Evaluation Report: Baobab Centre for Young Survivors in Exile

Profiling a Traumatised Community

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Within this evaluation study, 63 young people (79% male, 21% female) ranging in age between 15 and 29 years old (mean = 22.6 years), were administered an interview consisting of a series of standardised questionnaires and more qualitative/experiental questions as part of a monitoring and evaluation process. Within this sample, the young people came from 14 different countries, most of which were in the African continent (the three most common countries from which the sample came were Democratic Republic of Congo, Uganda, and Nigeria). The remaining countries of origin were all from the Asian subcontinent, the largest of which was Afghanistan. The experiences of this sample were multifarious with high incidences of close family members being killed or tortured, their own experiences of being abused including rape and being trafficked, amongst other political and financial situations. Within this report, 36 of these young people were followed up 12 months following this first assessment, and a further 10 were followed up after 24 months.

This report draws upon data from all three time points and initially reflects upon the overall profile of the challenges, competences and internal worlds of a heterogeneous sample of adolescent and young adult asylum seekers who in most cases have experienced overwhelming and violent events during their developmental years. Their experiences and narratives are often ones of humiliation, violence, trafficking and violation in their home countries and/or on their often prolonged journeys into exile in the UK. The second section endeavours to explore their trajectories in order to identify whether there are some elements in their psychological and social world which may improve, stabilise or even worsen during their new life and affiliation with the Baobab Centre for Young Survivors in Exile. The third and final section addresses the more global perceptions of this population in terms of their difficulties, sense of belonging and beliefs in relation to both benefits and challenges, and their relationship to the Baobab Centre. Throughout the report, we report on numerical and statistical changes, particularly within a number of established questionnaires that have been systematically and universally used in a diverse range of mental health settings. We also

draw upon the more qualitative and experiential narratives that provide a deep and more enriched picture of these young people's worlds. In the latter section, we will introduce two case studies of young people within this study.

"I'm an outsider…….it's a slow torture"

"My current situation is five years with no news from my family. No asylum. I can't study, I have no status. I am always dependent upon money and no status".

"They treat you like an animals even though they say human rights, they don't exists for us refugees".

"What do you do when you feel anxious or scared? That is the worst because I can't find a way to solve it, if I'm scared, I'm scared, I haven't got a solution for that, there's no rehabilitation for me within that".

Part 1: Profiling Young Survivor's Worlds

This section addresses the presenting characteristics of this community of young people. It draws upon the baseline or initial measurements across a range of questionnaires that tap into different psychological and social dimensions.

A Depression

We were able to explore depressive symptoms in this population using the *Moods and Feelings Questionnaire (MFQ; Angold, Costello, Pickles & Winder, 1987),* a 33-item self report measure. In a partial sample, if we consider that clinical cut off scores recommended by NICE are reported to be above 27, then at baseline when they were first assessed an overwhelming 91% of this sample fell into this range. On a further subsample (n=14), who were administered the Patient Health Questionnaire (PHQ9), a standardised measure of depression, 70% were rated as suffering from depression.

Young people's accounts of their depression and distress were at times emotive in content.

"I cry and wish that the sadness will go away".

"Sometimes I harm myself when I see my blood I feel a bit better"….

"If I feel miserable, I go to bed and sleep for a long time"

At other times, accounts were more descriptive and related to their own narratives and journey.

"Thinking that I don't have people or family in this country, I am alone. I worry that people will find me (the ones that brought me here) and they might take me".

"I think about the past and future. I do nothing".

B **Anxiety**

Levels of anxiety were captured using the *Revised Children's Manifest Anxiety Scale (RCMAS; Reynolds & Reynolds, 1978*), a 28-item self-report measure. Within the sample, 51% fell into the clinical or borderline range on first assessment. On a further subsample (n=14), who were administered the Generalised Anxiety Disorder Scale (GAD7)), a further standardised measure of anxiety, 90% were rated as suffering from anxiety (50% were rated as 'severe').

Young people's accounts of their anxieties and fears were again at times emotive in content.

