Baobab Centre for Young Survivors in Exile

Monitoring and Evaluation Report 2022

Evaluating Service User Demographics, Mental Well-Being and Perceived Service Impact

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Executive Summary

Services working with unaccompanied refugee minors have little research upon which to draw from for service development. Up-to-date information is needed to ensure meaningful input to meet the needs of asylum seekers and refugees in the UK. A service evaluation was conducted within The Baobab Centre for Young Survivors in Exile (the Baobab Centre, hereafter), a UK-based charity working with unaccompanied refugee minors. It aimed to describe service user characteristics and psychosocial wellbeing and explore the perceived impact of the Baobab Centre. A questionnaire was administered in the form of a structured interview to 41 service users (85% male, mean age = 24.05 years).

- The findings suggest participants experience significant and prolonged mental health and psychosocial difficulties, coupled with low levels of resilience.
- Many participants reported not feeling they belonged in the UK.
- Service activity was varied, highlighting the diversity in provision offered, and engagement was generally high and frequent.
- The Baobab Centre was largely perceived as helpful, particularly individual psychotherapy and casework sessions. The Baobab Centre also positively impacted a large majority of participants' lives in different ways, from practical support in accessing asylum and housing to psychosocial support with understanding feelings and strengths and vulnerabilities.

Findings and their implications are discussed, along with specific recommendations for the Baobab Centre and beyond.

Introduction

Refugees or persons seeking asylum are individuals who have been forced to flee to a foreign country because of a fear of threat to life or human rights (e.g., through war or persecution) or not being able to meet their basic needs in their home country (Amnesty International, 2023). In 2023, refugee numbers worldwide are at an all-time high with 110 million people forcibly displaced (UNHCR, 2023), an increase driven by conflicts in Ukraine, Sudan, and Afghanistan. This is mirrored in the increasing numbers of persons seeking asylum in the UK, up 33% in the year ending March 2023 compared to the previous 12 months (Home Office, 2023). In contrast, protection through refugee or humanitarian status was offered to 31% fewer people in the year ending March 2023 compared to the previous year (Home Office, 2023).

Many refugees and asylum seekers have experienced adversity at different stages along the migration journey and during resettlement (Jannesari et al., 2020; Li et al., 2016; Porter & Haslam, 2005). An especially vulnerable group are unaccompanied refugee youth (URY), who are those who flee and enter host countries without a legal guardian. URY have been found to experience more instances of traumatic events and have more severe mental health difficulties, particularly post-traumatic stress disorder (PTSD), compared to accompanied refugee youth (Fazel et al., 2015; Huemer et al., 2009; Michelson & Sclare, 2009).

Mental health services working with asylum seekers and refugees face challenges to support this group in a meaningfully adapted and culturally sensitive manner. Of concern, most of the URYs residing in Europe or the United States are not in contact with mental health services (Mitra & Hodes, 2019). There are known challenges deterring this group from accessing support, such as finance, language barriers, mental health stigma and literacy (Asgary & Segar, 2011; Byrow et al., 2020; Franks et al., 2007; Pollard & Howard, 2021).

There is limited understanding of the needs and characteristics of this population upon which services can draw from to inform service development. There is a particular paucity of

research on the needs and experiences of URY (Groark et al., 2011). This is complicated by the unstable landscape in which services work, both in terms of the populations who constitute asylum seekers, changing in response to global events and conflict, and of the evolving nature of services and policies which accommodate asylum seekers in the UK. For example, in 2021 there were 27,562 Ukrainian refugees, increasing to 5,679,880 in 2022 in response to major conflict in Ukraine, becoming one of the largest groups of refugees and asylum seekers in the world within 12 months (UNHRC, 2023). Asylum seeker policies are also regularly developed or revised. Across 2022 and 2023 alone, the UK government introduced the Nationality and Borders Act (2022) and the Illegal Migration Act (2023) extinguishing access to asylum to all who arrive in the UK illegally and significantly affecting how and where asylum seekers are hosted and how claims are processed.

To ensure service delivery is appropriate and impactful, up-to-date understanding of the characteristics and needs of the asylum seekers services work with is required. It is also important to measure impact of the service delivery, to identify areas and groups at risk of not being sufficiently supported.

Project Context and Aims

The Baobab Centre for Young Survivors in Exile (the Baobab Centre hereafter) is a UK-based charity working with URY, which offers a variety of services, including practical support, therapeutic work, social activities, and legal counselling. All service users will have entered the UK as unaccompanied minors; however, the Baobab Centre continues to work with young people into adulthood and following asylum being granted and/or family reunification.

Each year the Baobab Centre conducts an evaluation with the aims of obtaining an up-to-date understanding of service user needs and experiences and assessing the perceived impact of the service on its community. The evaluation questions are as follows:

1. What are the demographics and mental well-being of service users of the Baobab Centre?

2. What is the impact of the Baobab Centre on different areas of support and functioning?

Methods

Design and Procedure

A questionnaire was administered in the form of a structured interview. Data was collected virtually or in person by volunteers associated with the Baobab Centre. Interpreters were offered to support with translation. Data was captured via Microsoft Forms and stored on the Baobab Centre's secure servers. The questionnaire is mixed methods (Appendix 1). It includes both standardised psychometric measures and bespoke questions using Likert-scale responses, as well as open ended questions. The present report focuses on presenting the quantitative findings, however, it presents findings of the qualitative data using content analysis in corresponding sections and uses illustrative quotes where appropriate.

Participants and Recruitment

Participants were current service users of the Baobab Centre, recruited using non-probability sampling. Service users were eligible for inclusion in the evaluation if they were aged 16 or above, had been in contact with the Baobab Centre for 6 months of longer and were able to communicate in English or through an interpreter. Services users were not eligible for inclusion if there were significant concerns about their mental wellbeing (e.g., active suicidal thoughts or psychotic symptoms) and/or if they were deemed to lack mental capacity to provide informed consent, as reported by service users or their associated clinicians.

Eligible service users were approached by a member of staff and invited to take part. They were provided with Participant Information Sheets outlining the purpose and scope of the evaluation (Appendix 2) and offered the opportunity to ask questions. Written consent was

obtained before service users participated in the questionnaire (Appendix 3). Participants did not receive compensation for their time, but travel expenses were reimbursed.

The Baobab Centre works with approximately 80 asylum seekers at a time and aimed to recruit at least 40 participants. In total, 41 participants took part. Interviews lasted between 1- 2 hours and were held in 2022.

Measures

The questionnaire collected information on participant demographics, psychosocial wellbeing, and their experience of the Baobab Centre.

Demographics

Demographic information, including age, sex, and ethnicity, as well as information regarding service users' migration journey, including country of origin, year of arrival in the UK and immigration status, were collected. Other background information collected included education status and accommodation.

