Baobab Centre for Young Survivors in Exile

Monitoring and Evaluation Report 2023

Monitoring Service User Demographics and Psychosocial Well-Being and Evaluating Service Use and Perceived Service Impact

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February 2025

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Introduction

The Baobab Centre for Young Survivors in Exile is a non-residential community that has a holistic, integrated and multidisciplinary approach and offers several levels of therapeutic intervention and support to young and unaccompanied asylum seekers and refugees who arrived in the UK before the age of eighteen. All have experienced child-specific human rights abuses, including violence in various contexts in their home countries (including organized community violence, imprisonment as a consequence of the actions of their parents, forced recruitment or trafficking for labour, sexual exploitation or crime). All have arrived in the UK suffering significant mental health and developmental difficulties. All have sought asylum in the UK as unaccompanied minors.

The two focus areas of the Baobab Centre are rehabilitation and justice. To aid healing from trauma and enable stability and independence in the young people's lives, they adopt a specialised approach to rehabilitation, based on five combined key pillars of intervention:

- individual psychotherapy,
- group psychotherapy,
- casework support,
- psychosocial- based group activities (therapeutic retreats, group outings, art therapy and music)
- and the experience of a community in exile (community meetings, advocacy work) which provides a transitional space on each young person's journey to involvement in the community of exile.

These vulnerable young people need significant mental health, developmental and casework involvement. The comprehensive model seeks to foster healing, resilience, and to empower young people to rebuild their lives. By providing a safe and nurturing environment, the Centre enables young refugees to overcome challenges and practical and personal barriers to their forward development and achieve long-term stability and integration.

In order to evaluate the impacts of the therapeutic interventions offered, the Baobab Centre for Young Survivors in Exile has been conducting monitoring and evaluation projects since 2013, adjusting the questionnaire each year based on previous recommendations and responding to clinical observations or need. Evaluations and monitoring efforts are key to improve service quality and impact and align services with client needs. They provide evidence which guide decision-making, support innovation, and build an evidence base for effective practices through outcome measuring and service user feedback (Gibbard et al., 2022). The present report details the findings of the monitoring and evaluation project conducted in 2023.

Aims

The evaluation sought to address the following aims:

1. Provide up-to-date information on service user's characteristics, mental health and psychosocial wellbeing
2. Assess service use
3. Identify areas of improvement based on service user feedback

Methods

Design and Procedure

The Baobab 2023 Monitoring and Evaluation questionnaire was administered in two parts. In the first section, participants were asked about their psychosocial wellbeing in the form of a structured interview by volunteers associated with the Baobab Centre. The second part of the questionnaire asked about service use and views of the service, collecting feedback, and was completed online. Interpreters were offered to support with translation for both parts of the questionnaire.

The questionnaire included both standardised psychometric measures and bespoke questions using Likert-scale responses, as well as open ended questions.

Participants and Recruitment

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. Service 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 using a non-probability sampling method. Eligible service users were reassured that participation was voluntary and would not affect the care they receive from the Baobab Centre. Written consent was obtained before service users participated in the questionnaire.

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, generalised anxiety, PTSD, psychological wellbeing, alcohol or substance use, affect regulation, resilience, belonging, and relationships. For further information on the measures used, please see Appendix 1.

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.

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. All involved held honorary contracts with the Baobab Centre and had received enhanced DBS checks, including volunteer interviewers and the author of this report. Interpreters had non-disclosure agreements in place.

Analysis

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.

Results

24 services users of the Baobab Centre completed the questionnaire between 23rd May to 15th November 2023.

Section 1. Participant background

Demographics

23 participants were male and 1 was female. Participants were 15-38 years old (m= 24.21, sd= 4.99). Participants reported 16 different countries of origin, with the largest group (n=6, 25%) coming from Afghanistan. By continent, the country of origin of 50% of the sample was in Asia (n=12) and 50% in Africa (n=12).

Education and livelihood

9 participants were in full-time education at the time of the evaluation and 5 were in part-time education. One participant was completing an apprenticeship, 10 were in college, 2 at university and 1 at a language school.

10 participants were not in education. 3 had reported they had completed their education, 4 were working, were looking for work or had no time due to other responsibilities, 1 applied but was waiting for feedback and 1 did not feel ready yet.

Participants' time in education ranged from less than one year of education in their lifetime to 22 years: 8 participants with under 4 years of education, 8 with between 5-12 years of education and 8 with 13-22 years of education.

Regarding employment, 6 were full-time students, 6 were employed part-time, 2 were employed full-time, 9 were unemployed and 1 was waiting to start employment. Reasons provided for unemployment included not being physically or mentally well or ready (e.g., illness, health conditions, anxiety), not having time or being in education, and not having the right to work in the UK.

Accommodation and homelessness

Most participants reported the council/social services/home office paying for their accommodation (n=13), one participant reported sometimes this was self-funded and sometimes by the council, whilst 3 others paid for this themselves or with financial support from friends/family. One participant was staying with family. 4 were using Universal credit to pay for their accommodation and for 1 participant it was paid for by their university. One participant reported 'Other'.

One participant was homeless at time of data collection and had been for 4 years since the age of 17. 14 participants had previously been homeless, ranging from 4 months to 8 years.

