Baobab Evaluation Report
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Introduction

The Baobab Centre for Young Survivors in Exile was set up to meet the psychological and developmental needs of child, adolescent and young adult asylum seekers and refugees. This group of young people have all experienced organized violence, loss and massive change. Significant numbers suffer from the consequences of sequential traumatisation. The Baobab Centre offers a holistic child and adolescent centred non-residential therapeutic community approach where the community members have the opportunity for long term individual psychotherapy, group psychotherapy, attendance at various arts based groups (storytelling, drama, art, music) shared meals and events. There are regular therapeutic retreats which offer an opportunity for intensive group work, shared living and fun. They also hold regular community meetings where young people who have experienced violent community conflicts have the opportunity to develop their confidence in having dialogues and disagreements and expressing difference, with peers and adults. In addition to therapeutic work, young people can access practical advice and support through the care and asylum systems, along with physical health, education, care and access to housing and benefits.

Within this evaluation study, 29 young people (22 males, 7 females) ranging in age between 15 and 29 years old (mean = 21.4 years), completed a series of questionnaires as part of a monitoring and evaluation process. These were administered by 5 therapists who work closely with the young person. The young people who agreed to be interviewed came from 14 different countries, though the full population of young people at Baobab spans as many as 32 countries, most of which (69%) were in the African continent (the most common countries from which the sample came were Afghanistan, Uganda, Sierra Leone and Nigeria). The remaining countries of origin were all from the Asian subcontinent (31%) including Afghanistan, Vietnam and China. The experiences of the sample were multifarious with high incidences of close family members being killed or tortured, their own experiences of being abused including rape, forced recruitment and being trafficked, amongst other political situations such as internally conflicted failed states including situations where children and adolescents were seen as expendable by many adults.

This report is divided into two parts. Part One will focus on the presenting difficulties and challenges faced by the full sample of young people in the study (n=29). Part Two will focus on the

smaller sub-cohort of 16 young people who have been followed up one year later on a briefer version of the interview (following feedback from the young people at time point 1). Follow-up interviews were conducted by two postgraduate researchers. At this second stage there was an attrition of 5 young people who were no longer in contact with the Baobab Centre; efforts made to interview this group were unsuccessful. At the Baobab Centre there is an active community of 63 young people thus approximately 50% of the population are represented in the current evaluation research.

Within both sections, the report will be further sub-divided up into several sub-sections which explore the young people's internal world (behaviour, depression, anxiety, affect regulation, resilience and sense of belonging). A third section considers the overall feedback and evaluation from the users of the service. This is followed by a brief presentation of a research study which focused on how this population experience attachment to both their country of origin and their adopted country (UK). Finally, two case studies which provide further depth to these evaluation findings.

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Part 1: The Internal World of Young Asylum seekers

The evaluation research made use of 5 established questionnaires of emotional well-being and psychopathology. These were able to provide us with a window into young people's behaviour, mood levels, anxiety, and ability to regulate emotions. In many cases, we are able to look at this sample of 29 participants in relation to standardised norms and previous research, though it must be noted that at times this number drops if certain questionnaires were not completed.

A 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.

- There were behavioural difficulties in this sample with 90% suffering from a lack of concentration/restlessness, 45% engaging in disruptive behaviour, 24% injuring or harming themselves intentionally, and 10% engaging in alcohol or other drug consumption.
- The impact on young people's learning was evident with 38% experiencing educational difficulties.
- There were many psychological difficulties with nearly three-quarters (72%) suffering from anxiety, over two-thirds (69%) hearing voices/abnormal thoughts, 41% with self induced somatic symptoms (e.g. vomiting), and 31% being restricted through a disability or illness.
- There were social impairments too with 64% reported suffering in relation to close friendships, 59% struggling with independence and responsibility, 41% lacking satisfactory friendships, and 25% struggling with responsibility.

B Depression

We were also 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 the sample (n=27), the mean score on the MFQ was 37.96 (sd 10.10). If we consider that clinical cut off scores recommended by NICE are reported to be above 27, then an overwhelming 25 participants (93%) of this sample fell into this clinical range.