Psychosocial Wellbeing

The questionnaire makes use of standardised questionnaires and bespoke items capturing the following mental well-being and psychosocial functioning constructs:

Depression. Depression was measured using the Patient Health Questionnaire-9 (PHQ-9; Kroenke et al., 2001). The PHQ-9 is a nine-item measure capturing experiences of depression symptomology within the previous two weeks. Respondents rate their experience of each item on a four-point scale from "*Not at all*" to "*Nearly every day*". Total scores are used to assess depression severity. The PHQ-9 has strong internal and test-retest reliability and criterion and construct validity and shows satisfactory use as a diagnostic tool for depression (Kroenke et al., 2001).

Generalised anxiety. This was measured using the Generalised Anxiety Disorder 7-item (GAD-7; Spitzer et al., 2006). The GAD-7 is a seven-item questionnaire, measuring the frequency of anxiety symptoms experienced within the previous two weeks. Responses to items are captured on a four-point scale from "*Not at all*" to "*Nearly every day*". Total scores are used to assess anxiety severity. The GAD-7 has good reliability, as well as criterion, construct, factorial, and procedural validity (Spitzer et al., 2006).

Psychological wellbeing. The Warwick Edinburgh Mental Wellbeing Scale (WEMWBS; Taggart et al., 2015) was used to capture aspects of mental wellbeing within the previous two weeks. Respondents rate 14 positively worded items on a five-point scale from "*None of the time*" to "*All of the time*". Scores range from 14 to 70, with higher scores indicating greater positive mental wellbeing. The WEMWBS has been found to have high internal consistency and test-retest reliability (Tennant et al., 2007). The questionnaire also employed bespoke items adapted from the Health of the Nation Outcome Scales (HoNOSCA; Gowers et al., 1999) to capture difficulties with aggression, hearing voices and caring for oneself. Bespoke items were rated on a five-point scale from "*Not at all*" to "*Severely"*.

Alcohol or substance use. A bespoke item was used to capture absence or presence of alcohol or substance use.

Affect regulation. The Affect Regulation Checklist (ARC; Moretti, 2003) was employed to examine three subscales of affect dysregulation, suppression, and reflection in the previous six months. Respondents rated 12 items on a three-point scale from "*A lot like me*" to "*Not like me*". The ARC shows good internal consistency and external validity (Goulter et al., 2023). In particular, the dysregulation scale has been found to be positively associated with all forms of psychopathology (Goulter et al., 2023) and offers a proxy measure of risk due to its association with instrumental and reactive aggression (Penney & Moretti, 2010).

Relationship difficulties. The questionnaire uses bespoke items to capture difficulties with relationships, loneliness and bullying adapted from the HoNOSCA (Gowers et al.,1999). Items were rated on a five-point scale from "*Not at all*" to "*Severely*".

Belonging. Sense of belonging was measured using the Challenged Sense of Belonging Scale (CSBS; Fuchs et al., 2021), validated for use with refugee and asylum seeker populations. The CSBS examines different elements of belonging (1) connectedness, (2) participation, (3) identification, and (4) congruence. Respondents rate the four items on a five-point scale from "*Strongly agree*" to "S*trongly disagree*". The CSBS shows good internal reliability and convergent validity (Fuchs et al., 2021). Bespoke items exploring participants' sense of belonging were employed to better understand nuances in experiences across groups and contexts.

Resilience. The 10-item Connor-Davidson Resilience Scale (CD-RISC; Campbell-Sills & Stein, 2007) was used to measure trait resilience. Respondents rate each item on a five-point scale from "*Not true at all*" to "*True nearly all the time*". Total scores were calculated where higher scores indicate higher resilience. The 10-item CD-RISC has been shown to have good internal consistency and construct validity (Campbell-Sills & Stein, 2007).

Service Use and Perceived Impact

The questionnaire used bespoke items to capture service use, including frequency of attendance and type of input received from the Service. Participants also reported on perceived impact of the service across different domains.

Ethical Considerations

Participation

Participants provided informed consent prior to taking part. Eligible service users were reassured that participation was voluntary and would not affect the care they receive from the

Baobab Centre. They were also made aware that confidentiality and its limits. Staff were trained to attend and respond to risk issues following local safeguarding procedures.

Although no participants withdrew from the study, all participants were informed of their rights to withdraw at any point until data anonymisation was complete. Participants were also given the opportunity to review their transcripts.

Data Handling

All data was stored electronically on the Baobab Centre's secure server in compliance with the Data Protection Act (2018), the General Data Protection Regulation (EU 2016/679) (GDPR) and ISO27001. Data with personal identifiable information was only accessed by a member of staff at the Baobab Centre. Participants were assigned an ID number, which was used for record keeping and to support with anonymisation. Unique ID numbers were stored in a password-protected spreadsheet and stored in a separate secured drive. Following anonymisation, data was transferred and stored on UEA OneDrive for data analysis.

Ethical Compliance

All interviewers held honorary contracts with the Baobab Centre and had received enhanced DBS checks. Interpreters involved had non-disclosure agreements in place. This project was approved by the University of East Anglia's Faculty of Medicine and Health Sciences Ethics Committee (REF: ETH2223-0070; Appendices 4, 5).

Analysis Plan

Data cleaning in preparation for analysis was supported by Excel and Stata (StataCorp, 2021). This included steps such as transforming string or categorical variables to numerical data. Missing data was omitted from any analyses (i.e. Listwise Deletion) and all analyses were conducted using Stata (StataCorp, 2021).

Descriptive statistics examining measures of central tendency and frequency distributions were used to report demographics characteristics of the sample and their scores on psychometric measures. They were also employed to explore how the service has worked with service users and what impact this work is perceived to have had on their lives. Quantitative comparative descriptive analyses were performed to explore group differences in psychosocial functioning according to service use (length of contact with the service and support received in previous twelve months).

Values of measures of central tendency were reported to two decimal places and percentages were rounded up or down to the closest number. To protect participant anonymity, small numbers (<3) were not reported.

An overview of findings is reported in text and detailed results are presented in Supplementary tables and figures (Appendix 6).