Section 2. Mental health and wellbeing

Depression

Many participants reported difficulties and symptoms consistent with depression within the previous two weeks when completing the PHQ-9. 8.33% (n=2) of participants

scored in the minimal depression range (scores between 1-4); 37.50% (n=9) scored in the mild depression range (scores between 5-9); 25% (n=6) scored in the moderate depression range (scores 10-14); 12.50% (n=3) scored in the moderately severe depression range (scores 15-19); and 16.67% (n=4) scored in the severe depression range (scores 20-27). Participants' mean depression score as measured by the PHQ-9 was 11.54 (SD=5.96).

Generalised anxiety

Many participants reported experiencing considerable symptoms of anxiety within the previous two weeks when completing the GAD-7. 8.33% (n=2) of participants scored in the minimal anxiety range (scores between 0-4); 29.17% (n=7) scored in the mild anxiety range (scores 5-9); 29.17% (n=7) in the moderate anxiety range (scores 10-14); and 33.33% (n=8) in the severe anxiety range (scores over 15). Participants' mean anxiety score as measured by the GAD-7 was 11.13 (SD=5.36).

Trauma responses

75% of participants (n=18) endorsed at least one of the two symptoms of affective dysregulation as measured by the ITQ and at least one of the two items describing relationship difficulties. 41.67% (n=10) endorsed at least one of the two symptoms of negative self-concept. For 66.67% of participants, at least one of these difficulties had a functional impairment on their relationships or social life, their work or ability to work, or other important parts of their life (e.g., parenting, school, activities). 29.17% of participants (n=7) endorsed at least one symptom of affective dysregulation, relationship difficulties and negative self-concept, as well as reporting a functional impairment on their day-to-day.

Emotion regulation

Mean scores for each ARC subscale were: 2.96 for affect dysregulation (SD = 1.00, range=1-4.5), 3.44 for reflection (SD = 0 .82, range=1.75-5) and 3.25 for suppression (SD = 0.86, range=2-5). Compared to self-report of a clinical sample of young people presenting with serious behavioural and social–emotional problems in Canada (N = 608; 56.6% female; age 7–19, Mage = 13.98, SD = 2.36; Goulter et al., 2023), participants on average reported less difficulties with affect regulation (M=3.04, SD=1.18, range=1.00-5.00), more difficulties with emotional suppression (M= 2.93, SD=.96, range=1.00-5.00) and greater reflection (M= 2.26, SD=1.03, range=1.00-5.00).

Psychosocial wellbeing

A minority reported being "moderately" or "severely" bothered by their own physical or verbal aggression (12.5%). Most shared that they keep their anger inside as opposed to expressing it.

"I feel ashamed if I get angry and shout at someone and feel regret."

"I only get aggressive to people who deserve it, so I don't feel bad about it. I also don't get angry quickly, so you really have to cross a few lines."

Participants were asked about what makes them feel angry. Responses included being lied to, being labelled, not feeling understood, remembering past experiences, their football team losing, feeling like they have been treated unfairly or used or bullied, when goals take too long to achieve, feeling helpless, or being interrupted.

"If someone lies to me it makes me angry. Last week, someone called me handicapped and that made me angry. I just ignore and I leave the person. I try to find another place to relax, have a seat and be calm."

When feeling angry, most spoke about isolating themselves, going somewhere calm to relax, talking to themselves, whilst others shared they might shout or argue, or feel the need to retaliate.

"When I cannot realize my goals quickly enough and it takes too long, or when I am feeling used or bullied - treated unfairly. If I'm angry with someone, I'll usually argue with them and it might escalate to a physical fight."

"What makes me feel angry.. […] When people don't understand what I say or what I meant. And they took it completely different, that makes me angry. Feeling misunderstood. I normally its a battle in my head, so I try to calm myself in my head. Speaking in my head. There is no outward reaction, it's mostly inside."

Five participants shared that nothing makes them angry whilst a few others shared lots of things make them angry, life generally.

"Sometimes without any reason I just get very angry, and I have to calm down..."

Participants were asked about what makes them feel sad, sharing that their families being harmed or unsafe, being bullied or feeling rejected, being betrayed or lied to, issues with the Home Office or council, concerns about the future and thinking about the past makes them feel sad. In response, many expressed that walking helps, as well as sleep, connecting with others, mindfulness, praying, exercise, or being alone. One participant spoke about watching TV, drinking alcohol, or take sleeping tablets.

"What makes me feel sad is past experience. When that happens, I go see friends, or go for a walk just to forget. But I don't speak to my friends about these memories."

Participants were also asked about what makes them feel anxious or scared. Participants spoke about feeling anxious or scared when they have responsibility and experienced pressure, when they remember things from their past, or compare themselves to others, worry about their health, if they are recognised by strangers, and when they concerns about work.

"Pressure (taking responsibility). When I'm feeling like this I stay at home and prefer not to speak to anyone."

"When I think about my mother I get really anxious and scared because she is back home and she is unwell. I try to talk to my mum and my sister when I'm feeling stressed about this."

When feeling anxious or scared, participants said they might go for a run, distract themselves by watching football or a program, avoid watching the news, stay home alone, not talk about it, speak to family or go out with friends, take a cold shower, and speak to their therapist.