The level of emotional need in this population was great with over half of respondents scoring 'most' or 'often' on many of the items:

- 63% blamed themselves for things that were not their fault.
- 61% felt miserable or unhappy in the previous two weeks.

- 61% thought bad things would happen to them.
- 59% were sleeping worse.
- 56% had difficulties making up their mind.
- 48% did not feel as good as people their age.
- 44% were prone to crying.
- 44% thought that there was nothing good for them in the future.
- 41% were talking significantly less.
- 30% thought about killing themselves.

'My difficulties make me angry and depressed, sometimes I feel helpless and as if I have no control of my life.'

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

'The difficulties stop me achieving my goals – (I) feel sad, and low self-esteem, less confident sometimes.'

C Anxiety

Levels of anxiety were captured using the Revised Children's Manifest Anxiety Scale (RCMAS: Reynolds & Richmond, 1978), a 28-item self-report measure. Stallard, Velleman, Langsford and Baldwin (2001) recommend that an overall cut off point of 19 out of 28 can be used to identify young people experiencing clinically significant levels of anxiety. Within the sample (n=29), 27 fell into this clinical or borderline range. Only 3 had levels of anxiety within the normal range on the RCMAS. The overall mean for this sample was 24.93 (sd 4.1). When anxiety is explored in more detail, worry/oversensitivity had the most clinically significant scores; those relating to physiology were moderate, whilst those relating to social concerns/concentration were at the lowest level.

'Cannot sleep well, worrying a lot, thinking too much, too many/much responsibilities to handle very little income, small home, difficult to concentrate.'

'I feel very scared and frightened I stay at home for one day and maybe for several days.'

D Affect Regulation

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 aspects of regulation.

This population of young people had clear dfficulties in relation to affect regulation and emotional control. Considerable difficulties appeared in relation to self-control with nearly two thirds (61%) taking time to get over feeling upset, and 48% struggling to control their feeilngs. Suppression was also very evident with over two thirds (68%) trying to do other things to keep their mind off how they felt, and 61% stating that they felt worse if they try to think about things. The participants 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. 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).

'I hit my head against the wall or hurt myself to feel pain so I can forget other pains.'

E Resilience

The WEMWBS is a 14 item scale of mental well-being covering subjective well-being and psychological functioning. Within the sample (n=30), the average well-being score of 41.4 (sd 11.9) was significantly below the average score in 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 was 50.7.

Indeed, only 5 participants (16.7%) in the sample were over the standardised average of 50.7 demonstrating how this population clearly had a very low positive psychological functioning.

F Sense of Belonging

The concept of 'belonging' is central to the work of The Baobab Centre. Many of the young people have suffered loss and violence at the hands of their communities, their experiences in the UK can place them once more in positions of vulnerability and rejection. The 'Therapeutic Community' and group work intends to build trust in others, experience non-violent conflict and share current and past experiences with other Baobab members.

Some of the findings from this section suggest the 'community' approach to Baobab highly valued by the young people. 87% only mention someone from the Baobab community when asked '*Who do you feel you can talk to?*

Many young people did not '*feel part of their ethnic and cultural community in the UK'* (58%). The young people seem to be negotiating mixed feelings with regards to where they 'belong':

'My country, but I feel safer in the UK.'

'I don't know, it is a hard question, I am getting connected to Baobab but it takes time, I grew up in a different way from my friends even if they are Ugandan. I connect with people who have had similar experiences to me of war; also you need to connect with others with differences in order to move forward.'

Section 2: One year on: Looking at change in young people at Baobab

For this part, we draw upon a smaller subsample of 16 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 Behaviour

The HoNOSCA (see Appendix A for further details)
The items relating to behaviour showed mostly significant improvement over the one year period.

- Disruptive behaviour was exhibited by 31% - a drop of 14%
- Concentration difficulties was exhibited by 67% - a drop of 23%
- Predisposition to self-harm or injure was evident in 25% and had not shown any change.
- Alcohol and drug consumption had interestingly increased from 10% to 19%

The items relating to learning highlighted changes in the other direction with evidence of more problems.

- Over half (53%) had difficulties with education – which was an increase of 15%
- Similarly, over a third (33%)had had to stop education sections – which was increase of over 20%

The items relating to symptoms showed some variability.