Results

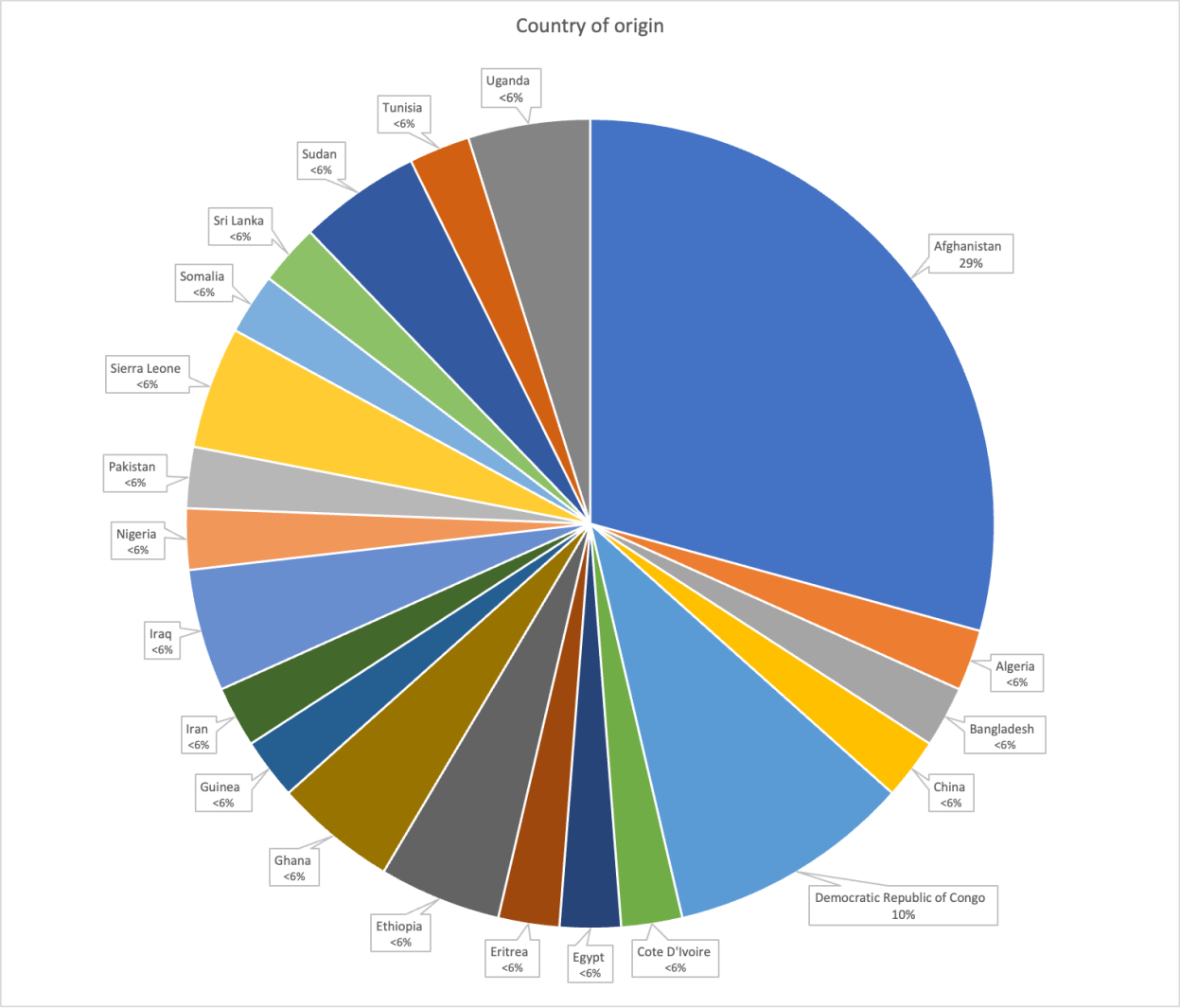
Demographics and Mental Well-being

Demographics

Most participants (85%) were male. Participants' mean age was 24.05 years (*SD* = 3.96; range: 18-36). The largest reported ethnicity groups were Afghan (15%) and Black African (15%). Participants reported coming from 21 different countries of origin, with the largest group being from Afghanistan (29%) (see Figure 1).

Figure 1

Participant country of origin



Note: SN—small numbers are not reported to protect anonymity. Other than Afghanistan (29%) and Democratic Republic of Congo (10%), all other countries of origin had 3 or fewer participants from each (<6%). These were Algeria, Bangladesh, China, Cote D'Ivoire, Egypt, Eritrea, Ethiopia, Ghana, Guinea, Iran, Iraq, Nigeria, Pakistan, Sierra Leone, Somalia, Sri Lanka, Sudan, Tunisia and Uganda.

Participants reported arriving in the UK between 2000-2020, with 21% arriving before 2010, 38% arriving between 2011-2015 and 41% arriving in 2016 and later. Many participants were granted refugee status (32%) or had indefinite leave to remain in the UK (32%). Over half

of participants received accommodation funding from the council or social services (57%). See Supplementary Table 1 for detailed demographics.

Mental Health and Wellbeing

Depression. Mean PHQ-9 score was 10.90 (*SD* = 6.52, range: 0-24). Most participants scored between the *moderate* and *severe* range for depression (61%), see Table 1. Mean scores for male participants (11.37) were higher than for female participants (8.17).

Generalised anxiety. Mean GAD-7 score was 9.41 (*SD* = 6.41, range: 0-21). Most participants' scores indicated minimal or mild generalised anxiety (54%), see Table 1. Mean scores for male participants (9.89) were higher than for female participants (6.67).

Table 1

Participant depression and anxiety severity according to PHQ-9 and GAD-7 scores.

Measure	n	%
Depression (PHQ-9)		
None (0-4)	8	19.51
Mild (5-9)	8	19.51
Moderate (10-14)	11	26.83
Moderately severe (15-19)	10	24.39
Severe (20-27)	4	9.76
Generalised Anxiety (GAD-7)		
Minimal (0-4)	11	26.83
Mild (5-9)	11	26.83
Moderate (10-14)	8	19.51
Severe (>15)	11	26.83

Psychological wellbeing. Mean WEMWBS score was 42.02 (*SD* = 13.33, range: 17-70), below that of a UK general population (*M* = 51, *SD* = 7; Tennent et al., 2007). Mean scores for male participants (41.49) were lower than for female participants (45.17). Most (51%) scored in the "low/clinical" range for psychological wellbeing (*M* ≤ 40; Taggart et al., 2015), which is associated with high risk of depression. A minority reported being "*moderately*" or "*severely*" bothered by their own physical or verbal aggression (17%), by strange or unusual thoughts in

their head, e.g., hearing voices (10%) or found it difficult to look after or take responsibility for themself (15%).

Alcohol or substance use. Most participants did not report using drugs, alcohol, or solvents (81%). Participants who were with the Service longer indicated usage more than those in contact with the Service for less time.

Affect regulation. Mean scores for each ARC subscale were: 1.02 for *affect dysregulation* (*SD* = 0.66, range: 0-2), 1.17 for *reflection* (*SD* = 0.54, range: 0-2) and 1.37 for *suppression* (*SD* = 0.54, range: 0-2). Compared to a sample of young people involved in the justice system or with serious behavioural problems and associated comorbid conditions (*N* = 179; 46% female; mean age = 15.34 years; Moretti & Craig, 2013), participants on average reported more difficulties with affect regulation (*M* = 1.02, *SD* = 0.66 vs. *M* = 0.96, *SD* = 0.61).