"I think a lot, when I feel this things [anxiety or fear]. But then I take a shower and I feel better. But one week ago, when then things were going on with the home office my heart was beating really fast but when I take a shower I feel better. Cold

water showers help me come down. Before I used to break things, but now I have to pay for thing. I used to break things, but now I go into the shower. I go into the shower quick to come down before I break things."

Some shared that many things make them feel scared whilst one expressed nothing makes him feel scared. A few that they don't know what causes their anxiety.

"Many things make me feel scared. When I am scared I stay in my room on my own, I don't go out for a walk."

When participants were asked about what they do to make themselves feel positive, happy and hopeful, most shared many activities and factors that keep them happy, present in the moment and connected to others. For example, participants spoke of art and photography, singing and music, dancing, cooking, walking or exercising, playing football, studying, reading or watching movies, praying, going to school, going to the countryside and travel, talking to others or spending time by themselves. Some spoke of the outlook they try to hold, for example only controlling the things they can control and letting go of those they can't, being optimistic, not giving up and making themselves the priority.

"focus on things I can change, and try not to worry about things I cannot"

One explained that he struggles to be hopeful due to his health whilst another explained that he can't find happiness or hope at present.

"I have no interest whatsoever in anything - I keep setting goals and they have to be changed due to long COVID. Putting too much passion into things only leads to a greater feeling of loss when things fall through."

"Happy is finished. I want to be happy. […] but where is happy? I can't find it. I don't like fighting, i don't like being sad. When you find happy, you call me. […] Walks makes me happy but not like happy happy. It's not like house, money, wife, kids. My mind is just shut down right. But that is not happiness. Sometimes people smile but inside they are not happy. […] Same thing goes for hopeless, I have no hope. I have many questions for life, but no answers. When I came to this country, I was very down. [My therapist] helped a lot where I became a gentleman but now I am very sad and down again. There are many things in my life that are unanswered."

A quarter of the sample (25%) reported being "moderately" or "severely" bothered by strange or unusual thoughts in their head, e.g., hearing voices. Of those who provided more context to their response (16/24 participants), one shared he hasn't experienced this and four shared they have but in the past. Some spoke about hearing things or voices from the past, for example the voice of a brother who has passed away.

"hearing voices or noises from past, or see images Taliban-related"

"When I first came to UK, but not recently."

Six spoke of experiencing strange or unusual thoughts at night or when they are asleep, mostly describing nightmares but also hearing things that are not in the room.

"Only hearing things, especially at night that are not there in the room. Might have the feeling that someone is walking behind me when I am on the street or following me."

Some also reported finding it “moderately” or “severely” difficult to look after or take responsibility for themself (20.83%). Although most report few difficulties with looking after themselves or taking responsibility for themselves, a few spoke of limited mobility due to challenges walking or injuries or feeling very tired due to challenges with sleep and poor appetite, affecting their ability to care for themselves. A couple mentioned lack of work or financial challenges. Others spoke about having difficulties with everything.

> *“Anything - eating, stop drinking, anything!”*

Although many spoke about being independent, a couple described being *“lazy”* finding it difficult to find the motivation for example to cook, clean or exercise.

> *“Now yes, because my mind is not working and I am so lazy. I don't want to do anything. I have cleaned the house but my body doesn't want to do it. I touch the hoover but 10 minutes later I throw the hoover away. I find it boring. I am very down, I have no energy.”*

Alcohol or substance use

Most participants did not report using drugs, alcohol, or solvents (79.17%). Of the 5 participants who reported using drugs, alcohol, or solvents, 3 had been with the service for 7 or more years.

Many shared that they do not use drugs, alcohol, or solvents as it is against their religious or spiritual beliefs. A few shared they occasionally drink alcohol or smoke. One participant used to smoke cannabis. One participant reported liver poisoning due to alcohol use.

Resilience

Mean CD-RISC score was 23.33 (SD = 10.54, range: 2-40). Similarly to findings of the 2022 evaluation, 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).

Section 3. Relationships and belonging

Relationships

A quarter of the sample reported being “moderately” or “severely” bothered by bullying (25%). Experiences of being bullied varied, from feeling bullied by the home office, to being physically assaulted in the street. Some spoke about being bullied when they were younger, for example when they first came to the UK due to not being able to speak English well or else spoke about being bullied in the past *“back home”*.

> *“Racial bullying in my neighbourhood, one time in the bus, other time when kids are being let out of school. I am still frightened of these teenagers. Police did not believe him...”*

> *“I am not outside enough to be bullied.”*

Although a large minority reported being “moderately” or “severely” bothered by not having good friends (20.84%), 70.84% reported being “moderately” or “severely (strongly)”

supported by a good friend. Many spoke about having friends who they see and speak to frequently.

> *"I have a friend who always makes sure I am fine, he checks on me when I have problems, he does his very best to help me if he can. He is very nice to me. "Sometimes he visits me, sometimes I go to his place and spend two nights, and things like that."*

Some spoke about the social workers and therapists from Baobab and the interpreters they work with. Others spoke about friends who they share meals with and go out, have sleepovers, and can rely on to socialise or for support when in need. One shared that although he feels supported, he can find it hard to ask for help and is worried about becoming dependent.

> *"I've been supported by good friends so many times, when needing money for example, or giving me clothes, or driving me where I need to go. I feel like I can rely on them and they can rely on me."*

One participant pointed to the lack of support that is received when arriving in the UK, when support systems need to be developed, and they may not speak English.