- The biggest decrease was in hearing voices which had dropped from 69% to 56%, still a significant proportion of the sample

- There were further decreases in anxiety (72% to 62%)

The items relating to social behaviour showed some significant improvements.

- Difficulties in close relationships was much less of a problem now than it had been (37% compared to 64%). This was statistically the most significant change in the HONOSCA.
- Problems in relation to independence had also dropped from 59% to 44%

Overall, there were some areas that were clearly changing but given the challenges in this population, progress was slow and variable. The overall HoNOSCA score had decreased from 19.6 to 18.3 but some individual items above demonstrated a different picture.

B Anxiety

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 from 25.26 ($13<x<28$) to 21.69 ($3<x<28$). Though the decrease was by no means strong, it represented some change. Indeed, at the first time point, 25 out of 27 (93%) were in the clinical range, whilst one year later, 12 out of 16 (75%) were.

Further significant changes were apparent in individual scales.

- Physiological anxiety was especially decreasing (e.g. I feel sick to my stomach, My hands feel sweaty)
- Worry/oversensitivity also showed a number of changes (e.g. I worried about what was going to happen, I worried when I went to bed at night)
- Social concerns showed a few changes as well in the expected direction (e.g. I felt that others did not like the way I did things)

C Affect Regulation

We also were interested in change in young people's ability to manage their emotion, and for this, used the Affect Regulation Checklist (Moretti, 2003). Young people's capacity to regulate their emotion only marginally decreased from 15.6 to 14.9 though on reflection, 9 out of the 12 individual items did go down or stay the same. The individual subscales all show slight improvements with the greatest change in the 'dyscontrol' and 'suppression' domains.

'Always we are here but the mind is somewhere else, body is here but thinking about the past, mind is somewhere else.'

'My difficulties stop me sleeping - feeling worried all the time, not feeling safe, I don't sleep normally, my body is strong, but my brain is week. I can't make decisions, my social worker made me cry, I can't make decisions. Paralysed in decisions.'

D Resilience

Resilience scores, as tracked on the WEMWBS scale, only showed a marginal improvement from 42.2 to 45.6 but more significantly, 81% were in the clinical group at the first time point; only 56% were one year on. This is very strong evidence of improvement. 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

Section 3: Evaluation of Experience of Baobab Centre

The Baobab Centre recognises that the psychological needs of this population can be largely influenced by difficulties in the UK. A Social Worker provides support with negotiating the system in the UK. The young people reported:

- 88 % had been helped with access to asylum
- 77 % had been helped with access to education
- 71 % had been helped with access to health services
- 53 % had been helped with access to housing
- 53 % had been helped with access to benefits

86% felt had been helped getting used to life in the UK. The vast majority of these young people rated their current difficulties as 'very strong' (59%) or 'quite strong' (18%). Over 90% of the young people identified Baobab as the key place where they were able to talk about difficult experiences.

'I feel part of it. Safe and it gives me confidence - even if I have problems I can call someone, it makes me feel I have someone behind me you know.'

'It makes me feel happy and feel like I'm part of a family or group of people who can appreciate my talent and who I am. Basically I feel accepted.'

Their use of Baobab for psychological support was reflected in the young people reporting:

- 100 % had been helped with their 'feelings'
- 100 % had been helped with their 'memories'
- 79 % had been helped with conflicts
- 100 % had been helped with feelings about the self
- 96 % had been helped with their relationships
- 92 % had been helped with their behaviour
- 96 % had been helped with understanding the past
- 73 % had been helped to bear the loss of their parents/family

Self-reporting 'change'

Perhaps most tellingly, when they first arrived at Baobab, 78% described themselves as having strong or quite strong difficulties. This number dropped to 59% when asked about their current thoughts about their problems. Clearly, the challenges were very pronounced but had diminished. Even more interestingly, the strength of their feeling about the 'problem' had dropped from 81% to 38%.

Has anything been unhelpful at Baobab?

Two young people did express finding aspects of Baobab therapeutic work difficult, particularly talking about their experiences and listening to those of others. There was a sense that 'talking' could not help them:

'Not talking so much about the past, because you try to forget it and they remind you and so when you leave you don't feel good.'