Resilience. Mean CD-RISC score was 22.51 (*SD* = 10.25, range: 0-40), representing the lowest quartile (Campbell-Sills et al., 2009). Mean resilience scores among the present sample were lower than a clinical sample of refugee torture survivors in the US (*N* = 102, 54.9% male), with a mean score of 29.11 (*SD* = 6.49; Walker, 2022). Resilience scores in the present sample were lower for male participants (*M* = 22.03) than for female participants (*M* = 25.33).

Relationship difficulties. A minority of participants reported being "*moderately*" or "*severely*" bothered by bullying (12%), by not having good friends (15%) or by relationships with people where they live (15%). Most participants (78%) reported having someone they can talk to about their feelings.

> *"I don't have good friends; it is very difficult for me to find friends because I am new and don't know much about the culture" (20-year-old young man from Bangladesh)*

Analysis of qualitative responses to the following questions shed light on the diverse range of relationships and support networks participants had access to: *Have you been*

supported by a good friend?; Have you been bothered by not having good friends?; Who do you feel you can talk to?

A total of 33% of participants reported not being supported by a good friend. Amongst them, some participants experienced profound loss, such as the death of a best friend, whilst others reported having no friends or being separated from them due to distance or minimal contact.

28% of participants reported being impacted in some way by not having good friends. They reported having trust issues, difficulty finding genuine friends, and encounters with unreliable or uncaring individuals. This underscores the challenges they can face in forming meaningful friendships. Isolation due to lack of contact with friends could further aggravate these difficulties.

Nonetheless, 80% still reported they had someone trustworthy enough to talk to. Participants identified varied sources for support and conversation, including friends, family members, and spiritual entities like God. Some participants mentioned seeking solace in themselves or seeking guidance from past relationships. Additionally, the support provided by organisations like the Baobab Centre, as well as specific individuals such as Sheila, therapists, and social workers, play significant roles in their lives.

Belonging. Mean scores across CSBS items were lower than those of a sample of asylum seekers and refugees in Germany who completed the measure in English (N = 341, 43% female; mean age = 31.9; Fuchs et al., 2021): connectedness (M = 2.41, SD = 1.36 vs. M = 3.4, SD = 1.5), participation (M = 2.34, SD = 1.26 vs. M = 3.6, SD = 1.5), identification (M = 2.73, SD = 1.28 vs. M = 3.4, SD = 1.5) and congruence (M = 3.05, SD = 1.38 vs. M = 3.7, SD = 1.4).

Most participants reported feeling that they belong "*to a place or group of people*" (65%), with many endorsing feeling they belong "*to a community in the past or who has passed away*"

(46%). Just over a quarter of the sample (27%) reported feeling like they belong "*to an ethnic or cultural community in the UK*'. A large majority (84%) expressed feeling they belong "*in the Service community*".

Participants who felt they did not belong "*to a place or a group of people*" or "*to an ethnic or cultural community in the UK*" had higher GAD-7 and PHQ-9 scores compared to those who felt they did belong (GAD-7: *M* = 10.67 vs. 8.91 and *M* = 10.65 vs. 8.1, respectively; PHQ-9: *M* = 13.67 vs. 10.13 and *M* = 12.91 vs. 9.5, respectively). Difficulties with affect regulation were also higher among those who felt they did not belong "*to an ethnic or cultural community in the UK*" compared to those who did (*M* = 1.13 vs. 0.93).

Analysis of qualitative responses to the following questions improved understanding of experiences of belonging, including which factors improve or decrease sense of belonging: *Where do you feel you belong the most?; Some people say there is a place that they call 'home', other people say they have several homes. Which one is it for you?; What helps you to feel that you belong?; What makes you feel that you don't belong?*

Participants responses varied widely. Some participants expressing uncertainty or identifying personal space as their primary sense of belonging, whilst the majority felt a sense of belonging with family, the Baobab Centre community, or in specific geographical locations such as London/UK. Some expressed feeling they belong where there is safety (e.g., "*wherever is safe*"). Many participants acknowledged belonging to specific groups or places, such as the Afghan, Sudanese, or Ugandan communities, Baobab, groups of friends, or family. Some participants identified with multiple groups, including cultural communities or partnerships.

"Where I am safe, no place at the moment" (26-year-old young man from Tunisia)

Responses regarding the concept of "home" varied, with some feeling at home everywhere, in the UK, or specific countries like Uganda or Sudan. For some, home represents

where family resides, where they feel comfortable, or where they can freely express themselves.

> *"For me, home is where my family is, home is where I can sleep without hearing anything because I'm subconsciously scared that something may happen. Home is where I am comfortable and right now, I do not have a home." (19-year-old young woman from Uganda)*

Participants cited various factors contributing to their sense of belonging, including connections with friends and family, cultural affiliations, feeling cared for, personal happiness, and acceptance in social settings.

> *"[Being around] people who listen and have respect for me, not being judged, not feeling uncomfortable, people having good intentions [helps me feel like I belong]" (28-year-old young man from Sierra Leone)*

Conversely, feelings of not belonging stemmed from experiences of discrimination, exclusion, maltreatment, or internal struggles. Factors cited by participants as contributing to their sense of not belonging, or difference/rejection, included: feeling unwelcome, discriminated against, or disrespected or excluded due to nationality, ethnicity, or migrant status; negative portrayals in media, unfair treatment by government institutions, and reminders of one's origin or status contributing to feelings of alienation; struggles with maintaining cultural identity while assimilating into a new culture, including discomfort with speaking one's native language outside of the home environment; experiencing maltreatment, racism, disrespectful behaviour, and feeling misunderstood or unloved by others; feeling rejected, judged, or uncomfortable due to differences in interests, behaviours, or personal beliefs. Participants also cited environmental stressors which contributed to their feelings of disconnection and alienation, such as chaos, conflict, and restrictions on personal freedom, as well as internal factors and processes,

including overthinking, self-criticism, conflicts with faith, and feeling disconnected from one's emotions and lack of fulfilment.

> *"Not being welcomed and being reminded of where I come from" (27-year-old young man from Congo, DRC)*

Some participants struggled with complex identities and conflicting feelings, including the tension between cultural authenticity and integration, as well as the temporary nature of belonging in a dynamic world. Participants' responses reflect the intricate interplay between personal identity, cultural affiliations, and societal dynamics in shaping their sense of belonging and connection to communities, both past and present.

Discrimination. Many participants did not report receiving any negative remarks from others about their nationality, ethnicity, religion, skin or colour or status (41%), whereas 19% reported experiencing this '*quite often*' or '*all the time*'.