"When I'm really scared I'm just there, it's nothing else matters to me until that thing is over. I get flash backs, nightmare, scared a lot and scream a lot".

"Two years ago something happened to me when I am asleep I see myself die. I saw a fire in a few days ago it was so scary, I just sit and can't go to sleep".

At other times, accounts were more descriptive and related to their own narratives and journey.

"I am scared of being returned to my home country"…

"If I am facing someone with more power or an authority I am scared".

"Situations that I don't have control over, fear of being judged and people talking about me, fear of being misunderstood, I go into hiding".

C Anger

Though sadness, distress and anxiety were dominant emotions within this population, anger and aggression were strongly evident too. Young people's descriptions of both the experience and manifestation of anger were very evocative of how overwhelming their experiences had been in often very young lives.

Many young people struggled to understand their anger.

"I don't know what makes me feel angry. I'm no angry easily. I easily leave the place where I am or I fight".

Others were more defended against such feelings.

"I feel nothing, I just keep quiet".

"I don't get angry, I don't have anger".

But in most cases, young people were able to think about how they displayed it.

"Sometimes I hit the wall and shout. I want to fight with someone or make them hurt me so I can feel something sometimes …I don't know what I am doing".

D Controlling Emotions

We also were interested in young people's ability to manage their emotion, and for this, used the *Affect Regulation Checklist (Moretti, 2003)* (a 12-item measure adapted from published scales of emotion regulation. The measure focuses on both maladaptive (e.g., lack of control, suppression) and adaptive (reflection) aspects of regulation. This population of young people had clear difficulties in relation to affect regulation and emotional control. The affective dyscontrol subscale is the most predictive of risk and within this Baobab sample had a mean of 1.37 (sd 0.60) which showed considerably high affective dysregulation on first assessment. This was considerably higher compared to a sample of high-risk youth (N = 179; 46% female) collected by Moretti and Craig (2012) from juvenile justice and clinical settings with a mean of 0.97 (sd 0.61).

Young people often lacked the capacity to manage their emotions. This was often about being out of control with one's own emotions.

"I have a short fuse, if people make fun of me or are stupid or irresponsive or careless, if people think I am stupid, people being unfair, I lose my temper and shout…I lose my cool"

"I just cry and my temperature goes high and I get a headache".

"I can't get out of a mood and if I can't I just break something, I'm the best at breaking things".

In other ways, poor regulation was about suppressing their feelings.

"I lock myself in shut the door make the room dark, more like hiding in my own house".

"I just don't do anything"

E Resilience

The WEMWBS is a 14 item scale of mental well-being covering subjective well-being and psychological functioning. Within the sample, 84% had scores which fell below the average and were in the lower range, whilst 65% were in the lowest quartile, when this was compared to the general population. In the national data set survey in Scotland in 2006 (*Health Education Population Survey and the Well What do you think Survey*), the average had been 50.7.

Though levels of well-being were very low in comparison to a normative sample, many did, however, report a broad set of positive strategies for making themselves feel better, more comfortable and more hopeful.

"I read the bible and pray and talk to my girlfriend".

"Listening to music, talking to people makes me think of the future and optimism".

"I do good deeds. When the situation is bad, I try to be positive anyways. I surround myself with people that care about me and I care about".

"I like helping people. I like studying".

"Going out on long walks makes me feel better".

"Coming to individual and group psychotherapy at Baobab".

F Behaviour

The HoNOSCA, a measure of clinical outcome for use within Child and Adolescent Mental Health Services, provides a global assessment of the behaviour, impairments, symptoms and social functioning of children and adolescents with mental health problems. Over half the sample experienced moderate to severe levels of concentration/restlessness and also low mood/anxiety/obsessions. These were the most prevalent symptoms and manifestations within the sample. There were many other psychological difficulties with approximately one in four experiencing abnormal thoughts/hearing voices, psychosomatic problems or restrictive lives owing to a disability or illness. Similar levels of over one in five young people struggled with self-care/independence and maintaining satisfactory social relationships. Other more visceral and violent behaviours either towards oneself (i.e. self harm) or others (disruption/aggression) were at lower levels, but nevertheless still prominent. Finally, education and learning was hampered in about one third of young people in this sample.