Just over 30% of the young people commented on the size of the Baobab Centre and their desire for it to expand both in terms of physical space as well as the hope for wider awareness. It was felt that the organisation should continue to promote itself in order for other young people to access the support.

'Evaluation of Services Questionnaire' (ESQ)

The population felt highly satisfied with what Baobab offered (94%).

- 100% felt they were 'listened to', 'treated well by those who saw them', 'helped';.
- Around 90% of the population felt that their 'views and worries were taken seriously', 'they had enough explanation about the help', appointments were easy to get to and convenient

'Yes, I feel part of it. Safe and it gives me confidence - even if I have problems I can call someone, it makes me feel I have someone behind me you know.'

'Social events made me forget everything, made me feel good.'

'It makes me feel happy and feel like I'm part of a family or group of people who can appreciate my talent and who I am. Basically I feel accepted.'

Surviving Violence, Creating Hope, Rebuilding Lives.

BAOBAB CENTRE
for Young Survivors in Exile

All of the young people reported feeling better around friends who are refugees. Here are some of the themes that came out of being part of the Baobab community

'We share the same realities, same troubles in life… I have to tell them my feelings and problems because they are in the same situation so we share our problems and find a solution'

'Sharing experiences'

'Trusting others'

'Feeling safe'

Reflecting on their own lives

Taking a new perspective

'Understanding'

'Because they understand what I'm going through and we have similar things, even though we have different things about war or family we are all running for safety. I feel safe around them

'I understand how people are feeling, and that everyone has different experiences I share my ideas, see that other people have similar experiences. I used to love it for the friendship, being inside, eating together.'

'I've seen other people in my group they have all left their family back home so sometimes I'm being patient and I'm thinking to myself I'm not the only one'

'Because I feel like they are the same as me and my situation, we have common background, that's why I feel safe.'

Section 4: A Research study on Place Attachment

Asylum-seeking young people are the most disadvantaged group of refugees and yet the most understudied. The importance of identifying with and feeling connected to new residences are paramount in place attachment and the development of self for unaccompanied asylum-seekers. The displacement that they have experienced can be detrimental to their psychological well-being, the assimilation process and to their involvement in their new communities and cultures. The field of 'place attachment' has been developed by Elisabeth Brocato (2007) who formulated four dimensions of place attachment, identified as: affective attachment, place identity, place dependence and social bonds.

This independent study carried out by an MSc student Chalanie Stiebel (Anna Freud Centre/University College London) examined four dimensions of place attachment in 18-30 year old unaccompanied asylum-seekers in order to gain understanding in how they form attachment to place, both their place origin and their new residence. The current study drew upon the experiences of 16 young people (service users) at Baobab Centre (13 male, 3 female) and involved short interviews about their experiences and perceptions.

Content analysis and thematic analysis were used to examine the experience of place in the young peoples' homelands and their experience of place in the UK. The content analysis found four distinctive categories that were common across all the interviews for home country and the UK. These categories are defined as follows: *spatial range and level, relationship, activity* and *feeling complete*. Similarities were found in the young people's place descriptions. The places described in their homelands usually centred on others, such as family or classmates, and involved descriptions of nature. In contrast, the places described in the UK were private places and less community- and family-based. A more in depth thematic analysis was carried out on two participants. Subsequently, four major findings emerged: t*he use of place as a coping strategy, the use of place as an identifier of self, the influence of nostalgia on place attachment* and *the role of safety in place attachment.*

This research has important implications on a political, clinical and social level. The understanding of the attributes of a place and what they cultivate in the users of the space can be invaluable in clinical settings. Therapeutic spaces that encompass feelings of safety, togetherness and activity foster a greater sense of belonging among its service users, in turn adding to the therapeutic experience and treatment of these individuals. Therapeutic centres like the Baobab Centre can function as a secure base for these young people as they assimilate to their new home and life.

In sum, the study has shed light on the importance of attachment in the formation of identity and in providing a secure base for these young people to explore their new home country from. It is only through this exploration that they can begin to foster feelings of safety, gain mastery and develop a sense of trust in themselves and their new lives.

