people’s concerns about health and health services

Our first study showed that health was rarely child migrants’ top priority, even for those with health problems (Liabo et al., 2017). Gaps in the provision of general practice and mental health services were apparent in England. In Sweden, the absence of specialist or tailored services for young people in care, and the need for a key worker with overall responsibility for the young person and his or her everyday care has been noted (Socialstyrelsen, 2013). First-hand accounts from young migrants regarding their own health and welfare needs and priorities are lacking and the limited evidence shows that young migrants prioritised the determinants of health such as education, employment and housing rather than access to clinical services. The vital role of a trusted and caring contact, whether friend, health or social care provider, carer or official guardian, was underlined for Swedish and British settings (Roberts et al., 2017).

Interviews with former asylum seekers in Sweden revealed concerns that the underlying purpose of any professional contact could be to assess an asylum claim rather than improve their well-being:

I went to the health centre and it was like an interrogation ... ‘When did you come to Sweden? Why did you come here?’ ... It was the same as they asked me at the migration authority.

... if they find something, how will that affect my chance to obtain asylum, and if they find a disease, will they help or what will happen? (Jonzon et al., 2015: 553)

This uncertainty about whether healthcare professionals’ examinations will be passed on to other official agencies was taken up in our interview material. Below we summarise the main matters that young people raised before focussing on what they said about health and social care services that failed to make them feel secure and how these difficulties might be addressed.

## Interviews – trust and uncertainty in health and care services

Young asylum seekers in out-of-home care are a highly heterogeneous group as reflected in our studies. A range of experiences with respect to illness, disability, educational and linguistic attainment, family and cultural background and foster care were reported, as well as variable ambitions for the future. A range of opinions about healthcare services was also expressed: one young woman described the health system as both safe and fair and others who mentioned health services were generally happy. But some did not know what help the general practitioner (GP) could offer or were worried that information might be used against them should a health problem be found. A few felt that services should be avoided due to bad experiences in the past, either with a healthcare professional or another service provider. One young person became distressed when a nurse attempted an internal examination until the foster mother intervened. A young man whose asylum claim was being processed in Sweden had not lost hope of being reunited

with his family and reported his most pressing issue as finding them, such that making contact with the local Red Cross was prioritised over registering with primary care.

A young man linked his acute mental health problems to his uncertain migration status and the pain of having to explain himself to professionals. He described an intense pain in his chest ‘that wants to blow and it’s like grenade’. He found the pain alarming, as he ‘couldn’t find the difference between a physical pain or an emotional’. When admitted to hospital he described being looked after by two people overnight in a way that was ‘really, really friendly’. But he found repeating his story to each new professional distressing. A woman of unknown (to him) status was described as ‘a blonde girl, tallish’ was ‘asking me the same questions. They just asked me the same questions’. He reported this repeated questioning as feeling

really bad because you feel like you are just going through what you ... Like basically they are asking you those questions and you have to give those answers to them that they are the trigger that you are there.

Repeating the distressing circumstances of his life to professionals compounded the panic and misery that had led him to seek acute care. When discharged, he was referred for specialist mental health support. He went once but decided not to return again because he was asked questions he had already repeatedly answered:

I didn’t want to go because it was just like all the time, it was too much for me going in front of psychiatrists, going in front of someone I don’t even know, crying in front of them and going through what happened to me, it came out to be like a story for me, you know, I was praying so hard for that story to not come up in my dreams, you know, because it was like a broken loop, every time I met someone who’s supposed to help me I have to go through that bit.

Being asked to rehearse his unhappy history was inscribing his story in a way that intensified his distress, to the extent that he avoided seeking care. He connected the mental health professionals’ questions with two Home Office interviews about his migration status. At four and seven hours, the Home Office interviews were so long and so stressful that he described fainting. He linked this stressful experience with his unwillingness to pursue healthcare that he thought might involve questioning that could bring on the intense anxious uncertainty that was disrupting his life.

In a group discussion, he described how he had lost touch with his social worker:

She told me, she was very happy and she told me that ‘I’m left, I’m leaving this job and I’m not gonna be your Social Worker any more’, I was very [sad], because when it’s your first Social Worker I was very connected with her and I was very like happy or something and then I got disappointed so ...

Another young person,

Yeah, that happens to me.