Part 2: Changes Over Time in Young Survivors

For the second part, we draw upon a smaller subsample of 36 young people who were followed up one year following their initial assessment. We explore where there are changes in a number of the same areas as reported in the previous section.

A Anxiety

As reported in the previous section, levels of anxiety were captured using the Revised Children's Manifest Anxiety Scale (RCMAS; Reynolds & Richmond, 1978).

There was a statistically significant decrease in anxiety levels. The total score dropped significantly over the 12-month period. Indeed, at the first time point, 51% had been in the clinical range, whilst one year later, 28% were. Overall, 66% decreased their anxiety scores over the time period. On the small subset of 10 young people who were followed up 24 months later, the decrease was still evident.

B Affect Regulation

As reported in the previous section, young people's ability to manage their emotion was captured using the Affect Regulation Checklist (Moretti, 2003) (a 12-item measure adapted from published scales of emotion regulation). Young people's capacity to regulate their emotion marginally increased and this was most pronounced for the domain that related to 'ability to manage control'. The 'suppression' scale also showed improvement.

C Resilience

As reported in the previous section, subjective well-being and resilience was measured using the WEMWBS. Levels of resilience/mental well-being, as measured through the WEMWBS, changed during the 12-month period, however, at the initial time point, a large proportion of participants (84%) had scores below the national average in the low range for this measure, whilst at follow-up, this number in the clinical range had decreased significantly to 63%; Overall, participants were feeling more confident, feeling closer to others, feeling good about self, feeling optimistic, not being restricted by physical or mental problems, and feeling more useful

D Behaviour

As reported in previous section, a more global assessment of children's behaviour, impairments, symptoms and social functioning was elicited through the HoNOSCA. Global levels of well-being, as measured through the HONOSCA, improved significantly during the 12-month period, and this was

noted most so for 'behavioural problems' (e.g. concentration/restlessness, disruptive behaviour) and 'psychological symptoms' (e.g. low mood); Overall, there were some areas that were clearly changing but given the challenges in this population, progress was slow and variable.

HONOSCA	**% moderate/severe Baseline**	**% moderate/severe Year f/up**
Behaviour	**%**	**%**
Concentration/Restlessness	60%	44%
Disruptive behaviour	19%	12%
Self harm	16%	9%
Alcohol/Drugs	4%	9%
Learning	**%**	**%**
Difficulties keeping up with education	32%	31%
Psychological symptoms	**%**	**%**
Physical illness/disability restrictive	27%	21%
Hearing voices/seeing things/abnormal thoughts	25%	24%
Psychosomatic complaints (e.g. stomach aches)	25%	18%
Low mood/anxiety/fears/obsessions	51%	42%
Social impairments	**%**	**%**
Lack of satisfactory friendships	21%	24%
Difficulty looking after self	23%	18%

Table 1b – Changes over time in HONOSCA proportions of moderate/severe behaviour

As stated earlier, total problems across the HONOSCA diminished over time.

Behavioural problems mostly diminished over time including concentration/restlessness, disruptive behaviour and self-harm.

Learning and education impairments also changed but in this case, there was a large increase of the young people who were struggling to attend their education sessions.

Psychological symptoms all diminished marginally in terms of severity.

Social impairments were less positive in terms of change with difficulties with relationships appearing to become more problematic, with time. This is most probably related to the young person becoming more socially integrated.

PART 3: Evaluation of Difficulties

This third section reflects upon some of the more global perceptions of young people in terms of their difficulties and how they were integrating within their communities in the UK including at the Baobab Centre.

Young people arrived at Baobab with a multitude of practical and psychological issues that were prevalent in their life:

- 82 per cent stated that they had difficulties when they arrived.
- 70 per cent stated that they had difficulties following engagement with Baobab.

Though the percentage had decreased from their initial engagement with Baobab, it is unsurprising that the vast majority were still confronting challenges and difficulties given how complex and traumatised their lives had been.