Qualitative analysis highlighted that, for those who experienced negative remarks, their experiences encompassed various forms of racism and discrimination. Examples of racism provided by participants included being subjected to disrespectful behaviour, encountering salary discrepancies, facing unfair treatment due to ethnicity, and being stereotyped. Incidents occurred during college, while socialising with individuals in the UK as well as in foreign countries, such as Greece, where physical violence was involved. Additionally, remarks were noted at the workplace, by classmates, and by authorities such as the Home Office.

> *"If I say I am from Afghanistan, people think I am a terrorist" (24-year-old young man from Afghanistan)*

Negative remarks stemmed from factors such as faith, refugee status, and immigration status, often resulting in feelings of shame and displacement. While some participants

expressed resilience and indifference towards negative remarks, others admitted to feeling affected by such experiences but chose to ignore them.

> *"I have gotten negative remarks about my immigration status. Like it's my fault and something to be ashamed of." (19-year-old young woman from Uganda)*

Service Use

Participants had been in contact with the Baobab Centre for an average of 5.49 years. 39% of participants had been in contact with the Baobab Centre for 1-3 years, 27% for 4-6 years and 34% for 7 years or longer. Male participants had been in contact with the Baobab Centre for longer compared to female participants (5.6 vs. 4.83 years). Most participants (66%) attend the Baobab Centre at least weekly.

Service use indicated that participants have engaged in a variety of activities in the last 12 months (see Supplementary Table 2). The majority accessed individual psychotherapy (90%) and attended this very regularly (68%). Most participants also attended casework sessions (56%) and creative activities (51%), many of whom attended on occasion or very regularly (56% and 49%, respectively). Many participants reported attending group psychotherapy (49%), of whom 29% attended very regularly. Many also reported attending Community meetings (46%), retreats which occur twice a year (44%), and dinners (39%). For the latter activities, the proportion of participants attending very regularly were smaller (7%, 7% and 12%, respectively), possibly due to less frequent provision.

Many participants accessed both individual and group psychotherapy (39%), whilst the majority attended only individual psychotherapy (51%) and a minority attended only group psychotherapy (10%). Participants who attended only group psychotherapy had all attended the Baobab Centre for over seven years.

The majority of participants reported having difficulties before accessing the Baobab Centre (95%), and 93% reported these to be '*strong'* or '*very strong'*. At the time of the evaluation, 73% of participants reporting having problems, with 37% reporting these to be '*strong'* or '*very strong'*.

Impact of the service on different areas of support and functioning

Perceived service impact. Participants reported on the perceived impact of the different services available at the Baobab Centre since they first attended (see Supplementary Table 3). Of those for who this was applicable, most participants reported that individual psychotherapy and casework input was "*very helpful*" (84% and 87%, respectively). Most participants found other aspects of the service "*somewhat helpful"* or *"very helpful*": group psychotherapy (66%), activities (76%), community meetings (69%), dinners (70%) and retreats (74%).

Most participants reported receiving practical and psychosocial support from the Baobab Centre which had an impact across a wide range of domains, see Table 2. The most significant areas of support reported by participants were support to access asylum or housing and support with feelings and understanding strengths and vulnerabilities.

Table 2

Participant reports of support received by service impacting different domains.

Type of support	Area of support received	n	%
Practical support			
	Access asylum	36	87.8
	Access education	28	68.29
	Prepare specialist report for asylum claim	31	75.61
	Access health	32	78.05
	Access housing	35	85.37
	Access benefits	33	80.49
	Prepare specialist report to support	32	78.05
	Access social service support	27	65.85
Psychosocial support			
	Feelings	37	90.24
	Memories	33	80.49

	Relationships	26	63.41
	Behaviour	29	70.73
	Understanding the past	32	78.05
	Understanding strengths and vulnerabilities	35	85.37
	Adapting to the UK	30	73.17

Service use and psychosocial functioning.

Length of contact with the service*.* Participants who had been with the Baobab Centre for over 7 years reported more optimal psychological wellbeing and resilience (lower PHQ-9, GAD-7 and ARC mean scores, higher CD-RISC and WEMWBS mean scores) compared to participants with the service for 6 years or less (See Supplementary Table 4). The group reporting the poorest psychological wellbeing and resilience (higher PHQ-9, GAD-7 and ARC mean scores, lower WEMWBS and CD-RISC mean scores) were those who had accessed the Baobab Centre for 4-6 years, in comparison to those with the service for 1-3 years or over 7 years.

Activity type. Participants who attended individual psychotherapy reported poorer psychological wellbeing and resilience compared to those who did not (see Supplementary Table 5). In contrast, those who attended group psychotherapy, creative activities, and community meetings reported greater psychological wellbeing and resilience compared to those who did not. Psychosocial functioning according to other activity types was more nuanced. In comparison to those who did not attend casework sessions, those who did reported more difficulties with affect dysregulation and lower psychological wellbeing and resilience (lower WEMWBS and CD-RISC mean scores). Compared to those who didn't attend dinners or retreats at the Baobab Centre, those who did largely reported poorer psychological wellbeing and resilience (higher PHQ-9 and ARC mean scores, lower WEMWBS and CD-RISC mean scores), except for difficulties with anxiety which were less severe (GAD-7 mean score).

Those attending group psychotherapy only reported greater psychological wellbeing and resilience compared to both those attending individual psychotherapy only and those attending both individual and group psychotherapy (see Supplementary Table 6).

Discussion

The aim of the current service evaluation was to provide an up-to-date understanding of the characteristics and psychosocial experiences of service users in contact with the Baobab Centre and explore the perceived impact of the service.

Service User Demographics and Mental Well-being

The present findings highlight the vulnerability of participants who have significant mental health and psychosocial difficulties. Difficulties with affect regulation, as well as high levels of anxiety and depression, were reported. Across areas of psychosocial functioning and resilience, difficulties in the present sample were more significant than those of groups with comparably high exposure to traumatic experiences and mental health difficulties (Fuchs et al., 2021; Moretti & Craig, 2013; Walker, 2022). In addition, our current sample of unaccompanied minors reported low trait resilience, consistent with previous research focusing on a group of Iraqi refugees in Sweden (Çetrez et al., 2021). Males were highlighted in the present findings as having greater difficulties compared to females. This result goes against the findings from a systematic review (Mohwinkel et al., 2018), however the relatively small number of females recruited in this sample may limit the reliability of the finding and explain this inconsistency.

In addition, those in contact with the Baobab Centre for 4-6 years were found to have more significant difficulties with their mental health and psychosocial functioning. This finding is consistent with a systematic review by Henkelmann et al. (2020) demonstrating mental health difficulties among refugees and asylum seekers years following resettlement, as well as a

longitudinal follow-up of URY by Vervliet et al. (2014) finding long-term persistence of mental health problems. Some participants found comfort and strength in their support networks, whilst others grappled with profound loneliness and challenges in forming meaningful connections. Together, these finding stresses the need for ongoing support and community-based for URY beyond being granted asylum, in line with the Baobab Centre's service model.