> *"Lots of people don't know anyone here when they come, they don't know the language, they don't have support from the government - these people need a support."*

A few shared they do not feel like it is safe to have friends and don't trust people easily, with one specifying that he was betrayed by a friend in the past and therefore chooses to no longer have friends.

> *"Because I had a friend who I trusted, and they betrayed me. So I no longer have friends."*

Some shared they are not very bothered about not having many friends, one participant shared he does not have any friends and another explained that it is friends who cause him problems. Two spoke about talking to their clinician at Baobab, which helps them calm down or not feel alone.

> *"I have a friend and [my therapist]. So that is good. When I am angry, I go walk but if it doesn't work I go see [my therapist] and she helps me calm down. She is like my auntie."*

Others explained feeling let down by friends, or feeling disconnected from friends as they don't feel understood and feel more mature. One participant shared that he feels a key barrier to him developing friendships is his level of English.

A couple of participants (8.34%) reported being "moderately" or "severely" bothered by relationships with people where they live. One participant spoke about initially being bullied, but this stopped after he spoke with his neighbour. Another mentioned this as an issue in the past, but not currently an issue.

Most participants (75%) reported having someone they trust enough to talk to about their feelings. Mostly participants spoke about staff at the Baobab Centre and their therapist, with a few noting friends, girlfriends or family they also feel they can speak to.

"Baobab only because I trust them and they make me feel comfortable and something one of my friends"

"I dont have anyone else apart from my therapist that I talk to about my feelings, when I see my friends we just have fun."

Belonging

Similarly to the 2022 findings, 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): identification (M = 2.42, SD = 1.38 vs. M = 3.4, SD = 1.5), participation (M = 2.63, SD = 1.17 vs. M = 3.6, SD = 1.5), congruence (M = 2.67, SD = 1.05 vs. M = 3.4, SD = 1.5) and connectedness (M = 2.58, SD = 1.32 vs. M = 3.7, SD = 1.4).

Participants were asked about their experience and perceptions of a place called home. A few participants (12.50%) reported having no home, while 37.50% reported having one place they call home and 33.33% having several homes.

"I consider my country my home but I also consider the UK my home because I have freedom."

"I have two homes, one is my own home, the other is the Baobab centre."

Sense of belonging was complex, pointing to both present and past and to different sorts of communities. Initial results here indicate that more detailed probing should be conducted in separate studies on belonging.

Most participants reported feeling that they belong "to a place or group of people" (83.33%), with most also endorsing feeling they belong "to a community in the past or who has passed away" (83.33%). Just over a third of the sample (37.5%) reported feeling like they belong "to an ethnic or cultural community in the UK'. A large majority (95.83%) expressed feeling they belong and are part of the community at the Baobab Centre. 37.50% reported feeling the same around refugees in general compared to others, whereas 41.67% reported feeling better. Participants experiences of belonging are complex, speaking of safety and their sense of belonging depending on this.

"If I had a choice and my country was safe, I would have a greater sense of belonging in my country but given that my country is not safe, I feel like I belong here more."

"Now I feel I belong to my own immediate family first, and then Baobab at the second place."

Participants were asked about what makes them feel they belong. Some responses highlighted the importance of trust and honesty, feeling understood, and being treated with respect. Others spoke of "*songs*", being with friends and feeling safe and free. One participant shared "*My culture my skin colour*".

"Respect, honesty and no-judgement"

"People who understand my feeling and help me advise me"

Participants were also asked about what makes them feel that they don't belong. Whilst some did not know what to respond or stated "*Nothing*", others spoke of being around

negative people, feeling rejected or ignored, and feeling forced to do things that. One mentioned the culture and another mentioned their past.

"Being outcasted or isolated from plans or people that I expect to be with"

"When you don't receive the feeling of being welcomed and appreciated"

Discrimination

Many participants did not report receiving any negative remarks from others about their nationality, ethnicity, religion, skin or colour or status (66.67%), whereas 12.5% reported experiencing this 'quite often' or 'all the time'.

"People make fun about asylum status, generally"

"I had several instances, where I have been bullied and beaten up badly because of my skin colour and nationality."

Section 4. Service use and perceived impact

Service use

Participants had been in contact with Baobab for 1-15 years (m= 5.29, se= 0.81). 25% of the sample had been in contact with Baobab for 1-2 years (n=6), 37.5% (n=9) for 3-6 years and 37.5% (n=9) for 7 years or more.

75% (n=18) of participants reported attending the Centre weekly (n=10) or several times per week (n=8). The remaining 25% reported attending fortnightly (n=5) or monthly (n=1).

Areas of difficulty

Before attending the Baobab Centre, 83.33% of participants (n=20) reported they had difficulties in their life. Of those who endorsed having problems in their life, 79.17% (n=19) shared their difficulties were 'very strong'. Difficulties listed by participants included immigration and asylum challenges, poor mental health and relational challenges relating to trust or loneliness, homelessness and housing problems and challenges accessing benefits or education.

"At the time I was homeless, I was being helped by the Redcross right before coming to the Baobab. I was feeling very stressed and depressed."

"When I first came to the Baobab, I had problems in all aspects of life, including how to register for the GP, dentist, jobcentre for benefit, language barrier of communicating, and no social connection with any person, including Chinese people. Then I had no trust in anyone, I was very afraid and didn't know what Baobab's people were doing to me or for me."