"Dealing with my past experiences"

"I am trying to cope with what happened to me back home"

"Depression for all my life – the (African country name) government killed all my family – I was alone – my problems".

Perhaps, what is most indicative of improvement is their rating of the severity of their difficulties.

- 73% rated that these difficulties were very moderate/severe when they arrived
- 27% rated that these difficulties were very moderate/severe after engagement with Baobab.

Baobab supported young people in a range of practical areas.

	Asylum	**Education**	**Health**	**Housing**	**Benefits**
Initial	71%	66%	62%	60%	58%
12 month f/up	80%	80%	70%	70%	65%

Table 1c –Baobab Areas of Practical Help

The figures above show that the majority were being served across the five key practical areas and this was perceived to be more useful as their engagement increased at 12-month follow up.
Their use of Baobab for psychological support was reflected in the young people reporting in nearly all cases significant help with 'feelings', 'memories', 'conflict management', 'relationships', 'behaviour' and 'understanding about the past'. These areas below were supported by nearly all

participants.

Feelings	**Memories**	**Relationships**	**Behaviour**
95%	97%	94%	89%
Conflicts	**Feelings about past**	**Understanding**	**Getting used to life**
86%	95%	97%	91%

Table 1d –Baobab Areas of Psychological Help

"I was not belonging to nowhere, it was psychological".

"Stress, thinking all the time about my past, harming myself, wanting to end my life.I had difficulties being around people, communicating to others, and I was afraid about my past and my future".

Young people's coping skills were limited, diminished or in many cases dysfunctional when faced with these problems.

Responses were psychological and emotional in nature.

"I cannot sleep well, worry a lot"

"My difficulties make me not trust people and think they are against me, it makes me defensive"

"I become very stressed when I have bad dreams or hear bad news like not getting benefits".

Other responses are more physiological.

"I feel sick, have loss of appetite and I shut down".

Other responses were about their own thought processes.

"It makes me feel stuck, no life, no purpose, no happiness"

"I can't think properly"…

Other responses were about their own behaviour.

"My problems stop me opening up and being loved"

"….from achieving my goals and to look after my siblings".

"Going to college"

"Stops me from working, having a bank account",.

Perhaps, the greatest number of responses related to the future

"They stop me looking for work and being with people".

"The difficulties keep me away from what I am doing like studying".

As time elapsed, for most of these young people, they were learning more positive ways of negotiating conflicts and difficulties. Such qualitative accounts from the young people strongly indicated that they were learning both through Baobab and their own respective lives in the UK. Though their predicaments and struggles were often very challenging and multilayered, they were increasingly more resilient and competent at utilising such resources.

At one level, they were learning to draw upon their own external resources to facilitate change in their lives.

"I feel good around nice lovely people".
" I can feel better when I watch a movie or play".
"I dress up and go out".
"I meet people and do things together so I no longer feel bad".

Many skills were interpersonal and involved some form of communication.

"I ask my brother or speak to Sheila (Baobab), she guides me and is really helpful".
"When I have thoughts running around in my head, I talk".

Other strategies were more internal for managing difficulties.

"I think I'm not the only person going through this, I get strength from this".
"I try to stay optimistic and accept them".
"I ignore things, believe in myself and reassure myself".
"I just pray"
"I think of better solutions".

Finally, some strategies were more specifically about learning to regulate one's emotions.

"I squeeze my stress ball, just walk off".
"I relax myself and listen to soft music".
"I calm myself down by not talking about what makes me angry".
"I go to cool off if I don't like it, I go to be alone".

Belonging and attachment was a strong feature throughout the evaluation. Besides the more obvious areas such as obtaining refugee status and meeting others from their country and attending groups, there were other more psychological areas.

- 92% felt that they belonged to a place or group of people
- 100% felt that they belonged to the Baobab Centre
- 67% felt that they belonged to a community (place or people) who had passed away

They were aware of what ingredients helped enable them to feel that they belonged to a community.

"If you feel care and love, no discrimination towards me".

"Acceptance of me as a person, as a human, being not an animal or an object".

"Understanding my situation".

"Welcoming me, and just supporting me and respect me".