Conclusion

This monitoring and evaluation report has highlighted a number of significant areas, all of which emphasise how this population of vulnerable young people face significant external changes which in turn dramatically impacts their internal worlds.

The first section of this report displayed alarming, high and clinical levels in a number of psychosocial domains. The standardised measures consistently pointed to this population of young people being an extremely vulnerable and traumatised group:

- 93% had depression scores in the clinical range
- 90% had anxiety scores in the clinical range
- Emotional dysregulation and dyscontrol was even higher than equivalent high risk groups of youths
- 15% had resilience levels which were above the clinical cut-off
- Problems were reported across many domains including behaviour, symptomology, social functioning and learning.

The second section set out to explore whether in a relatively short period of time (12 months) change across such domains was possible. Considering the entrenched difficulties and backgrounds with multiple trauma, change was variable and slow, however, there were some notable findings:

- Levels of 'clinical' anxiety were down from 90 to 75% which was suggestive of slow improvement
- Levels of affect regulation also improved slowly
- Resilience levels increased marginally, but of most interest, those below the clinical threshold increased from 19 to 44%
- Overall, many domains did improve but given the complicated past and present conflicts, the trajectory was by no means linear.

It is perhaps important at this juncture to reflect upon the shape of this 'change' in a little more detail. At one level, we can glean from this small study conducted on a relatively small sample (n=16) and over a short time period (one year) that certain dimensions are suggestive of improvement, however on closer examination of the data, we can reflect differently and view

these with more caution given that these young people were still struggling psychologically. It is important to view these 'changes' through the lens of attachment theory and internal working models. The findings in this study are supportive of what would be expected from John Bowlby's Internal Working Models (IWMs) where new experiences are only being very slowly assimilated into existing models. Pat Crittenden went further (1988) and pointed out that attachment models may be both adaptive in one situation and maladaptive in others if conditions change. Bowlby's theory and framework were naturally formed around children with the strong evidence that previous abusive experiences from the past (i.e. previous caregivers in the case of adopted or foster children) are likely to become part of their 'taken for granted' understanding of relationships, and though new, healthier models (i.e. new foster or adoptive caregivers) are being absorbed by the child, the older, maladaptive strategies are still very entrenched and take a while to shift. Indeed, children's painful experiences are often likely to give rise to self-protective behaviours which in turn govern their expectations of subsequent attachments. With this population of adolescents and young adults, who all experienced their own violent, abusive and abhorrent pasts, they too will need time to unlearn long-standing habits, thought patterns, and maladaptive coping mechanisms, with the result that in spite of new stability, support and reduced/absent conflict in their lives, progress can be more fragmented and staggered, and not follow the linear curve that we often simplistically seek in models. In reality, the picture is much more complex and challenging with these young people arriving in the UK with scripts, where initially they may perceive their environment and other attachment figures (including Baobab) as repeating past experiences , with the consequence that their current model is confirmed or strengthened. With time, they are more able to delineate the past from the present, however, the potential for 'change' is confounded by the many predicaments and conflicts that are likely to be consuming their lives, whether it's unresolved loss and grief, or current difficulties with finances, studying/work, language, culture, friendships, relationships, and above all in the case of this population, their asylum status. Given this myriad of challenges, it is inevitable that there will be steps forwards and backwards.

The third section focused on how the participants have viewed the Baobab Community and there were high levels of satisfaction reported for help in areas covering asylum, education, health, to name a few. Participants were also able to see how psychological and emotional health had been helped through the therapeutic support. And most tellingly, their perception of their own problems and challenges were significantly less than they were when they arrived.

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 50 per cent of the population of young people at Baobab, and use a wide range of standardised measures. In addition, this evaluation process has ensured that the therapist and young person receive summary feedback based on each assessment so that they are able to make sense of the whole exercise. It is hoped that this will help inform the young person's engagement and therapy.

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).

In order to take this evaluation and research in these populations forward, there are two suggestions to consider. First, it may be necessary to develop a more specific and tailored tool that existing measures may fail to have within their armoury. This tool may need to be developed with cultural sensitivity very much at the heart of its focus. Second, the importance of qualitative and experiential data is absolutely essential to understand more about the meaning for the young people, including the factors that may contribute towards their resilience.

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.