At the time of the questionnaire, 66.67% (n=16) shared they still had difficulties in their life. These were as 'strong' or 'very strong' by 41.66% (n=10) of participants. These included challenges with housing, immigration, education, stress, finances, mental health challenges and emotion regulation, taking decisions, sleep and health.

"difficulties in my life. I can't control myself when I'm angry. Difficulties and thinking in my head always. I can't take a step forward. I feel disappointed. Health problems . I applied for a house but it was rejected. . Many difficulties"

"Taking decisions and planing ahead"

Areas of support

Most participants reported that the Baobab Centre helped them access asylum, education, health, housing, benefits, and social service support. Most also shared that Baobab provided them with specialist reports, for example to support their asylum claims or housing, benefits, or social service appeals.

"Baobab helped me with Asylum processes, education finances, and personal feelings."

"So far whatever I need help I've got it from Baobab."

Most participants also reported that the Baobab Centre had helped them with their feelings, memories, relationships, behaviour, understanding the past, understanding their strengths and vulnerabilities and getting used to life in the UK. Please see figures in Table 1 below.

A few participants spoke of how helpful they have found the support provided by the Baobab Centre and the impact it has had on their lives.

"I really appreciate to them for all received supporting. I feel my life getting better and following my future many many thanks to baobab and thanks who ever support us"

"If they hadnt helped me I would have considered suicide. If they did not help me, I would have gone crazy"

One participant explained that he did not receive the support he needed from the Baobab Centre, but did not elaborate on why or what support he would have benefitted from.

"they may have tried but it did not helped me."

Table 1. Participant reports of support received by the Baobab Centre across different domains.

Type of support	Area of support received	n	%
Practical support			
	Access asylum	18	75
	Access education	17	70.83
	Prepare specialist report for asylum claim	19	79.17
	Access health	18	75
	Access housing	17	70.83
	Access benefits	18	75
	Prepare specialist report to support housing/benefits/social services appeal	17	70.83
	Access social service support	13	54.17
Psychosocial			
	Feelings	21	87.5
	Memories	19	79.17
	Relationships	18	75
	Behaviour	19	79.17
	Understanding the past	19	79.17
	Understanding strengths and	18	75
	Adapting to the UK	16	66.67

Baobab services, activities and interventions

Participants engaged with a range of support and activities provided by the Centre, ranging from psychotherapy to casework support, activities and community meetings. Participants also shared coming to the Baobab Centre for their Summer BBQ, their Christmas party and their seaside trips. Please see below for further feedback on the primary types of support and activities provided by Baobab.

Psychotherapy

Individual psychotherapy

All participants accessed individual psychotherapy within the previous 12 months (n=24). Most attended this very regularly (79.17%, n=19), whilst 8.33% reported attending individual psychotherapy on occasion (n=2) and 12.50% just once (n=3). 83.33% (n=20) of participants reported individual psychotherapy to have been ‘very helpful’.

Group psychotherapy

Most participants also attended group psychotherapy within the last year (62.50%, n=15). 26.67% (n=4) reported this on occasion and the remaining 73.33% (n=11) reported attending group psychotherapy very regularly. Group psychotherapy was attended by

participants who had been in contact with the Centre for 1-2 years (n=5), 3-6 years (n=4) and 7 or more years (n=6). The vast majority of participants (86.67% ; n=13) reported group psychotherapy to have been ‘somewhat helpful’ or ‘very helpful’.

Case work

In the last year, 87.50% of participants reported using case work support at Baobab (n=21), for example for housing, benefits, healthcare or legal issues. 9.52% (n=2) attended this once, 42.86% (n=9) attended on occasions and (n=10) attended very regularly. Case work support was accessed by participants who had been in contact with the Baobab Centre for 1-2 years (n=6), 3-6 years (n=8) and 7 years or more (n=7). 80.95% (n=17) reported casework to be ‘very helpful’.

Activities

Most participants also attended activities at the Baobab Centre (62.50%, n=15), for example art, music, philosophy, film or sports. A quarter of the those who reported attending activities shared they attended very regularly (26.67%, n=4), whilst 66.67% (n=10) reported attending on occasions and 6.67% (n=1) reported attending once. More than half of participants (86.67% ; n=13) reported the activities they attended to have been ‘somewhat helpful’ or ‘very helpful’.

Teaching

37.50% of participants attended teaching at the Baobab Centre, either very regularly (77.78%, n=7) or on occasions (22.22%, n=2). Most participants who attended teaching had been with the service for 1-2 years (n=5) or 3-6 years (n=3). 1 participant who attended teaching had been in contact with Baobab for 7 or more years.

Retreats

Over the last year, retreats were attended by 45.83% of the sample (n=11). Of those who attended retreats in the previous years, 45.45% (n=5) attended three retreats, 36.36% (n=4) attended two retreats and 18.18% (n=2) attended one retreat. Retreats were more commonly used by participants who had been in the contact for 1-2 years (n=5) or 3-6 years (n=4), but continued to also be attended by some participants who had been in contact with the service for more than 7 years (n=2). 54.54% (n=6) of participants shared they found the retreats they attended ‘very helpful’ and the rest, 45.45% (n=5) shared these were ‘somewhat helpful’.