They were also able to identify what made them feel alienated and not belonging. There are so many reasons that prevent young people feeling integrated within their new lives.

"When I feel rejected".

"When I'm in class a girl tells me I am only an asylum seeker for benefits".

"Everything, the accent, the way you dress, the way you behave is different here. You're not from here, that speaks for itself, my background obviously".

In their current lives, there were other connections that they were able to feel a belonging towards.

- 55% belonged to a religious centre or group
- 49% felt part of their own ethnic or cultural group
- 77% felt better around friends from their own countries and cultures

Trust was a recurring theme throughout the evaluation.

"Meeting strange people is a difficult experience for me and I worried about if I should trust people or not".

"Opening up and accepting what happened to me".

Finally, it is important to acknowledge how the Baobab Centre itself was consistently attributed as being helpful in most areas by the young people. When participants were asked who they feel in their community they can talk to, an overwhelming 95 per cent referred to Baobab, nearly all of of whom were not able to refer to any other people or organisations. 90% felt that they had someone who they trusted enough to talk to. In nearly all cases, this was worker(s) at Baobab.

"I AM here because of Baobab".

"It helped me accept the past, be reassured of a brighter future, to stay determine and to keep pushing".

"To gain confident and more self esteem about myself"

"I can share my emotions and understand the same difficulties as from other people"

"To learn to integrate more into the community and by not escaping the past but learning to face it".

PART 4: Two Case Studies – Two Journeys

This final section reflects upon two young people who have been followed up over three time points.

- For Case X, the trajectory from the evaluation demonstrated a clearer and more positive improvement.
- For Case Y, the progress was less smooth and demonstrated the reality that often these complex and traumatised lives would take a while to change.

X

X is a 21 year-old male from Uganda who as a 16 year old had seen his own parents and grandmother murdered. *"I went through so much when I was younger with Dad dying. Nothing I miss a part of my family, all my family is dead, nothing there for me"*

He was helped by a priest who instigated his move to the UK in 2010.

"I had difficulties with immigration, flashbacks, my behaviour at that time was weird I reacted easily. Inside me my worry was that I didn't have enough energy to do what I wanted to do".

Initially, X had strong depressive traits and described 'going to bed and sleeping for a long time'. Similarly, his anxiety levels were high where he described how he had to 'walk around till I am calm'. At follow up, his depression was lower and this was also evidenced qualitatively where he said that 'he just goes out, visits friends, goes to a club' if he is feeling sad. Similar improvements were observed in his anxiety levels where again he found more positive resources and would 'find something to eat, put TV on or watch music' if he felt anxious. These resources were even stronger at the 24-month follow-up where he referred to the importance of people as being positive in his

life. He was also learning anger management strategies and said if he felt such feelings 'he would move away from that person'. He identified education as being the most important area in his life that had enabled his improvement whilst the ongoing immigration issues represented the greatest barrier to change. He was more integrated in the UK now and felt more belonging from the help he received which enabled him to access college. X also was able to identify how Baobab had helped him with his 'thoughts' and 'feelings' and when he first arrived in the UK, he had problems choosing words for what happened to him. He was now more able to 'talk to people to ask advice' His help drew upon psychotherapists, case workers, teachers and lawyers. Once immigration status had been obtained, DK said he could focus on his 'difficulties in the present'. He referred to the challenge in understanding UK society.

Y

Y is a 21 year old male from West Africa who was kidnapped when he was only 10 years old by a trafficker and forced to be a sexual slave in West Africa. Initially, Y presented as having many difficulties, stresses, thinking all the time about his past, harming himself and wanting to end his life. *"Sometimes I harm myself when I see my blood I feel a bit better".* Though his scores across all the questionnaires were in the clinical range, he was still able to identify the positive function of talking and in particular seeing his psychotherapist. At follow-up, his resources were stronger for coping with difficulty: 'I think of possible solutions' and 'I always talk through things with people'. Though Y drew upon resources within Baobab, his struggles were still very dominant 'thinking about the future and not knowing what was going to happen' and 'feeling by yourself'. His feelings of hopelessness at 24 months extended to homelessness, 'not being able to do normal day to day activities' or 'move on with my life'. Y remained angry with recurring thoughts about not being allowed to stay in the UK. Though he tried to manage this by talking to himself, listening to music and other strategies, he was finding it a struggle.