Another young man, with secure migration status, described feelings of anger and intense reluctance to cooperate with a range of officials, including police and doctors. He

had a visible physical disability and he felt that when people saw it, they had a ‘little feeling, this sorry feeling’ which he could not bear. He reported disliking doctors ‘because they lie’ and described how a doctor had assured him that his broken wrist would heal properly, which he felt had not been borne out. He did not like police officers because he had been stopped so often while out walking, on account of ‘looking suspicious’ and ‘not doing the average walk’. This police contact made him feel angry because ‘I don’t want them to make a criminal out of me’. He felt that his foster carers had not looked after him properly and cited the lack of attention to his diet, which should have been tailored to his heart condition, and the current poor state of his teeth. He went so far as to say that children should never be put in care, since they would not get a healthy life.

Later in the interview this young man described how much he enjoyed eating and how, when he had a full belly, the feelings of anger that made his life difficult, were less troublesome. He had not been taught to cook vegetables and found it hard to regulate his food intake and his mood, despite having the insight of their connection to one another. He had been referred for therapy to help with his feelings of anger but was unwilling to follow it up, given his distrust of professionals and carers. He described having a foster-carer or social worker who could be relied upon to help him through the crises of anger and unhappiness as central, a point to which we return to below under ‘Interviews – Key contacts’.

## Interviews – visibility and vulnerability

Some young people shared an intense awareness of their own appearance in terms of age, disability and being Muslim that they linked to how they were treated. Feeling visible could be an ordinarily frustrating part of expressing an identity that was sometimes thwarted, as with two young women who reported difficulties in cooking ‘my country food’, echoed by young men in a group meeting, while a young Christian woman said that her Muslim foster mother did not like her wearing teenage fashion.

In common with other young people living in care, some young migrants did not want to reveal their background to others. One young woman did not mind her teachers knowing she was ‘in care’ but felt the other students would judge her negatively. A young man offered evidence to an All Party Parliamentary Group that ‘in care’ status should be highlighted on medical records, but others were more cautious as to whether this was something they would welcome, feeling that a ‘looked after’ status carried a stigma.

Regardless of what they chose to reveal about themselves, some described feeling that they were treated in a different way from UK-born young people:

- |               |  |
|---------------|--|
| Young person: | Also want to say that where I live ... I think there’s two category where the young people that live in the building, same building as me, all of them were, they were there because their parents are not in the UK so they’ve come as a refugee or asylum seeker and I’m one of them as well. And I felt that if you’re come from such circumstances you’re encouraged to move out of the foster family. |
| Interviewer:  | Okay.  |
| Young person: | Yeah.  |

- Interviewer: So there's a difference in how ...?
- Young person: Yeah, you're being treated.
- Interviewer: Okay.
- Young person: Because when you're living with a foster family there's more financial to that where the Social Workers and the service needs to pay you a lot more, whereas you live by, in a semi-independent there's less money involved.
- Interviewer: Oh okay, alright.
- Another young person: That's true.
- Another young person: True.  
With a disability, others' pity could increase feelings of vulnerability:

I think people look at me and I've got [physical disability] and they think, they think to themselves oh sorry, like, you're not supposed to feel sorry for me, just it's quite ridiculous behaviour and I don't like it to be honest, you know, like why you feel sorry for me? Do you know what I mean?

Feeling he had very noticeable dark shadows under his eyes because of anxiety and lack of sleep, a young man used 'loads of make-up to hide it' because otherwise he felt he 'would scare the people in college if I go like without'. He planned surgery later in life to remove the shadows. But this was more than just a cosmetic worry, since he felt his appearance affected the assessment of his age: when he told people he was 17, the response was: 'no, you are twenty, you look like twenty!' During a dental examination, he said a health professional commented that: 'your teeth don't look like you are 17!' At the time he had not understood the meaning of this comment, but later, after discussion with his foster carer, he interpreted this as a response to all the 'people who come here and lie about their age or something, you know, like that'.

At a group discussion, another young person reported that during a routine and voluntary health check a nurse doubted the truth of the information he gave:

Because I am, um, maybe because, I don't know, she was quite surprised when I told her that I am 16 years old and she was like 'no you're, you don't look like you are 16 years old' and actually when people tell me that I am not 16 years old I find it offensive.

On top of anxiety about appearing 'too old', a young person reported anxiety about his appearance as a Muslim. Although he felt that aspects of Islam were helpful in coping with high levels of anxiety, he wondered whether public hostility to Muslims made him unsafe. He said, 'I like to look Muslim, dress like a Muslim, but I'm just scared what, how would I be treated on buses or trains?' He felt badly affected by his own uncertainty and fear about how his appearance might lead to hostility in public.

A young woman felt that when trying to access primary care a receptionist, who could neither understand her English nor find her name on the patient register, blocked her. Despite these frustrations, she could not imagine changing to another doctor, since this would entail having to rehearse her medical history and with the trauma that this implied, she would then 'feel sad'.