Community meetings

70.83% (n=17) of participants reported attending community meetings at the Baobab Centre in the last year, with most (58.82%, n=10) reporting attending on occasions, 11.76% (n=2) attending very regularly and 29.41% (n=5) attending once. 88.23% (n=15) of participants shared they have found community meetings ‘somewhat helpful’ or ‘very helpful’.

Dinners

Most participants attended dinners at the Baobab Centre in the last year (66.67%, n=16). Of those who attended dinners, 18.75% reported attending very regularly (n=3), 62.50% reported attending on occasion (n=10) and 18.75% reported attending once (n=3). Most participants (93.75% ; n=15) reported the dinners they attended to have been ‘somewhat helpful’ or ‘very helpful’.

Section 5. Views of the service and feedback

Participants described the various ways in which they perceive the Baobab Centre to have helped them. These included providing them with community, helping them with challenges with mental health and practical support, for example with immigration or education. Many participants did not specify but instead for example shared "*in everything*", "*to be a better man*", or "*saved my life*".

> *"I don't have words to describe it, I can't say one specific thing, they've helped me hugely to cope with my emotions."*

> *"Very good centre for refugee people or people with flashbacks, kind people work in the Baobab Centre"*

> *"Baobab has helped me to live well in the U.K., how to face my past, resolve my problems with my council tax, rent, electricity etc., register schools for English learning, and so on."*

> *"Through Sheila I have gotten psychological help, through social workers like Jodie and Mina, I have gotten other assistance with housing, benefits, doctors, and my status in the U.K."*

> *"Help me with my health, help me control myself Help me with the trauma in my brain. Help me at a very difficult time. They were my family when I had no one. Help me when I cannot solve my problems on my own, Help me when I had many difficulties in my life."*

When participants were asked about whether anything in their experience was unhelpful or unpleasant or made them feel uncomfortable, a large majority (n=19, 79.17%) said no. One participant spoke of the travel to the Centre being tired as they were living far. Two said yes but one did not remember the event and the other wished not to speak about it, and one participant said they did not know. The last participant who did not state 'no' to this question explained "*Not a lot, accessing education on time but I understand that's much more difficult then it seems*".

Participants were asked how the Baobab Centre could be more helpful. Most participants shared that they cannot think of ways which Baobab could offer more than they do.

> *"The activities currently offered are quite a lot and very helpful, so I can't think of anything else to add."*

> *"Baobab is all around and I can't think about anything that has to be covered"*

One participant mentioned requiring more help with housing problems. Another participant mentioned doing different activities so they change year on year, and a few mentioned having more activities and trips, such as a trip to Jamie's farm, or sports clubs like football or cricket. One participant shared "*So far so good, community meetings could be improved to be more engaging*".

> *"It would be great if there were more activities for all Baobab staff and members. which could help everyone have fun together."*

> *"Place for young to do activities spend time"*

Section 6. Hopes and wishes for the future

In the final part of the questionnaire, participants were asked about their hopes and wished for the future. Themes spoken of surround participants health, education and careers. Some spoke of travel and building or reuniting with families. Many spoke of wanting to be supportive and good to others, for example speaking of becoming a nurse or helping orphans or people who are homeless or refugees.

> *My hope and wish is to help change as many lives as I possibly can*
>
> *Getting my family to join me here in the UK. Running my own business and help other people. Having my own foundation to help orphans and children & single moms.*
>
> *1. I always have job, and that I earn a lot of money. 2. I hope that I can start my own family, and produce offspring. 3. I wish I could earn a lot of money to help people with background like myself.*

Discussion

The findings underscore significant mental health challenges within the sample, particularly high levels of anxiety and depression, and difficulties with emotion regulation. More than half of participants reported moderate to severe symptoms of both depression and anxiety, which highlights widespread psychological distress and is higher than prevalence figures among forcibly displaced groups in systematic reviews (Blackmore, Boyle, et al., 2020; Blackmore, Gray, et al., 2020; Patanè et al., 2022).

Trauma-related symptoms were also common, with a third of the sample endorsing symptoms across all three diagnostic areas of complex PTSD. However, as the study did not employ the full ITQ (Hyland et al., 2017), these findings should be interpreted with caution and cannot diagnostically infer difficulties with PTSD or complex PTSD.

Participants exhibited less difficulties with affect regulation compared to a clinical sample of young people presenting with serious behavioural and social–emotional problems in Canada (Goulter et al., 2023). In contrast, participants reported more emotional suppression than this clinical sample (Goulter et al., 2023), potentially associated with responses to trauma (Chung et al., 2018), which is concerning given the possible mediating role of emotional suppression in the relationship between adverse child experiences and suicidal ideation (Kaplow et al., 2014).

Notably, a quarter of participants reported experiencing unusual thoughts or auditory perceptions, such as hearing voices. For many, these experiences were linked to deceased significant figures, hypervigilance, or a persistent sense of being watched or followed. This rate is higher than in other studies among forcibly displaced groups (Blackmore, Boyle, et al., 2020; Blackmore, Gray, et al., 2020; Patanè et al., 2022), which may warrant further investigation.