Impact of the Baobab Centre on Different Areas of Support and Functioning

This evaluation sheds light on the variety of ways that the Baobab Centre works with and supports a diverse sample of URY at different stages of the resettlement in the UK. The findings show heterogeneity in service use and high uptake to the services offered. Specifically, individual psychotherapy and casework sessions received excellent feedback. Service use varied according to contact length with the Baobab Centre and psychosocial need. For example, those accessing individual psychotherapy reported more difficulties with emotional regulation and their mental health than those who did not. In contrast, those accessing group psychotherapy reported better mental health compared to those accessing individual psychotherapy or both individual and group psychotherapy and had been in contact with the Baobab Centre for more than seven years. The Baobab Centre's long-term and multi-modal approach to support is consistent with recommendations for best practice in offering scalable and tailored interventions for this vulnerable group (Henkelmann et al., 2020).

Service users feeling like they belong is highlighted as a particular strength of the Baobab Centre and is represented in the variety of ways the Baobab Centre had positively impacted their lives. In contrast, most young people did not feel like they belonged to a community or group in the UK, including those with Indefinite leave to remain and British citizenship, and a quarter of the sample frequently received negative comments regarding their status or ethnicity. For this large minority, participants described encountering racism and discrimination across various settings, highlighting the pervasive nature of such attitudes in their

daily lives. This particular area of concern must be understood and improved across socio-ecological levels.

Strengths and Limitations

The present findings represent a valuable contribution to the literature, where the evidence base on the needs of URY is scarce (Groark et al., 2011). Considerable amounts of data were collected, offering a holistic description of needs beyond mental health outcomes. However, all findings must be interpreted with consideration of the characteristics and needs of the cohort who took part in the evaluation. Selection and non-participation bias may have contributed to an underestimation of difficulties and overestimation of wellbeing in the present sample. Furthermore, the proportion of service users accessing the Baobab Centre for over 4 years was relatively high which may affect findings on service use. For example, those accessing the service for longer are less likely to attend casework sessions. Social desirability bias as well as trust, may have impacted on disclosure. For example, those accessing the Baobab Centre for longer reported more drug and alcohol use. Finally, quantitative, descriptive comparisons were used to examine group differences due to a small sample size. A larger sample size would allow for more in-depth analyses examining statistically significant differences.

Recommendations

Based on the findings and discussion from the current service evaluation, the following recommendations are made:

1. Recruit a larger sample to assess statistically significant differences between groups. This may be achieved by extending the evaluation period, as well as by recruiting those in contact with the Baobab Centre for fewer than 6 months.
2. Reduce the duration of interview. If possible, this report recommends mapping data collected as part of the evaluation onto data already held by the Baobab Centre to

reduce participant burden (e.g., data on length of contact with the Baobab Centre). This would also allow to make use of clinician reported data, for example information of trauma exposure, and offers opportunities for triangulating information from different sources.

3. Affect regulation was assessed using a 3-point scale of the ARC (Moretti, 2003), however this approach is less commonly mentioned and applied according to existing literature. We recommend using a more widely used measure of affect regulation (e.g., Difficulties in Emotion Regulation Scale, Gratz & Roemer, 2004; Emotion Regulation Questionnaire, Gross & John, 2003) to aid with interpretation of findings. We also recommend using all 13 HoNOSCA items and retaining the original wording (Gowers et al., 1999).
4. To further assess service impact, this report recommends collecting pre- and post-measures for different activity types.
5. More is needed to improve integration and sense of belonging for URY in the UK. Change must occur at a community-level with increased out-reach and activities, at service-level through improved access to services and education, as well as at a wider societal and cultural level with accurate media reporting and receptive and humane policies.

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Appendices

Appendix 1: Questionnaire

Appendix 2: Participant Information Sheet

Appendix 3: Consent Form

Appendix 4: Ethical approval confirmation

Appendix 5: Ethical approval protocol

Appendix 6: Supplementary findings

Appendix 1: Questionnaire

[redacted] EVALUATION QUESTIONNAIRE 2022

* Required

Filling in the questionnaire

- This task should be pleasurable and a learning and reflecting experience for everyone involved.
- We can take more than one session to complete the questionnaire.
- Please try to persuade everybody to go through the form with you and fill it in. If young people are really reluctant they should not be pressured.
- Try to give each young person the option of saying that nothing is helpful, make it clear nobody will be angry and nothing bad will happen if they give negative responses. Also, say that they do not have to please you or [redacted] and underline that we all learn from constructive criticism.

1. At what time point are you taking the questionnaire? *

- ◯ T1
- ◯ T2
- ◯ T3
- ◯ T4
- ◯ T5
- ◯ T6
- ◯ T7
- ◯ T8

Appendix 2: Participant Information Sheet

Information Sheet

What is the purpose of the study?

- To have direct feedback from the young people at Baobab in order to understand their experiences
- To improve the work that Baobab does and to see how services can be improved.

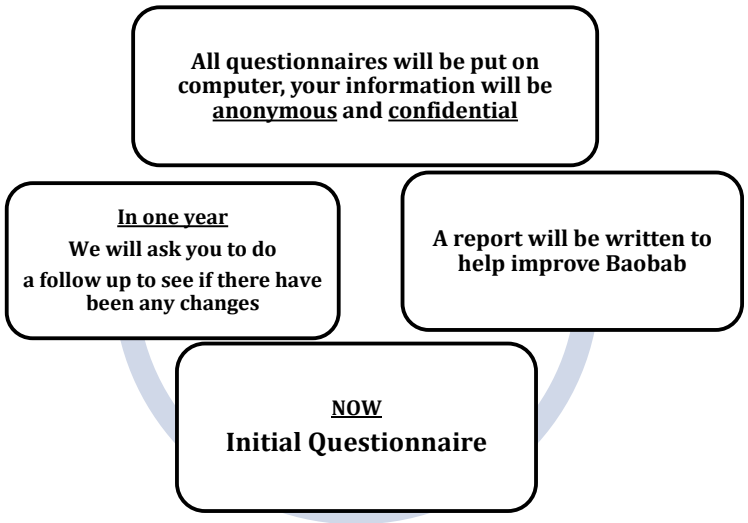
Why have you been chosen?

- We are inviting all young people at the Baobab Centre to take part in the research. You do not need to take part if you do not wish to. If you do not, your position at the Baobab Centre will not be affected.

How will it work?

- The interviewer will go through the questionnaire with you.
- The questionnaire should take about an hour but it may take longer.
- If you would be easier for you, you can complete the questionnaire over two sessions. Please just tell the interviewer if you would like to take a break at any stage.

What happened after I complete this questionnaire?