Conclusion

In sum, this report underlines what a challenging population this is considering both pasts of such adversity, catastrophe, trauma and pain, and current conflicts they are facing in their everyday existence. Clearly, their lives are unpredictable and this report has endeavoured to capture this.

The strengths of this report are clear since they have given voice to over two thirds of the population of young people at Baobab, and use a wide range of standardised measures. We have also attempted to capture the 'voice' of each young person to add a qualitative and more enriching layer.

There are nevertheless a number of challenges worth reflecting upon. Some of these challenges were about engaging a very alienated population who needed flexibility in terms of the evaluation, the timing and location. In many cases, the interviewers needed to be quite persistent and creative in ensuring that the interviews were undertaken. In addition, considering the chaotic and changing lives, we need to be mindful that the evaluation process is a 'snapshot' of what is going on in the current internal and external world. It is possible that responses in many of the measures would have been different if the interview was conducted on a separate occasion. In order to counter this, we did use predominantly standardised questionnaires with clinical and non-clinical cut-off points. Again, this population is a very specific one and these tools may not be sensitive to such young people who have quite unique experiences. Furthermore, when conducting the interviews, many of the young people laughed at reporting their feelings about only the last two weeks, expressing their current situations and feelings as highly variable.

It is imperative that further evaluation work continues so we can continue to monitor what these young people look like across these domains over a longer period of time. The methodology for this evaluation was carefully conceived in order to incorporate a number of standardised measures within the field of mental health that were believed to be necessary for exploration of this population. Levels of depression and anxiety were deemed to be of great relevance and interest given that across clinical populations, these are invariably and significantly elevated.

Nevertheless, a word of caution must be exercised given that phenomena such as anxiety and depression may be conceived and experienced very differently given the contexts of people's lives. Though these established measures were created and researched with cultural sensitivity in mind, they are conceived with reference points that may not always be applicable to the highly divergent and idiosyncratic populations around the world that this sample emanates from. Here, there may be a different baseline as far as experiencing anxiety and depression is concerned, or an incapacity on the part of such individuals to reflect upon their vulnerabilities in the way that we do in the Western world. Besides considerations of these limitations, these still felt important domains to include within this evaluation and were able to demonstrate some change. Affect regulation was similarly thought of as being pertinent with traumatised groups as it went beyond the pathology and focused on the self-management of difficulties, enabling individuals to control and regulate how they were feeling. Again, similar reflections can be applied for this measure as to the ones on depression and anxiety. Finally, resilience and positive well-being represented an important

perspective in demonstrating how individuals were able to use positive strategies in their lives. Similarly, this measure was conceived in the western world, and may not include all the ingredients that may be significant for those who were former child soldiers and/or individuals who had experienced the murder of one or more family members. Research on such populations demonstrates that these children and their families demonstrate profound strength and resilience in their survival strategies, coping mechanisms, and abilities to adapt within what are often completely unfamiliar environments. They are, of course, exposed to many more and different protective and risk factors. Though inevitably there will be great risk for mental health difficulties after exposure to adversity and trauma from war and other such hardships, the literature and clinical experience suggest that war-affected children demonstrate tremendous resilience (Garmezy, 1988; Klingman, 2002). In sum, this particular evaluation and its methodology are still felt to be appropriate as the measures serve an important benchmark to view this population in relation to others. Of course, it can be criticised for a narrow and western-centric focus, and one that assumes a universal response to trauma. Traditional Western measures and assessments of psychopathology with individuals from a wide array of cultures and backgrounds is challenging (Birman & chan, 2008; Hollifield et al., 2002).

This evaluation has provided great insight into the vulnerabilities, complexities and potential for change within the right holding environment. With increases in sample size, refinements of measurement and a longitudinal focus over a greater time period, we will learn considerably more about the challenges for this population.