Resilience scores were lower in the present sample than those recorded in a clinical sample of refugee torture survivors in the US (Walker, 2022), which may speak to the documented amplified mental health and resource challenges and trauma experiences faced by children and young people who seek asylum and refuge unaccompanied by parents or guardians (Bean et al., 2007; Fazel et al., 2015; Höhne et al., 2023; Von Werthern et al., 2019). Coping strategies varied; while some participants sought connection, others engaged in distraction or avoidance, a pattern consistent with broader research among unaccompanied refugee minors (Behrendt et al., 2023; McGregor et al., 2015; Nasir, 2012).

The findings highlight significant relational challenges and social isolation faced by participants, particularly difficulties in trusting others and forming friendships. Some reported difficulties in building meaningful relationships, expressing that previous experiences of betrayal and not feeling understood taught them to keep their distance from others. Feelings of unfair treatment were common, further exacerbating emotional distress and reinforcing difficulties in social engagement. Experiences of bullying were prevalent, with approximately one in four reporting no close friendships and one in ten frequently experiencing discrimination or negative remarks. The difficulty of not having close friends and not wanting or feeling able to develop friendships likely has an impact on mood and ways of coping. Language barriers, particularly difficulties with English, was highlighted as an obstacle to social integration, making it harder for participants to form friendships and increasing their vulnerability to bullying and social exclusion.

Beyond relational struggles, independent living posed significant challenges. It is possible, and likely, that this is a result of having limited opportunities to develop key life skills due to disrupted childhoods, preoccupation with real threat to life or trauma and a lack of guidance or scaffolding. One participant highlighted the particular vulnerability upon arrival in the UK, facing isolation and language barriers at a time when social support was most crucial. There is a critical need for services to prioritise social integration, trust-building, and tailored support, ensuring that unaccompanied refugee minors not only develop practical skills but also foster a sense of belonging and emotional security.

The findings also reveal that homelessness is a significant issue, with more than half of the sample having experienced homelessness at one point. This is a newly identified challenge in the monitoring and evaluation survey, highlighting an additional layer of instability and marginalisation faced by unaccompanied refugee young people attending the Baobab Centre. Research indicates that experiences of homelessness can significantly exacerbate poor mental and physical health, disrupt social integration, increase experiences of stigma and discrimination, and hinder access to essential resources and support systems (Bower et al., 2018; Collins & Barker, 2009; Mejia-Lancheros et al., 2021; Smith et al., 2019). Previous research has identified that risk of homelessness is high for newly-recognised refugees in the UK (Mitton, 2021), with findings highlighting refugee and asylum policy to directly contribute to homelessness. This finding underscores the urgent need for targeted interventions addressing housing stability at a governmental and policy level, alongside provisions of social and emotional support.

The support, activities and interventions provided by the Baobab Centre were well and frequently utilised by participants, particularly individual psychotherapy which was attended by all participants. There was continued uptake for all activities among participants who had been in contact with the service for over seven years, which may demonstrate the complex and enduring challenges that young people may continue to experience. It would be interesting to explore the needs and experiences of this cohort further to ensure they are able to access support that is tailored to their individual needs. Teaching was attended by approximately a third of the sample, with greater uptake who had been in contact with the Baobab Centre for less time. Of those who used different aspects of the services, most engaged with these very regularly. Positive feedback was provided for each type of support or intervention; more than half of participants reported each service activity to be ‘somewhat or very helpful’.

The proportion of participants reporting difficulties in their lives was lower at time of data collection compared to when they first came into contact with Baobab, however it is important to note that more than half of participants still reported difficulties. Examples of difficulties provided were varied, encompassing different aspects of participants lives, from poor psychosocial wellbeing and mental health to physical health or sleep difficulties, problems with housing or seeking asylum, and challenges with education or finances. The Baobab Centre is reported to have helped with many aspects of participants lives, offering practical support, as well as psychological and relational support. Most participants spoke very positively of the service and the support offered, with a few sharing that there is nothing the Baobab Centre could do to improve and describing the impact of the service to be lifechanging. A minority provided constructive feedback for the service, such as offering more support for housing problems, varying or rotating a range of activities, increasing the

number of activities and trips, and setting up sports clubs or other ways that the space could be used by the Baobab community.

There was good uptake of community-driven and creative activities, with participants taking part in community meetings, trips and art or music, beyond seeking help for asylum and engaging in 'traditional/Western' conceptualisations and models of therapy. This suggests the community psychology model adopted and promoted by the Baobab Centre, which offers holistic support aimed at building resilience and connection, is well implemented. Whilst the Baobab Centre works with a relatively small caseload of unaccompanied refugee minors (relative to the increasing numbers of asylum applications (Home Office, 2023)), those who attend and use the service do so regularly and appear to build lasting, trusting, and meaningful relationships. The feedback participants have provided largely describes and showcases the comprehensive impact of Baobab Centre on the participants lives. This reaches further than accessing asylum and receiving mental health support, with the Baobab Centre facilitating access to both housing and education and ultimately promoting sense of community and community integration, as illustrated by participants describing Baobab as "home" or "family".

Strengths and limitations

The evaluation has considerable strengths. It provides the service with regular constructive feedback that can help improve the service. Additionally, it enhances understanding of participant characteristics and needs, offering valuable insights for service development. It gathers data from a broad sample of service users in terms of length of contact with the service, offering insight into the experiences of unaccompanied asylum-seeking minors who may have already obtained asylum. Finally, it is conducted by independent interviewers which might reduce social desirability bias and uses interpreter support where needed to promote participation.