Confidentiality

It is important that you feel you can answer honestly. We want to know about positive and negative experiences; there are no right or wrong answers. Your responses to the questionnaire **will not** affect how you are treated by the Baobab Centre. We will not use your name in storing the data and any data we use will be anonymised and will not be linked back to you. The consent form that you sign will be held separately from the answers that you give the researcher.

The consent form will not contain any information that you have shared with the interviewer about Baobab or your therapist. This consent form will be given to your therapist so that they can explain what it means to you.

What will happen to the results of the study?

The results will be used by the Baobab Centre to develop services.

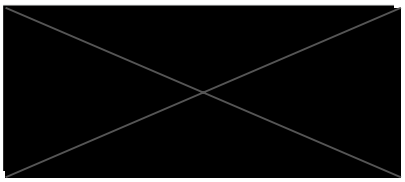
The results will first be used in an evaluation report to present the experiences of the young people in therapy at the Baobab. This report will be presented outside the Centre and will become available online. It may be written by a University trainee in Psychology as part of a University service-related project, under the supervision of the trainee's University advisor and a Baobab supervisor. No publication resulting from this analysis will include any information that would reveal personal identity.

In some cases we may ask that the first part of the survey that relates to your mental health measures be used to support your asylum claim in response to a request from your solicitor for a report of your mental health. You will be notified of this in advance and you can say no. It will not affect any services that you receive at Baobab. If you consent, it is only this part of the questionnaire that will be shared. Nothing you say about your experiences of Baobab will be reported to anyone outside of the evaluation team.

Anonymised data collected as part of the monitoring and evaluation may also further be used for specific, Baobab-approved related research projects. No publications will contain any information that would reveal personal identity, and the Baobab Centre reserves the right to refuse publication in any case.

If you have any question about this, please contact Fabrice in the office, or talk to your clinician about it.

Appendix 3: Consent Form



CONSENT FORM for Staff
Evaluation of the work of the

The participant should complete the whole of this sheet him/herself if the interview is conducted in person. If online, the interviewer will read the form and initial it if consent is given.
If interview is in person, note that the interviewer should help with reading the information on this sheet provided if necessary.

INITIALS OF YOUNG PERSON ☐

INITIALS OF RESEARCHER ☐

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw from this study at any time, without having to give a reason and without my medical or legal rights being affected.

3. I understand that the questionnaire data will remain confidential and will only be used for this study and related research. All data will remain anonymous.

4. I am happy for some numerical information and summaries from the questionnaire regarding my mental health (and not my experience of), to be shared with my therapist so they can have more information for how I am and so it can be used to support any legal proceedings to further my case.

5. I understand that data may be used in future reports presenting research outcomes. All data will remain anonymous.

6. I agree to take part in the above study.

Participant name:_____

Signature (initials only if consent given electronically) :_____ Date:_____

Researcher name:_____

Signature (initials only if consent given electronically):_____ Date:_____

Appendix 4: Ethical approval confirmation

University of East Anglia

Study title: Evaluating Service User Demographics, Mental Well-Being and Perceived Service Impact of A Charity Organisation for Young Asylum Seekers and Refugees

Application ID: ETH2223-0070

Dear Rebecca,

Your application was considered on 30th September 2022 by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee).

The decision is: **approved**.

You are therefore able to start your project subject to any other necessary approvals being given.

If your study involves NHS staff and facilities, you will require Health Research Authority (HRA) governance approval before you can start this project (even though you did not require NHS-REC ethics approval). Please consult the HRA webpage about the application required, which is submitted through the IRAS system.

This approval will expire on **30th September 2024**.

Please note that your project is granted ethics approval only for the length of time identified above. Any extension to a project must obtain ethics approval by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) before continuing.

It is a requirement of this ethics approval that you should report any adverse events which occur during your project to the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) as soon as possible. An adverse event is one which was not anticipated in the research design, and which could potentially cause risk or harm to the participants or the researcher, or which reveals potential risks in the treatment under evaluation. For research involving animals, it may be the unintended death of an animal after trapping or carrying out a procedure.

Any amendments to your submitted project in terms of design, sample, data collection, focus etc. should be notified to the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) in advance to ensure ethical compliance. If the amendments are substantial a new application may be required.

Approval by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) should not be taken as evidence that your study is compliant with the UK General Data Protection Regulation (UK GDPR) and the Data Protection Act 2018. If you need guidance on how to make your study UK GDPR compliant, please contact the UEA Data Protection Officer (dataprotection@uea.ac.uk).

Please can you send your report once your project is completed to the FMH S-REC (fmh.ethics@uea.ac.uk).

I would like to wish you every success with your project.

On behalf of the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee)

Yours sincerely,

Paul Linsley

Ethics ETH2223-0070 : Miss Rebecca Lane

Appendix 5: Ethical approval protocol

Ethics ETH2223-0070 : Miss Rebecca Lane

Date Created	19 Aug 2022
Date Submitted	14 Sep 2022
Date of last resubmission	30 Sep 2022
Date forwarded to committee	30 Sep 2022
Researcher	Miss Rebecca Lane
Category	PGR
Supervisor	Dr Kenny Chiu
Faculty	Faculty of Medicine & Health Sciences
Current status	Approved

Ethics application

Applicant and research team

Principal Applicant

Name of Principal Applicant
Miss Rebecca Lane

UEA account
hdk21myu@uea.ac.uk

School/Department
Norwich Medical School

Category
PGR

Primary Supervisor

Name of Primary Supervisor
Dr Kenny Chiu

Primary Supervisor's school/department
Norwich Medical School

External Co-applicant(s)

Name of external Co-applicant where applicable.
[redacted]

Name of external Co-applicant's organisation/institution where applicable.
[redacted]

Appendix 6: Supplementary findings

Supplementary Table 1

Participant demographics and background

Variable	Category	n	%
Gender			
	Female	6	14.63
	Male	35	85.37
Ethnicity			
	Afghan	6	14.64
	African	3	7.32
	African British	<3	-
	Arab	<3	-
	Asian	4	9.76
	Asian Pakistani	<3	-
	Black	<3	-
	Black African	6	14.64
	Chinese	<3	-
	Cote D'Ivoire	<3	-
	Egyptian	<3	-
	Ghanaian	<3	-
	Hazaras	<3	-
	Kurdish	<3	-
	Other	4	9.76
	Pashtu	<3	-
	Sri Lankan	<3	-
	Sudanese	<3	-
	Tigrinjan	<3	-
	Berber	<3	-
	Undefined	<3	-
Country of origin			
	Northern Africa	3	7.32
	Western Africa	7	17.07
	Middle Africa	6	14.63
	Eastern Africa	6	14.63
	Central Asia	16	39.02
	Southern Asia	<3	-
	Eastern Asia	<3	-
Immigration status			
	Application pending	4	9.76
	Asylum granted	<3	-
	British citizen	3	7.32
	Discretionary leave	<3	-
	Fresh claim	<3	-
	Humanitarian Protection granted	<3	-
	Indefinite leave to remain	13	31.71
	Refugee status granted	13	31.71
Accommodation funding			
	Self	9	24.32
	Friend/relative/family	3	8.11
	Council/social services	21	56.76
	Other	4	10.81