## Interviews – key contacts

Even when in great distress, friendly contact with service providers could make a difference to young people. The young man seeking care for mental ill health appreciated his overnight care as ‘really, really friendly’, before meeting the ‘tall girl blondish’ who he felt asked insensitive questions. He described how sad he was when his first social worker announced that she was moving jobs and leaving him behind. The young woman who had communication problems with her General Practice said that her foster carer made her appointment for her, thereby protecting her from annoyance and upset.

Some young people spoke about how their foster carers had helped them and made them feel secure:

With my new carer she was really open ... I always keep to myself when I used to live in the other ... with other people like it was more of that, yeah, and I feel more better with [foster carer’s name].

Others said their foster carers imposed strict rules such as no toilet-use after 11 o’clock at night, or restrictions on showering or cooking ‘own country food’. Strict rules were then hidden from the social workers. A young man in a group discussion said that

When a Social Worker come and they ask ‘have you cooked?’ I say ‘no!’ And she say ‘Because he’s too tired!’ or something. She doesn’t even let me use the gas oven to cook!

Some foster carers were themselves immigrants and there were moments where their views collided regarding appropriate behaviour, for instance, around teenage fashion. Other rules seemed more arbitrary, as reported by the following 17-year old:

But you know what’s the most ridiculous thing in here is that she will [say] and if you do the wee you should use the shower.

Young migrants’ best support can be another young migrant: a group of boys who were all from the same country, were clear that they supported each other. One Christian and one Muslim described how important they were to each other as ‘best friend, like a sister’. The interviewer asked,

And they’re important to you?

Yeah. Because like they are my second, like I always see them as my sister and like they are my second family and stuff like that.

A good health professional was described as someone who would ‘attend to the young person quickly and try to sort the problem and not to judge somebody’. Given that some young people felt judged to the extent that they did not seek healthcare, the avoidance of negative judgement is no trivial matter.

Having a person who listened, cared and offered support was highly valued whether that person was a healthcare professional, a social worker or a carer, like the ‘good foster

mum', prepared to fight at key moments. We describe elsewhere (Liabo et al., 2017) the importance young people place on the determinants of health including education, but the support of individuals in the education system was also crucial. One young woman told us,

Thank god I had a nice teacher, you know, I still love her, she kept an eye on me, I didn't even know how well she protected me and she saved me, you know what I mean, all those days.

The lack of protection from intrusive questions in hospital, or in the dentist's chair, or from the insensitivity of a Primary Care receptionist, were moments where young migrants felt in need of support.

An unwavering advocate was crucial to supporting young people's sense of themselves as resilient in negotiating not only transitions in education, housing and healthcare but also the challenges of the migration system. Where a trusted contact was not available, difficulties were described as intractable and frustrating. A young woman who had escaped domestic work in a country that was not her birthplace, before arriving in the United Kingdom aged 16, described the difficulty of arriving in the United Kingdom for the first time:

Young person: Oh my God, when I come the first time it was like very hard, I was scared something because the first time I was not ... I don't speak English and I have interpreter, oh my God, the questions something [laughs] but now ...

Interviewer: What the interpreter, what was ... ?  
Yeah, she explain to me, I know but they ask like too much question, yeah.

She spoke about how helpful the advocate had been in helping her change placement:

Like when I was, the first time I was foster care she was not nice and I tell [name] and [participation worker] tell [advocate] and [advocate] change, she tell the Social Worker and she change it for me.

## Discussion

Our scoping review found very little research on young unaccompanied migrants' own experiences of, or priorities for, health and social care services. Our study of young migrants addresses a gap in understanding the needs of this group.

While some young people were happy with the services they received, others avoided services because of worries about being misunderstood or subject to insensitive questions or examination. The cost of re-telling one's story to a new professional could be high, to the extent that health professionals were avoided. Young people could extrapolate from an unfortunate experience with one official, to distrust contact with other professionals, including health and social care workers. While one young man was confident enough to

offer evidence to an All Party Parliamentary Group, others felt self-consciously visible, with a sense that their status as 'in care', an asylum seeker or disabled made them vulnerable. Young people said they felt self-conscious about their age being judged. Having one's age contested was connected to a wider uncertainty about rights to residency and entitlement to services. One young man who was particularly self-conscious about appearing older than 17 years also worried that looking like a Muslim made him vulnerable to being mistreated in public. Stressful or otherwise negative encounters with migration or law enforcement officers could have an overbearing influence on subsequent expectations of healthcare professionals. A negative experience with a single healthcare professional querying entitlement to care could have a disproportionate effect when press and social media echo an unwelcoming anti-migrant message. At a time when young migrants' rights to seek asylum are being denied by statutory authorities, an off-hand comment from a professional is not an isolated incident. If young people expect to be treated with insensitivity or disregard, their engagement with services risks being minimal or absent, which, given the evidence of unmet health need, is problematic.