The evaluation also has a number of limitations. Importantly, the evaluation recruited a small number of participants therefore findings must be interpreted with some caution. The sample size and sample characteristics limit subgroup analyses. For example, the sample is relatively homogenous in regard to gender, recruiting predominantly male participants. This limits the understanding of the needs and experiences of participants of other genders and precludes subgroup analysis according to gender. In addition, the full ITQ measure was not used, making participant responses challenging to score and interpret.

Recommendations

Recommendations for future service development

A number of recommendations are made for the service to consider in their service delivery and design:

1. It is recommended that the service continue to adopt a resilience building community model, which is well utilised and appears to foster sense of belonging. With recognition that this may be out of scope, the service could consider training or mentoring interested ex-service users or service users to support others, leaning into a peer support model where safe and appropriate. It might be that this is focussed on encouraging engagement with the service or else on confidence/trust building once service users have received initial support.

2. On the back of service user feedback, it is recommended that the Baobab Centre consider (where feasible) to vary their activities or trips year on year. It is also recommended the Baobab Centre encourage the creation of other community activity groups, perhaps led by service users for service users, around special interests, such as football or cricket.
3. Given the challenges participants speak of in looking after themselves with everyday living tasks, it is recommended that the service consider groups or workshops targeting independent living skills, such as budgeting or cooking. This might involve partnering with other services or signposting to services which exist and have these offers.
4. Participants spoke to a variety of difficulties, for example with sleep, chronic pain or with trusting others. Therapeutic models that might be helpful to draw from are Acceptance and Commitment Therapy and Compassion Focussed Therapy, to promote reappraisals and reduce feelings of shame. The service might consider facilitating workshops on different topic areas, reaching more service users and reducing feelings of isolation and normalising difficulties experienced. These might focus on symptom management or psychoeducation in the first instance, for example for sleep challenges or pain. Recommendation 3 and 4 may alternatively take the form of self-directed resources. It is important these are available in languages other than English.

Recommendations for future evaluations and research

Recommendations are also made for the service to consider for future monitoring and evaluation efforts:

1. It is recommended that the service recruit a larger sample, although this is a recognised difficulty in this area given the specific nature of the sample and other barriers to participation such as epistemic mistrust or mental health difficulties. Furthermore, whist taking into account the challenges of recruitment and that the majority of URMs are male, the understanding of the experiences and characteristics of participants of other genders is lacking due to small numbers. It is not known whether there are gender differences. It is recommended the service increase efforts to recruit service users of other genders where possible.
2. Following from this, it would be helpful for future reports to include other service-held data, which allows for contextualisation and triangulation of findings. For example, reports could include the total number of young people in contact with the Baobab Centre and how many were new to the service within that year. Other data could also be included, for example participants' asylum status, which might enable further subgroup analysis.
3. In regard to the measures which the service employs in the evaluation and monitoring survey, it is recommended that the service use a complete trauma scale administered by clinicians. The service might consider using the HTQ-5 (Berthold et al., 2019), which although does not differentiate between PTSD and CPTSD, was specifically developed as a cross-cultural screening measure for refugee populations.
4. It is also recommended the service employs a more commonly used measure of emotion regulation (e.g., Difficulties in Emotion Regulation Scale, Gratz & Roemer, 2004; Emotion Regulation Questionnaire, Gross & John, 2003). Whilst this would mean losing longitudinal data attached to using the measure, it would increase comparability with other groups.
5. It is recommended the survey employs a more systemic measure of resilience, such as the ARM or CYRM (Clark et al., 2022; Jefferies et al., 2019). This aligns more with the service's community and systemic ethos.

6. Since a quarter of participants reported experiencing unusual thoughts or auditory perceptions, such as hearing voices, it might be useful for future monitoring and evaluation efforts to consider employing a validated measure to better understand these experiences.
7. A subsample of participants with the service for more than 7 years continued to report difficulties with their mental health. The service might consider developing a research project, most likely qualitative, which explores the challenges experienced by this cohort more deeply.
8. It is recommended that, where possible, longitudinal data is examined to better understand trends over time. This may be challenging given small samples and would therefore likely be descriptive rather than measuring significant change.
9. Overall, it is suggested to further reduce the questionnaire to minimise repetition and burden for the participant and to keep the survey focused, aligning with ethical standards in data collection. This might also aid with recruitment. For example, some sections are only able to be ‘surface level’ due to the breadth of the questionnaire, such as the section exploring belonging. More focussed projects on these areas would yield more in-depth findings.

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Appendix 1 – detailed information on measures used

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 ( ).

Psychological wellbeing. The questionnaire 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. Participants were also asked about how they respond to different emotions. 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 and 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).

Trauma history and Post-Traumatic Stress Disorder (PTSD). The International Trauma Questionnaire (ITQ; Cloitre et al., 2018; Hyland et al., 2017) is a self-report measure of PTSD and CPTSD and was used to measure complex trauma. The measure has been validated (Cloitre et al., 2018) with good internal consistency and factorial and construct validity (Haselgruber et al., 2020; Hyland et al., 2017). The 7 items of the Complex PTSD scale were included in the questionnaire, measuring disorganised sense of self. This subscale measures symptoms of affective dysregulation, negative self-concept and disturbances in relationships.