Note: small numbers (<3, <6%) are not reported to protect anonymity, data may also not be reported to prevent calculation of small numbers

Supplementary Table 2

Participant reported frequency of attendance at the Service

Variable	Category	n	%
Service attendance			
	A few times per week	10	24.39
	Weekly	17	41.46
	Fortnightly	4	9.76
	Monthly	5	12.2
	Less than monthly	5	12.2
Individual psychotherapy attendance			
	Never	6	14.63
	Once	0	0
	On occasion	7	17.07
	Very regularly	28	68.29
Group psychotherapy attendance			
	Never	20	48.78
	Once	0	0
	On occasion	9	21.95
	Very regularly	12	29.27
Community meetings attendance			
	Never	18	43.9
	Once	5	12.2
	On occasion	15	36.59
	Very regularly	3	7.32
Casework session attendance			
	Never	14	34.15
	Once	4	9.76
	On occasion	13	31.71
	Very regularly	10	24.39
Activities (art, music etc.) attendance			
	Never	18	43.9
	Once	3	7.32
	On occasion	12	29.27
	Very regularly	8	19.51
Attendance at Dinners			
	Never	21	51.22
	Once	5	12.2
	On occasion	10	24.39
	Very regularly	5	12.2
Attendance at Retreats			
	Never	23	56.1
	Once	6	14.64
	On occasion	9	21.95
	Very regularly	3	7.32

Supplementary Table 3

Perceived impact of each activity type across length of time spent with Service

Variable	Category	n	%
Individual psychotherapy			
	Very unhelpful	<3	-
	Somewhat unhelpful	0	0
	Neither helpful nor unhelpful	0	0
	Somewhat helpful	4	10.81
	Very helpful	31	83.78
Group psychotherapy			
	Very unhelpful	<3	-
	Somewhat unhelpful	<3	-
	Neither helpful nor unhelpful	8	27.59
	Somewhat helpful	5	17.24
	Very helpful	14	48.28
Community Meetings			
	Very unhelpful	<3	-
	Somewhat unhelpful	3	11.54
	Neither helpful nor unhelpful	4	15.38
	Somewhat helpful	9	34.62
	Very helpful	9	34.62
Casework Session			
	Very unhelpful	0	0
	Somewhat unhelpful	<3	-
	Neither helpful nor unhelpful	<3	-
	Somewhat helpful	<3	-
	Very helpful	27	87.10
Activities (art, music etc.)			
	Very unhelpful	<3	-
	Somewhat unhelpful	0	0
	Neither helpful nor unhelpful	6	20.69
	Somewhat helpful	6	20.69
	Very helpful	16	55.17
Dinners			
	Very unhelpful	<3	-
	Somewhat unhelpful	0	0
	Neither helpful nor unhelpful	6	22.22
	Somewhat helpful	5	18.52
	Very helpful	14	51.85
Retreats			
	Very unhelpful	<3	-
	Somewhat unhelpful	0	0
	Neither helpful nor unhelpful	6	22.22
	Somewhat helpful	<3	-
	Very helpful	18	66.67

Note: small numbers (<3, <6%) are not reported to protect anonymity, data may also not be reported to prevent calculation of small numbers

Supplementary Table 4

Participant psychosocial functioning scores according to years of contact with the service

Measure		mean	Standard error
Anxiety (GAD-7)			
	1-3 years	10.38	1.46
	4-6 years	13.82	1.88
	7+ years	4.86	1.12
Depression (PHQ-9)			
	1-3 years	12.75	1.56
	4-6 years	13.27	1.98
	7+ years	6.93	1.39
Wellbeing (WEMWBS)			
	1-3 years	40.81	3.20
	4-6 years	32.36	2.77
	7+ years	51	2.99
Resilience (CD-RISC)			
	1-3 years	22.69	2.32
	4-6 years	13.73	2.14
	7+ years	29.21	2.26
Affect control (ARC)			
	1-3 years	0.98	0.15
	4-6 years	1.41	0.2
	7+ years	0.77	0.17

Supplementary Table 5

Mean psychosocial functioning scores of those attending activities in the previous 12 months and those who did not attend.

Activity	Measure	Mean scores	
		Attending	Not attending
Individual psychotherapy			
	PHQ-9	11.41	6.25
	GAD-7	9.89	5
	Affect control (ARC)	1.09	0.44
	WEMWBS	40.78	53.5
	CD-RISC	21.73	29.75
Group psychotherapy			
	PHQ-9	10.15	11.62
	GAD-7	7.3	11.43
	Affect control (ARC)	0.98	1.07
	WEMWBS	44.15	40
	CD-RISC	24.35	20.76
Community Meetings			
	PHQ-9	9.53	12.09
	GAD-7	6.9	11.59
	Affect control (ARC)	0.99	1.06
	WEMWBS	43.84	40.46
	CD-RISC	23.37	21.77
Casework Session			
	PHQ-9	10.83	11
	GAD-7	9.26	9.61
	Affect control (ARC)	1.13	0.89
	WEMWBS	40.04	44.56
	CD-RISC	21.22	24.17
Creative activities			
	PHQ-9	9.33	12.55
	GAD-7	7.38	11.55
	Affect control (ARC)	0.87	1.19
	WEMWBS	44.05	39.9
	CD-RISC	23.1	21.9
Dinners			
	PHQ-9	11.75	10.36
	GAD-7	8.75	9.84
	Affect control (ARC)	1.19	0.92
	WEMWBS	39.69	43.52
	CD-RISC	20.56	23.76
Retreats			
	PHQ-9	11.28	10.61
	GAD-7	9.11	9.65
	Affect control (ARC)	1.11	0.96
	WEMWBS	40.33	43.35
	CD-RISC	20.44	24.13

Supplementary Table 6

Mean psychosocial functioning scores of those attending individual psychotherapy only, group psychotherapy only or both.

Activity	Measure	Mean scores
Individual psychotherapy only		
	PHQ-9	11.62
	GAD-7	11.43
	Affect control	1.07
	WEMWBS	40
	CD-RISC	20.76
Group psychotherapy only	*PHQ-9*	6.25
	GAD-7	5
	Affect control	0.44
	WEMWBS	53.5
	CD-RISC	29.75
Individual and group		
	PHQ-9	11.13
	GAD-7	7.88
	Affect control	1.11
	WEMWBS	41.81
	CD-RISC	23