With everyday frustrations about cooking 'my country food', dressing appropriately and getting a doctor's appointment, a trusted supportive contact, which could be a mate, a social worker or foster parent, was important. When a young person was highly anxious or facing a challenge, such as needing to change a care placement, then the trusted contact's ability to advocate for the young person could make a crucial difference. Young people's understanding that social workers, caring health professionals and foster parents matter was clear in their expression of disappointment when, for instance, a trusted social worker 'moved on', such that new contacts had to be established to regain similar support.

Individual support or 'social anchoring' was apparent with individual professionals who were determined to make a difference. Young people sought support from foster carers, social workers, a participation worker, health professionals and an advocate to withstand change and challenge, to adapt and integrate, without becoming destabilised from their own ambitions.

Alongside supportive contact from professionals, informal contact also made a difference and young people spoke warmly about fellow migrants, foster carers and teachers who gave them support at crucial moments. Young migrants described themselves as coping, despite their experience of loss and trauma, with self-determination to keep going, to help others, maintain friendships and, crucially get an education. They spoke at length about wanting to get an education, but those without support found this difficult. Without someone who could 'fight like a good foster mum', making the most of the opportunities available through health and social care to make an independent life, get an education and eventually employment, was clearly tough. The loss of a trusted social worker was experienced as a disaster especially if he or she was the young person's only social anchor.

The social anchoring of a professional or a mate was important but so too was a wider sense of social solidarity, whereby entitlement to support was acknowledged by those who were not key contacts. When young people felt their legitimacy to access services was questioned, a feeling of being highly visible, vulnerable and 'othered' as disabled, Muslim, in care, or immigrant, was destabilising with the lack of trust preventing further contact. A suspicion that professionals were policing access to services could be overcome with the robust intervention of a key contact, but if this was lacking isolation

ensued. The prospects for services providers supporting the development of resilience in the absence of trust are clearly poor.

Young people needed not just friendly support and advocates who could fight for their rights but also a wider sense of solidarity – the institutional expression of mutual support through the availability of services – in order to withstand the occasional unfriendly encounter. Health and social care services cannot replace parents' role in young migrants' lives as they try to adapt to and integrate in new circumstances. However, continuity and trust with a personal supporter is important, as is a more general sense of solidarity permitting and facilitating access to services.

The provision of good quality health and social care for young migrants, including those leaving care, is a difficult task. England has developed tailored services to offer more responsive support for care leavers than for their age-peers living with parents. However, where resources and key workers are over-stretched, young people do not always receive the support to which they are formally entitled. In Sweden, the universal approach assumes that a single access route will be appropriate for all service users. Since care leavers have no special priority, there is no stigma associated with being too visible, but there is a suggestion that young people without parents to advocate for them in health and social systems become lost to the professionals' view (Ringsby Jansson and Olsson, 2006).

This article reports from limited empirical material and our commitments to privacy and confidentiality mean that we are restricted in how much we can report the context of these young people's lives to interpret their words. Consulting with people considered vulnerable may be motivated by recognition and the inclusion of 'marginal perspectives' in building resilience (Bottrell, 2009), but the encounter with ethical governance brings in protection as a consideration. Depending on the individual, recognition may be more or less personally important compared with protection at a given research moment and this balance cannot be prescribed by ethics committees in advance (Liabo et al., submitted). The interviewer has to develop a sense of when it is appropriate to ask and when to remain silent – an ethical solidarity.

Solidarity with young migrants implies recognising their successes and their entitlement to services as a good investment for the future (Cuthill, 2017). Service providers are valued for the support and advocacy they offer individuals to overcome adversity and allow young migrants to work towards their own ambitions. A wider collective support is also part of an environment that nurtures resilience and the negative consequences of its absence were shown as young people described a sense of vulnerability that impaired everyday life.

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### Notes

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3. <http://www.bbc.co.uk/news/world-europe-34278886>
4. <http://www.dailymail.co.uk/news/article-3850840/Third-batch-child-migrants-begin-journey-Calais-Jungle-UK-Home-Office-admit-two-thirds-past-children-lied-age-officials.html>
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6. [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/257462/assessing-age.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/257462/assessing-age.pdf)
7. [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/432724/Age\\_Assessment\\_Joint\\_Working\\_Guidance\\_April\\_2015\\_Final\\_agreed\\_v2\\_EXT.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/432724/Age_Assessment_Joint_Working_Guidance_April_2015_Final_agreed_v2_EXT.pdf)
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